Muckamore Abbey Hospital Inquiry

Module 3 – Policy and Procedure

MODULE 3 ADDENDUM WITNESS STATEMENT
ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, Chris Hagan, of the Belfast Health and Social Care Trust (the "Belfast Trust"), make the following addendum statement for the purposes of the Muckamore Abbey Hospital Inquiry (the "MAH Inquiry"):

1. This addendum statement is made on behalf of the Belfast Trust in response to a request for evidence from the MAH Inquiry Panel dated 9 December 2022.

2. This is my second witness statement to the MAH Inquiry. My first witness statement dated 20 March 2023 addressed MAHI Module 3 relating to various policies and procedures. In my first statement I explained that there had been a limit as to what material it had been possible to retrieve in the time available. I also stated that the Belfast Trust would continue to endeavour to identify relevant material that bore on the various topics raised in the Module 3 witness statement request, and, should such material be identified, the Belfast Trust would ensure it was brought to the attention of the MAH Inquiry.

3. The purpose of this second statement is to provide and explain such further material that colleagues at the Belfast Trust have identified since I made my first witness statement dated 20 March 2023. In particular, I address material relevant to the following topics of my first witness statement:

a. Topic 1 – Policies for delivering health and social care to learning disability patients 1999 to 2021 (dealt with between paragraphs 16 to 18 of my first statement between internal pages 8 and 14);

b. Topic 3 – Policies regarding restraint/seclusion (dealt with between paragraphs 32 to 47 of my first statement between internal pages 18 and 27);

c. Other – Management of violence and aggression policies/ training (dealt with between paragraphs 48 to 63 of my first statement between internal pages 27 and 32); and

d. Topic 7 – an additional connected sub-topic of policies and procedures in relation to the AHP discipline of podiatry (topic 7 is dealt with between paragraphs 106 to 191 of my first statement between internal pages 54 and 83).

4. As I explained in my first witness statement, it is not possible for any one person in the Belfast Trust to address the matters the MAH Inquiry has asked the Belfast Trust to address in Module 3. Accordingly, while I am the witness statement maker on behalf of the Belfast Trust for the purposes of the MAH Inquiry Module 3 hearings, I make this further statement having had the assistance of the following individuals:

a. Estella Dorrian, Senior Planning and Equality Manager, Belfast Trust;

b. Caroline Parkes, Senior Manager, Occupational Health, Belfast Trust;

c. Neil Walsh, Safety Intervention Trust Advisor/Trainer, Safety Intervention Team, Belfast Trust;

d. Samuel Warren, Safety Intervention Trust Advisor/Trainer, Safety Intervention Team, Belfast Trust;

e. Wendy McLaughlin, Interim Head of Podiatry Services, Belfast Trust; and

f. Aidan McAlinden, AHP Business & Information Manager, Belfast Trust.

5. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "CH2".

Topic 1 – Policies for delivering health and social care to learning disability patients 1999 to 2021

6. In paragraph 17bbb. of my first witness statement, I referred to, and provided a copy of, the draft 2021 Department of Health ("DoH") "*We Matter: Learning Disability Service Model For Northern Ireland*" ("We Matter").

7. Although the DoH has not yet published a final version of "We Matter", this document is an important framework for the delivery of services for people with learning disabilities in Northern Ireland. The draft policy is a significant piece of work which has been contributed to by a wide range of stakeholders. To assist the MAH Inquiry in the context of Topic 1 of my first witness statement (which deals with the policies for delivering health and social care to learning disability patients), I consider that it may be helpful to the MAH Inquiry if I were to provide some further details as to the nature and extent of this work.

8. In providing the information below, I have drawn on the assistance of Estella Dorrian, Senior Planning and Equality Manager within the Belfast Trust. As I explain further below, Ms Dorrian was the Belfast Trust Project Lead for the Regional Adult Learning Disability Service Model Project from October 2019 – March 2020. This is the project that led to the draft "We Matter" policy.

9. Work began in late 2018, led by the Health and Social Care Board (the "HSCB") (now the "SPPG"). A copy of the January 2019 HSCB Regional Adult Learning

Disability Service Model Project Initiation Document is provided behind Tab 1 of the CH2 exhibit bundle to this witness statement.

10. As stated within the 2019 HSCB Regional Adult Learning Disability Service Model Project Initiation Document, the overarching aim of the regional project was to stabilise and secure, and thereby to improve, the long-term provision of Adult Learning Disability Services for the population in Northern Ireland. This was to be achieved through the design of a new outcomes based, regionally consistent, service model that:

    a. Reflected the needs and expectations of individuals and families;

    b. Reduced the reliance on hospital services and developed person centred individualised, inclusive models of community care that promote equality of access; and

    c. Provided a strategic response to the significant challenges currently facing the Adult Learning Disability programme of care, including:

        i. The complexity of need;

        ii. Transitions from children's services;

        iii. The growing number of delayed discharges from hospital;

        iv. Appropriate accommodation;

        v. The provision of short breaks; and

        vi. Support for older carers.

11. The new regional service model was intended to be informed by, and to draw upon, a number of the key policy and strategic developments relating to the delivery of services for adults with a learning disability which I identified at paragraph 17 of my first witness statement. For the purposes of this project, the key Northern Ireland specific considerations, recommendations and objectives derived from:

    a. The Bamford Review of Mental Health and Learning Disability publications and the associated DHSSPS Action Plan (2012-2015). The significance, and specific contributions from the Bamford Review, and the "actions" set out in the implementation plans have been addressed in detail as part of the Belfast Trust's response to the MAH Inquiry's Evidence Module 1;

    b. November 2011 DHSSPS "*Quality 2020. A 10-year strategy to protect and improve quality in health and social care in Northern Ireland*". This strategy identified three core themes: safety; effectiveness; and patient and client focus;

    c. December 2011 DHSSPS "*Transforming Your Care: A Review of Health and Social Care in Northern Ireland*". In addition to specific principles and recommendations for change, this document included a model for future service delivery entitled "*Future Model for Integrated Health and Social Care*". It also highlighted the need for a new service framework setting out standards of care for those with learning disability (resulting in the revised DoH publication addressed at paragraph 12 below);

    d. 2014 DHSSPS "*Making Life Better: A Whole System Strategic Framework for Public Health 2013-2023*". This framework set out a vision for a whole system approach to increasing personal control, improving health and wellbeing, reducing health inequalities across the population. A copy is provided behind Tab 1 of the CH2 exhibit bundle to this witness statement;

e. October 2016 RQIA "*Review of Adult Learning Disability Community Services (Phase II)*". In his evidence to the MAH Inquiry in March 2023, Professor McConkey referred to his involvement with this report on community services in the five HSC Trust areas. For completeness, a copy is provided behind Tab 1 of the CH2 exhibit bundle to this witness statement;

f. October 2016 DoH "*Systems not Structures – Changing Health and Social Care" (known as the Bengoa Report)*. Guided by "*The Triple Aim*" to improve the patient experience of care (including quality and satisfaction), to improve the health of populations and to achieve better value by reducing the per capita cost of health care, the Bengoa Report provided a "*Transformation Model*" which may be used in the development of the new adult learning disability service model;

g. October 2016 DoH "*Health and Wellbeing 2026: Delivering Together*". This is the policy response to the Bengoa Report, which contained recommendations for transformation and actions to be taken forward; and

h. 2017 Northern Ireland Executive "*Draft Programme for Government (2016-2020)*". This document outlined a vision for improved quality of life and 14 population-level outcomes that the Northern Ireland Executive aimed to deliver and the key indicators that would be monitored to evaluate progress against each one.

12. At paragraph 17cc. of my first witness statement, I also highlighted the DHSSPS "*Service Framework for Learning Disability*" first published in 2012 and revised in January 2015. It identified 34 standards which service users and their carers were entitled to expect, organised into nine broad themes and with associated Key Performance Indicators (KPIs) identified for each area of work.

13. It is the case that there are important differences which exist between Northern Ireland and each of the other UK jurisdictions in terms of health and social care. For example, issues of scale, and the use of an integrated Health and Social Care model in Northern Ireland. Nonetheless, the new Northern Ireland model has also been developed in the context of, and with the benefit of learning from, the regional learning disability service models already in operation in each of England, Scotland and Wales.

14. The HSCB regional project involved the establishment of a regional reporting structure. This involved the formation of the following groups:

    a. Project Board;

    b. Project Steering Group;

    c. Regional Service User Reference Group;

    d. Expert Panel for review of Assessment and Treatment; and

    e. Project Implementation Team comprising a Project Manager and a Project Lead from each of the five HSC Trusts.

15. The respective roles and responsibilities of each group are detailed at Annex 2 of the Project Initiation document. As referred to above, the Belfast Trust Project Lead from October 2019 to March 2020 was Ms Dorrian, who took over the role from Ms Rhona Brennan.

16. The Project Board reported to the Transformation Implementation Group via the Mental Health and Learning Disability Improvement Board (and, if required, to the Minister and Health Committee).

17. I am informed by Ms Dorrian that for a number of months, until September 2019, there was an extensive engagement and consultation process with service users, families, carers and other key stakeholders across Northern Ireland in order to obtain a firm understanding of their lived experiences and to seek their views as to which services should continue, which services should cease and which new services should be considered for introduction. This process spanned some 190 public engagements, three online surveys, individual and group meetings with staff, carers and representatives from professional organisations and the community and voluntary sector. There were also three regional workshops with local provider organisations.

18. The various Trust Project Leads worked closely to process and analyse the feedback received from the engagement (in total, 3,654 responses) and to develop and structure a number of new and innovative evidence-based priorities for the new model. These included, for example, the creation of a Learning Disability Champion, a Learning Disability People's Parliament, a Learning Disability Observatory and other aspects derived from the engagement and/or leading research, such as the lifetime cycle of care and issues around accommodation provision. Monthly meetings also took place with the HSCB Project Manager, then Heather McFarlane (to whom I referred in paragraph 141 on internal page 67 of my first witness statement in relation to occupational therapy). In this 2019 period, the HSCB Social Care Lead was Martina McCafferty. As part of this process, the Project Leads also developed a mock-up model entitled "*An Equal Life*". Although approved by regional co-directors, this was not favoured by the HSCB.

19. Despite the development of a number of draft models as a result of this work and feedback, unfortunately no version of the new Regional Adult Learning Disability Service Model could ultimately be agreed between the HSCB and the Trust Project Leads.

20. This was an ambitious project given its short timeframe and its non-recurrent funding source (namely, the confidence and supply funds). There was significant

concern that the models produced did not adequately reflect the valuable feedback from engagement. In particular, it is important to state that the proposed models concerned adult services only and excluded acute services/assessment and treatment. My colleagues do not know why that was the case. An Independent Review of Acute Level Care in Learning Disability was commissioned in parallel to the project and was led by Lorna Conn at the HSCB. These may be aspects which the MAH Inquiry wishes to explore in due course.

21. I am aware that a final draft of the "*We Matter*" Learning Disability Service Model for Northern Ireland was formally presented by the HSCB to the DoH in October 2021.

22. A costed implementation plan for the new model was stated to be a key deliverable which would sit alongside the new model. This aspect was separately led by the Strategic Investment Board, specifically, Ms Sarah Wylie, a System Dynamic Lead. The Belfast Trust Project Lead was not involved in this aspect, other than in providing relevant data requested by Ms Wylie. The Belfast Trust has not seen a copy of any accompanying costed implementation plan which may have been developed.

Topic 3 – Policies regarding restraint/seclusion

23. In paragraphs 41 to 43 of my first witness statement, I referred to a 2021 consultation run by the DoH in relation to a new draft regional policy entitled "*Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion*".

24. At paragraph 42 of my first witness statement, I stated that the final regional policy had not yet been published. I made that statement on 20 March 2023. Incidentally, later that same day, the DoH published the regional policy in final form. A copy of the March 2023 DoH policy, which is entitled "*Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure*

for the use of Seclusion" is now provided behind Tab 2 of the CH2 exhibit bundle to this witness statement.

25. The DoH also published on its website a "*Consultation Analysis Report*", which summarises the findings from the consultation to which I have referred, together with a number of (redacted) consultation response documents. For ease of reference, a copy of the Report is provided behind Tab 2 of the CH2 exhibit bundle to this witness statement.

26. The new March 2023 regional policy on restrictive practices and seclusion (following the DoH commitment as part of the May 2020 Mental Health Action Plan) is the first departmental and regional contribution to this area in many years.

27. At paragraph 38 of my first witness statement, I referred to the August 2005 Human Rights Working Group on Restraint and Seclusion commissioned by the DHSSPS and the resulting "*Guidance on Restraint and Seclusion in Health and Personal Social Services*". Until March 2023, this 2005 publication had been the last specific regional document on the subject. Inevitably there has been significant learning and development in relation to restrictive practices since 2005, both as to their use within health and social care settings generally, and within learning disability services specifically.

28. At paragraph 38 of my first witness statement, I sought to identify the key sources of post 2005 learning at a national and regional level. As addressed at paragraphs 39 and 44 of my first witness statement, there have been four iterations of the Belfast Trust's Restrictive Practices policy (SG 15/09) during that period.

29. I do not seek to repeat or comprehensively summarise the contents of the new regional policy. It is necessarily detailed in nature and must be read in full. However, in broad summary only, it seeks to set the standards required for minimising the use of restrictive interventions, in particular, restraint and seclusion, and for the decision making, reporting and governance arrangements

when any restrictive practices are used. The new regional policy recognises that the use of restrictive practices may, on occasion, be necessary, for example, as one element of managing a high-risk situation. It states that the standards are underpinned by the principles of early intervention, least restriction possible and last resort. For ease of reference, the seven Standards it identifies are as follows:

a. Standard 1 - All organisations must use the standard definitions to identify all interventions which are potentially restrictive;

b. Standard 2 – All local policies and practices must embed use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions;

c. Standard 3 – Effective and person-centred communication must be central to care and treatment planning;

d. Standard 4 – Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans;

e. Standard 5 – Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content;

f. Standard 6 - Roles and responsibilities are defined in terms of monitoring, reporting and governance; and

g. Standard 7 – that any use of seclusion as a last resort intervention must follow the regional operating procedures.

30. Through the above Standards, the new regional policy seeks to ensure the development of a standardised, regional approach to recognition, implementation, recording, monitoring, learning and quality improvement.

31. In addition to the May 2015 NICE Guideline 10, the regional document which appears to be given most prominence in, and to have had the greatest influence on, the new regional policy is the 2017 publication identified at paragraph 38hh. of my first witness statement, entitled "*Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions*".

32. Although often credited to the Royal College of Nursing, this publication was a collaborative Royal College framework designed and endorsed by the Royal College of Nursing, Royal College of Psychiatrists, the British Association of Social Workers and the Royal College of Occupational Therapists.

33. The "*Three Steps to Positive Practice"* Framework is intended to encourage close and careful consideration and reflection as to the use of any potentially restrictive practice. This is by means of the "three steps", before the restrictive practice is implemented and throughout the entire timeline when the restrictive practice may be used. This includes through assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment. In summary only, the three steps, each of which pose a series of questions to guide decision-making, are: consider the plan; implement the safeguards; and review and reflect. The new DoH regional policy states that the routine use of the *Three Steps to Positive Practice* Framework will ensure adherence to rights-based and evidence-based positive and preventative approaches and the minimisation of restrictive interventions by ensuring that any use is the least restrictive, most therapeutic available to meet a person's needs.

34. I wish to briefly address a particular aspect of the new policy which I referred to at paragraph 43 of my first witness statement – namely, the development of standard definitions to identify all interventions which are potentially restrictive.

35. The new regional policy adopts the overarching definition for restrictive practices previously shared with HSC Trusts for consideration in February 2021: "*Restrictive practices are those that limit a person's movement, day to day activity or function*". The term encompasses the broad range of interventions that are considered restrictive and each broad sub-category of restrictive intervention. Restraint is thereafter defined and addressed, as is seclusion. The development of these definitions for adoption by all organisations is intended to assist staff in understanding and therefore identifying those practices which are potentially restrictive and to which the policy applies.

36. At paragraph 44 of my first witness statement, I referred to the latest version of the Belfast Trust's local restrictive practices policy (SG 15/09), which became operational in February 2022. In the period during which the Belfast Trust policy was being reviewed and updated, the DoH shared the February 2021 draft definitions (a copy of which I provided behind Tab 4 of the exhibit bundle to my first witness statement). Accordingly, although the previous and working draft versions of the Belfast Trust policy similarly included definitions as to the different forms of restrictive practices which reflected prevailing national guidance (from BILD and the Department of Health England), as a result of the DoH's indication as to the direction of travel in the new regional Northern Ireland policy being developed, the Belfast Trust Policy Committee requested that the authors of the updated Belfast Trust policy use the proposed DoH definitions. This explains why the definitions at section 2.1 of the February 2022 Belfast Trust are in materially similar terms to those on page 9 of the new regional policy. The two sets of definitions are however not identical because the DoH has revised certain aspects of the draft definitions circulated for comment in February 2021.

37. In anticipation of the publication by the DoH of the new regional policy, the authors of the updated Belfast Trust policy included a one-year review date of February 2023. Now that the new policy has been issued, the Belfast Trust will reconvene a Task and Finish Group (with representation from relevant key areas

across the Belfast Trust, including mental health, adult and older people and children's services) to discuss and operationalise the new regional policy in a way that is most accessible to the Belfast Trust staff to whom it will apply. The group is scheduled to meet in April 2023 and will be chaired by Sam Warren, Advisor/Trainer on Management of Aggression within the Belfast Trust Safety Intervention Team based at Knockbracken, and one of the authors of the 2022 Belfast Trust policy.

38. Although after the primary date range of the Terms of Reference of the MAH Inquiry, for completeness, I should add that the Belfast Trust has since updated the seclusion procedure to which I referred at paragraph 39(g) of my first witness statement. Version 2 of this policy, now entitled Belfast Trust "*Policy and Procedure for Use of Seclusion in Adult Learning Disability Inpatient Services*" (BHSCT/ASPC/LD (01) 2021) became operational in August 2021. A copy is provided behind Tab 2 of the CH2 exhibit bundle to this witness statement. This policy will also require review and revision in light of the new regional policy and operational procedure for the use of seclusion in the way that I have described.

Other – Management of violence and aggression policies/ training

39. In paragraphs 48 to 61 of my first witness statement, I explained the roles of two specialist teams which manage restrictive practices training within the Belfast Trust.

40. In paragraph 46 of my first witness statement, I stated that detail of training relating to the use of restraint and seclusion (two forms of restrictive practices) would also be addressed as part of the Belfast Trust's Module 4 response.

41. Further to the above, I now provide further detail as to how the training which I addressed in my first witness statement has been developed and delivered for and by the two teams. I also provide examples of certain training-related material to

which I referred my first witness statement. I repeat again that I am not an expert in the management of violence and aggression, or the training in relation to it. Therefore, in order to provide the detail below, I have drawn on the considerable assistance and expertise of:

a. Caroline Parkes, Senior Manager, Occupational Health, Belfast Trust (referred to in my first witness statement);

b. Neil Walsh, Safety Intervention Trust Advisor/Trainer, Safety Intervention Team, Belfast Trust; and

c. Samuel Warren, Safety Intervention Trust Advisor/Trainer, Safety Intervention Team, Belfast Trust (currently on secondment as a Senior Nurse Manager at Muckamore Abbey Hospital).

42. At paragraph 56 of my first witness statement, I explained that all training in the use of restrictive practices within the Belfast Trust must accredited. By that I mean all training in the management of actual and potential aggression and in the use of physical interventions: this is required by the Belfast Trust Restrictive Practices policy. I also outlined that the accredited training programmes used by the Belfast Trust are those offered by the Crisis Prevention Institute ("CPI"). The CPI training model was, until more recently, known as the *Management of Actual or Potential Aggression* (or *MAPA*®) training. It is now divided into, and known as, *Verbal Intervention*™ and *Safety Intervention*™ training.

43. In its letter dated 9 December 2022, the MAH Inquiry asked the Belfast Trust to address staff training in relation to a number of specific areas, including as to "*use of restraint, use of seclusion, use of medication… communication strategies for persons with learning disabilities, positive behavioural support… and challenging behaviour*". Although, for clarity, the Belfast Trust has sought to address these areas separately, it is important to recognise that there is a degree of overlap between them, and specific training programmes should not be considered in isolation.

44. In that regard, I wish to clarify and to explain the nature of the CPI training model. Importantly, both *MAPA*® and the new SI model include, but are not limited to, training in physical intervention skills. In broad terms, they are training in the safe management of behaviours that challenge and/or risk behaviours. Training in the use of restrictive physical interventions is part of that. However, consistent with Belfast Trust policy in this area, the focus of the training is on prevention.

45. Accordingly, a considerable portion of the training involves training in decision-making and risk assessment in crisis situations as well as management techniques to achieve de-escalation without recourse to (verbal or physical) intervention techniques. This requires a proper understanding of the individuals, their behaviour (as a form of communication) and its triggers. Verbal, paraverbal and nonverbal communication strategies are key modules of (formally assessed) learning. Specifically, within the current framework:

    a. *Verbal Intervention*™ training covers prevention using verbal de-escalation skills; and

    b. *Safety Intervention*™ training covers verbal de-escalation skills as well as preventative non-restrictive and restrictive physical interventions including holding skills. This acknowledges that, although a last resort, sometimes such interventions are required to manage more complex or extreme risk behaviours.

46. There is therefore considerable overlap between this training in relation to the management of challenging and/or risk behaviours and the training that has, over time, been provided at MAH in relation to positive behaviour support and specific communication strategies for people with learning disabilities. As I describe below, there is also overlap with specific training in relation to the use of medication since the use of Rapid Tranquilisation (a form of pharmacological/chemical restraint or intervention) and the guidelines in this area

form part of the 5-day MAPA/Safety Intervention programme. Some aspects of this training (and the training material which I provide below) also refer to seclusion. In due course, the MAH Inquiry may therefore wish to consider in more detail the chronological development and delivery to particular staff groups of the training in each area.

47. The *MAPA*® model which I have described is a long-standing training model. CPI took over the model following its acquisition of the previous UK provider, "Positive Options" around 2011. There are, of course, other providers and other training models in this area. However, following an extensive scoping exercise, the Belfast Trust identified this model as the optimum model based on the ethos and skills taught, having regard to the nature of the organisational values and risk profile. In addition, it is certified by the BILD Association of Certified Training and therefore complies with the Restraint Reduction Network Training Standards (to which I referred at paragraph 38kk., paragraph 38mm. and paragraph 38nn. of my first witness statement).

48. I explained at paragraph 56 of my first witness statement that each of the Safety Intervention Teams within the Belfast Trust (formerly known as the "*Management of Aggression*" Teams, and for ease referred to as the Trust Team and the MAH Team) are separately licensed by CPI. By this, I mean that each of Knockbracken Healthcare Park and Muckamore Abbey Hospital are licensed by the CPI as an Approved Training Centre ("ATC") for the provision of the CPI training programmes to which I have referred. As far as my colleagues are aware, the Belfast Trust is the only HSC Trust with ATC status. Examples of the annual licence Certificates for each Belfast Trust ATC are provided behind Tab 3 of the CH2 exhibit bundle to this witness statement.

49. The separate accreditation and licensing of MAH reflects no more than the historical position; this arrangement was already in existence, and continued, following the merging of the different legacy Trusts to form the Belfast Trust in 2007. Each ATC was first licensed by Positive Options around 2005. There has

been, and remains, a positive and collaborative working relationship between the two teams. For example, programme and attendance availability sometimes means that MAH staff may be trained at Knockbracken. Further, each team attends regional support meetings with the teams from other HSC Trusts to share ongoing learning and best practice.

50. However, for now, Knockbracken and MAH remain separate ATCs with responsibility for the delivery of training within their respective areas as I described in my first witness statement. I previously explained that the MAH Team also oversees the provision of training at Iveagh. In addition, in October 2017, the MAH ATC was extended to incorporate Community Learning Disability Services. Each ATC has a designated "*ATC Co-ordinator*". Neil Walsh, to whom I have referred, currently serves in that role for the Trust Team. Mr Kevin Mackel is the current ATC Co-ordinator for MAH.

51. Before addressing the training structure, I wish to explain that the relicensing of an ATC is informed by the CPI Annual Centre Verification and Support Visit process to which I referred at paragraphs 58-59 of my first witness statement, as well as routine reports and other information provided by the ATC.

52. Such visits are undertaken within the first year following the approval of the ATC and thereafter on a three yearly cycle by an assessor appointed by CPI. In addition to offering support and advice, the assessor undertakes a detailed assessment of the ATC's performance in meeting the standards and expectations of the BILD Code of Practice and the license agreement, including for compliance with policies, techniques, record-keeping, monitoring and governance. The assessor also reviews the self-assessment provided by the ATC Co-ordinator in advance of the visit.

53. The assessor's decision is reflected in a report, which may also include conditions for relicensing, recommendations and/or considerations of best practice. It may also recognise or comment on particular areas of good practice. By way of example,

copies of the 2010 Annual Reports for Knockbracken and MAH, and the 2015 and 2018 Verification Reports for MAH are provided behind Tab 3 of the CH2 exhibit bundle to this witness statement. Should further details of this framework assist the MAH Inquiry, a copy of the 2019 and 2023 CPI ATC Affiliation Agreements for Knockbracken are also provided Tab 3 of the CH2 exhibit bundle to this witness statement.

54. CPI supports an organisation to meet the required standards. Where conditions are imposed, it monitors the ATC's progress until it is assured that the conditions are met. As part of the verification visit, the assessor will also review any conditions, recommendations and/or considerations for best practice identified during the previous visit. Ultimately, if resolution cannot be achieved, CPI may revoke affiliated status and that decision will be notified to BILD. Each of Knockbracken and MAH have been relicensed on each occasion without conditions.

55. The training structure is that CPI train and support certified instructors within each ATC. The certified instructors, in turn, deliver workplace training to the staff of the organisation who need it. I address each part of this structure in turn.

56. As to the training of instructors (referred to within the Belfast Trust as MAPA/Safety Intervention "*Trainers*"), CPI runs Instructor Certification Programmes for staff nominated by the organisation. Upon completion, attendees are awarded "*Certified Instructor*" status. The certified individuals are listed on the ATC licence Certificate. Instructor certification must be renewed every 12 months by attending the appropriate Instructor Certification Renewal Programme. Over time, the specific training programmes have been:

    a. Previously, the 5-day MAPA® Foundation and Advanced Instructor Certification Programme and the 2 and 5-day annual MAPA® Renewal programme for recertification; and

b. Currently, it is the Verbal Intervention™ and Safety Intervention™ Foundation Instructor Certification Programmes, the Safety Intervention™ Advanced and Advanced & Emergency programmes, Clinical Holding™ and Verbal Intervention™ and Safety intervention™ Renewal programmes.

57. New trainers within the Belfast Trust are recruited through substantive applications and expressions of interest. No specific professional registration background is required. The Belfast Trust has recently introduced a new "Associate Instructor" role for individuals who remain in ward-based clinical practice. Such trainers, once accredited, will be able to deliver training programmes in addition to their ongoing clinical work. Although this will likely mean that they can provide fewer training hours than full time instructors, it is hoped that they will be a valuable resource in providing training within their clinical areas and in assisting staff colleagues to identify appropriate methods of managing patients exhibiting challenging/risk behaviours. In parallel, the Belfast Trust has introduced a new framework of safeguards and internal audit in order to ensure the consistency of training across the Belfast Trust (including as between substantive trainers and associate clinical based trainers). A copy of the March 2023 Belfast Trust Safety Intervention Team (Knockbracken ATC) "*Roles and Responsibilities of the ATC and the Associate Instructors*" document is provided behind Tab 3 of the CH2 exhibit bundle to this witness statement.

58. The instructor courses are delivered by CPI instructors and using CPI materials, in person and, most often, on-site at the organisation. They also now include a limited virtual element. The ATC Co-ordinator arranges course provision with CPI on an ad hoc basis as and when new trainers require training. As this is standardised training, attendance difficulties on particular dates can be resolved by the new trainers attending available courses being delivered by CPI elsewhere, including in England or the Republic of Ireland.

59. The CPI instructor training covers both the substantive course and how to deliver it as a CPI-accredited instructor. By way of example, a copy of the CPI Safety Intervention™ Advanced and Emergency Instructor Guide is provided behind Tab 3 of the CH2 exhibit bundle to this witness statement.

60. There is an assessment aspect to the training. During the course, individuals are selected to demonstrate delivery of part(s) of the course to the CPI instructors and the broader group.

61. The level of instructor training required (i.e. which level of programme instructors are trained to deliver) is determined by completion of an organisational training needs analysis, informed by the risk assessment and training needs analysis within service areas. I addressed this at paragraph 53 of my first witness statement. Within the Trust Team, all certified instructors are trained to deliver both Foundation and Advanced level training. Some also deliver a related CPI course in holding skills known as Clinical Holding™.

62. As to staff training, this is delivered by the Belfast Trust certified instructors/trainers using CPI approved and authorised training materials. I have already referred above to the Instructor Guide. To assist the MAH Inquiry, the following other course materials relating to this training are provided Tab 3 of the CH2 exhibit bundle to this witness statement:

    a. Sample CPI Safety Intervention Advanced and Emergency Participant Workbook;

    b. CPI Safety Intervention Participant Training Programme Supplement;

    c. CPI "*Keep Me Safe, Treat Me With Respect. An easy read guide on the use of restrictive interventions*" brochure;

    d. CPI "*My Safety and Support Plan*";

e. CPI Risk Assessment guidance entitled "*An Independent Review and Assessment of Risks Associated With the Safety Intervention Contained Within all CPI Training Programmes*";

f. CPI Safety Intervention Foundation Electronic Presentation, 2021 (the core material for the 5-day course and 2-day update course); and

g. CPI Safety Intervention Advanced and Emergency Electronic Presentation, 2021.

63. Within the Belfast Trust, there is some limited variation in the delivery of the staff training programmes. However, this relates to additional bespoke aspects of the delivery intended to align with and further support the needs of the particular service of the staff being trained. For example, in the case of learning disability, the service user "lived experience" aspect has been added and additional sessions are also delivered by the positive behaviour support and adult safeguarding teams. A key part of their contribution relates to the course aspects in respect of communication strategies for individuals living with a learning disability. Further, since 2020, Trust Team/Knockbracken ATC have a session delivered by service user "lived experience" and by the Pharmacy team during their 5-day Safety Intervention Advanced and Emergency addressing Rapid Tranquilisation and the guidelines in this area (to which I referred within my first witness statement). On the 2-day update course, a video version of the "lived experience" aspect is shown to staff.

64. The Belfast Trust requires all staff training programmes to be delivered by two trainers in order to ensure safe levels of instruction and supervision. This is a requirement of the CPI licence in the case of the Foundation and Advanced and Emergency programmes, which in turn reflects a requirement of the Restraint Reduction Network Training Standards (to which I have already referred). It also

reflects the recommended trainer/participant ratios outlined in the BILD Code of Practice. Further, the Belfast Trust seeks to ensure a period during which newly certified instructors deliver all training programmes alongside another more experienced instructor with a larger number of training hours to ensure the safe and effective implementation of their training.

65. As with instructor training, the staff training programmes include formative assessment. This includes assessment of both values and the staff member's physical condition, capacity or ability to perform the training. It is important to state that if a staff member is not deemed competent, the Belfast Trust's trainers can (and do) flag that concern. This is reported to the staff member's line manager with advice that the staff member does not perform in practice the relevant aspect(s) of the training until it can be delivered safely. This generally results in a referral to occupational health and further efforts at training (including, where necessary, through 1-1 sessions with trainers). I say this because the training which I have described is challenging and dynamic in nature, and the intervention skills are physically challenging. Copies of the CPI Formative Assessment materials, which cover the different aspects of the training programmes (Verbal Intervention, Non-Restrictive and Restrictive Safety Interventions) are provided behind Tab 3 of the CH2 exhibit bundle to this witness statement.

66. Training needs for staff within each service (including the nature and extent of any training in this area) are determined at service level and through the method I explained in relation to the training of instructors – i.e. based on a completed Risk Assessment and Training Needs Analysis (the template for which is appended to the Belfast Trust's "Zero Tolerance" policy which I identified in my first witness statement). This requirement is reflected in the CPI licence agreements to ensure that only the physical skills identified are delivered to the staff by whom they may be required. For individual staff, training depends on their clinical role. For example, cleaning and administrative staff, even in an inpatient facility such as MAH, do not have the same training needs as patient-facing nursing staff and healthcare assistants. Equally, within a facility such as MAH, which involves the

care of individuals who are more likely to demonstrate more complex or extreme risk behaviours, a higher proportion of staff are likely to require the higher-level Advanced and Emergency course. The course length ranges from one to five days, depending on the level required and refresher training for all Safety Intervention courses must take place annually.

67. I explained at paragraph 53 of my first witness statement that the Trust Team play an important role in advising and supporting service areas in relation to the completion of the Risk Assessment and Training Needs Analysis document. This ensures that the risk is accurately scored and the correct level of training needs are identified.

68. Trainers must complete and maintain accurate training records for all staff training they deliver, and must log their courses on the CPI website. Course documentation including certificates, post-tests, evaluations, sign-in sheets and formative assessment are shared with the relevant Team for safe storage.

69. The training managed by each Belfast Trust team/ATC is extensive, and demand within the Belfast Trust now exceeds the resources available to deliver it. The Belfast Trust currently has approximately 13,500 patient-facing staff. By way of example, last year, the Trust Team managed training was delivered to approximately 3,000 staff. The Trust Team is currently preparing a business case in relation to the enhancement of this resource.

Topic 7 – Policies and procedures re podiatry

70. In Topic 7 of my first witness statement, I addressed the policies and procedures governing the work of certain professions that form part of the group commonly referred to as "Allied Health Professions" or "AHPs". I did not address podiatry as that profession was not expressly identified in the MAH Inquiry's request for evidence.

71. However, as podiatry has formed an important part of the service provision at MAH since at least the beginning of the primary time period of the Terms of Reference of the MAH Inquiry, I now provide a brief overview of the applicable policy and procedural framework relating to podiatry.

72. In providing the information below, I have drawn on the assistance of:

    a. Wendy McLaughlin, Interim Head of Podiatry Services, Belfast Trust; and

    b. Aidan McAlinden, AHP Business & Information Manager, Belfast Trust.

73. In brief overview, the Podiatry Service at MAH began in the 1990's under the North and West Belfast Health and Social Services Trust. Initially, three sessions per week were provided by Ms Ruth Lines. In 1995, a Band 7 Podiatrist, Mr David Lewis, was recruited.

74. From the outset, there was an open referral system whereby other MAH health and social care staff could contact the Podiatry Service to refer any patient who required foot care or education. From the outset, the Podiatry Service has provided a broad range of care in the assessment, diagnosis and treatment of problems affecting feet, ankles and lower limbs. In the context of MAH, service user care needs have included nail cutting, debridement of corns and callouses and nail surgery for ingrown toenails (this would be carried out by the Podiatry Service, under general anaesthetic provided by dental colleagues).

75. This Podiatry Service continued largely unchanged following the establishment of the Belfast Trust in 2007. It was provided by Mr Lewis and any patient with a medical or podiatric foot need was referred.

76. As the MAH resettlement agenda progressed, the frequency of the service provision reduced to two sessions per month. As in the case of the other services

which I addressed in my first witness statement, this necessitated prioritisation. Within the Podiatry Service, this was done on the basis of urgency of treatment needs.

77. More recently, a further Band 6 Podiatrist has been recruited. This is Mr Gary Monteith.

78. Podiatrists working at MAH were bound by all general Belfast Trust policies and the general provisions and guidance in relation to the provision of learning disability care identified in Topic 1 of my first witness statement, such as the June 2010 GAIN "*Guidelines on caring for people with a learning disability in general hospital settings*".

79. In addition, they were bound by their professional training and the professional standards, guidelines and best practice guidance set by:

    a. The Health and Care Professions Council (the "HCPC"), the common AHP regulator which I addressed in Topic 7 of my first witness statement;

    b. Their professional body. From 1945 until 2018, this was the Society of Chiropodists and Podiatrists (the "SOCP"). From 2018 to 2021, it was the College of Podiatry (the "COP"). Since 2021, it has been the Royal College of Podiatry (the "RCOP"); and

    c. The National Institute for Health and Care Excellence (or "NICE") Guidelines and Quality Standards identified within Topics 1 and 2 of my first witness statement as well as:

        i. January 2004 NICE Clinical Guideline 10 "*Type 2 diabetes food problems: Prevention and management of foot problems*"; and

ii. August 2015 NICE Guideline 19 "*Diabetic foot problems: prevention and management*".

80. As with the professions addressed in my first witness statement, it is beyond the scope of this statement (and the MAH Inquiry's request for evidence) to address the educational or professional training of podiatrists. However, as I explained in relation to the other professions, the key guidance governing the safe and effective provision of the service was generally found not in Belfast Trust policy or procedural documents but, rather, in the specialist and prominent standards and guidance of the regulatory and professional bodies. This framework can be seen in the most recent version (version 6, November 2020) of the Belfast Trust Podiatry Department "*Staff Induction/Handbook*" is provided behind Tab 4 of the CH2 exhibit bundle to this witness statement.

81. I therefore endeavour to address in turn each source of regulatory and professional guidance, with the caveat that the material (in particular, the historic material) which my colleagues have been able to retrieve in the time available is not exhaustive. Copies of all available documents are provided Tab 4 of the CH2 exhibit bundle to this witness statement.

82. Relevant HCPC material includes:

a. 2003, 2007, 2009 and 2013 "*Standards of Proficiency – Chiropodists/podiatrists*"; and

b. 2003, 2006, 2012 and 2016 "*Standards of Conduct, performance and ethics*" (which apply equally to registrants across the 15 HCPC-regulated professions, as identified within Topic 7 of my first witness statement).

83. Relevant professional standards, guidance and guidelines include:

a. April 2003 SOCP "*Minimum Standards of Clinical Practice*" (version 3.0);

b. (Undated) SOCP "*Guidelines on the Minimum Standards of Clinical Practice*" (version 3.0); and

c. The following COP "Clinical Standards" for which copies of the 2020 versions are provided behind Tab 4 of the CH2 exhibit bundle to this witness statement:

   i. Standard 1 – Patient Confidentiality;

   ii. Standard 2 – Patient Consent;

   iii. Standard 3 – Safeguarding Children and Vulnerable Adults;

   iv. Standard 4 – Delegation and Supervision;

   v. Standard 5 – Patient Record Keeping;

   vi. Standard 6 – Clinical Abbreviations;

   vii. Standard 7 – Single Use Instruments with Podiatry;

   viii. Standard 8 – Decontamination of Reusable Instruments;

   ix. Standard 9 – Infection Control;

   x. Standard 10 – Waste Management;

   xi. Standard 11 – Management of Sharps and Exposure Incidents;

   xii. Standard 12 – Domiciliary Podiatry Care;

xiii. Standard 13 – Clinical Environment; and

xiv. Standard 14 – Immunisations for Podiatrists.

84. I do not address Belfast Trust material developed or used by the Podiatry Service which is more general or procedural in nature, such as that relating to good hygiene and covid-19 protection measures. However, other material which has been relevant to the work of podiatrists at MAH includes:

a. Regional guidance such as:

i. 2011 HSCNI "*Neuropathic pain – pharmacological care pathway for non-specialist settings*";

ii. 2017 Belfast Diabetes Network "*Guidelines for early identification of people with Type 2 Diabetes*";

iii. January 2018 "*Regional Standard Operating Procedures for the Podiatric Assessment of Vascular and Neurological Status and Wound Classification*"; and

iv. North West Podiatry Services Clinical Effectiveness Group – Rheumatology "*Guidelines for the Management of Foot Health for People with Rheumatoid Arthritis*". A copy of version 4, issued in February 2019, is provided behind Tab 4 of the CH2 exhibit bundle to this witness statement;

b. Belfast Trust material including:

i. "*Guidelines for empirical antibiotic prescribing in hospitalised adults*". A copy of the latest iteration of these guidelines (BHSCT/SSS/Pharm

(01) 2021, version 9) is provided behind Tab 4 of the CH2 exhibit bundle to this witness statement;

ii. Belfast Trust Podiatry Service "*General foot care advice*" (a copy of the latest 2022 version is provided behind Tab 4 of the CH2 exhibit bundle to this witness statement); and

iii. Belfast Trust Podiatry Service "*Standard Operating Procedure (SOP) for a Podiatrist - completing a nail surgery assessment*" (2022 version).

85. For completeness, at paragraph 333 of my first witness statement (addressing Topic 13), I outlined the key regulatory and regional sources of guidance in relation to further staff training and/or CPD in respect of AHPs. This was in the context of the Belfast Trust policy framework I explained at paragraphs 322 to 330. In addition, at Tab 4 of the CH2 exhibit bundle to this witness statement is a summary of the Belfast Trust Podiatry Service "*Mandatory Training Requirements*".

Conclusion

86. I hope this additional statement, and the material exhibited to it, is of assistance to the MAH Inquiry. I am very grateful to the colleagues from the Belfast Trust who have contributed to it.

87. The Belfast Trust continues to consider the topics raised by the MAH Inquiry in order to try to ensure that all relevant material has been found and provided. If further material is found then it will be provided to the MAH Inquiry.

88. It is unfortunately inevitable that I, personally, may not be able to answer all questions that the MAH Inquiry may have arising from the various broad topics addressed across my two witness statements. Where that is the position, I will take away any questions I cannot answer and ensure that as full and complete a response as possible is provided to the MAH Inquiry.

Declaration of Truth

89. The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the further documents which, collectively, the contributors to this statement believe are necessary to address the matters on which the MAHI Panel has requested the Belfast Trust to give evidence.

Signed: **Chris Hagan**

Dated: **17 April 2023**

Belfast Trust Module 3 Statement (Addendum) Exhibit Bundle – "CH2"

HEALTH AND SOCIAL CARE BOARD

REGIONAL ADULT LEARNING DISABILITY SERVICE MODEL

PROJECT INITIATION DOCUMENT

January 2019

PROJECT NAME	Transformation Project – Adult Learning Disability Service Model and costed implementation plan
DOCUMENT ISSUE DATE	15.01.19
STATUS (Draft, Final)	FINAL
PROJECT SRO	JEROME DAWSON
DOCUMENT OWNER	LORNA CONN

Version history

Version	Key Changes	Date	Author
Draft 1			Lorna Conn
Draft 2	To include proposed timescales	26/10/18	Lorna Conn
Draft 3	As per workshop	9/11/18	Lorna Conn
Draft 4	Incorporating additional feedback	11/12/18	Sara Templer/ Lorna Conn
Draft 5	Incorporating Steering Group feedback	15/01/19	Sara Templer / Lorna Conn

Regional Adult Learning Disability Service Model Transformation Project - Project Initiation Document

This document covers the following areas:

1 Purpose

1.1 The purpose of this Project Initiation Document (PID) is to define the Regional Adult Learning Disability Service Model project, to form the basis for its management, and assist with the assessment of its overall success.

1.2 The PID has two primary uses:

- To ensure that the project has a sound basis; and
- To act as a base document, against which TIG, DoH and HSCB/PHA can assess progress, risks, issues, change, and ongoing viability questions.

2 Introduction/Background

2.1 A number of recent strategic developments and directives have highlighted a need to review Adult Learning Disability service provision. These include:

- The outcomes of the *Bamford Review of Mental Health and Learning Disability*,[1] and the associated *Bamford Action Plan (2012-2015);*[2]
- The *Review of Adult Learning Disability Community Services (Phase II)* (October 2016);[3]
- The draft *Programme for Government (2016-2021);*[4]
- The 10 year approach to transforming health and social care*: Health and Wellbeing 2026: Delivering Together* (2016);[5]
- The *Mental Capacity Act (Northern Ireland) 2016*;[6] and
- Recommendations for the Reform of Adult Social Care, outlined in *Power to People: Proposals to reboot adult care & support in Northern Ireland* (2017).[7]

2.2 Within this broader context, this review is underpinned by the principles and processes outlined in the *Co-Production Guide for Northern Ireland - Connecting and Realising Value Through People* (2018).[8]

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[1] Available at: https://www.health-ni.gov.uk/publications/bamford-published-reports
[2] Available at: https://www.health-ni.gov.uk/publications/bamford-action-plan-2012-15
[3] Available at: https://rqia.org.uk/RQIA/files/4a/4a883fbc-92a7-4fda-97b0-ac2e664e5d8d.pdf
[4] Available at: https://www.executiveoffice-ni.gov.uk/topics/making-government-work/programme-government-and-budget
[5] Available at: https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[6] Available at: http://www.legislation.gov.uk/nia/2016/18/contents/enacted
[7] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/power-to-people-full-report.PDF
[8] Available at: https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

2.3 Any new model(s) developed and agreed on this basis will also need to take cognisance of emerging relevant reviews and strategic developments, including the independent review of Learning Disability acute level care, which is expected to report in May/June 2019.

3 Project Aims

3.1 The overarching Project Aim is to design a new outcomes based, regionally consistent model for Adult Learning Disability Services that:

- Reflects the needs and expectations of individuals and families;
- Reduces reliance on hospital services and develops person-centred, individualised, inclusive models of community care that promote equality of access; and
- Provides a strategic response to the significant challenges currently facing the Adult Learning Disability programme of care, including:
    - health and social wellbeing,
    - the complexity of need,
    - transitions from children's services,
    - the growing number of delayed discharges from hospital,
    - appropriate accommodation,
    - the provision of short breaks, and
    - support for older carers.

4 Project Objectives

The Project Objectives are to:

4.1 Develop and agree the core principles of the Regional Adult Learning Disability Service Model for Northern Ireland.

4.2 Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.

4.3 Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.

4.4 Contribute to the development of regional consistency in the thresholds, access routes, and range of services available to support adults with learning disabilities and their families.

4.5 Improve regionally consistent electronic data bases and collation of existing data which will begin to identify key health and social care needs of adults with learning disabilities and produce local and regional data to inform future commissioning and service planning.

4.6 Contribute to the development of a workforce development and training strategy to support the delivery of effective and efficient services.

4.7 Review current Trust expenditure on Learning Disability services to inform a costed implementation plan to support the successful transformation of Adult Learning Disability Services.

4.8 Produce locally costed implementation plans which can inform development of a regional implementation plan required to support transformation of services.

4.9 Lead consultation events with Trust stakeholders that contribute to the stakeholder consultation on the draft Service Model and implementation plan.

5 Project Terms of Reference

5.1 The Project will deliver:

- A new Model for Adult Learning Disability Services; and
- A costed implementation plan for this Model.

5.2 These outputs will provide the framework for a regionally consistent, whole systems approach to delivering high quality services and support to adults with learning disabilities. This approach will be underpinned by a person-centred focus to ensure individuals receive "*the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome,*"[9] with consideration given to the interfaces and pathways between the Departments and services involved.

6 Project Benefits

6.1 The delivery of this transformation programme will stabilise and secure long term service provision of Adult Learning Disability Services for the population of Northern Ireland, within the projected funding envelope for the Learning Disability programme of care and the re-alignment of existing funding streams.

[9] See: *Quality 2020: A 10-Year Strategy To Protect And Improve Quality in Health and Social Care In Northern Ireland,* available at: https://nipecportfolio.hscni.net/compro/attributes/quality2020.pdf

6.2 In providing a strategic response to the significant challenges currently facing the Adult Learning Disability programme of care, the new Service Model will aim to create a context that:

- Allows providers flexibility to design and deliver good services to meet the diverse and changing needs of their local populations; and
- Enables improved planning and increased resilience in the delivery of adult Learning Disability services at a regional level.

6.3 Adults with learning disabilities will experience an improved quality of life through increased choice and access to non-HSC activities and services such as education, employment, day opportunities, social, and sports/leisure activities.

6.4 Carers will experience a higher level of support, and family and community placements are sustained for longer periods, reducing demand for/reliance on care in institutional settings.

7 Project Constraints

Key constraints that apply to this Project include:

7.1 Workforce/recruitment resources within HSC organisations to take forward this project and implement the resulting model.

7.2 Securing buy-in from stakeholders including the ability to demonstrate meaningful engagement and how best to ensure a representative group(s) for all, through the principles and standards of Personal and Public Involvement (PPI), within the time available.

7.3 Ensuring delivery of an evidence-based high quality model for Adult Learning Disability Services that both addresses current pressures and is consistent with the overall vision set out in *Power to People* (2017), within the projected funding envelope for the Learning Disability programme of care, re-aligning existing funding streams as required.

7.4 Limited availability of local, comparable data relating to Learning Disability services.

7.5 Timescales for completion of the programmes of work.

7.6 Resources, both capital and revenue.

8 Assumptions

It is understood from the outset that the Project Implementation Team should ensure that the new Service Model:

8.1 Is outcomes based and aligned with the principles and recommendations of relevant overarching strategic documents and directives (see **Section 2**).

8.2 Is developed through comprehensive stakeholder engagement and involvement arrangements aligned with statutory PPI requirements and the ethos and principles of co-production. The Project communications and engagement strategy will support this approach.

8.3 Takes into account the evidence base for modern, timely, and accessible care, including National Institute for Health and Care Excellence (NICE) and Social Care Institute of Excellence (SCIE) guidelines, professional advice from practitioners and academics across the HSC sector, and the views of users and other stakeholders across the region.

8.4 Will reflect emerging research findings, recommendations, and policy developments, including for example the Independent Review of Acute Level Care in Learning Disability, which will be commissioned in parallel to this Project.

9 Proposed Approach

9.1 To ensure that the Aims and Objectives outlined above are achieved, the Project will be managed and controlled in broad compliance with appropriate project management methodologies. Priority will be placed on achieving progress on agreed and recommended outcomes, rather than process management. A detailed outline of this approach is included at Annex 1.

10 Project Implementation & Timescales

10.1 The Project will be implemented in four phases over the period November 2018 – March 2020. These phases and the draft schedule of delivery are outlined in **Table 1** below.

Table 1: Phased Project Implementation & Timescales

This table should be read in conjunction with the Project Gantt Chart, included at **Annex 3**.

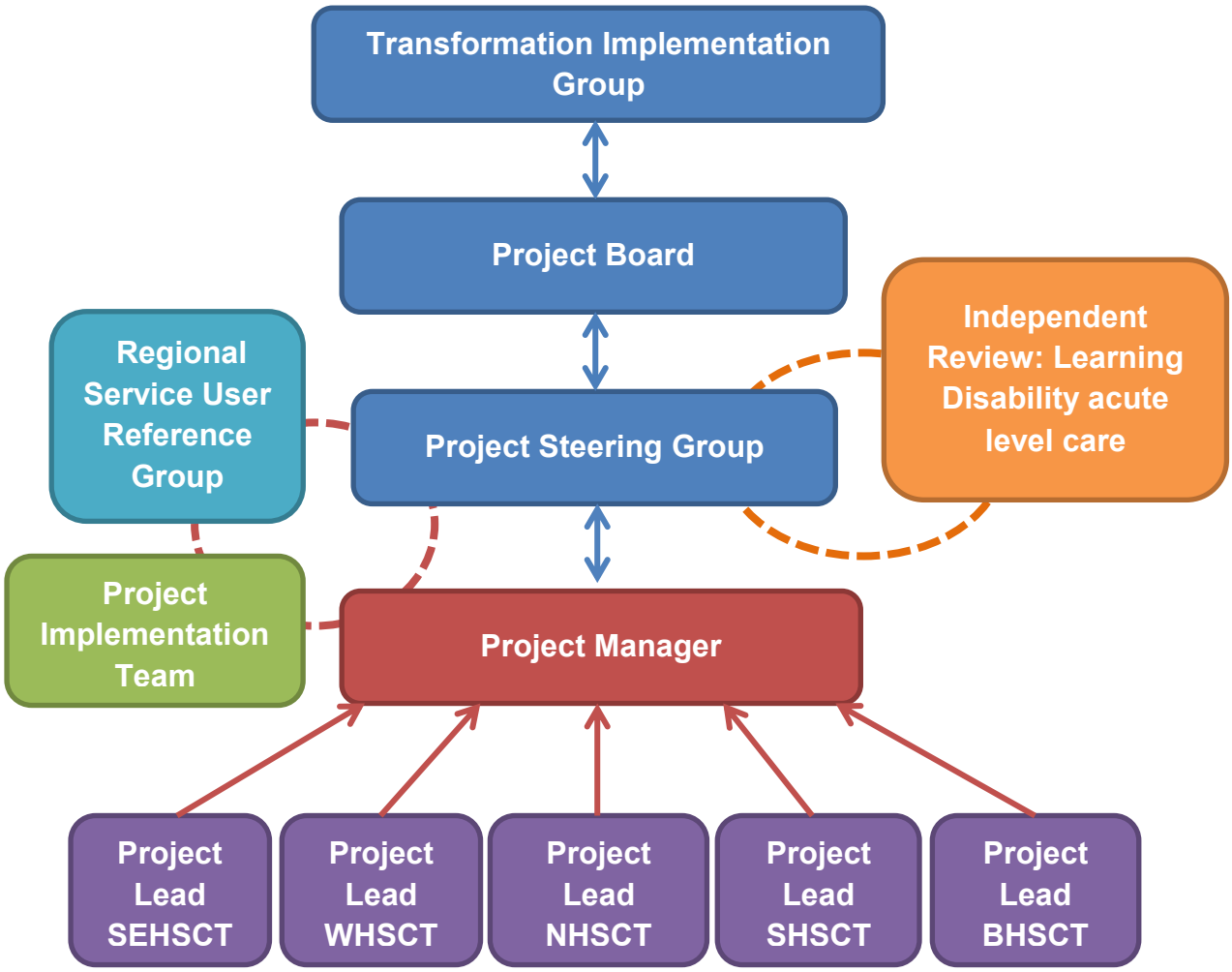
PHASE	DETAIL	PROPOSED TIMESCALES (subject to ongoing review)
1 Establishment of the Project	- Draft and agree the Project Initiation Document (PID), which will set out the objectives, governance arrangements and terms of reference of the project, and associated timescales, including for the appointment of the necessary staff.	- PID completed and signed off by Senior Responsible Officer (SRO) and Project Steering Group by 10 January 2019 - Staff appointed: January/February 2019
2 Scope, Plan, Design ***and*** **Pre-Consultation Stakeholder Engagement**	- Develop Communication & Engagement Strategy. - Conduct stakeholder engagement. - Review and define project work streams (Steering Group and HSCT Project Leads) (incorporating themes per Planning Workshop on 5 November 2017) - Establish Working Groups to take forward key priorities. - Establish Regional Service User Reference Group. - Develop a regional approach and 'script' for engagement, which draws on techniques from service design and system dynamics. - Develop the draft Regional Adult Learning Disability Service Model. - Develop the draft costed high level implementation plan. - Engage interested parties and stakeholders to seek views on the draft model and costed implementation plan. This phase will include use of available strategic data sources and local data sources to undertake a wider needs assessment which will consider:	- **Overall timescale: 1 December 2018 – 30 September 2019** *Key target dates within this period:* - *Review and define work steams: December 2018 – January 2019* - *Working Groups established: 31 January 2019* - *Regional Service User Reference Group established: 31 March 2019* - *Data collection, research completed: 31 May 2019* - *Development of draft Service Model and costed implementation plan underway: 1 May 2019* - *Draft Service Model and costed implementation plan v1 completed: 31 July 2019* - *Draft Service Model and costed implementation plan v2* ***for consultation*** *completed: 30 September 2019* - *Pre-Consultation communication and engagement completed: 30 September 2019*

PHASE	DETAIL	PROPOSED TIMESCALES (subject to ongoing review)
	- *background to service provision* - *key drivers for change* - *current service profile, including current spend on this Programme of Care* - *current user profile* - *staffing profile* - *geographical profiles* - *rural impact considerations* - *equality impact considerations* - *relevant interdependencies* - *emerging research and policy developments, including for example the independent review of Learning Disability acute level care (expected to report in May/June 2019)* - *Human Rights* It will also include, as appropriate, benchmarking activities aimed at identifying best practice in the delivery of Learning Disability services elsewhere throughout the UK, Ireland, and internationally.	
3 Consultation	- Conduct comprehensive engagement and consultation with the system and service users via regional workshops with a wider group of stakeholders to test proposals in draft Service Model.	- Communication and engagement - Ongoing 1 October 2019 – 31 December 2019
4 Finalise Proposals	- Refine the draft Regional Adult Learning Disability Service Model and costed implementation plan. - Submit these to the Project Board for consideration and sign off. - Submit approved version to Department of Health.	- Review and integrate consultation feedback: December 2019 – January 2020 - Draft version to Project Board: 23 January 2020 - Final version to Project Board: 26 March 2020 - Submit Final Report and costed implementation plan to Department of Health: by 31 March 2020

11 Project Structure & Governance Arrangements

11.1 Figure 1 below summarises the Project structure and governance arrangements. Further detail is provided at **Annex 2**.

Figure 1: Project Structure & Governance



11.2 Given the time constraints and range of stakeholders involved in this Project, participant organisations and staff are required to demonstrate commitment to the Project purpose, aims, and objectives from the outset. Flexible co-working, timely action, and consistent responsive engagement will be fundamental to the Project's success.

12 Cost/Financial Arrangements

12.2 Financial arrangements will be managed in line with normal governance procedures per HSC governance arrangements.

12.3 The main cost associated with the achievement of the overall objective of the Project will be staff salaries.

12.4 All expenses incurred will be managed by the HSCB/PHA Programme Manager, the Social Care Lead, and Project Manager on a day to day basis and approved by the Project Board.

13 End Project Notification

13.1 In line with the proposed timescales (see **Section 10** above), the Project Manager will submit a Final Report (or end of project report) by 31 March 2020. Once this has been considered by the Transformation Implementation group (TIG), the Project will be closed.

Annex 1: Project Management Approach

1. The Project scope will cover the work necessary to explore and define a draft Service Model to transform adult Learning Disability services in Northern Ireland.

2. A project management approach will be employed to manage the Project and ensure the completion of the Project on time, within available resources and to deliver on the agreed outcomes and objectives.

3. Progress on work plans will be monitored by the Project Manager and the HSCB/PHA Social Care Lead on at least a monthly basis or more frequently as required. This monitoring should ensure that risks are quickly identified and addressed or escalated as appropriate.

4. Following staff appointments, further refinement of work plans will be undertaken to ensure realistic timescales have been established. A Project Gantt chart has been included in **Annex 3**.

5. The Project Manager will report to the Project Board and Project Steering Group in accordance with timescales agreed. Progress reports will:

    - Provide brief verbal (and written) progress reports from the Project Manager on objectives, achievements, communication activity, forward objectives, and any critical issues.
    - Raise any new risks that could impact the Project and determine any actions to mitigate against the risk and/or an approach to mitigate the risk.
    - Consider matters requiring approval and/or issues referred under escalation procedures.

6. Exception reporting to Project Board will be carried out by the Project Manager as required.

7. Risks and Issues may be raised by anyone with an interest in the Project at any time.

8. The Project Manager will have responsibility for maintaining a Risk Register and managing the Risks and Issues Log.

9. Day to day administration for the Project will be managed by the Project Manager and Project Leads.

10. Stakeholders will be regularly informed regarding project progress, its achievements and the actions for the next phase of the Project. This engagement will be specified in the Communication & Engagement Strategy.

Availability of Resources

11. The main assumption at this stage is that staff will be appointed in a timely manner.

12. Capacity building may be required to ensure meaningful engagement with service users and carers.

External Dependencies

13. The Project is externally dependant on the following:

    - The co-operation and understanding of Senior Management and Staff of the relevant HSC and stakeholder organisations; and
    - Timely decision making.

Key Deliverables

14. The following **key products** will be delivered throughout the life of the project:

    - Project Initiation Document;
    - Overall project plan;
    - Risk Register;
    - Interim reports;
    - Final Service Model, with costed implementation plan; and
    - Post Project Evaluation.

Communication & Engagement Strategy

15. Regular progress reports will be provided to the Project Board and Project Steering Group via the Project Manager and by the Senior Responsible Officer (SRO) to the Transformation Implementation Group (TIG), and if required to the Minister and Health Committee.

16. A communication and engagement strategy will be developed to ensure all relevant stakeholders are kept informed as to the progress of the Project.

Key Stakeholders

17. The key stakeholders for the project include but are not limited to:

- Minister (when appointed)
- NI Assembly Health Committee (when appointed)
- Local populations
- Public Representatives
- Service User Representative Groups/service users/carers/families
- Trade Unions/Staff Representatives
- Health and Social Care Trusts
- Health and Social Care Board (HSCB)
- Public Health Agency (PHA)
- Regulation and Quality Improvement Authority (RQIA)
- Other Government Departments and statutory agencies
- The Community and Voluntary sector, including both advocacy and service providers

Project Controls/Governance Arrangements

18. The Project Governance Arrangements are reflected in Figure 1, Section 11 above. The key internal stakeholders in this governance framework include:

- Transformation Implementation Group
- Project Board
- Service User Reference Group
- Project Steering Group
- Project Implementation Team
- Project Manager
- 5 HSC Trust Project Leads

Further details are provided in **Annex 2**.

Project Initiation

19. The project will formally start on confirmation of allocation of Transformational funding.

Annex 2: Group Membership & Project Support

1. **Project Board:** The Service Model Project Board will provide governance and oversight of the project. It will be chaired by HSCB/PHA and will include representation from DOH, Directors with responsibility for Adult Learning Disability from each of the 5 HSC Trusts, HSCB/ PHA, Service Users, and carers. Meetings will be held on a bi-monthly basis in Ballymena, commencing in January 2019.

2. **Regional Service User Reference Group:** The Regional Service User Reference Group will provide lived experience, insight, and expertise, and will be designed to ensure meaningful engagement can occur with service users across each phase of the Project's implementation. This mechanism will allow concepts to be developed and tested. The frequency and location of meetings will be determined by the phase of work, and will be service user led.

3. **Project Steering Group:** The Service Model Project Steering Group will oversee the development of the regional model in accordance with the business case and the transformational bid. It will monitor that the overall vision, objectives and outcomes for the project are delivered within the specified timescales. It will also ensure any risks are identified and mitigated or resolved. It will authorise any deviations from the original project bid. It will be chaired by HSCB/PHA and will comprise representatives from DOH, Assistant Directors of Learning Disability from each of the 5 HSC Trusts, HSCB/PHA, Service Users, carers, and the Project Manager. Membership for the Project Steering Group will be kept under review and will evolve to draw on relevant multidisciplinary experience across HSC as required as the work proceeds. Meetings will be held monthly, at agreed locations.

4. **Project Implementation Team:** The Project Implementation Team will consist of the 5 Trust Project Leads and the Project Manager. The Team will lead on and undertake the detailed analysis and work as outlined within the PID to develop the new Service Model. It will meet as required, at minimum on a monthly basis.

5. **Project Manager:** The Project Manager will coordinate the work of the Project Leads within each of the Trusts and be responsible for ensuring the formulation of an overall regional Service Model and the associated costings that will be co-produced with the key stakeholders. The Project Manager will provide regular updates and reports to the Project Board and the Project Steering Group and monitor progress against the PID to ensure the Project adheres to the agreed timescales.

6. **Project Leads:** Each Project Lead will take specific responsibility within their host Trust for delivering on the Phases 2-4 of the Project. They will take the lead within their Trust for stakeholder engagement as well as in the development of a costed high level implementation plan. Each Project Lead will have responsibility to ensure all relevant stakeholders are involved at local level across the programme of care and multidisciplinary contexts.

7. **Project Administrative Support:** The Project Manager will be supported by secretarial and administrative support which will be located in the HSCB/PHA.

Annex 3: Project Gantt Chart

REF	PROJECT PHASE	DESCRIPTION	OWNER	2018			2019											2020								
				October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	September
1	1	Develop and sign off Project Initiation Document (PID)	Project Manager																							
2	1	Recruit Staff	Project Implementation Team																							
3	2	Develop Communication & Engagement Strategy	Project Manager																							
4	2, 3, 4	Stakeholder Communication & Engagement	Project Implementation Team																							
5	2	Review and define project work streams	Project Steering Group and Implementation Team																							
6	2	Establish Working Groups to take forward key priorities	Project Steering Group																							
7	2	Establish Regional Service User Reference Group	Project Implementation Team / TILII																							
8	2	Data collection and research	Working Groups																							
9	2	Develop Draft Regional Adult Learning Disability Service Model	Project Implementation Team																							
10	2	Develop draft costed high level implementation plan	Project Implementation Team																							
11	2	Refine Draft Service Model and costed implementation plan v2 for consultation	Project Implementation Team																							
12	3	Conduct consultation with the system and service users via regional workshops to test proposals in Draft Service Model and costed implementation plan	Project Implementation Team																							
13	4	Refine and finalise Draft Regional Adult Learning Disability Service Model	Project Implementation Team																							
14	4	Refine and finalise draft costed high level implementation plan	Project Implementation Team																							
15	4	Submit draft version to Project Board for consideration	Project Manager																							
16	4	Submit final version to Project Board for sign off	Project Manager																							
17	4	Submit Final Report outlining recommended Regional Adult Learning Disability Service Model and costed implementation plan to Department of Health	Project Manager																							

Annex 4: Communication & Engagement Strategy

1. The successful development of the Regional Adult Learning Disability Service Model and costed implementation plan will only be achieved through the sharing of information and experience.

2. Each phase of this Project is therefore underpinned by a commitment to enable and facilitate communication and engagement among the stakeholders to this important work, in line with the ethos and principles of co-production.[10] This means that service users, carers, and staff will be empowered to design the system, work together to develop pathways of support and services, and be partners in the care they receive with increased self-management and choice.

3. The **key stakeholders** for the project include but are not limited to:

    - Minister (when appointed)
    - NI Assembly Health Committee (when appointed)
    - Local populations
    - Public Representatives
    - Service User Representative Groups/service users/carers/families
    - Trade Unions/Staff Representatives
    - Health and Social Care Trusts
    - Health and Social Care Board (HSCB)
    - Public Health Agency (PHA)
    - Regulation and Quality Improvement Authority (RQIA)
    - Other Government Departments and statutory agencies
    - The Community and Voluntary sector, including both advocacy and service providers
    - Local Engagement Partnerships (LEPs)

4. The Project Communication & Engagement Strategy aligns with the phased Implementation Plan, and includes provision to incorporate feedback at every stage as the Draft Service Model is developed. It will culminate in a robust consultation process that will aim to deliver a way forward that is accessible, acceptable to all stakeholders, and that will deliver effective and sustainable services across the region.

5. **Table 1** below shows the outline Implementation Plan aligned to the key Communications Objectives of each phase.

[10] See: https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people

Table 1: Regional Adult Learning Disability Service Model: Phased Implementation Plan and Associated Communications Objectives

Implementation Phase	Associated Communications Objectives	
1 **Establishment of Project**	**1**	Develop a Project Initiation Document that is informed by the Project's stakeholders.
2 **Scope, Plan, Design *and* Pre-Consultation Stakeholder Engagement**	**2**	Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.
	3	Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.
3 **Consultation**	**4**	Lead stakeholder consultation on the draft Service Model and the costed implementation plan, including consultation events with HSC Trust stakeholders.
4 **Finalise Proposals**	**5**	Ensure stakeholders are provided with up to date information on the outcomes of the consultation process, and the progress and submission of the final proposals.

6. **Table 2** below shows the outline Implementation Plan along with the key Communications Activities relevant to each phase.

7. This Communication & Engagement Strategy will be kept under review over the implementation of the Project, and adjusted as necessary in line with learning, feedback, and progress.

Table 2: Regional Adult Learning Disability Service Model: Communications Activities

Objective		Targeted Actions & Implementation Protocol	Timeframe
1	Develop a Project Initiation Document (PID) that is informed by the Project's stakeholders.	- Facilitate stakeholder workshops. - Circulate draft PID for feedback.	Workshop dates: - 1 August 2018 - 9 November 2018
2	Create an infrastructure which supports service users, families, carers, and other key stakeholders to be involved in the design and development of the service model.	**Internal Communication** - Project Implementation Team will meet **monthly** over the whole implementation period. - Project Working Groups will meet **as required** by the relevant work stream over the period January 2019-31 May 2019 to ensure progress on the key priorities, data collection, and research. - Project Steering Group will meet **monthly** over the whole implementation period. - Project Board will meet on a **bi-monthly** basis. **Service User, Carer and Community & Voluntary Sector Engagement** - Regional Service User Reference Group will meet **regularly** in line with the phase of work, and will be service user led **External Communication and Engagement** - Establish stakeholder contact database (email communication). - Circulate 5 quarterly email updates to stakeholder contacts with headline information about Project structure, progress towards consultation, and providing ample information about consultation and events to maximise engagement.	- Ongoing: January 2019 – 31 March 2020 - Regional Service User Reference Group Established: 31 March 2019 - Contact database established: January 2019, kept under review - Webpage established: February 2019 - Quarterly stakeholder email update: commencing March 2019 (coinciding with establishment of Regional Service User Reference Group), concluding March 2020 (with submission of final proposals) - Inclusion in DoH updates on all transformation projects
3	Ensure meaningful engagement with service users, families, carers, and other key stakeholders in the membership of project oversight and working groups, and participation in consultation events.		

Objective		Targeted Actions & Implementation Protocol	Timeframe
4	Lead stakeholder consultation on the draft Service Model and the costed implementation plan, including consultation events with HSC Trust stakeholders.	- **Deliver regional consultation events with HSCT stakeholders.** - **Deliver wider stakeholder consultation events** designed to engage wider stakeholders (per contact database).	- September – October 2019 - October 2019 – January 2020
5	Ensure stakeholders are provided with up to date information on the outcomes of the consultation process, and the progress and submission of the final proposals.	- Maintain **Service User, Carer and Community & Voluntary Sector Engagement** and **External Communication and Engagement** as described above.	- January – 31 March 2020

MAKING LIFE BETTER

A WHOLE SYSTEM STRATEGIC FRAMEWORK FOR PUBLIC HEALTH

2013-2023

June 2014

MAKING LIFE BETTER

CONTENTS

MAKING LIFE BETTER

THE MAKING LIFE BETTER CHARTER

Our Objective

The Northern Ireland Executive is committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Our Approach

Our approach to public health focuses on working collaboratively with individuals, communities and partner organisations to address the factors that impact on health and wellbeing in Northern Ireland. We are also committed to ensuring that there are effective mechanisms in place to ensure protection of the community from current and future threats to public health.

Social justice, equity and inclusion

People in different social circumstances experience different levels of health. We will focus on addressing the challenges of disadvantage and inequality that afflict society and work to close the gap in health between those who are least and most disadvantaged.

Engagement and Empowerment

We want individuals and communities to be active in improving their own health. This means that we will work with people to address agreed priorities and build on the assets we have in our communities to improve health. As far as possible we will devolve responsibility and activity to community levels of working. Information about the state of health and wellbeing in Northern Ireland and the ways that health can be improved will be made available to the public.

Collaboration

Our Programme for Government (PFG) 2011/15 sets the broader context for working together. It recognises the inter-relationship between health, disadvantage, inequality, childhood development and education, employment, the social and physical environment, and economic growth.

Building a healthier Northern Ireland will hinge largely on what is done collaboratively, through both policy and practice, to influence these wider factors that impact on lives and choices. Everyone has a role to play. We look to everyone to play their part, including individuals and communities as well as the public, private and third sectors.

MAKING LIFE BETTER

Evidence and Effectiveness

We must use existing resources wisely to have a positive impact on health and wellbeing. We will focus on action which is informed by evidence to help us ensure that public money is spent on actions that will achieve better health and wellbeing for all our people and reduce health inequalities.

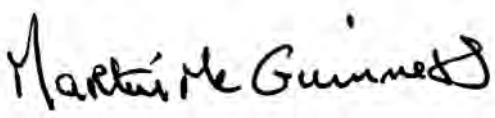
Addressing Local Need

We will support joint working at local level between councils, statutory bodies, community and voluntary sectors and others, to optimise opportunities to plan and shape services around the needs of local communities in order to create communities that are healthy, safe, united and thriving.

Our Resources

We will seek to maximise the benefit that we can achieve with our resources and make effective use of the public health budget. We will also promote better use of public resources generally, as well as those of our partners, in order to achieve better health and wellbeing.

We will work collaboratively with partners across Northern Ireland and in other countries to build and share public health capacity to achieve greater impact in public health actions. Where appropriate, we will advocate for changes to national policies in order to achieve local improvements in health and wellbeing.



Rt Hon Peter D. Robinson MLA
First Minister

Martin McGuinness MLA
deputy First Minister

Signed by First and deputy First Ministers on behalf of the Executive

FOREWORD

International evidence demonstrates that improving population health and wellbeing requires the involvement of the whole of Government and all of society, individually and as communities.

We have seen many health improvements as a result of actions in areas such as better housing, safer roads and safer workplaces. Action to address poverty and inequality is also key to the successful delivery of this framework.

Many studies relate health and health inequalities to the conditions in which people are born, grow, live, work and age. There are no doubt challenges ahead in creating the conditions which will enable us all to achieve our full health and wellbeing potential.

A recently published "Review of the social determinants and the health divide in the WHO European Region" states that in countries with the best health and narrowest health inequities the evidence suggests "this is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high quality education and health services."

I welcome the support of my Executive colleagues in this long–term aspiration. We have assets on which to build and which will help set us on a new trajectory. There will be opportunity through local government reform, for example, to strengthen the already significant contribution at local level, working with local communities to create thriving communities and healthy, safe and sustainable places.

As Minister of Health, I am determined to play my part in making life in Northern Ireland better and in giving everyone a fair chance to lead a healthy life. I will continue to progress legislation, strategies and programmes which contribute to better health and tackle health inequalities. I will collaborate with other Ministers to promote a whole of Government approach to health improvement, and to promote greater coherence of action across all sectors and at all levels of delivery. I would like to thank all those who contributed to the development of the framework, either in drafting or through the consultation process. I hope that the energy and expertise shown so far can be maintained as we move forward in implementing the framework over the next ten years.

MAKING LIFE BETTER

Through collaborative effort and through individual choices and action, I believe that we can make life better in Northern Ireland – for ourselves, our families and our communities.

Edwin Poots MLA
Minister of Health, Social Services and Public Safety

EXECUTIVE SUMMARY

Part One – Context

1. This ten year public health strategic framework provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. The framework builds on the *Investing for Health* Strategy (2002/12) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing. It brings together actions at government level and provides direction for implementation at regional and local level.

2. While in general the health of people in Northern Ireland has been improving over time, health inequalities remain. Too many people still die prematurely or live with conditions they need not have. This situation is not unique to Northern Ireland.

3. In addition to factors such as health behaviours and the provision of health and social care services, population health is to a larger extent affected by economic, social and environmental factors. A number of the priorities outlined in the Programme for Government (PFG) 2011/2015 acknowledge the interrelationship between health, disadvantage, inequality, the social and physical environment, and longer term economic growth.

4. The proposed new framework *Fit and Well – Changing Lives* was consulted on in 2012. A summary of the consultation responses has been published on the DHSSPS website. In addition, the Assembly Health Committee conducted an inquiry into health inequalities, which reported in January 2013 with 9 recommendations. These included the need for a focus on thematic work across government; emphasis on early years interventions and parenting; legislation to support breastfeeding, identification of assets and upskilling for health professionals; funding for projects and increasing spend on ill health prevention. This final framework - “Making Life Better” - builds on “Fit and Well – Changing Lives” and has been re-shaped to take into account the feedback received through the consultation, the Health Committee report and subsequent cross-sectoral discussions.

Part Two – The Framework

Vision and Aims

5. Through strengthened co-ordination and partnership working in a whole system approach, the framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where **All people are enabled and supported in achieving their full health and wellbeing potential. The aims are to achieve better health and wellbeing for everyone and reduce inequalities in health.**

Values

6. A shared set of values is proposed to underpin action –

Social justice, equity and inclusion	All citizens should have the right to the highest attainable standard of health.
Engagement and empowerment	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
Collaboration	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
Evidence - Informed	Actions should be informed by the best available evidence and should be subject to evaluation.
Addressing Local Need	Action should be focused on individuals, families and communities in their social and economic context

A Thematic Approach

7. The consultation document proposed a **life course approach** to reflect the findings of the *Strategic Review of Health Inequalities in England post 2010* (the Marmot Review), and structured action around five life course stages, with underpinning themes of **sustainable communities** and **building healthy public policy**.

8. Consultation identified a qualified welcome for the life course approach, but also concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In addition, the Health Committee's report on health inequalities supported a thematic approach.

9. In light of this the framework has been re-structured around 6 themes:

1. Giving Every Child the Best Start
2. Equipped Throughout Life
3. Empowering Healthy Living
4. Creating the Conditions
5. Empowering Communities
6. Developing Collaboration

10. "Giving Every Child the Best Start" and "Equipped Throughout Life", take account of particular needs across the life course and cover childhood and adulthood, with emphasis given to children and young people, and to supporting individuals' transitions into and through adulthood and older age. "Empowering Healthy Living" addresses support for individual behaviours and choices, including embedding prevention across Health and Social Care services.

11. "Creating the Conditions" and "Empowering Communities" address the wider structural, economic, environmental and social conditions impacting on health at population level, and within local communities. These will align with key government strategies such as those to develop the economy, tackle poverty and promote community relations.

12. "Developing Collaboration" considers strengthening collaboration for health and wellbeing at regional and local levels. This theme identifies three areas of work (in relation to **food, space/environments and places, and social inclusion**) around which a number of partners have been developing collaborative approaches. These areas have been recognised as being of importance in improving health and reducing health inequalities. They have the potential to bring together communities and relevant organisations at local level, supported where necessary at regional level.

Outcomes and Supporting Actions

13. For each of the six themes long-term outcomes have been set with strategic supporting actions and commitments over the current budgetary

period that work towards these. They include actions which are particularly relevant to influencing the determinants of health and wellbeing. It is intended that departmental commitments will be updated on a rolling basis over the period of the framework.

14. The framework is not just about actions and programmes at government level. There are many good examples of joint working underway at a local level that remain relevant. The framework reaffirms and updates the mandate to strengthen collaboration and promote better communication and co-ordination across the system.

The Gradient Approach

15. In order to achieve the aims of better health and wellbeing for everyone and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient, as recognised by Marmot, and requires action to improve universal services as well as more targeted services for those in greater need.

16. There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and take account of identified need.

Part Three - Implementation

17. The framework recognises:

- the key roles of DHSSPS and the wider Health and Social Care system;
- importance of collaboration across government departments; and
- that inter-agency and inter-sectoral partnership working is vital.

It seeks to create a **whole system approach** across the various levels of the system at which work needs to be taken forward.

18. At strategic level the framework illustrates the inter-connectedness of many government policies and programmes. It highlights opportunities to

strengthen these linkages through, for example, consideration of health and health equity in policy making, and governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.

19. This will require clear lines of communication and accountability, and clarity on how governance and implementation is to work. Connections with other relevant structures, strategies and initiatives need to be managed and maximized.

Structures

20. At strategic level a **Ministerial Committee for Public Health** will be established. Key functions will be to provide strategic leadership, direction and coherence with other key strategic programmes and structures, such as Programme for Government (PFG), NI Economic Strategy and Delivering Social Change, agree shared goals and priorities and oversee implementation on behalf of the Executive. This group will be chaired by the Minister for Health, Social Services and Public Safety and supported and informed by the All Departments Officials Group (ADOG).

21. The **All Departments Officials Group** (ADOG), chaired by the Chief Medical Officer, will comprise senior officials from all departments. It will inform and make recommendations to the Ministerial Committee; co-ordinate collaborative working at departmental level; connect with the Regional Project Board, directing, or supporting action as appropriate; and monitor and report on progress.

22. The **Regional Project Board**, led by the Public Health Agency (PHA) will focus on strengthening collaboration and co-ordination to deliver on shared strategic priorities across sectors at a regional level, and on supporting implementation at a local level. Membership of the group will comprise the Chief Officers of relevant statutory agencies, and include representation from local government, the community and voluntary sector and the private sector.

23. This Group will be informed by and will support **Local Partnerships** of key statutory, private, community and voluntary bodies, based on an agreed geographic coverage. These should be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined under **"Developing Collaboration"** (in relation to **food, space/ environments and places, and social inclusion**).

24. The Partnerships' role will focus on local delivery and will be to identify local opportunities for partnership working based on local need; drive local interventions/services to support those most in need and ensure regional priorities are reflected in local plans.

25. These arrangements should link into and align with local **community planning** arrangements over time. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.

Resources

26. The actions committed to are supported by funding from across Government. This is underpinned by the Executive's commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.

27. The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition, it will be important to continue to collaborate with other departments as appropriate, to deliver relevant cross-cutting programmes. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of the framework. Opportunities to pool resources should be explored. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

Monitoring

28. Overall activity will be reported on annually. The framework also identifies a number of high-level indicators which will serve as proxy measures to monitor progress towards the outcomes, and which will be used to measure progress over time. Many of these will measure the scale of inequalities in addition to overall levels. Recognising the influence of the wider socioeconomic determinants of health, a number of the indicators derive from the strategies of other Departments. It will be important to improve the availability and use of data on an ongoing basis.

PART ONE – CONTEXT

MAKING LIFE BETTER

CHAPTER 1 – INTRODUCTION

1.1 In general, the health of the Northern Ireland population has been improving over time. Social, economic, environmental and health improvements have meant that people are living longer than before – between 1981 and 2010[i] life expectancy has increased here for both men and women by 8 and 6 years respectively. Advances in treatment and care have also meant that chronic conditions can be managed differently to secure better quality of life for longer.

1.2 Unfortunately not everyone has had an equal chance of experiencing good health and wellbeing. Too many still die prematurely or live with conditions that could be prevented. This is particularly the case for those who are disadvantaged, leading to a gap in health between those who live in more affluent circumstances and those whose circumstances are deprived.

1.3 An illustration of this is provided by the "Barcode" [Figure 1] which shows the variation in life expectancy of people in each of Northern Ireland's electoral wards ranked by level of deprivation. (White bars represent those wards where life expectancy is lower than the NI average, black represents those where life expectancy is higher than the NI average, and grey represent wards where life expectancy is similar to the NI average). The general trend is that people are more likely to live longer the more affluent their circumstances, although as illustrated this is not always the case. There are wards towards either end of the scale where life expectancy does not follow the general trend. (Further information about health and health inequalities in Northern Ireland is at Annex A.)

Figure 1: Male Life Expectancy[i] in Electoral Wards by level of deprivation.[ii]

i Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.

ii Despite ward-level life expectancy estimates being based on 11 years of data, they are subject to a degree of fluctuation due to the small numbers involved. In addition, it should be noted that small area estimates for life expectancy are normally calculated separately for each gender and there are a number of limitations to the data when estimating overall life expectancy at this level.

MAKING LIFE BETTER

1.4 In 2002 the Northern Ireland Executive recognised the importance of the social, economic, physical and cultural environment to health and published a cross-cutting public health strategy, *Investing for Health*[1]. A review of *Investing for Health* (2010)[2] highlighted key areas of success, for example the extent to which local stakeholders had been energized and inspired to work for health improvement, providing a good foundation on which to build. It also found that much of its approach remains relevant, but that the current, more developed evidence base and the changed socio-economic context needed to be reflected in an updated public health strategy.

1.5 *Investing for Health* sought to reduce health inequalities – avoidable differences in health status between different population groups. The last ten years have not seen a noticeable narrowing of the gap in health status between those living in the most deprived areas and the Northern Ireland average. Northern Ireland is not unique in this – health inequalities have widened in many countries across the world.

1.6 A proposed new ten year public health framework, *Fit and Well – Changing Lives 2012-22*[3], was published for consultation from mid-July 2012 to mid-November 2012.

In addition to publication on the Department's website, the Department engaged with a number of network organisations and partnerships to seek the views of key stakeholder sectors and population groups. Including reports by the network organisations, a total of 141 responses were received, with many of these directing the department to additional evidence, views and recommendations.

1.7 There was a general welcome for the framework aims of improving health and reducing inequalities in health, and for a "whole of society" approach across government and other sectors at various levels. Some key sectors, in particular the community and voluntary sector and local government, felt that their contribution was insufficiently recognised and this has been strengthened in the revised framework.

1.8 Respondents generally felt that the document was too long and complex, with too many priorities. It was also the view that, by concentrating on life stages, there was insufficient focus on actions to address the social and economic determinants that are shown to impact most powerfully on health and inequalities across life stages. Feedback also pointed out that there was no recognition of the potential of legislation as a lever for change.

1.9 A summary of the responses to the consultation, with an indication of how these have been reflected in this final version of the framework, is available on the DHSSPS website. One obvious change is the framework's revised title – **"Making Life Better"** – which is intended to reflect that effort is required on a number of fronts, and that health and quality of life are inextricably linked.

1.10 At the same time as the consultation, the NI Assembly Health Committee conducted an inquiry into health inequalities[4] which took evidence from a range of expert witnesses nationally and internationally. The Committee's report called for greater joined up working across Departments, including those not traditionally associated with health matters, and recommended a thematic approach across Departments to tackle inequalities. Recommendations in relation to the importance of early years interventions and for provision of support for parents were made. Identifying all assets that can be used to tackle inequalities and prioritising funding to support collaborative working were also recommended. The Committee called for an increasing share of the overall health and social care budget to be devoted to prevention.

The Committee's report, published in January 2013, and the DHSSPS response are also available on the DHSSPS website.

1.11 Following on from the consultation process, in 2013 two cross-sectoral workshops were held to consider the feedback received on "Fit and Well – Changing Lives" and to explore how this should influence the final framework. The outcomes of all of these processes and subsequent cross-sectoral discussions have informed this revised framework "Making Life Better."

1.12 Importantly, the framework also draws on the updated evidence base and direction provided by a number of key reports and policies, including –

- World Health Organisation Commission on the Social Determinants of Health 2008[5]
- Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post 2010 (the Marmot Review)[6]
- Health 2020 – European policy framework and strategy, WHO 2012[7]
- Strengthening public health services and capacity: an action plan for Europe[8]

- Review of social determinants and the health divide in the WHO European Region, WHO, 2013[9]

Impact of Inequalities

- Approximately **one fifth** of the NI population are in relative poverty. In 2011-2012 there were approximately 379,000 people (21% of the population), including almost 95,000 children (22%) in relative poverty[iii].

- Between 2009 and 2011, on average **5,500** premature deaths[iv] per year occurred which accounted for **38%** of all deaths over the same period and an average of **17** potential years of life lost per person.

iii derived from Family Resources Survey NI, DSD

iv deaths of those aged under 75 years

What the Framework Seeks to Achieve

1.13 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives, and move towards a vision for Northern Ireland where:-

"All people are enabled and supported in achieving their full health and wellbeing potential."

The framework aims to:

"Achieve better health and wellbeing for everyone and reduce inequalities in health."

1.14 The vision and aims make clear that a societal effort is required. Many contributions need to be made at all levels – from government, to regional and local levels – and in many settings, such as communities, workplaces, schools, and homes.

1.15 The framework provides strategic direction for co-ordinated action by identifying themes and outcomes to guide planning and implementation for the next ten years. However, it is also intended to be a "living" document." Short-term commitments are included for the current PFG and budgetary period which will be reviewed and updated on a rolling basis over the ten year period of this framework.

MAKING LIFE BETTER

Northern Ireland at a glance

- Average male life expectancy was now 77.5 years (2009/11), and female life expectancy was 82.0 – an increase of 8 and 6 years respectively since 1980/82.
- In the same period the gender gap in life expectancy decreased by 2 years to 4.4 years.
- The absolute gap in life expectancy between the 10% most and least deprived areas (2009/11) was 10.7 years for males and 7.7 years for females.
- Coronary heart disease, cancer and respiratory disease continue to be the main causes of death for both sexes.
- Northern Ireland has a 25% higher overall prevalence of mental illness than England – 1 in 5 adults here have a mental condition at any one time.
- During 2009/11 the suicide rate in males was 25.1 deaths per 100,000 population and in females 7.4, with the suicide rate in the 10% most deprived areas almost five times that within the 10% least deprived areas.
- In 2011/12 almost a fifth (19%) of adults (18 and above) stated they drank in excess of weekly recommended drinking limits.
- Hospital admission rates due to alcohol-related causes in the most deprived areas were consistently more than **double** the NI rate in 2008-10, and between **five and six times** the admission rate in the least deprived areas throughout the period.
- 61% of adults surveyed in 2011/12 were either overweight or obese (68% of males and 56% of females), and a tenth of both boys and girls aged 2-15 were also assessed as being obese.
- In 2011/12 of those surveyed, 25% of adults were smokers, with a proportion of 30% in the 20% most deprived areas.

MAKING LIFE BETTER

Some estimated costs-

- The impact of the misuse of alcohol on society is estimated at some £900 million each year – almost £250 million of these costs are borne by the Health and Social Care Sector[v].

- Loss to the local economy as a result of obesity is estimated at £400 million, £100m of these costs were direct healthcare costs[vi].

- DHSSPS has estimated the 2011/12 hospital costs of treating diseases, of which smoking could be a contributory factor, as £164 million[vii].

v Social Costs of Alcohol Misuse in Northern Ireland for 2008/09, Research commissioned by Public Health Information and Research branch, DHSSPS

vi The Cost of Overweight and Obesity on the Island of Ireland – Safefood, November 2011

vii Methodology adopted from report by the Tobacco Advisory Group of the Royal College Of Physicians

CHAPTER 2 – WHAT DETERMINES HEALTH AND WELLBEING

2.1 Health is more than just the absence of disease – it is a state of "complete physical, mental and social wellbeing"[10]. Wellbeing has physical, cognitive, social and emotional dimensions, and is influenced by development across the life course. The World Health Organisation (WHO) defines mental health as a "state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[11]

2.2 While genetic make-up plays some part in people's chances of leading long and healthy lives, there are many more factors which interact to influence health and wellbeing at various stages in their lives[12]. This is illustrated in the figure below, which has been developed from earlier work by Dahlgren and Whitehead, 1993[13].

Figure 2: Health Map for the Local Human Habitat

MAKING LIFE BETTER

2.3 Health and wellbeing is about so much more than health and social care. A recent American study[14] ranked factors determining the best health outcomes for local populations. According to the study:

- Social and economic issues such as education, employment and violent crime accounted for 40%;
- Health behaviours (alcohol, tobacco and sexual behaviour) accounted for 30%; and
- Clinical services, including quality of and access to health care, accounted for 20%.

In other words health is affected more by economic, social and environmental factors than by anything else.

Health Inequalities

2.4 In 2008 the World Health Organisation (WHO) Commission on the Social Determinants of Health completed a two-year investigation into the social causes of health inequalities. The report concluded that health inequalities cannot be fully explained by variation in income alone. In addition to income, the Report concluded that health inequalities are caused by inequitable distribution of more fundamental social, political and economic forces, the 'social determinants of health' already referred to, much of which is outside of the remit of health ministries.

2.5 The Marmot Review into health inequalities *(Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England 2010)* presented a substantial body of evidence on health inequalities. The Review's findings reinforce that addressing health inequalities requires co-ordinated action across the social determinants of health. Both this and the 2008 reports affirm that inequalities in health arise because of inequalities in society – "in the conditions in which people are born, grow, live, work and age".

2.6 This evidence has since been supplemented by WHO's publication in 2013 of the "Review of social determinants and the Health Divide in the WHO European Region". The experience of countries in the European Region shows that there are widespread inequities in health between and within societies – there should therefore be two clear aims: *"Improving average health and reducing health inequities by striving to bring the health of less – advantaged people up to the level of the most advantaged".*

Life Course

2.7 Central to the Marmot review is a life course perspective. There is an accumulation of advantage and disadvantage across the life course and each of life's transitions can affect health by moving people onto a more or less advantaged path. The review emphasised that action to reduce health inequalities must start before birth, and be continued through the life of the child, if the close links between early disadvantage and poor outcomes throughout life are to be broken. For this reason "giving every child the best start in life" was the review's highest priority recommendation.

2.8 Health 2020 and the "Review of social determinants and the health divide in the WHO European Region" re-emphasise the life course approach as the recommended way to planning action on the social determinants of health. Whilst the life course approach begins with the important early stages of life – pregnancy and early child development – action is needed at every stage and continues with school, the transition to working life, employment and working conditions and circumstances affecting older people.

Social Gradient

2.9 Studies such as those mentioned above show that there is a social gradient in health. The social gradient in health means that health gets progressively better as the socioeconomic position of people and/or communities improve. This pattern is also evident in the Northern Ireland population (illustrated in Annex A). The social gradient of health exists across the whole population, while the most profound differences in health can be seen between the most and least disadvantaged. To reduce the steepness of the gradient, it is important to act across the whole gradient, and to address the needs of people at the bottom of the social gradient, and those who are most vulnerable, with a view to bringing the health of the least advantaged up. To achieve this, actions are needed that are universal, but implemented with a scale and intensity proportionate to the level of social and health needs. This is known as *proportionate universalism*. It must be acknowledged however that "more of the same" does not always work, and in some cases a different or new approach may be required.

2.10 It has been argued[15] that health promotion initiatives and improvements in technology and service delivery can increase inequalities - because people in higher social classes are more likely to avail of them. Policies that have achieved overall improvements in key determinants, like living standards and smoking, have often increased inequalities in these major influences on health. It is therefore important to distinguish between the overall level and the social distribution of health determinants and interventions, and to seek to avoid public health interventions increasing inequalities.

CHAPTER 3 – WIDER CONTEXT

3.1 Government policies and programmes have a significant impact on health and wellbeing. A number of key policies are highlighted in this and later chapters which illustrate the inter–relationships between various government programmes and the ways in which they benefit population health and wellbeing.

Wider Public Policy and a Whole System Approach

3.2 The aims of this Framework and the challenges being addressed are not unique to Northern Ireland. In recent years many governments have increasingly come to realise that they can achieve health, social and economic goals by actively exploring the mutual benefits in sectors such as education, employment, environment, transport and agriculture. Major determinants of ill health can be addressed, and major assets for health can be harnessed by engaging non–health sectors. Collaboration in such a way, alongside engagement of communities and individuals, is a "whole system approach" to health and wellbeing.

3.3 Health 2020 is a joint commitment by the WHO Regional Office for Europe and the 53 European member states to a new common policy framework, which can be adopted and adapted to the different realities within the region. Behind Health 2020 lies the idea that health and wellbeing are essential for human, social and economic development, and of vital concern for the lives of every person, family and community. It reflects a renewed commitment to public health with shared goals to *"significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality".*

3.4 Health 2020 argues strongly that all parts of government need to work together through increased whole-of-government working to recognize risk patterns and identify solutions, share responsibility across policy fields and sectors and act at multiple levels. Health 2020 proposes a set of areas for policy action and for inclusion in strategies for reducing health inequities, to include:–

- action on social determinants across the life course, with the highest priority given to ensuring the best start to life for every child;

- promotion of cohesion and resilience at local level through a whole of society approach;

- addressing links between environmental social and economic factors: and

- focusing on whole of government and whole of society delivery and governance.

3.5 These themes are also reflected in the English White Paper *Healthy Lives, Healthy People – Our Strategy for Public Health in England*[16] published in November 2010. In response to Professor Sir Michael Marmot's Review the White Paper outlined the cross- government framework to enable local government and local communities to be at the heart of improving health and wellbeing and tackling inequalities for their populations. A new integrated public health service – Public Health England – has since been created to strengthen public health across national and local government levels.

3.6 In March 2013, the Republic of Ireland published *Healthy Ireland - Framework for Improved Health and Wellbeing 2013- 2025*[17]. The framework draws on existing policies but proposes new arrangements to ensure effective co-operation and collaboration and to implement evidence- based policies at government, sectoral, community and local levels. A key shift through Healthy Ireland is towards a whole government/ whole society approach.

Northern Ireland Policy context

3.7 The Northern Ireland Executive's *Programme for Government 2011-2015: Building a Better Future*[18] sets out the key goals for government and outlines a number of Executive commitments to achieve its key priority of "a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations".

3.8 PFG recognises the relationship between health, disadvantage, inequality, the social and physical environment, and economic growth. These inter-relationships require that departments work together to produce policies and plans consistent with the five priorities. This framework will be one of the "building blocks" for the achievement of a number of priorities identified in PFG, particularly Priority 2, Creating Opportunities, Tackling Disadvantage and Improving Health and Wellbeing and a key element in efforts to build a "shared and better future for all".

Context for Implementation

Wider public sector

3.9 Effective co-ordination at strategic and delivery levels between this framework and other key government strategies will be vital to ensure maximum impact. Key examples include:–

- *NI Economic Strategy;*
- *Anti-poverty Strategy and Action Plans;*
- *Children and Young People's Strategy and Action Plans;*
- *Delivering Social Change;*
- *Together: Building a United Community; and*
- *Active Ageing Strategy*

3.10 For *Making Life Better* to succeed there is a need for policy coherence and consideration of health and health equity in policy making. Co-ordinated implementation across and beyond government departments and agencies at regional and local levels is also required, ensuring all parts of the system are connected. Efforts must be renewed to strengthen links and maximise resources, particularly during a time of financial constraint coupled with ongoing reform of public administration.

Development of new public health legislation

3.11 A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. Subject to Executive approval for the review to be carried out, it will put forward proposals for updating the current legislation, in line with reforms carried out in other jurisdictions which reflect an 'all hazards' approach. The 1967 Act is outdated and requires modernisation to enable government to deal effectively with 21st Century threats to public health. A review of the legislation, resulting in an updated statute, will provide an important mechanism for the delivery of a broader strategy for public health.

The Health and Social Care System

3.12 Health is increasingly acknowledged as having a significant influence on the economic aspects of society and on social cohesion. The health care industry is one of the world's largest and most rapidly growing sectors. It is a major employer encompassing a wide range of services, manufacturers and suppliers. At the same time expenditure on health poses a greater challenge than ever before, posing a threat to the long –

term sustainability of the health care system. Chronic disease affects the labour market and productivity at work, and the development of expensive medical technologies and treatments drive up the cost of managing chronic diseases and multiple morbidities. These cost pressures provide a strong economic case for action and investment to promote health and prevent disease.

3.13 The capacity and efficiency of health and social care systems is an important health determinant. The sector plays many roles in improving population health and addressing inequalities in health determinants: a direct leadership role, as a large employer, and as an influencer, mediator and collaborator. Since the recent Health and Social Care Reform in Northern Ireland, public health and wellbeing has been placed firmly at the centre of the system, with greater emphasis on prevention, early intervention, and on addressing health inequalities. It is vitally important that all organisations and individuals within the Health and Social Care system work coherently together to fulfil their respective roles and responsibilities in support of the vision and aims of this framework and related strategies.

3.14 The Department of Health Social Services and Public Safety (DHSSPS) has a statutory responsibility to promote an integrated system of health and social care (HSC) designed to secure improvement in:

- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and
- the social wellbeing of the people in Northern Ireland

3.15 The department takes this forward both by direct action and through its Arms Length Bodies which make up the sector.

3.16 Under the Health and Social Care (Reform) Act (NI) 2009 (the Act) the Health and Social Care Board (HSCB) supported by 5 Local Commissioning Groups (LCGs) has delegated statutory responsibility for commissioning the range of health and social care services on behalf of the entire population of Northern Ireland. The HSCB has the capacity therefore to greatly influence improvements to population health, and has a statutory duty to co-operate with the PHA in carrying out its commissioning function.

3.17 At sub-regional level there are 5 Health and Social Care Trusts which provide services as commissioned by the HSCB and PHA. The Act places a statutory duty on the PHA and Health and Social Care (HSC) Trusts to work to “improve the health and social well-being of, and reduce health

inequalities between, people in Northern Ireland".

3.18 In addition all the main HSC bodies have a statutory duty of public involvement and consultation – Personal and Public Involvement (PPI). This requires them to involve people at a personal and public level, ensuring everyone, including vulnerable groups, can influence decisions about service design and delivery.

3.19 Key strategic priorities have been identified for the overall Health and Social Care system. These also reflect the Department's specific commitments to the wider PFG:

- to improve and protect health and wellbeing and reduce inequalities, through a focus on prevention, health promotion and earlier intervention;
- to improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services;
- to improve the management of long-term conditions in the community with a view to improving the quality of care provided, and reducing the incidence of acute hospital admissions for patients with one or more long term conditions;
- to improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- to improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities; and
- to ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all services.

3.20 A number of key policies and strategies also inform service direction including –

- Quality 2020[19], which aims to protect and improve the quality of services and achieve excellence, based on three key components – safety, effectiveness, and patient and client focus;
- Service Frameworks which set out the type of service that patients

and users should expect, and aim to secure better integration of service delivery along the whole pathway of care from prevention of disease/ill health to diagnosis/treatment and rehabilitation, and on to end of life care.

3.21 A further key report, *Transforming Your Care (TYC): A Review of Health and Social Care in Northern Ireland*[20] published in December 2011, set out proposals for the future shape of services across the range of service areas. Both the original review and subsequent consultation and implementation documents include a focus on prevention and earlier interventions as a key part of the model of care closer to home, with helping people to stay healthy and make good health decisions a central goal. TYC is a key element of the wider, holistic approach to tackling inequalities.

Role of Public Health Agency

3.22 The PHA was established to bring renewed focus on public health goals and has the lead role in integrating and supporting health improvement across all parts of the Health and Social Care system. It also has a general responsibility for promoting improved partnership working with local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social wellbeing and for anticipating the new opportunities offered by community planning. The PHA operates at both regional and local levels. The PHA will make a major contribution to the co- ordination of the delivery of the aims of this framework.

Role of the Institute of Public Health

3.23 The Institute of Public Health in Ireland (IPH) was established in 1998 and promotes cooperation for public health on the island of Ireland through:

- strengthening public health intelligence;
- building public health capacity;
- policy and programme development, and evaluation.

The IPH has had a lead role in promoting the application of Health Impact Assessment through the development of practical tools, training, research and facilitating networking opportunities.

Local Government

3.24 There is a key interface between public health, health and social care and the role of local government. Local government will continue to be a natural partner in helping to deliver health improvements and address health inequalities at the community level. The joint working arrangements that exist between the PHA and district councils in support of health and wellbeing improvement, and the commissioning responsibilities of Local Commissioning Groups of the Health and Social Care Board, need to be visible in the proposed new community planning responsibilities of councils. This framework provides a mandate for the joint working arrangements between the PHA and local councils on local delivery, and sets a direction for the public health element of community planning.

3.25 The reform of local government is a priority of the PFG. The Executive's vision for local government is of one that is "strong and dynamic, creating communities that are vibrant, healthy, prosperous, safe, sustainable, and which has the needs of all people at its core". Local government reform will reduce the number of councils from 26 to 11, modernise and streamline public administration, and transfer a number of functions and powers from central government departments to the new councils. It is being managed in line with the 2015 timetable proposed in the Executive's Programme for Government 2011/2015.

3.26 The functions being transferred to councils include planning, aspects of urban regeneration, local economic development and tourism. Councils will also have a new duty to make arrangements for community planning. The integration through community planning of the functions being transferred and councils' existing functions should provide a productive joined up approach which optimises opportunity and makes best use of all the assets available. It will change the way cities, towns and rural areas are planned, and place a sharper focus on sustainable local economic development.

3.27 Community planning will bring councils, statutory bodies and the community and voluntary sector together to develop and implement a shared vision for promoting the wellbeing of an area. Councils will set up a community planning partnership to provide leadership to the process. This will include organisations, central government departments and agencies operating in their area that will work in partnership with them to plan and provide services at the local level, and contribute to PFG objectives at the regional level. Departments will also be required to promote and encourage community planning and have regard to the councils'

community plans in planning the delivery of services.

3.28 The broader range of powers, combined with partnership working with other Departments and agencies operating in their area, means that Councils will be able to better co-ordinate service delivery and avoid duplication, and will lead to more efficient, high quality services. Within the reconfigured, larger Council areas care must be taken not to lose the necessary focus on the most disadvantaged areas.

3.29 Although DHSSPS will not be transferring any functions to local government in 2015, maintaining and strengthening inter-sectoral working between local government and Health and Social Care is key and will provide an important opportunity to maximise the potential for improving the health and wellbeing of communities and tackling health inequalities at the local level.

Community and Voluntary Sector

3.30 Tackling inequalities in health cannot be achieved by statutory agencies alone. This framework will seek to create the conditions for individuals and communities to take control of their own lives, and can only be achieved in full partnership with local communities, communities of interest, volunteers, and the community and voluntary sectors to aid the development of policies and actions that are applicable to the issues faced by communities.

3.31 Community and voluntary organisations play a vital role in enabling and empowering people to improve their health, and in representing and supporting particularly vulnerable interest groups. Development of community capacity and social capital, and drawing on the strengths or assets within communities, will be key to making progress.

3.32 A key government aim is to ensure a vibrant and sustainable voluntary and community sector that can thrive and work closely with Government in the design and delivery of policy and services in the interests of the people of Northern Ireland. This framework fully supports the shared values and principles in the Concordat between the Voluntary and Community sector and the Northern Ireland Government (2011)[21].

> "Working effectively together will help, for example, to develop sustainable, safer communities, ensure a well protected and valued environment, contribute to economic growth, tackle poverty, disadvantage and inequality, and assist in the promotion of health and well being."
>
> *Concordat between the Voluntary and Community Sector and the NI Government 2011*

3.33 Within the health and social care sector, the Health and Social Care Board and PHA have produced "Working in Partnership – Community Development Strategy for Health and Wellbeing 2012 – 2017."[22] This recognises community development as a practice which "assists the process of people acting together to improve their shared conditions, both through their own efforts and through negotiation with public services." The strategy aims to strengthen communities and improve health and social wellbeing by placing an increasing emphasis on community development, prevention and early intervention. It provides guidance and direction on how community development approaches are to be taken forward within health and social care, with an expectation that every HSC organisation incorporates a clear and transparent community development approach into their programmes.

3.34 In the Health and Social Care context, community development also links with mechanisms to improve services and care. The statutory duty of public involvement and consultation – Personal and Public Involvement (PPI)[23] - on Health and Social Care organisations is a central component of the agenda to improve health and social care provision.

3.35 The empowerment of communities, assisted by implementation of community development approaches and PPI, will be key to improving health and reducing inequalities in health. Partnership working with grassroots community and voluntary sector organisations will help release and support the energy within communities, and encourage further development of community capacity to address local needs (see also Chapter 9 – Empowering Communities).

Other Organisations and Partnerships and Business sector

3.36 A variety of partnership arrangements already exist at both regional and local levels in relation to health, or to take forward other government strategies and programmes which impact on health. Both Belfast and Derry are part of the WHO Health Organisation Healthy Cities Network*. Belfast Healthy Cities has recently celebrated 25 years of advocacy and effort on behalf of the city and has a reputation as a key contributor to the Healthy Cities Network. There are many other organisations, including professional bodies, trade unions, advocacy and/or philanthropic organisations, sporting and cultural organisations, and funding bodies, which make important contributions. Appropriate and effective linkages and information sharing with and between such organisations will be beneficial to population health.

3.37 Many partners within the business sector can play a key role. In England this has been recognised through DOH England's collaboration with the sector in promoting "Public Health Responsibility Deals" to promote socially responsible approaches, including for example in relation to consumer information about food. Northern Ireland stands to benefit from these wider relationships and will continue to advocate through relevant networks.

3.38 Retailers, media, sports and leisure businesses can contribute in many ways to promote or support healthy choices. Business in the Community NI is a membership organisation which works to support companies committed to doing business in a way which helps them impact positively on their "People, the Planet and the Place".

* The WHO European Healthy Cities Network consists of cities around the WHO European Region that are committed to health and sustainable development: more than 90 cities and towns from 30 countries. They are also linked through national, regional, metropolitan and thematic Healthy Cities networks. A city joins the WHO European Healthy Cities Network based on criteria that are renewed every five years.

MAKING LIFE BETTER

PART TWO – THE FRAMEWORK

CHAPTER 4 – VISION, AIMS, VALUES AND THEMES

Vision and Aims

4.1 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where –

"All people are enabled and supported in achieving their full health and wellbeing potential."

The aims of the framework are to:

"Achieve better health and wellbeing for everyone and reduce inequalities in health"

Values and Principles

4.2 While values and principles of *Investing for Health* still have merit, the consultation highlighted that some of the concepts did not reflect current thinking or language. The values and principles have been revised to provide a shared set of values to underpin action at strategic and local levels:

Social justice, equity and inclusion	All citizens should have the right to the highest attainable standard of health.
Engagement and empowerment	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
Collaboration	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
Evidence - Informed	Actions should be informed by the best available evidence and should be subject to evaluation.
Addressing Local Need	Action should be focused on individuals, families and communities in their social and economic context.

4.3 The **"right to health"** has been enshrined in the World Health Organisation (WHO) Constitution[24] and in international and regional human rights treaties, such as the UN Convention on the Rights of the Child, including *General Comment No 15 (2013)*, Convention on the Elimination of all forms of Discrimination Against Women, and Convention on the Rights of Persons with Disabilities[25].

4.4 The right refers to the *"highest attainable standard of physical and mental health"* as a fundamental right of every human being, and means that governments must create conditions in which everyone can be as healthy as possible – such actions range from ensuring the availability, affordability and accessibility of health services to taking public health measures for healthy and safe working conditions, adequate housing and nutritious food and other conditions for protecting and promoting health. Citizens, in turn, need to understand the value of their health and contribute actively to creating better health in society at large.

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition. (WHO Constitution)"

4.5 At the heart of human rights is the recognition that they are universal, that everybody should be treated equally and with dignity, and that all human rights are interrelated, interdependent and indivisible. Health 2020 asserts that "human rights standards and principles - such as participation, equality, non-discrimination, transparency and accountability - should be integrated into all stages of the health programming process and should guide health policy making."

4.6 Health inequalities result from social inequalities. Reducing health inequalities that are preventable by reasonable means is a matter of fairness and social justice requiring action across society. This aligns with the PFG priority of addressing the challenges of disadvantage and inequality that afflict society, and working to close the gap in health between those who are least and most disadvantaged.

4.7 Promoting equality of opportunity is fundamental to the achievement of the aims of this framework. The social determinants of health affect Section 75 groups differently, for example the social and economic roles performed by men and women significantly affect the health risks to which they are exposed over the life course. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic

position in shaping people's health and wellbeing. A key purpose of this framework is to set out a strategic direction and actions that will actively pursue health equity and social inclusion. Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations.

4.8 The value of community development as a process to empower and bring about changes to individuals, communities and wider society founded on social justice, equality and inclusion is recognised. Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices (see also Chapter 10 – Developing Collaboration)

This approach goes hand in hand with the statutory duty of public involvement and consultation - Personal and Public Involvement (PPI) on Health and Social Care organisations in empowering people to make decisions about services and care.

Themes

4.9 The consultation document *Fit and Well – Changing Lives* proposed a life course approach to reflect the Marmot Review findings, and structured action around five life course stages, with underpinning themes of "sustainable communities" and "building healthy public policy". The document also proposed two strategic priorities – Early Years and Vulnerable People and Communities.

4.10 In the responses to the consultation there was a qualified welcome for the life course approach. There was concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In particular, respondents highlighted the need to mitigate the effects of poverty, support people through welfare reform and into employment. In addition the Health Committee's report on health inequalities supported a thematic approach. In the consultation responses, there was general support for making early years a priority, and Giving Every Child the Best Start is retained in the framework as a theme.

4.11 In light of this feedback the Framework has been re-structured around the following themes:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration.

4.12 "Giving Every Child the Best Start" and "Equipped throughout Life" take account of the particular needs across the life course and have been broadened to cover childhood and adulthood. They address the key social determinants at each stage. Particular emphasis is given to children and young people, and to supporting individuals' transitions into and through adulthood and older age. "Empowering Healthy Living" addresses support for individual behaviours and choices, and embedding prevention in Health and Social Care services. The next two themes address the wider structural, economic, environmental and social conditions impacting on health - at population level, and within local communities.

4.13 "Developing Collaboration" considers strengthening collaboration for health and wellbeing at regional and local levels. A number of strategic actions are identified, and in addition it identifies three areas of work around which a number of partners have been developing collaborative approaches.

4.14 For each theme, key long-term outcomes have been set. These are outlined in the next series of Chapters along with strategic supporting actions and commitments over the next 2-3 years that work towards these outcomes. These include actions planned either as PFG commitments or business commitments of particular departments; all are relevant to influencing the determinants of health and wellbeing. Progress on these supporting actions will be monitored and, in due course, the actions will be updated in line with PFG and budget periods.

4.15 However this is not just about actions and programmes at government level. It is acknowledged that there are many good examples of joint working underway amongst key partners such as public sector agencies, local government, the community and voluntary sector, local communities and the private sector. The framework reaffirms and updates the mandate to strengthen collaboration at all levels, and promote better communication and co-ordination across the system.

The Gradient Approach

4.16 There was less consensus in the consultation response on the second priority ("Vulnerable People and Communities") with many responses suggesting additional vulnerable population groups. The groups and communities within society who require targeted support vary depending on need and the issue being addressed. Furthermore, the findings from the Marmot and other reviews highlight the social gradient that exists across the entire socioeconomic spectrum. These reviews call for universal action, but with a scale and intensity proportionate to the level of disadvantage – proportionate universalism.

4.17 In order to achieve the aims of better health and wellbeing for everyone, and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient and requires action to improve universal services as well as more targeted services for those in greater need. This is with a view to narrowing the health gap by bringing up the level of health of the groups of people who are worse off.

4.18 There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. The gradient approach adopts a combination of broad universal measures with strategies targeted at high- risk groups. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and include careful targeting of resources to meet greatest need, with the aim of reducing health inequalities.

CHAPTER 5 – GIVING EVERY CHILD THE BEST START

Key long term outcomes:

1. **Good quality parenting and family support**
2. **Healthy and confident children and young people**
3. **Children and young people skilled for life**

5.1 What happens to children in their earliest years is key to outcomes in adult life. This is supported by a wide range of research evidence from education, health, justice and economic experts[26]. Individuals and communities benefit from the strong attachment and emotional links that are created by good parenting and positive early life experiences. These give children the best start in life and help to prepare children to get the most out of education and social interactions.

1 GOOD QUALITY PARENTING AND FAMILY SUPPORT

5.2 From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and care givers, have a significant impact on their cognitive, emotional and social development. The importance of working in partnership with parents and care givers to enable them to encourage a positive home environment, and to provide continuity in their child's early experiences from home to pre-school, is clear.

5.3 Research shows that a shift in emphasis towards co-ordinated support for children in their early years is the most likely route to breaking the cycle of disadvantage and reducing inequalities in health. This is consistent with obligations under the Child Poverty Act 2010. In view of this, and supported by recommendations by the Health Committee for greater focus on early years interventions, this framework places the highest emphasis on the significance of parenting and family support as providing the foundation for realising the potential of children and young people, and for longer term public health and wellbeing.

5.4 The need to shift investment towards early intervention services and programmes for children and families has been recognised more widely across government, for example through two projects underway with funding from the Delivering Social Change

programme to support the development of an additional 10 Family Support Hubs, and a number of targeted parenting programmes over the 2012/13–2014/15 period.

5.5 A collaborative approach is required to bring about the incremental development of universal and targeted programmes to include ante and post natal care and parenting programmes. This progression will need to be co-ordinated to link with a number of relevant strategic programmes such as: Children and Young People's strategy, Delivering Social Change, DE policy and programmes for early years and school age children (such as Learning to Learn: A Framework for Early Years Education and Learning), Families Matter, Child Health Promotion Programme, Maternity and Breastfeeding strategies.

5.6 On behalf of a collective of government departments, it is proposed that DHSSPS will lead the implementation of an Early Intervention Transformation Programme from 2014, subject to funding being approved. It is intended that this Programme will facilitate a systemic change in how services are provided to children and families in Northern Ireland in order to measurably improve outcomes. The emphasis will be on intervening early in a child's life, or at the stage when family difficulties are emerging, so that they can be successfully addressed before problems become entrenched.

5.7 In terms of delivery, the Children and Young People's Strategic Partnership, which brings together key agencies to plan and integrate children's services, in partnership with the Child Development Board established by the PHA to review and advise on evidence, will be key to taking forward this co-ordinated approach. This work reports to and is guided by the Ministerial Sub- committee for Children and Young People.

5.8 A review of the Families Matter Strategy will seek to consolidate and further strengthen efforts to ensure that parents and families continue to receive the information, support, and gain the skills they need to help their children reach their full potential. It will aim to address the barriers that hard to reach families experience in accessing services, address the potential stigma associated with using family support services and raise awareness and uptake of relationship support and family mediation.

5.9 *Bright Start - The Executive's Programme for Affordable and Integrated Childcare (A Strategic Framework and Key First Actions)* sets out the framework, principles and a range of key first actions

to help deliver the establishment of an improved and expanded system of childcare, with a key aim of supporting the development of children and young people, and enabling children and young people from all backgrounds, including the most deprived, to avail of life opportunities.

OUTCOME 1 GOOD QUALITY PARENTING AND FAMILY SUPPORT

Actions and Commitments 2013 – 2015

A Promote and support positive parenting through –

- establishment of Family Support Hubs and systematic expansion of a range of initiatives and evidence based parenting support programmes, *with a particular focus on children in need and children in families in areas of disadvantage and experiencing inter-generational unemployment*
- establishment of a cross-departmental/sectoral Early Intervention Transformation Programme
- roll-out of Family Nurse Partnership programme
- implementation of the PHA/HSCB Hidden Harm Action Plan
- improved safeguarding outcomes for children
- parents and other relatives who can play a role in the lives of children who are in care or on the edge of care
- improved availability of high quality, accessible and affordable childcare through a new Childcare Strategy
- implementation of an infant mental health training plan
- implementation of the Education Works campaign and website

Key Partners
DHSSPS / OFMDFM / HSC / PHA / CYPSP / DSD / SSA / DE / DOJ / DEL Safeguarding Board/ Community and Voluntary sector

OUTCOME 1 GOOD QUALITY PARENTING AND FAMILY SUPPORT Continued

Actions and Commitments 2013 – 2015 Continued

B Ensure appropriate family based financial support to children through –

- effective Child Maintenance arrangements in place
- encouraging and enabling families to take financial responsibility for their children
- providing information and support for separated and separating families

Key Partners
DSD

Healthy and confident children and young people

Family Nurse Partnership

The Family Nurse Partnership programme, an intensive preventive home visiting programme, is being introduced to Northern Ireland. It aims to improve antenatal health, child health and development and parents' economic self-sufficiency. Over the next few years it will be offered to around 500 first time young parents from early pregnancy until their child is 2 years old. The programme can deliver tangible outcomes which have been evidenced through 30 years of research in the US'.

2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE

5.10 An updated programme for 0-19 year olds, known as "Healthy Child – Healthy Future (HCHF): a Framework for the Universal Child Health Promotion Programme in Northern Ireland,"[27] was issued in 2010. The framework is central to securing improvements in child health for all children aged 0-19 years, across a range of issues. The framework sets out a core programme of child health contacts that every family can expect, with access to a universal programme of preventative care and additional services for those with specific needs and risks, e.g. neonatal blood spot screening, childhood immunisations, family health assessment, growth monitoring, infant feeding and family nutrition, routine inquiry etc. HCHF aims to identify and respond to families in need at the earliest opportunity.

15% of women in Northern Ireland smoke throughout pregnancy and reflects the general increase in the number of young women who smoke. The risk of complications for the baby includes premature delivery, low birth-weight and cot death. To aid behavioural change, consistent advice should be given to any woman who is smoking and pregnant. Smoke Free Wombs is an exciting initiative by midwives in the South Eastern HSC Trust to encourage mums-to-be to stop smoking. "Smoke Free Wombs" uses Facebook, a powerful DVD, and cartoon images to try and get the message across that smoking harms the unborn child.

Midwives are asking mums-to-be to sign a pledge to work in partnership with them to give up. Mums-to-be will receive a letter outlining how smoking can harm babies in the womb, and offering the opportunity to meet with the Health Improvement Midwife. Women are provided with consistent information through face-to-face contact, phone support, text message and Facebook. Since this initiative began, data suggests a 52% increase in referral to no smoking programmes and that the "quit" rate has trebled.

5.11 Success in learning at school is rooted in the stimulation and encouragement received at home, in the family and in the community. If parents do not have these skills then it is more likely that children fall behind and disadvantage is passed on. This emphasises the importance of support during early years to aid the transition to more formal learning at school, and of maintaining support involving the family, communities and social networks.

5.12 Growing up is a time in life of considerable health and social needs. Whilst investment in early years is crucial, it needs to be combined with sustained commitment to children and young people throughout their school years. How children progress at school beyond early and into teenage years is clearly important to emotional, cognitive, physical and social development throughout their life. Schools are vitally important settings for personal and social development, and the development of life skills and behaviours which will influence later life chances. Implementation of programmes such as nurture provision, a short term early intervention addressing barriers to effective learning; and iMatter, the Pupil's Emotional Health and Wellbeing Programme in post-primary schools, will make a key contribution to building confidence, empathy, self esteem and resilience, and social skills.

5.13 Adolescence is a critical transitional period that includes biological change and the need to negotiate key development tasks such as increasing independence and normative experimentation. Adolescents and young adults are particularly sensitive to influences such as family, peer group, school, neighbourhood, and developmental changes can either support or challenge young people's health and wellbeing. Promotion of positive social competences and abilities such as self worth, aspiration and connectedness, not only facilitates healthy behaviours but also helps to ensure a healthy and productive future adult population.

5.14 Effective collaboration between the health and education sectors, from early years right through school, is crucial to supporting children and young people's development, in terms of their personal and social development, their educational attainment and future life outcomes.

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE

Actions and Commitments 2013 – 2015

A Ensure high quality public health and social care services are provided for all children and young people, from ante natal care onwards to include –

- the full range of health protection, health promotion, surveillance and screening and immunisation programmes
- implementation of the breastfeeding strategy including support programmes for those least likely to breastfeed
- additional and tailored support to those who need it, *for example families with children with a learning or physical disability, young children with speech, language and communication needs, traveller children*
- targeted support for low income, vulnerable pregnant women and young families through the continued promotion and delivery of the Healthy Start scheme

Key Partners
DHSSPS / HSC

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued

Actions and Commitments 2013 – 2015 Continued

B Children are cognitively, emotionally and socially ready to benefit from education by the time they start P1 through –

- linking learning and development more effectively through relevant strategies and policies around early intervention and early years, for example implementing 'Learning to Learn – A Framework for Early Years Education and Learning' to strengthen and develop early years education and learning services

- maintaining high quality Sure Start services in designated areas of disadvantage, to support parenting and services for children aged 0-4; and evaluating through a review how effectively the Programme is making a difference to young children and their families, especially the most disadvantaged

- making at least one year of pre-school education available to every family that wants it - *children from socially disadvantaged circumstances likely to experience barriers to learning identified for targeted action*

Key Partners
DE / DHSSPS/ others

C Maximise opportunities for every child and young person to develop confidence, personal resilience and basic skills required for life through for example –

- ensuring all children's and young people's settings (such as schools, colleges and youth organisations) provide environments which support good health and wellbeing through, for example, implementation of anti-bullying policies, promotion of healthy eating and physical activity

- continuing development and implementation of the "iMatter" programme across post-primary schools and special schools

- Delivering Social Change Nurture Units Project – establish 20 new Nurture Units within Primary Schools, to address early emotional and behavioural difficulties among children in Years 1-3 – *children who have missed early nurture experiences, and their parents identified for targeted action*

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued

Actions and Commitments 2013 – 2015 Continued

C Continued –

- implementation of Priorities for Youth policy

Key Partners
DE / DHSSPS / PHA / Local government / Community and voluntary sector

D Increase parents and children's awareness of child internet safety

Key Partners
Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

E For looked after children and young people ensure –

- greater involvement in the preparation of their care and personal education plans
- improved engagement in special interests, culture and leisure and extra-curriculum activities
- regular school attendance by all children and young people in care

Key Partners
Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

F Promote the benefits of play and leisure and increase the opportunities for children and young people to enjoy it

Key Partners
Departments led by OFMDFM/ Local government / DE / DHSSPS / HSC

Rhythm and Rhyme

Libraries, for example, play a key role in early years development though activities such as "Rhythm and Rhyme".

Many Northern Ireland Branch libraries host Rhythm and Rhyme sessions for babies and toddlers accompanied by parents and carers. Each session lasts around 30 minutes and gives the adults and children time to have fun together. The session is led by a member of staff, and carers and children are invited to participate at whatever level they wish. Musical instruments are also used to add a noisy dimension. Rhythm and Rhyme sessions are an excellent opportunity for parents/carers to meet up at the library and discover how much babies and toddlers love songs and rhymes. They are also a great way to help children's talking and listening skills. Good rhymers make good readers.

3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE

5.14 Evidence shows that children who start off well at school are more likely to achieve good qualifications that lead to a job with good income and social status, which in turn affects health and quality of life. Conversely, children growing up in poorer families are less likely to do well at school and in later life outcomes, than those from more affluent backgrounds. As well as affecting educational achievement, children who do not thrive at school are more likely to become disengaged, and try "risky behaviour" such as smoking and drinking at an early age.

5.15 Inequalities in education outcomes are subject to a similar social gradient as those for health. As with health inequalities, reducing education inequalities involves understanding the interaction between the social influences on education, including family background, and the local community context, as well as the school context. Evidence on the most important factors influencing educational attainment suggest that it is families that have the most influence rather than schools, and that closer links between schools, the family, and the local community are needed.

5.16 Sustained commitment to children and young people throughout their years of education will be vital to reducing inequalities in both health and education. Raising standards of educational attainment especially in areas of social need has a positive impact on improving employability and reducing social exclusion.

5.17 Further support for young people is vital in the form of broader skills development for work and training, including management of relationships, advice on continuing education, budgeting and debt management, parenting etc. Without life skills and readiness for work, young people will not be able to make the most of opportunities and take control over their lives.

5.18 Outside the formal education setting, effective youth work provides young people with valuable opportunities to build self esteem, learn new skills, develop new relationships, and helps them to develop as active citizens and members of their communities. While relevant for all young people, youth work can be particularly relevant for those who are at risk of disengaging from society or disaffected at school. "Priorities for Youth" outlines a framework for youth work within education to support young people to mature to reach their potential as valued individuals and responsible citizens.

OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE

Actions and Commitments 2013 – 2015

A Through implementation of "Every School a Good School" and the Literacy and Numeracy strategy –

- increase the proportion of primary pupils achieving at the expected level in Key Stage Two in both Communication and Using Maths
- address numeracy and literacy issues at transition between primary and post primary school through provision of a professional development programme for teachers of English and Mathematics across Key Stages 2 and 3
- increase the proportion of school leavers achieving at least 5 GCSEs at A* – C or equivalent, including GCSE English and Maths
- increase the proportion of school leavers from disadvantaged backgrounds achieving at least 5 GCSEs at A* – C or equivalent including GCSE English and Maths

Key Partners
DE / Education sector / OFMDFM

OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE Continued

Actions and Commitments 2013 – 2015 Continued

B Provide young people with an awareness of budget management including the financial implications of parenthood

Key Partners
DE / others

C Provide young people with access to –

- a broad and balanced range of courses, including Essential Skills, that have coherent pathways to HE, FE, training or employment, and that meet the needs of the local economy

Key Partners
DE / DEL / FE / HE

D Identify and intervene early to support children and young people up to age 19 with special or additional educational needs through –

- pilot approaches and building capacity in line with the Review of Special Education Needs (SEN) & Inclusion
- full roll out of Personal Education Plans (PEPs) process for all Looked After Children in school and training
- development of guidance for schools on promoting attendance

Key Partners
DE / DHSSPS / HSC

E Provide 100 Shared Summer Schools for post primary young people to create opportunities as a step towards greater sharing in education

Key Partners
OFMDFM / DE

Active School Travel

Recent research by University College London showed that children in Northern Ireland are the least physically active in the UK. Half of 7 year old children here are not getting the recommended one hour of physical activity each day (recommended through the Chief Medical Officers guidelines for physical activity: Start Active, Stay Active) and this is posing real, long term risks to their health and wellbeing.

To help combat these worrying statistics the Department for Regional Development (DRD) and the DHSSPS/PHA jointly fund an Active School Travel initiative, to be delivered through SUSTRANS, which was launched in October 2013 at St. Joseph's School at Ballyhackamore. This was launched with participation from staff and pupils from both St. Joseph's and Strandtown Primary Schools and aims to encourage more children to walk and cycle to school. The Active School Travel Programme will be delivered to at least 60 schools per year (180 in total) over a three year period to encourage pupils to adopt walking and cycling as their main mode of transport to and from school.

http://www.ucl.ac.uk/news/news-articles/0813/22082013-Half-of-UK-7-year-olds-sedentary-Dezateux

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf)

Key Strategies/ strategic programmes – Families Matter, Co-operating to Safeguard Children, Healthy Child Healthy Future, Breastfeeding strategy – A Great Start 2013 – 2023, Children and Young People's strategy, Child Poverty Action Plan, Delivering Social Change Framework/Signature Programmes, Revised Curriculum, Learning to Learn – A framework for Early Years Education and Learning, iMatter programme, School Improvement policy - Every School a Good School, Raising numeracy and literacy levels – Count, Read: Succeed, Entitlement Framework, A Fitter Future for All, Healthy Food for Healthy Outcomes – Food in Schools policy, Education Works campaign, Bright Start - Childcare strategy, Priorities for Youth, Pathways to Success, Community Family Support Programme, Essential Skills for Living, Hidden Harm Action Plan, Child Maintenance programmes, Play and Leisure Policy statement and Play and Leisure Implementation Plan, Care Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community.

CHAPTER 6 – EQUIPPED THROUGHOUT LIFE

Key long term outcomes:

4 **Ready for adult life**

5 **Employment, life-long learning and participation**

6 **Healthy active ageing**

6.1 Initiatives which encourage and engage people at any age in social, cultural, sport and leisure activities impact on both physical and mental health and wellbeing, as well as on such issues as creativity, social inclusion, and good relations. They can also support interaction across generations. In addition to individual and wider societal benefits, there are environmental benefits to be gained. Participation in such interests offers lifelong enjoyment and fulfilment and is an essential part of healthy living.

6.2 Volunteering also benefits individuals, communities and wider society. It helps to connect and support people, and to progress issues or interests. It also helps individuals develop new skills, and utilises the resources of those with skills and expertise to promote the transfer of skills to others. Volunteering has the potential to build capacity, capability and self esteem in the young, and also promote social inclusion and intergenerational activity.

4 READY FOR ADULT LIFE

6.3 As children grow into adults, they face very different opportunities and challenges – some will be moving into further or higher education, others may be leaving education and seeking work for the first time. Within the health system it is also a time of transition from childrens' to adults' services, with the need to become more self reliant. Some will be moving into their own accommodation. It is also a time of developing relationships. The social and economic context of their lives is changing – for many it is a new and different world, exciting and also challenging. It is a time of adjusting to new responsibilities and the transition can involve positive and negative experiences, with increased freedom or independence, but also increased stress.

Ready for Adult Life

Down Community Arts

Based in Downpatrick, Down Community Arts provides a programme called "Healthy Headz" targeted at young people from Ballynahinch, Saintfield, Crossgar and Killyleagh identified through the Youth Service of SEELB as being at risk, marginalised or unattached to existing provision. The programme aims to address areas such as anti-social behaviour, drug and alcohol misuse, mental, sexual and physical health, self-confidence and community ownership.

6.4 While it is generally a time of peak health[28], it is often associated with risk taking behaviour – such as alcohol and drug misuse – with little realisation of the potential impact on future health. Maintaining healthy behaviours and sustaining good physical, sexual and mental health through this period into adulthood is important.

6.5 Young people are the group most likely to be unemployed and to be in low-skilled, low paid jobs. The number and type of jobs available to those with low level skills is increasingly in decline, with jobs growth predominantly in employment which requires higher skills. The evidence points to the importance of providing the opportunities for young people to acquire higher levels of skills and qualifications, and work based learning routes beyond the compulsory education age of 16.

6.6 DEL's "Access to Success" aims to widen participation in higher education by students from groups who are currently under-represented, in particular students from disadvantaged backgrounds and those with disabilities and learning difficulties.

6.7 A key concern relevant to the current economic climate is the high number of young people who are not in employment, education or training (NEETS). This has the potential to impact negatively on longer term outcomes for this group in terms of their future economic status and ultimately their health and wellbeing. DEL leads on the 'Pathways to Success' Strategy which is the Executive's formal strategy for addressing their needs. This has a particular focus on helping those young people who face barriers to participation.

6.8 DEL's Employment Service and a range of other government programmes will also work to address this and the wider issue of unemployment through a range of schemes (including those targeted at particular groups such as young care leavers, people affected by drug/alcohol misuse, etc). In addition, through the new "Building a United Community" a number of planned initiatives, such as the "United Youth Programme" will benefit this group. Other key mainstream DEL provision, such as the Careers Service, will continue to support young people in identifying and progressing towards their career goals.

OUTCOME 4 READY FOR ADULT LIFE

Actions and Commitments 2013 – 2015

A Provide young people with access to –

- careers information advice and guidance as required, to enable them to make effective career/learning choices
- a guarantee of a training place for those in the 16 and 17 year old age group (up to age 24 in special circumstances) who have left school
- opportunities to gain Essential Skills qualifications in literacy, numeracy and ICT from entry level to level 2 that will help young people improve their employability as well as overall quality of life

Key Partners
DEL

B Make tailored health and safety information available to all young people entering work for the first time

Key Partners
DETI / HSE

C Promote employability schemes in public and private sectors targeted at young and long term unemployed

Key Partners
DEL / others

OUTCOME 4 READY FOR ADULT LIFE Continued

Actions and Commitments 2013 – 2015 Continued

D Implement the cross–departmental "Pathways to Success" Strategy for young people not in education, employment or training. (NEETS)

Key Partners
DEL / DE / others

E Development and delivery of the United Youth Programme offering young people employment, work experience, volunteer and leisure opportunities along with a dedicated programme designed to foster good relations and a shared future

Key Partners
DEL / OFMDFM / DE

F PCSPs work collaboratively with local government and relevant partners to intervene early with young people at risk of offending

Key Partners
DOJ / Local government / other local partners

G Take forward relevant outcomes in Care Matters aimed at reducing exclusion and marginalisation –

- maintain appropriate support for young people in and leaving care in higher and further education
- enhance current employability services for each Trust area providing dedicated education and training support
- maintain young people in and leaving care in suitable, affordable and safe accommodation with financial support whilst in higher education/training
- continue to provide fostering services for 18+ in care and provide a point of contact adviser up to age 25

Key Partners
DHSSPS / DEL / HSC

5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION

6.9 Adults in Northern Ireland now generally enjoy better health and can expect to live longer than previous generations. However there are still many challenges in respect of health inequalities, including increasing long term damage related to health behaviours such as poor diet, low levels of physical activity, smoking, and alcohol consumption for many.

6.10 As well as physical health it is clear that mental health is a major public health concern in Northern Ireland, necessitating a strong strategic drive to prevent mental illness (where possible) and promote positive mental health and wellbeing in the general population. This will be taken forward through the development of a new cross-departmental strategy to promote positive mental health in the Northern Ireland population. (see Chapter 7)

6.11 Being a parent is a life-changing experience which can be wonderful and challenging at the same time. Good parenting is a key life skill – chapter 5 outlines the importance to both individuals and society as a whole, of giving every child the best start through positive and nurturing early life experiences and through maintaining strong, loving and respectful family relationships as they grow. Supporting and empowering the current generation of parents to shape the next is of vital importance to building a better future for Northern Ireland society. Early intervention initiatives in schools, such as Roots of Empathy[29], also help to build the capacity of the next generation for responsible citizenship and responsive parenting.

6.12 There is a clear link between work and the health of individuals and their families. Being in good employment is protective of health[30]. Conversely, unemployment and poor quality employment contribute to poor health. Employment with a reasonable wage is the best path out of disadvantage and poverty, therefore getting people into such work is of critical importance for reducing health inequalities. However, jobs need to be sustainable and be of sufficient quality, to include not only a decent living wage, but also opportunities for development, the flexibility to enable people to balance work and family life, and protection from working conditions that can damage health.

6.13 In addition to supporting the growth of the labour market and ensuring access to good jobs, there must be support for overcoming the barriers to employment – for example through employability schemes, investing in work experience and qualifications, and in education, childcare and health condition management.

Employment, lifelong learning and participation

CAWT – Travellers

Co-operation and Working Together (CAWT) is the cross border health and social care partnership, comprising the Health Service Executive in the Republic of Ireland and the Southern and Western Health & Social Care Trusts, the Health and Social Care Board and the PHA in Northern Ireland.

The CAWT Social Inclusion Project is focused on reducing health inequalities for specific groups, one of which is travellers who are the most marginalised ethnic minority in Ireland with the worst health indicators. The project includes training programmes for twenty Travellers. One update reported that of the 18 participants who completed the Employment and Skills Training, three were working full time in community development, youth work and HGV driving. Another four were completing work placements in the Southern Trust and HSE DNE areas.

After the EU funding phase, the PHA and Western Local Commissioning Group planned to build on the work done by the project to promote social inclusion for Travellers and to create a steering group with representation from interested agencies, to help build the infrastructure to support work to improve Travellers' health and wellbeing.

6.14 Lifelong or adult learning has the potential to impact on health inequalities by providing skills and qualifications to enhance employment opportunities, and also by improving self esteem and confidence, which have been shown to be associated with healthier behaviours. Evidence which informed the Marmot Review also suggests that adult education increases social capital, which is in turn associated with better health. DEL's Essential Skills for Living Strategy aims to ensure that all working age adults have the opportunity to gain recognised qualifications from Entry Level to Level 2 in Literacy, Numeracy, and Information Communication

Technology (ICT), to help them gain employment as well as promoting greater economic development, social inclusion and cohesion.

6.15 DEL's Skills Strategy *"Success Through Skills – Transforming Futures"* aims to raise the skills level of the whole workforce, raise productivity and increase levels of social inclusion, by enhancing the employability of those currently not in the labour market. DEL and its key providers, such as the Further Education colleges, will provide developmental opportunities to support those who wish to enter the Northern Ireland workforce, as well as those already in work.

6.16 Childcare is a critical enabler to help parents into work, move families out of poverty and help to break the cycle of inter-generational deprivation. Supported by an affordable, flexible and accessible childcare sector, parents can access work, improve their workplace skills and their employability, or continue to be economically active. *Bright Start – The Executive's Programme for Affordable and Integrated Childcare* sets out the framework, principles and a range of key first actions, to move towards the establishment of an improved and expanded system of childcare.

OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION

Actions and Commitments 2013 – 2015

A Contribute to rising levels of employment by supporting the promotion of 25,000 jobs by 2015 as set out in the Northern Ireland Economic Strategy

Key Partners
DETI / DEL

B Provide all citizens as required, with careers information advice and guidance to enable them to make effective career/learning choices

Key Partners
DEL

C Support all citizens who avail of Employment Service programmes and services towards employment

Key Partners
DEL

OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION Continued

Actions and Commitments 2013 – 2015

D Up-skill the working age population by delivering over 200,000 qualifications

Key Partners
DEL / FE

E Provide continued access by adult learners to FE provision including Essential Skills, subject to demand locally, for their economic and/or social benefit

Key Partners
DEL / FE

F Through **"Access to Success"** the NI Strategy for Widening Participation in Higher Education provide support to the most able but least likely people from disadvantaged backgrounds to raise their aspirations, and educational attainment, in order that they can progress to the higher education provision that is right for them, irrespective of their personal or social background (particular focus on people identified as under–represented in higher education)

Key Partners
DEL / DE / HEIs / FECs / and others

G Assist people with mental and physical health and disability related barriers to employment to improve their chances of finding and sustaining employment through the provision of appropriate services and programmes

Key Partners
DEL / DHSSPS / HSC Third sector specialist disability organisations

Employment, lifelong learning and participation

Men's Shed

The 'Men's Shed' concept has gained popularity in Northern Ireland in recent years, as a way to promote social interaction and wellbeing of men.

The Shed is a space for men to come together to work on DIY projects, learn new skills and socialise. It provides a safe, friendly and inclusive

environment where older people can feel more supported and secure in their own community and within their own peer group. Participants can, among other things, work on a meaningful project at their own pace, in their own time and in the company of other men. The primary objective is to use the facility and the support network generated, as a means to advance the health and wellbeing of the participants by encouraging them to become involved in a broader range of programmes targeted at addressing their specific needs.

The Men's Shed is open to men aged 50 years and over. There are Men's Shed in Ballymena and Armagh.

5 HEALTHY ACTIVE AGEING

6.17 Longer life expectancy is a positive outcome to be welcomed. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. Older people can be a valuable resource for their families, communities and the economy. However, for some, old age brings with it a high risk of social isolation and poverty, including fuel poverty, with limited access to affordable, good quality services. Many care for a partner, which can bring physical and psychological burdens, while others living alone can feel isolated. Older people living in rural areas may be particularly vulnerable to social isolation and in need of support and access to services.

6.18 It is important for older people to be able to maintain active independent lives, with access to all the income and benefits to which they are entitled, and opportunities to engage in social and educational activities. There is a need to ensure that future policies, programmes and investment across government are "age friendly" and complementary to each other. Areas such as housing, transport, access to community services, safety, opportunities for lifelong learning and employment can have a major impact on the health and wellbeing of older people. A new cross-cutting strategy is under development to promote and enable "active ageing".

Healthy Active Ageing

Silver Surfer's Day

For a number of years a "Silver Surfer's Day" has been run for the over 50s in local libraries.

Organised by Business in the Community in partnership with the Department of Finance and Personnel and Libraries NI, business volunteers are on hand to help and provide invaluable advice to those wishing to get to grips with technology and surf the internet with free training.

"Silver Surfers" learn how to set up an e-mail account, send e-mails, bank online, access government services through the nidirect website, shop etc. "Silver Surfers' Day" encourages people to go online, addressing barriers, promoting the benefits of accessing the Internet, and seeing the convenience of online public services. Library services are free for everyone, with free computer and internet use for library members.

6.19 To meet the challenges of ageing populations, including older people with disabilities, there needs to be an increased emphasis on health promotion, disease prevention and physical and mental rehabilitation, which incorporates a life-long approach to positive health. Action should focus on:

- advancing health and wellbeing into older age;
- reducing inequalities experienced by older people;
- promoting the inclusion and full involvement of older people in society and their local communities; and
- improving the provision, quality and safety of services and care to address the needs of people as they age.

Me Unlimited

In 2011 a report from the Princess Royal Trust for Carers found that:

- *70% of older carers suffer poor health because of their caring role;*
- *65% have a long-term health problem or disability; and*
- *69% reported that caring has an adverse impact on their mental health.*

A social economy initiative "Me Unlimited", has been commissioned by the PHA to provide tailored personal development programmes to support older carers. The programme aims to build coping, resilience and self-management and self-care skills, encouraging carers to plan for a positive future. Older carers of people with dementia and isolated older male carers have been among those to benefit.

6.20 "Transforming Your Care" promotes the home as the "hub" of care for older people where it is safe and appropriate to do so. This will include developing Integrated Care Partnerships* to support the provision of joined up care and support for frail older people, developing safe, suitable alternatives to statutory residential accommodation and working to address carers' needs.

6.21 Work is already under way in Belfast to establish "age friendly[31]" environments, which can support both older people and those with children, and we wish to encourage the new Councils being established here to commit to the WHO "age friendly" approach. There is a need to consider how the concept can be extended to other communities, including those in more rural areas. This issue is also considered in Chapter 10 in relation to "space and place".

* Integrated Care Partnerships "are multi-sector collaborative networks of health and social care providers that come together to respond innovatively to the assessed care needs of local communities."

OUTCOME 6 HEALTHY ACTIVE AGEING

Actions and Commitments 2013 – 2015

A Improve job outcomes by providing temporary work for those aged 50+ who are unemployed and claiming benefit through the Steps to Work – Step Ahead 50+

Key Partners
DEL

B Promote healthy active ageing, through opportunities to participate including for example through volunteering and opportunities for learning

Key Partners
OFMDFM / DHSSPS / DEL / DCAL/ DSD / HSC other Departments / Volunteer Now / Local government / Community and Voluntary and Business sectors

C Delivery of the cross-cutting Active Ageing Strategy which will promote age friendly environments using the WHO Age Friendly Environments programme

Key Partners
OFMDFM and DOE in association with PHA and Councils

D Promote home as the "hub" of care for frail older people through the outworking of TYC

Key Partners
DHSSPS / HSC / Community and Voluntary Sector

E Take forward public engagement to promote good nutrition.

Key Partners
DHSSPS / PCC / Nutrition Coalition

Key Strategies/ strategic programmes – Essential Skills for Living, Success through Skills – Transforming Futures, Access to Success – an Integrated Regional Strategy for widening Participation in Higher Education, Further Education means Business, Pathways to Success, Build Pathways to Employment, Employment Service programmes, Training for Success / Bridge to Employment / Youth Employment scheme, draft Economic Inactivity strategy, Delivering Social Change Signature Programmes, Community Family Support Programme, NI Economic strategy, Reducing Offending strategy, Care Matters, Join In – Get Involved, Sport Matters, Draft Active Ageing strategy, Transforming Your Care, Making it Better – A Strategy for Pharmacy in the Community, Promoting Good Nutrition – A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016.

CHAPTER 7 – EMPOWERING HEALTHY LIVING

Key long term outcomes:

7 **Improved health and reduction in harm**

8 **Improved mental health and wellbeing, and reduction in self harm and suicide**

9 **People are better informed about health matters**

10 **Prevention embedded in services**

7 IMPROVED HEALTH AND REDUCTION IN HARM

Healthy Behaviours

7.1 People's behaviours – whether they smoke, how much they drink, what they eat, whether they take regular exercise – are widely recognised as affecting their health and risk of dying prematurely. Recent work by the *Kings' Fund: Clustering of unhealthy behaviours over time (2012)*[32] which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found that a significant minority of people in western developed countries have three or more risk factors. This trend is more common in some groups than others - several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower socio economic groups and with lower levels of education being more likely to exhibit multiple lifestyle risks.

7.2 This work argues for a move away from a silo approach to promoting particular healthy behaviours, towards interventions which adopt a more holistic and integrated approach. The "clustering" of lifestyle with medical risk factors is the most important issue related to risk and will require integrated approaches which take account that many people will present with several risk factors at the same time.

7.3 *The House of Commons Health Committee's Health Inequalities inquiry (2009)*[33] highlighted several reasons why the poorest in society are less likely to adopt beneficial health behaviours. These included:

- lack of information;
- lack of material resources to live healthily;
- environments in which they live may make it difficult, for example smoking tends to be more " heavily entrenched in those from lower socio-economic groups which makes positive change harder"; and
- more difficult lives including problems such as low income, lack of employment or personal safety concerns – these may mean that changing health behaviour is unlikely to be a major priority.

7.4 Men and women are prone to different diseases and prevalence of health behaviours. In addition some population groups such as ethnic minorities including travellers, LGB&T, people with disabilities face specific challenges to their health and wellbeing including vulnerability to certain conditions and to broader issues such as social exclusion. Programmes and services at regional and local level should be accessible and address specific needs and risk factors, including those of vulnerable groups.

Health Protection

7.5 Population screening programmes have a key role to play in early detection of disease and a range of programmes are currently available in Northern Ireland. Organised screening programmes are only established on the recommendation of the UK National Screening Committee and according to the best available evidence. Any condition being considered as a screening programme must meet a number of stringent criteria before it is recommended by the Committee.

In Northern Ireland the following screening programmes are in place:

- Abdominal Aortic Aneurysm (AAA) Screening
- Antenatal Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Bowel Cancer Screening
- Diabetic Retinopathy Screening
- Newborn Screening

Work needs to continue to address any potential inequalities in the uptake and coverage of all screening programmes.

7.6 Vaccination programmes are the best and most effective way to prevent someone becoming sick from various infectious diseases. In Northern Ireland as in the rest of the UK, vaccination policy is informed by the Joint Committee on Vaccination and Immunisation (JCVI), an independent expert advisory committee that advises the four UK Health Ministers. In formulating its advice and recommendations, the Committee's aim is to ensure that the greatest benefit to public health is obtained from the most appropriate vaccination and immunisation strategies. Young babies are most vulnerable to infections and therefore the majority of vaccination programmes are aimed at babies and children. There is also an annual seasonal flu vaccination programme and in 2013 a shingles vaccination programme aimed at those aged between 70 and 79 was introduced.

7.7 Antimicrobial resistance (AMR) has been recognised for many years and efforts have been made to arrest or mitigate the development of resistance by using antibiotics more appropriately and effectively in both humans and animals. However, the threat of AMR is now a priority internationally, across the UK and in Northern Ireland. DHSSPS published the Strategy for Tackling Antimicrobial Resistance in July 2012. Link - **http://www.dhsspsni.gov.uk/star-doc.pdf**

This is in line with the UK 5-year AMR strategy published in September 2013. Actions include improving infection prevention and control to prevent cases of infection occurring in the first place; educating professionals and the public to use antimicrobials appropriately; improving the monitoring and surveillance of resistant organisms, and research. Everyone has their part to play, and coordination of efforts is crucial.

7.8 The Department's role as Lead Government Department for the health and social care consequences arising from emergencies places a responsibility on it to respond at a strategic level and maintain a state of readiness to address and mitigate certain threats and hazards which have the potential to affect Northern Ireland.

7.9 In Northern Ireland four regional statutory bodies have lead roles and responsibilities in relation to food safety, diet and nutrition: the Department of Health, Social Services and Public Safety; the Food

Standards Agency in Northern Ireland, which is a non-ministerial government department; the PHA, and the Food Safety Promotion Board (*'Safefood'*) which is a Northern Ireland-Republic of Ireland implementation body established under the terms of the 1998 Belfast Agreement. Other bodies have a remit in this field, including other government departments and local authorities, who are responsible for certain enforcement functions. In 2012, at the behest of the Health Minister for Northern Ireland, a review was carried out with the aim of ensuring that the lead bodies would work effectively, would complement each other and would provide maximum value for money in respect of the provision of high quality scientific and policy advice relating to food safety, diet and nutrition. The recommendations of the review are being implemented. These include arrangements to strengthen coordination between the four lead bodies concerned.

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM

Actions and Commitments 2013 – 2015

A Develop and implement strategies, action plans and targeted programmes to –

- reduce the number of people who:
  - smoke;
  - are overweight or obese;
  - drink above the recommended alcohol limits;
  - misuse drugs.
- reduce the number of births to teenage mothers, particularly in disadvantaged areas
- reduce sexually transmitted infections (STIs) including HIV
- increase breastfeeding rates
- improve oral health through a regional caries prevention programme, and programmes to increase dental services utilisation
- reduce preventable hearing and sight loss

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM Continued

Actions and Commitments 2013 – 2015

A Continued –

- halt the rise in the incidence of skin cancer
- encourage more proactive ill health prevention amongst men

Key Partners
DHSSPS / PHA / DE / DCAL / DSD / other public bodies including local government, community and voluntary sector.

B Achieve and maintain high uptake rates of screening programmes, immunization and vaccination programmes across all areas and target populations, and introduce new vaccination programmes in line with expert advice

Key Partners
DHSSPS / HSCB / PHA / Trusts

C Establish a group to coordinate efforts to tackle antimicrobial resistance in both human and veterinary medicine

Key Partners
DHSSPS / DARD

D Maintain state of readiness for emergencies through management and replenishment of regional stockpile of health countermeasures and any associated vaccination programme

Key Partners
DHSSPS / HSCB / PHA / Trusts / BSO

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM Continued

Actions and Commitments 2013 – 2015

E Develop and deliver a joint healthcare and criminal justice strategy to improve the health and wellbeing of offenders and reduce the risk of poor health (including mental health problems) leading to offending or reoffending

Key Partners
DHSSPS / DOJ / HSCB / PHA / HSCTs

F Ensure a co-ordinated approach across lead bodies with responsibility for food safety, diet and nutrition

Key Partners
FSA / DHSSPS / PHA / FSPB

8 IMPROVED MENTAL HEALTH AND WELLBEING, AND REDUCTION IN SELF HARM AND SUICIDE

7.10 New policy is under development to set the strategic direction to improve mental health and wellbeing and reduce self harm and suicide. In the meantime, a broad range of programmes and services are in place to promote positive mental health and reduce suicide. These include the Lifeline service, support for community-led initiatives, "gatekeeper" training, education and awareness programmes, and intervention on deliberate self harming. DHSSPS is working with DARD and DCAL on a joint initiative to promote mental health awareness and help-seeking behaviour through rural networks, sporting and cultural organisations. The Health In Mind project delivered by Libraries NI promotes positive mental health and wellbeing through the provision of information, activities, learning and reading resources. The project aims to reduce the stigma attached to mental illness. Departments of Education and Health, Social Services and Public Safety have also worked together to promote mental health awareness through the pupil's emotional health and wellbeing programme ("iMatter"). Progress on all of these areas is reported regularly to a Ministerial Co-ordination Group.

7.11 In the context of an ageing population, dementia is growing as a public health issue. It is intended that the new positive mental health promotion policy will address two main tasks in relation

to dementia: firstly, public health efforts to prevent/ delay dementia as far as possible and to encourage early diagnosis; and secondly, improving the mental wellbeing of people who have dementia.

OUTCOME 8 IMPROVED MENTAL HEALTH AND WELLBEING, REDUCTION IN SELF HARM AND SUICIDE

Actions and Commitments 2013 – 2015

A Develop new policy to promote positive mental health, reduce self harm and suicide

Key Partners
DHSSPS / other Departments / HSC / Voluntary and Community sector.

B Increase resilience and improve mental wellbeing in children and young people through implementation of initiatives outlined in theme 1 including eg Family Support, Roots of Empathy, iMatter (pupil's emotional health and wellbeing programme) – *particular focus on children and young people from families at risk*

Key Partners
DE / DHSSPS / PHA

C Reduce the levels of self harm through roll out of successfully evaluated approaches, *focussing in particular on people who repeatedly self harm, people treated at A&E for injuries due to deliberate self harm*

Key Partners
DHSSPS / PHA / HSC / others

D As part of the joint healthcare and criminal justice strategy, work to identify and support people with mental ill-health or other vulnerabilities who have offended. *Young people with mental health / communication problems in the juvenile justice system identified for targeted action.*

Key Partners
DoJ / DHSSPS / PHA / HSCB / HSC Trust

Sport's Support for 'Protect Life,' Suicide Prevention Strategy and Action

Plan

SportNI, an arms-length body of DCAL, has developed a 'Suicide Awareness through Sport Communications Strategy' with the support of the PHA and Lifeline. This was launched in June 2012. The purpose of the Communications Strategy is to raise awareness of suicide within the sporting community; provide suicide awareness training to sports providers; and encourage sport and sports personalities to support public information campaigns. A range of activities are now being undertaken by sport in support of the Protect Life Strategy.

The 'Suicide Awareness Through Sport Communications Strategy' will continue to be developed and strengthened in line with experience and new ideas emerging from sports organisations, counselling service groups and other stakeholders and partners.

Health in Mind

Health in Mind brings together Libraries NI, Aware Defeat Depression, Action Mental Health, MindWise and CAUSE, who work together and use their expertise to support people to learn more about mental health and how to look after their wellbeing.

Health in Mind is an innovative partnership project which brings together four mental health charities and Libraries NI. By working together and using their expertise in new and fresh ways, it aims to give adults affected by poor mental health, the chance to improve their lives.

Funded by the Big Lottery and Learn Programme until 2015.
For further information: ***www.healthinmindni.net/about/***

9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

"Health Literacy – the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health." – Nairobi, WHO, 2009

7.12 Health literacy means more than being able to read pamphlets; it empowers people to make healthier choices, decide to change their life style and take action. Some published definitions[34] present health literacy as a set of individual capacities that allow the individual to acquire and use new information. Health literacy is dynamic, being influenced by both the individual and the health care system.

7.13 Everyone has a personal responsibility for making decisions which can impact on their own health and wellbeing, but some may need more support than others, for example, when there are conflicting messages. Health and social care professionals including the independent Family Practitioner Services can help and guide people to make appropriate choices - the role of all professionals is not just about treatment when people are ill. It also encompasses supporting people to stay well and live more healthily, including those already living with a condition. This may be through giving them information and support about healthy living and guiding them to any further help they may need. The potential of the front-line workforce needs to be maximised. To this end, DHSSPS is considering the workforce implications and recommendations following England's strategy *"Healthy Lives, Healthy People"* and the associated Public Health Workforce Strategy.

7.14 In many cases it may be that individuals could be supported by a different service either within or outside of the Health and Social Care system, or perhaps by a wider public or community-based service. It will be important that HSC professionals look to build linkages to support services beyond their own specialty, and beyond the HSC to be able to signpost access to appropriate help.

7.15 Improving health literacy aims to influence not only individual lifestyle decisions, and decisions about treatment and self care, but also raise awareness of the determinants of health, and encourage individual and collective actions – at all levels of society - which may lead to a modification of these determinants. Improving health literacy needs to go beyond a narrow concept of health education and individual behaviour, and address the environmental, political and social factors that determine health.

OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

Actions and Commitments 2013 - 2015

A Empower people to make healthier choices and informed decisions about their health by improving health literacy. This will include –

- providing appropriate and accessible health information (making greater use of modern communication technology) and advice to all, which is evidence informed and tailored to meet specific needs, and which

  - encourages more people to present with early symptoms of health problems to HSC services

  - promotes self-care, and sign-posts to appropriate support through, for example patient education/self management programmes

This should have a specific focus on groups at risk of developing conditions, and those with conditions who are at risk of exacerbating or developing complications. It will be important that appropriate links are made with the work being taken forward through Integrated Care Partnerships as part of TYC.

Key Partners
DHSSPS / PHA / HSC / Local government / Community and Voluntary sectors, others including eg NUS – USI

B Promote healthy active ageing, including further opportunities for more active promotion of health and wellbeing in nursing and care settings

Key Partners
DHSSPS / HSC / others

OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

Actions and Commitments 2013 - 2015

C Develop and deliver a Community Resuscitation Strategy to focus a drive to increase the number of people, of all ages, trained in Emergency Life Support skills and to coordinate the use of available resources

Key Partners
DHSSPS / PHA / DE / DCAL community and voluntary sector

One-Stop-Shops

In 2009, the PHA to developed a pilot programme of 4 'One Stop Shop' drop in services for children and young people that provide information, education, sign-posting and, where appropriate, referral to specialist services. The programme sought to address a range of issues including but not exclusively: substance misuse; suicide and self harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping with school/employment.

Following positive evaluation, the PHA has been rolling out a range of 'One-Stop-Shops' across Northern Ireland. There are now eight services as follows:

- *Carrickfergus YMCA – Carrickfergus*
- *FUEL – Enniskillen*
- *Magnet Centre – Newry*
- *FASA – Belfast*
- *FASA – Bangor*
- *Dove House – Londonderry*
- *Opportunity Youth – Ballymena*
- *REACT – Banbridge*

10 PREVENTION EMBEDDED IN SERVICES

7.16 The HSC's role in preventing poor health and promoting healthy living is vital to reduce health inequalities, but also to sustain the HSC into the future. The ethos of supporting individuals, families and communities to maintain and improve their health needs must be fully embedded as a normal way of working right across all organisations, environments and activities within the HSC system. This is not just in day to day interactions with every member of the public, but also as part of commissioning and designing health services. Service Frameworks are a key reference point for commissioning and designing services to secure better integration of service delivery along the whole pathway of care from prevention of disease /ill health to diagnosis / treatment and rehabilitation, and on to end of life.

7.17 Commissioners must ensure that health improvement and addressing health inequalities are embedded within commissioning plans. Healthcare providers must build the promotion of good health into service and pathway design, contracts and service delivery and ensure that it is both integral to the care they provide and the work that they do with their communities. This also includes ensuring that health settings are health promoting for those receiving treatment or care, visiting and for those working there. Health organisations should also consider their contribution to tackling the wider determinants of health through, for example, providing opportunities for volunteering, work experience and employment, or employability schemes, and through maximising the use of social clauses in procurement contracts.

7.18 *"Transforming Your Care: Review of Health and Social Care in Northern Ireland"* set out key proposals for change across a range of service areas, including mental health services, services for older people, acute services and primary care. It also includes a focus on prevention, and earlier interventions, as part of the model of Integrated care closer to home. Key outcomes for TYC include:

- more services will be provided locally with opportunities to access specialist hospitals where needed;

- more people will be cared for at home, where it's safe and appropriate to do so;

- doctors, nurses, social workers and everyone providing care will work together in partnership to help keep people healthy;

- people will get support to stay healthy, make good health decisions or manage their own conditions; and

- investment in new technology will help people stay at home or receive care locally rather than in hospitals.

7.19 HSC efforts must combine integrated planning, commissioning and service delivery including community development and engagement approaches, collaboration, and personal effort.

OUTCOME 10 PREVENTION EMBEDDED IN SERVICES

Actions and Commitments 2013 - 2015

A Increase the emphasis on prevention and early intervention in the commissioning and delivery of Primary, Community, and Secondary Care services including –

- health professionals, particularly within primary care and Emergency departments, trained and encouraged to undertake substance misuse brief interventions and suicide prevention/mental health promotion intervention programmes across NI

- arrangements for Primary and Community sector to deliver accessible sexual health services

- strengthening the focus on improving the mental and physical health and wellbeing of those in contact with mental health services or with a learning disability

- encouraging public health and patient education/self management interventions alongside clinical approaches for people with long term conditions, for example diabetes

Key Partners
DHSSPS / HSCB / PHA / Trusts / GPs

OUTCOME 10 PREVENTION EMBEDDED IN SERVICES Continued

Actions and Commitments 2013 - 2015

B Continue implementation of Integrated Care Partnerships with an initial focus on frail elderly and aspects of long term conditions, namely stroke, diabetes and respiratory conditions and end of life and palliative care in respect of these areas of initial focus

Key Partners
DHSSPS / HSC / other partners inc community and voluntary sector

C Increase the share of the health budget spend on prevention and early intervention and develop mechanisms to monitor this across the HSC, in line with the PFG commitment

Key Partners
DHSSPS / HSCB / PHA / Trusts

CAWT (Co-operation and Working together for Health Gain and Social Wellbeing in Border Areas)

CAWT has been taking forward a GP training scheme. This training provided practical tips in carrying out consultations with a range of minority groups such as Travellers, LGBT, the hearing impaired, those with sight loss etc. The participating GPs commented that the session provided much that they had been unaware of previously in terms of knowledge and attitude.

Key Strategies/ strategic programmes - Protect Life, Tobacco Control Strategy, New Strategic Direction for Alcohol and Drugs, A Fitter Future for All, Teenage Pregnancy and Parenthood strategy, Sexual Health Promotion strategy, Breastfeeding - A Great Start, Strategy for Tackling Antimicrobial Resistance, Sport Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Long Term Conditions Policy Framework, Strategy for improving the lives of those with disabilities 2012 - 2015, NI Civil Contingencies Framework, UK Influenza Pandemic Preparedness Strategy (DHSSPS as NI lead), Programme for Government Commitment 44 - patient education for people with long term conditions, Programme for Government Commitments 22 – investment in public health and 45 investment to tackle obesity.

CHAPTER 8 – CREATING THE CONDITIONS

Key long term outcomes:

11 **A decent standard of living**

12 **Making the most of the physical environment**

13 **Safe and healthy homes**

8.1 This theme focuses on the wider economic and environmental determinants that provide the fundamental conditions to support good health and wellbeing. These include the economy, which affects employment and income levels, the wider physical environment and infrastructure, and living conditions.

8.2 This theme is confined to policies and programmes which are within the remit of the NI Executive. Where appropriate DHSSPS and the Executive will advocate for changes to national policies in order to bring about improvements in the health and wellbeing of the Northern Ireland population.

8.3 There is growing recognition of the impact and mutual reliance of public policies on each other and the need therefore for inter - connectedness, reinforcement and cross–cutting collaboration both in policy development and implementation. Creating the conditions for good health and wellbeing will require a "whole system" approach across government and through intersectoral working, which ensures that connections between relevant initiatives are maximised. Chapter 11 considers this issue further, including the option of establishing thematic sub-groups where it may be considered beneficial.

11 A DECENT STANDARD OF LIVING

8.4 The *WHO* asserts that poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. The Executive has made the economy the top priority in the 2011-2015 PFG with the challenge to re-build the Northern Ireland labour market and rebalance the economy to increase living standards.

8.5 Health is a key factor in productivity, economic development and growth. Both the PFG and the *NI Economic Strategy* acknowledge the inter–relationship between prosperity and population health. Healthier people are more productive and improved health and wellbeing will contribute to positive economic outcomes for both individuals and wider society. At the same time enhancing employability, skills development, incentives and job creation, vital to promoting a vibrant economy, are conducive to improved population health. In addition to efforts to promote employment and prosperity, action is needed to mitigate the impact of poverty and the potential for negative impact of welfare reforms, and to provide more opportunities for work experience and employment. Other commitments on improving benefit uptake and improving budget management skills aim to support individuals and families to maximise their income.

OUTCOME 11 A DECENT STANDARD OF LIVING

Actions and Commitments 2013 – 2015

A Increase employment and prosperity for all by delivering the commitments set out in the Northern Ireland Economic Strategy

Key Partners
All Executive Departments

B Reduce economic inactivity through development and implementation of a strategy for skills, training, incentives and job creation, and careers advice

Key Partners
DEL / DETI / others

C Mitigate the impact of poverty and the potential for negative impact of individual welfare reforms through –

- delivering a range of key targeted actions, by way of the Delivering Social Change Framework, including the Social Investment fund
- reduce the number of births to teenage mothers, particularly in disadvantaged areas

Key Partners
OFMDFM / DSD / DHSSPS / DE / DEL / DETI / DARD / others

OUTCOME 11 A DECENT STANDARD OF LIVING Continued

Actions and Commitments 2013 – 2015

C Continued –

- publishing and implementing a plan for improving uptake of benefits to ensure people have the opportunity to maximise their income levels

Key Partners
DSD

- developing and implementing a new discretionary support service to help people most in need through the provision of immediate financial assistance and encouraging longer term financial independence

Key Partners
DSD / SSA

- developing a financial capability strategy to ensure people have budget management skills

Key Partners
DETI

- developing a co-ordinated strategic approach to address food poverty.

Key Partners
DHSSPS / DSD / FSA / PHA / DARD / other departments / Safefood / Local government / other sectors

D Provide more opportunities for work experience and employment through, for example, maximising the use of social clauses in procurement contracts, and the potential contribution of employability schemes through public and private sector organisations – *this focuses on the unemployed, particularly the young and long term*

Key Partners
Government departments / public agencies inc HSC / Local government etc.

Mitigating the impact of poverty and social isolation in rural communities

MARA (Maximising Access in Rural Areas)

The MARA project is a cross departmental regional project funded by DARD through the Tackling Rural Poverty and Social Isolation Framework and managed by the PHA. Other key organisations involved include DSD (Social Security Agency and Fuel Poverty Unit), DRD, NIHE, DHSSPS and local community and voluntary organisations.

The MARA project aims to improve the health and wellbeing of rural dwellers in Northern Ireland living in or at risk of poverty, and social exclusion by increasing access to services, grants and benefits.

The project proactively targets vulnerable households in identified rural communities using a community development approach. Community lead organisations across a number of designated zones recruit and train enablers to undertake household visits and highlight services available (local and regional) using the local directory of services, a copy of which is left in the household pack following the visit. Target groups include older people, carers, disabled people, lone parents, ethnic minorities, lone adults, farming families and/or low income families.

The MARA project in Phase I targeted the 88 (30%) most deprived rural Super Output Areas (SOAs) in Northern Ireland in 2010/11. A total of 4,135 household visits were completed and over 10,000 onward referrals were made to various departments and agencies e.g. home safety checks, benefit entitlement checks, energy efficiency checks, occupational therapy assessments for disabled facilities grants, community transport and public transport (smart pass).

Evidence from Phase I of the project suggested that visiting people in their own homes and using a "personal touch" encouraged people to avail of services and grants which they would not otherwise have known about or been able to apply for. An independent post project evaluation identified £8.62 leverage for every £1 invested.

Using lessons from Phase 1, the project is now being rolled out into the remaining 70% (198) rurally deprived SOAs in Northern Ireland over 3 years to include approx 12,000 home visits.

12 THE PHYSICAL ENVIRONMENT

8.6 Health and wellbeing is also influenced by the wider physical environment. This includes the direct and indirect effects of chemical, physical and biological hazards on health and wellbeing. It also encompasses aspects of the physical and social environment that influence individuals' health and wellbeing, such as the quality of housing and the neighbourhood environment, urban development, land use, and transport.

8.7 Physical environments can be designed to promote health and wellbeing through providing access to services and opportunities for social interaction. Numerous studies point to the physical and mental health benefits of access to green spaces and better air quality. A range of actions recognise the importance of making the most of the physical environment in promoting healthy and active living. This includes the preparation of a new single strategic planning policy statement, which will reinforce the positive role that planning can play through an approach to the development and use of land that is supportive to the health and wellbeing of people generally.

OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT

Actions and Commitments 2013 - 2015

A Protect and promote good health and wellbeing through –

- improving air quality to achieve objectives and targets established to protect health, and alerting those more likely to be affected when levels of air pollution are high
- providing high quality drinking water which is clean and safe, and ensure that waste water is treated in a manner that will not harm the environment and will be if no danger to plant and animal life
- preventing waste and increasing recycling and re-use, through the Northern Ireland Waste Management Strategy
- minimizing the harmful effects of exposure to environmental noise, in line with the Environmental Noise Directive (END) by designating and protecting Quiet Areas

Key Partners
DOE / Local government

OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT Continued

Actions and Commitments 2013 - 2015

B Enhance the capacity of our physical infrastructure to protect, support and provide access to healthy and active living and wellbeing through –

- completing work on the current Planning Policy Statement (PPS) programme and publish a single, strategic planning policy document which will, inter alia, address sustainable development and how health and wellbeing considerations are taken into account within the planning system
- formulating and co-ordinating policy for the orderly and consistent use of land with the objective of furthering sustainable development and promoting or improving wellbeing
- producing guidance on urban stewardship and design to promote a positive sense of place encompassing local involvement, distinctiveness, visual quality and potential to encourage social and economic activity which are fundamental to a richer and more fulfilling environment
- promoting “safe by design” approaches
- promoting age friendly environments
- addressing dereliction through the Social Investment Fund to make areas more appealing for investment and for those living there
- ensuring easier access to and sustainable use of publicly owned land including forests for sport and physical recreation
- implementation of an Active Travel Strategy Action Plan, providing increased opportunities for sustainable transport options such as walking and cycling and promotion of a number of demonstration projects

Key Partners
DRD / DOE / OFMDFM / DARD / DCAL / DOJ / DHSSPS / Local government

OUTCOME 12 MAKING THE MOST OF OUR PHYSICAL ENVIRONMENT Continued

Actions and Commitments 2013 - 2015

C Improve transportation infrastructure and services to help achieve a modern, sustainable, safe and fully accessible transport system which actively contributes to social inclusion and everyone's quality of life – this has a particular focus on older people and people with disabilities

Key Partners
DRD

D Produce a Northern Ireland Climate Change Adaptation Programme that will contribute towards building Northern Ireland's resilience to a changing climate.

Key Partners
DOE lead / all other depts. including DHSSPS

E Carry out a cross-departmental review of the implementation of the UK Children's Environment and Health Strategy in NI

Key Partners
DHSSPS / DOE / other depts and agencies

Making the most of our physical environment

Regenerated Lapwing Way Park in Clooney Estate, Londonderry.

A collaboration between the DSD - under its Neighbourhood Renewal programme, Clooney Estate Residents Association, Groundwork NI, Ulster Garden Villages, the Garfield Weston Foundation and the City Council in Londonderry has brought the Lapwing Way park back into full usage for children and families within the Clooney Estate and surrounding areas of the Waterside.

Green spaces are vital in communities to encourage community cohesion and promote healthy lifestyles. Projects like this are also instrumental in renewing civic pride in local communities.

Lapwing Way's regeneration has ensured that this outdoor space, which greatly enhances the physical appearance of the Clooney Estate as a whole,

remains a safe, secure, sustainable and neutral environment for children to play, and a vital space which can be utilised by the entire family and generations to come.

Derry City Council will continue to oversee the planning, designing and delivery of regenerated play spaces under their Parks Development Programme, and the success of the work of Clooney Residents Association at Lapwing Way will be a model for further projects, a good example of the benefit of the collaborative approach in which associations, funding and support agencies worked together for the benefit of the overall community.

13 SAFE AND HEALTHY HOMES

8.8 Housing design, accessible housing and planning that involve communities can improve social cohesion and address some of the most fundamental determinants of health for disadvantaged individuals and communities. Warm secure housing is vital for mental and physical wellbeing. Efforts will continue to deliver affordable homes, reduce levels of homelessness and to tackle Northern Ireland's high rates of fuel poverty.

OUTCOME 13 SAFE AND HEALTHY HOMES

Actions and Commitments 2013 – 2015

A Deliver 8,000 social and affordable homes as set out in the PFG

Key Partners
DSD / NIHE

B Improve the quality of the housing stock through –

- undertaking a review of the statutory fitness standard for homes in all tenures
- reviewing support for repair and improvement in the Private Housing sector with the aim of providing a new scheme to assist homeowners to deal with deterioration in their properties
- addressing dereliction and deprivation
- interventions that help those most in need and/or in fuel poverty

OUTCOME 13 SAFE AND HEALTHY HOMES Continued

Actions and Commitments 2013 – 2015

B Continued –

- improving thermal efficiency of housing stock and ensure full double glazing in all Housing Executive properties

- reviewing policy and associated legislation regulating standards within Housing of Multiple Occupation (HMO) to improve physical and safety standards and occupant behaviour

Key Partners
DSD / NIHE / others

C Deliver practical support through the Supporting People Programme which targets older people, people with disabilities and people with learning disabilities to live independently

Key Partners
DSD / NIHE / DHSSPS / HSC Board / PHA / HSCTs / OFMDFM

D Develop a new strategy to reduce unintentional injuries and deaths resulting from accidents in the home. Children and older people identified for targeted action

Key Partners
DHSSPS / PHA / Local government / Community and Voluntary sectors / NIFRS / HSCTs / HSENI / NIHE

OUTCOME 13 SAFE AND HEALTHY HOMES Continued

Actions and Commitments 2013 – 2015

E Reduce levels of homelessness and mitigate the effects of homelessness by providing support and services to those who are homeless

Key Partners
DSD / DHSSPS / HSC / others

Key Strategies/ strategic programmes - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco strategy, Transforming Your Care, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012 - 2015.

CHAPTER 9 – EMPOWERING COMMUNITIES

Key long term outcomes:

14 **Thriving communities**

15 **Safe communities**

16 **Safe and healthy workplaces**

14 THRIVING COMMUNITIES

9.1 The communities and social networks to which people belong also have a significant impact on health and wellbeing. Support from families, friends and communities is associated with better health. Social capital – the links that connect people within communities - can promote resilience against difficulties and give people a feeling of control over their own lives.

9.2 In recent years there has been a growing recognition of the added value that participation in sport, arts and cultural activities can bring to communities. In addition to direct physical and mental health and wellbeing benefits, sports, arts and culture provide common interest and inspiration which promotes cohesion and good relations. Sports and cultural activities provide a vehicle for building social capital and creating resilient communities, and they provide opportunities for engagement, particularly of vulnerable or hard to reach groups, and for creativity. They can also generate intergenerational and environmental benefits.

9.3 It will be important to work in partnership with communities, local government and other key agencies in seeking ways both to tackle community issues and to build social capital. A number of policies and programmes operate in urban and rural communities to tackle disadvantage – including Delivering Social Change, the Urban Regeneration and Community Development Framework, and the Tackling Rural Poverty and Social Isolation Framework.

Local Government Role

9.4 Local government already makes a vital contribution to creating healthy, safe, sustainable places and thriving communities and this contribution will be further enhanced through the new arrangements

put in place by Local Government Reform. Local decision makers will play a major role in planning and shaping services around many of the physical, environmental, economic and social conditions which affect people's lives. Councils will lead and facilitate the community planning process by effective and genuine engagement with citizens and by building cross sectoral partnerships.

9.5 Local government also has a 'hands on' role in the provision of arts, leisure and community services and has regulatory functions relating to environmental health and health and safety. Its role in good relations, regeneration and planning means that it has a unique "place shaping" role which in itself is critical in creating the right conditions for thriving communities.

Capacity building

9.6 Community development is a practice which assists the process of people acting together to improve their shared conditions both through their own efforts and through negotiation with public services. It is recognised as an effective way to address imbalances in power and work with marginalised people. Its commitment to collective ways of addressing problems can be used to bring about change based on equality and inclusion, and can be used to enable people to improve the quality of their own lives, the communities in which they live and societies of which they are part.

9.7 Community development produces multiple health and wellbeing benefits precisely because it fosters the interconnections of all issues affecting a community as well as building social capital. Building bonds between individuals and communities is known to be a protective factor promoting health and wellbeing and increasing resilience. Community development projects can have dual impact – they can address a health, or social issue, while at the same time the values and processes involved begin to tackle some of the social and political processes which deal with the unequal distribution of the determinants of health. Community development is therefore a natural tool in efforts to reduce health inequalities.

9.8 There are many excellent examples of local people taking the initiative on the issues which are important to them. However there is a need for further community development to enable people to organise and work together.

9.9 The Voluntary and Community Unit (VCU) in the DSD plays a lead role, on behalf of the NI Executive Departments, in supporting a vibrant, effective and efficient Voluntary and Community Sector (VCS), which is well placed to deliver key services to often disadvantaged communities. Much of the work of VCU is geared to supporting the VCS at a regional level across Northern Ireland, or through local councils, thereby enabling the VCS to deliver vital and important services on behalf of government. Key priorities are to promote collaboration, empowering and strengthening communities, increase community participation and ensuring high quality voluntary advice services which are readily available and free at the point of need.

9.10 The Volunteering Strategy acknowledges the contribution that volunteering makes, both in benefits to those who volunteer and to wider communities. Volunteering is a shared experience, it is rewarding and of benefit to the volunteer in building skills, confidence and extending social networks. Volunteering is of benefit to society in contributing to the building of social capital and progressive social change.

9.11 Within Health, the implementation of "Working in Partnership – Community Development Strategy for Health and Wellbeing 2012-2017" will make a vital contribution to this framework. The aim is to strengthen communities and improve health and wellbeing by placing increasing emphasis on community development, prevention and early intervention. This approach will be adopted at a range of levels - with individuals, communities – recognising the different needs of rural and urban communities, and with specific groups in need to ensure the active engagement of those most marginalised.

9.12 The Building Change Trust is resourced through a National Lottery grant of £10 million as an investment for community capacity building and promotion of the voluntary and community sector in Northern Ireland. The Trust supports the sector through the delivery of and learning from a range of programmes including commissioned work, awards programmes and other interventions.

9.13 In order to empower and mobilise local people and communities to address issues for themselves, learning needs to be shared across communities and funders to ensure that benefit from actions can be demonstrated on a consistent basis. This requires a move to a shared understanding of evaluation techniques and tools, with a focus on outcomes. Work already underway through Community

Evaluation Northern Ireland (CENI) will contribute to greater collaboration in this area.

OUTCOME 14 THRIVING COMMUNITIES

Actions and Commitments 2013 – 2015

A Strengthen and promote thriving communities which are welcoming, accessible and safe, and which support social inclusion through –

- the Urban Regeneration and Community Development Policy framework which sets out clear priorities through policy objectives and supporting actions for operational programmes *(includes targeted action for disadvantaged and areas at risk)*

- supporting the development of shared and safely accessible commercial centres in our towns and cities

Key Partners
DSD / NIHE / DOE

- the new duty of community planning which will see councils, statutory bodies and the community and voluntary sectors work together to develop and implement a shared vision for promoting the wellbeing of an area

- delivery of Rural Community Development Support programmes

Key Partners
DOE / Local government / other depts and sectors / DARD / others

B Develop more cohesive and engaged communities by developing volunteering and active citizenship, and empower local people

Key Partners
DSD / DHSSPS

C Through the Social Investment Fund, support communities to Build Pathways to Employment by tackling educational under achievement and barriers to employment; tackling skills deficits and promoting job brokerage, widening access to the labour market, promoting business start up and increasing sustainability through social enterprise – *focus on targeted areas and population groups*

Key Partners
OFMDFM / DEL / DE / DETI / others

OUTCOME 14 THRIVING COMMUNITIES Continued

Actions and Commitments 2013 – 2015 Continued

D Promote healthy and thriving communities at local level, *with a particular focus on disadvantaged areas*, through –

- maximising collaboration to tackle determinants of health
- increasing access to and use of sports, arts and other leisure programmes
- maximising land/green space/woodlands use at local level to promote outdoor activities, allotments etc
- increasing access to public facilities for use by the local community
- supporting investment in social enterprise growth to increase sustainability of social enterprises and the broader community sector
- supporting the growth of the local economy through encouraging people to buy local and use local services and facilities

Key Partners
DHSSPS / DSD / DCAL / DETI / PHA / HSC / Arts Council NI / Sport NI / National Museums and Libraries NI / Local government / Education / community and voluntary sector

E Through the Extended Schools programme, which enables those schools that draw pupils from some of the most disadvantaged areas to provide a range of services and programmes which focus on improving educational outcomes, reducing barriers to learning and providing additional support, to help improve the life chance of disadvantaged children and young people

Key Partners
DE / DCAL / PHA / HSC

F Through the Community Education Initiatives Programme fund community based organisations working with local schools in *areas of social deprivation and under attainment* to help address the high levels of educational under-attainment

Key Partners
DE

OUTCOME 14 THRIVING COMMUNITIES Continued

Actions and Commitments 2013 – 2015 Continued

G Implement the new good relations strategy "Together: Building a United Community" which sets out the strategic framework for improving good relations. *Children and young people, communities of interface areas and areas of contested space identified for targeted action*

Key Partners
All relevant Departments and stakeholders

H Implement support arrangements for the voluntary advice services to help ensure that citizens have access to quality advice which is free at the point of need

Key Partners
DSD

I Ensure that everyone has an opportunity to volunteer and that volunteering is representative of the diversity of the community

Key Partners
DSD / DCAL / DHSSPS / HSC / others

J Maintain provision of Rural Transport Fund Services to enable people in rural areas improved access to work, healthcare and recreational activities

Key Partners
DRD

Measuring Change, an approach for the Voluntary and Community Sector - CENI

The current economic climate, coupled with increasing social need, places an even greater imperative on public funders to show the impact of their investments and for funded projects to evidence the outcomes of their activities.

The Concordat (i) and a recent Public Accounts Committee report on creating effective partnerships (ii) recommend that greater emphasis be given to evaluating and demonstrating the outcomes being delivered by the sector: 'It is important that Government and the Sector work collaboratively to develop output and outcome measures'.

The focus on outcomes is not new and there has been a long history of efforts to grapple with the issue of outcome measurement. However, due to multiple factors this remains difficult.

Community Evaluation NI (CENI) has been working for many years to support the voluntary and community sector to evidence the difference it is making. Measuring Change is an approach which helps organisations and funders to capture outcomes. It enables funders and organisations to capture and use outcomes data to improve delivery, inform planning and make more effective use of resources.

It has been applied in a range of community settings to capture difficult to measure outcomes of programmes.

i Concordat between the Voluntary and Community sector and the NI Government, DSD 2011

ii Public Accounts committee, Report on Creating Effective Partnerships between Government and the Voluntary and Community sector, Jan 2012

15 SAFE COMMUNITIES

9.14 The 2012 Community Safety strategy *Building Safer, Shared and Confident Communities* recognises that addressing crime, disorder and the fear of crime in communities cannot be achieved by the Department of Justice or the justice system alone. Policing and Community Safety Partnerships (PCSPs) at council level provide new opportunities for statutory agencies, local political leaders, voluntary and community groups and local communities to work together to build safer communities.

9.15 Good relations across all communities are also essential to building a prosperous, peaceful and safe society. Key strategic projects within the strategy *'Together: Building a United Community'* focus on housing, regeneration and deprivation, and young people not in education, employment, or training; all have relevance to the aims of this framework.

OUTCOME 15 SAFE COMMUNITIES

Actions and Commitments 2013 – 2015

A PCSPs work collaboratively with the community and relevant agencies at local level and deliver Community Safety programmes so that people feel safer, have reduced fear of crime and increased confidence

Key Partners
DOJ / Local government

B Develop and implement a revised joint Domestic and Sexual Violence and Abuse Strategy to provide victims and witnesses with protection and support, and bring perpetrators to justice

Key Partners
DHSSPS / DOJ / PSNI / Safeguarding Board / other statutory and voluntary sector partners

C Reduce the numbers of people of all ages killed or seriously injured in road collisions through implementation of road traffic collision prevention programmes

Key Partners
DOE / PSNI / other partners

16 SAFE AND HEALTHY WORKPLACES

9.16 A key statutory responsibility for employers is to protect the health and safety of their workforce. Control of risks is important in all work areas but particularly so in some – for example the construction and farming environments. A good working environment, where people are protected and valued, has the potential to increase wellbeing, and there is clear evidence that actively promoting health at work contributes not just to workforce health but also to improved business performance and productivity through, for example, reduction in illness-related absence, increased motivation among staff and improved working atmosphere, leading to more flexibility, better communications and improved use of resources.

9.17 Effective workplace health programmes can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to

encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place.

OUTCOME 16 SAFE AND HEALTHY WORKPLACES

Actions and Commitments 2013 – 2015

A Support more businesses to provide workplace health and wellbeing programmes to secure –

- improved physical and mental wellbeing
- reduction in the number of reportable work related injuries
- prevention, control and management of key occupational health hazards
- awareness raising and advisory campaigns to highlight the dangers of carbon monoxide and promote appropriate management of risk
- appropriate control of risks to the public from harmful organisms encountered in, or associated with workplaces such *as legionella sp, E.coli sp*

Key Partners
DETI / HSE / PHA / Business sector / Local government

B Implement initiatives to improve safety, and reduce casualties and work-related deaths on farms including through –

- the work of the Farm Safety Partnership
- tailored information delivered in rural primary schools
- "Stay Farm Safe" awareness raising campaign

Older farmers and children identified for targeted action

Key Partners
DETI / HSE / DARD / DE / Farm Safety Partnership

Safe and Healthy Workplaces

Credit Union in Londonderry

The PHA-sponsored Healthy Workplace Award 2013 was presented to Derry Credit Union Limited at the Derry/Londonderry Business Awards.

Derry Credit Union Limited has established a health promotion committee made up of staff, management, directors and volunteers.

The committee has organised and delivered more than 150 workshops, activities and events around health and wellbeing. The majority of these activities are offered during the working day and staff rotas are drawn up to accommodate those who wish to participate.

Activities to date have included stress management workshops, healthy eating sessions, taster sessions in yoga and Tai Chi. Staff have also been able to avail of bi-annual cardiac risk assessments and one-to-one consultations with a fitness instructor, and have been given information on foot and eye care, cancer awareness, mental health first aid, and smoking cessation sessions.

In addition, the credit union established a quiet room, a refuge from the hustle and bustle, where staff can listen to calming music and relax. Staff members are also encouraged to get involved in gardening and space has been made available outside the premises to grow vegetables.

Key Strategies/ strategic programmes – Community Safety, Strategic Framework for Reducing Offending, Together – Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, People and Place - Neighbourhood Renewal, Areas at Risk programme, Community Asset Transfer framework, Tackling Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Delivering Social Change – Social Investment Fund / Build Pathways to Employment, Tackling Domestic and Sexual Violence and Abuse Action Plan, Join In - Get Involved, Sport Matters, Extended Schools and Community Education Initiatives Programme, Transforming Your Care, Workplace Health, (Draft) Active Ageing Strategy, Making It Better - A Strategy for Pharmacy in the Community.

CHAPTER 10 – DEVELOPING COLLABORATION

Key long term outcomes:

17 **A Strategic Approach to Public Health**

18 **Strengthened collaboration for health and wellbeing**

17 A STRATEGIC APPROACH TO PUBLIC HEALTH

10.1 Earlier chapters have outlined the continued need for collaboration on issues that influence health and wellbeing, and the importance of seeking to strengthen this and integrate public health principles more systematically across all parts of society.

There are already a number of strategies and programmes underway which address the wider determinants, which include objectives relating to health and wellbeing, and which engage people and organisations working together to achieve improvements. It will be important to consolidate and build on those connections to ensure maximum benefit for population health. In line with Health 2020, and widely welcomed by the response to the consultation on *"Fit and Well – Changing Lives"*, a key aim of this framework will be to put in place strengthened collaboration for health through a "whole system approach". This will require improved cohesion and communication between all levels of the system, and arrangements to achieve this are covered further in Chapter 11.

10.2 The framework will be delivered in the context of local government reform, which will take place from 1 April 2015. The new Councils will be responsible for Community Planning with a duty to plan for the 'economic, social and environmental well-being' of council districts. This provides an opportunity to redefine and strengthen the way in which the health and social care sector, local government and others work together to improve health and wellbeing and reduce health inequalities. The good working relationships that have been established under Investing for Health form a strong base for this work.

Belfast Strategic Partnership for Health and Wellbeing

The Belfast Strategic Partnership (BSP) was set up in 2011 by the PHA, Belfast City Council and Belfast Health and Social Care Trust to address the significant levels of inequality across the Belfast area.

The Partnership has been set up in order to:

- *Support a citywide collaborative approach across sectors to better address the inequalities and health and wellbeing challenges faced within Belfast; and*

- *Set the strategic direction for health and wellbeing improvement in Belfast, through the development of agreed priorities for the city and the alignment of corporate plans and resources of the key service providers.*

It includes representatives from the following sectors:

- *Statutory sector – Belfast City Council, PHA, Belfast Health and Social Services Trust, Northern Ireland Housing Executive, Police Service of Northern Ireland and the Education sector;*

- *Private sector;*

- *Community and voluntary sector, including representation from the five Belfast Area Partnership Boards and community nominees; and*

- *Local Elected Members.*

Active Belfast *is one of the BSP's key projects. The Active Belfast project aims to promote healthy living and increase physical activity. A range of activities have been set up to encourage a healthier lifestyle for example:*

- ***Community gardens*** *- A community garden is a shared project where people from all age groups, abilities and backgrounds come together to grow their own fruit, flowers and vegetables. Community gardens have been opened at a number of locations around Belfast including Whiterock Leisure Centre, Finlay Park and Knocknagoney Linear Park. Benefits include learning new skills, making friends, improving diet, relieving stress, saving money on groceries, keeping active and getting outdoors.*

- ***Cycling and walking routes****, orienteering opportunities and eco trails*

- ***Outdoor gyms*** *throughout the city to provide access to a free fitness workout.*

Health in All Policies

10.3 The "whole system" governance and implementation arrangements will aim to ensure that health and health equity are considered coherently across ministerial and departmental policy making through a "Health in All Policies" approach.

10.4 The term Health in All Policies (HiAP)[35] describes an approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Health Impact Assessment (HIA) is a practical tool used to support HiAP by judging the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. HIA can inform the decision-making process with the aim of maximising the proposal's positive health effects and minimising its negative health effects. HIA has been promoted to policymakers across Government departments in Northern Ireland with some evidence of use. There have also been examples of HIA at local level, for example in relation to housing programmes. DHSSPS will continue to work with departments and with the IPH, who provide support for HIA, to review and strengthen processes in support of a Health in All Policies approach, and with other sectors such as local government to support wider implementation.

10.5 To safeguard the interests of future generations from the perpetuation of social and economic inequities it will be important to identify the links between environmental, social and economic factors and apply the principles of sustainable development to policies and their implementation.

Research

10.6 Building capacity for research and strengthening the evidence base relating to public health issues will be vital to secure health benefits across all socioeconomic groups. The NI Public Health Research Network and collaborations such as the Centre of Excellence for Public Health and the European Centre for Delivering Social Change will seek to maximise research effort. Evaluation and sharing the learning across government from action taken to address the wider determinants will also be crucial. Such learning will inform future investment.

Legislation

10.7 Legislation in relation to issues such as tobacco control and road safety has been an effective mechanism to secure health improvements and this approach will continue. The Breastfeeding Strategy *"Breastfeeding – A Great Start"* proposes the introduction of legislation to support mothers' breastfeeding their children in public places in Northern Ireland, subject to public consultation, and consideration is being given to introducing minimum unit pricing for alcohol.

10.8 There are examples from other jurisdictions of legislation being used in a broader way to promote and protect public health and the need for similar legislation will also be considered here. A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. It is proposed that the review will put forward recommendations for updating the current legislation and will examine how to promote a broader strategy for public health.

Supporting the development of the wider Public Health Workforce

10.9 Public health interventions are delivered by people who work in a range of settings, which includes the Health and Social Care sector but also comprises community and voluntary and Local government activity. It is important to recognise that if the aspirations of this framework are to be fulfilled then public health capacity and competency amongst those working towards improving public health across different sectors and from whatever professional background should be supported and developed. For example, nursing will have a key role in the public health outcomes to be delivered. This will encompass all of the existing roles e.g. surveillance, screening, health promotion, but will be much more focused on building community capacity, advocacy, social development and contributing to future policy development.

10.10 Across the UK, a range of initiatives to support professional development and to make public health "everybody's business", have been initiated. These include the UK Public Health Register (UKPHR), the development of the Public Health Skills and Career Framework (PHSCF) and PHORCaST - Link - **http://www.phorcast.org.uk/** - a web based resource to support career development and skills and training for the wider public health workforce.

10.11 In April 2013 the DOH England published a workforce strategy to support England's strategy *"Healthy Lives, Healthy People"*. DHSSPS will examine the actions arising from this strategy including examples of innovation and good practice, and consider how this can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.

OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH

Actions and Commitments 2013 – 2015

A Establish governance, implementation, engagement and monitoring arrangements at strategic, regional and local levels which interconnect to create a whole system approach

Key Partners
DHSSPS and PHA lead / all other relevant partners

B Create the conditions and processes for all departments and other relevant bodies to develop public policies which support improved health and wellbeing and a reduction in health inequalities, including a review of health impact assessment processes

Key Partners
DHSSPS lead / all other relevant partners

C Strengthen collaboration North / South, East / West and internationally, particularly across Europe, on areas of mutual interest

Key Partners
DHSSPS / DOHs in England, Scotland, Wales, ROI / PHA / PHE / IPH / WHO / Healthy Cities organisations

D Maximise the spend on prevention and early intervention through –

- increasing the share of the health budget spend on prevention and early intervention and developing mechanisms to monitor this across the HSC

Key Partners
DHSSPS / HSCB / PHA / Trusts

- securing the reallocation of resources from hospitals into the community envisaged in TYC and the PFG commitment

- monitoring funding contributions of other partners to improving health and tackling health inequalities

Key Partners
DHSSPS / PHA / others

OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH Continued

Actions and Commitments 2013 – 2015 Continued

E Promote a planned and co-ordinated approach to research and development (R&D) activity to support improved public health

Key Partners
DHSSPS / DETI / DSD / PHA / others (including universities)

F Consider and implement legislative change to support public health Including in relation to –

- tobacco control
- misuse of alcohol and drugs
- promotion and support of breastfeeding

Key Partners
DHSSPS

- road safety

Key Partner
DOE

G Review the Public Health Act (Northern Ireland) 1967, consult on proposed changes and update as appropriate

Key Partners
DHSSPS

H Assess the actions and recommendations arising from the public health workforce strategy associated with Healthy Lives, Healthy People and consider how good practice and innovation can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.

Key Partners
DHSSPS / PHA / others

Key Strategies / strategic programmes - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Breastfeeding - A Great Start, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Making it Better - A Strategy for Pharmacy in the Community, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012- 2015.

18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

Asset – Based Approach

10.12 Historically, approaches to the promotion of population health have been based on a "deficit" model. That is, a focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on public services. It is no doubt important and necessary to identify levels of needs and priorities, but this model tends to define communities and individuals in negative terms, without consideration of what is positive and works well in particular populations.

10.13 Recently an asset – based[36] approach to community development has been gaining momentum. This focuses on the factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and wellbeing and meet identified needs, rather than a focus on the "deficits" or problems, needs and deficiencies such as deprivation, crime, anti-social behaviour, exclusion, illness and health-damaging behaviours. Assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses. The report "A Glass Half Full - how an asset approach can improve community health and well-being"[37] demonstrates that when practitioners begin with a focus on what communities have (their assets) as opposed to what they don't have (their deficits) a community's ability in addressing its own needs increases, as does its capacity to lever in external support.

10.14 Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices. "People" assets vary across communities; some have stronger support and social networks than others. "Physical" assets also vary across localities. In line with a Health Committee recommendation, it is intended to work collaboratively across government agencies and with other organisations to map assets (both physical and social) which could be used to tackle inequalities in health. This will assist in informing the ongoing implementation of the framework and development of a whole system approach, and may be replicated at other levels of delivery.

Assets may include:

- *the practical skills, capacity and knowledge of local individuals, families and groups;*
- *the passions and interests of local people that give them energy for change;*
- *the networks and connections – known as 'social capital' – in a community, including friendships, neighbourliness and volunteering;*
- *the effectiveness of local community groups and voluntary associations;*
- *the resources of public, private, voluntary and community sector organisations that are available to support a community; and*
- *the physical and economic resources of a place that improve wellbeing.*

(National Institute for Health and Clinical Excellence, 2009)

Local Partnership Action

10.15 The actions outlined in this framework involve a range of government departments and other agencies. Many of the actions are inter-linked and require delivery at local as well as strategic or regional level. Three further areas of work have been identified around which a number of partners have been developing collaborative approaches and which lend themselves particularly to local partnership action.

These are:

- **Food – GROW and EAT;**
- **Space and place – MOVE and MEET; and**
- **Social inclusion – CONNECT FOR A BETTER LIFE.**

10.16 These issues are particularly relevant to current public health challenges and to tackling health inequalities. They inter-relate and overlap. They are included with the aim of building momentum and galvanising communities and relevant organisations at local level, supported where needed by coordination at regional level. Their inclusion provides a focus for collective action over the next three years – the intention is that this work will provide a foundation on which to build in the next wave of actions under this 10 year framework.

(a) Food - GROW AND EAT

Why?

10.17 Food impacts on people's lives on a daily basis in many ways. Eating is essential for survival, but food can be a source of enjoyment and a focus for social engagement. For some it is part of their cultural identity. Good healthy food can be a means to achieve broader goals of improving health and wellbeing, reducing social isolation and increasing civic engagement. It engages individuals and communities in a fundamental way that can cut across socio-economic groups and cultural boundaries.

Food facts from Health Survey NI 2011-12

61% of adults measured were either overweight (37%) or obese (23%)

10% of children aged 2-15 years were assessed as being obese

Rates of obesity tend to rise in association with increasing social disadvantage

86% of respondents said they were aware of the advice to have at least 5 portions of fruit or vegetables each day, but only 33% of respondents met this guideline

87% of respondents in households had enough of the kinds of food that they wanted to eat

Food facts from Health Survey NI 2011-12 continued

A further 12% had enough to eat but not always the kind of food they wanted

7% of respondents in the past year ate less because they felt that there was not enough money to buy food

1% of respondents sometimes did not have enough to eat while 0.4% of respondents often did not have enough to eat

1% of respondents did not eat for a full day because there was not enough money for food; around half of this proportion said that this happened almost every month

10.18 In the current economic climate, food poverty is becoming an increasingly important issue. Food poverty is a complex aspect of poverty that has health and social consequences. It is defined as the "inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation." Households experiencing food poverty consume less nutritionally-balanced diets and suffer from higher rates of diet-related chronic diseases such as heart disease, diet related cancers, and overweight and obesity.

10.19 Currently there is no agreed measure of food poverty across Ireland to inform practice and policy. IPH, using Living Costs and Food Survey data for Northern Ireland, reported that 14.8% of NI households were at risk of food poverty in 2009. Members of the Food Poverty Network, co-chaired by Food Standards Agency in Northern Ireland and Safefood in ROI, have been tasked with developing a food poverty indicator based on routinely available data. This will potentially provide a North/South indicator and allow for comparison.

Food Waste

In the UK 7.2m tonnes of food and drink is thrown away from homes each year.

*NI shoppers could save around £480 per year per household by cutting down on food waste**

* Household Food and Drink Waste in the UK (WRAP 2009)

10.20 Local developmental work should aim to –

- increase access to healthy foods and reduce risk of obesity and malnourishment in a way that promotes dignity, builds health and community and tackles inequalities at a local level for all ages.

This could be taken forward for example through support for initiatives such as community gardens and allotments, community cafes offering free or low cost healthy meals, community farmers' markets, food co-operatives.

Key features of such initiatives could include offering a range of participation opportunities to learn how to grow, cook and choose healthy food; building on existing community assets and linking them, and strengthening capacity and skills.

Community Food Initiative

The Community Food Initiative funded by SafeFood and managed by Healthy Food for All Ireland, aims to support community projects in promoting greater access to affordable and healthy food. Two NI projects are among those receiving funding through the 2013-15 programme.

Incredible Edible Cloughmills

The Incredible Edible Network is a network whose members believe that providing access to healthy, local food can enrich their communities. Typically their work involves setting up community growing plots, reaching out to schools and children and backing local food suppliers. This reflects the movement's drive to provide access to good local food for all through:

- *working together*
- *learning – from field to classroom to kitchen*
- *supporting local growers, retailers and outlets*

Incredible Edible Cloughmills is one such group which seeks to reconnect people and food. It is constantly evolving by putting people at the heart of decision making and action, and aims to improve wellbeing by making 5 actions a reality in its community – connecting, being active, taking notice, learning and giving.

Fareshare

FareShare sources surplus, 'fit for purpose' food and drink from retailers and manufacturers throughout Ireland and redistributes it to local charities feeding hungry and vulnerable people in the community. Food is distributed through ***Community Food Members (CFMs)*** *to disadvantaged groups such as the homeless and vulnerably housed people. This enables these organisations to reinvest funds into other much needed services such as housing advice, training and support. In NI FareShare works in partnership with the Council for the Homeless Northern Ireland with contributions from local retailers and food producers.*

(b) Space and place - MOVE AND MEET

Why?

10.21 The physical and social characteristics of communities and the extent to which they enable and promote healthy behaviours can make a major contribution to improving health and reducing social inequalities in health.

10.22 Many reports note how the quality of both the natural and built environments impact on, for example, mental health and wellbeing, obesity, and health inequalities, and on the development and sustainability of social networks and communities. People with poorer health often live in environments which support unhealthy lifestyles, for example, lacking in green space with limited access to environments for walking or cycling, or for children to play, and more likely to pose a threat to health through higher rates of crime or risks from traffic.

10.23 Much can be done to create safe, health-enabling neighbourhoods and environments for everyone. Physical environments can be designed or maximised to promote health and wellbeing through, for example, providing access to services, green spaces including woodlands and forests, opportunities for being physically active and for safe social interaction. At a broader geographical level opportunities may exist for "joining up" planning and provision of for example transport, walkways, cycle paths, existing infrastructure or services to better connect communities and increase access.

10.24 Active travel – journeys using physical activity, such as walking and cycling – has a role to play in improving and achieving a fairer distribution of health as well as bringing economic benefits to the individual. Making neighbourhoods more "walkable" and making roads more cycle-friendly could make a significant difference to people's levels of physical activity. This would link with DRD's *Building an Active Travel Future for Northern Ireland (2013)* Action Plan which contains measures that will be taken by government departments, local authorities and voluntary bodies to encourage more cycling and walking and less dependency on private cars up to 2015. The establishment of a Cycling Unit in DRD is also aimed at ensuring that cycling provision is a key element in both transport strategy and delivery.

35% of respondents to the 2011/12 Health Survey were classified as meeting the recommended level of physical activity[1], with males (40%) more likely than females (31%).

73% of journeys in Northern Ireland are made by car, 16% are walked whilst a very small proportion of journeys (1%) are cycled (Travel Survey Northern Ireland 2010/12).

Aim

10.25 Work should aim to –

- maximise the use of physical assets to increase access to and use of safe, sustainable, health nurturing spaces and places, and opportunities for social interaction in a way that builds health and community and tackles inequalities at a local level for all ages.

Ways to do this might include for example – maximising and promoting shared use of public and community facilities; public realm schemes; greenways or routes, woodlands and forests for walking, cycling, running etc; green gyms / outdoor gyms; allotments.

Key features of such initiatives could include; incorporating promotion of health and wellbeing, social inclusion and safety in design and use of such spaces and assets; improving links with and capacity between planning, regeneration, public health and community safety; increasing physical activity and improving mental health and wellbeing; promoting age friendly environments.

WHO Healthy Urban Planning and Age-friendly Environments

The WHO International Healthy Cities movement has developed the concept of Healthy Urban Planning focussing on people, and how they use buildings and their surroundings, rather than simply on the urban fabric. An aim is to ensure environments are accessible, and support active participation in the city, for people of all ages. This underpins each phase of the Healthy Cities roll-out. Belfast and Londonderry are part of the Healthy Cities movement.

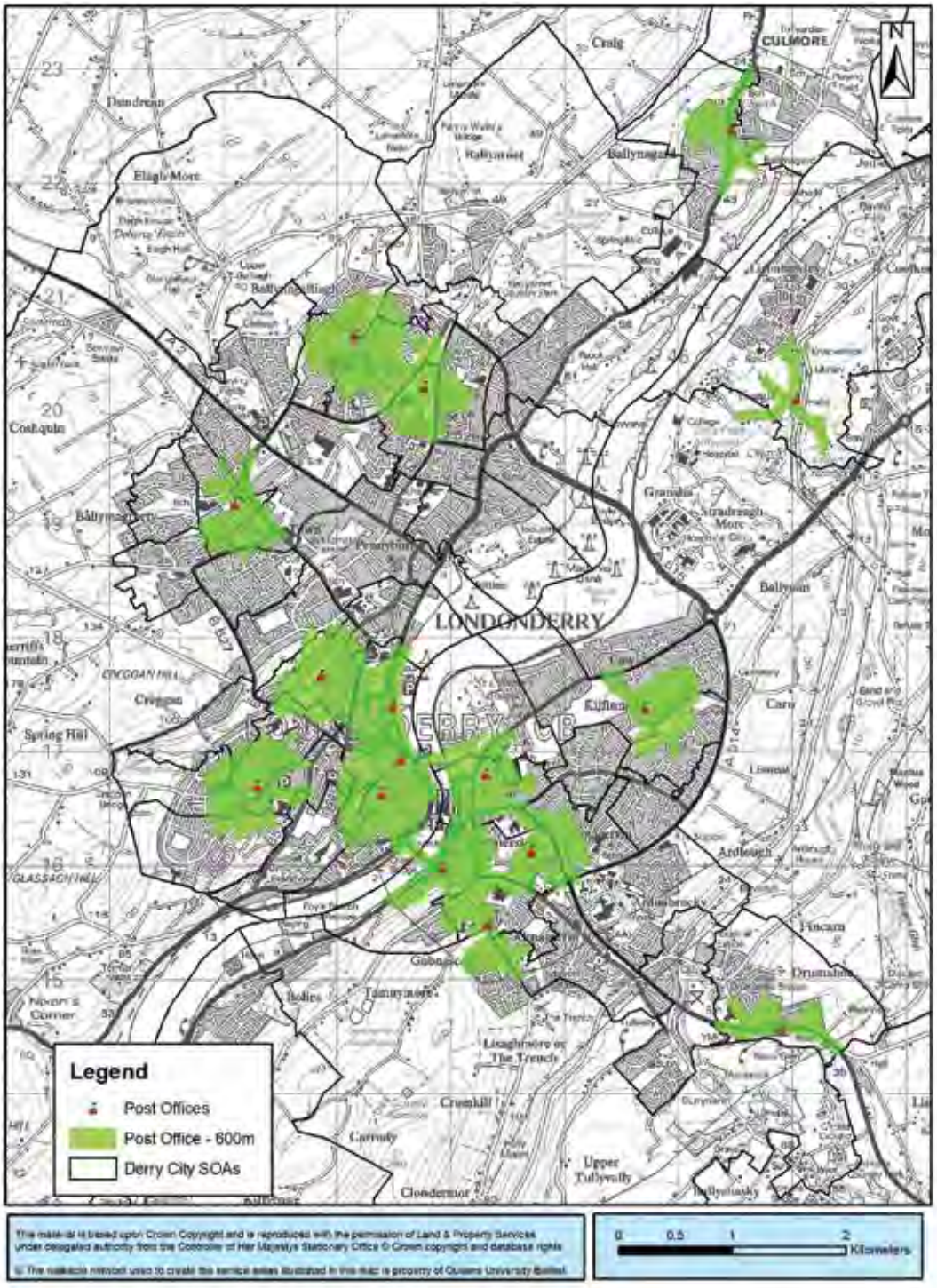
The Age-friendly Environments Programme aims to address the environmental and social factors that contribute to active and healthy ageing. Making cities and communities age-friendly is one of the most effective local policy approaches for responding to demographic ageing. Physical and social environments are key determinants of whether people can remain healthy, independent and autonomous long into their old age. WHO provides guidance and promotes the generation and dissemination of knowledge on how to assess the age-friendliness of a city or community, how to integrate an ageing perspective in urban planning and how to create age-friendly urban environments.

Knowledge Exchange, Spatial Analysis and Healthy Urban Environments

The KESUE project, led by the School of Planning, Architecture and Civil Engineering at Queens University Belfast, aims to maximise the policy impact of research undertaken on walkability, particularly the development of a Real Walkability Network. Initially generated as part of the Physical Activity and Rejuvenation of Connswater (PARC) project, based on a study area of East Belfast, this project has extended the applicability of the developed policy tools to cover the two main cities of Northern Ireland, Belfast and Londonderry, so that the model then covers 37% of the population and some of the most deprived communities in the region. The project has disseminated the use of this model to practitioners to increase the evidence base for interventions in the built environment aimed at promoting physical activity.

The value of the Project is reflected in the large number of public bodies that have been willing to become partners, including Belfast and Derry City Councils, DRD, DHSSPS, PHA and Belfast Healthy Cities.

Accessibility to Post Offices in Londonderry



NIRSA

Comber Greenway

The Comber Greenway is a traffic free walking and cycling route running from Comber to Belfast along the old railway line (which closed in 1950).

Groundwork

Groundwork engages and motivates people to improve their quality of life by investing in people and place through supporting community-led regeneration. Daisy Hill Wood, owned by Newry and Mourne District Council and managed by the Woodland Trust, is a main feature on the hill above Newry city. Originally it was a plant nursery from 1890 to 1990 and most of the current wood has resulted from the planting of exotic species during that period. The aim of the M&S Greener Living Project was to encourage local people to use the wood both as an educational and as a recreational resource.

A local community group – Daisy Hill Nursery Woods Conservation Group was set up. Members of the group met every Saturday from October to March and carried out various practical tasks to make access safer for walkers, to remove invasive species, which prevent trees from regenerating naturally, and to plant native trees and shrubs.

Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust planted nearly 10 hectares of new native woodland at its Knockbracken site in south Belfast and a launch day was held in March 2013 for the Trust staff and patients. The woodland is open to all and additional access has been created to encourage community use.

The Trust had wanted to find a way to make best use of the land available to maximise health and therapeutic benefits for patients, staff, visitors and the local people whilst also providing good quality wildlife habitats. Options were explored and, in partnership with Woodland Trust and with support from Forest Service Woodland Grant Scheme, it was decided to plant almost 20,000 trees. The new community woodland is now an asset for both the Trust and the local community.

(c) Social inclusion – CONNECT FOR A BETTER LIFE

Why?

10.26 In addition to physical places, the communities and social networks to which people belong have a significant impact on health and health inequalities. Social capital can provide a source of resilience against particular risks of poor health, helping people get through economic or other difficulties, and contributing to wellbeing and as a result to other outcomes.

10.27 There are links between poverty and social exclusion, but not everyone who is poor is socially excluded. Many people living in poverty are supported through social, family and community support networks. Not everyone who is socially excluded is poor. Poverty may not be the main issue, for example, for people from minority ethnic groups, people with a disability, or mental health problems, people who are homeless or lesbian, gay, bisexual and transgender people.

10.28 Those living in rural areas may have difficulties in accessing the types of services that other people take for granted and feel isolated. Loneliness and social isolation among older people is also a growing problem. Social networks and social participation act as protective factors against dementia or cognitive decline over the age of 65.

10.29 Exclusion is driven by unequal power relationships, which can be economic, political, social or cultural. Exclusion can operate at individual, household, group or community level. Community involvement can be the key to successful policy and/or action to reverse exclusion.

- The Marmot Review identified that individuals who are socially isolated are between 2 - 5 times more likely to die prematurely than those who have strong social ties.

- Social exclusion can lead to alcohol misuse, poor mental health, lack of physical activity, greater disadvantage, higher levels of social isolation and reduced uptake of services and support.

Aim

10.30 Work in this area should aim to –

- bring together and maximise the resources invested in an area to ensure people of all ages have access to support networks and opportunities to participate, and to build individual and community resilience, capacity and social capital.

This could be taken forward for example through targeted support for particularly vulnerable population groups locally, befriending schemes, schemes to promote access to services and advice, assisted transport, arts and cultural programmes, reading schemes etc.

Key features would include securing the participation of the individuals/groups at risk of exclusion, building individual and community resilience, building on and linking community assets.

Fab Lab

Ashton Community Trust (Belfast) in partnership with the Nerve Centre (Derry/Londonderry) jointly launched the first Fab Labs in Northern Ireland in May 2013. The concept was originally set up in the Massachusetts Institute of Technology to inspire people and entrepreneurs to turn their ideas into new products and prototypes by giving them access to a range of advanced digital manufacturing technologies.

The two Northern Ireland Fab Labs will offer support on a local basis to communities, entrepreneurs, students, artists, small businesses and anyone who wants to create something totally unique through access to manufacturing technology from precision laser cutters and 3D printers to electronic circuit fabrication equipment.

Fab Lab is a prime example of positive social intervention. The project will deliver on a number of levels, for example encouraging greater levels of positive cross-community contact - people from all communities can come together and develop their creative and entrepreneurial skills, as an educational tool helping children and young people to turn their ideas into reality, and by increasing the capacity and employment potential for people living within deprived areas.

Funded by PEACE III managed by Special European Union Programmes Body, the project will also link into and share experiences with the worldwide network of Fab Labs.

Words Alive

The "Words Alive" group is a creative writing group established as a means of encouraging socially isolated people aged 60+ to come together to discuss their shared interest in reading, storytelling and recalling old memories. The members have published their first anthology Pen to Paper in 2012. The group is planning to reach out to other isolated older people by doing readings of their work in nursing and residential homes. The group also plans to secure funding to enable it to engage with the local Polish community.

Keep Warm

The PHA works with partner organisations such as Homeplus, the Welcome Centre, Rosemount House and the Salvation Army to provide protection against cold weather by delivering Keep Warm packs to rough sleepers and homeless people in Belfast.

Ardoyne Library Read Aloud

Ardoyne Library sits at the heart of its community and provides a welcoming space for local people. Following on from a learning initiative, an informal group of mostly senior male users evolved and were offered the chance to try 'Read Aloud' reading from a number of authors and poets over four, weekly sessions.

The common experience of reading is as a solitary activity that takes the reader on a journey based on their own experiences and perceptions of the world. Reading and discussing great literature or poetry in a group context can create a different and unexpected journey of discovery. How someone else interprets a line, a word, or the intent behind a passage can be very different from what an individual reads into it. It can be insightful, thought provoking, and encourages respect for others' opinions.

Read Aloud allows thoughts, connections and understanding to emerge. Group members can choose to join in, or not, and at times the reading will stop to allow discussion about parts of the text – what it might mean – or for reflecting on similar experiences. The effects are subtle and can be profound.

Research is uncovering an intimate connection between reading and wellbeing. The scientific findings indicate that being read to, stimulates thought and memory and encourages the sharing of ideas, feelings, hopes and fears.

Reading for the individual is a therapeutic activity but reading with others is a shared pleasure and rewarding experience for both the reader and the listener. Encouraged by a request from group members, Read Aloud workshops are continuing with the Ardoyne Library Group on a monthly basis.

OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

Actions and Commitments 2013 - 2015

A Maximise opportunities to strengthen local collaboration through the joint working arrangements between PHA and local government, and the outworking of local government reform and the new statutory duty of Community Planning process

Key Partners
DHSSPS / DOE / PHA / Local government

B Work collaboratively across government agencies to map assets (physical and people) which could be used to tackle inequalities in health

Key Partners
DHSSPS / DSD / other departments and agencies

C Improve availability and use of data across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective

Key Partners
Departments / agencies / Local government / other sectors

D In partnership with relevant departments, agencies, other sectors, local government and communities, develop and implement regional programmes to address health and wellbeing priorities in line with this framework

Key Partners
DHSSPS / PHA lead–partners at regional and local levels

OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING Continued

Actions and Commitments 2013 - 2015 Continued

E Maximise opportunities for local partnership action working with local communities to –

- establish a network of community led gardens and allotments which promote health and wellbeing
- develop child friendly spaces through a neighbourhood approach to community safety
- promote health and wellbeing of older people in their own homes through a home visitation scheme

Key Partners
PHA to lead with local government, police and community safety partnerships, community and voluntary sector and other partners

Key Strategies / strategic programmes - NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Delivering Social Change Framework, Tackling Rural Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Local Government Reform programme, Community Safety, Strategic Framework for Reducing Offending, Community Relations – Together, Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, planned Community Asset Transfer framework, Social Economy strategy, Build Pathways to Employment, Success through Skills – Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Transforming Your Care, Join In - Get Involved, Sport Matters, Extended Schools, Workplace Health, (Draft) Active Ageing Strategy, A Fitter Future for All.

MAKING LIFE BETTER

PART THREE – GOVERNANCE AND IMPLEMENTATION

CHAPTER 11 – MAKING IT WORK

11.1 Health 2020 argues that, in order to improve population health and wellbeing and reduce health inequalities, all parts of government need to work together to recognise risk patterns and identify solutions, act at various levels, and share responsibility across policy fields and sectors.

11.2 At strategic level this framework emphasises the inter-connectedness of many government policies and programmes, and the mutual benefits and shared goals that can be achieved by working together effectively. It is clear that there are opportunities to strengthen these linkages through governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.

11.3 The reform of local government will also provide an opportunity to strengthen the already significant contribution at local level to improving health and reducing health inequalities. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.

11.4 A whole system approach is required, with clear lines of communication, accountability and clarity on how governance and implementation is to work. Connections with other relevant strategies and initiatives need to be managed and maximised. Collaboration should be embedded in every aspect of governance and monitoring, and with clear recognition of and relevant linkage with structures and partnerships which will contribute - examples are Children and Young People's Strategic Partnership, and Public Health Local Government Steering Group.

Governance and Implementation

11.5 This chapter outlines the governance and implementation arrangements for "Making Life Better". These arrangements reflect the concerns raised in the Investing for Health Review on disconnect between strategic direction and local implementation. Key roles, responsibilities, monitoring and reporting mechanisms are also outlined. In promoting a thematic whole system approach it may be beneficial to establish additional thematic sub – groups to tackle particular issues. These may be at any level within the proposed structure.

Strategic Level - Ministerial Committee for Public Health

11.6 At strategic level, a Ministerial Committee for Public Health to be chaired by the Minister for Health, Social Services and Public Safety will be established. The key functions will be to provide strategic leadership at government level, provide direction and coherence with other key strategic programmes and structures, such as Delivering Social Change, and oversee implementation on behalf of the Executive. The Ministerial Committee will be supported and informed by the All Departments Officials group (ADOG)

All Departments Officials Group (ADOG) for Public Health

11.7 The ADOG, chaired by the Chief Medical Officer, will comprise senior officials from every department. Its role will be to:

- inform and make recommendations to the Ministerial Committee;
- develop and support a Health in All policies approach to promote coherence;
- co-ordinate collaborative working at departmental level;
- connect with the Regional Project Board, directing, or supporting action as appropriate; and
- monitor and report on progress.

This group will report to the Ministerial Committee. The chair of the Regional Project Board (see below) will be a member of and report to this group.

Regional Project Board for Public Health

11.8 The Regional Project Board, to be chaired by the Chief Executive of the PHA, will focus on strengthening collaboration and co-ordination to deliver on the strategic priorities across sectors at a regional level, and on supporting implementation at a local level.

11.9 Membership of the group will comprise the Chief Officers of relevant statutory agencies. There will also be representation from local government, the community and voluntary sector and the private sector.

11.10 The primary focus of this group will be to drive implementation of agreed priorities through:

- building connections between strategic drivers and local implementation;
- driving forward opportunities for regional initiatives that cut across common themes;
- directing, providing co-ordination for and monitoring the work of local partnerships;
- examination of emerging data, evidence and best practice in terms of addressing health and social wellbeing inequalities; and
- providing advice and recommendations to the ADOG and Ministerial Committee on emerging issues and potential areas for policy and legislative consideration and joint working.

11.11 This Group will be informed by and will support local partnerships. It may also be supported through the establishment as appropriate of thematic sub-groups or time bound working groups on priority themes. The Group will report through the Chair to the ADOG. Individual members will also be required to make effective links into their relevant Department/ organisation in terms of emerging issues and implementation.

11.12 In conjunction with local level partnerships the Regional Board will develop an Implementation Plan, focussed on strengthening co-ordination in relation to the priorities identified in this framework.

Local Level Partnerships

11.13 Local strategic partnerships of key statutory, private, community and voluntary bodies will be established based on an agreed geographic coverage. Each Partnership should in the first instance be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined in Chapter 10.

11.14 The partnerships' role will focus on local delivery and will be to:

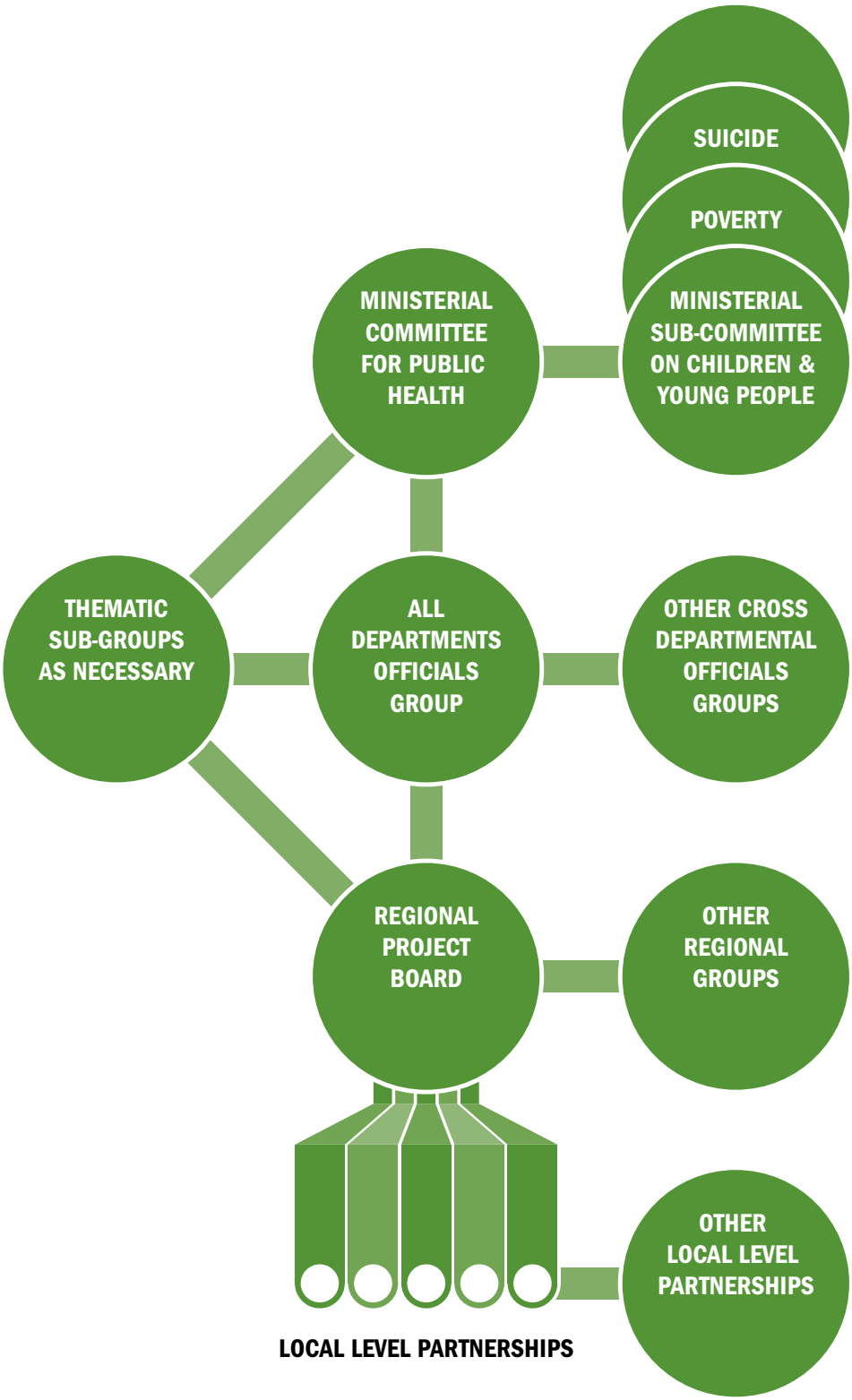
- identify local opportunities for collaboration and partnership working based on local need;
- drive local interventions/services to support those most in need;
- develop and promote new ways of working and models of intervention and test concepts;
- ensure regional priorities are reflected in local plans;
- ensure that local priorities are fed into the strategic process; and
- report to the Regional Project Board (the Chair of the local partnership will be a member of the Regional Project Board).

11.15 These arrangements should link into and align with local Community Planning arrangements over time. New legislation will place a duty on councils to lead the community planning process and on other public bodies to participate. Departments will also be required to promote and encourage community planning and have regard to the councils' community plans in planning the delivery of services.

11.16 Legislation will establish a statutory link between the community plan and the local development plan. This will ensure that issues relating to the general wellbeing of the community will be taken into account in the preparation of a council's local development plan.

MAKING LIFE BETTER

Figure 3: Making Life Better - Governance and Implementation



Local strategic partnerships established on an agreed geographic coverage, and including a balance of statutory and non-statutory partners.

Monitoring Framework

11.17 To support the proposed structures a monitoring framework will be developed to include:

- reports from local partnerships to Regional Project Board;
- reports from Regional Project Board on regional and local activity with advice and recommendations to ADOG;
- reports from ADOG to the Ministerial Committee on strategic issues, key indicator trends, overall activity and provide advice and recommendations; and
- an annual report on overall progress.

11.18 *It is not the intention to duplicate reporting where other mechanisms are already in place, for example, there are already reporting processes for PFG commitments.*

11.19 Through the Data and Research Groups established to support the framework, a set of key indicators has been agreed to facilitate high-level monitoring of progress. The indicators are linked to the framework's themes and will serve as proxy measures to monitor progress towards the outcomes - the indicators with baseline positions are listed in Annex B. This set of indicators may be expanded as work progresses. Data and Research Groups will continue to support the monitoring of progress. Members will also work to secure better record linkage and make recommendations on research and evaluation to inform the framework's implementation and evaluation.

11.20 DHSSPS Information and Analysis Directorate will undertake the role of collating and publishing updates on the key indicators including on those relating to the social determinants. The Health and Social Care Inequalities Monitoring system maintained by DHSSPS and such services as that provided through the Northern Ireland Neighbourhood Information Service (NINIS) will continue to be useful tools supporting policy and service planning and delivery. It will be important to improve the availability and use of data on an ongoing basis across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective.

11.21 Effective communication will be required across all levels if the framework is to achieve results. An "Engagement and Communications" strategy will be developed by the Regional Board in collaboration with the All-departments Officials Group to support implementation and monitoring of the framework.

Funding

11.22 Funding from across government is already committed to supporting the strategic actions identified in Chapters 5-10 of this framework. This is underpinned by the Executive's commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.

11.23 The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition it will be important to continue to collaborate with other departments, exploring opportunities to pool resources or levering funding as appropriate to deliver relevant cross-cutting programmes such as the MARA project, and Parent Support programmes through Delivering Social Change. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of this framework. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

Early Action

11.24 Over the next three years:

- the structures outlined above will be put in place and processes developed to ensure a whole system approach;
- the actions committed to in the framework will be advanced;
- local developmental work on the three key areas outlined in Chapter 10 will be taken forward; and
- progress will be monitored and outcomes evaluated.

All of this will inform the next wave of actions to advance the long-term vision:

“All people are enabled and supported in achieving their full health and wellbeing potential”

and aims:

“Achieve better health and wellbeing for everyone and reduced inequalities in health”

MAKING LIFE BETTER

ANNEXES

ANNEX A - HEALTH AND HEALTH INEQUALITIES

1. The consultation document Fit and Well – Changing Lives set out a detailed analysis of the current health challenges and of the underlying social determinants. It also covered information on health and wellbeing of particular vulnerable groups. This Annex summarises and updates some key data.

2. Northern Ireland currently has a population of around 1.8 million people. This is the fastest growing population in the UK and is projected to rise by 111,000 (6%) by 2020 to around 1.9million.

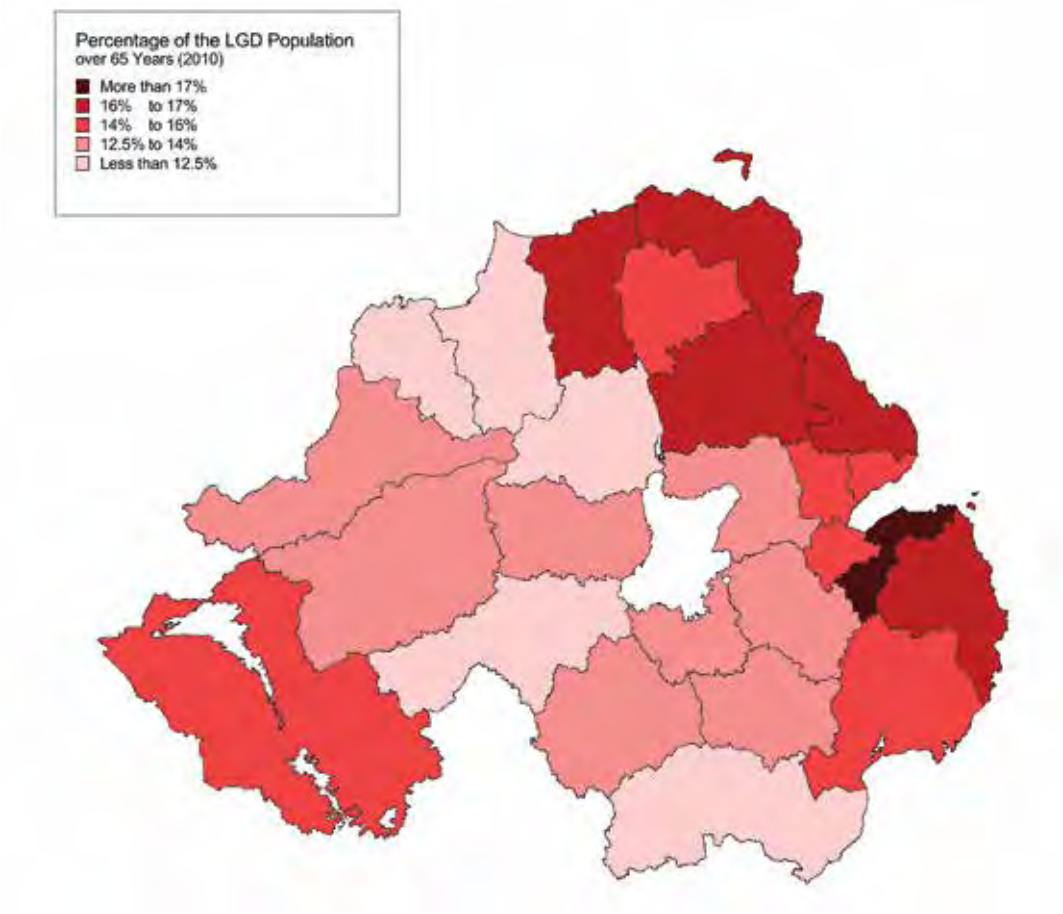
Figure 4: Number (percentage) of population by age group in 2010 and 2020 (projected)

AGE BAND	2010	2020
0 - 15	382,000 (21%)	398,000 (21%)
16 - 64	1,157,000 (64%)	1,175,000 (62%)
65+	260,000 (14%)	327,000 (17%)
85+	30,000 (1.6%)	44,000 (2.3%)

3. During this period, the age profile of the population is expected to gradually become older. The number of people aged 85 and over is also projected to increase, from 30,000 (1.6% of the total population) to 44,000 (2.3% of the total population). An ageing population is a significant achievement, reflecting advances in health and quality of life. A key challenge will be to enable older people to remain in good health for as long as possible.

4. In addition to these overall trends, there are also significant demographic differences within the region, for example, some localities have higher than NI averages of older people, or young children, which can put disproportionate pressure on local services and communities. These differences make targeting interventions a local rather than a regional matter.

Figure 5: Map of NI population 2010 – % of population aged over 65 years (LGD)

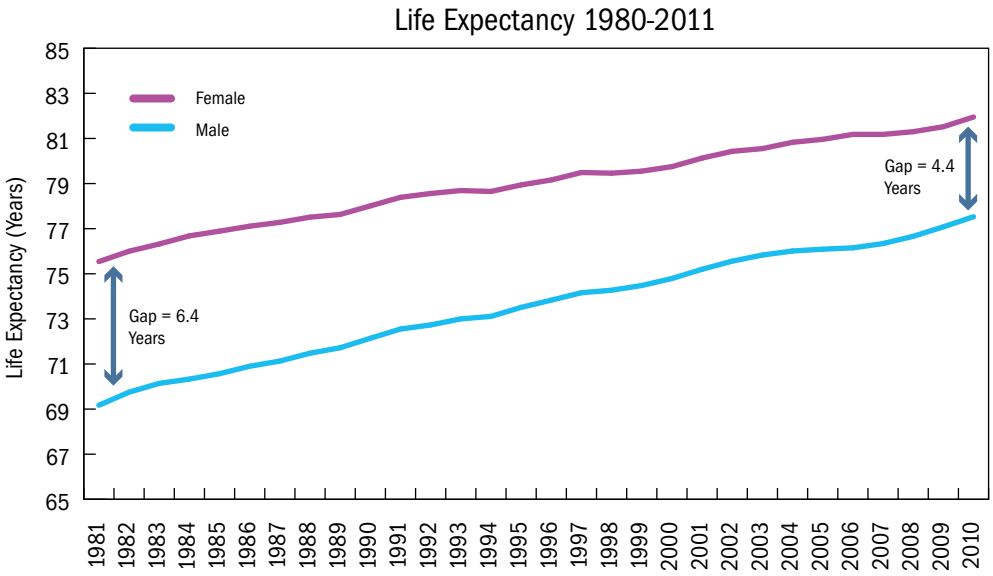


Life Expectancy

5. Since the 1980s life expectancy (used internationally as a measure of population health) has increased steadily for both males and females and is projected to continue to increase. Between 1980/82 and 2009/11[1], male life expectancy has increased by over 8 years, from 69.2 to 77.5, and female life expectancy has increased by over 6 years, from 75.5 to 82.0. During this time, the gender gap has decreased by 2 years, from 6.4 to 4.4 (Figure 6). Healthy life expectancy – the number of years an individual might expect to live in good health – shows similar patterns to overall life expectancy.

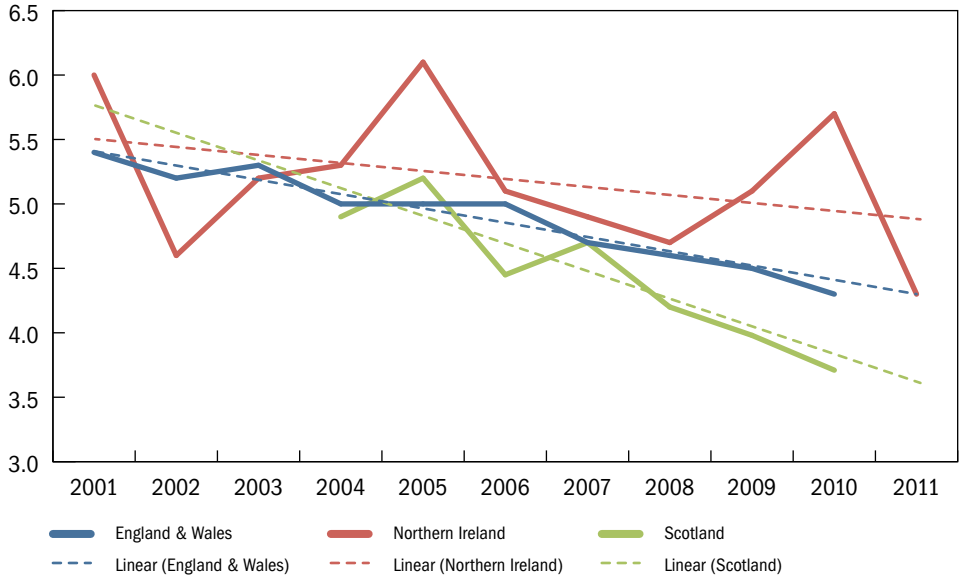
1 Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.

Figure 6: Life Expectancy for men and women in Northern Ireland 1980 – 2011



6. Infant mortality rates are key measures of health outcomes. Infant mortality rates (the number of children dying before their first birthday per 1,000 live births) have fallen across the UK in recent years. Despite sizeable year-on-year fluctuation in the NI rate, it can be seen to be generally improving however at a slower rate than in the rest of the UK (Figure 7).

Figure 7: UK Infant Mortality Rates (2001–2011)



Health Inequalities

7. While there has been general improvement in health, not everyone has been able to avail fully of the benefits of this progress. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic position in shaping people's health. Some vulnerable groups and communities, for example people with learning disabilities or travellers, have significantly poorer life expectancy than would be expected based on their socioeconomic status alone. For many of these groups poorer health outcomes are linked to wider social determinants such as access to education and employment.

8. Figures 8 and 9 show that the absolute gap in life expectancy in men between the 10% most and least deprived areas (2009/11) was 10.7 years, while the female life expectancy gap stood at 7.7 years.

Figure 8: Life Expectancy of men in Northern Ireland ranked by deprivation (2009-11)

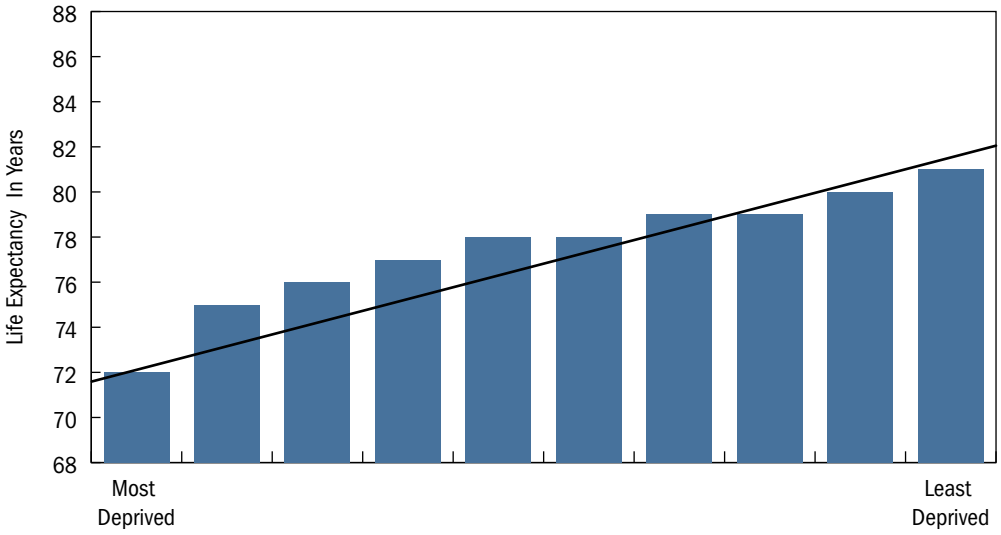


Figure 9: Life Expectancy of women in Northern Ireland ranked by deprivation (2009/11)

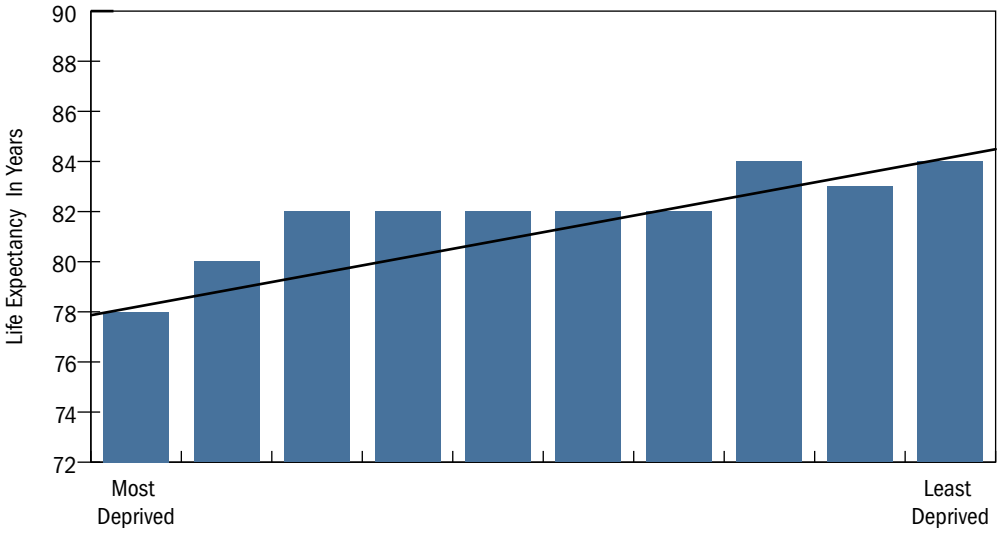


Figure 10: Male Life Expectancy Deprivation Gap: Proportion of Contributing Causes (2008 - 10)

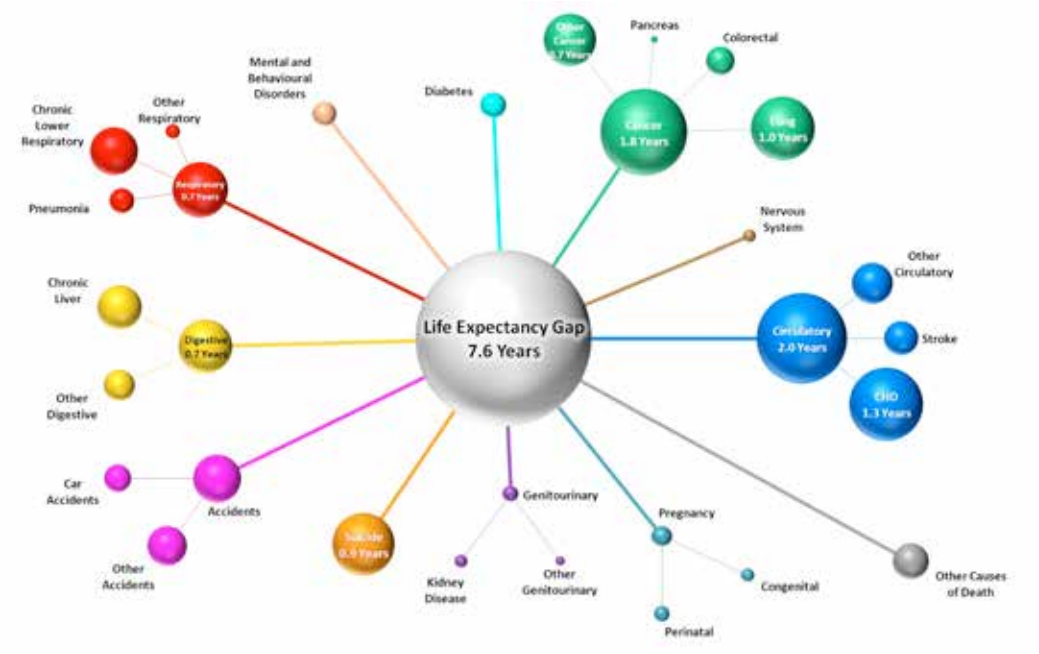


Figure 10 illustrates the decomposition analysis of the gap in life expectancy at 2008 – 10.The size of each sphere represents the proportion of the gap in life expectancy between deprived and non deprived areas attributable to each cause of death. Where appropriate, these causes are further broken down into sub-categories, the sum of which is equal to that cause. Causes contributing less than 0.01 years are not displayed.

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9. Male mortality rates for all overarching causes of death were higher in the 20% most deprived areas of Northern Ireland than in the 20% least deprived areas. In total, male life expectancy in deprived areas of Northern Ireland was 7.6 years less than in the least deprived areas. More than half of this gap is accountable to circulatory diseases and cancer, contributing 2.0 years and 1.8 years respectively. Coronary heart disease is responsible for over 65% of the circulatory disease gap, at 1.3 years. Other notable causes include suicide (0.9 years), respiratory disease (0.7 years), digestive diseases (0.7 years) and accidental deaths (0.6 years).

10. Coronary heart disease (CHD), cancer, and respiratory disease continue to be the main causes of death for both sexes. Many of these deaths occur before 65 years of age and are potentially preventable, since smoking, unhealthy diet, raised blood pressure, diabetes and physical inactivity are major contributors to a large proportion of these conditions.

Figure 11: Death rates from Cancer in people under 75 years in Northern Ireland ranked by deprivation (2007/11)

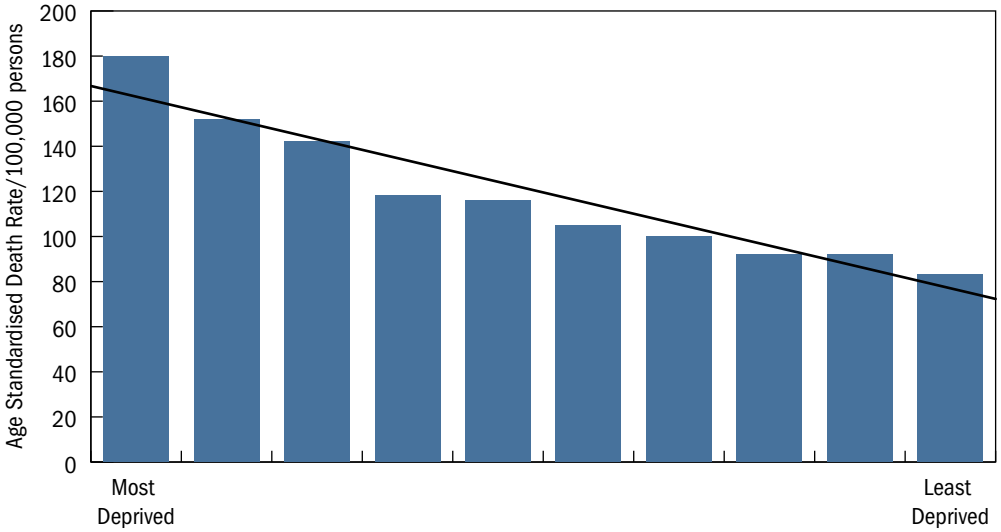

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Figure 12: Death rates from Coronary Heart Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)

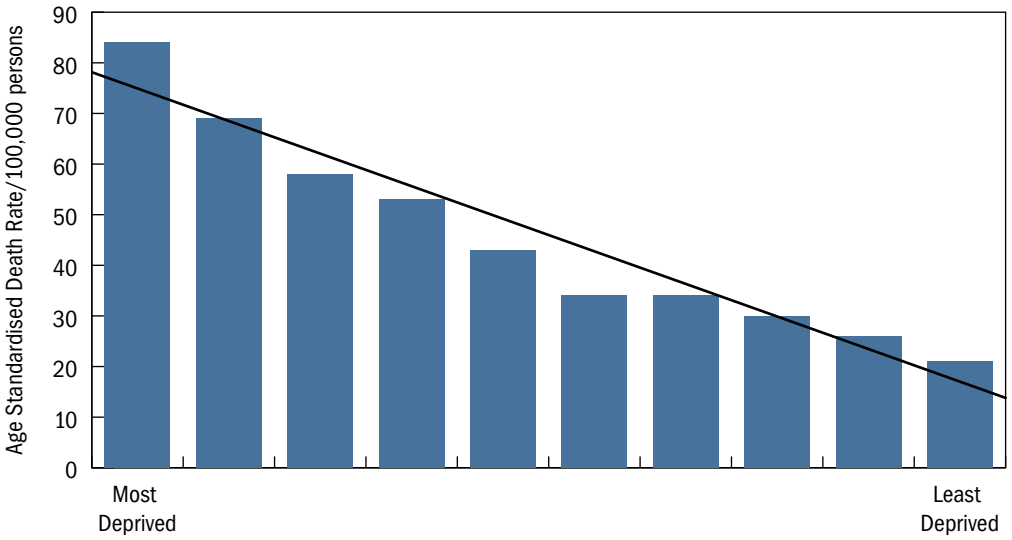
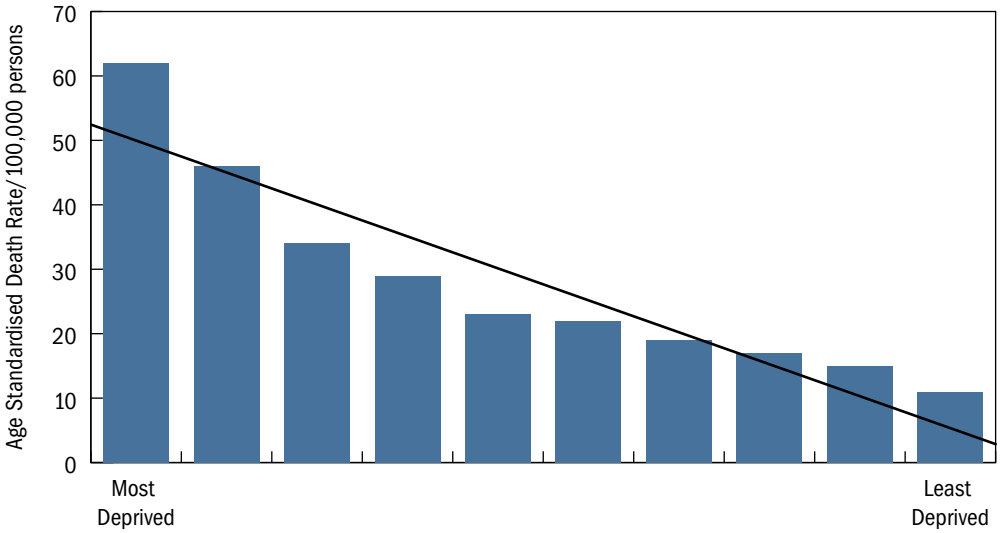


Figure 13: Deaths rates from Respiratory Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)



11. Figures 11, 12 and 13, shows there is a notable increase in death rates from cancer, CHD and respiratory disease as level of deprivation increases.

Mental Health

12. Mental illness is one of the major causes of ill health and disability in Northern Ireland which has 25% higher overall prevalence compared to England. One in five adults in NI has a mental health condition at any one time. Mental ill health is more prevalent in areas of deprivation. People with poor physical health are at a higher risk of experiencing common mental health problems and people with mental health problems, especially those with severe and enduring mental illness, are more likely to have poor physical health.

13. Mental wellbeing is related to, but not the same as, the absence of mental illness. It is possible to have a diagnosed mental illness and still be coping well with life and enjoying a high level of wellbeing. Likewise, someone can have poor mental wellbeing but have no clinically identifiable mental illness. However, in populations where individuals have higher mental wellbeing, fewer people tend to develop mental illness. The Warwick-Edinburgh Mental Wellbeing Scale is a measure of the positive mental health of people over time and has been included in the annual NI Health Survey and, for the first time, in the Young Person's Behaviour and Attitudes Survey. Results from the 2010/2011 and 2011/12 surveys have provided a baseline for monitoring mental wellbeing trends over the coming years (see Annex B).

14. There were 289 deaths by suicide in NI in 2011. During 2009/2011 there was an average annual suicide rate of 16.1 deaths per 100,000 population. The suicide rate in males was 25.1 deaths per 100,000 population, and the suicide rate in females was 7.4 deaths per 100,000 population. During this period, the suicide rate in the 10% most deprived areas was almost five times that within the 10% least deprived areas. A similar picture emerges when examining self-harm admissions to hospital over the same period, with the rate in the 10% most deprived areas over five times that in the 10% least deprived areas.

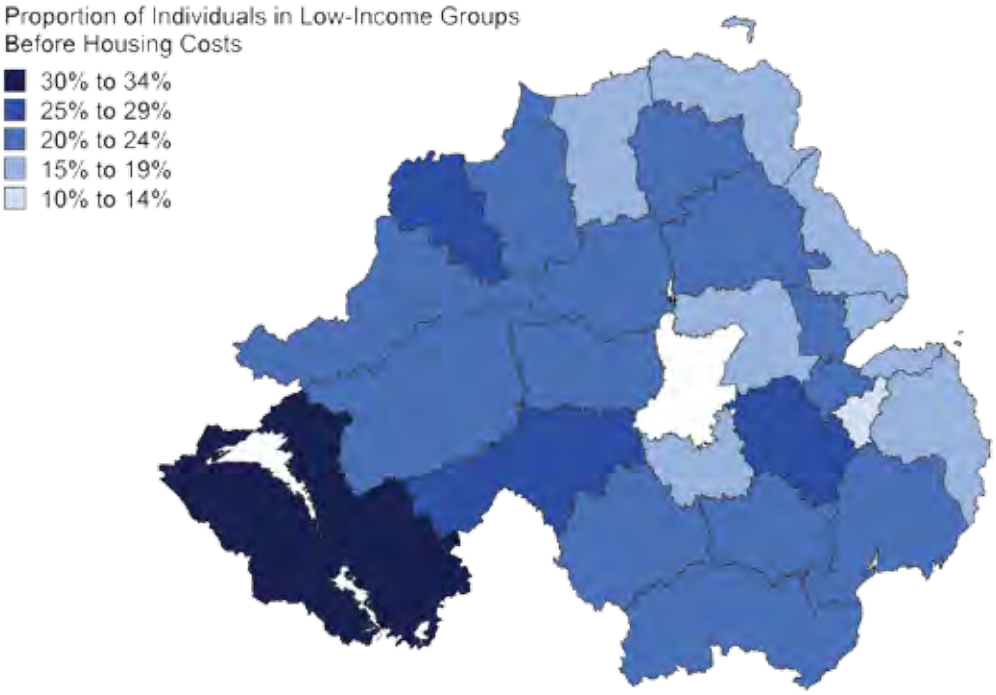
Wider Determinants

15. A wide range of socio-economic and environmental factors, such as poverty, neighbourhood deprivation, housing conditions, employment, education and physical environment, impact on the level of control people have in their lives and the choices they are in a position to make, and therefore on health and wellbeing and health inequalities.

16. Poverty is the greatest risk factor for health and wellbeing, affecting health in many ways, for instance, by creating barriers to buying nutritious food, heating one's home, or participating in activities and social interaction. People living in poverty are less likely to feel in control of their lives and more likely to face damaging stresses. They are also more likely to leave school with few or no qualifications.

In 2011/12, the percentage of individuals in relative poverty (before housing costs) was 21%, broadly similar to that in 2002/03 (20%). The percentage of children in relative poverty in 2011/12 was 23%, compared with 25% in 2002/03.

Figure 14: Percentage of individuals in relative poverty* by Local Government District, 2009/10 -2011/12



* Relative poverty is measured as having income of less than 60% of the UK median.

17. Education impacts on health in many ways – on self-esteem, social skills, training and employment opportunities and income. Inequalities in educational attainment are as stark as those in health and follow a similar social gradient, for example:

In 2011/12, 67.9% of school leavers not entitled to free school meals achieved at least 5 GCSEs at A-C or equivalent including GCSE English and Maths, compared with 34.1% of school leavers entitled with free school meals.*

"A strong positive relationship exists between education and health outcomes whether measured by death rates (mortality), illness (morbidity), health behaviours or health knowledge."

IPH – Health impacts of education – a review 2008

18. There is a clear link between employment and health. Unemployment has both short and long term effects on health, through lower self esteem, reduced social integration, anxiety and depression. Employment on the other hand is generally protective of health, however insecure work or adverse working conditions can impact negatively. Under-employment, where people are working part-time hours because they cannot find full time jobs, can place a strain on family finances and damage career prospects.

The Northern Ireland economic inactivity rate decreased each year from 30.1% in 2009 to 27.6% in 2012.

Northern Ireland's unemployment rate for 2011 was estimated at 7.3%, an increase of 0.2 percentage points from the figure for 2010 (7.1%) and an increase of 0.6 percentage points from the figure in 2009 (6.7%).

The long-term unemployment rate (1 year and over) increased from 37.6% in 2007 to 46.8% in 2012. During this time, the percentage of 16 to 24 year olds that were not in employment, full-time education or training increased from 15.6% to 22.1%.[2]

19. Good quality, warm, secure housing is also vital to both mental and physical health, with the very young and very old most vulnerable to the impacts of fuel poverty.

In 2011, more than two fifths (42.0%) of homes in Northern Ireland were in fuel poverty. During this time, 3.7% of Social Housing dwellings were classed as non-decent homes.

According to the Northern Ireland Housing Executive, as at 31st March 2013, the social housing waiting list amounts to 41,356 households, of whom around 22,414 are considered to be in housing stress, including 9,878 households deemed to be statutorily homeless.

20. Physical surroundings – the quality of the built and natural environment - buildings, green spaces, roads and walkways - have a significant impact on health and wellbeing, for example, on mental health and levels of obesity. They can also influence social networks and sense of belonging. Wider environmental factors – air and water quality for example – are also important to health.

Between 2007 and 2011, Northern Ireland air quality fluctuated slightly year on year but remains at a high standard.

During this time, Northern Ireland water quality improved year on year and is at a high standard in terms of compliance with regulations for drinking water standards (99.83%).

21. Globalisation and increased movement between countries can impact on the rate and spread of disease or infection. The emergence of novel viruses and continuing risk attached to future occurrences of pandemic influenza necessitates that a state of readiness is maintained to minimise adverse impact to public health.

22. Antimicrobial resistance (AMR) is regarded by WHO as one of the top three global threats to human health. Antimicrobials are medicines used to treat infections caused by bacteria, viruses or fungi, and so comprise antibiotics, antivirals and antifungals. The organisms evolve and survive by developing resistance to the antimicrobials. When that happens antimicrobials are no longer effective; simple infections become untreatable, and many complex medical procedures that depend on antibiotic cover become impossible to perform.

23. Factors such as increased international travel, including medical treatment abroad, an ageing population who are moving between care in hospitals and the community, and the use of antimicrobials in veterinary medicine contribute to the rapid spread of resistant organisms between countries, throughout healthcare systems and between animals and humans.

Impact of the Past

24. It is important to acknowledge that a particular challenge for the health and wellbeing of Northern Ireland society is the need to deal with the consequences of the past. A history of sectarianism, intolerance and violence has left a legacy of hurt and division, and physical and mental scars that must be addressed in building a better and healthier future.

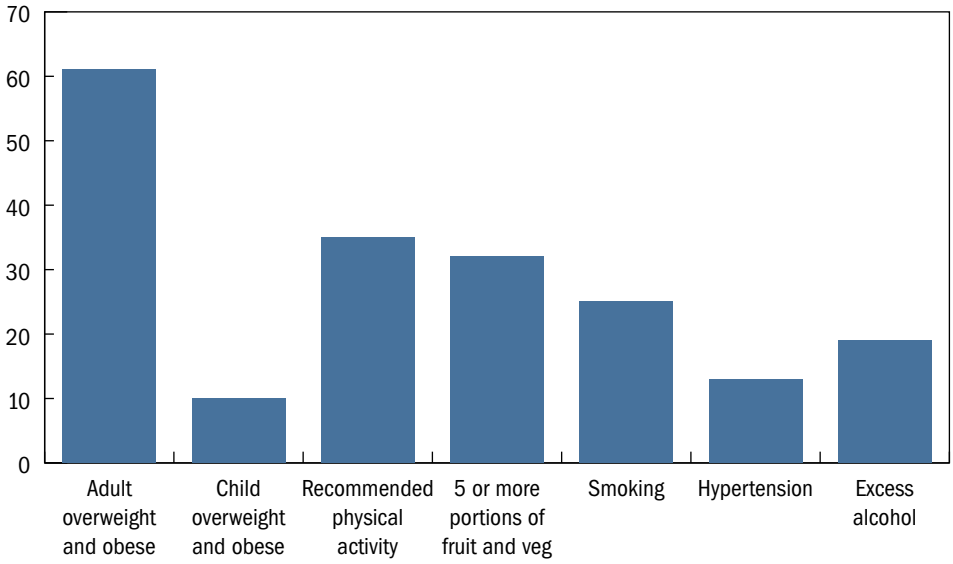
25. The Childhood in Transition Report[38] points to a number of specific factors that influence the present day lives of young people as a result of their direct or indirect exposure to the past conflict and the sectarianism that continues to exist. The legacy of the conflict continues to impact on everyday lives - local research indicates that Northern Ireland has high levels of, (often untreated), Post Traumatic Stress Disorder as a result of the 'Troubles'. Use of anti-depressants has a higher prevalence amongst those living close to peace walls[39], suggesting that people living in these areas have worse than expected mental health.

26. Society here has seen a number of significant milestones in achieving change and research demonstrates that there is strong desire across communities to continue working towards a more shared and positive future.[40]

Health Behaviours and Risk Factors

27. A recently published study[41] reported that the three risk factors that account for the greatest disease burden in the United Kingdom are dietary risks, tobacco smoking, and high blood pressure. In 2010 the leading risk factor for both children under 5 and adults aged 15-49 years was tobacco smoking. Tobacco smoking as a risk factor for children is due to second-hand smoke exposure.

Figure 15: Health Behaviours and Risk Factors in Northern Ireland



* 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011

1. Data for adults and children's weight, recommended physical activity, eating 5 or more portions of fruit and vegetables, smoking and excess alcohol relate to the Health Survey Northern Ireland 2011/12.
2. Data for hypertension come from the Quality and Outcomes Framework 2013.
3. 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011
4. In adults, a Body Mass Index of between 25 and 29.9kg/m2 is considered overweight.
5. A Body Mass Index of 30kg/m2 or above is considered obese.
6. The Chief Medical Officer issued guidelines on the amount of physical activity a person should do to achieve a healthy lifestyle. During the fieldwork of the 2010/11 HSNI, the recommended guidelines for adult physical activity were 30 minutes of moderate activity on at least 5 days a week.

28. The Health Survey Northern Ireland 2011/12 reported that a quarter of adults (aged 16 and above) smoked (27% males and 23% females). Similarly, almost a fifth (19%) of adults (aged 18 and above) stated that they drank in excess of the weekly recommended drinking limits[3]. Over three-fifths (61%) of respondents were either overweight (37%) or obese[4] (23%). A higher proportion of males were either obese or overweight (68%) than females (56%). A tenth of both boys and girls aged 2-15 years were also assessed as being obese.

Over a third (35%) of respondents were classified as meeting the recommended level of physical activity[5], with males (40%) more likely than females (31%) to fulfil this. Similarly, almost one-third of respondents (32%) reported consuming the recommended 5 or more portions of fruit

and vegetables per day. Females (36%) were more likely to meet this recommendation than males (26%).

Figures from the 2013 Quality and Outcomes Framework (QOF) reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.

Clustering of risk factors

29. Much of the available information on health behaviours focuses on the prevalence of specific individual risk factors. While this provides a useful insight, often these risk factors occur alongside one another. Recent work by the *Kings' Fund: Clustering of unhealthy behaviours over time (2012)* which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found for example that:

- a significant minority of people in western developed countries have three or more risk factors:
- multiple risk factors are not randomly distributed across populations but are more common in some groups than others;
- the overall proportion of the population engaging in three or more risk factors is declining, but mainly among those in higher socio-economic and educational groups; and
- several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower social classes and with lower levels of education being more likely to exhibit multiple lifestyle risks.

30. The Health Survey Northern Ireland 2010/11 looked at lifestyle choices based on five guidelines that can help individuals stay healthy or improve their health:

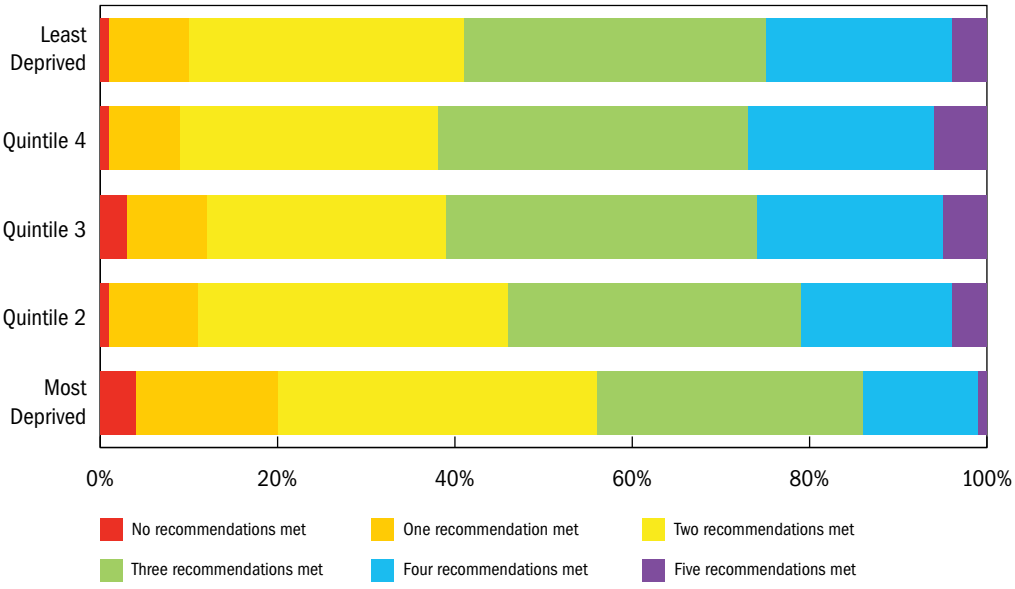
1. Ensuring alcohol intake is within weekly guidelines.
2. Not being overweight or obese by maintaining a Body Mass Index (BMI) of less than 25 kg/m^2.
3. Eating at least five portions of fruit and vegetables a day.

4. Meeting the recommended weekly level of physical activity. In 2010/11 the guidelines recommended exercising for at least 30 minutes 5 days a week. This has since changed to 150 minutes per week.

5. Not smoking cigarettes.

As shown in Figure 13, just over half of respondents (57%) met three or more of the lifestyle choice recommendations (50% of males and 61% of females), while 2% did not meet any of the recommendations. However, respondents in more deprived areas were less likely to meet the lifestyle choice recommendations when compared with those in less deprived areas.

Figure 16: Number of lifestyle choice recommendations met by deprivation quintile in Northern Ireland



Health Survey NI 2010/11

Further Information

31. Baselines for key indicators identified for monitoring progress, are at Annex B.

In addition, reports of the Health and Social Care Inequalities Monitoring System can be found at the link below:
http://www.dhsspsni.gov.uk/index/statistics/health-inequalities.htm

Notes

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.

ANNEX B - KEY INDICATORS AND BASELINES

A set of key high level indicators, to be monitored annually where possible, will help inform the monitoring process.

These include a small number of overarching indicators, and indicators which relate to each of the framework's themes, as follows

Key Overarching Indicators					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Life Expectancy	Differential between NI average and most disadvantaged areas for men and women.	2009 – 2011	In 2009-2011, the differential between the NI average and the 20% most deprived areas was 4.5 years for males and 2.8 years for females.	IAD (NI HSCIMS)	Annual (March)
	Healthy Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 7.2 years for both males and females.	IAD (NI HSCIMS)	Annual (March)
	Disability Free Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 5.4 years for males and 5.0 years for females.	IAD (NI HSCIMS)	Annual (March)
1. Give Every Child the Best Start					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Infant Mortality	Number of children dying before their first birthday per 1,000 live births	2007 - 11	For the period 2007 to 2011, the infant mortality rate was 4.9 per 1000 live births, with a rate of 5.2 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (December)

1. Give Every Child the Best Start - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Smoking During Pregnancy	Proportion of mothers smoking during pregnancy in NI and the most disadvantaged areas	2012	In 2012, 16.5% of expectant mothers in Northern Ireland smoked during their pregnancy, with a rate of 29.6% within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Breastfeeding	Proportion of mothers breastfeeding on discharge and differential between NI average and most deprived.	2012	In 2012, 42.3% of mothers discharged were breastfeeding, including those partially breastfeeding and those breastfeeding only. The differential between the NI average and the 20% most deprived areas was 14.6 percentage points.	IAD (NI HSCIMS)	Annual (March)
Educational Attainment	Proportion of primary pupils achieving at the expected levels in Key Stage Two assessment in Communication and Using Mathematics	2012/13	In 2012/13: - 77.1% of pupils achieved at or above the expected level in Communication at KS2 in 2012/13 - 78.5% of pupils achieved at or above the expected level in Using Maths at KS2 in 2012/13 NOTE: 2012/13 data are based on the new Levels of Progression; these results are not directly comparable with Key Stage Assessment outcomes from previous years. The Department of Education also recognises that these new arrangements will need time to embed and has recommended caution in analysing data and benchmarking performance from the first year's implementation.	DE (CCEA)	Annual (December)

1. Give Every Child the Best Start - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Educational Attainment	Proportion of school leavers achieving at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths.	2011/12	In 2011/12, 62.0% of school leavers achieved at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths. The differential between the NI average and the 10% most deprived areas was 21.9 percentage points.	DE (NI School Leavers Survey)	Annual (May)
2. Equipped throughout Life					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Unemployment	Long Term Unemployment Rate: proportion of unemployed that have been unemployed for one year or longer.	2012	The long-term unemployment rate in 2012 was 46.8%.	DFP (Labour Force Survey)	Annual (October)
	Proportion of 16 to 24 year olds who are not in employment, full time education or training (NEETS).	2012	In 2012, 22.1% of 16 to 24 year olds were not in employment, full time education or training.	DFP (Labour Force Survey)	Annual (October)
3. Empowering Healthy Living					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Smoking	Proportion of adults (aged 18 and over) who smoke and proportion in the most deprived areas	2011/12	In 2011/12, of those surveyed in Northern Ireland, 25% were smokers, with a proportion of 39% in the 20% most deprived areas	IAD (Health Survey)	Annual (March)
Alcohol –related Admissions	Standardised rate for alcohol-related admissions in NI and the most disadvantaged areas	2009/10 – 2011/12	For the period 2009/10 to 2011/12, the standard rate for alcohol-related admissions was 618 per 100,000 of the population, with a rate of 1,413 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)

3. Empowering Healthy Living - continued

Indicator	Description	Baseline Period	Baseline	Source	Availability
Adults who drink above sensible drinking guidelines	Proportion of adults who drink above the sensible drinking guidelines suggested, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 19% drink above the sensible drinking guidelines suggested, with a proportion of 24% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Teenage Births	The teenage birth rate for mothers under the age of 17 – NI and most deprived areas	2011	In 2011, the teenage birth rate for mothers under the age of 17 was 2.2 per 1,000 females, with a rate of 4.6 per 1,000 females within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Adult Obesity	Percentage of adults surveyed classified as obese, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 23% were classified as obese, with a proportion of 25% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Childhood Obesity	Percentage of children surveyed classified as obese.	2011/12	In 2011/12, of those children surveyed in Northern Ireland, 10% were classified as obese.	IAD (Health Survey)	Annual (March)
Mental Health and wellbeing	Mean Warwick-Edinburgh Mental Wellbeing Scale by deprivation quintile	2011/12	The 2011/12 Health Survey results indicate a mean score of 50: Quintile 1 (most deprived) – 48 Quintile 2 – 50 Quintile 3 – 51 Quintile 4 – 51 Quintile 5 – 52	IAD (Health Survey)	Annual (March)
Suicide	Crude suicide Rate in NI and the most disadvantaged areas	2009 – 11	For the period 2009-11, the crude suicide rate in Northern Ireland was 16.1 suicides per 100,000 of the population, with a rate of 30.1 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)

3. Empowering Healthy Living - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Blood Pressure/ Hypertension	Number of patients with established hypertension and % of GP registered patients with established hypertension	2013	Figures from the 2013 QOF reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.	IAD (QOF)	Annual (April)
Long term conditions	Number of people with one or more long term condition attending structured patient education/self management programmes	2011/12	An audit of structured patient education/ self management programmes showed that in 2011/12 there were 10,189 attendances at structured patient education/self management programmes in Northern Ireland	IAD (QOF)	Annual (June)
4. Creating the Conditions					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Investment in public health	Amount invested in public health.	2011/12	In 2011/12, the PHA Resource outturn was £77.2 million.	PHA Annual Audited Accounts	Annual (June)
Poverty	Percentage of individuals in low-income groups before housing costs	2009/10 – 2011/12	For the period 2009/10 -2011/12, 21% of the population were in relative poverty (Before Housing Costs).	DSD *(Households Below Average Income Report)*	Annual (February)
Child Poverty	Percentage of children in low-income groups before housing costs.	2009/10 – 2011/12	For the period 2009/10 -2011/12, 23% of children were in relative poverty (Before Housing Costs).	DSD *(Households Below Average Income Report)*	Annual (February)

4. Creating the Conditions - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Economic Inactivity	Economic Inactivity Rate: proportion of the working-age population that is not in the labour force.	2012	In 2012, the economic inactivity rate in Northern Ireland was 27.6%.	DFP *(Labour Force Survey)*	Annual (October)
Housing Standards	Proportion of social housing dwellings classified as non decent homes.	2011	In 2011, the Non Decency Rate of Social Housing Dwellings was 3.7%.	DSD *(House Condition Survey)*	3 Years
Air Quality	Annual mean concentration level of Nitrogen Dioxide at urban background sites and urban roadside sites.	2011	In 2011, the annual mean concentration level of Nitrogen Dioxide was 22.0 µg/m^3 at urban background sites and 35.2 µg/m^3 at urban roadside sites.	DOE (Nitrogen Dioxide Survey)	Annual (February)
	Annual mean concentration level of particulate matter (PM 10).	2011	In 2011, the annual urban background sites mean concentration level of particulate matter was 21.3 µg/m^3.	DOE (Particulate Matter Survey)	Annual (February)
	Annual mean concentration level of Benzo(a) pyrene at monitored sites.	2011	In 2011, the annual mean concentration level of Benzo(a)pyrene was 0.86 ng/m^3 at Lisburn Dunmurry High School, 0.95 ng/m^3 at Derry Brandywell, and 1.12 ng/m^3 at Ballymena Ballykeel.	DOE (Benzo(a) pyrene Survey)	Annual (February)
	Annual number of ozone breaches (days) at monitored sites.	2011	In 2011, there were 4 ozone breach days at Belfast site, 12 at Lough Navar and 9 at Derry.	DOE (Nitrogen Dioxide Survey)	Annual (February)

4. Creating the Conditions - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Water Quality	Annual percentage compliance of Water Utility Sector Waste Water Treatment Works.	2011	In 2011, the overall Water Utility Sector WWTW had a 93% compliance with numeric standards.	DOE (WWTW Survey)	Annual (February)
	Annual percentage mean zonal compliance of drinking water quality	2011	In 2011, the mean zonal compliance with Northern Ireland water regulations drinking water standards was 99.83%.	DOE (Drinking Water Quality Survey)	Annual (February)
5. Empowering Communities					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Social Capital	Proportion of respondents having volunteered in the past year	2012	29% of respondents to the 2013 NI Omnibus Survey stated that they had volunteered in the past year.	DSD (NI Omnibus Survey 2013)	Annual (February)
Road Collisions	Number Killed or Seriously Injured (KSI) casualty numbers per capita	2012	In 2012, there were 843 casualties (killed or seriously injured) as a result of road traffic collisions in Northern Ireland.	PSNI (PSNI Collision Report Form)	Annual (March)

Notes

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.

- Health Survey runs annually though topics may not be included every year.

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ANNEX C - GLOSSARY

ADOG	All Departments Officials Group
AMR	Antimicrobial Resistance
BMI	Body Mass Index
BSP	Belfast Strategic Partnership
CAUSE	Regional charity run by carers for carers
CAWT	Co-operation and Working Together
CCEA	Council for the Curriculum Examinations and Assessment
CENI	Community Evaluation Northern Ireland
CFC	Community Food Centres
CFI	Community Food Initiatives
CFM	Community Food Members
CHD	Coronary Heart Disease
CMP	Condition Management Programme
DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DIY	Do It Yourself
DNE	Dublin North East
DOE	Department of the Environment
DOH	Department of Health
DRD	Department for Regional Development
DSC	Delivering Social Change
DSD	Department for Social Development
END	Environment Noise Directive
EU	European Union
FASA	Forum for Action on Substance Abuse and Suicide Awareness
FE	Further Education
FEC	Further Education College
FUEL	Youth Organisation, Enniskillen
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HEI	Higher Education Institution
HCHF	Healthy Child Healthy Future
HGV	Heavy Goods Vehicle
HIA	Health Impact Assessment
HiAP	Health in All Policies
HMO	Houses in Multiple Occupation
HSC	Health and Social Care

HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
HSE	Health and Safety Executive
ICT	Information and computer technology
IDeA	Improvement and Development Agency
INTERREG	an initiative that aims to stimulate cooperation between regions in the European Union
IPH	Institute of Public Health in Ireland
JCVI	Joint Committee on Vaccination and Immunisation
LCG	Local Commissioning Group
LGBT	Lesbian, Gay, Bisexual and Trans-gender
LGD	Local Government District
MARA	Maximising Access (to services, grants and benefits) in Rural Areas
NEETS	Young People not in education, employment or training
NHS	National Health Service
NI HSCIMS	Northern Ireland Health and Social Care Inequalities Monitoring System
NIHE	Northern Ireland Housing Executive
NINIS	Northern Ireland Neighbourhood Information System
NISRA	Northern Ireland Statistics and Research Agency
NUS-USI	National Union of Students-Union of Students of Ireland
OFMdFM	Office of the First Minister and deputy First Minister
PARC	Physical Activity and Rejuvenation of Connswater
PCC	Patient Client Council
PCSP	Policing and Community Safety Partnerships
PEACE III EU	Programme for Peace and Reconciliation in NI and the border region of Ireland, 2007 - 2013
PFG	Programme for Government
PHA	Public Health Agency
PHE	Public Health England
PHORCaST	Public Health Online Resource for Careers, Skills and Training
PHSCF	Public Health Skills and Careers Framework
PPS	Planning Policy Statement
PSNI	Police Service of Northern Ireland
QOF	Quality and Outcomes Framework
REACT	Family Support Services, Banbridge
ROI	Republic of Ireland
SEELB	South Eastern Education and Library Board
SOA	Super Output Areas
SSA	Social Security Agency
SUDS	Sustainable Drainage System
TYC	Transforming Your Care
UKPHR	United Kingdom Public Health Registry

UNCRC	United Nations Convention on the Rights of the Child
VCS	Voluntary and Community Sector
VCU	Voluntary and Community Unit
WHO	World Health Organisation
WWTW	Waste Water Treatment Works
YMCA	Young Men's Christian Association

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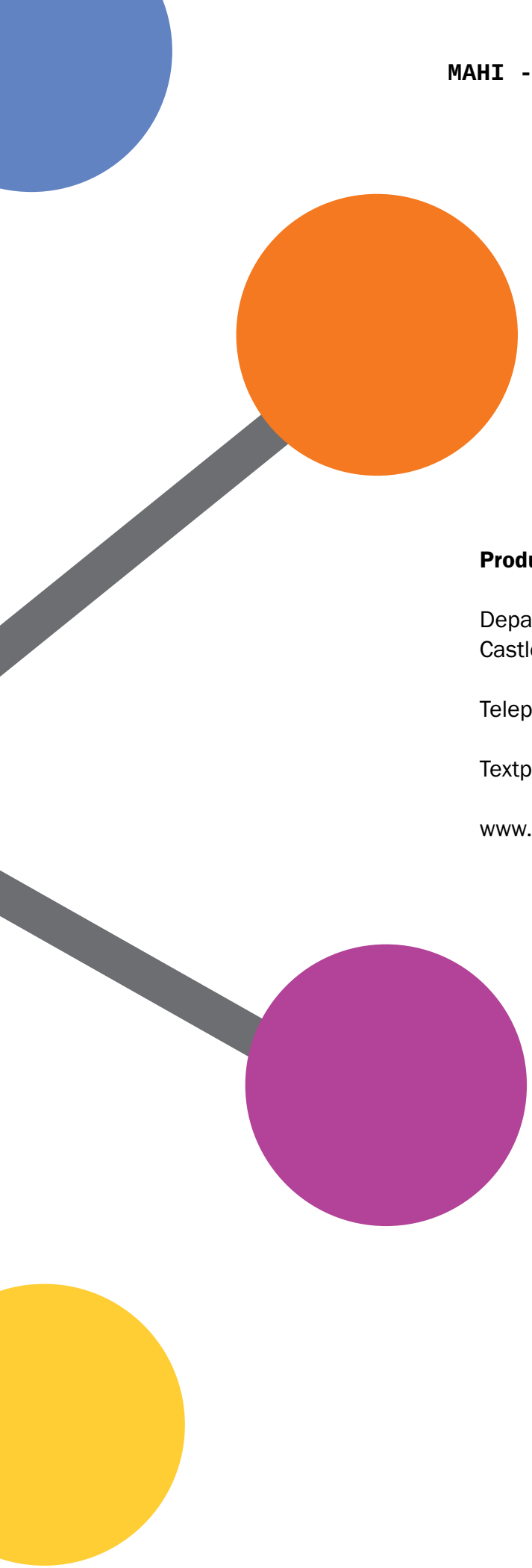

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The Regulation and Quality Improvement Authority

Review of Adult Learning Disability Community Services Phase II

October 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

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RQIA thanks all those who provided data, responded to questions in an open and helpful manner, and assisted in the organisation of the fieldwork.

Contents

Executive Summary

The purpose of this report is to highlight the progress made by the five Health and Social Care (HSC) trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework.

This framework was launched by the Department of Health, Social Services and Public Safety (DHSSPS) now Department of Health (DoH) in 2013.

The responsibility for monitoring the implementation of these standards rests with the Health and Social Care Board (HSC Board) in Northern Ireland.

RQIA completed a baseline review of each trusts' initial benchmarking of the standards in 2013.

The review team is satisfied that significant improvements have been made since 2013 in:

- safeguarding of vulnerable adults regionally
- providing access to a much wider range and choice of day activities for adults with a learning disability
- conduct of assessments by General Practitioners (GP) of the health needs of adults with a learning disability, with a much higher uptake of screening noted in four trusts (A lower uptake was noted in the Belfast Health and Social Care Trust (Belfast Trust).)
- establishment of specialist teams, to help carers to manage challenging behaviours improved in every trust
- communication with each trust having developed a range of stakeholder reference groups

More meaningful improvement however is required in the following areas:

- provision of an easy to read page on trusts' websites for adults with a learning disability
- the development of a single unified community based regional information system, as access to clear, reliable information continues to be problematic (This makes it difficult for the commissioner to monitor and measure outcomes across trusts. The review recommends that this matter should be reviewed by the HSC Board as a priority.)
- the use of family support services and in the numbers of direct payments made across the trusts (The uptake of direct payments also continues to lag behind the rest of the United Kingdom. The review team was concerned that the South Eastern Health and Social Care Trust (South Eastern Trust) and the Western Health and Social Care Trust (Western Trust) are only paying the minimum payment rate of £10 per hour, suggested by the HSC Board in November 2015. This matter should be monitored by the commissioner for improvement.)

Progress regarding the implementation of individual Health Action Plans has been slow, despite this being a target for achievement for trusts since March 2015. No regional agreement has been made as to the form these should take. The review recommends that this work is completed by the Public Health Agency (PHA). The trusts should also put in place a plan to measure and report on the health improvements annually to the PHA.

The evidence of admission of people with a mild learning disability to mainstream mental health services remains very low. Given the variation noted in practice regionally, trusts should be held to account by the HSC Board/PHA for the delay in the implementation of this standard.

The composition of learning disability community teams continues to show disparity with a multiplicity of job descriptions for team members evident across the five trusts. There was evidence in four trusts of consultant psychiatrists working in a more integrated way as part of the community teams.

None of the five community teams, however, demonstrated an evidence base for the model of service configuration they have put in place. The community teams have developed more as a result of historic custom and practice in each trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The review found that there is no agreed uniform model for behavioural support services across the five trusts.

The Northern Health and Social Care Trust (Northern Trust) was the only trust, able to report having a comprehensive database of outcomes in their positive behaviour psychology support service over the past 11 years.

The review team recommends that the commissioner should consider if the model used by the Northern Trust could be used as a model for other trusts to follow, to determine the effectiveness and outcomes of their challenging behaviour support services.

The review team recommends that a formal evaluation should be undertaken, of the effectiveness of these specialist teams, and this should be commissioned by the HSC Board, involving professional organisations such as the Royal College of Psychiatrists (RCP) and the British Psychological Society (BPS).

The proportion of people with a learning disability in employment continues to be very low. Use of unpaid work experience placements still dominates, which runs the risk of trainee exploitation.

Trusts, as large employers, should consider, as part of their organisational development plans, a model of positive discrimination that seeks to provide employment opportunities for adults with a learning disability.

Young people with a learning disability making the transition to adult services continue to present challenges for carers as arrangements are handled differently across the five trusts.

Earlier planning from the age of 14 years is required in line with best practice guidance. Given the known complex physical and behavioural needs of a growing cohort of young people, clearer financial projections need to be made over the next five years to identify the increased resources required to meet their needs.

The review team found that despite funding being made available by the HSC Board to trusts, it is unlikely that the target of all long stay patients being resettled in the community will be achieved by June 2017. This delay is causing frustration for a number of people in hospital who wish to be resettled to a new home in the community. Sometimes when placements break down, an admission to a learning disability hospital has been used. Trusts should review best practice from other areas in preventing such hospital admissions and involve independent sector colleagues in service developments to help avoid the emerging development of new long stay patients.

A low uptake of carers' assessments was evident across Northern Ireland, but trusts were unclear why this might be the case. The review team recommends that the carers coordinator in each trust should meet with the HSC Board to review this matter and any action required to help avoid crisis intervention planning in the future.

Whilst the review team found staff were mostly familiar with the content of the service framework, the approach used by trusts in applying the standards varied across trusts. Trusts have also not all interpreted key performance indicators consistently. No evidence of comparative benchmarking was evident across trusts regarding the models of delivery of care, or with other models of service provision in the United Kingdom.

The report makes 25 recommendations to support the continual improvement of standards for adults with a learning disability in Northern Ireland.

In view of the closure announcement of the HSC Board, the DoH needs to now agree a future process for monitoring the implementation of the standards contained in the service framework for adults with a learning disability.

Section 1: Introduction

1.1 Introduction and Background

Learning disability includes the presence of a significantly reduced ability to understand new or complex information, or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development. People with a learning disability may also have difficulties with social and/or communication skills and with carrying out activities of daily living independently. They may also have associated physical and sensory disabilities.

It is estimated that there is a population of 26,500 people in Northern Ireland with a learning disability of whom half are aged between zero to19 years[1]. It is projected that the number of people with a learning disability will increase by one percent each year over the next 15 years and that adults with complex needs will be a particularly large growth area.

Societal attitudes to learning disability have changed significantly in recent years. It is now widely recognised that people with a learning disability have the right to live independently within the community and to be provided with the opportunity to make meaningful choices in respect of housing, care and support needs.

In 2007, a United Kingdom Government commissioned inquiry chaired by Sir Jonathan Michael – Healthcare For All[2] - found that

- People with learning disabilities find it much harder than other people to access assessment and treatment for general health problems that have nothing directly to do with their disability.
- There is insufficient attention given to making reasonable adjustments to support the delivery of equal treatment, as required by the Disability Discrimination Act 1995[3].
- Parents and carers of adults and children with a learning disability often find their opinions and assessments ignored by healthcare professionals, even though they have the best information about and understanding of, the people they support.
- The health needs, communication problems and cognitive impairment characteristics of learning disability in particular are poorly understood by healthcare staff.

The Confidential Inquiry into the Premature Deaths of People with Learning Disabilities[4] (CIPOLD) in 2013 reviewed the death of 247 people with learning disabilities over the period 2010-2012.

[1] Bamford Action Plan, DHSSPS, 2009.
[2] Healthcare For All, Sir Jonathan Michael, 2007.
[3] Disability Discrimination Act 1995.
[4] Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) 2013.

The findings demonstrated that people with a learning disability were a very vulnerable group in the context of health needs:

- 17 per cent were underweight compared to two per cent the general population
- 66 per cent lacked independent mobility
- 50 per cent had problems with vision
- 25 per cent had hearing problems
- 97 per cent had one or more long term or treatable health conditions

People with learning disabilities should also be supported to live independently in the community wherever possible. Delivery of the changes necessary to improve services requires effective partnership working with a variety of agencies, to design and provide a range of options to meet assessed needs, such as employment opportunities, day centres, day opportunities and accommodation. People with a learning disability should also be provided with clear information about self-directed support in order to give them control and choice over the type of care and support they receive.

1.2 Context for the Review

A key priority for health and social care services and also for the wider community is to tackle discrimination and inequality and to empower and support people with a learning disability and their families to be actively engaged in their care.

The onus on public authorities to promote equality of opportunity is enshrined in the Northern Ireland Act[5] which states that "a public authority shall, in carrying out its functions in Northern Ireland, have due regard to promote equality of opportunity between people with a disability and those without."

Other pieces of relevant legislation include:

- the Human Rights Act[6]
- the United Nations(UN) Convention on the Rights of Persons with Disabilities[7]

In October 2002, following similar exercises in Scotland and England, DHSSPS[8] initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The review was overseen by a steering committee comprising representatives from professional and other interested groups in the mental health and learning disability fields, under the chairmanship of Professor David Bamford of the University of Ulster.

[5] Northern Ireland Act 1998
[6] The Human Rights Act 1998
[7] Convention on the Rights of Persons with a Disability 2006
[8] The Department of Health (DoH) encompasses the functions of the former Department of Health, Social Services and Public Safety (DHSSPS) as of 9th May 2016.

The Equal Lives[9] report made a number of recommendations, designed to secure improvements in the mental and physical health of people with a learning disability. The aim was to achieve this through developing access to high quality health services that are locally based and responsive to their particular needs.

Broadly the review called for:

- continued emphasis on promotion of positive mental health
- reform of mental health legislation
- a continued shift from hospital to community based services
- development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system
- an adequately trained workforce to deliver these services

The review also promoted involvement of service users to enable them to access mainstream services and be fully included in the life of the community.

The review envisaged a 10-15 year timescale for full implementation of its recommendations.

The Northern Ireland Executive accepted the broad thrust of the review's recommendations. The Executive's response to the findings of the Bamford Review, Delivering the Bamford Vision, led to the publication, in October 2009 of the Bamford Action Plan 2009-2011. The 2009-2011 plan set out the Executive's commitment across Departments to improving the mental health and wellbeing of the population of Northern Ireland and to improving services for those with a mental health need or a learning disability.

A follow on action plan was developed for 2012-2015 based on the lessons learned from the 2009-2011 evaluation, consultative workshops, new research and evidence based practice and the views of service users and their carers

A further report in December 2011, Transforming Your Care[10] (TYC), set out a review of health and social care in Northern Ireland and provided the blueprint for future health service provision in Northern Ireland. This has many parallels with the Bamford Vision in respect of mental health and learning disability service provision and enhancement including:

- early intervention and health promotion
- a focus shift to community care
- promotion of recovery practices
- personalisation of care
- resettlement
- service user and carer involvement
- advocacy
- provision of clearer information
- access to respite provision

[9] Equal Lives DHSSPS, 2005.
[10] Transforming Your Care 2011

In March 2016, the Minister for Health announced his intention to establish a commission[11] to reform adult care and support. This new three-person commission will be tasked with assessing the many challenges facing the care and support system and producing a set of recommendations to reform the funding structures, in order to ensure its future sustainability.

Service Frameworks

The DHSSPS Service Framework aims to set out clear standards of health and social care that service users and their carers can expect.

They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process.

The Service Framework for Learning Disability[12] was initially launched in 2013 and revised in January 2015. It sets out 34 standards in relation to the following key thematic areas:

- safeguarding and communication and involvement in the planning and delivery of services
- children and young people
- entering adulthood
- inclusion in community life
- meeting general physical and mental health needs
- meeting complex physical and mental health needs
- at home in the community
- ageing well
- palliative and end of life care

The standards provide guidance to the sector on how to:

- improve the health and wellbeing of people with a learning disability, their carers and families
- promote social inclusion
- reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society

Baseline Assessment and Review of Community Services for Adults with a Learning Disability 2013

In August 2013, RQIA published a report of a Baseline Assessment and Review of Community Services for Adults with a Learning Disability. This highlighted the role and composition of community learning disability teams and the level of investment in services for adults with a learning disability. The report set out recommendations for trusts and for commissioners in relation to the provision of learning disability services for adults.

[11] Health Minister to Establish Commission to Reform Adult Care and Support, DHSSPS 9 March 2016
[12] Service Framework for Learning Disability DHSSPS 2015

In November 2015, the Patient and Client Council (PCC) published its report on the findings from their engagement with 11 focus groups across Northern Ireland in relation to learning disability.

The PCC met with 48 service users and 24 carers who highlighted concerns about the following issues:

Service users	Carers
Day opportunities	Respite (short break) services
Supported housing	Transition from child to adult services
Respite (short break) services	HSC staff
Further education	Joined up working
Training and work	Information
HSC staff in learning disability support services	

The findings of this report have been considered by RQIA as part of this review.

The review also noted that the Northern Ireland Assembly Committee for Employment and Learning published in 2016 a report on day services that made 44 strategic recommendations.[13]

Focus of this Review

This review assesses the quality of learning disability services against 30 of the adult standards contained in the Learning Disability Service Framework. It also reports on the progress made by the trusts and the HSC Board in the implementation of the recommendations contained in the 2013 RQIA review report.

The report is structured to reflect the four RQIA domains of:

- safe care
- effective care
- compassionate care
- well led services

1.3 Terms of Reference

The terms of reference for this review are:

1. review the progress made against Phase 1 of RQIA's 2013 report, 'A Baseline Assessment and Review of Community Services for Adults with a Learning Disability'

[13] Report of the Inquiry into post Special Educational Need (SEN) Provision in education, employment and training for those with Learning Disabilities in Northern Ireland

2. review the quality and effectiveness of services for adults with a learning disability against the DHSSPS Service Framework for Learning Disability

3. gather the views of service users and carers

4. report on findings and make recommendations in a single report for publication

Exclusions

This review excludes services for children, and services provided for adults with learning disabilities that are currently regulated by RQIA, as set out below:

Adult placement agencies	Day care settings	Domiciliary care agencies
Independent clinics	Independent hospitals	Nursing agencies
Nursing homes	Residential care homes	Residential family centres

Autism services are not included in this particular review as RQIA is undertaking a specific review of autism in the future. However adults with a learning disability whose service provision is provided by adult community learning disability services were included in this review.

1.4 Outline Methodology

1. A review was undertaken of trusts' action plans and progress in relation to Phase 1 of the RQIA review.

2. A questionnaire was sent to all trusts asking them to provide information on progress against standards applicable to adults as set out in the service framework for learning disability.

3. Validation meetings were held with staff responsible for providing and managing learning disability services

4. Stakeholder engagement was held with adults with a learning disability and with carer groups, from all five trusts.

5. The review met with a range of voluntary organisations involved in providing adult learning disability services.

Section 2: Findings from the Review

2.1 Introduction to the Findings

In its 2013 report, RQIA made a number of recommendations for improvement. One of these recommendations was that trusts should provide better information regarding the number of people with a learning disability receiving care and their investment in the learning disability programme of care. This includes community service costs, community teams, day services, family support services, day centres and people in receipt of domiciliary care services. This review received updated information from the HSC Board and trusts regarding this area.

Total Number of People with a Learning Disability

The trusts remain unable to provide the HSC Board and the review team with an accurate figure of the total number of people with a learning disability in their area. This information is not collected in a single regional common information system with agreed data sets. All trusts have different systems to record information about people who have been identified with a learning disability. However the population of people with a learning disability is known to be larger than these figures. In addition to those people receiving social care, there are people in hospitals, people receiving only health services, people known to the trust who are no longer receiving any service (so-called dormant cases), and possibly people who would qualify for learning disability services but have never requested them. A figure of 8,326 was provided but it is likely to be much lower than the true prevalence of learning disability in the adult population in Northern Ireland. In the Phase 1 review RQIA reported that in 2010-2011 the number of adults in receipt of services from community learning disability teams was 7965. There has been an increase of 361 since the last RQIA review.

Number of People with Learning Disability in receipt of Health and Social Services in each HSC trust in 2014-2015

The number of people with learning disability in receipt of social care services in each trust in 2014-2015 is shown in Table 1 (note: social care includes social work, nursing homes residential homes, supported and other accommodation, day care facilities, domiciliary care grants, goods and services, meals delivered to clients' homes). In order to facilitate comparisons across trusts, the number of adults with learning disability is expressed as a proportion of the adult population in each trust area. Variation is evident across the trusts with proportionately more people with a learning disability receiving social care in the Southern Health and Social Care Trust (Southern Trust) and fewer in the Western Trust.

Table 1: The number of adults with learning disability receiving social care services 2014-2015

	Belfast	Northern	South Eastern	Southern	Western	Total
Number of adults with a learning disability receiving social care 2014-2015*	1816	1926	1516	1981	1087	8326
Adult population of trust (NISRA mid-year estimates)	265,372	348,254	263,059	265,794	216,431	1,358,910
2014 rate per 1,000 adult population	**6.84**	**5.53**	**5.76**	**7.45**	**5.02**	**6.13**

*Data provided by HSC trusts to HSC Board as of 31 March 2015

HSC Investment in Learning Disability Programme of Care 2015-2016

In 2015-2016, the HSC Board investment in the learning disability programme of care was £265.2 million, which was 7.79 per cent of the total investment in health and social care in that year (£3.406 million). This proportion has remained around this level since 2005-2006 (range 7.21per cent to 7.79 per cent). This investment covers services to children as well as adults. A breakdown of the apportionment is not available.

The amount invested by each Local Commissioning Group (LCG) in the learning disability programme of care is shown in Table 2. This includes specialist hospital costs as well as community service costs. Please note the following cautions regarding the tables.

Cautions

As all trusts do not keep a single common information system of people with learning disabilities, it is difficult to accurately calculate the number of people who receive services in any one year.

Variations in record keeping across trusts may also account for some of the differences noted above, which results from the lack of a common information system for community services.

Some of the information presented to the review was for 2013-2014 and may in some instances not reflect recent changes. However there are unlikely to be substantial variations from the patterns reported here.

Table 2: Investment by the HSC Board in the Learning Disability Programme of Care (PoC) compared to other non-acute programmes of care (based on Strategic Resource Framework Investment 2015-2016)

	Local Commissioning Groups (LCG)					
	Belfast	**Northern**	**South Eastern**	**Southern**	**Western**	**Grand Total**
Learning Disability PoC £k	£57,106	£60,708	£53,615	£55,418	£38,357	**£265,204**
All non-acute programmes of care £k (excluding regional investment)	£415,074	£448,916	£342,503	£358,371	£322,455	**£1,887,318**
Percentage invested on Learning Disability PoC	13.76%	13.52%	15.65%	15.46%	11.90%	**14.05%**
Population of Trust - Weighted for Learning Disability need	383,107	430,093	285,799	384,594	345,543	**1,829,136**
Average cost per capita of LCG	£149	£141	£188	£144	£111	**£145**

Table 2 shows the 2015-16 SRF investment split by Local Commissioning Group areas (LCGs). The learning disability PoC figures cover all people with a learning disability including children, adolescents and adults. The HSC Board uses a capitation formula to help inform the allocation of new funds across localities. Trusts may provide services to residents across a number of localities and residents from localities may access their local trust or another trust depending on the services used.

It should be noted that caution should be exercised when comparing investments at programmes of care level and between individual LCGs. For example, it is recognised that capitation formulae are less robust at smaller population levels and at individual programme of care levels and therefore variations between individual Programmes of Care at LCG level would not be unexpected. Within programmes of care, services may also be delivered differently across localities. The capitation formula for the learning disability programme of care is being reviewed.

Variation across trusts in the total investment in non-acute programmes of care is evident. The South Eastern LCG has a higher proportion of this investment, 15.65 per cent, allocated to the learning disability programme of care with the Western LCG having the lowest percentage at 11.90 per cent. When the differing size of the population in the trusts is taken into account and weighted for learning disability need, the South Eastern LCG has the highest per capita investment with the Western LCG having the lowest. These figures are however skewed by specialist hospital costs as outlined further in Table 3 which demonstrates that a differential continues to exist across trusts.

Investment in learning disability services is further subdivided into monies invested in specialist hospitals and in extra contractual referrals (generally used for person(s) with complex needs to be treated outside of Northern Ireland) and in community services. In 2015-2016 the planned investment in extra contractual referrals amounted to £1.110 million.

Table 3: The investment (£k) by HSC Board in Learning Disability Programme of Care in community and hospital services (Based on SRF Investment 2015-2016)

	Belfast	Northern	South Eastern	Southern	Western	Grand Total
Community/ Personal Social Services £k	£49,875	£52,665	£46,522	£50,676	£34,441	£234,180
Hospital £k	£7,231	£8,042	£7,093	£4,742	£3,916	£31,024
Total £k	**£57,106**	**£60,708**	**£53,615**	**£55,418**	**£38,357**	**£265,204**

Around 11.7 per cent of the total investment provided by the HSC Board, to trusts, was invested in specialist hospitals, notably Muckamore Abbey Hospital which serves three trusts with total costs of £22.3 million. The HSC Board reported commissioning 147 beds in 2015-2016, across the region which gives a cost per bed of £203,497 for hospital services (excluding ECR investment). However the number of beds should reduce as the resettlement of long stay patients continues, although it is not yet complete.

Community and Personal Social services costs accounted for around 88 per cent of the total investment. It is not possible to calculate an average cost per person in receipt of community services as the numbers of people in receipt of such services is not available.

The trusts in their financial returns provide a further breakdown of the monies spent on community services (i.e. AHPs expenditure, nursing costs, day services, residential accommodation, community medical/dental expenditure, grants, goods and services step up step down facilities, incontinence products) and on personal social services.

Usage of Social Care Services

The number of people availing of various social care services across the trusts is shown in Appendix 1 Table A1. Although information on costs per place was not available to the review, this data could perhaps account for the variation in trust's investment in learning disability social care services.

Supported Accommodation

There is a marked differential in the proportion of people in residential and nursing homes, with the highest in the Western Trust (23 per cent) and lowest in the Southern Trust (12 per cent). The variation was less marked for people in supported housing. However, taken together, these figures would suggest that most adults with a learning disability, using social care services are living with family carers or independently, with the Southern Trust having the highest proportion (76 per cent) and the lowest noted in the Western Trust (65 per cent).

Day Centres and Day Opportunities

Overall, around two-thirds of people with a learning disability, use day services, although the proportion that do so, is markedly higher in the Western Trust compared to the Southern Trust. The provision of day opportunities places compared to day centre places is most equal in Belfast and Southern trusts. Day opportunities in further education courses, horticulture and gardening enterprise schemes, or in catering establishments are procured by the trust to provide experiences leading to upskilling of people with a learning disability, to enable them to apply for work. A greater use of day centre places, solely run by the trusts was evident in the Western and South Eastern trusts as shown in Appendix 1 Table A2.

Family Support Services

Adults with a learning disability who live at home with carers may require additional support to help them live a full life in their community. Trusts provide a range of family support services including short break services, domiciliary care and direct payments.

Appendix 1 Table A3 shows the number and percentage of people in receipt of family support services in 2013-2014. Some disparity was evident in the use of family support services across the trusts. More families availed of short breaks in the Northern Trust with least doing so in the Western Trust. Domiciliary Care was provided to higher percentages of people in the South Eastern and Southern trusts but fewer in the Belfast and Northern trusts. Direct payments provided to either the person or family and carers were noted to be highest in the Belfast Trust, with a lower but similar proportion across the other trusts.

The variation in both the financial investment and services provided across the five trusts suggests that inequities persist across Northern Ireland in provision of these services for people with learning disabilities.

Recommendation 1	Priority 1
The commissioner should ensure effective use of resources through accountability meetings and seek evidence based improvements in learning disability services across trusts. The investment in learning disability hospital provision should also be kept under review given the current resettlement target set for achievement in 2016.	

2.2 Standards Reviewed Relating to SAFE Care

The review aligned specific standards for adults contained in the service framework to RQIA's four key stakeholder outcomes selected for use in 2016 – 2017. These are described in Table 4.

Table 4: Four RQIA Stakeholder Outcomes.

Is care **safe**?	Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
Is care **effective**?	The right care, at the right time in the right place with the best outcome.
Is care **compassionate**?	Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.
Is the service **well led?**	Effective leadership, management and governance which creates a culture focused on the needs and experiences of service users in order to deliver safe, effective and compassionate care.

Questionnaires were sent to the five trusts and the line of questioning during discussions with staff focused on these four areas.

Findings

Safeguarding

All trusts had a safeguarding policy in place with a named safeguarding lead, who oversees the learning disability programme. A designated non-executive director with a particular responsibility for safeguarding was in place, with the exception of the Northern Trust, where the non-executive directors assume responsibility collectively. A new regional policy, Adult Safeguarding: Prevention and Protection in Partnership[14], was published in July 2015. Trusts await further operational guidance from the HSC Board before they can finalise their procedures. Currently all trusts are following the extant HSC policy and procedures.

[14] https://www.dhsspsni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership

All trusts had their own whistle blowing policy, the implementation of which is subject to a separate review by RQIA.

Equality of Access to Health Services

The HSC Board provided the following information from their 2015 file audit:

- 100 per cent of GPs have a system for identifying people with a learning disability.
- Over 70 per cent of the files had evidence that people with a learning disability and their family and carers have been involved in making choices or decisions about their individual health and social care needs.

A directed enhanced service (DES) for general practitioners to undertake health checks had a good uptake by GP practices across four trusts, except the Belfast HSC Trust.
A higher uptake of health checks by people with a learning disability was noted in the Northern Trust. The review was informed that some practices were more difficult to engage with. Where there is proactive engagement by a health facilitator, with local GP practices, better outcomes are evident.

A separate review was undertaken by the HSC Board in 2013 of The Enhanced Service Specialising in Health Care for Adults with a Learning Disability Provided by General Medical Services (GMS) Practices and of the effectiveness of Health Facilitators provided by HSC trusts.[15] The report shows there is significant variation across the trusts in relation to the uptake of health checks with the Belfast Trust GPs providing fewer health checks than other trusts.

This may be due to their lower levels of staff in this service. The review noted that the HSC Board has provided the Belfast Trust with temporary additional funding for one year to drive improvement in this area.

Employment of Health Facilitators

Health Facilitators are funded across the five trusts using GMS monies. The trusts were able to produce a wide range of examples ranging from easy read health screening materials to evidence of service users consenting to the health care facilitators undertaking their health checks.

There were examples of all HSC organisations making information accessible to people with a learning disability. Despite this, progress around the implementation of individual Health Action Plans (HAP) has been slow, with no agreement across trusts as to the form these might take. HAPs are an easy read plan for an adult with a learning disability to keep, usually formatted into a table that lists goals for better health and engagement with healthcare staff. In those instances where a plan was in place, there was also no demonstrable evidence of the trust demonstrating improvements in health outcomes arising from the HAPs.

[15] Professor Roy McConkey. University of Ulster and HSC Board. October, 2013

The Regional Health Facilitators Forum, a sub group of the Regional Learning Disability Health Care Improvement Forum chaired by PHA, has been developing guidance on the regional implementation of health and wellbeing plans (formally known as health action plans). These are currently out with trusts for comment. The guidance will be agreed by the Bamford Monitoring Group and disseminated to trusts.

The development and use of health action plans for adults with a learning disability needs to be reassessed, with agreement as to their final format and a method of recording health outcomes arising from their use.

A process also needs to be agreed regionally by the PHA for implementing the recommendations arising from the health screening as this differs from trust to trust.

Recommendation 2	**Priority 1**
The Regional Learning Disability Health Care and Improvement Steering Group, set up by the Public Health Agency should ensure each trust has a plan that can demonstrate measureable evidence of health improvements for adults with a learning disability.	

The trusts all advised of a range of staff who provide support and advice, including community learning disability nurses, speech and language therapists, epilepsy nurses, district nurses and a wide range of AHPs. A number of examples or specific initiatives undertaken with small groups or on specific topics were provided.

The review was advised of a number of regional screening programmes that trusts promote and utilise for adults with a learning disability.

In meetings with service users across all five trusts, adults with learning disabilities advised the review that they had received information on smoking cessation, healthy eating, levels of physical activity and alcohol consumption from health facilitators and general practitioners. The review was given limited examples of improvements in fitness of adults with a learning disability across the region, or in e.g. reduction of obesity to promote better health.

Health Related Outcome Measures

In 2014, a Regional Learning Disability Health Care and Improvement Steering Group was established by the PHA, to agree a regional approach to health screening and improving health and social care outcomes.

Trust databases in relation to adults with a learning disability, involved in regional screening programmes, do not contain health related outcome measures. There is no plan to collate the health outcome measurement information gathered about individuals, or to record details of action required in the future, to ensure improved health outcomes, although the Belfast Trust indicated their intention to review this in the future.

Development of a Clinical Quality Dashboard

A clinical quality dashboard is a tool, developed to provide clinicians, with relevant and timely information to inform daily decisions that improve quality of patient care.

Although the trusts provided examples of their dashboards, these were used to demonstrate e.g. figures for delayed discharges, admissions to specialist hospitals and staff absences. There was an absence of data which demonstrated for example a reduction in smoking, obesity, diabetes or a reduction in challenging behaviours. Dashboards had not been designed to capture information on health outcomes or service users' health improvements. This makes it difficult to gauge the effectiveness of clinical interventions, for adults with a learning disability.

Trusts reported using other reporting tools such as a RAG (red, amber, green) rating to report on their general activity in learning disability services, to senior management and to the HSC Board.

Other reports included local facility plans, statutory function reports, risk registers, incident databases and monitoring reports to ensure their managers have access to quality checks in a timely manner.

Recommendation 3	**Priority 1**
The PHA in conjunction with trusts should develop a regional dataset of information in relation to outcome measurement in 2016-2017 across two key areas to drive improvement in the health status of people with a learning disability. Targets should be considered in relation to the reporting of a reduction in smoking and obesity in the 2017-2018 year.	

Development of Interfaces between Services

All trusts described progress in improving their interfaces with mental health and older peoples' services; this work, however, remains at an early stage. The Northern Trust Rapid Assessment Intervention and Discharge (RAID) Team indicated they had developed a learning disability pathway and co-working arrangements with learning disability teams. Individuals with a learning disability within an acute hospital or presenting at an emergency department are assessed and supported by the RAID Team who help provide them with direct support at times of crisis. Some examples were provided by the Northern Trust of access to mental health services for people with mild learning disability. The other trusts described difficulties in getting an adult with a mild learning disability into mental health services. The pathway used by the Northern Trust should be reviewed by other trusts to see if it can be applied elsewhere.

There is also little interface with older peoples' services except in respect of people with dementia.

Some progress however appears to have been made with forensic and palliative care teams – possibly because of the small number of people involved in these more specialised areas.

The Belfast Trust stated that service users have access to psychological and psychiatric services provided by both specialist learning disability and primary mental health teams. The Northern Trust confirmed its PROMOTE team provides specialist learning disability interventions for people with complex mental health needs. PROMOTE is a treatment service for adults with a learning disability with additional forensic and or mental health needs.

The RQIA review found that there had been slow progress in relation to adults with a mild learning disability accessing mainstream mental health services. Further collaboration across teams is required to ensure appropriate access to mainstream mental healthcare services for patients with a mild learning disability.

Recommendation 4	**Priority 2**
The HSC Board should set an access target for inclusion of people with a mild learning in mental health services in order to achieve the standard set up in the service framework.	

2.3 Standards Reviewed Relating to EFFECTIVE Care

Findings

Provision of a Community Service

The review team looked at the composition of learning disability teams and models of service provision, developed since the last review.

Learning disability services continue to sit within different directorates across the five trusts. Broadly, teams include the same range of professionals identified in the initial RQIA review e.g. social work, learning disability nurses, specialist occupational therapists and speech and language therapists. The multidisciplinary team composition was being reviewed by each trust and deemed by trusts to be appropriate to the discharge of their functions.

A continued disparity exists since the last RQIA review, in the composition and in the description of roles across community teams that make comparisons of effectiveness difficult. A positive development since the last review is that the psychiatrists are now working directly in learning disability teams.

The Belfast Trust informed the review team that it had fully reviewed its community treatment and support services, agreed a new model of service provision and is in the final stages of implementing their new structures and processes. The trust visited services in Scotland in 2013 and out of hours

behaviour support services in England. The new model of service provision is based on prevention and early intervention. It was described as being multi-disciplinary with co-ordinated working, with the aim of creating a person centred, flexible and responsive service.

The Northern Trust has moved from a locality management model to a multidisciplinary model of management that delivers services according to their functions. A service improvement project commenced in September 2015, to build on progress already made, with a focus now on consolidating their new team structures for service delivery across all their learning disability services.

In the action plan provided to the review the South Eastern Trust did not clearly provide information on the overall outline of their adult community learning disability team, but rather described how services are delivered through a tiered process and the types of professionals involved in the adult learning disability teams.

The Southern Trust reported that a review of their team structures has been recently completed. A new model of service delivery has been agreed that includes clearer multi-disciplinary roles and responsibilities for staff.

The Western Trust has restructured its teams and now operates a social worker led service, supported by a multi-disciplinary team model as required. At the time of the review, recruitment for social workers, occupational therapists, family support workers and team leaders was nearly complete. The trust acknowledges that further work is required to secure the investment needed to enhance its new model in working with adults with a learning disability.

The review team notes that the leadership of the teams in each of the trusts and their lines of accountability varies as do referral procedures and the criteria for access to learning disability services.

Despite the changes made by the trusts in the delivery of learning disability services, the review found limited evidence of trusts actively seeking information about new service models beyond Northern Ireland.

There was very little evidence of trusts learning from other trusts' experiences or of those of the voluntary sector in the revision of their structures.

Recommendation 5	**Priority 2**
The HSC Board should review the current models of service provision in place in the five trusts in terms of evidence of best practice and ensure that this is disseminated regionally.	

Delivery of an Extended Hours Service by Community Learning Disability Teams

The review found little evidence of Community Learning Disability Teams (CLDT) operating outside of 09.00 to 17.00. Four trusts had plans to extend their intensive support services, particularly for people who are at risk of breakdown in the community from 17.00 to 20.00 or 22.00 on weekday evenings. While a welcome development, this leaves weekends uncovered except by out of hours social services.

At the time of the review, the Western Trust had no plans to extend the CLDT hours of service.

The South Eastern Trust has recently commenced a pilot of an out of hours intensive support service which will operate Monday to Friday 17:00 to 21:00.

This service was set up to support service providers outside of normal working hours and to help manage individuals with challenging behaviours, to prevent hospital admission and placement breakdown. On call practitioners advise and support service providers and if appropriate will refer patients to the trust community team for follow up the next working day.

Establishment of Challenging Behaviours/Specialist Teams

Positive changes were noted in the development of challenging behaviour teams in each trust since the review in 2013. However, the five trusts are developing their own unique teams and models to deal with challenging behaviours. The trusts have been provided with financial resources by the HSC Board, to enable challenging behaviour teams to be strengthened.

All trusts had increased the support services that staff in the community teams can offer. There was evidence in four trusts of consultant psychiatrists working in a more integrated way as part of the community teams. The review lacked clarity in terms of their role in community teams which should be reviewed by each trust. It was unclear to the review how they were involved in leading service changes to become more effective, especially for clients with challenging behaviours and or mental health problems who are on psychotropic medications.

Recommendation 6	**Priority 2**
Each trust should review the specific role of the consultant psychiatrist in their community team in terms of how best they can assist in the delivery of improvements in clinical outcomes for people with a learning disability.	

The Belfast Trust is providing positive behaviour interventions support to address challenging behaviours using a stepped model of intervention. Part of the trust's community infrastructure development plan has resulted in an increased capacity in services for prevention and earlier intervention. The introduction of behaviour practitioners to community teams and the integration

and enhancement of psychology services within their community teams is designed to support this approach.

The trust advised that when recruitment is complete, all the trust's day and residential/supported living services will have a behaviour support link person who will work with them to develop effective positive behaviour support models. Individual behaviour support for service users can be provided by a range of and combination of practitioners in the community teams, depending on the nature of the presenting problem. An intensive support service is also available.

The Northern Trust's clinical psychology learning disability services are available to adults with a learning disability, offering interventions for a range of psychological difficulties. These include offering assessment, support and advice in relation to behaviours that challenge.

If service users have behaviours that severely challenge, more intensive support is provided by the Positive Behaviour Support Service (PBSS), which operates at Tier 3 of the stepped care model. This service consists of a consultant clinical psychologist, supported by behavioural specialists, behavioural associates and a speech and language therapist. All those referred to the PBSS have been identified as either displaying high risk behaviour or having their community placement deemed at risk. The PBSS completes comprehensive assessments, develops, implements and supports behaviour support plans. They may offer training to staff teams, carers and families in order to increase their understanding and skills and how to follow specific behaviour support plans.

The South Eastern Trust has developed a behaviour support service (BSS) to assess those with challenging behaviour, to identify their needs and determine how they can be supported by the service.

The service consists of a skill mix of behaviour nurse therapists, psychology assistants and clinical psychologists. A number of band 6 behaviour practitioner posts, and band 3 behaviour assistant posts, were being recruited at the time of the review.

Referrals can be made to this team by any professional working with an individual with challenging behaviours.

The BSS works in partnership with families, community learning disability teams, statutory, voluntary and private service providers, schools and others to provide advice, support and behaviour support plans to meet the needs of the individual. Service users are reviewed at least annually, but more frequently as necessary.

The trust expects that this team will provide a more intense and flexible service to individuals with challenging behaviours, their families and service providers as required. The service is led by a senior manager and a consultant clinical psychologist. A speech and language therapist is also employed to provide advice and support, in relation to communication and swallowing assessments.

The Southern Trust community learning disability BSS comprises a team with a wide range of professional backgrounds including clinical psychology, nursing and social work. This team works collaboratively with a range of community learning disability staff, including AHPs, clinical psychologists, psychiatrists, day care, supported living and respite staff, as well as parents or carers and independent sector providers.

Comprehensive behavioural assessments are carried out, depending on the needs of service users, from which appropriate interventions are developed. To enhance the service, new protocols and proformas were developed to ensure collection of relevant information. The BSS team has developed a number of visual strategies and evidence based resources for use in direct work with service users and their families, in order to enhance the effectiveness and the likelihood of positive behavioural outcomes.

The Southern Trust advised that to manage increasing referral rates, it is developing a Tier 2 and Tier 3 level of intervention as required and provides a variety of training programmes for staff. The aim of this approach is to build capacity both in the BSS team and within community teams and the wider multidisciplinary service including service users, parents and carers. To further build capacity within the team, a number of BSS staff are currently pursuing further training in Positive Behaviour Management Support.

The Western Trust reported that service users with challenging behaviours are supported by both staff and carers to ensure that they are managed safely and that agreed strategies are in place to provide support. Intensive support workers have recently been appointed in the Western Trust. Their role is to provide rapid and intensive support in cases where there are significant challenges in managing behaviour, with a risk of breakdown of the family or placement.

They also have a behavioural support service which plays a key role, ensuring that people are properly assessed and that behaviour plans are in place. This service provides direct support and advice to staff on these issues. Advice and support is also provided through the sensory occupational therapy (OT) service on a case by case basis.

The Northern Trust is the only trust which has a comprehensive database of outcomes in the positive behaviour support service for over 11 years and their psychology services have outcome data on all their service users. The review team considers that this model should be reviewed by other trusts for effectiveness.

The review found that there is no agreed uniform model for behavioural support services across the five trusts. Some of the teams established with new funding are more expensive than others. An evaluation of the effectiveness of these teams would be valuable. The review was not told of any plans to do this by the five trusts. The Belfast Trust is collecting a range of data in preparation for a review of their Intensive Support Services, including outcome measurements for individual service users.

Given the extra financial investment provided to the trusts, it would be prudent for the commissioner to commission research on the outcomes and effectiveness of these teams, as well as review the costs of each of these teams. The commissioner should also gain insurance that policies are aligned with the principles of positive behaviour management.

Recommendation 7	**Priority 2**
An assessment of the activity and effectiveness of challenging behaviour teams should be undertaken by the commissioner. The outcome model used by the Northern Trust should also be reviewed to see if it could be applied regionally.	

Carers and Public Actively Involved in the Planning and Delivery

The five trusts described in their written submission to the review, how they involve service users and carers in meetings, forums, public consultations and also in some reviews of services, for example day opportunities or short breaks.

Meetings called 'Carers Voice' occur two to three times a year in the Western Trust. These meetings have included presentations on self-directed support, reporting on outcomes of the day care review or short breaks services.

Every trust had various parents and carers groups some of whom met with the review team. The review did not routinely find robust evidence that parent and carer groups were actively involved in the planning, delivery and monitoring of health and social care at all levels. Rather, meetings seemed to focus more on informing carers about trust plans to modify service provision. This does not meet the Service Framework for Learning Disability, Standard 3 (all patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels). This has resulted in some carers groups stating to the review that they considered their views are not valued.

Developing a Personalised Pathway of Care for Learning Disability Services

All five trusts advised that they completed service users' assessments and reviews in an individualised and person centred way.

Recommendation 8	**Priority 1**
Each trust, as part of their Personal and Public Involvement (PPI) Strategy, should proactively involve people with a learning disability and their carers in the planning of change to service delivery or in creating new service developments.	

Each trust described to the review individual pathways of care for assessments, care planning, monitoring and reviews of the needs of an adult with a learning disability.
However, these care pathways were not necessarily inclusive of all services provided to the person, such as residential care, day services and short breaks, even when provided by the trusts and also do not include non-statutory provision.

Direct Payments

All trusts reported that they were progressing the implementation of self-directed support and had updated their information for carers and service users in relation to accessing direct payments. It was reported to the review that this information is now in an easy read or an accessible format. The trusts provided training for their staff in arranging self-directed support.

The Belfast, Northern and Southern trusts are not paying the HSC Board recommended minimum rate of £10.00 per hour for self-directed support as suggested in November 2014 by the HSC Board senior management team. This was communicated to the HSC trusts in a letter to the chief executives in January 2015.

The uptake of direct payments and self-directed support in Northern Ireland lags behind the rest of the United Kingdom[16]. The trusts claim they are unable to fund direct payments from existing budgets and further monies cannot be extracted from ongoing service provision. The current limitations on the amount paid through direct payments and what it can be used to buy requires to be urgently reviewed. The existing disparities across trusts also need to be addressed. Consistency of provision of direct payments between child and adult services is also variable.

A number of carers stated to the review that the services they were provided with, in terms of meeting the needs of young people under 18 years cannot be replicated by adult learning disability services. This makes the transition difficult for many families who stated that on reassessment of their young person's needs by adult services, they were not provided with services at a similar level.

Recommendation 9	**Priority 2**
The commissioner should review the regional disparity in the uptake of direct payments and continue to monitor the consequences of trusts paying below the directed standard rate.	

Assessment of Clinical and Social Care Needs

All trusts advised the review of the information they gather from a wide range of areas including day opportunities, outcomes from service user

[16] Community Care Statistics, Social Services Activity, England 2013-14

assessments, directed enhanced services (DES) and engagement with carers. The Belfast Trust reported they were carrying out a needs assessment in the areas of accommodation needs, transitioning from children's to adult services and short breaks usage.

The Northern Trust reported on completing audits of their screening process and care management. The Western Trust has completed a review of day care and short breaks and is currently working on the first draft of a day care review report. They have also completed a five year projected accommodation needs analysis.

Trusts advised that they are using other forms of assessment tools and not the Northern Ireland Single Assessment Tool (NISAT) to assess the need of adults with a learning disability, over 65 years of age. The DoH has not introduced the NISAT tool for adult learning disability services as a requirement.
However, the Southern Trust reported using the NISAT after making some modifications to it, but not an electronic version. The Belfast Trust uses its own easy read assessment tool About You, which it developed in line with the content of NISAT.

The appropriateness of the use of NISAT within learning disability services needs to be addressed urgently at a regional level and revised regional guidance issued by DoH to HSC trusts concerning their expectation about the use of this tool in the future.

Recommendation 10	**Priority 1**
The Department of Health should review the appropriateness of NISAT for use within adult learning disability services and issue guidance to trusts in respect of the trusts' use of this tool to assess needs regionally.	

Information Systems

Many trusts described the manual collection of information, which is time consuming, can create errors in reporting of information and does not make bench-marking easy for the commissioner. No trusts were using an identical system. Trusts reported there are many limitations to existing systems, resulting in a lack of robust information to inform trusts and commissioners about clinical and social care needs of adults with a learning disability.

There is no agreed single regional information database system to record activity, performance or outcomes in community learning disability services. There was some evidence of collaboration commencing across trusts, to seek a single unified community information system that would capture information about adults with a learning disability in the community, whether attending hospital or general practice. A community informatics group had been recently formed to review information requirements and current databases used by trusts.

Patient Record Information System (PARIS) is a community information system used in adult learning disability services in the Belfast Trust. The Western and Southern trusts will change to PARIS in the future. The South Eastern Trust prefers to retain its own community information systems. The Northern Trust would prefer one regionally agreed information system.

The review team considers this is an area that must be addressed at a regional level in order that accurate and up to date information is available for meaningful planning of service delivery, investment and monitoring of outcomes.

Recommendation 11	**Priority 3**
The regional informatics group should consider and agree how best to capture information in a single unified regional IT solution, to ensure meaningful planning and consistency of reporting on learning disability services and outcomes across the five trusts.	

Day Services and Day Opportunities

Current thinking in relation to most school leavers with severe learning difficulties is to move away from traditional day centres towards other options such as college, vocational training, work experience and supported employment. Service users availing of directly provided day services require an annual review by the trust. This provides an opportunity to discuss their ongoing needs and aspirations.

Each trust had different schemes and a range of different opportunities for the provision of day services and day opportunities.

The Belfast Trust described to the review a range of day opportunities and appropriate employment opportunities provided through direct payments or contractual arrangements with the independent sector. These included buildings based day opportunities, community day services and a number of activity clubs. The trust contracts with Mencap, NOW[17] and Orchardville to provide work and training opportunities and works closely with the Belfast Metropolitan College in relation to further education. The trust also purchases individual day-care and day opportunity packages from the independent sector. Adults with a learning disability are referred for trust day support services using the About You tool, which outlines the specific needs and aspirations of the individual in relation to their day opportunities requirements.

The Northern Trust reported that it has invested in its day opportunities programme to develop a range of community-based day opportunities in four service areas, leisure; vocational; volunteering and further education. These opportunities are processed using a 'Railtrack' Model ensuring individual need

[17] NOW – a training and employment social enterprise group in Belfast

is met in line with assessed need, using local provision. A range of opportunities are in place, which are monitored and reviewed.

The trust advised that it has developed social enterprise vocational training provision across its 12 sites, involving four voluntary sector partners and also a trust-wide supported employment scheme, in partnership with the Department for Employment and Learning (DEL) and two voluntary sector providers. Individual employment progression is tracked, from training to paid employment, through monthly provider meetings.

As part of its Widening Choice and Opportunities Strategy, the Northern Trust has developed a number of satellite facilities, staffed by trust employees, which provide adults with a learning disability with a structured day service, in a smaller setting, in their local community away from larger adult centres. A satellite can also provide an assessment centre in order to prepare individuals, where appropriate, for community based day services such as employment and further education. The Northern Trust had positively evaluated the outcome of provision of care in one of their satellite units. The South Eastern Trust's adult learning disability services had a range of contracts with providers of day care and day opportunities, to provide support in order to access volunteering and employment based opportunities. Ongoing contract monitoring by staff ensures service delivery is provided against agreed targets and activity levels.

The South Eastern Trust advised that it has reviewed all current day care and day opportunities provision and is working actively with key stakeholders, including service users, carers, provider organisations and community groups to develop a range of options to increase choice for individuals. Adult services are also offering self-directed support as a means of delivering person centred day opportunities. Sector based day opportunity panels provide a local approach, which links service users with their local community. At the time of the review, a number of people with a learning disability and their carers had raised concerns with the trust about the trust's plans for the future development of their day care services.

The Southern Trust described to the review how community key workers seek to access appropriate day opportunities, to meet individual service users needs within their local community. These opportunities may be leisure based, volunteering, training, educational, full and part time or supported employment. The trust has directly employed two support workers and is in the process of recruiting a third, to ensure that every service user assessed as needing support to avail of day opportunities, is provided with appropriate support.

The Southern Trust is also in the process of procuring an independent brokerage system, which will be responsible for creating and expanding the range of day opportunities available to service users in each locality and for maintaining an online resource listing these opportunities. The trust already holds a number of contractual agreements with voluntary organisations including Clanrye Developments, Mencap and Appleby Print It Employment Services to promote supported employment opportunities for service users

with a learning disability. A number of patients spoke to the review team and expressed concern about the trust's management of the change process.

A draft directory of partners was supplied by the Southern Trust to some parents and carers which in terms of supplying information was expected to be a positive development. However, it caused some anxiety for carers, as prospective providers when telephoned by carers, were not aware of the inclusion of their respective services in the directory. This emphasises the need for information to be reviewed and updated as required, given the service availability in the community by a range of providers.

The Western Trust reported that it is continuing to develop its approach and a review of care and day opportunities is yielding useful information which they are using to make service improvements. Community teams and day care managers continue to work proactively with service users and their carers, to assess need and source appropriate opportunities for day services for each individual. This is undertaken as a normal part of care and support planning and results in access to a range of trust, voluntary, independent and other statutory provision. The Western Trust also stated that it is participating in a review of day care and day opportunities, which will assess the projected needs for the next five to 10 year period.

The trust also has a new dedicated community access worker whose role through the New Directions Service is specifically to source bespoke packages, where requested, including day care, supportive employment opportunities or college placements. This is working effectively for 27 service users on a trust-wide basis and is continuing to develop.

There was no evidence of the trusts having evaluated the effectiveness of their different schemes in relation to provision of day services and day opportunities.

Recommendation 12	**Priority 2**
Each trust should annually update their directories of services for people with a learning disability to ensure they provide information about current services.	

Recommendation 13	**Priority 3**
Each trust should evaluate the benefits and effectiveness of outcomes for adults with a learning disability of the various models of day care and day support. This should be reviewed by the HSC Board regionally in terms of their future commissioning plan for day care and day support services.	

Development of Partnership Arrangements

The trusts advised the review of close working partnerships with a range of providers of day care and day opportunities. These were in the areas of education, leisure, employment and vocational training for adults with a learning disability.

In addition, there is ongoing work involving supported employment and social enterprises with the Department for Education and Learning and volunteering with the Department of Social Development and the voluntary sector.

Although all trusts outlined their involvement with the non-statutory sector, the review team considered that there was no real sense of sustained partnership around broader service development plans but rather engagement takes place on a specific project basis as required.

All five trusts advised the review of close working relationships with a range of partners, in particular Northern Ireland Housing Executive (NIHE), but also the Department of Social Development (DSD) and a range of housing associations. A move towards tendering of services runs the risk of setting up competition among non-statutory providers with the lowest price becoming the most significant factor, which should be monitored by the HSC Board.

Supported Employment Opportunities

There are some very good examples of innovative and possibly very cost-effective schemes taking place in individual trusts, such as the Rail Track model in Northern Trust. This model illustrates a clear process from referral through to allocation of services.

It illustrates a person centred approach commensurate with the HSC Board's regional day opportunities model and Equal Lives report for vocational opportunities and educational opportunities. The review notes this good practice was not replicated by other trusts and types of service models were not routinely shared across trusts.

The proportion of people with learning disability even in part-time employment remains very low. Unpaid work experience placements still dominate, which run the risk of trainee exploitation.

Protection of their social security benefits may be a contributory factor in the low percentage in full time employment, but the review team saw evidence of a number of people who could graduate to paid employment. Some people subsequently reported that they had not been provided with an opportunity to do so. The review noted that trusts had employed very few people with a learning disability. The trusts as large employers should consider providing paid employment opportunities for people with a learning disability, as this would serve as an example to other statutory agencies and private businesses.

Recommendation 14	Priority 3
The trusts, as large employers should, as part of their organisational development strategies, seek to provide a model of positive discrimination by promoting more employment opportunities for people with a learning disability.	

Managing Transitions from Children's to Adult Services

None of the five trusts were approaching transition planning in the same way. All trusts reported that a regional protocol or pathway for children transitioning to adult services is in place. In some trusts the protocol is still in draft.

A number of families reported experiencing difficulties, when transitioning to adult services, particularly with continuing provision of short break services, therapeutic input and alternative options to school.

Many families indicated that they face a significant reduction in services yet with no change in the person's needs. It was reported to the review team by carers that they understand that this is solely driven by capacity of trusts to provide services.

Carers are finding it difficult to manage the interfaces between services in the absence of a lead medical consultant, especially where a young adult has a number of complex needs which cover more than one medical speciality. Up until a young person was 14 years old their needs were coordinated under paediatric services.

In the Belfast Trust, the learning disability service has engaged the Orchardville Society and NOW[18] to provide two transition officers to support young people, from the age of 14, to plan their transition from children's to adult services. The transition officers work routinely with education, children's and adult services.

The Belfast Trust has updated its policy on transition pathways; relevant managers from children's and adults services meet bi-monthly to share information, plan and track progress on plans made by the trust.

The Northern Trust has recently completed a baseline report, detailing potential known transitions for the next five years. Using a Transition Co-ordinator and working in partnership with children's services and education transition services, the trust now has incorporated transition work as part of the community learning disability team rather than as a separate transition team.

The South Eastern Trust reports that they hold a monthly community integration meeting. One aspect of this is to specifically consider children with

[18] NOW – a training and employment social enterprise group in Belfast

complex needs or who have been looked after by the trust, who will require placements within adult services.

The Southern Trust reported to the review team that a scoping exercise is underway to identify all young people from age 14 years so that a transition database may be collated. The trust is prioritising young people who turn 18 in 2016 and young people on an extra contractual referral who will return to the trust.

The Western Trust is currently managing transition from children's to adult services on a case by case basis. There is joint working by children's and adult services, in most cases, in advance of a young person's 18th birthday.

Arrangements are in place with local schools, to co-ordinate efforts to manage effective transitions for children from school to day care and day opportunities placements.

In the Western Trust, transition from children's to adult services has seen some improvement since the last review, due to the appointment of two people within adult teams.

They have a remit to work with children's services, to develop a transition plan for school leavers and to help adults make a transition to other services in the trust e.g. older peoples services. However, resources do not normally follow young people in transition and are often not available to adult services to maintain the levels of support provided in children's services.

Transition planning needs to be consistent with legislative requirements, guidance and best practice standards.

An options appraisal needs to be undertaken of how resources could follow the person across service boundaries in order to maintain services following their transition to adult services. It was unclear to some trust staff, if the transition funding for Looked After Children could be made available to cover services from 14 to 25 years and if funding is drawn from both children's and adult services.

Recommendation 15	**Priority 1**
Each trust involved in making transition arrangements should ensure that they follow legislative requirements and best practice standards and that the criteria for the continuity of service provision are made clear to people with a learning disability and their carers.	

The review team noted that the proportion of school leavers with more complex physical and behavioural needs continues to rise. This will create further pressure in adult services in the future.

Recommendation 16	Priority 3
All trusts should carry out an assessment of the needs of school leavers over the next five-year period to enable financial projections to be made for the increased resources required to maintain adults with a learning disability in the community adequately.	

Managing Transitions from Hospital to Community

All trusts were asked to provide information regarding their arrangements for adults transitioning from specialist hospitals. Resettlement of patients from Muckamore Abbey Hospital remains incomplete. The Belfast Trust has a dedicated care manager attached to Muckamore Abbey Hospital who works closely with the hospital and community teams in relation to all resettlement and delayed discharge patients.

The Northern Trust has developed effective alert and discharge planning arrangements with their hospital social workers, to ensure suitable planning for adults transferring from general hospital to the community. The Northern Trust's senior staff responsible for learning disability services meets quarterly to review all admissions to and discharges from Muckamore Abbey Hospital to assist in identifying any patterns and gaps in services.

The South Eastern Trust reports it has two dedicated transition workers who provide in reach services for patients in Muckamore Abbey Hospital, to help facilitate person centred discharge planning arrangements. The Southern Trust follows the pathway agreed with Belfast Trust for patients from Muckamore Abbey Hospital who are transitioning from hospital into the community. Trusts are continuing to work with patients who refuse to leave hospital despite a number of placements being identified. One trust is awaiting advice from the HSC Board and DoH in this matter. The Western Trust has completed its original resettlement strategy. At the time of the review they had only two patients on the delayed discharge list to relocate. This was expected to be completed by July 2016.

The review team looked at the number of beds in Muckamore Abbey Hospital in 2013-2014 and the number of people continuing to require resettlement in the community, as shown in Appendix 3 Table A7. Twenty beds are available for treatment, ten beds each in the Southern and Western Trusts. The trusts have been unable to fully meet the expectation of the DoH in terms of all long stay hospital patients being discharged to the community by March 2016, due to some of the above factors. It is anticipated that the patients referred to in Appendix 3 awaiting resettlement, will leave in November 2016, January 2017 and June 2017. Placements are provided mostly in nursing homes or other group living arrangements, when indicated by the person's assessment of need.

Number of Patients in Active Treatment and Delayed Discharge

There is a concerning trend of new patients experiencing delays in their discharge to the community. A snapshot of the position at the end of January 2016 is set out in Table 5.

Table 5: Numbers of Patients by Trust in Active Treatment and Delayed Discharge at the 31 January 2016.

	Inpatient Treatment	Delayed Discharge
Belfast Trust	15	18
Northern Trust	10	16
South Eastern Trust	9	14
Total in Muckamore	**34**	**48**
Southern Trust	5	3
Western Trust	2	7

Figures in Table 5 are based on end of month positions as reported in the returns for Muckamore Abbey Hospital to the HSC Board.

By 16 May 2016 the position was 68 patients were delayed in their discharge, 29 from Belfast Trust and 39 from the other trust areas in Muckamore Abbey Hospital.

Supported Accommodation and Support Services

The South Eastern Trust has worked with the NIHE, Supporting People and Housing Associations to create new and extended supported living schemes.

The HSC Board expressed concern about continued availability of funding from the DSD to support adults with a learning disability in supported living accommodation, if, in the future, they do not strictly meet their criteria, in the future. Discussions are being held with NIHE and trusts about the future of commissioning of these services and the intentions of NIHE.

Accommodation Needs of Adults with a Learning Disability

The Belfast Trust has reviewed the likely accommodation needs for people with a learning disability for the next four years. This information is used for financial and accommodation planning purposes. Individual accommodation plans are progressed through their care management processes which assess need, source accommodation and commission and review the service.

The Northern Trust has undertaken a similar exercise to examine the current and future accommodation needs of young adults in residential care, including individuals living with their parents long term and adults awaiting resettlement or involved in a delayed hospital discharge.

The Western Trust has carried out a five year needs analysis of accommodation and is anticipating accommodation needs of various types for 222 people between 2015 and 2019. This is more likely to increase than decrease based on changing needs within families. Most service users are

living in residential, nursing care, and supported living with day care support or 24 hours seven days a week support needs as required.

The availability of emergency accommodation in the community, for a short period, to support the work of behaviour support teams was commonly noted as a means of avoiding unnecessary hospital admissions. Sometimes patients whose placements break down in a crisis have returned to Muckamore Abbey Hospital. They risk becoming a new category of delayed discharges. However no trust to date has been able to provide such a crisis facility. The Northern Trust provides two stepdown beds in two separate facilities at Hollybank and Woodford Park to assess patients at risk of their placements breaking down and work with them intensively in the community.

Recommendation 17	**Priority 2**
The HSC Board, supported by the five trusts, should review the models of best practice in preventing hospital admissions and consider the feasibility of developing a pilot of a regional crisis admission house.	

Placements Out of Own Trust Area

The review was aware of a number of people who are placed out of their own area due to the lack of suitable care options in their home trust.

This creates funding implications for host trusts as new community services are needed to support the person in the new trust area. In the Northern Trust, in one new facility, 19 out of 20 beds were being purchased by other trusts.

Recommendation 18	**Priority 3**
Each trust should review the impact of the transfer of people to other trust areas in relation to the consequences for their learning disability team's infrastructure, the cost to the receiving trust and the possible disruption to family relationships and share their findings with the HSC Board.	

Review of Needs of Older Parents

All trusts informed the review of identifying, profiling, recording or reviewing older carers and their needs. This was frequently undertaken as part of other work, such as Transforming Your Care respite projects, review of short breaks or an exercise in scoping future accommodation needs. In addition to annual reviews and direct payments, all trusts advised that, based on the assessment of need and eligibility criteria, adults with a learning disability parents, carers and families are supported with short breaks. These take many different forms, such as day sitting, night sitting, flexible respite or direct payments.

The uptake of assessments by carers remains low across all trusts. Trusts advised that some carers have declined the recording of their needs. The

trusts all reported that they continue to offer carers assessments; in 2015, one trust wrote to all carers offering an assessment.

The HSC trusts advised that some families had declined to discuss future planning and reported that it is a subject that some families find difficult to talk about.

A number of families involved in the focus groups, stated they were unaware that support was available from the trust, to assist with future planning and would welcome this input. Set rules about when future planning should commence will not suit every family, although trusts should try to encourage this discussion during the review of the care plans for adults with a learning disability. This may help in reducing crisis intervention planning in the future.

Recommendation 19	**Priority 1**
The carer coordinator in every trust should report to the HSC Board about the reasons given by carers specifically not wishing to progress with a carer's assessment. The HSC Board should consider if any further action should be taken by trusts to increase the uptake of assessment.	

Recommendation 20	**Priority 2**
Each trust should monitor and ensure that effective future planning is taking place and monitor crisis admissions to care annually and disseminate any lessons for learning.	

Developing Capacity to Give or Refuse Consent

The trusts advised the review that staff have undertaken capacity and consent training. Where the service user has been assessed and does not have capacity, advocates can be used by the trust to ensure the best interests of the service user are considered. The majority of trusts also advised that leaflets explaining consent are made available for service users. Trusts currently await the implementation of the new Mental Capacity Act (Northern Ireland) 2016 and further guidance in relation to assessing capacity.

Advocacy

All trusts made advocacy services, funded regionally by the HSCB, available during the resettlement process. Four trusts advised of a contracted arrangement with an independent advocacy service, provided by ARC, Bryson House, Disability Action or VOCAL. The Northern Trust is undertaking a review of their current advocacy arrangements and developing a paper to confirm their future model. The Western Trust had just ended a contract with VOCAL and will now negotiate a new contract, although their funding to do so is very limited. TILII is used by the Belfast and South Eastern trusts to provide peer and self-advocacy.

The Belfast Trust is also supported by MENCAP to assist in the development of advocacy skills, which has led to significant improvements in the services provided by the transport department.

The Belfast Trust commissions separate advocacy services for the hospital and community.

The contract for community advocacy services prioritises cases where the trust is seeking some form of legal authority in relation to the service user and cases where there is some form of conflict between the trust and the service user.

The Southern Trust has used independent advocacy services for adults involved in the resettlement process and for adults living in trust supported living schemes. Speech and language therapy input was dedicated to this to ensure as many views as possible were captured, by assisting with service user communication. A number of service users and carers said they did not like group sessions, so the trust changed its plans. People are met in their own homes on an individual basis. The Western Trust has invested £20,000 in the provision of advocacy services.

Commissioned advocacy schemes seem to be more focussed on resettlement in other trusts.

The review team did not detect any initiatives to promote advocacy for persons with learning disability more widely; rather they are available on demand, although the Southern Trust stated that self-referral and referral from other agencies can be made to this service. The trust has doubled its investment in this service in the past two years. Advocacy may be especially crucial for the successful uptake of direct payments and other new service options. All trusts indicated that they promote people's human rights, although few specific instances were provided to the review as to how this occurred.

Recommendation 21	**Priority 3**
Each trust should review their investment in advocacy services and ensure it is available to a wider group of people, other than just those involved predominately in resettlement from hospital.	

Appropriate Support for Service Users in Contact with the Criminal Justice System

All trusts referred to advocacy services as part of the support available to adults within the learning disability service that come into contact with the criminal justice system. The Belfast and South Eastern trusts advised that they provide both peer and self-advocacy using the TILII group. The Southern Trust is using Disability Action to provide an independent advocacy service. The Northern, Southern and Western trusts have social work support available in their forensic teams to support people in contact with the criminal justice system.

Increased Staff Training and Awareness

Generally, trusts responded to this question by describing training for learning disability staff that includes the previous RQIA recommended areas of human rights and good communication. The Belfast and Western trusts reported that, where possible, service users had input into staff training.

The review notes that the Belfast Trust's two day induction programme for learning disability staff was shortlisted for a social work award in the learning and development category in 2013.

2.4 Standards Reviewed Relating to COMPASSIONATE Care

Findings

All trusts described to the review that they have established a carers' forum and carers' groups in their respite units to allow carers to freely express their views. Others ways in which the carer's voice was heard were described: during carers' assessments, annual satisfaction questionnaires, surveys, reviews of services users and during the care and support planning processes.
In addition, the Belfast Trust contacts two carers per day centre every month to seek feedback on their level of satisfaction with services.

Engaged through Effective Communications

In addition to the groups and structures that the trusts had previously described, they all made reference to the provision of some easy read material and accessible formats.

The Belfast Trust informed the review of service user committees in each of its day services. Each committee sends a representative to the trust wide service user forum.

The Northern Trust has provided information in accessible formats, and described the speech and language therapists training provided to other trust staff to promote better communication with service users. A pilot has been established using social media to share information with a wider group of service users and carers. The trust has also produced a DVD of the last 10 years provision of day opportunity services, to help promote uptake of this service.

The South Eastern Trust uses trust wide speech and language therapy services and has devised a person centred template titled How Best to Support my Communication. The trust provides accessible information about Promoting Quality Care assessments, videofluroscopy, numerous health appointments and the use of a hospital passport.

The Western Trust reported using communication plans, has developed easy read material and has some accessible information on the trust's website.

While supporting all initiatives described above, the review found that the trust websites are not very user friendly and have limited information available instead of specific easy to read information.

Recommendation 22	**Priority 1**
Each trust should have an identified area on their website for people with a learning disability which has more easily accessible information in terms of easy to read material with more use of signs / symbols for ease of access to information.	

End of Life Care Needs

All service users in nursing and residential homes should have end of life or dignity plans in place. The review found that community staff engage with families to produce end of life plans when requested.

Many positive examples were provided to the review from across Northern Ireland, which provided evidence of trusts supporting service users requiring palliative care with person centred care, in their home at the end of their life. All trusts described working with GPs, hospital staff, community nursing, rapid response teams, psychology, hospices and Macmillian nursing care to provide appropriate end of life care.

In the Northern Trust, learning disability services are represented on the trust's Palliative Care, End of Life Programme and the Bereavement Forum. The Belfast and Northern trusts described palliative care training opportunities available to their staff.

Care plans are agreed with service users, carers and families and updated following service user reviews. The Western Trust advised that its staff identify people with learning disabilities with no relatives, to ensure dignified end of life plans and arrangements are in place.

2.5 Services are Well Led

Findings

This review assessed the effectiveness of the leadership, management and governance of services while focusing on the needs and experiences of service users. Levels of leadership were assessed at both team and senior management levels in focus groups and from written responses to self-assessment questionnaires which were analysed by the review team. In addition, a meeting was held with the HSC Board as commissioner, to validate some of the information provided about actions taken by trusts.

Use of Service Framework by Trusts as a Tool for Improvement

Following the 2013 Phase I, Review of Community Services for Adults with a Learning Disability, all trusts reported in their action plans that they were progressing the service framework and contributing through regular reports, to monitoring by the HSC Board.

All trusts described their structures, confirmed the governance arrangements in place for learning disability and demonstrated linkages across their own trust with other directorates. Professional leads have responsibility to ensure that staff remained up to date with contemporary theories, interventions and best practice guidelines. Trusts advised the review of the types of processes in place, to gain assurance as to performance against the Service Framework for Learning Disability, including contributing to the HSC Board's monitoring of key performance indicators (KPIs) and participation in the HSC Board's file audit. The trusts provided a list of their internal audits of practice; for example audits of safeguarding, staff supervision, direct payments and carers assessments.

Proposals for gathering evidence to demonstrate improved outcomes for service users were reported to the review by three trusts, Belfast, Northern and Western. The Belfast Trust is introducing a Health Equality Framework as an outcome measurement tool.

This will be piloted across part of adult learning disability services later in 2016. The Northern Trust has an outcome evaluation framework for people in receipt of psychological services.

The Northern Trust reported increased numbers of direct payments, increased opportunities in supported living and day services and described their bespoke packages for resettlement.

The Western Trust similarly demonstrated an increase in supported living placements for resettlement of patients out of hospital, increased numbers of direct payments and developments in self-directed support.

The review team noted that most staff they met were familiar with the content of the service framework, although the review team received assurances that the Service Framework for Learning Disability has been rolled out across trust staff.
The Service Framework for Learning Disability should guide service developments, monitor outcomes and underpin the formulation of annual disability service development plans. The approach used by trusts in applying the standards varied across trusts.

Recommendation 23	**Priority 2**
The formulation of annual learning disability service development plans in trusts should be consistently underpinned by the standards set out by DoH in the Service Framework for Learning Disability.	

Use of Best Practice Evidence and Guidelines

All trusts advised that they use best practice evidence and that appropriate guidelines were available. Sources listed by the trusts included National Institute for Health and Care Excellence (NICE), Royal Colleges, external reviews and RQIA Quality Improvement Plans. The Belfast Trust is currently exploring membership of the National Health Service Bench Marking Network of Learning Disability Services.

Transferability of Skills between Mental Health and Learning Disability Teams

The Belfast Trust reported that their teams are working closely together in a number of ways such as audit forums and in monthly monitoring meetings with independent providers. The Northern Trust is developing opportunities for co-working with their RAID and Promote teams. The South Eastern Trust described the link between the CLDT's approved social worker, who engages directly with mental health services through a forum. The Western Trust advised that learning disability staff share knowledge and expertise on a case by case basis.

The Department of Health advised that students on the Approved Social Work Course (who are already experienced social workers) have to undertake a placement in mental health and or learning disability depending on their specific learning needs. Mental health social workers will undergo a Learning Disability placement in order to widen their experience and vice versa. However the review was not advised of any placements of learning disability staff in mental health services and vice versa to encourage experiential learning, or consideration of secondments of staff to learn more about mental health or learning disability services.

The trusts did not provide any data to quantify any skills exchange between mental health and learning disability teams. Limited improvement has been noted in this area.

There continues to be reluctance for mental health services to take people with a mild learning disability into their services, despite the standard set out in the Service Framework for Learning Disability.

Leadership of Services, Governance and Service Improvements

All trusts advised the review of a wide range of ways in which their staff are supported. Staff have regular supervision, attend team and MDT meetings, professional forums, knowledge and skills framework (KSF) appraisals, participate in staff surveys, complete induction training and specialised training for existing staff is available.

The trusts described regular learning disability team meetings, MDT meetings, supervision and visits by senior managers and directors. This demonstrates that staff are supported, able to make suggestions, have a team approach to addressing key concerns and is included in decision making.

Additionally, the review was advised that workshops are held in the Northern and Southern trusts to enable staff to offer suggestions for improving the service.

Trusts had service plans, directorate plans and corporate plans in place for adult learning disability services. Managers are described as having an open door policy when listening to their staff; staff were encouraged in many ways to be involved in decision making, for example the Southern Trust Assistant Director wrote to all learning disability staff asking them to identify any ineffective or inefficient practices.

Learning from incidents is disseminated across the teams during de-briefings by managers, in MDT meetings and regular incident review meetings. The trusts have incident review forms, Datix processes and risk registers, to ensure that learning is captured and shared. All trusts provided evidence of numerous audits carried out within learning disability services; files and care plans are regularly audited to ensure services users' notes are current and that relevant information is recorded. The Northern Trust continues to have leadership walk arounds involving both the Assistant Director and the Director and promotes staff engagement across all services.

All trusts have complaint, compliment and feedback systems and indicated that they reviewed the outcomes.

The chairman, non-executive directors, directors or heads of service conduct walk around visits to services. In the Southern Trust, this was developed further into a patient and staff safety leadership walk around programme. All trusts reported having person centred planning processes with Promoting Quality Care (PQC) risk assessments being completed with service users.

Difficulty in Implementation of the Service Framework for Learning Disability

Trusts stated that there is still a need to update the service framework, and amend the language in some parts to ensure trusts are meeting the KPIs consistently. The review noted that trusts have not all interpreted the KPIs in exactly the same way. Further work is required by the commissioner to agree definitions to ensure accuracy of reporting and comparability of outcomes.

Trusts described their difficulty in obtaining data, as it was not readily available or accessible. This has resulted in some cases in estimates being submitted. This can lead to inaccuracies if comparisons are made about performances of trusts. There are concerns therefore that this potentially inaccurate information is being used to measure performance by the HSC Board.

All trusts expressed concerns about the lack of specificity in some of the standards set out in the service framework and consider that the information provided to date, is unlikely to have enough reliability or validity to make accurate comparisons between trusts. However the HSC Board advised the review team that they consider the comparative data to be sufficiently robust.

The following benchmarking information of the KPIs to date, has been provided by the HSC Board to the RQIA review.

Table 6: Status of key performance indicators (KPIs) from Service Framework for Learning Disability

The Service Framework for Learning Disability contains 34 standards, 4 are specific to children and there is a set of 10 that are identified as generic. These essentially are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping.

The HSC Board is monitoring performance against the 20 standards that specifically relate to adults with a learning disability. The HSC Board reports separately on the generic and children's standards to the Department of Health.

Within the 34 standards there are 85 KPIs, however within the 20 standards relating to the adults with a learning disability there are only 56 KPIs.

Status of KPIs	Green	Amber	Red	Total number
Number of KPIs	27	25	4	56

This indicates that at the time of the review 27 KPIs were achieved, 25 KPIs were with an acceptable tolerance and four KPIs were not met.

Given that the Service Framework for Learning Disability is now in its third year, the review concluded that a higher level of achievement should have been evident. Closer partnership working by trusts would have been helpful to achieve a more consistent approach across Northern Ireland.

Recommendation 24	**Priority 3**
The DoH should assess the progress and the implementation of the standards contained in the Service Framework for Learning Disability.	

Recommendation 25	**Priority 1**
Each trust should produce action plans to demonstrate how they meet the KPIs in the Service Framework for Learning Disability and present this to their Trust Board for monitoring and to evidence their demonstration of improvement.	

Section 3: Stakeholder Consultations

The review team met with over 200 adults with a learning disability, from all of the HSC trusts across Northern Ireland, in 17 separate groups and in a range of one to one meetings with service users. The composition of the groups included adults with learning disabilities, adults with a learning disability who advocate for others, parents, carers and advocates. The review team met adults in settings ranging from their own homes, to day centres and trust facilities. Some groups were organised by the trusts, others by the voluntary sector, such as ARC, Destined, Positive Futures, TILII and VOCAL.

Generally, information obtained from this consultation process agreed with findings from interviews with trust staff. Annual health reviews were experienced by everyone with a learning disability, in general practice settings involving both nurses and GPs. However, parents wanted to receive a copy of appointment letters as the adult with a learning disability easily forgot the appointment and the family might not be aware of the date and time. GP practices also provided most of the health promotion advice regarding smoking cessation, healthy eating and exercise to service users who were also able to describe the process of consent and knew they could say no. The general consensus across the groups was that GPs were flexible and understanding of the needs of adults with a learning disability.

There were several examples of available work opportunities all unique to the services user's particular circumstances. Some people with a learning disability said they would like to be paid for work undertaken but as they relied on their social security benefits, they could not risk losing these as they were vital to them managing in the community. The cost of transport to attend day opportunities was raised by service users and parents as an issue.

Future planning was an area that was difficult to approach for people with a learning disability and their carers. There was a low level of acknowledgment of any plans in place. Parents and carers were quite concerned that plans have not been developed and that emergency planning would be the only fall-back position when carers were ill or no longer able to manage. Other parents whose current situation was more stable reflected that they would like to commence planning for the future, although no discussions had taken place with trust staff.

Transitioning to adult services was not a recent experience for most people we interviewed, but for the few adults who had experienced this, they described being offered one choice of activity or one choice of accommodation at resettlement. No service user interviewed described being offered two or more alternatives for either a day activity or accommodation. When children with a mild learning disability are in mainstream education, they were not identified as needing to make the transition into adult learning disability services until they finished their education. Consequently no planning and preparation was in place for these young people. A lack of structure and drift in the engagement by trusts was experienced by some carers.

Whilst the South Eastern Trust had examples of effective engagement with parents and carers, a number of parents and carers in the South Eastern Trust and Southern Trust also expressed their frustration to the review at the lack of engagement in ongoing development of learning disability services. Lack of contact and lack of support were both expressed by parents who felt that they were not being heard. Parents explained that they know their own son or daughter's needs best and found it difficult when trust staff did not take their views into consideration. Parents described being offered services that were very different and in their opinion, irrelevant to what their young person needed.

A group of parents and carers in the Southern Trust expressed dissatisfaction with communication from the trust in respect of day opportunities and respite. In Londonderry, parents and service users commented on the lack of contact with social workers. Most service users who met the review team did not have a social worker. A number were living fairly independent social lives and may not necessarily have required a social worker but stated they would value a telephone number to ring for advice if required. They believed the trust had difficulties in recruiting social workers who did not stay in employment very long.

Day centres and their satellite units were praised by service users and the parents. The staff were highly thought of and local community involvement was recognised as providing a significant contribution towards their success.

GPs highlighted that referrals made to learning disability services were managed well, however a referral to other secondary care services often required a second referral. Some adults with a learning disability did not understand the trusts' letters from partial booking systems. When no action is taken by an adult with a learning disability, because they do not know to phone the hospital to make an appointment or share the letter with someone who would understand the appointment process, they are discharged without having attended an appointment. Some concern was expressed by voluntary organisations, around the small but growing numbers of adults with a learning disability whose first language was not English, and the requirement for translators.

In Londonderry a group called Destined was very proactive in providing classes and services for a wide range of adults with learning disabilities. Activities and sports were developed for different age groups. Young adults were provided with classes and opportunities more appropriate to their age, while more mature adults had their preferred activities at alternative times of the day. Adults with a learning disability were supported to become involved in a wide range of activities across the city.

This scheme demonstrated an excellent model of community integration and also provides placements for young people who are considering a career in social work or social care services. Grant aid had been obtained from the European Union which has enabled a multiplicity of day options and services for young people with a learning disability to be developed.

Section 4: Conclusion

It is estimated that there is approximately 26,500 people with a learning disability in Northern Ireland, of whom; half are aged between zero to 19 years[19].

The Service Framework for Learning Disability was disseminated to all HSC trusts in September 2013. It contains 34 standards to provide guidance to trusts on how to improve the health and wellbeing of people with a learning disability.

This review assessed the quality of services delivered to adults with a learning disability against 30 standards. The standards relating to children will be reviewed at a later stage by RQIA. The processes established by the HSC Board to monitor and seek assurances regarding the delivery of safe, effective, compassionate and well led services were also reviewed. The review found evidence of improvements in a number of standards. In particular, the regionalisation of adult safeguarding practices, the enhancement of health promotion and screening undertaken by GPs, and the establishment of specialist teams to manage behaviours that challenge staff and carers.

In addition, a large array of creative day opportunities have been offered in place of the previous more limited choice of attendance at a day centre in each trust.

An evaluation of the effectiveness of different models of day opportunities in terms of improved outcomes for service users would be helpful regionally. Whilst there have been very welcome developments, trusts are still on an improvement journey and gaps remain in the full implementation of the standards in many areas.

Multiple information systems exist in very trust, to record activity, with a heavy reliance on paper based files. A more collaborative approach is required by trusts to develop and agree one single unified community based information system that will enable the commissioner to compare and contrast the effectiveness of outcomes in relation to the funding invested in learning disability services.

Guidance was delivered by the HSC Board in November 2014 regarding the introduction of a minimum payment rate of £10 per hour for direct payments as Northern Ireland considerably lags behind the rest of the United Kingdom. To date, only the Western Trust and the South Eastern Trust are paying this amount per hour. The review recommends this should be reviewed by the commissioner.

The uptake of carers' assessments continues to be low in Northern Ireland, as does the number of people with a learning disability in paid employment.

[19] Bamford Action Plan, Dhssps (2009-2011)

However, a number of people we spoke to expressed fear about losing their entitlement to their social security benefits.

This factor needs to be reviewed further by trusts, to ensure that people who can work daily can progress without fear into more meaningful employment opportunities.

There were examples of more consultations being held by each trust, with service users and carers, but less evidence of trusts actually developing services jointly or in direct partnership with service users, in keeping with the standard.

Transition planning between children and adult services continues to be problematic. Clearer projections of numbers and costs are required across all five trusts to identify the financial resources required to meet the known physical and behavioural needs of young people who have now entered adolescent services.

A low number of people with a mild learning disability are able to access mental health services which is not in keeping with the expectations set out in the standard.

Community learning disability teams continue to have a similar composition of professionals, as in 2013. Due to the varied range of roles, tasks, job descriptions, size and types of teams, it was difficult to compare and contrast teams for effectiveness. It is surprising given the small size of Northern Ireland, that such a variance is required to deliver essentially the same type of service provision.

Despite numerous targets being set by the HSC Board, the resettlement target of all long stay patients leaving learning disability hospitals by June 2017 may not be achieved.

The review noted a limited access to advocacy apart from those living in supported living schemes or transitioning from long stay hospitals. This inequality should be reviewed to ensure that all people who require this service can access this in the future more equitably.

In relation to the achievement of the key performance indicators contained in the service framework, the HSC Board demonstrated to RQIA that 27 of these have been fully achieved, 25 are in progress and 4 have not been achieved. The review concluded that a higher level of achievement should have been evident. Closer partnership working across trusts would have been helpful to achieve a more consistent approach to delivery of the standards across Northern Ireland.

Section 5: Recommendations

Recommendation 1	Priority 1
The commissioner should ensure effective use of resources through accountability meetings and seek evidence based improvements in learning disability services across trusts. The investment in learning disability hospital provision should also be kept under review given the current resettlement target set for achievement in 2016.	

Recommendation 2	Priority 1
The Regional Learning Disability Health Care and Improvement Steering Group, set up by the Public Health Agency should ensure each trust has a plan that can demonstrate measureable evidence of health improvements for adults with a learning disability.	

Recommendation 3	Priority 1
The PHA in conjunction with trusts should develop a regional dataset of information in relation to outcome measurement in 2016-2017 across two key areas to drive improvement in the health status of people with a learning disability. Targets should be considered in relation to the reporting of a reduction in smoking and obesity in the 2017-2018 year.	

Recommendation 4	Priority 2
The HSC Board should set an access target for inclusion of people with a mild learning in mental health services in order to achieve the standard set up in the service framework.	

Recommendation 5	Priority 2
The HSC Board should review the current models of service provision in place in the five trusts in terms of evidence of best practice and ensure that this is disseminated regionally.	

Recommendation 6	Priority 2
Each trust should review the specific role of the consultant psychiatrist in their community team in terms of how best they can assist in the delivery of improvements in clinical outcomes for people with a learning disability.	

Recommendation 7	**Priority 2**
An assessment of the activity and effectiveness of challenging behaviour teams should be undertaken by the commissioner. The outcome model used by the Northern Trust should also be reviewed to see if it could be applied regionally.	

Recommendation 8	**Priority 1**
Each trust, as part of their Personal and Public Involvement (PPI) Strategy, should proactively involve people with a learning disability and their carers in the planning of change to service delivery or in creating new service developments.	

Recommendation 9	**Priority 2**
The commissioner should review the regional disparity in the uptake of direct payments and continue to monitor the consequences of trusts paying below the directed standard rate.	

Recommendation 10	**Priority 1**
The Department of Health should review the appropriateness of NISAT for use within adult learning disability services and issue guidance to trusts in respect of the trusts' use of this tool to assess needs regionally.	

Recommendation 11	**Priority 3**
The regional informatics group should consider and agree how best to capture information in a single unified regional IT solution, to ensure meaningful planning and consistency of reporting on learning disability services and outcomes across the five trusts.	

Recommendation 12	**Priority 2**
Each trust should annually update their directories of services for people with a learning disability to ensure they provide information about current services.	

Recommendation 13	**Priority 3**
Each trust should evaluate the benefits and effectiveness of outcomes for adults with a learning disability of the various models of day care and day support. This should be reviewed by the HSC Board regionally in terms of their future commissioning plan for day care and day support services.	

Recommendation 14	**Priority 3**
Each trust, as large employers should, as part of their organisational development strategies, seek to provide a model of positive discrimination by promoting more employment opportunities for people with a learning disability.	

Recommendation 15	**Priority 1**
Each trust involved in making transition arrangements should ensure that they follow legislative requirements and best practice standards and that the criteria for the continuity of service provision are made clear to people with a learning disability and their carers.	

Recommendation 16	**Priority 3**
Each trust should carry out an assessment of the needs of school leavers over the next five-year period to enable financial projections to be made for the increased resources required to maintain adults with a learning disability in the community adequately.	

Recommendation 17	**Priority 2**
The HSC Board, supported by the five trusts, should review the models of best practice in preventing hospital admissions and consider the feasibility of developing a pilot of a regional crisis admission house.	

Recommendation 18	**Priority 3**
Each trust should review the impact of the transfer of people to other trust areas in relation to the consequences for their learning disability team's infrastructure, the cost to the receiving trust and the possible disruption to family relationships and share their findings with the HSC Board.	

Recommendation 19	**Priority 1**
The carer coordinator in every trust should report to the HSC Board about the reasons given by carers specifically not wishing to progress with a carer's assessment. The HSC Board should consider if any further action should be taken by trusts to increase the uptake of assessment.	

Recommendation 20	**Priority 2**
Each trust should monitor and ensure that effective future planning is taking place and monitor crisis admissions to care annually and disseminate any lessons for learning.	

Recommendation 21	**Priority 3**
Each trust should review their investment in advocacy services and ensure it is available to a wider group of people, other than just those involved predominately in resettlement from hospital.	

Recommendation 22	**Priority 1**
Each trust should have an identified area on their website for people with a learning disability which has more easily accessible information in terms of easy to read material with more use of signs / symbols for ease of access to information.	

Recommendation 23	**Priority 2**
The formulation of annual learning disability service development plans in trusts should be consistently underpinned by the standards set out by DoH in the Service Framework for Learning Disability.	

Recommendation 24	**Priority 3**
The DoH should assess the progress and the implementation of the standards contained in the Service Framework for Learning Disability.	

Recommendation 25	**Priority 1**
Each trust should produce action plans to demonstrate how they meet the KPIs in the Service Framework for Learning Disability and present this to their Trust Board for monitoring and to evidence their demonstration of improvement.	

Glossary

BPS - British Psychological Society

BSS - Behaviour Support Service

CLDT - Community Learning Disability Teams

DEL - Department for Employment and Learning

DES - Directed Enhanced Services

DHSSPS – Department of Health Social Services and Public Safety

DoH – Department of Health

DSD - Department for Social Development

EPEX – Electronic Information database

GMS - General Medical Services

GP – General Practitioner

HSCB – Health and Social Care

KPIs - Key Performance Indicators

LCID – Local Community Information Database

NIHE - Northern Ireland Housing Executive

NISAT - Northern Ireland Single Assessment Tool

OT – Occupational Therapist

PARIS – Patient Record Information System

PBSS – Positive Behaviour Support Services

PHA – Public Health Agency

RAID - Rapid Assessment Intervention and Discharge

RCP - Royal College of Psychiatrists

SLT – Speech and Language Therapist

TILII - Tell It like It Is (An ARC advocacy group)

TYC - Transforming Your Care

References

Department of Health. (2007) Services for people with learning disabilities and challenging behaviour or mental health needs: Revised edition (Chairman: Prof J.L. Mansell) London: Department of Health.

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McGill, P., Cooper, V. & Honeyman, G. (2010) Developing better commissioning for individuals with behaviour that challenges services - a scoping exercise Canterbury/Chatham: Tizard Centre/Challenging Behaviour Foundation.

DHSSPS (2015) Service Framework for Learning Disability. Belfast: DHSSPS.

United Nations. Convention on the Rights of Persons with Disabilities. Ratified by UK 2009.

Appendices

Appendix 1

Table A1: The number and percentage of people in receipt of various social care services in 2013-2014

Supported accommodation	Belfast	Northern	South Eastern	Southern	Western	Total
Residential / Nursing Home	313	282	281	234	253	1363
% in Residential / Nursing Homes	**17**	**15**	**19**	**12**	**23**	**16**
Supported Housing	238	265	234	243	129	1109
% Supported Housing	**13**	**14**	**15**	**12**	**12**	**13**

Note percentages are calculated as a proportion of the total number people in receipt of social care service.

Table A2: The number and percentage of people using day services 2013-2014

Day Services	Belfast	Northern	South Eastern	Southern	Western	Total
Day Centres	673	823	696	509	680	3381
% use day centres	**37**	**43**	**46**	**26**	**63**	**41**
Day Opportunities	604	542	402	402	295	2245
% day opportunities	**33**	**28**	**27**	**20**	**27**	**27**
Total Day Services	1277	1365	1098	911	975	5626
% day service	**70**	**71**	**72**	**46**	**90**	**68**

Table A3: The number and percentage of people in receipt of family support services in 2013-2014

Family Support Services	Belfast	Northern	South Eastern	Southern	Western	Total
Short breaks	470	563	406	515	177	2131
% short breaks	**26**	**29**	**27**	**26**	**16**	**26**
Domiciliary Care	167	179	459	530	162	1497
% domiciliary care	**9**	**9**	**30**	**27**	**15**	**18**
Direct Payments	201	148	101	132	91	673
% Direct Payments	**11**	**8**	**7**	**7**	**8**	**8**

Appendix 2

Standards from the Service Framework for Learning Disability grouped by RQIA's four key stakeholder outcomes.

Table A4: Standards reviewed relating to SAFE care

Standard	
1	All HSC staff should ensure that people of all ages are safeguarded from harm through abuse, exploitation or neglect.
19	All people with a learning disability should have equal access to the full range of health services including services designed to promote positive health and wellbeing.
20	All HSC staff, as appropriate, should advise people who smoke of the risks associated with smoking and signpost them to well-developed specialist smoking cessation services.
21	All people with a learning disability should be supported to achieve optimum physical and mental health.
22	All people with a learning disability who experience mental ill health should be able to access appropriate support.
23	All HSC staff, as appropriate, should provide people with healthy eating support and guidance according to their needs.
24	All HSC staff, as appropriate, should provide support and advice on recommended levels of physical activity.
25	All HSC staff, as appropriate, should provide support and advice on recommended levels of alcohol consumption.

Table A5: Standards reviewed relating to EFFECTIVE care

Standard	
2	People with a learning disability should as a matter of course make choices or decisions about their individual health and social care needs. These needs to be balanced with the individual's ability to make such decisions and then the views of their family, carers and advocates should be taken into account in the planning and delivery of services, unless there are explicit and valid reasons to the contrary agreed with the person.
3	All patients, clients, carers and the public should have opportunities to be actively involved in the planning, delivery and monitoring of health and social care at all levels.
14	Young people with a learning disability should have a transition plan in place before their 15th birthday and arrangements made for their transition to adulthood by their 18th birthday.
16	Adults with a learning disability should be able to access support in order that they can achieve and maintain employment opportunities in productive work.
17	All adults with a severe or profound learning disability should be able to access a range of meaningful day opportunities appropriate to their needs.
26	All people with a learning disability whose behaviour challenges should be able to get support locally from specialist learning disability services and other mainstream services, as appropriate, based on assessed need.
28	HSC professionals should work in partnership with a variety of agencies in order to ensure that the accommodation needs of people with a learning disability are addressed.
31	All people with a learning disability should have the impact of ageing taken into account in having their future needs assessed and proactively managed.
32	All people with a learning disability should have access to dementia services at whatever age it becomes appropriate for the individual.

Table A6: Standards reviewed relating to COMPASSIONATE Care

Standard	
4	Adults with a learning disability should be helped by HSC professionals to develop their capacity to give or refuse informed consent.
5	All patients, clients, carers and the public should be engaged through effective communications by all organisations delivering health and social care.
6	People with a learning disability should expect effective communication with them by HSC organisations as an essential and universal component of the planning and delivery of health and social care.
7	People with a learning disability should receive information about services and issues that affect their health and social wellbeing in a way that is meaningful to them and their family.
8	People with a learning disability, or their carer, should be able to access self-directed support in order to give them more control and choice over the type of care and support they receive.
9	Service users and their carers should have access to independent advocacy as required.
15	People with a learning disability should be supported to have meaningful relationships, which may include marriage and individual, unique, sexual expression within the law, balancing their rights with responsibilities.
18	All parents with a learning disability should be supported to carry out their parenting role effectively.
27	All people with a learning disability who come into contact with the Criminal Justice System should be able to access appropriate support.
29	All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity to work in partnership with them and to ensure that they have effective support as needed.
30	All family carers should be offered the opportunity to have their needs assessed and reviewed annually.
33	All people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care.
34	All people with a learning disability being assessed for supportive and palliative care should have their learning disability taken into account in consultation with them, their carers and learning disability services when appropriate.

Appendix 3

Table A7: Muckamore Abbey Hospital Indicative Beds and the number of patients still awaiting resettlement into the community

Indicative position	Wards -	Total - Inpatient Beds		
		2013 - 2014	1 April 2015	31 March 2016
Core Treatment Phase 1	CP Cranfield (PICU)	6	6	6
	CM Cranfield (Men)	14	14	14
	CM Cranfield (Women)	15	15	15
	Sixmile (Assessment)	3	3	3
	Sixmile (Treatment)	16	16	16
	Donegore	9	9	9
	Killead	24	24	24
Total Muckamore Assessment & Treatment		**87**	**87**	**87**
Children's Services, under 18	Iveagh Centre	8	8	8
TOTAL Assessment & Treatment Beds		**95**	**95**	**95**
MAH -Resettlement	Erne	10	17	21
	Greenan	15	0	0
	Moylena	19	16	7
	Ennis	15	0	0
	Rathmullan	12	0	0
	Oldstone	23	3	0
Total Muckamore Resettlement Beds		**94**	**36**	**28**

Table A8: Southern Trust Learning Disability Hospital Beds

Assessment & treatment	Dorsey	10	10	10

Table A9: Western Trust Learning Disability Hospital Beds

Assessment & treatment & PICU	10	12	8

Appendix 4

RQIA Published Reviews

Review	Published
Review of the Lessons Arising from the Death of Mrs Janine Murtagh	October 2005
RQIA Governance Review of the Northern Ireland Breast Screening Programme	March 2006
Cherry Lodge Children's Home: Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities	September 2007
Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland	February 2008
Review of Assessment and Management of Risk in Adult Mental Health Services in Health and Social Care Trusts in Northern Ireland	March 2008
Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	April 2008
Clostridium Difficile – RQIA Independent Review, Protecting Patients – Reducing Risks	June 2008
Review of The "Safeguards in Place for Children And Vulnerable Adults in Mental Health and Learning Disability Hospitals" in HSC Trust	June 2008
Review of the Outbreak of Clostridium Difficile in the Northern Health and Social Care Trust	August 2008
Review of General Practitioner Appraisal Arrangements in Northern Ireland	September 2008
Review of Consultant Medical Appraisal Across Health and Social Care Trusts	September 2008
Review of Actions Taken on Recommendations From a Critical Incident Review within Maternity Services, Altnagelvin Hospital, Western Health and Social Care Trust	October 2008
Review of Intravenous Sedation in General Dental Practice	May 2009
Blood Safety Review	February 2010
Review of Intrapartum Care	May 2010
Follow-Up Review: Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children	July 2010
Review of General Practitioner Out-of-Hours Services	September 2010
RQIA Independent Review of the McDermott Brothers' Case	November 2010
Review of Health and Social Care Trust Readiness for Medical Revalidation	December 2010
Follow-Up Review of Intravenous Sedation in General Dental Practice	December 2010
Clinical and Social Care Governance Review of the Northern Ireland Ambulance Service Trust	February 2011
RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland	February 2011
A Report on the Inspection of the Care Pathways of a Select Group of Young People who Met the Criteria for Secure Accommodation in Northern Ireland	March 2011
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase One	March 2011

Review	Published
Review of Child Protection Arrangements in Northern Ireland	July 2011
Review of Sensory Support Services	September 2011
Care Management in respect of Implementation of the Northern Ireland Single Assessment Tool (NISAT)	October 2011
Revalidation in Primary Care Services	December 2011
Review of the Implementation of the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults	February 2012
RQIA Independent Review of Pseudomonas - Interim Report	March 2012
RQIA Independent Review of Pseudomonas - Final Report	May 2012
An Independent Review of Reporting Arrangements for Radiological Investigations – Phase Two	May 2012
Mixed Gender Accommodation in Hospitals	August 2012
Independent Review of the Western Health and Social Care Trust Safeguarding Arrangements for Ralphs Close Residential Care Home	October 2012
Review of the Implementation of Promoting Quality Care (PQC) Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services	October 2012
Review of the Northern Ireland Single Assessment Tool - Stage Two	November 2012
Review of the Implementation of the Cardiovascular Disease Service Framework	November 2012
RQIA Baseline Assessment of the Care of Children Under 18 Admitted to Adult Wards In Northern Ireland	December 2012
Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland, Overview Report	February 2013
Independent Review of the Governance Arrangements of the Northern Ireland Guardian Ad Litem Agency	March 2013
Independent Review of the Management of Controlled Drug Use in Trust Hospitals	June 2013
Review of Acute Hospitals at Night and Weekends	July 2013
National Institute for Health and Care Excellence Guidance: Baseline Review of the Implementation Process in Health and Social Care Organisations	July 2013
A Baseline Assessment and Review of Community Services for Adults with a Learning Disability	August 2013
A Baseline Assessment and Review of Community Services for Children with a Disability	August 2013
Review of Specialist Sexual Health Services in Northern Ireland	October 2013
Review of Statutory Fostering Services	December 2013
Respiratory Service Framework	March 2014
Review of the Implementation of NICE Clinical Guideline 42: Dementia	June 2014
Overview of Service Users' Finances in Residential Settings	June 2014
Review of Effective Management of Practice in Theatre Settings across Northern Ireland	June 2014
Independent Review of Arrangements for Management and Coordination of Unscheduled Care in the Belfast Health and Social Care Trust and Related Regional Considerations	July 2014
Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House	July 2014

Review	Published
Review of Actions Taken in Response to the Health and Social Care Board Report Respite Support (December 2010) and of the Development of Future Respite Care/Short Break Provision in Northern Ireland	August 2014
Child Sexual Exploitation in Northern Ireland - Report of the Independent Inquiry	November 2014
Discharge Arrangements from Acute Hospital	November 2014
Review of the Implementation of the Dental Hospital Inquiry Action Plan 2011	December 2014
Review of Stroke Services in Northern Ireland	December 2014
Review of the Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014
Baseline Assessment of Access to Services by Disadvantaged Groups in Northern Ireland (Scoping Paper)	December 2014
RQIA Quality Assurance of the Review of Handling of all Serious Adverse Incidents Reported between January 2009 and December 2013	December 2014
Review of the Care of Older People in Acute Hospitals	March 2015
Review of the Diabetic Retinopathy Screening Programme	May 2015
Review of Risk Assessment and Management in Addiction Services	June 2015
Review of Medicines Optimisation in Primary Care	July 2015
Review of Brain Injury Services in Northern Ireland	September 2015
Review of the HSC Trusts' Arrangements for the Registration and Inspection of Early Years Services	December 2015
Review of Eating Disorder Services in Northern Ireland	December 2015
Review of Advocacy Services for Children and Adults in Northern Ireland	January 2016
RQIA Review of the Implementation of the Palliative and End of Life Care Strategy (March 2010)	January 2016
Review of Community Respiratory in Northern Ireland	February 2016
An Independent Review of the Northern Ireland Ambulance Service	March 2016
RQIA Review of HSC Trusts' Readiness to comply with an Allied Health Professions Professional Assurance Framework	June 2016
Review of Quality Improvement Systems and Processes	June 2016
RQIA Review of Governance Arrangements Relating to General Practitioner (GP) Services in Northern Ireland	July 2016
RQIA Review of the Operation of Health and Social Care Whistleblowing Arrangements	September 2016

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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

March 2023

TABLE OF CONTENTS

1. Introduction

Purpose of this Guidance

1.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

1.2. This policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland, with the emphasis on, ideally, elimination of their use, but certainly a minimisation of their use. It is applicable across the lifespan - children, young people[i], adults and older people, to all health and social care staff and within all health and social care services.

1.3. The policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This will assist in protecting people, reducing the risk of misuse and potential over-reliance on restrictive practices.

1.4. The use of restrictive interventions, restraint or seclusion may be necessary on occasion, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others.[ii] [iii] [iv] Nevertheless, some of those who have been involved with or subject to seclusion, restraint or restrictive interventions recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.[v] [vi] [vii] [viii] [ix]

1.5. The use of restraint and seclusion across health and social care settings and services in Northern Ireland is difficult to quantify, with challenges in capturing and articulating data on a regional basis. Whilst many organisations will have their own governance systems relating to monitoring the use of seclusion, there will be clear benefits to an agreed regional approach to this.

What will this Policy do?

1.6. This regional policy sets out the expectations for minimising use of restrictive interventions, restraint and seclusion. It also provides requirements for decision making, reporting and governance arrangements for the use of any restrictive practice. The policy provides this through seven standards.

1.7. The standards are underpinned by the principle of early intervention measures to minimise and eliminate their occurrence and promote the principle of least restriction possible. The standards set out in this policy must be applied to the

management of behaviours of concern and distressed reactions, even if they are unforeseen, or in contexts where they cannot be anticipated and/or responses pre-planned.

1.8. This policy sets accountability for the minimisation strategy at the top level of each organisation, emanating from the drive for a rights-based approach to practice, culture, and policy from the centre of organisational decision-making. Organisations must establish a baseline of the use of all restrictive interventions to enable organisational minimisation strategies.

1.9. This policy requires the development of a standardised, regional approach to recognition, implementation, recording, monitoring, learning and quality improvement. This will improve the understanding of what constitutes restraint, seclusion and interventions that fall under the umbrella term of restrictive practices and will drive minimisation strategies, embedded in a rights-based approach.

Who is this Policy for?

1.10. This policy is intended for use by people who work in health and social care across all health and social care services in both statutory (which refers to all six Health and Social Care Trusts) and non-statutory sectors (which refers to all other services providing health and social care). Health and social care staff working in non-health settings, and the employing organisation, should also consider the requirements of this policy document in conjunction with other legislation, policy and procedure relevant to the particular work setting, using it to inform their decision-making and practices.

Status of this Policy

1.11. This policy is issued by the Department of Health with the clear expectation that all Health and Social Care organisations understand their individual and collective roles and that they implement the guidance in full.

1.12. This policy is issued with strong recommendation for implementation in full by non-statutory health and social care providers.

1.13. HSC organisations commissioning services from non-statutory health and social care providers will include compliance with this policy within contracting arrangements.

1.14. Anyone working in a health and social care setting must follow all relevant legislation. There are a number of legal requirements relating to restrictive practices. At all times people working in the health and social care system must be mindful of the requirements under human rights obligations and must always act with the best interests of the patient/person in mind.

1.15. In Northern Ireland care homes are by law required to only use restraint when it is in the welfare of the patient. Each instance of restraint must be recorded in respect of each resident[x] [xi]. This policy does not remove or change this requirement.

1.16. When commenced in full, the Mental Capacity Act (Northern Ireland) 2016 will provide requirements relating to restraint when a person over 16 lacks capacity to consent to the action[xii]. This policy is compatible with that Act.

1.17. If restraint becomes a deprivation of liberty, a legal authority must be in place for the deprivation of liberty to be lawful. This can be the Mental Health (Northern Ireland) Order 1986[xiii], the Mental Capacity Act (Northern Ireland) 2016, an Order from a Court or another statute. Only in emergency situations can the common law defence of necessity be relied upon.

1.18. Seclusion is always a deprivation of liberty and must therefore have a legal authority prior to being carried out. Secluding a person without a legal authority is unlawful.

2. The Standards

1. All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

2. All local policies and practices must embed use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions.

3. Effective and person-centred communication must be central to care and treatment planning.

4. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.

5. Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.

6. Roles and responsibilities are defined in terms of monitoring, reporting and governance.

7. Any use of seclusion as a last resort intervention must follow the regional operating procedures.

3. Key Principles

3.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

3.2. Evidence of therapeutic benefits for use of restraint and seclusion is limited.

3.3. Organisations must have robust monitoring arrangements in place that provide assurances that restrictive practices are used only as a last resort, and that any restrictive practice used provides a therapeutic benefit to the person.

3.4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation.

Rights Based Approach

3.5. The value of each and every person receiving services is recognised through service delivery founded on a rights-based approach which empowers and involves the individual in decision making.

3.6. The lived experience is a critical contribution for all aspects of minimisation strategies.

3.7. Rights based approaches, evidenced based interventions, robust monitoring and governance, and a drive to "always do better" for people receiving services and staff delivering care, treatment and support will be the foundations of any and all policy and practice. The routine use of *Three Steps to Positive Practice*[xiv] will contribute to ensuring that any use of any restrictive practice, restraint or seclusion has been considered as the least restrictive, most therapeutic intervention available to meet a person's needs.

3.8. The routine use of *Three Steps to Positive Practice* will drive any culture change necessary to realise the organisation's minimisation strategy at both practice and strategic levels.

3.9. Transparency is key in building relationships, authentic communication, developing person-centred, rights based and evidence-based care. Transparency must therefore be part of treatment and support plans, reviewing and debriefing incidents, and improving service delivery.

4. Key Actions

Leadership and Accountability throughout Health and Social Care Statutory and Non-Statutory Organisations

Action 1. Health and Social Care organisations, where restrictive interventions are used, must develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 2. HSC organisations must embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 3. Non-statutory health and social care organisations, where restrictive interventions are used, should develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 4. Non-statutory organisations should embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 5. Identified senior staff are responsible and accountable for leading the restrictive practice minimisation strategy for their own organisation, as well as contributing to a regional vision of eliminating unnecessary restrictive interventions, restraint and seclusion.

Action 6. Leadership will be modelled in practice by organisations adopting/developing "Positive Practice" champions/teams.

Monitoring, Oversight and Assurance

Action 7. Each individual organisation is responsible for ensuring the requirements of this policy are implemented, providing evidence of monitoring, oversight and action to address deviation from the policy.

Action 8. Identified individuals in each organisation will lead the minimisation strategy, driving culture change and practice improvement underpinned by robust monitoring, oversight and assurance.

Action 9. The DoH Strategic Performance and Planning Group (SPPG) will be tasked with overall monitoring of organisations' implementation of restrictive practice minimisation strategies and plans and providing assurances. SPPG will work with all organisations involved to set the systems and structures in place to facilitate this.

Action 10. This will include establishing systems and processes for standardising terminology across the region to allow data collection, mandatory reporting etc., leading to a baseline position to inform minimisation strategies. This will also involve developing regional quality improvement programmes, aiming to

support organisations and staff in safely and effectively implementing the minimisation strategy.

Action 11. The Public Health Agency (PHA) through its safety and quality functions, will support analysis of incident reporting for the purposes of learning and service improvement and develop regional quality improvement initiatives informed by that data analysis and learning.

Action 12. The Regulation and Quality Improvement Authority (RQIA) will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Mental Health (Northern Ireland) Order 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This will include reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

5. Standard 1 – All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

Restrictive Practices

Restrictive practices are those that limit a person's movement, day to day activity or function.

Restrictive Interventions

Environmental restrictions

The use of obstacles, barriers or locks to prevent a person from moving around freely. This could also include the use of electronic monitoring.

Psychological restrictions

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion

The practice of persuading someone to do something by using force or threats.

Observation

A restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Restraint

Physical Restraint

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person.

Mechanical Restraint

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Chemical Restraint

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Seclusion

The confinement of a person in a room or area from which free exit is prevented.

5.1. The use of restrictive interventions can be traumatic for all those involved. They have the potential to have a long-term negative impact on people subject to the intervention and the staff involved, with damage to any therapeutic relationship. There must be a focus on person centred practice and promotion of positive relationships, to support recognition of any potentially restrictive intervention is recognised as aiming to minimise/eliminate such interventions.

General principles for any use of restrictive practices

These principles apply across the lifespan, but specific techniques may need adjusted to suit individuals, for example, children, young people, older people, condition specific considerations, etc.

Decisions to use restrictive practices must be supported by robust justification.

Children and young people should never be subject to seclusion.

Restrictive interventions, restraint and seclusion should not be used for reasons related to disability.

Any use of restrictive practices must only be considered as a last resort.

Initial attempts of restraint should as far as possible be non-physical.

There must be a real possibility of imminent harm to the person or to staff, the public or others if no action is undertaken.

Any use of restrictive practice must be most effective and therapeutic intervention possible with regards to reducing behaviours associated with risk and/or their impact.

The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

Restrictive interventions, restraint or seclusion must never be used as discipline, to inflict pain or humiliation, or a substitute for the provision of proper, person-centred care.

Use of restraint or seclusion must be considered in the context of the legal authority for its use, and fully compliant with a rights-based approach.

5.2. There is significant value in all health and social care organisations using the same language and descriptors to identify all interventions which are potentially restrictive[xv]. Therefore, all organisations must use the standard definitions to identify all interventions which are potentially restrictive, including restraint measures and seclusion, across all health and social care settings, statutory and non-statutory. This will support staff in identifying which practices are restrictive and contribute to considered decision making about their use.

5.3. "Restrictive practice" is an umbrella term that refers to the entire range of interventions that are considered restrictive – from a person's walking aid, controlling their access to kitchen cupboards, covert administration of medication, or continuous observations, through to various methods of restraint and on to seclusion at the far end of restrictive measures that infringe a person's rights.

5.4. This definition encompasses all restrictive practices and is wide enough to invoke a considered thought process around any and all interventions that may be potentially restrictive. Even though an intervention may be considered to be in an individual's best interest or to ensure safety, it may still potentially be restrictive and should be considered as such.

Restrictive Practices

5.5. In its broadest sense, the regional definition incorporates any and all restrictive practices; those which are obvious, for example, hands on physical restraint or the use of seclusion, as well as those which are less obvious, including coercion and psychological measures like controlling how often and for how long someone watches television.

5.6. Organisations must identify and include all potentially restrictive interventions, including those that are not always obvious. With effective definitions it will be possible to monitor the use of restrictive practices or put in place mechanisms to minimise their use; actions which protect both people who use health and social care services and staff implementing the measures.

5.7. Recognising and acknowledging the use of restrictive interventions in the context of the regional definition will enable organisations and individual staff to understand the extent to which restrictive practices are used in the everyday care, treatment and support they deliver, realising the ethical and legal implications.

5.8. Every use of restrictive practice must be described in a care/support/treatment plan that meets the requirements of the *Three Steps to Positive Practice Framework,* ensuring that it is the least restrictive, most effective and therapeutic intervention that will be used for the shortest period of time possible, with a defined review period specified. Using the *Three Steps to Positive Practice Framework* will ensure that the intervention is supported by best evidence for its use and is human rights compliant and lawful.

Environmental Restrictions

5.9. Environmental restrictions include the use of obstacles, barriers or locks to prevent a person from moving around freely. It could also include the use of electronic monitoring in the form of 'wandering' technology such as 'tag' monitors or alarm mats. If the restrictive intervention prevents a person from leaving, the intervention constitutes a deprivation of that person's liberty and a breach of the international Human Rights law (European Convention of Human Rightsxvi Article 5, or the United Nations Convention on the Rights of the Childxvii, Article 37), and is unlawful unless undertaken within a legislative framework.

5.10. The Mental Health (Northern Ireland) Order, 1986, The Mental Capacity Act (Northern Ireland) 2016, The Children (Northern Ireland) Order, 1995, and in some cases individual Court Orders provide authorisations for lawful health and social care related deprivations of liberty. Whilst the common law Doctrine of Necessity will allow a temporary deprivation of liberty, to keep a person safe from immediate danger, any sustained or planned deprivation of liberty is only lawful when used with the most appropriate legislation. This includes any use of seclusion.

5.11. Organisations have a responsibility to ensure that staff are aware of and fully understand the relevant legislation and apply that legislation comprehensively and correctly. At an individual practitioner level, the values, competencies and professional registration requirements of health and social care staff dictate understanding and practice compliant with current legislation.

Psychological/Psychosocial Restrictions

5.12. Psychological/psychosocial restriction refers to depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do. This could include "punishment" interventions for children such as potentially removing contact with parents or carers[xviii] or access to social interaction/digital access, withholding nutrition or fluids, or corporal punishment, to force compliance.

5.13. All staff must be aware that the use of body language, non-verbal and paraverbal communication, in an attempt to apply control or force compliance are equally restrictive interventions, and possibly constitute coercion.

5.14. Health and social care staff have a responsibility to keep people safe and healthy. For those who cannot understand the consequences of making positive and negative choices/do not have the capacity to understand such consequences, due to neurodevelopmental and/or cognitive difficulties and challenges, there will sometimes be a necessity to "control" choices to keep people safe, for example limiting access to unhealthy food choices.

5.15. There are times when strategies to increase motivation to complete less preferred, but essential or important tasks required to build skills and independence, could be considered as making "someone do something they don't want to do". However, health and social care professionals must understand how this can relate to the imbalance of power between those who provide a service - staff - and those who

use the service. Power imbalance can lead to the use of coercion, abuse and degrading treatment[xix].

Coercion

5.16. Coercion is defined as the practice of persuading someone to do something by using force or threats. However, in reality, coercion may not be obvious "force or threats", but much subtler. Coercive atmospheres create tension and conflict, with the potential to generate increasingly restrictive staff interventions and environments. Coercive language and behaviour will harm relationships and damage therapeutic milieus and is something of which staff must always be conscious. Coercion should never be used in any of its forms.

> *"If you take all your medicines, I will be able* ***to tell the doctor and you won't have to go*** *back to hospital"*
>
> *"If* ***you don't have any fizzy drinks this week,*** *you will be able to see your mummy at the weekend"*
>
> *Some examples of more subtle coercive practice*

Observation

5.17. Observations are "*restrictive interventions of varying intensity in which a member of the healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others*". While it is clear that the intention is to provide a therapeutic component or opportunity, observation as an intervention is restrictive and often limits a person's movement, day to day activity or function[xx] [xxi].

Restraint

5.18. Restraint must only be used as an emergency last resort when all other non-restrictive measures have been exhausted and only when the specific risks to self or others posed by the individual's behaviour cannot be managed by other reasonable means. The use of restraint should always be viewed as a temporary solution to any behaviour causing concern and should only be used following assessment and decision making measuring the likelihood and severity of the outcome.

5.19. Any restraint should represent the least restrictive intervention, for the least amount of time possible, and a reasonable, and proportionate response to the prevailing risks[xxii].

5.20. The application of restraint for any reason is an imposition on an individual's rights and dignity, by its nature restricts a person's liberty, and in some cases may subject the person to an increased risk of physical and/or psychological harm[xxiii].

5.21. The use of restraint must also be considered in the context of the legal authority for its use. All use of restraint must be monitored and recorded. Monitoring must be proportionate to the level of restriction. Regulated services registered with the Regulation and Quality Improvement Authority[xxiv] must ensure alignment with any relevant standards applicable to the setting. For the statutory sector, this means ensuring that the same level of recording takes place, regardless of setting.

Physical Restraint

> *"Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others."*

5.22. Physical restraint is defined as any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. The use of any physical restraint is not without risks, despite any legal and professional justifications. Staff must be aware of the potential risks involved when applying any physical restraint technique to minimise the potential impacts that are associated with the use of physical restraint[xxv]

5.23. Health and social care staff must also be aware that certain groups are more vulnerable to risks and adverse outcomes associated with restraint – either intrinsically, or because they are more likely to be restrained. These groups are those people with serious mental health illness, intellectual disabilities or cognitive impairment, people from ethnic minority groups, individuals with high BMI, men aged 30-40, children and young people below the age of 20[xxvi].

5.24. Prone restraint must not be used by health and social care staff unless in exceptional circumstances[xxvii xxviii xxix].

5.25. Any other uses of physical restraint must not be prolonged (exceeding 10 minutes) unless in exceptional circumstances and must follow best practice standards. Alternative non-physical interventions must be considered before and during the restraint episode. If restraint is required for longer than 10 minutes alternative non-physical interventions such as rapid tranquillisation or seclusion should be considered.

5.26. For these reasons and in line with NICE guidelines any use of physical restraint reaching or exceeding the threshold of "prolonged" must be subject to a formal incident review, in line with organisational policy.

5.27. A person who suddenly stops resisting a physical restraint intervention may be experiencing cardio-respiratory de-compensation which is a medical emergency.

5.28. In the circumstance where physical restraint may be required:

- Staff must be appropriately trained by an accredited training organisation;

- Deliberate pain or the threat of use of pain must not be used by staff in an attempt to force compliance;

- People must not be restrained in a way that impacts their airway, breathing or circulation - pallor, cyanosis or complaining of not being able to breathe are clear indicators of respiratory arrest or positional asphyxia;

- The mouth and/or nose must never be covered, and techniques should not incur pressure on the neck region, ribcage and/or abdomen;

- There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor;

- One member of staff involved must take overall responsibility for monitoring the person's airway and physical condition throughout the restraint event. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint should cease immediately;

- Avoid "taking the person to the floor". If this is unavoidable, any movement towards the floor is dictated by the person as they descend; staff involved should support the safety of the descent. Where possible a supine position must be used instead of a prone position. However, **if** there are exceptional circumstances where prone restraint is unavoidable, it should be for the shortest amount of time possible[xxx] [xxxi].

- Clinical observations including pulse, respiratory rate, temperature, blood pressure and observation of the person's colour should be undertaken during the event and for a period of time after the event to be determined by the lead clinician.

5.29. In the exceptional circumstances where physical restraint is considered for use for a child or young person[xxxii], staff must have the appropriate training to ensure that they undertake any interventions in line with NICE guidelines[xxxiii]. NICE advise that restraint[xxxiv] techniques are adjusted according to the child or young person's height, weight and physical strength. Staff must also be trained in the use of resuscitation equipment on children and young people.

5.30. If possible, staff members who are the same sex as the child or young person should undertake the physical restraint intervention. There may be times when physical restraint is required to safely support a person with essential personal care needs, specialist care and treatment or in an emergency for essential medical treatment, in the circumstances where the person cannot provide/lacks the capacity to provide informed consent[xxxv] [xxxvi]for the intervention.

5.31. The use of restraint for clinical treatment, essential treatment in an emergency or for essential care tasks has been differentiated from that of physical restraint in regard to the rationale and intention of using holding skills.[xxxvii] However, health and social care staff must be aware that these techniques are considered physical restraint and they must be trained in their use.[xxxviii] [xxxix]

5.32. Physical restraint for clinical treatment, essential treatment in an emergency or for essential care tasks cannot proceed where a person has the capacity to provide informed consent but chooses to withhold that consent.

5.33. In circumstances where a person requires physical restraint to meet their needs as result of lack of capacity and inability to consent to an intervention, then this should be agreed within the context of best interests and by a multi-disciplinary team, using the *Three Steps to Positive Practice Framework*. As with all restrictive practices, physical restraint in these circumstances must only be used in the context of a last resort, least restrictive and most effective intervention. A detailed care plan is required where physical restraint might be used for essential clinical treatment, essential treatment in an emergency or for essential care tasks.

5.34. Any and every use of physical restraint, including when used for clinical treatment, essential treatment in an emergency or for essential care tasks, should be subject to a review of the restraint event and the person's care and treatment plans amended where required and appropriate, to mitigate against continued need for the use of restraint.

5.35. The review should include:

- the type of restraint technique employed;
- the date and the duration of the intervention;
- the names of the staff and people involved;
- reasons for using the restraint technique employed (rather than an alternative less restrictive approach);
- whether the person or anyone else experienced injury or distress;
- the person's views of the incident (if appropriate, through family, caregiver or advocate);
- what follow-up action was taken, including the need for any formal emotional support.

Mechanical Restraint

5.36. Mechanical restraint is the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control[xl].

5.37. Mechanical restraint can involve the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of a person's body. This type of intrusive mechanical restraint should not be used outside of a designated secure setting[xli]. It must only be used in limited and exceptional circumstances for management of extreme violence directed towards others, or to limit self-injurious behaviour of extremely high frequency or intensity.

5.38. Nice guidelines[xlii] advise against use of this type of restraint for children and young people.

5.39. Organisations must have policies for the use of this type of restraint, detailing what would constitute the limited and exceptional circumstance of extreme violence/self-injurious behaviour that would warrant use of such equipment, in which designated facility and the robust governance arrangements that authorises, monitors, and reviews their use.

5.40. The use of mechanical restraint should be avoided where possible. However, there may be exceptional circumstances where mechanical restraints (other than those for exceptional use within secure settings only (5.31 above)) are required to limit self-injurious behaviour of high frequency or intensity, for example, use of arm splints, use of cushioned helmets etc.

5.41. Mechanical restraint may also, for example, be the use of "safe space" equipment, lap straps, bed rails and harnesses for the purposes of preventing harm to the person or endangering others, and by their nature restrict liberty. The use of the *Three Steps to Positive Practice Framework* will assist in the assessment, planning and review of these measures in these exceptional circumstances and provide assurances regarding the application of a proportionate and least restrictive use of mechanical restraint.

5.42. Mechanical restraint in these cases must be:

- robustly assessed as the least restrictive measure possible that will maintain the safety, well-being and dignity of the person;
- part of a support/care plan that includes actions and interventions that aims to bring about the circumstances where continued use of mechanical restraint will no longer be required (where possible);
- reviewed at pre-determined intervals, according to the individual's unique situation, to include:
    - the type of mechanical restraint used;
    - the date and the duration of the intervention;
    - reasons for using the type of mechanical restraint (rather than an alternative less restrictive approach);
    - whether the person or anyone else experienced injury or distress;
    - the person's views on the use of mechanical restraint (if appropriate, through family, caregiver or advocate);
    - any amendments to care/support plans or follow up action, including the need for any formal emotional support.

5.43. Mechanical restraint should not be used:

- as a substitute for other less restrictive interventions;
- as a form of discipline or punishment;

- as a substitute for inadequate staffing levels;
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours; or
- when seclusion is being used simultaneously.

Chemical Restraint

5.44. Chemical restraint refers to the use of medication to control or subdue acute behavioural disturbance, or the management of on-going behavioural disturbance. It is important to recognise that it can bring therapeutic benefit to a person experiencing particularly distressing symptoms, such as hallucinations.

5.45. Acute Behavioural Disturbance is an acute mental state associated with an underlying mental or physical disorder[xliii]. The symptoms associated with acute behavioural disturbance range from agitation, distress and actual or potential aggression and violence, that causes the person to harm themselves or cause harm to another person, or where a person causes damage to property, with the intent to use objects to harm self or others.

5.46. Responses to and management of acute behavioural disturbance will require combined evidence based and therapeutic strategies, including management and treatment of physical ill health, de-escalation, and other non-pharmacological approaches[xliv], to be used in advance of a pharmacological approach, and/or along with a pharmacological approach.

5.47. In these cases, the purpose of the use of medication is to “control or subdue” behaviours which may potentially result in harm to the person or to others. This use of medication is considered chemical restraint.

5.48. Potentially sedating medications might be used over months or even years in the management of on-going behavioural disturbance. This captures a wide range of practice from high dose sedating medications over a period of weeks (when an individual might be experiencing a very acute disorder) through to occasional use of low dose medications which may cause a degree of sedation in individuals with long term conditions. The use of these medications aims to bring relief from behavioural or psychological symptoms associated with long term neurodevelopmental or neuropsychiatric conditions (e.g. autism, dementia etc) and will therefore be therapeutic

5.49. Staff should assess whether the person will accept oral medication as part of a de-escalation technique where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, and there is not an immediate risk of violence or aggression. This is sometimes known as “pre-rapid tranquillisation. NICE[xlv] guidelines advise that oral Pro Re Nata (PRN) medication on its own is not de-escalation.

5.50. If the pharmacological response is rapid tranquillisation – medication by the parenteral route (which means by methods other than taken orally, usually intramuscular injection or exceptionally, intravenously, if oral medication is not possible or appropriate and urgent sedation with medication is needed) – a formal incident review is required for each episode of administration.

5.51. Health and social care staff who are involved in the management of Acute Behavioural Disturbance using pharmacological responses must follow the requirements set out in local policy and procedure, relevant best practice guidance and/or regional protocols.

5.52. There are situations where the use of medication to undertake a specific procedure – for example general anaesthesia for dental extraction - *is* intended to subdue, control or restrict the individual, to allow the intervention to proceed. The use of pharmacology in this circumstance is not in response to acute behavioural disturbance but is nonetheless considered chemical restraint. Staff should recognise the intervention as chemical restraint and use the *Three Steps to Positive Practice Framework,* to determine that the proposed pharmacological response is the least restrictive, most proportionate intervention available at that time.

5.53. There are situations where the use of medication in the treatment of a particular illness, condition or presentation is not intended to subdue, control or restrict that individual, but potentially has restrictive side effects. In these cases, the intent behind the medication must be considered.

5.54. In all cases where potentially sedating medications are being used for management of behavioural symptoms, irrespective of the nature or degree of 'restriction' these might cause, the *Three Steps to Positive Practice* will provide a useful framework for decision-making and interdisciplinary review of the use of potentially sedating medications in line with NICE guidance.

Frequency of review of the use of restrictive practices

5.55. The regional procedures for use of seclusion (Standard 7) dictate a specific timeline for review of its use. However, it is not appropriate to define a "minimum/maximum" timeframe for review of other restrictive practices within this policy document.

5.56. The frequency for review of the use of restrictive practices will be agreed on an individualised basis and in the context of changing presentation, assessed risk of harm to the person or others, changing circumstances and/or any fluctuation in capacity to consent to interventions.

5.57. For example:

- the presentation of a person with delirium who is subject to restrictive practices, such as close observation or deprivation of liberty, may change day to day, meaning that any restrictive practice should be reviewed on a daily basis;

- a person with advanced dementia who requires to be deprived of liberty is unlikely to present significantly differently day to day, meaning that the intervals between review periods will likely be longer;
- the requirement for the use of arm splints to manage the risk of a person causing harm to themselves will be assessed and reviewed at every use, possibly multiple times per day, with the shortest interval possible between review to allow the mechanical restraint intervention to end;
- the use of PRN medication and Rapid Tranquillisation will be reviewed after every use as part of an incident review with the intention of mitigating against recurring use;
- The use of physical restraint will be reviewed after the restraint event with the intention of mitigating against recurring use.

5.58. The Three Steps to Positive Practice requires an agreed timeframe for review of any restrictive practice, before the intervention is initiated.

Seclusion

5.59. Seclusion is the confinement of a person in a room or area from which the person is not free to leave.

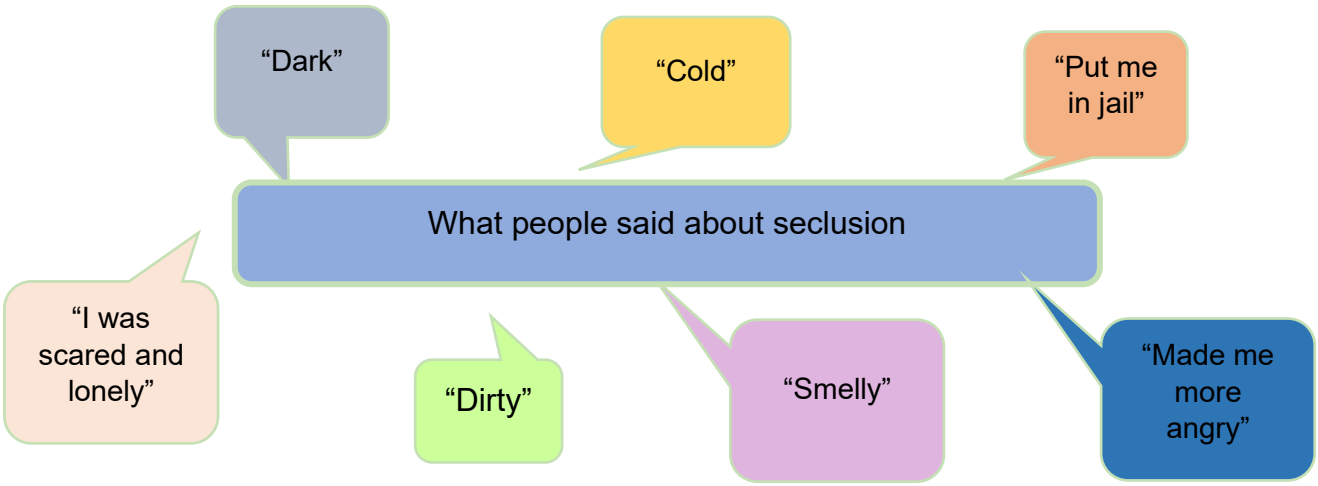
5.60. Children and young people should not be subject to seclusion.

5.61. Not being free to leave does not require a locked door. It can be staff locking the door but can also be the person believing that the door is locked, staff holding the door handle, blocking exit, refusing exit, coercing the person and so on. The key point being that the person being secluded can only leave the confinement area when permitted to do so.

5.62. If seclusion is required, it must only be used:

- As a last resort intervention in an emergency where there is an unmanageable risk to others and other less restrictive methods are deemed insufficient to manage that immediate risk;
- When a person is, or is liable to be, detained in accordance with an appropriate legal framework;
- In a hospital setting in a room or suite specifically designated for this purpose;
- In accordance with the regional operating procedures (see Standard 7).

5.63. Worldwide evidence provides no definitive conclusion that the use of seclusion has a therapeutic benefit[xlvi]. It can be seen as punitive and can cause psychological harm.[xlvii] [xlviii] The use of seclusion can often be a traumatic experience for those involved and can cause potential damage to therapeutic relationships compromising recovery and well-being.



5.64. In every circumstance where a person is confined in a room, or an area, and the person is not free to leave, no matter the name given to the intervention, the person is subject to deprivation of liberty, which may also amount to seclusion.[xlix] Seclusion used outside of the circumstances set out at 5.62 is not acceptable. Seclusion used outside of a legal framework breaches human rights and is unlawful. This applies to both adults and children. A health and social care professional using seclusion outside of a lawful process may be subject to prosecution for false imprisonment or unlawful detention of the person.

5.65. There is no such thing as "consenting" to deprivation of liberty and therefore no one can consent to seclusion, even if the situation is believed to be one where the person has "requested" seclusion and/or can "ask" to be released. Health and social care staff must consider the practice in question in the context of the definition and the circumstances in which it is considered for use. Plans should be put in place to replace the seclusion intervention as soon as is possible with an intervention that has an evidence based therapeutic intent, with the aim of eliminating any use of seclusion for that individual.

5.66. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances that they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person "consenting" to seclusion but can be an important aspect of care planning. Advance statements – a written statement which primarily informs all staff of the person's wishes, feelings, beliefs, values and preferences regarding their future treatment – is recommended.

5.67. All those who are capable and wishing to do so should be encouraged to make an advance statement with regards to the use of any restrictive intervention. An advance statement does not provide legal authority but must be taken into account by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

5.68. There may be circumstances where a person is confined to an area supported by staff, promoting the use of a lesser stimulating environment to support emotional

regulation. Decision making around an intervention such as this must provide therapeutic benefits and outcomes for the person, which must be clearly set out in care/support plans.

5.69. All staff must be aware that their actions, if preventing free exit, amount to a deprivation of liberty. All staff must consider if, in implementing the intervention, their action amounts to secluding the person, that is – are they acting in an emergency, confining a person in response to an unmanageable risk of harm to others where other responses have been deemed insufficient?

5.70. Where the intervention amounts to deprivation of liberty, there must be a regular review process that reflects the least restrictive approach for the least amount of time possible. The person's care and treatment plan must be reviewed to consider other proactive and positive approaches to prevent re-occurrence.

5.71. Where the intervention amounts to seclusion, there must be an urgent, in-depth review of the person's care and treatment plan, with the aim of eliminating any use of seclusion for that individual with an intervention that has an evidence based therapeutic intent.

5.72. All staff need to ensure that they are acting within the requirements of this regional policy, and relevant legislative frameworks.

5.73. Seclusion must not happen outside of the hospital environment. NICE guidelines[l] advise against the use of seclusion in the emergency department.

5.74. If an emergency situation occurs outside of the hospital setting where a person requires to be deprived of their liberty in circumstances that amount to seclusion, urgent and in-depth review of the incident and the person's care and treatment plans is required, and appropriate therapeutic actions taken to avoid recurrence. However, seclusion outside hospital cannot be part of the person's care plan and must only ever be in response to an emergency.

Long term segregation

5.75. People can be subjected to a range of restrictions that fall short of seclusion but may result in an extreme restriction of social contact over a prolonged period of time. It is different from seclusion.

5.76. While formal 'long term segregation' is not a recognised form of care in Northern Ireland, people can spend very long periods of time with minimal or no contact with their peers and without having any time out of the health and social care facility, be that a hospital, a care home, or their own home. This is comparable to long term segregation. It is key that policies and procedures provide safeguards for people who may be subject to this type of arrangement. Segregation from others is a form of restrictive intervention.

5.77. Staff must be alert to this practice, recognise it as restrictive and use the *Three Steps to Positive Practice Framework* to ensure there is a clear plan to minimise and eliminate the use of segregation as quickly as possible.

5.78. Organisational policies must include mechanisms and safeguards that prevent any person being cared for, supported, or treated in a situation that amounts to long-term segregation.

6 Standard 2 – All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions

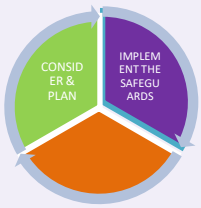
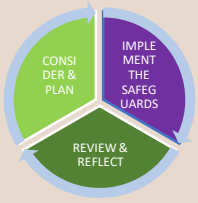
6.1. All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of any restrictive intervention, from locking cupboard doors right through to use of seclusion.[i] [iii]

6.2. There are occasions when the use of restrictive practice is unavoidable in order to keep a person or others safe from harm. Not all restrictive interventions are inherently wrong, harmful or illegal; they are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practice is therapeutic, ethical and lawful.

6.3. *The Three Steps to Positive Practice* is a collaborative Royal College framework designed and endorsed by the Royal College of Nursing, Royal College of Psychiatrists, the British Association of Social Workers, and the Royal College of Occupational Therapists. This framework assists health and social care professionals to think about culture and practices and to guide professional, ethical and legal decision making when considering the use of potentially restrictive practices document, supporting legal, ethical and professional decision making around the use of restrictive interventions, every time a decision is made, or an action is taken.

6.4. *The Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to routinely adhere to all three steps of the framework. This framework has been designed to be applied at points of assessment, implementation, evaluation and review, and in situations where the use of restrictive interventions has been in place for some time or associated with a particular environment.

STEP 1 Consider and plan 	Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice? Does the proposed intervention or the way in which care is being delivered: • limit the person's movement, daily activity or function; • result in the loss of objects or activities that the person values; or, • require the person to engage in a behaviour that he/she would not engage in given freedom of choice? If you answer yes to any of these questions, then the proposed intervention is potentially restrictive.	You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties. Remember that some decisions may require a legal opinion.
	What other less restrictive options have been considered?	You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time.
	How will the proposed intervention reduce risk, and build or retain the person's skills and the opportunities available to them?	You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person's ability to develop and retain skills and learn through experiences.

Implement the safeguards 	Is this proposed intervention considered to be in the person's best interests?	You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person's best interests. Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement.
	How do I ensure that I am using a rights-based approach?	You must ensure that the plan is fully considerate of human rights and the FREDA principles and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints.
	What professional accountability frameworks must be considered?	You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation's accountability and governance structures.
STEP 3 Review and reflect 	Has a regular and timely review of the intervention been planned?	You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented.
	Is there a plan to ensure that the intervention will be for the shortest length of time possible?	You must ensure that there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2.
	Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions?	You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues.

6.5. The Three Steps to Positive Practice Framework seeks to build a culture of practice embedded in a rights-based approach as the “norm”. The truest articulation of a rights-based approach that meets the needs and circumstances of the individual is based on person-centred culture and practice, which will be realised with embedding the rights-based approach of this framework in policy. A professional using the framework is directed towards the use of a rights-based approach, thereby ensuring the minimisation of such interventions. As the agreed regional framework, every member health and social care staff must follow the Three Steps to Positive Practice Framework when considering the use of any restrictive practice. Where the process is not being implemented and staff are aware of the use of restrictive practices, it should be recognised as a potential safeguarding issue. Staff must escalate their concerns using organisational reporting processes highlighting the requirements of this regional policy.

Rights Based Approach

6.6. A rights-based approach to health and social care means two things – ensuring that the rights of individuals enshrined in law, known as “Human Rights”[liii] [liv] [lv] are upheld and influence decision making about health and social care delivery; and practice that is shaped by the core principles and values that put the person receiving the service at the centre of decision making about that service, the FREDA principles. A rights-based approach means that all restrictive practices must be subject to appropriate procedural safeguards. In particular, a fair balance must be struck between the severity and consequences of interfering with the rights of the person restricted, the main purpose of which is to ensure the safety of the individual and others.

6.7. A rights-based approach puts the person at the centre of decision making supporting an individualised plan to meet their individual needs. The person subject to the restrictive practice and/or their representatives must be actively involved in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices. This is an essential aspect of the partnership working that is required in developing proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people**.**

Human Rights

6.8. The application of Human Rights is particularly relevant to a rights-based health and social care provision. These rights are realised through European Convention on Human Rights (ECHR), The United Nations Convention on the Rights of the Child (UNCRC) & the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). There are additional internationally accepted human rights standards, which may have relevance for how health and social care staff and organisations shape rights-based practice[lvi] [lvii]

6.9. These legal frameworks set out how both individual practitioners and organisations must provide and deliver health and social care services. They recognise and protect the dignity of all human beings, and impose legal duties on authorities, both local and national, to respect the human rights set out in the Conventions in their

decisions and actions. Importantly, ECHR, UNCRC and UNCRPD are vital in providing a rights-based approach to health and social care delivery, protecting the key human rights set out in the table below:

	Specific Article		
	ECHR	**UNCRC**	**UNCPD**
Right to life The right to life is protected by law.	2	6	10
Prohibition of Torture The right not to be tortured or treated in an inhumane or degrading way.	3	37	15
Right to Liberty and Security The right not to be deprived of liberty "arrested or detained" – except where there is proper legal basis.	5	37	14
Right to Respect for Private and Family Life The right to family, relationships, well-being, privacy, correspondence and home, including seeing family and being heard.	8	16	22 23
Prohibition of Discrimination The right not to be treated differently because of race, religion, sex, political views or any other personal status, unless this can be justified objectively.	14	2	5

6.10. Every health and social care professional must understand the rights enshrined in human rights law and how this must influence their practice and be alert to the potential for breaches of human rights in everyday practice[lviii].

6.11. These laws are not mutually exclusive. The ECHR applies to every human being, adult and child, with the UNCRC and UNCRPD providing more explicit detail of

human rights law and rights specifically for children and persons with disabilities respectfully. The additional internationally accepted human rights standards contribute to full recognition and application of human rights.

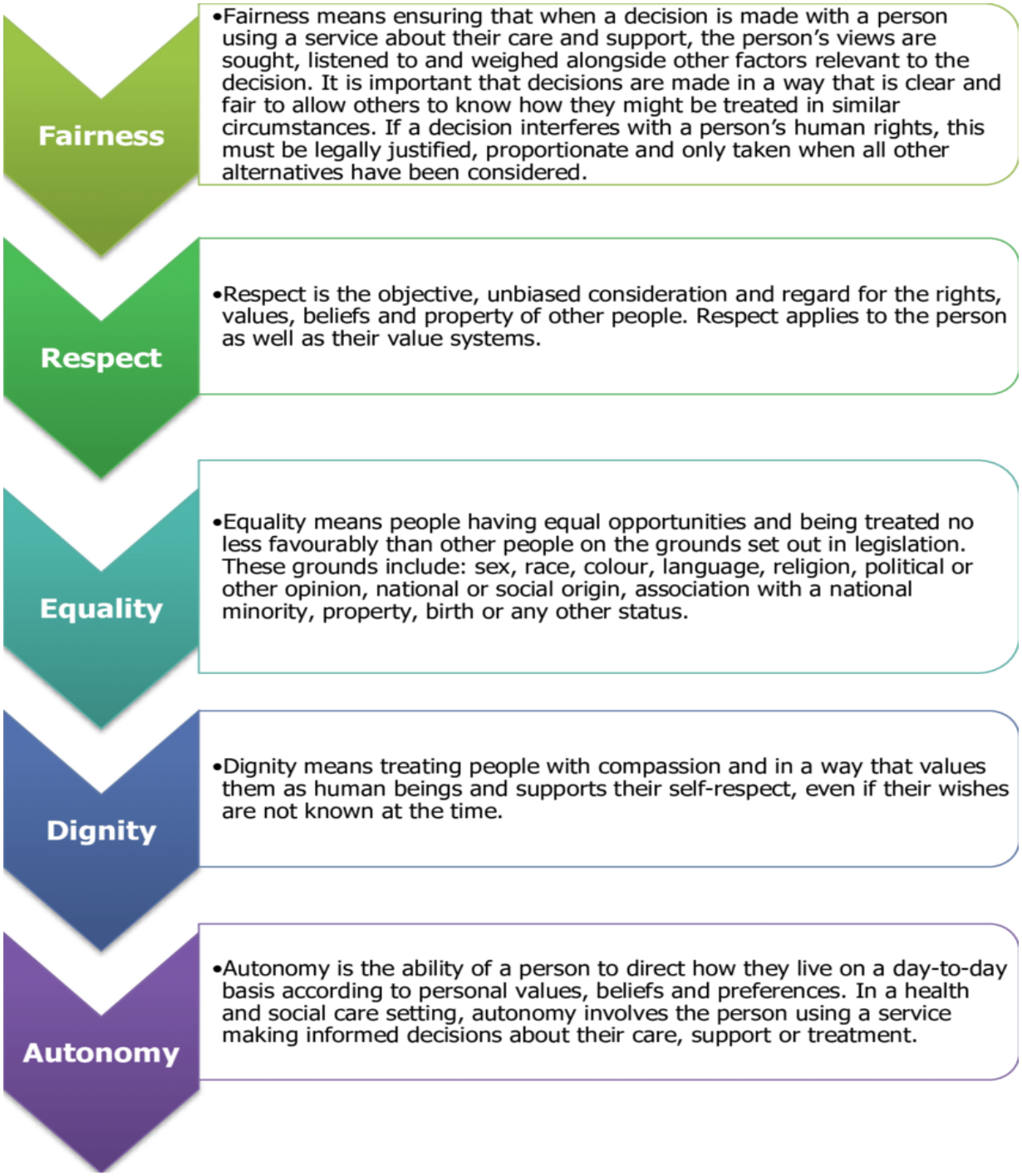
6.12. Health and social care organisations are corporately responsible for creating the circumstances which ensure that staff understand and apply human rights laws and for ensuring that the human rights of everyone who uses their services are upheld. All organisations should ensure that all policy and practice are compatible with the relevant human rights instruments[lix].

FREDA Principles

6.13. A rights-based approach can be achieved by applying the FREDA Principles, the core values that shape practice and which underpin the articles in the human rights frameworks.

6.14. The FREDA Principles are the basis of good health and social care which should be used mutually and individually to inform decision making, supported by inclusive communication strategies. They are a useful guide for health and social care staff to ensure that everyone for whom they are providing care, treatment, support and/or services is:

- Treated with dignity and respect;
- Provided with care which best suits their individual needs;
- Able to live free from abuse, neglect or discrimination;
- Able to participate in the choices and decisions made about their lives;



6.15. Whilst the principal components of a rights-based approach are modelling the core values in the FREDA principles to support the fulfilment of an individual's human rights, there are other elements that are essential in the realisation of a rights-based approach.

Working within a Legislative Framework

6.16. Restrictive interventions must only be used within a relevant legislative framework. All health and social care professionals must be familiar with the laws which are

relevant, to them, their area of practice and their organisation. This protects the individual, staff and the organisation.

6.17. The use of legislative frameworks allows staff to make reasonable and proportionate decisions regarding the use of restrictive interventions. It is important that the justification process is reflective and inclusive of legal, professional and ethical considerations. Organisations must provide the necessary mechanisms, supports and environments to ensure employees can operate within all relevant legislative requirements.

6.18. This includes understanding that every starting point in decision making regarding care, support and treatment is presuming that every adult can make that decision independently (given the correct support to do so where needed), and that the person can provide or withhold consent to that care, support or treatment. This is a foundation step in a rights-based approach to service delivery, putting the person at the centre of the decision-making process.

6.19. Continuing with a restrictive intervention in the situation where a capacitous person withholds consent can only happen in circumstances permitted by the Mental Health (Northern Ireland) Order, 1986, a High Court Declaratory Order or in response to an immediate risk of harm to a person or others around them using the common law Doctrine of Necessity.

6.20. In the situation where a person aged over 16 years has been assessed as lacking the capacity to independently make decisions regarding care, support or treatment, (and if detention for care and treatment in a hospital in accordance with the Mental Health Order does not apply) the Mental Capacity Act (Northern Ireland) 2016 sets out the requirements in terms of lawful deprivation of liberty with all other decisions requiring collective “best interests’” discussions and agreements.

6.21. An adult with parental responsibility can provide consent for a child. In addition to the legislation above, The Children (Northern Ireland) Order 1995, The Children (Secure Accommodation) Regulations (Northern Ireland) 1996, The Age of Majority Act (Northern Ireland) 1995 as well as Gillick Competence principles must be considered relating to decisions involving children.

6.22. As noted at 5.64, there is no such thing as consenting to deprivation of liberty. For a young person aged 16-17, where legislation permits a parent or the State with parental responsibility to provide consent for care and treatment, health and social care staff and organisations must be aware that this does not extend to consenting to deprivation of liberty[lx].

6.23. The situation is less clear for those under 16 years of age. However, in the absence of any definitive Court ruling, where a legal process exists, for example, the Mental Health Order or The Children Order, it is advisable to use the legal process to ensure the child or young person has access to the safeguards within the processes that protect their rights.

6.24. In all circumstances, adherence to a rights-based approach to minimising the use of restrictive interventions will be achieved through the routine use of the *Three Steps to Positive Practice Framework*.

6.25. A list of relevant legislation is provided at Appendix 9. Whilst this is a wide-ranging list, it may not be exhaustive. Health and social care staff may be aware of other legislation that may be applicable to their practice and/or where they deliver their service.

6.26. It is vital that organisations and individual staff work to the legislative framework applicable to their service delivery and practices at any particular time and be aware of and responsive to changes in relevant legislation.

Staff Support

6.27. Even when a decision to implement a restrictive intervention is the last resort, lawful, ethical and in a person's best interests, staff involved can find the implementation of restrictive practices morally and emotionally challenging. Witnessing or being directly involved in a restrictive practice could contribute to work-related stress.

6.28. The Three Steps to Positive Practice includes "reflection" as a supportive mechanism for staff within the Framework and must be considered as important and essential as every other part of the process. There are various evidence-based methodologies to guide this type of activity, for example, structured de-briefing. Structured de-briefing (which has been included as a requirement within the operational procedure for use of seclusion) provides emotional and educational support immediately following incidences of behaviours that challenge and can contribute to the reduced use of restrictive practices. However, those involved should be mindful that the process of discussing incidences in which restrictive practices have been used may be traumatic for both person subject to the intervention and the staff involved or witnessing the event. Organisations must ensure that opportunities for supportive discussions and reflection for individuals and teams are provided as standard, with other pastoral type support available where an individual member of staff might require additional support.

Advocacy

6.29. Advocacy in all its forms seeks to ensure that people can have their voice heard. Organisations should involve an independent advocate in all "best interests" decision-making processes, particularly where a restrictive practice is proposed, if there is an advocate available. For those unable to articulate their views about their care, support and treatment for whatever reason advocacy can be an important method by which a person can be considered and protected in what might be quite complex decision making about how they live their lives and how their care is provided. This is an essential element of a rights-based approach.

Provision of Appropriate Training

6.30. Organisations providing services where people's behaviours can present as a risk, have at times a challenging job that requires a specialised skill set to balance risk, welfare and safety. Training that includes any form of restrictive intervention has potential risks associated and is distressing for everyone involved.

6.31. For this reason, organisations must ensure that the training delivered to staff in the management of such behaviours is accredited and provided by a certified training body. The content must provide training models which are strong on proactive and preventative strategies, human rights-based interventions, and embrace the monitoring, oversight and assurance required in relation to restrictive practices. This approach minimises the use of restrictive practices and creates and maintains a positive and enabling service delivery culture beyond the application of physical restraint or other restrictive interventions.

6.32. Organisations and line managers are responsible for continual assessment of staff competence.

6.33. Education providers are expected to incorporate the principles in this policy into all pre-registration courses preparing future health and social care practitioners.

Co-Production

6.34. Working in partnership is about realising value through people; identifying and using their different skills, experience, and expertise and working supportively and collaboratively to deliver improved outcomes and experiences of health and social care by being part of designing, planning and delivering those improvements.[lxi]

6.35. Crucially, it is also about providing a direct link to the co-design, co-production and co-delivery of services, at strategic level, so those improvements can be embedded and cascaded to benefit everyone in Northern Ireland.

6.36. By connecting those providing health and social care, those with lived experience of care, their families and carers, staff, policy makers and local communities in the planning, delivery and evaluation of healthcare services, people will truly be at the heart of making decisions and choices about services. Doing so supports people to receive the service they want and need with better outcomes and enables service providers to deliver better quality, more targeted health and social care provision.

7 Standard 3 – Effective and person-centred communication must be central to care and treatment planning.

7.1 Inclusive, effective and person-centred communication must be central to care and treatment planning. Inclusive or total communication means sharing information in a way that everybody can understand.[lxii] A person centred approach to communication is a commitment to include a person in all aspects of their care, to gain an understanding of who they are and how to support them best,[lxiii] promoting proactive and ethical methods of reactive and ethical restrictive interventions.[lxiv]

7.2. The Royal College of Speech and Language Therapists has developed a set of practice standards[lxv] that describe what "good communication" looks like, with supporting references and resources. Whilst these were developed in the first instance to support inclusive and effective communication for people with learning disability and autism, they are equally applicable and supportive for anyone who experiences speech, language or communication challenges. Organisations should use the standards to shape their communication policies and practice.

Standard 1 There is a detailed description of how best to communicate with individuals.	In order to communicate effectively it is essential that everyone understands and values an individual's speech, language and communication needs. Individuals should be supported and involved, together with the people who know them best, to develop a rich description of the best ways to interact together. This description needs to be agreed, active, regularly updated and readily available. The description is sometimes referred to as a communication passport, guideline or profile. It includes the best ways of supporting their understanding and expression, the best methods of promoting interaction and involvement and describes 'how to be with someone'
Standard 2 Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.	Individuals with speech, language and communication needs are often either excluded from patient experience feedback processes or included in a tokenistic way. There is a risk that their needs and opinions are assumed, misinterpreted or ignored. All communication needs to be inclusive. For service providers, this means making sure they recognise that people understand and express themselves in different ways. For individuals this means getting information and expressing themselves in ways that meet their needs[lxvi]. Inclusive Communication is an approach that seeks to 'create a supportive and effective communication environment, using every available means of communication to understand and be understood'.[lxvii] For services to demonstrate inclusion and involvement innovative and creative solutions to understanding the views of individuals are often required due to the nature of communication needs.
Standard 3	Staff working in specialist hospital and residential services must recognise communication difficulties. They must

Staff value and competently use the best approaches to communication with each individual they support.	understand that they need to change their communication style to support the service user and have the knowledge and skills to adapt their communication levels, styles and methods. Staff are aware of factors that impact on communication, especially hearing, sight and sensory integration. They understand that what they say and how they say it matters and can impact positively or negatively on the individual. Staff also understand how good communication underpins informed consent and capacity. They are able to promote the individual's understanding and expression and create opportunities for positive communication.
Standard 4 Services create opportunities, relationships and environments that make individuals want to communicate.	An understanding, welcoming and socially rich environment is fundamental to relationships for all individuals, and particularly people with communication needs. Relationships are central to wellbeing. Getting the communication environment right will contribute to enabling people to live valued and meaningful lives. Individuals need to have the opportunity to communicate about all the things that all people talk about in everyday life such as dreams, hopes, fears, choices as well as everyday wants and needs. Good communication needs to be considered broadly. It is about social interactions – greetings, sharing stories and fun. It is the quality of interaction that contributes to overall emotional and mental wellbeing; providing a sense of belonging, involvement and inclusion. Interaction may not necessarily involve speech. For someone without formal language, interactive approaches are a way of 'being' with another person, making meaningful contact with those who are hard to reach or easy to ignore. It may be about very basic early developmental interaction and communication and relationship building.
Standard 5 Individuals are supported to understand and express their needs in relation to their health and wellbeing.	It is essential to consider communication needs in order to support individuals with their health. Arriving at a diagnosis can prove difficult if a person cannot describe signs and symptoms easily, or their behaviour is misunderstood and misconstrued. Staff need to be aware of how individuals communicate about their health and how they show that they are in pain. This includes considering ill health as a cause for changes in behaviour. Knowing how much a person can understand is also essential in making a decision about their capacity to have a health treatment. It is also required to meet the principles of nursing practice that everyone can expect[lxviii]. This includes treating individuals with compassion and dignity and providing person-centred care.

Key Themes underpinning inclusive, effective and person-centred communication

7.3. Inclusive and effective communication is a key element within an organisational restrictive practice minimisation strategy, centred on collaborative relationships.

7.4. Transparent and trusting relationships support the foundation for effective communication sharing and being able to support a person and their families to be part of their care and treatment. Use of independent advocacy will be an important support for a person in articulating their views for planning their care and treatment. Relationships based on transparency and openness can address the power imbalance so often felt by people dependent on service provision.

7.5. This is especially important in terms of sharing of information[lxix]. Sharing of information between the members of the interdisciplinary team and the person's wider support system is to be expected in pursuit of positive outcomes for the person. However, a balance required with respect to what information can or should be shared with others regarding the person's care and treatment – balancing confidentiality and right to privacy in any communication seeking to develop care and treatment plans with those who know the person best.

7.6. Professionals must also remember that their professional registrations and “Codes of Conduct” require a professional duty of candour, regardless of any potential future statutory requirement.

7.7. A Partnership approach to care and wellbeing is vital. It underpins a rights-based approach, further developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected. The organisational ethos must be one of leading from the top and by example where policies, procedures and management of practice sets out a co-production approach as an organisational value.

7.8. How communication happens is important. Those with speech, language or communication needs (SLCN) require services and processes to be inclusive and accessible to enable full participation in all decision making. People with SLCN may need support to make decisions. Their needs must be considered in terms of how they communicate/understand and what support is required to promote involvement and empowerment. This will include those who know the person best – possibly a family member, or someone who works closely with them, as well as the possible need for specialist professional staff for example, nursing staff, speech and language therapy staff, psychology staff and other allied health professional staff. It is a potential breach of a person’s human rights if staff are unable to communicate in a way that the person understands.

7.9. Staff must be appropriately trained in a range of communication methods and inclusive communication strategies to ensure that the people that they care for are understood. For some individuals, the fluctuating nature of communication must be acknowledged and recognised, supporting flexibility whereby staff can adapt to meet the needs of the person. Effective communication skills and identifying a person’s needs are vital in supporting them and preventing situations escalating to the point where restrictive interventions, restraint or seclusion is required.

7.10. This may include identifying barriers to effective and inclusive communications, such as sensory impairment or the need for translation.

7.11. This also includes proverbial communication training (voice, tone, pace) which supports a trauma informed approach to care delivery and the use of de-escalation techniques which consist of a variety of psychosocial techniques, aiming to reduce disruptive and/or behaviours of concern and risk using verbal and non-verbal communication skills.

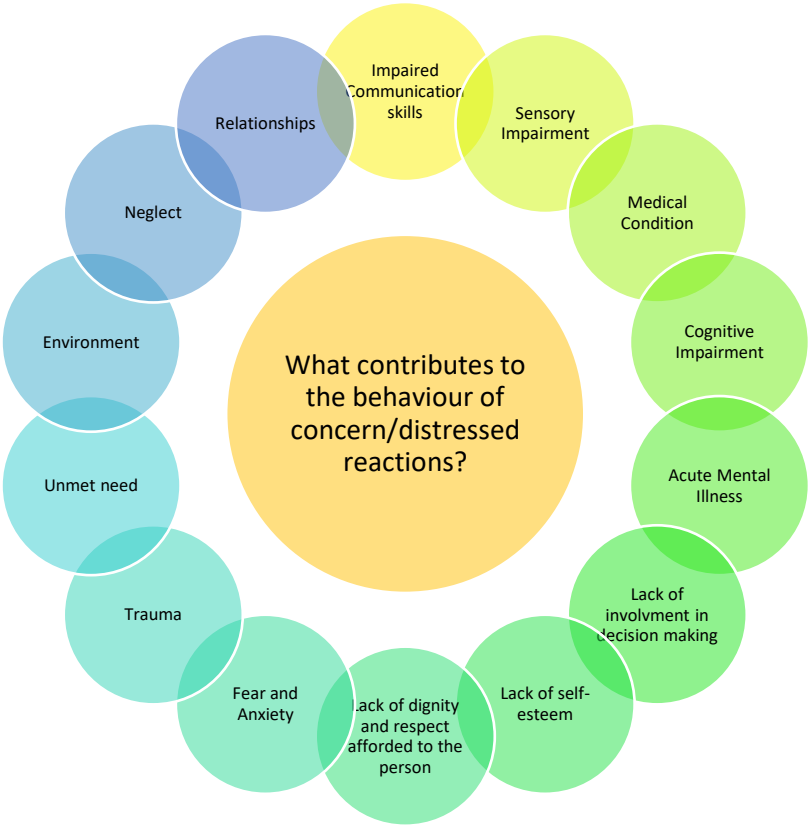
7.12. Organisations should recognise when additional staff training is required, with access to and use of appropriate communication support tools which assist staff to facilitate effective communication. Behaviours of concern and distressed reactions are communicating something; therefore, it is essential that people are helped to communicate in a way that is supportive and as safe as possible– physically and psychologically.

8 Standard 4 – Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans

8.1. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans. All organisations must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that support a better quality of life.

8.2. Using positive, proactive and preventative evidence-based strategies will support working towards reducing reliance on reactive and restrictive interventions[lxx]. This is a crucial component of a rights based, person centred approach, steering the organisational drive to minimise the use of restrictive interventions, restraint and seclusion, and must be reflected in organisational policy through to individual practice.[lxxi lxxii lxxiii lxxiv]

8.3. The key to establishing positive and proactive approaches is the need for health and social care staff to understand the reason and meaning behind behaviour. This will include areas such as environment, understanding history, and understanding family support and family dynamics, which could be influencing or contributing to how or why an individual behaves in a particular way.



8.4. Positive and proactive interventions assist the development of a therapeutic relationship between health and social care staff and those that they care for. The establishment of a therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

8.5. Underpinning positive, proactive and preventative approaches requires:

8.6. Proactive strategies may include:

- Incorporated meaningful activities.
- Promoting mental health and well-being.
- Promoting outdoor activity to support good mental and physical well-being.
- Promoting engagement using structured daily activities and routine.
- The removal of precipitating factors such as changes within the environment.

- Promoting the use of an environment and strategies to support the person to develop alternative behaviour patterns to support their needs.

- Use of communication aids to support identification and understanding of the person's needs[lxxv].

- Respecting culture and ethnicity.

- Working in partnership, ensuring that people (where capable) are involved in decision making around their care and treatment.

8.7. Creating a therapeutic culture and environment is key in supporting a person who may display a behaviour of concern and/or a distressed reaction which presents as a risk towards themselves and/or others. Staff must consider the physical environment, in addition to other external environmental factors, when thinking about proactive and preventative strategies to support the person.[lxxvi]

8.8. Preventative strategies may include:

- Use of relaxation.

- Individual personalised therapeutic activities/routines to promote wellbeing and behaviours and reduce avoid the need for a restrictive practice.

- Offering opportunity to discuss thoughts/feelings.

- Supportive approach – communicating in a way that suits the individual person and their needs.

- Environmental cues, optimal use of lighting, colour, contrast, signage, noise reduction, or stimulation as preferred by the individual, temperature, space and the ability to walk and explore freely but safely, other people.

- Timely access to specialist assessment and comprehensive, evidence-based treatment.

8.9. Providing person centred care is essential to the development of care and treatment plans. In order to provide good quality care and support to a person, it is important that all professionals are able to work together in partnership with the person, and their families and/or carers identified as partners in care, to ensure respect and dignity is afforded to everyone involved.

8.10. Cognisance of preventative and proactive measures in care and support provision are critical to the application of a rights-based approach in all health and social care settings. In order to ensure this is threaded throughout all policy and practice proactive measures must be considered in advance of any decision making regarding the planning and implementation of care, treatment and support plans. This requires staff, teams and services to define proactive measures several steps

back in any organisational and service delivery planning or decision-making processes.

8.11. Staff must be aware of the accumulative impact of a number of separate restrictive interventions, the potential for physical and psychological risks to the person, as well as unintended consequences of any restrictive practice.

8.12. When health and care needs are appropriately assessed and met, crises are rare. Analysing behaviours to identify antecedents and anticipating an individual's needs, including any current or potential behaviours of concern or risk assessments, should initiate discussion around proactive steps in care, treatment and support that are likely to reduce or prevent any need for consideration or use of restrictive practices. Where required, for those with SLCN challenges, specialist assessment and support by speech and language therapy services may be necessary.

9 Standard 5 – Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content

9.1 All organisations must follow a minimum policy content format in relevant policy documents that includes details of the organisational strategy for minimising the use of restrictive interventions. Language used must be free from jargon and accessible to all age groups and abilities. Terminology must be regionally standardised.

9.2 People using health and social care services have a legitimate expectation of consistent treatment and application of approaches, particularly those who might move between different settings. Scope for differing interpretation is unfair and potentially detrimental. Therefore, a consistent approach in all aspects of application of this policy and, in particular, setting the context for practice, implementation and oversight in local and organisational policy, is important in articulating the wider principles and values that people should expect and indeed be in receipt of, from health and social care provision.

9.3 All organisations must have clear vision, values and philosophy that demonstrate how they aim to eliminate, where possible, or minimise the use of restrictive interventions within services. Any restrictive practice elimination/minimisation programme should address leadership, the use of data to inform practice, specific reduction tools, development of the workforce, and use of models for post incident review

9.4 It is important there are mechanisms by which organisations can produce evidence demonstrating the steps have been taken within the service to eliminate or minimise restrictive interventions.

9.5 Local and organisational policy frameworks should be co-produced and must include as a minimum:

- the organisational values that underpin the approach to minimising restrictive interventions;
- the detail of the organisational vision and strategy for minimising restrictive interventions;
- details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability;
- communication requirements and strategies;
- standard definitions;
- clear professional/clinical guidance;
- reference to working within current legislative frameworks and professional registration requirements;

- an emphasis on positive, proactive, preventative and evidence-based interventions and strategies;

- how the Three Steps to Positive Practice Framework as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised;

- details of accredited training required, including training required for specific interventions;

- details of interfaces with other regional and local policies, agreed protocols and any associated requirements;

- reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy, ensuring alignment with the UK Data Protection Act 2018 (DPA18) & the General Data Protection Regulations (UK GDPR));

- support mechanisms for those who are subject to restrictive interventions; and

- support mechanisms for staff who restrict, restrain and/or seclude those in their care.

10 Standard 6 – Roles and responsibilities are defined in terms of monitoring, reporting and governance

10.1 Each organisation must define roles and responsibilities within their restrictive practice minimisation strategies in terms of monitoring, reporting and governance.

10.2 A total organisational approach is required in the minimisation of restrictive interventions at the organisational level[lxxvii]. A regional approach is also required to understand behaviours and responses, the impact of those responses with analysis of that understanding underpinning actions required to minimise use of restrictive interventions.

Roles and Responsibilities

Department of Health (DoH)

10.3 The Department of Health (DoH) is responsible for setting regional policy and holding overall accountability for regional minimisation of restrictive practices, restraint and seclusion.

Strategic Performance and Planning Group (SPPG)

10.4 The Strategic Performance and Planning Group (SPPG) in DoH is responsible for monitoring the effectiveness of Health and Social Care Trust (HSCT) strategies in minimising the use of restrictive practices, restraint and seclusion.

10.5 SPPG must appoint a relevant Director who is responsible for:

- Agreeing the structures for reporting data and supporting narrative with Trusts and non-statutory provider organisations to ensure that the requirements of this regional policy can be produced in the format that facilitates both organisational and regional information across all relevant services;
- Agreeing the detail of data to be collected and format for reporting (in line with the Information Commissioner's Office guidance for data sharing)[lxxviii] , ensuring consistency across statutory and non-statutory provider organisations, with particular reference to agreeing terminology;
- Providing assurances regarding robust incident specific review and analysis of use of prolonged physical restraint, rapid tranquillisation and seclusion (and any incidents that amount to seclusion); and
- Providing a monitoring and assurance report on behalf of the Department of Health on an annual basis regarding the effectiveness of Trust strategies in minimising the use of restrictive practices, restraint and seclusion.

Provider Organisations – Health and Social Care Trusts (HSCTs)

10.6 Each Health and Social Care Trust is responsible for approving their evidence-based and co-produced restrictive practices minimisation strategy.

10.7 Each HSCT must appoint an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.

10.8 The Director is responsible for:

- Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;
- Developing the required policy and embedding the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to mitigate against any recurrence;
- Oversight of assurances provided by non-statutory services regarding minimisation of the use of restrictive practices; and
- Preparation and submission of six-monthly assurance reports with monitoring data to SPPG.

Provider Organisations – Non-Statutory Provider Organisations

10.9 This policy cannot make requirements on non-statutory organisations. However, this policy provides non-statutory best practice recommendations:

- Non statutory provider organisations should appoint an identified health and social care Director /Senior Manager who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.
- The identified Director /Senior Manager is responsible for:
    - Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;

- Developing the required policy and embed the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to avoid any recurrence; and
- Providing reports where required to commissioning HSCTs and RQIA.

Regulation and Quality Improvement Authority (RQIA)

10.10 RQIA will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order, 2003, Mental Health (Northern Ireland) Order, 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This includes reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

Monitoring

Incident by Incident Review

10.11 Management of incidents that carry significant risk must be subject to incident-by-incident review (which should not be confused with de-briefing) no longer than 72[lxxix] hours after the incident to establish learning and promotion of preventative strategies in the work towards minimisation of restrictive interventions.

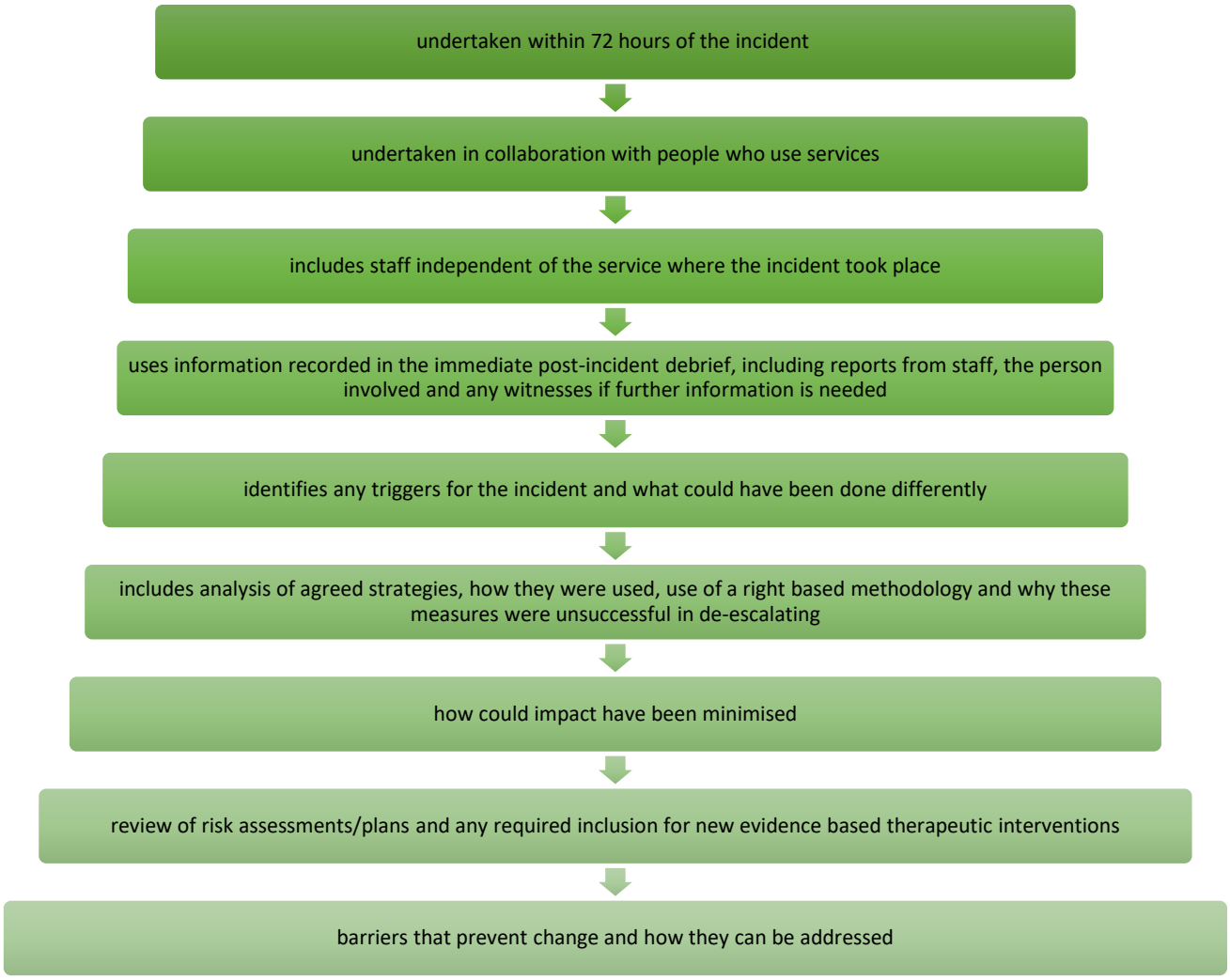
10.12 This includes incidents of: [lxxx]

- prolonged physical restraint;
- rapid tranquillisation;
- seclusion; and
- any incident that amounts to seclusion.

10.13 The use of a formal incident-by-incident review process is important in identifying the causes of the incident and the impact on all those involved. Doing so will create

learning for prevention of further incidents, improvements in an individual's care plan and safety improvements for all.

10.14 Incident by incident review considerations:



Restrictive Practice Register

10.15 All organisations must retain restrictive practice registers at local service level, maintained and reviewed by the local service manager.

10.16 The register must provide a current overview of the number and type of restrictive interventions in use within a service, supporting the link from local minimisation actions to the overall organisational strategy.

Leading Positive Practice

10.17 Organisations may wish to consider adopting a “Positive Practice Champion” role (smaller organisations), or “Positive Practice Teams” (larger organisations).

10.18 The Champion or Team is key in supporting the organisation’s minimisation strategy at service delivery level to produce better outcomes for people. This may include:

- assisting and contributing to the detail of minimisation strategy and implementation plans;
- supporting the implementation of minimisation plans, monitoring effectiveness and value to the individual, the service and the organisation;
- undertaking audit of practice in line with minimisation strategy and plans;
- advising on policy content, communication strategies, terminology and language;
- advising and supporting quality improvement initiatives for minimisation of restrictive interventions;
- supporting de-brief and review processes;
- undertaking training needs analysis;
- contributing to data analysis; and
- producing data reports, quality assessment reports, quality improvement recommendations.

Learning for Improvement

10.19 Learning for improvement in safety and quality is essential – for individuals, for services and for the system as a whole. The Public Health Agency through its safety and quality functions, is responsible for supporting analysis of incident reporting for purposes of learning and service improvement and developing regional quality improvement initiatives informed by that data analysis and learning.

11 Standard 7 – Any use of seclusion as a last resort intervention must follow the regional operating procedures

11.1 Seclusion is the confinement of a person in a room or area from which free exit is prevented.

Purpose

11.2 The operating procedure set out below provides the requirements for all health and social care organisations for the use of seclusion. HSC Trusts must follow this procedure.

Scope

11.3 Seclusion is an intervention of **last resort**. Seclusion must only be used in hospitals in a room or area that has been specifically designed for that purpose.

11.4 The designated room or area that has been specifically designed for the use of seclusion must not be used for any other purpose.

11.5 Seclusion can only be used where a person is (or liable to be) detained in hospital within an appropriate legal framework.

11.6 Seclusion can never be voluntary or consented to. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances where they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person "consenting" to seclusion and does not provide legal protection for seclusion. Expressed preferences may be part of care planning and may form part of an advance statement. This does not provide legal authority but should be considered by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

Responsibilities, Accountabilities, Duties

Chief Executive

11.7 The Chief Executive of each organisation is responsible for:

- Ensuring that there is a policy in place that governs the safe use of seclusion, which all staff have access to.
- Ensuring the ethos of *last resort* and *least restrictive* is embedded within organisational culture to work towards the minimisation of restrictive interventions.

Directors

11.8 The Directors of relevant areas are responsible for:

- Ensuring that all staff are aware and compliant in the delivery of the seclusion operating procedures.
- Ensuring that any local level procedures are reflective of the ethos outlined within the regional seclusion operating procedures.
- Ensuring that all episodes of seclusion are documented and recorded appropriately.
- Ensuring that all staff are appropriately equipped with knowledge and skills required in understanding and managing incidents of crisis behaviour/acute behavioural disturbance that may require seclusion.
- Ensuring that all incidents of seclusion are appropriately governed/audited in line with individual organisational procedures.

Service Specific Lead Nurse/Social Worker

11.9 Service Specific Lead Nurses/Social Workers are responsible for:

- Completion of a training needs analysis and overseeing training for seclusion awareness and any other relevant training needs (including Deprivation of Liberty Safeguards, Mental Health (NI) Order 1986, Human Rights etc.), and ensuring training is accessible for all staff.

Service Manager/Assistant Service Manager

11.10 Service Managers/Assistant Service Managers are responsible for:

- Monitoring overall compliance with the policy.
- Ensuring that all staff who require the training have access to it.
- Ensuring that clear systems for reviewing those who require seclusion and recording are in place.

Inter-disciplinary Team (IDT)

11.11 All Inter-Disciplinary Team staff are responsible for:

- Being aware of the policy and being compliant in the delivery of the operating procedures

- Ensuring that an IDT approach is taken in reviewing, developing and updating treatment plans and risk assessments.

- Ensuring that there is clear communication and regular incident reviews as per NICE guidelines.

Line managers

11.12 Line managers are responsible for:

- Ensuring that mechanisms are in place so that all staff are aware of the policy and are compliant in the delivery of operational procedures.

- Ensuring that all staff attend mandatory training which includes seclusion operating procedures.

- Promoting an ethos of human rights-based approach where staff are committed to protecting the rights of those they care for and treating them with dignity and respect.

- Ongoing monitoring and review of working practices regarding seclusion operating procedures.

- Where possible ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

All staff

11.13 All staff are responsible for:

- Complying with the operational procedures.

- Reporting any untoward incidents regarding seclusion in line with organisational safeguarding procedures and incident reporting procedures.

- Ensuring that any episode of seclusion is documented and recorded appropriately.

- Working with people in line with a human rights-based approach.

- Having an understanding of integrated experience – the understanding of the potential impact of their behaviour towards people in their care and how this can affect the behaviour of others, becoming a precipitating factor.

- Where possible, ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

- Ensuring care plans and risk assessments being kept up to date.

- Organisational policies must be referred to and contact should be made (where or if required) with the relevant organisation's training team for support and guidance on the management of a person presenting with unmanageable risk and/or supporting transition of the person to designated seclusion room.

Procedure for Seclusion

Use of seclusion

11.14 There are several factors that need to be considered with regards to the use of seclusion.

11.15 Seclusion can cause psychological harm with no definitive evidence that it has any therapeutic benefit. The use of seclusion can often be seen as negative and a non-therapeutic experience, with potentially harmful physical and psychological effects. The effectiveness and adverse effects of seclusion and restraint seem to be similar, although the evidence base for both is limited.

11.16 Seclusion must only be used in an emergency in response to an unmanageable risk of harm to others where other responses have been deemed insufficient. However, seclusion may form part of a patient's care plan for use in emergency situations.

11.17 In the absence of clinical guidance to review every potential situation that may arise, any interventions regarding the use of seclusion will be based on clinical judgement by the relevant nursing and medical staff who are involved. All interventions regarding the use of seclusion must be a last resort option that is proportionate and justifiable to the presenting risk.

11.18 Seclusion might be used as an alternative to physical restraint or rapid tranquillisation. The factors influencing this will be specific to the individual and situation, and the individual's preference should be determined as soon as possible.

11.19 The use of seclusion for a person not detained in accordance with a relevant legal framework will necessitate a review of their legal status with a view to legal detention. Seclusion, outside of an emergency, is unacceptable, potentially unlawful and in breach of human rights and could be considered as a crime as result of false imprisonment of the person.

11.20 Seclusion should **not** be used:

- Where there is a risk of suicide.
- Where a person is engaging in self-harm or there is evident risk of serious self-harm.
- Due to a lack of resources to manage an incident where the person is displaying risk behaviour.

- As a punitive action.
- As part of a treatment plan – unless the person has completed an advance statement expressing their wishes/preference.
- Where mechanical restraint is also in use.
- Where a person has a pre-existing condition that staff are aware of and where care plan documentation indicates seclusion should not be used.

Seclusion Room

11.21 Seclusion should only occur in a room or area designed specifically for that purpose.[lxxxi,lxxxii,lxxxiii]

11.22 Seclusion room specifics:

- The construction of the room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, window, doors and locks.
- There should be no:
  - ligature points;
  - access to electrical fixtures that could pose a risk of harm.
- There must be an anti-barricade door system.
- The room must allow for staff to be able to clearly observe and hear the person within the designated room.
- The designated room should be in an area free from others but not isolated.
- The person in seclusion must be able to have a clear view of the outside environment but those on the outside must not be able to have any view of the person within seclusion.
- The room must be large enough to support the person and team of staff (who may be) required to use physical interventions during transition to seclusion.
- Adequate lighting must be provided, in particular a window in order to provide natural light. Lighting should be able to be controlled both by the person within seclusion and those external.
- The room must be equipped with adequate temperature and ventilation system with heat sensor for effective monitoring.
- The room must be decorated in a calming manner that appears non-threatening to the person.

- The room must be kept clean and fresh.
- The room must have direct access to washing and toilet facilities.
- The room must be safe and secure.
- There must be a visible clock.
- There should be limited furnishings. Any furnishings must be as safe as possible and must not include anything that could potentially cause harm. Furnishing must be comfortable and in good condition.

11.23 To ensure that the designated seclusion room or suite is maintained appropriately, all organisations should ensure the following mechanisms are in place:

- Weekly maintenance check (see Appendix 1).
- Ensure the designated room remains locked at all other times when not in use.
- Is part of routine cleaning schedules (in situations where the room requires deep clean, each organisation should follow individual IPC procedures and set out interim guidance for management of the person should seclusion require early termination to facilitate deep cleaning).
- Ensure that only appropriate equipment i.e. soft furnishings are kept within the designated room/suite.

11.24 If at any stage there is requirement for maintenance work to be carried out, then each organisation should ensure that there is interim plan in place for management of a person in an emergency situation where there is deemed unmanageable risk and ensure that all staff are aware of the interim arrangements.

Commencement of Seclusion

Decision to seclude

11.25 Seclusion should only ever be used as an emergency intervention.

11.26 The use of seclusion must always be a reasonable and proportionate response to the level of risk shown and where decision making clearly shows that there has been consideration to the use of other restrictive interventions. Decision making might reflect the use of seclusion as a safer alternative than prolonged restraint or the use of medication.

11.27 The decision to seclude a person is based on clinical professional judgement regarding knowledge of the patient and potential unmanageable risk towards others.

11.28 The person making the decision to seclude should be:

- The nurse in charge of the team providing the person's care at the time of seclusion;

OR

- A doctor with responsibility for the care of the person or the duty doctor on call.

11.29 The person making the decision to seclude should ensure that:

- There is an appropriate legal framework in place;
- They have seen the person immediately before seclusion commences;
- They have consulted with the team providing the person's care at the time of seclusion;
- They are familiar with relevant aspects of the person's healthcare records (e.g. risk assessment) as far as possible;
- They are aware of the person's advance wishes in relation to what should happen in an emergency, as far as possible;
- The intervention is necessary, appropriate and can happen safely, and that reasonable alternatives have been considered;
- The necessary observation and review can take place to monitor the person's physical and mental wellbeing; and
- Where required, individual organisation search policies are adhered to, if there are concerns about any items that a person may have.

Review Process

11.30 There are a number of review processes which should be commenced as soon as a period of seclusion is initiated.

11.31 All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Roles and Responsibilities

Medical staff

11.32 Medical reviews must be carried out in person and must include the following:

- Assess and review the need for seclusion period to continue;
- Review mental and physical health;
- Review level of risk towards others;
- Review level of observations;
- Review potential risk to self; and
- Review prescribed medication and consider/assess any potential adverse effects of medication.

11.33 If a doctor was involved in the decision to seclude then their assessment at the time seclusion was commenced will be considered as the first medical review and they will not be required to complete a separate first medical review.

11.34 If a doctor was not involved in the decision to seclude then they must be notified to attend immediately to undertake the first medical review. The first review should take priority over routine tasks or any of those which are anticipated to cause further delay. Any potential delay should be discussed with the Consultant Psychiatrist on call, to ensure that any delays are considered reasonable and justifiable.

11.35 Where the seclusion period is so short that the doctor does not visit before termination then this must be recorded on the seclusion care plan and within the person's care record.

11.36 Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review.

11.37 A medical review should be undertaken by the Consultant Psychiatrist at least once in every 24-hour period.

11.38 Medical staff must complete an individualised seclusion care plan in partnership with nursing staff and provide input following the review process.

11.39 The outcome of the medical review must be documented in the person's care record.

Senior Management

11.40 Senior management staff will be contacted by nursing staff to inform them of the commencement of a period of seclusion.

11.41 The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of the report and any other information or advice provided. If the senior manager does not attend in person, the nurse in charge must document the detail of conversation and decisions agreed as per telephone

conversation. The senior manager should email confirmed details of the conversation and agreement reached to the nurse in charge as soon as possible

11.42 The senior manager should provide support and guidance to support the person within seclusion and staff involved in managing the period of seclusion.

11.43 The Senior Manager should discuss presentation, risks and agreed management plan with nurse in charge.

Nursing Staff

11.44 Nursing staff will contact and inform the multi-disciplinary team (who have caring responsibility for the person) of the commencement of a period of seclusion period as soon as possible, making a contemporaneous entry in the person's records. They will also contact the senior manager to inform them of the commencement of the period of seclusion.

11.45 The nurse in charge will complete a formal review of the on-going seclusion every one hour during the seclusion period to ascertain if there is an opportunity for seclusion to be terminated. If it is not yet safe to terminate seclusion, the nurse in charge will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.46 Every two hours, the nurse in charge will be accompanied by a registered nurse to ascertain if there is an opportunity for seclusion to be terminated. Ideally the second nurse should not be directly involved in the incident that led to a decision to seclude. If it is not yet safe to terminate seclusion, both nurses will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.47 Outcomes for the nursing reviews should be recorded contemporaneously in the person's care records.

11.48 Where a doctor fails to attend immediately, as requested, to complete the first medical review (where they were not a part of the initial decision to seclude) an incident form should be completed by the nurse in charge, for review by senior management.

11.49 The next of kin/significant others should be informed in a timely manner of the necessity for seclusion but in a considerate manner taking into account the time of day/night. Consent for sharing information should be clarified[lxxxiv].

Reviews of seclusion

Internal multi-disciplinary team review

11.50 An internal multi-disciplinary team review must include the patient, their doctor, nurse in charge, and other professionals who may usually be involved with the person. An initial review must be carried out as soon as practicable once the seclusion period commences.

11.51 An internal review must also take place once in every 24-hour period of continuous seclusion.

Independent multi-disciplinary team review

11.52 If a patient is secluded for more than 8 hours repeatedly or 12 hours over a period of 48 hours, there must be an independent review undertaken by professionals who were not involved in the incident that led to the period of seclusion or where part of the decision to commence the seclusion period. The review must include the patient, with a review team comprising of a doctor, nurse and other professionals, and an independent advocate.

11.53 Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing, then the independent review can make additional recommendations as appropriate to the seclusion care plan.

Recording and Documentation

11.54 Seclusion records must include as a minimum:

- Personal details of the person in seclusion;
- Date and time the seclusion commences;
- Decision to seclude the person, preceding incident(s) and other unsuccessful measures used to manage the situation (including use of physical intervention where required to support transition to seclusion room);
- If search procedure was required;
- Nurse in charge details;
- Details of doctor contacted;
- Details of senior manager (or others) contacted;
- Legal status of person – and any actions taken to review legal status;
- Date and time of termination of seclusion;

- Consent for information sharing with next of kin and / or family; and
- The Seclusion care plan.

11.55 A seclusion care plan must be completed as soon as the seclusion period commences. It must reflect the person-centred care needs of the person and record the actions that should be taken to end the period of seclusion in the shortest time possible.

11.56 A seclusion care plan must include as a minimum:

- Personal details;
- Known clinical needs (including mental and physical considerations);
- How de-escalation strategies will continue to be used;
- Outline actions towards termination of seclusion;
- Recognising signs where behaviour is no longer considered an unmanageable risk towards others, e.g. evidence of tension reduction, improved communication etc;
- How potential risks may be managed;
- Reference to individual care plans, support plans, behaviour support plans, sensory regulation strategies etc;
- Meeting of food/fluid needs;
- Meeting of needs in regard to personal hygiene/dressing;
- Meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
- Medication reviews (in consultation with a doctor or other as delegated);
- Monitoring of physical observations;
- Person’s views in regards to the seclusion process; and
- Information about informing next of kin and/or families as stated within individual support plans or as previously discussed in advance statements regarding emergency situations.

11.57 A template for a seclusion care plan is included in Annex B.

Observations

11.58 A registered nurse must observe and monitor the person and their action's whilst in the seclusion room and determine whether seclusion can be terminated.

11.59 The registered nurse may be outside the person's room (or in an adjacent room with a connecting window), provided that the person can fully see the registered nurse and can continuously observe and hear the person.

11.60 CCTV must not be used to replace continuous staff presence. CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room. The observing nurse should remain in the immediate vicinity (directly outside the seclusion room door) and be available to provide immediate (including discrete) observation and assessment at any stage during the seclusion period. Immediately after the commencement of the seclusion period, the person must be placed on 1:1 observation. **A registered nurse** must be delegated to undertake 1:1 observation of the person within the seclusion room, for the period of seclusion. The registered nurse must be exempt from undertaking other duties for the period of seclusion.

11.61 Observation of a person subject to seclusion involves a range of other professional and intricate competencies, including assessment, using clinical judgement, making clinical decisions, risk management, and, very importantly, the delivery of person centred and human rights-based care. Therefore 1:1 observation of a person in seclusion should be only undertaken by a registered nurse.

11.62 Consideration must be given to the registered nurse chosen to support the person in seclusion, and any potential impact on the person. This must be considered on an individual basis.

11.63 An observation record must be documented at a minimum of every 15 minutes; this can be reviewed based on clinical presentation and risk assessment.

11.64 The registered nurse completing the observations must monitor the following:

- Physical appearance and documenting any evidence of physical ill health such as shortness of breath, unusual facial pallor or potential cyanosis;
- Mental state presentation;
- What the person is doing or saying whilst in seclusion;
- Level of communication; and
- Level of alertness/awareness (particularly following administration of medication).

11.65 If medication has been administered prior to the person entering seclusion, with intent to subdue acute behavioural disturbance, individual organisational policies

(developed in line with regional guidelines) should be followed and the person should be observed in accordance with same.

11.66 It may be difficult at this time to complete full clinical monitoring and NEWS chart. As a minimum the registered nurse observing, should record:

- Person's respiration rate;
- Person's response to verbal or tactile stimulation;
- Person's level of movement;
- Person's level of awareness; and
- Any attempts to complete physical monitoring, whether successful or not, must be recorded.

11.67 Observing staff must have access to a personal alarm or call system should they need to seek urgent assistance in an emergency.

11.68 Handover between staff observing must be documented. Observing staff should be able to respond to a situation where patient safety becomes compromised i.e. self-injurious behaviour.

Care of the Person in Seclusion

11.69 During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that the person's privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Personal care/elimination/dressing needs

11.70 Seclusion rooms must have toilet and shower facilities.

11.71 Staff must be able to supply the person with toilet paper, hand soap, towels and other hygiene products as and when required.

11.72 If a person is in seclusion for a period prolonging 24 hours, they should be encouraged and, where required, assisted to meet their personal hygiene needs.

11.73 A persons' privacy and dignity must be maintained at all times throughout seclusion. Items of clothing must only be removed where there is potential for the person to use the items of clothing as ligatures and cause serious risk of harm to self.

11.74 Each individual organisation must consider the use of tear proof clothing should it be required.

Provision of food/fluids

11.75 The provision of food must not be denied to the person within seclusion. All meals and drinks must be provided as normal.

11.76 Crockery and utensil items that are considered safe to use i.e. plastic and non-metallic must be used.

11.77 All offers, acceptance and refusal of food and fluid items must be documented within the seclusion observation form and within the person's records.

Accessing seclusion room in planned or unplanned scenarios

11.78 Staff may at times be required to enter the seclusion room in planned/unplanned scenarios. Planned scenarios may include (but are not exhaustive to) facilitating reviews, supporting access to toilet/showering facilities, providing food/fluids or administering medication.

11.79 Unplanned scenarios may include (but are not exhaustive to) when the person's health, safety and wellbeing is compromised, deterioration in clinical presentation or engaging in risk behaviour where there is imminent risk to the person.

Administration of Rapid Tranquillisation whilst the person is in seclusion

11.80 There may be occasions where the person in seclusion may require the administration of medication via rapid tranquillisation. If required, staff should refer to the guidance within local policy and procedure, relevant best practice guidance and/or regional protocols.

11.81 Staff must be aware of potential side effects and be prepared to address any complications that may arise.

11.82 A registered nurse must observe the person within sight. A doctor and nurse in charge must review the seclusion care plan and associated risks and consider the termination of seclusion once rapid tranquillisation has had the desired effect.

11.83 If there is an identified risk to the person at any time, then the seclusion room must be entered at the earliest and safest opportunity.

11.84 In a scenario where staff are unable to clearly see the person within seclusion due to covering of the head or face, the observing staff member should encourage the person to remove the covering to maintain observations and also assess the person's clinical and physical presentation. If the person is non-communicative the observing staff member should seek immediate assistance and assess the need to enter the seclusion room. This will be a decision based on clinical judgement and the need to maintain safety of the person whilst in the seclusion room.

11.85 Any need for staff entry or exit of the seclusion room (outside of a response to an emergency) must be informed by careful application of specific skills learnt in training for managing situations where an individual presents with behaviour of concern/distressed behaviour.

Termination of Seclusion

11.86 Seclusion must be terminated at the earliest opportunity when it is assessed to no longer be required.

11.87 The seclusion care plan must detail safe management and support of the person on the ending of seclusion, and during reintegration of the person to the general ward setting within the hospital.

11.88 If the person is sleeping, then the risk is no longer immediate and unmanageable, and seclusion must be terminated. The continuation of observation if the person is sleeping will be based on clinical judgement of the situation at the time.

11.89 Opening of the seclusion room door in order to facilitate reviews, support access to toilet or showering facilities, provide food/fluids, administer medication does not constitute an end to seclusion.

Post Seclusion

11.90 Nursing staff will complete the documentation required for the seclusion period. The end of seclusion must be recorded in the observation record by the nurse in charge.

11.91 When seclusion is ended, a body chart must be completed. The next of kin must be informed of the termination of seclusion (taking into account consent from the person and appropriateness of the time of day/night to provide update).

11.92 Following seclusion, the nurse in charge must make arrangements for the room to be reviewed, maintenance checks to be complete and cleaning procedures in line with IPC guidance.

Incident review

11.93 The purpose of a post incident review is to provide opportunity for learning and provide support to the person and staff. A post incident review must take place as soon as possible, but no later than 72 hours[lxxxv] following termination of seclusion.

11.94 There must be a designated person to lead the incident review, and where possible they should not have been involved in the seclusion incident.

11.95 The review process must include discussing the incident with the person secluded to ascertain their thoughts and views.

11.96 The review will consider the following key points:

- What happened during the incident?
- Why did it happen? (Possible triggers, precipitating factors or early warning signs/Any noticeable patterns)
- How can a recurrence be avoided?
- What might be done differently the next time?
- What has been learned?
- Any changes to care plan or risk assessments?
- Any additional emotional support required for the person who has been secluded and any staff involved in the seclusion?

Use of CCTV in a Period of Seclusion

11.97 The use of CCTV for a period of seclusion within a hospital setting is to enhance the safety of all involved. The use of CCTV must not replace staff presence[lxxxvi]. Where organisations use CCTV, staff must refer to individual organisational policies for guidance. Data protection requirements[lxxxvii] related to the use of CCTV must be incorporated in organisational policies for use of CCTV and guide decision-making for each individual use of CCTV for monitoring a period of seclusion. This will include a Data Protection Impact Assessment[lxxxviii] that outlines the necessity, fairness and proportionality of the decision to use CCTV to monitor a period of seclusion. In addition to the above, each organisation that uses CCTV to monitor a period of seclusion should consider and outline how the proposed processing meets the seven key principles under the UK GDPR.

11.98 CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room.

11.99 The privacy and dignity of the person must be protected at all times.

Emergency scenarios

Fire Alarm

11.100 If the fire alarm was to sound whilst a person is in seclusion, the observing staff member must immediately seek direction from the nurse in charge and take direction in line with evacuation procedures.

11.101 Where there is a potential immediate risk to life, then seclusion must be terminated, and the person escorted out of the building in line with evacuation procedures to the nearest fire assembly point.

11.102 There must be an appropriate level of staffing in order to enter seclusion and evacuate the person.

Medical emergency

11.103 All staff involved must have the appropriate training and associated skills in order to manage a medical emergency.[lxxxix xc]

Monitoring and Governance

11.104 Organisations must develop their policies in support of the regional seclusion operating procedures in regard to the monitoring and governance arrangements for the use of seclusion.

11.105 The Seclusion Audit tool (see Appendix 6) provides an opportunity for the Nurse with overall responsibility of the hospital ward, in which seclusion occurred, to review key procedures and processes.

12 Appendices

Appendix 1 – Seclusion Maintenance Record

Seclusion Maintenance Record

DATE		TIME	

SIGNED	
PRINT NAME	
IS THE ROOM FIT FOR USE/SATISFACTORY/WORKING ORDER: **ALL STAFF SHOULD ASSESS THE ROOM AND ENSURE ADEQUATE STANDARDS**	

	YES/NO	COMMENTS/ACTION (IF REQUIRED)
Safe (free from harm/weapons)		
Clean		
Lighting		
Heating		
Clock		
Locks		
Appropriate furnishings		
Doors/Door Frames		
Vision Panels		
Flooring		
Windows		
Skirting/Window Frames		
CCTV		
Ventilation		
Safety alarms in area		

ANY OTHER COMMENTS/ACTIONS REQUIRED FROM MAINTENANCE CHECK:

Appendix 2 – Record of Seclusion

Record of Seclusion

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**
Name of those involved in decision to seclude:	**Name of professional initiating seclusion (doctor, nurse):** **Print Name:** **Signature:** **Designation:**
Medical Staff **Name of Doctor/Duty doctor informed of seclusion period:** **Time informed:** **Signature of Doctor who attended:** **Time attended seclusion:** **Were there problems in contacting doctor?** **If yes, please state what/why:** **Did Doctor attend to review immediately?** **If no, please state why?**	**Senior Management or Other (outside of usual working hours)** **Name of Senior Management/Other informed of seclusion period:** **Time informed:** **Signature of Senior Management/Other who attended:** **Time attended seclusion:** **Were there problems in contacting senior management?** **If yes, please state what/why:**

If no, complete incident form, reference no:	

Decision to seclude (Events leading to initiation of seclusion)

_____
_____
_____
_____
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_____

Alternative measures utilised prior to decision that seclusion was required as last resort option

_____
_____
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_____

Where Search procedures required due to potential risk of harms:

Yes ☐

No ☐

Items on the person within the seclusion room, if any items were removed for potential to cause harm (i.e. ligatures) Please detail below:

Not applicable ☐

Tear proof clothing required ☐

Consent to share information with NOK/family ☐

Consent to share information

Consent provided through advance statements ☐

Detail below where consent may not have been sought to information share/provide update (i.e. lack capacity)

_____

_____

_____

Were Physical intervention techniques required? Yes ☐ No ☐

Was 'as required' / 'rapid tranquillisation' medication administered? Yes ☐ No ☐

Incident Form Complete: Yes ☐ No ☐

Datix number:

Termination of Seclusion

Date seclusion terminated	**Time seclusion terminated**

Duration of seclusion (total):

Name of those involved in decision to terminate seclusion:

Name of professional terminating seclusion:
Print Name:

Signature:

Designation:

Post Seclusion

Clinical observations complete ☐

Debriefing with person ☐

Debriefing with staff ☐

Incident review ☐

Appendix 3 - Seclusion Care Plan

Seclusion Care Plan

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**

Clinical needs of the person/Physical and Mental state considerations/Potential risks
Management of any potential risks as outlined above
De-escalation strategies and outline of actions that will continue to be used to support termination of seclusion at earliest opportunity
How to recognise signs of tension reduction in person
Meeting person's needs and how this is planned for during seclusion period (food/fluid/elimination/personal hygiene/clothing)

Person's views regarding seclusion process
Process of information sharing as in main care plan

Appendix 4 – Seclusion Observation Record

Seclusion Observation Record

A documented report **must** be made at least **every 15 minutes** or more frequently if required (including during reviews etc.).

Things to observe: person's physical and mental state presentation, person's behaviour, communication, personal hygiene, therapeutic interventions, food and fluid intake.

		Person **DOB**	**Hospital No:** **Paris No:**	
		Name of professional who initiated seclusion:	**Hospital setting:**	
Date	**Time**	**Comments**	**Print and Sign Name** **Signature/Designation**	
	Hourly review by Nurse in Charge	**Comments**	**Outcome**	**NIC signature**
	Hourly review by Nurse in Charge	**Comments**	**Outcome**	**NIC Signature**

Appendix 5 – Seclusion Review Record

Seclusion Review Record

There are a number of review processes which should be commenced once a seclusion period is commenced.
All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Medical Staff Review

Initial Assessment by Doctor/Duty Doctor *(Required immediately if the Doctor is not the professional implementing period of seclusion):* **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Hour Review by Doctor/Duty Doctor: **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Nursing Staff Reviews

2 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

_____ Hour Review by 2 Registered Nurses, one who is the Nurse In Charge **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Internal IDT Review

Names of those participating in Internal IDT review: **Discussion:** **Outcomes and Actions**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Independent IDT Review

Names of those participating in Independent IDT review: **Discussion:** **Outcomes and Actions:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Appendix 6 – Seclusion Audit Form

Seclusion Audit Form

		Yes	No	N/A	Comments
1.	Is there evidence that other alternative interventions were considered prior to the use of seclusion				
2.	Has the following documentation been completed as required:				
	• Record of Seclusion				
	• Seclusion Care plan				
	• Seclusion Observation record				
	• Seclusion Review record				
	• Seclusion maintenance record				
	• Incident form				
	• NEWS Chart (or equivalent)				
3.	Is there evidence that seclusion process was explained to the person If additional resources are required to support/aid understanding, is it evidenced that they were utilised				
4.	If a doctor was not the professional authorising seclusion, did they attend for review immediately If not, was an incident form complete				
5.	Is there evidence of completion/attempts to complete clinical observations during seclusion period				
6.	Is there evidence that following administration of medication before/during seclusion period that the following was monitored:				
	• Respiration Rate				
	• Response to verbal or tactile stimulation				
	• Level of movement				
	• Level of awareness				
	If no, is it evidenced as to why staff were unable to monitor and record				
7.	Was the person searched prior to entering seclusion				
	• Is this evidenced				
	• Is it evidence that this was discussed with the person and rationale explained				
8.	Is it evidenced that the NIC completed an hourly review				

9.	It is evidenced that medical staff completed 4 hourly reviews after initial review				
10.	Is it evidenced that Nursing staff completed 2 hourly reviews x 2, one whom being the NIC				
11.	Is it evidenced that seclusion met the trigger for internal IDT review Did an internal review take place Are the outcomes of this evidenced and actions agreed				
12.	Is it evidenced that seclusion met the trigger for an independent IDT review Did an independent review take place Are the outcomes of this evidenced and actions agreed				
13.	Is it evidenced that consent has been given to share information with NOK/family. If not, are reasons explained as to why				
14.	Is there evidence that the person was offered food/fluids				
15.	Is there evidence of incident review by IDT following period of seclusion Is there key learning identified Are there actions set out to prevent incident from re-occurring Has this been reflected in the person's care record and where required care record and risk assessments updated				
16.	Is there evidence of post incident debrief • For the person who required seclusion • For staff involved				

Appendix 7 – Seclusion Flowcharts

Quick Reference Chart – Procedure for Seclusion

Seclusion period considered as an emergency intervention for unmanageable risk to others, where other less restrictive methods are deemed insufficient to manage that immediate risk

Decision to seclude

The Nurse in Charge of the team providing the person's care at the time of seclusion
OR
A Doctor with responsibility for the care of the person

Roles, Responsibilities, Review process

- Medical Team
- Senior Management
- Nursing Team
- Internal IDT
- Independent IDT

Consistent approach to terminate seclusion at earliest opportunity

Observations

- Minimum 15 minute documented observations
- Physical appearance
- Mental state presentation
- What the person is doing or saying whilst in seclusion
- Level of communication
- Level of alertness/awareness

Needs

- Provision of foods and fluids
- Personal Care
- Elimination
- Dressing needs

Seclusion Care Plan

- Known clinical needs
- How de-escalation strategies will continue to be used
- Actions towards termination Recognising signs where behaviour is no longer considered unmanageable risk towards others
- How potential risks may be managed
- Reference to individual support plans

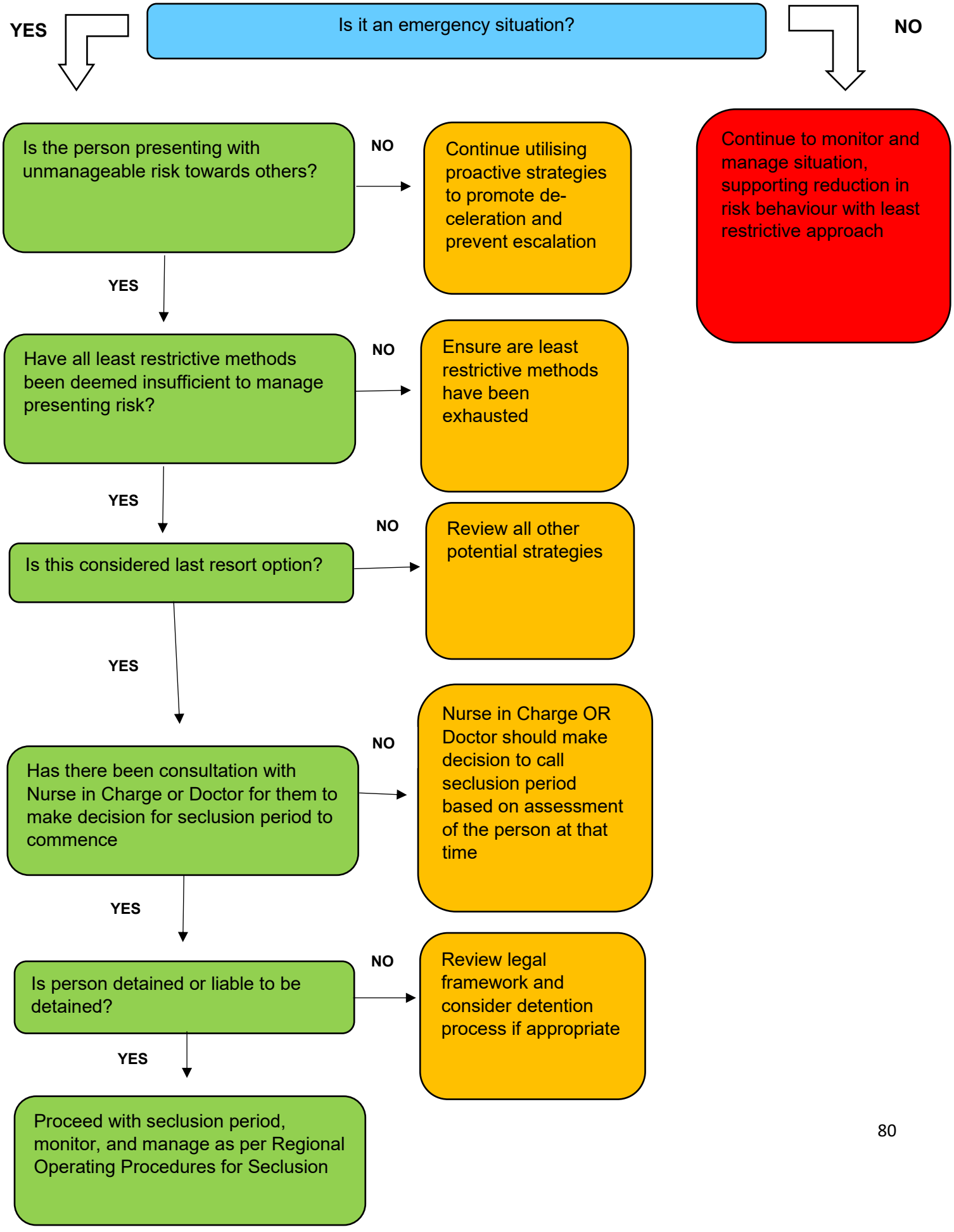
Post seclusion – Individual

- Supported to safely re-integrate into wider hospital setting
- Debriefing
- Thoughts/views sought to contribute to incident review

Post seclusion – Staff

- Supporting individual post seclusion
- Completion of clinical observations
- Body chart
- Completion of documentation
- Liaise with NOK
- Maintenance of room/area
- Debriefing
- Incident review
- Seclusion audit checklist

Quick Reference Flowchart – Decision to Seclude



Quick reference flowchart – Roles and Review process

Medical Team

- Assess and review need for seclusion period to continue
- Review mental and physical health
- Review level of risk to others
- Review level of observations
- Potential risk to self
- Review medication and potential adverse effects

- If the doctor was not involved in the decision to seclude the person, then they must attend immediately to complete review
- Medical review complete every 4 hours
- Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review
- Document review within review record and care plan
- Complete seclusion care plan with nursing staff and make amendments as required following review

Senior Management

- Provide support and guidance to person in seclusion and staff supporting
- Discuss presentation, potential risks and agreed management plan with NIC
- Assure appropriate resources in place until termination

- Senior management staff will be contacted by nursing staff to inform them of commencement of a period of seclusion
- The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of report and any other information or advice provided. If the senior manager does not attend in person, the NIC must document the detail of conversation and decisions agreed as per telephone conversation.

Nursing Team

- Monitor physical and mental state presentation of person via observations
- Inform and update professionals and NOK
- Complete and review seclusion care plan
- Completion of documentation

- Commence 1:1 observations at commencement of seclusion
- Registered nurse must monitor and observe the person in seclusion
- An observation record must be documented at a minimum of every 15 minutes
- NIC must complete formal hourly review
- NIC and further RN (ideally one not involved in decision to seclude) will undertake formal 2 hourly review

Internal IDT

- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An initial internal IDT review of the need for seclusion will be carried out as soon as practicable once the seclusion period commences.
- An internal IDT review will include the person's doctor, nurse in charge, and other IDT professionals who may usually be involved with the person
- An internal IDT review should take place once in every 24 hour period of continuous seclusion

Independent IDT

- Independent professionals **not** involved in initial incident or that led to decision to seclude
- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An independent IDT review should take place where a person has been secluded for 8 hours consistently or 12 hours intermittingly during a 48 hour period
- Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing then the independent IDT review should make recommendations as appropriate to the seclusion care plan

Quick reference guide– Care of the person in seclusion

During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that their privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Clothing

-If there are any concerns regarding use of clothing as potential ligatures or concealing of unsafe items

- Follow local organisational policy Search procedures
- Document if anything found during search that is deemed unsafe
- If any items or clothing deemed unsafe and require removal due to potential to compromise safety then they must be removed by staff who have received appropriate training and are competent
- Privacy and dignity should be maintained at all times
- If tear proof clothing is required then this must be provided

Personal Care/Elimination

- Encouragement and prompting for individual to meet personal care needs
- Support for individual where required
- Access to appropriate items/resources

- Privacy and Dignity should be maintained at all times
- Providing of resources i.e. hygiene products to support person to meet their needs
- Support individual as required to meet personal care and elimination needs

Food/Fluids

-All meals and drinks must be provided as normal

- All offers/acceptance and refusal of food and fluid items should be documented within the seclusion observation form and within the person's records
- Consider use of fluid chart to monitor and document fluid intake and promote adequate fluid intake as required
- Safe to use crockery and utensil items provided

Safety

- Any potential risk to the person
- Deterioration in clinical presentation

- If there is an identified risk to the person at any time then the seclusion room must be entered at the earliest and safest opportunity (Staff must have complete required training and be deemed competent)
- This will be a decision based on clinical judgement and need to maintain safety of the person whilst in the seclusion room.

Quick reference flowchart – Termination of Seclusion

Seclusion must be terminated at the earliest opportunity when it is no longer assessed as required. Seclusion can be terminated by one of the following:

- Nurse in Charge
- Doctor
- Medical Review
- Internal IDT Review
- Independent Review

Seclusion terminated

Yes

No

Identify management plan to safely support person following termination of seclusion and reintegration into general ward setting. Including offering/planning to support person in preferred activities, having meals with others and engaging in therapeutic activities with staff

Nursing team to complete relevant documentation:

- NIC must document termination on observation record
- Complete documentation in person's care plan
- Body chart
- Incident form
- Clinical Observations on NEWS Chart
- Inform NOK (as appropriate)

The seclusion room/area must be reviewed, maintenance record complete and cleaning complete in line with IPC procedures

Ensure debriefing process is completed with both the person and staff involved. All efforts to promote and encourage completion of debriefing but where person has not engaged should be documented

Incident review must be complete post seclusion period.

- Within 72 hours
- Person's thoughts/views included
- Identified learning

Completion of seclusion audit tool.

Quality assurance against regional operating procedures

Continue with review process and continue to monitor person, follow seclusion care plan and utilisation of de-escalation strategies and outline of actions that will continue to support termination of seclusion at earliest opportunity.

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Appendix 9 – Relevant Legislation

Legislative Context

Relevant legislation and Guidance should always be adhered to and staff should ensure that they are up to date with the most up to date Legal framework relating to use of Seclusion.

Criminal Law Act (1967)
Data Protection Act (2018)
Disability Discrimination Act (1995)
European Convention on Human Rights
Mental Capacity Act (Northern Ireland) 2016
Mental Capacity Act (Northern Ireland) 2016 – Deprivation of Liberty Safeguards – Code of Practice
Mental Health (Northern Ireland) Order 1986 and Code of Practice
Northern Ireland Act 1998
Northern Ireland Children's Order (1995)
Race Relations (Northern Ireland) Order (1997)
Section 75 of the Northern Ireland Act (1998)
Special Educational Needs and Disability Act (Northern Ireland) 2016
The Age of Majority Act (Northern Ireland) 1969
The Children (Northern Ireland) Order 1995
The Children (Secure Accommodation) Regulations (Northern Ireland) 1996
The Criminal Justice (Children) Northern Ireland Order 1998
The Day Centre Setting Regulations (Northern Ireland) 2007
The Equality Act 2010
The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
The Health and Safety at Work Act 1974
The Human Rights Act (1998)
The Protection of Children and Vulnerable Adults Order (Northern Ireland) 2004
The Public Order (Northern Ireland) Order 1987
The United Nations Convention on the Rights of the Persons with Disabilities, 2006
United Nations Convention on the Rights of the Child 1989
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Appendix 10 - Acknowledgements

Rosaline Kelly	Author and Project Lead
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The Project Team would like to offer thanks to those professionals, service user representatives, family members, carers, and other organisations who contributed to the guidance document through focus groups and staff engagement events.

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ArcNI	Bryson House	VOYPIC
Cause	Mencap	

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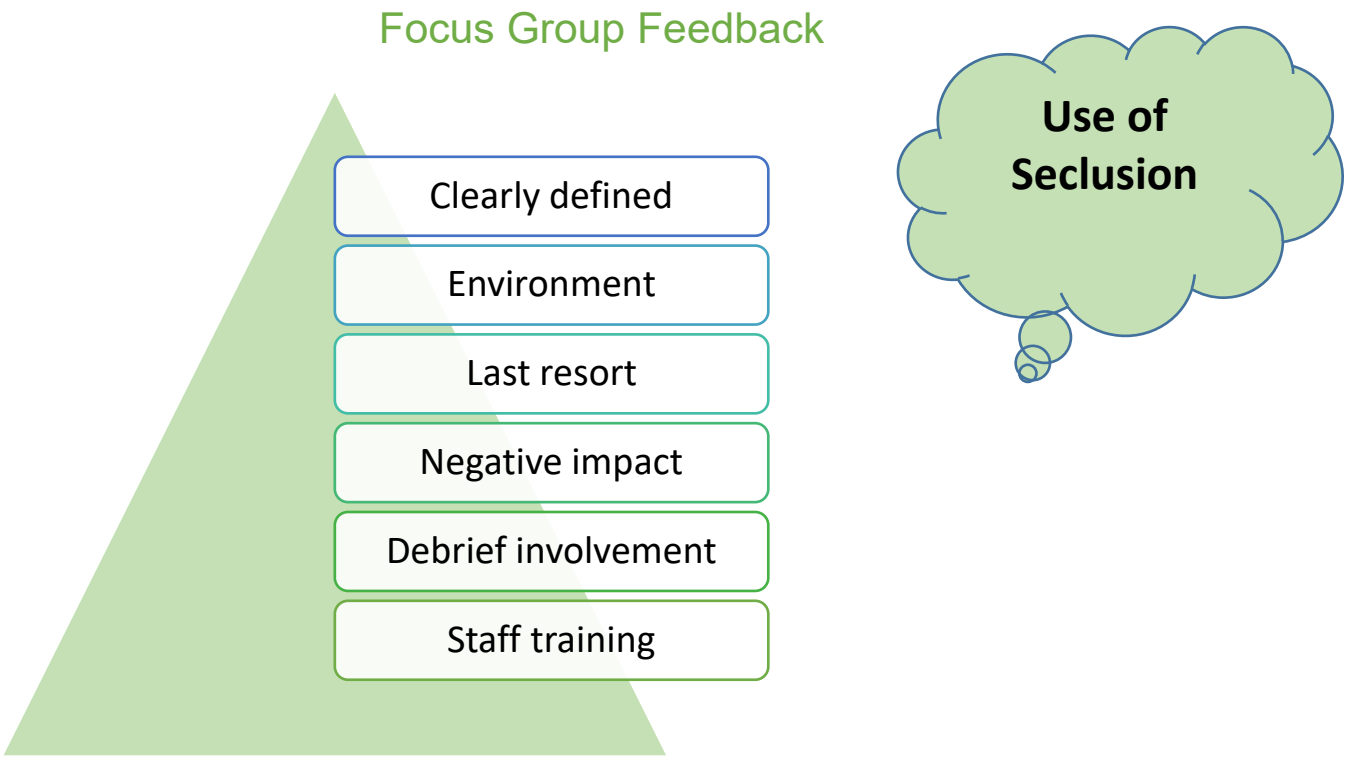
Appendix 11 – Themes and Feedback



All focus groups agreed that seclusion should only be used as a last resort once all other methods had been exhausted.

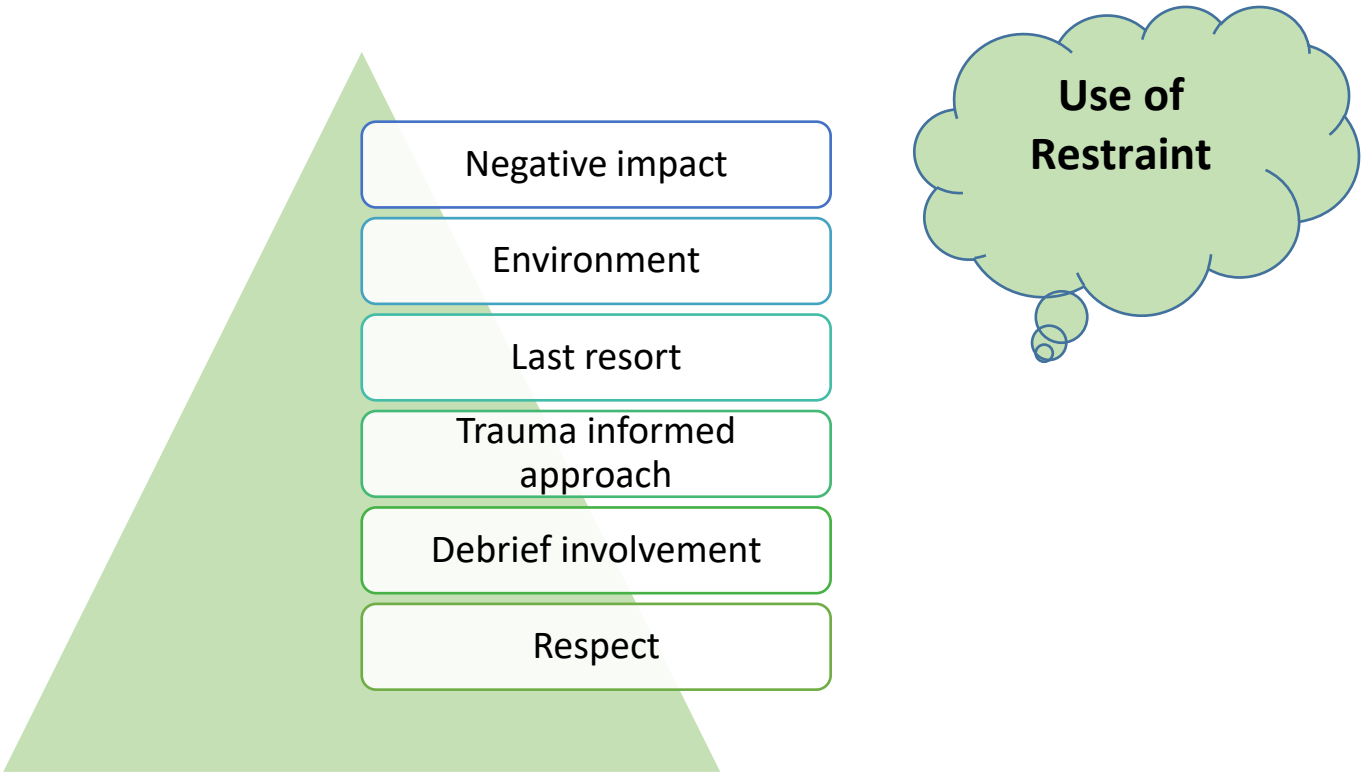
Focus groups agreed that reasons for using seclusion should clearly be defined and communicated to the person, their families and carers.

Focus groups fed back that seclusion had a negative impact on their health and wellbeing and in some cases made them feel worse.

Seclusion rooms have been described as “cold, dark, lonely, disgusting, like a jail”. A low stimulus room would be nice. Comfortable, safe, calming, with drinking water available. Possibly slow, quiet, calming music in the background.

Staff should know their patients and their specific needs; this would help to avoid incidents arising as staff would be able to recognise triggers. Staff should try to deescalate in the first instance. Focus groups members did recognise that sometimes staff are at risk too but felt that staff need more training.

Feedback suggested that staff should have conversations and a debriefing process should be completed, with the person and their families/carers, whenever an incident occurrs.



All focus groups agreed that restraint should only be used as a last resort, however members agreed that sometimes there is a need for restraint, especially if someone may hurt themselves or others.

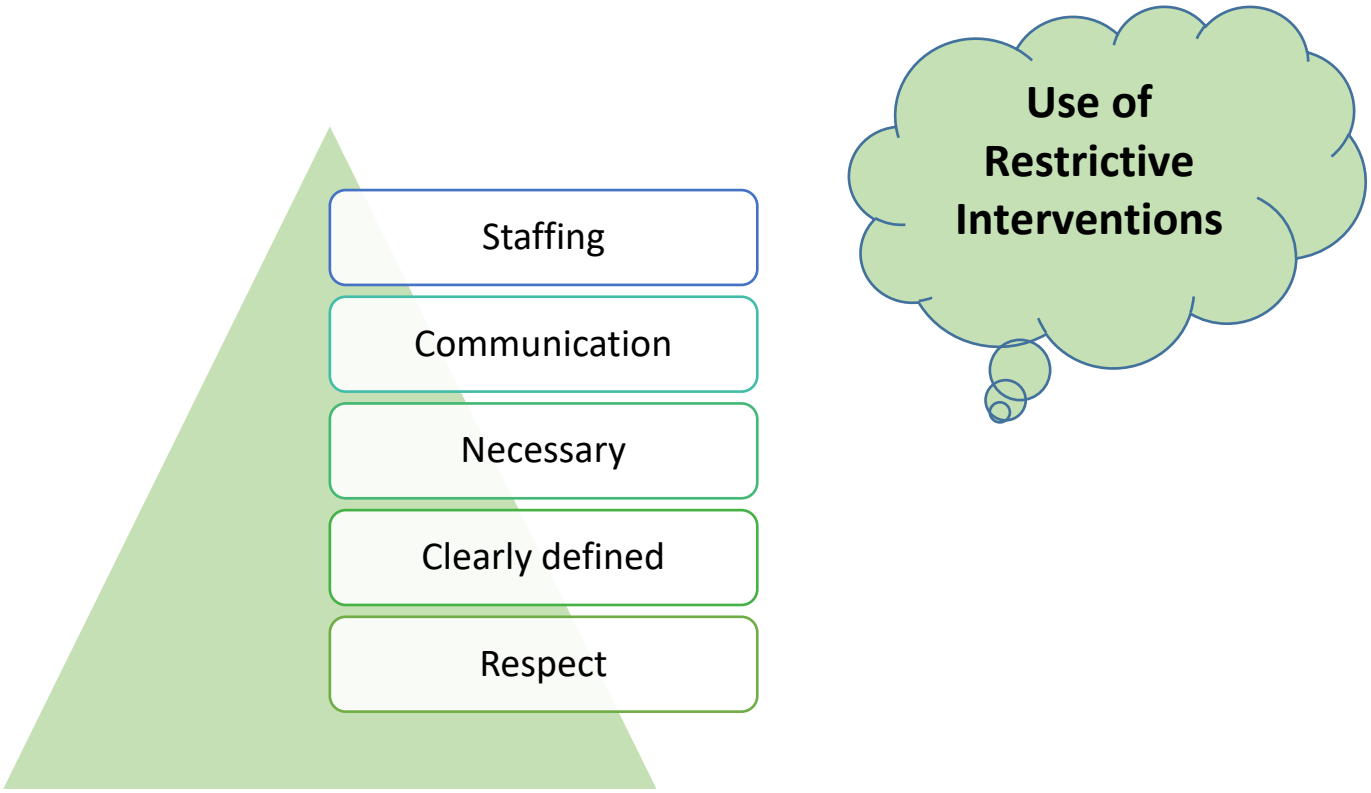
Accommodation or the environment in which a person is living should be spacious to help de-escalate emotion and reduce any potential for physical or chemical restraint.

All focus groups agreed that being restrained was negative to a person's health and wellbeing.

Group participants called for a trauma-informed care approach in order to help identify triggers and encourage sensitivity in approach.

Families should be informed about any use of restraint to discuss what and why, in order to create better understanding.

Focus groups said they realised staff were at risk of being hurt, but they want to be respected and listened to.



Feedback suggested that staff don't always have enough time and felt that staff shortages should not affect them being able to live their life or restrict their movements.

Focus group participants acknowledged that sometimes restrictive interventions are needed in order to keep individuals well, like sleep hygiene, but suggested restrictive interventions should be reviewed every fortnight/month.

Participants suggested there should be better communication between staff and patients. They thought staff should be explaining why they are taking things away or locking doors.

Feedback asked for clearer definitions of restrictive interventions and suggested that any restrictions should be agreed to through dialogue and not just enforced.

Feedback suggested that staff should be respectful of age and patient needs for example accommodating for later bedtimes, allowing freedoms like accessing beverage making facilities or items that are self-soothing.

Focus group feedback included suggestions regarding the use of developing technology in accommodations, such as use of keypads, water taps being on a timer, showers on a timer and better monitoring devices.

Staff Engagement Day

Feedback from breakout room discussions

It's important to identify and explore options around practises, while balancing risk and safeguarding patients.

We need to ensure all interventions are captured consistently.

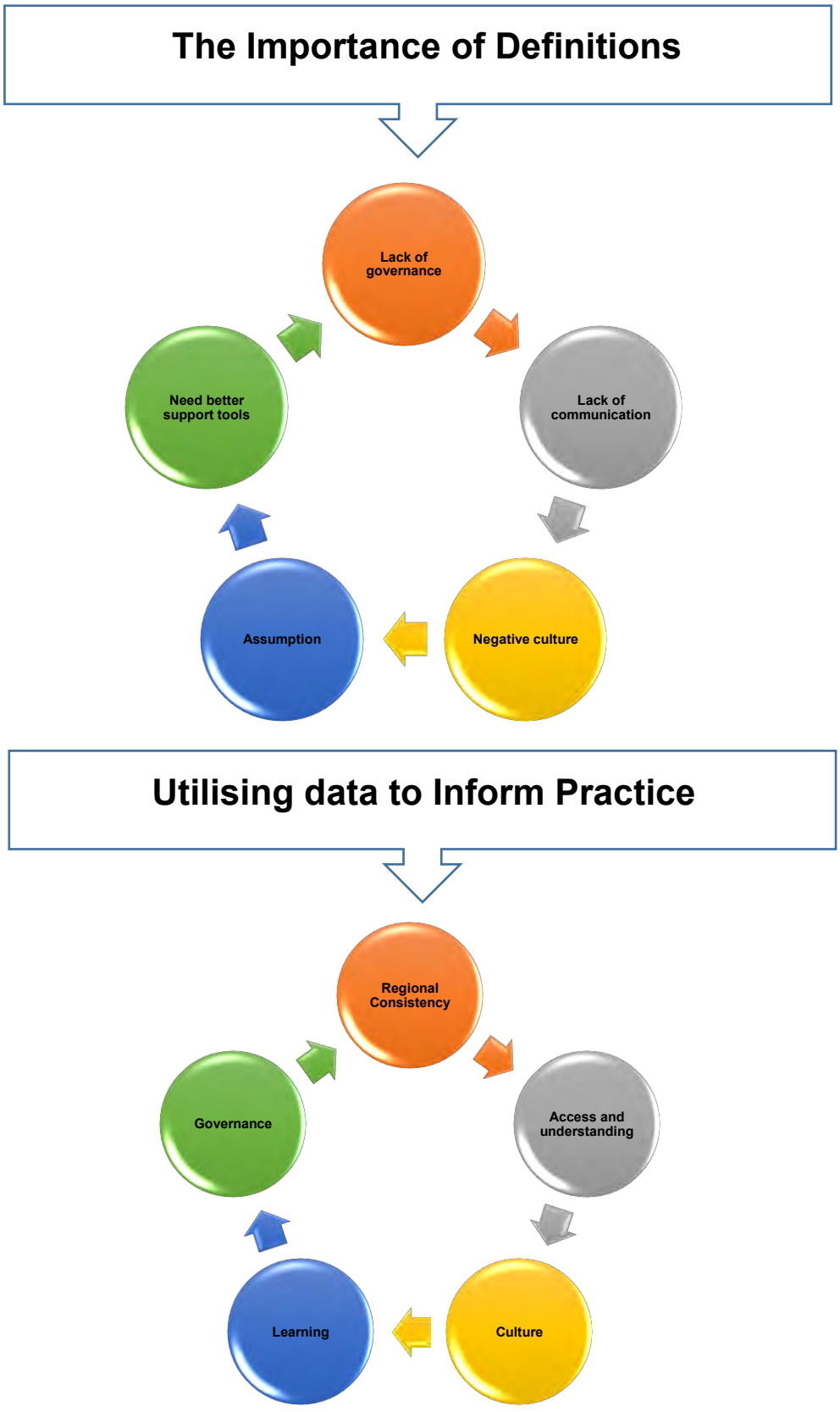
Human rights for patients starts on ground floor.

Better leadership to help staff to feel valued.

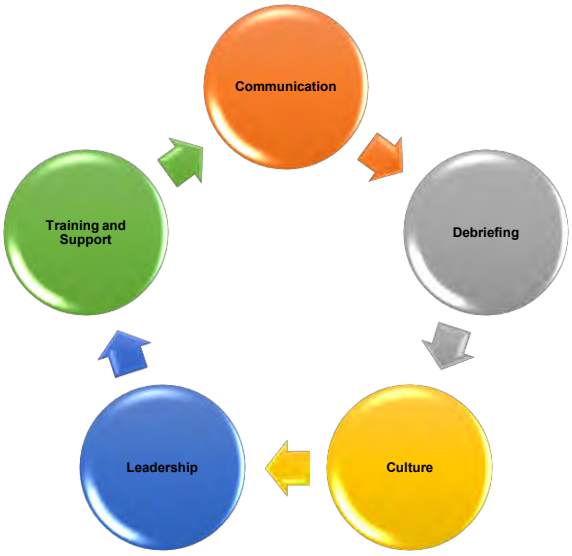
It's important to view the person as human.

There should be clearer evidence of how you're actually supporting people.

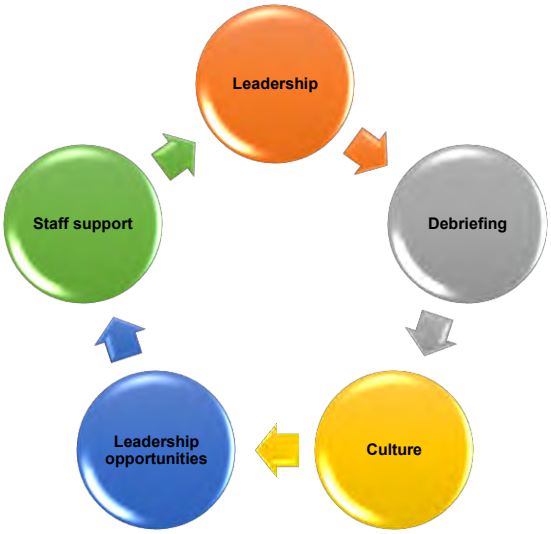
Emerging Themes



How human rights affects those that we care for



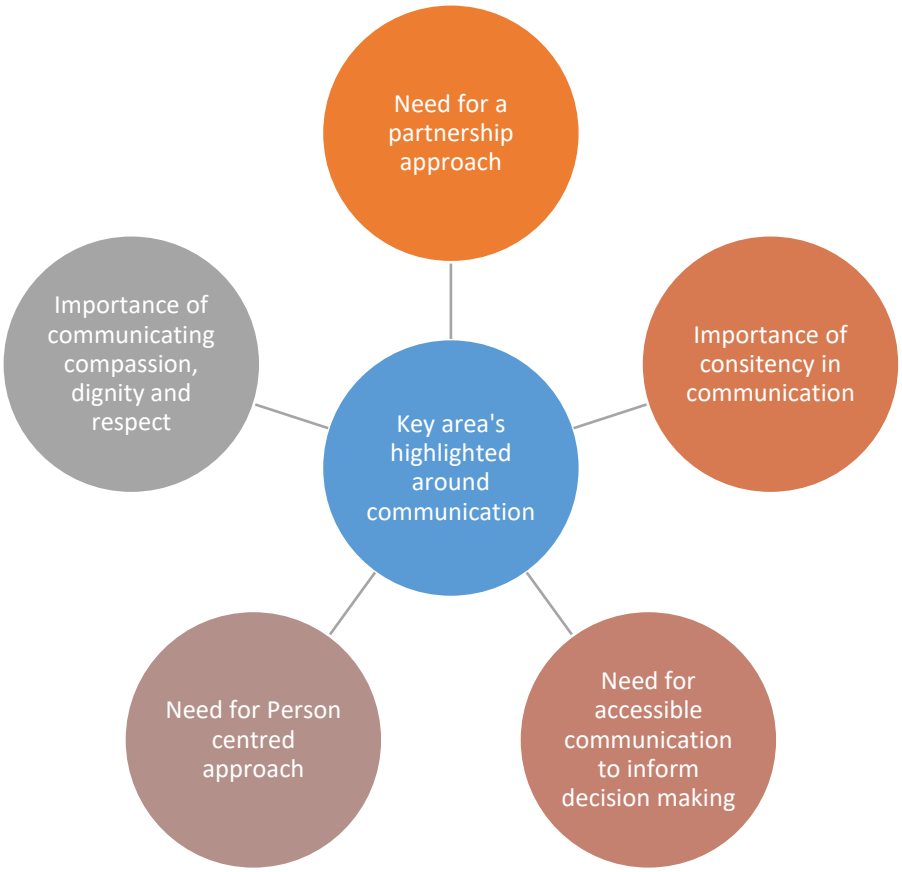
Supporting Cultural Change



Communication Sub-Group Feedback

Throughout engagement with those who helped develop this policy, communication was a repeated theme. Reports of poor communication impacting on the quality-of-care delivery could be rectified by a partnership approach and regular, authentic communication that will assist informed decision-making, allowing for more person-centred, more therapeutic and less restrictive alternative strategies to be agreed.

This is considered critical to minimising restrictive interventions.



Whilst not everyone expressed a negative experience, it was agreed that this did not suggest that improvements in effective communication would not be important.

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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

Consultation Report

March 2023

INTRODUCTION

1. This paper summarises the findings from the public consultation, which closed in October 2021, on Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the use of Seclusion, Northern Ireland.

2. The final Policy, incorporating feedback received where appropriate, has been published alongside this consultation report.

BACKGROUND

3. In August 2005, the Human Rights Working Group on Restraint and Seclusion issued *Guidance on Restraint and Seclusion in Health and Personal Social Services*. The working group was commissioned by the then Department of Health, Social Services and Public Safety (DHSSPS) and the guidance was issued by the DHSSPS.

4. In the period since this guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020, the Department of Health (DoH) committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion and a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5). The draft regional policy was the conclusion of this work.

5. The review commenced in February 2020. Due to impacts of COVID-19 and its restrictions, the project was paused from April 2020. The project recommenced in September 2020 and formally reported its findings in March 2021. The review team worked extensively with relevant stakeholders when developing the guidance and the input received was broadly positive throughout this development process.

PURPOSE OF THE POLICY

6. The regional Policy on the Use of Restrictive Practices in Health and Social Care Settings provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on elimination of the use of restrictive practices and on minimising their use.

7. The Policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions in the UK and across the world. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This Policy will play a key role in protecting people, by reducing the risk of misuse and the potential over-reliance on restrictive practices.

8. The use of restrictive interventions, restraint or seclusion may be necessary on occasions, for example, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as a last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others. Nevertheless, some of those who have been involved with or subject to seclusion, restraint and/or restrictive interventions, recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.

9. The Policy document sets out the standards required for: minimising the use of restrictive interventions, restraint and seclusion; and decision making, reporting and governance arrangements for the use of any restrictive practice.

10. The draft Policy was developed using co-production principles and has included involvement from service users, carers, people with lived experience, professionals, academics, providers of services and policy officials.

11. It is anticipated that the new Policy, once agreed, can be delivered within existing funding, as the policy represents current best practice and compatibility with statutory requirements. Consideration of any additional training requirements to implement the revised policy may be required.

12. Across the statutory sector, implementation of the policy will be led by the DoH Strategic Planning and Performance Group (SPPG) and HSC Trusts. In the independent and Community and Voluntary (C&V) sectors, it will be for each organisation to consider what, if any, implementation work will be required.

PUBLIC CONSULTATION

13. The draft regional Policy on the Use of Restrictive Practices in Health and Social Care Settings was published for a 12-week period of public consultation from 7 July 2021 to 1 October 2021, following an intensive period of co-production. Four impact assessment screening documents were also included as part of the consultation document:
    - Equality and Human Rights;
    - Regulatory;
    - Rural; and
    - Children's Rights.

14. Additional supporting documentation was provided in the form of:
    - A consultation document providing supporting background information.
    - An Easy Read version of the draft Policy.

15. All documentation was published on the DoH website and the draft Policy was available in alternative formats on request. All of the views, comments and suggestions made during the consultation period have been considered by the Department and have played a role in informing the final version of the revised Policy.

CONSULTATION RESPONSES

16. In total, there were 25 responses to the consultation. Of these, 20 were from professional organisations and 5 were from private individuals.

17. In Section 2 of the consultation questionnaire, respondents were asked if they agreed with the draft Regional Policy. Respondents were also asked if they agreed with the Equality Impact Assessment and associated Screenings.

18. There was broad agreement with the overall direction of travel, with 96% of respondents indicating that they agreed with the content of the draft Regional Policy.

19. As part of this feedback, it was particularly noted that:
    - Respondents demonstrated enthusiasm for the overarching vision and approach.
    - The principle of a rights-based approach, and of the involvement of the individual in decision-making regarding their care, were widely endorsed.
    - The Standards, Key principles and Key actions were welcomed.
    - The co–design and co–production undertaken to inform the draft Policy were welcomed, particularly service user representation.
    - There was strong advocacy that a wide range of stakeholders should be involved in the policy going forward, and in monitoring its implementation and evaluating its impact. This includes children and young people, parents and carers, representatives from equality and human rights organisations, and professional organisations such as for example, the Regulation and Quality Improvement Authority (RQIA).

20. Other key comments or emerging themes included:

- That the guidance appears to be focussed more on adult services, rather than children's services, and a suggestion that separate guidance in relation to children should be included.

- There was support for the embedded person-centred rights-based approach.

- There was an acknowledgement that those with communication difficulties experience challenges in being heard, with an emphasis on the value and importance of inclusive communication strategies and practices.

- It was noted and emphasised that a multidisciplinary approach is essential at all stages.

- There were a number of comments on training, with calls for it to be: regionally defined; provided for staff at all grades, particularly those who work in specialist roles and/or facilities; and that it should be based on low arousal techniques and be trauma informed.

- There were strong comments made in relation to regionally adopting all standards across statutory and non-statutory organisations.

21. Other more general points included:

- There were several suggestions on wording changes to support clarity.

- There was a request to provide more clarity on any use of mechanical restraint, and that the term 'secure setting' be defined.

- A number of responses mentioned the use of CCTV and suggested clarifying and refining the commentary on the use of this.

- There were also several responses suggesting that there should be recognition of the potential mental health impact on staff who are involved in restraint and seclusion.

DEPARTMENTAL RESPONSE AND NEXT STEPS

22. The completion of the final Policy has only been possible thanks to the significant contribution from many individuals and organisations who provided their expert advice throughout the co-production process. The Department is very thankful for the high levels of engagement and support received across sectors.

23. The Department welcomes the broadly positive response to the draft Policy, and a large proportion of the suggestions and comments made during the consultation have been incorporated in the final Policy document. The positive response, and all the constructive feedback, is a direct result of the ongoing engagement and co-production prior to the consultation.

24. As specified during the public consultation, responses from professional organisations will be published in full and these can be accessed via the Department's website at:

https://www.health-ni.gov.uk/publications/regional-policy-use-restrictive-practices-health-and-social-care-settings-public-consultation

ANNEX A

List of Organisations who responded

1. Association for Real Change (NI) (ARC)
2. British Association of Social Workers (BASW)
3. Belfast Health & Social Care Trust (BHSCT) Therapeutic Support Service
4. British Medical Association (BMA)
5. Education Authority NI
6. Equality Commission NI
7. Information Commissioners Office (ICO)
8. Northern Health and Social Care Trust (NHSCT)
9. NI Commissioner for Children and Young People (NICCY)
10. NI Human Rights Commission (NIHRC)
11. Praxis Care
12. Police Service Northern Ireland (PSNI)
13. Queen's University Belfast (QUB) – Mental Health Teaching Team, School of Nursing and Midwifery
14. Royal College of Nursing (RCN)
15. Royal College of Psychiatrists (RCPsych)
16. Royal College of Speech and Language Therapists (RCSLT)
17. The Regulation and Quality Improvement Authority (RQIA)
18. Southern Health and Social Care Trust (SHSCT) – Children and Young People Services
19. Southern Health and Social Care Trust (SHSCT)
20. Telling It Like It Is (TILII)

Belfast Health and Social Care Trust
caring supporting improving together

Policy Code: BHSCT/ASPC/LD (01) 2021

Title:	**Policy and Procedure for Use of Seclusion in Adult Learning Disability Inpatient Services**		
Policy Author(s)	Dr Colin Milliken, Consultant, Psychiatry Tel: [redacted] Sarah Meekin, Multi Ahp Manager, Clinical Psychology Tel: [redacted] Rhoda McBride, Divisional Social Worker, Learning Disability, Elderly Programme Of Care Tel: [redacted] Mairead Mitchell, Senior Nurse Tel [redacted] Dr Joanna Dougherty, Consultant, Psychiatry Tel: [redacted]		
Responsible Director:	Moira Kearney, Interim Director of Mental Health and Intellectual Disability		
Policy Type: (tick as appropriate)	*Directorate Specific ☒	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Learning Disability Governance Committe	17/06/2021		
Approval process:	Standards and Guidelines Committee Executive Team Meeting	**Approval date:**	03/08/2021 25/08/2021
Operational Date:	August 2021	**Review Date:**	August 2026
Version No.	2	**Supercedes**	V1 – November 2016 – November 2021

Key Words:	Seclusion, Inpatient, learning Disability
Links to other policies	BHSCT Use of Restrictive Interventions for Adult & Children's Services (2015) TP 59/09 BHSCT Adult Safeguarding policy and procedure (2020) SG 20/19 BHSCT Procedure for Reporting and Managing Adverse Incidents (2018) TP 94/14 BHSCT Policy and Procedure for the Management of Complaints and Compliments Policy (2020) TP 45/10 BHSCT A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace (2019) TP 02/08 BHSCT Rapid Tranquillisation Guideline for the immediate pharmacological management of violent and aggressive behaviour in adults and adolescent patients in the BHSCT (2017) SG 44/12 BHSCT Procedure for the Search of Patients, their Belongings and the Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh) (2016) SG 34/16 BHSCT Use of Physical Intervention Procedure by staff from Mental Health and Learning Disability Services (Children and Adults) (2016) SG 41/16 Regional Guidelines for the Search of Patients, their Belongings and Environment of Care within Mental Health and Learning Disability Inpatient Settings Positive Behaviour Support Policy Positive Behaviour Support Framework and Policy

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Seclusion is an emergency intervention.

Seclusion should only be used for acute, severe behavioural disturbance that is likely to cause harm to others and where all other interventions have failed.

Seclusion should not be used to manage self harm.

Seclusion should lead to a review of the patient's legal status if required.

Seclusion should only occur in a designated seclusion room.

Seclusion should NEVER be used as a threat or a punishment.

Seclusion should not be included in a treatment plan, seclusion is not a treatment

Staff must always use the least restrictive alternative and that seclusion should be used as a last resort and for the shortest possible time and be in the best interest of the patient.

The use of seclusion should be subject to regular review.

Caution should be exercised in using seclusion for those with physical health conditions.

1.2 Purpose

The purpose of this policy is to provide staff working within Adult Learning Disability services within BHSCT with clear directives in the use of seclusion.

BHSCT is one of three trusts within NI providing inpatient Learning Disability services. It is the only Trust to have a commissioned regional remit for such provision. This provision is provided onsite at Muckamore Abbey Hospital.

It is recognised that different areas of the trust use different terminology when it comes to patients/service users.

For the purpose of this policy the term 'patient' has been used for no other reason than that is the term used within the Mental Health (Northern Ireland) Order 1986 and throughout the associated Code of Practice.

All staff who may have occasion to use seclusion must receive Seclusion Awareness Training and Human Rights Training as part of their induction and ongoing training, this will will include appropriate monitoring arrangements for

patients placed in seclusion and awareness of the legal framework that authorises seclusion.

This training will be provided by the Ward Manager and supported by the Site Nursing Development Lead (NDL).

1.3 Objectives

To ensure the physical, psychological and emotional safety and wellbeing of patients

To ensure that restrictive practices remain proportionate, least restrictive, last for no more than necessary and take account of patient preference whenever possible (NICE NG 10, 2015)

To ensure that inpatient areas have robust and transparent governance processes that support, monitor, advise and report on the use of restrictive practice of seclusion.

To ensure that patients receive the necessary care and support before, during and after seclusion

To designate a suitable environment that takes account of patients' dignity and physical and psychological safety and wellbeing

To set out roles and responsibilities of staff

To ensure processes are followed for monitoring, recording and reviewing the use of seclusion and that learning is identified and shared.

To promote person centred practices by working in partnership with the patient and their carer (as appropriate) to review available options to minimise the potential for harm

To minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion with an aim to support the Trust commitment to reduce restrictive interventions.

2.0 SCOPE OF THE POLICY

This policy applies to all staff working with adults within Adult Learning Disability Inpatient Services within the BHSCT. It is the responsibility of all staff within Inpatient Learning Disability services to follow the policy.

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board

The trust board is responsible for ensuring that a policy is in place that governs the safe and appropriate use of seclusion via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

3.2 Medical Director

The Medical Director is responsible for ensuring that all medical staff are aware of, and operate within the policy and procedure for the use of seclusion.

3.3 Director of Nursing

The Executive Director of Nursing is responsible for ensuring mechanisms are put in place to ensure nursing professionals within the services are aware of and comply with the requirements of the policy and procedure for the use of seclusion.

3.4 Hospital Management Team is responsible for disseminating the policy and ensuring that all staff work to achieve policy standards. They are responsible for ensuring review of data with regards to seclusion and ensuring change is actioned as required.

3.5 Ward management teams/ heads of service/ ward managers are responsible for disseminating policy to their staff and ensuring that staff are trained in its use. They are responsible for monitoring use of seclusion and completing reports as requested**.** In conjunction with the hospital management team they are responsible for reviewing data with regards to seclusion and effecting change as required.

3.6 Nurse in Charge of the Ward

The nurse in charge of the ward is responsible for managing any incident of seclusion in accordance with this policy and procedure.

3.7 All staff

All inpatient LD staff within the Trust with front-line care to patients have a responsibility to provide care in accordance with this policy and procedure.

4.0 CONSULTATION

Consultation for this policy involved:

- All managers within Learning Disability
- Carer representatives
- TILI Group and Patients with capacity
- Bryson Advocate Service
- Colleagues from other Trusts
- Royal College of Psychiatry
- DLS

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Definitions

5.1.1 Seclusion

The Code of Practice relevant to the Mental Health (Northern Ireland) Order 1986 defines seclusion as:

" the forcible denial of the company of other people by constraint within a closed environment. The patient is usually confined alone in a room, the door of which cannot be open from the inside and from which there is no means of exit open to the patient."

This situation would also arise where the door is not locked from outside but the patient has no reasonable means of exit, due to, for example, the height of the door handles, the weight of the door or the person's physical, sensory, neurodiverse or learning disability.

The Code of Practice also states that:

"Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort, after all other reasonable steps to control the behaviour have been taken. The sole aim in using seclusion is to contain severely disturbed behaviour that is likely to cause harm to others. It should never be used where there is a risk that the patient may take his own life".

Seclusion should only be used in a hospital setting and in relation to patients' detained under the Mental Health Order. If an emergency situation arises involving a voluntary patient and, as a last resort seclusion is necessary to prevent harm to others, then an assessment under the Mental Health (NI) Order 1986 should be considered. Form 6 (nursing holding power) or Form 5 (Doctor's holding power) can be used as a holding power until an assessment is carried out by a GP and ASW or next of Kin under the Mental Health Order (NI) 1986.

NICE Guidelines (2015) require staff to consider rapid tranquilisation or seclusion as an alternative to prolonged manual restraint (ie longer than 10 minutes).

It is important that the Human Rights of all patients be upheld and that they are considered at every stage of the decision making and monitoring of seclusion –that the use of seclusion is legal, justifiable, least restrictive and proportionate. Article 2 the right to life, Article 3 the right to be free from inhuman or degrading treatment, Article 5 the right to liberty and security and Article 14 the right to be free from discrimination must be considered and documented and that the impact of seclusion in this context is understood and considered by staff. All patients should be treated with dignity and respect and equality and diversity issues should be maintained.

5.1.2 Voluntary confinement

The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended at a time of their choosing. Thus, the patient must have the ability to communicate their desire to do so, either verbally or non-verbally. It is this distinction that separates voluntary confinement from the definition of seclusion, which is “the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving”

5.1.3 Long term segregation

Long term segregation is a situation where a patient is prevented from mixing freely with other patients in the ward.

This form of restrictive intervention should rarely be used and only ever for hospital patients who present an almost continuous risk of serious harm to others. It will be agreed by the multidisciplinary team that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other patients.

The use of long term segregation must be supported by a person-centred, value based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship.

The use of Long term segregation will be agreed through a Multi-disciplinary Team approach with input and agreement sought from family and Carers.

5.2 Key Policy Statement(s)

5.2.1 Safeguarding is everybody's business

All Belfast Health & Social Care Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers,or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Belfast Health & Social Care Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

5.2.2 Equality and Human Rights: Everyone's Responsibility

Belfast Trust is committed to delivering safe, high quality and compassionate services. Employees are expected to deliver services and behave in a manner that is compatible with this commitment. Belfast Trust expects all employees to treat people with dignity and respect whether service users, visitors or colleagues.

Belfast Trust is committed to carrying out its functions in line with the core principles and values that underline human rights legislation namely Freedom, Respect, Equality, Dignity and Autonomy (FREDA). Staff should use FREDA principles to red flag any behaviour that is not compatible with the Trust ethos of delivering safe, quality and compassionate care or which violates our equality and human rights statutory commitments

In such circumstances, the least restrictive option will always be carefully considered. A Human Rights based approach will be explicitly evident in all decision making such that

1. Where possible the process of risk assessment and management will involve people with a learning disability and/or their carers.

2. Risk assessment and management processes will utilise positive risk-taking strategies, where appropriate to ensure that risks are not overstated nor overly risk-averse.

3. The processes will ensure shared, multi-professional collaboration and accountability within a supportive organisational structure.

4. Consistent and standardised processes will be promoted.

5. Robust documentation will exist including evidence of a human rights based approach.

All employees will make every effort to ensure that human rights are protected, that respect for human rights, is part of day to day work and that human rights are an integral part of all actions and decision making. The Trust will keep human rights considerations, relevant legislation and previous judicial reviews at the core of decision making

The decision to use seclusion will be robustly documented with explicit reference to human rights and with particular reference to issues relating to proportionality, necessity and the legitimacy of the aim which deprivation of liberty (seclusion) causes

In addition to anti-discrimination legislation Belfast Health & Social Care Trust employees have a duty to deliver services in a manner that meets our statutory equality, human rights and good relations duties. These duties include:

- Section 75 of the NI Act 1998:
  - Promotion of Equality of Opportunity in relation to the nine equality categories.
  - Promotion of Good Relations between persons of different religious belief; political opinion; and racial group.

- Section 49A of the Disability Discrimination Act 1995:
  - Promotion of positive attitudes towards disabled persons,
  - Encouraging the participation by disabled persons in public life.

- Duty to respect, protect and fulfil rights outlined in the Human Rights Act 1998 including:
  - Article 2 - the right to life
  - Article 3 - the right not to be tortured or inhumanly or degradingly treated or punished
  - Article 5 - the right to liberty and security of the person
  - Article 8 - the right to respect for one's private and family life, correspondence and home

- United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976] which includes the right to the highest attainable standard of health.

- The Trust is committed to upholding the principles of the UN Convention on the Rights of Persons with Disability (UNCRPD) which seeks to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.

5.3 Policy Principles

Trust staff will focus primarily on providing a positive and therapeutic culture, which aims at preventing behavioural disturbances through positive behavioural support, early recognition and de-escalation.

Discussion should be had with Next of Kin and the patient (if they have capacity) on admission regarding possible need for seclusion and they should be kept informed of its usage and be involved, where appropriate, in discussions with the patient. Inclusive communication and information in alternative formats will be available so that every effort is made to communicate effectively with patients with varying levels of capacity and cognisance.

De-escalation will be the first response and seclusion will always be a last resort once all alternative strategies have been exhausted. The use of seclusion must be safe, reasonable and justifiable. Its use must only be in order to preserve safety and to reduce any risk to others.

Staff need to be aware of the potentially harmful psychological consequences of seclusion, notably:

- Feelings of increased despair and isolation
- Feelings of anger and confusion
- Worsening of mental health symptoms including delusions and hallucinations
- Fear and trauma
- Worsening/heightening anxiety.

It is essential that patients receive the necessary care and support both during and after seclusion. At the earliest possible safe moment following the cessation of seclusion, and taking into account capacity and communication issues, the patient should be given the opportunity to discuss the incident with the most appropriate member of their clinical team. The aim of this discussion is to understand and discuss the patient's perceptions of what happened and why and consider future strategies in the event of a similar situation. The role of Next of Kin in this feedback should be discussed at admission.

Staff must also be involved in reflecting about the incident in order to learn from the patient and event and understand how the environment and antecedents may have contributed towards the incident. This feedback should inform patient care plans, Positive Behaviour Support Plans and wider service quality improvement work.

Seclusion must be used:

- As a last resort only for the management of acute behavioural disturbance
- For the shortest possible time
- In a room specifically designated as a seclusion room
- Be subject to continuous review.

Seclusion must not be used:

- As a punishment or threat
- As part of a treatment programme (although it may feature in a patient's PBS or Care plan)
- Because of staff shortages or lack of staff training
- As a method of controlling self -harming behaviour. Where the patient poses a risk of self harm as well as harm to others, seclusion must only be used when the professionals involved are satisfied that the need to protect others outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed.
- Solely to protect property.

Seclusion must be recorded on the seclusion record (**Appendix A**)

5.3.1 Where to seclude

Seclusion should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward.

These rooms are characterised as:

- Providing privacy from other patients
- Enabling staff to maintain observation at all times
- Safe and secure
- Povide access to toilet and refreshement access when required
- Not containing any item that could cause harm to patient or others
- Adequately furnished, heated, lit and ventilated
- Allowing for communication with patient when they are in the room and door is locked eg via intercom, visability through glass for non-verbal patients.

In exceptional circumstances and for cogent clinical reasons it may be considered more therapeutic and less restrictive to manage a patient requiring isolation from peers and/or staff in their own bedroom. Such occasions should be rare and should only be considered if the multi-disciplinary team believe there are cogent clinical reasons for doing so, there is no safe alternative and that any risks presented by the physical environment such as items that can be broken or cause harm or injury can be safely managed. Assessment of these risks should be kept under regular review. The decision to use a patient's bedroom for the purpose of seclusion or other isolation should be

based on a sound clinical rationale and not due to a lack of suitable designated seclusion facilities.

If seclusion takes place outside of designated seclusion rooms or a room not agreed in the patients care plan Eg: their bedroom or a shared communal area to prevent immediate risk of harm to the patient or others, this should be investigated and reviewed under an SEA methodology.

5.3.2 Voluntary Confinement

On occasion patients may request to be voluntarily confined to either their own room or a designated seclusion room as a means of self regulating and managing their own risks to others. Such occasions will be rare, but on those occasions where the patient requests such confinement, there needs to be robust monitoring and governance arrangements to ensure appropriate safeguards are in place. These should be the same as occurs for seclusion.

Patients must have capacity to agree to voluntary confinement.

When patients are deemed to have capacity, and are considered able to make decisions for themselves, an expressed wish to be confined in either their own room or seclusion room may not be considered seclusion as long as the following criteria has been met:

- There is a care plan previously agreed that has been collaboratively formulated and discussed with the patient, their family or carers and agreed by the multidisciplinary team.
- That the patient retains a means of summoning the attention of staff at all times
- That the patient retains the right to have the confinement curtailed at a time of their choosing.
- That the nurse in charge of the ward is satisfied that the conditions of confinement/environment do not present undue risk to the patient or others.

The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended at a time of their choosing. Thus the patient must have the ability to communicate their desire to do so, either verbally or non-verbally. It is this distinction that separates voluntary confinement from the definition of seclusion, which is “the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving”

All instances of patients enacting voluntary confinement will be recorded in the patient’s healthcare record and reported alongside the seclusion data as voluntary confinement.

To ensure the physical and psychological wellbeing of patients utilising voluntary confinement, the same observation and review requirements should be followed as for seclusion.

Should a patient voluntarily confined as part of a crisis intervention plan **not** have their confinement curtailed on request for **any** reason then this amounts to seclusion and will be managed and reported as such.

5.3.3 Decision to Seclude (Appendix B flowchart)

The decision to take a patient to seclusion should be made by the secluding nurse, who will always be a registered nurse.

The nurse in charge of the ward will contact the Consultant Psychiatrist for authorisation.

Following a decision to seclude the following people should be informed, within 30 minutes of initiating seclusion or as soon as is practical:

- Consultant Psychiatrist on call or patient's Responsible Clinician (in hours)
- The duty doctor (this can be trainee psychiatrist on-call, unless indicated otherwise by discussion with consultant, for example in the situation of serial seclusion episodes).
- Senior Manager on call with site responsibility
- Family and/or carer as agreed in care plan.

This may be by telephone and will include:

- The reason for seclusion
- A discussion that all strategies have been exhausted prior to seclusion starting
- A clear plan discussed as to how seclusion might be terminated.

The person making the decision to seclude should have seen the patient immediately prior to the commencement of seclusion.

There will be clear documentation regarding all other interventions tried prior to considering seclusion in the seclusion record. Staff should be familiar with PBS plans, recommended communications strategies, sensory needs and care plans in order to ensure seclusion is a last resort.

Seclusion should only be used in a hospital setting and in relation to patients detained under the Mental Health Order. If an emergency situation arises involving a voluntary patient and, as a last resort seclusion is necessary to prevent harm to others, then an assessment under the Mental Health (NI) Order 1986 should be considered. Form 6 (nursing holding power) or Form 5 (Doctor's holding power) can be used as a holding power until an assessment is carried out by a GP and ASW or next of Kin under the Mental Health Order (NI) 1986.

As far as possible, and taking into account their communication needs and any PBS plans (if relevant), patients who are being placed in seclusion should be informed of the reason that seclusion is necessary and how it might end.

This information will be made available in easyread/talking mats or other means of inclusive communication and shared with the patient on admission.

Where the decision to seclude was taken by someone other than a consultant psychiatrist on the ward, a first medical review (by duty Doctor) should be undertaken within one hour of beginning seclusion, unless indicated otherwise by discussion with consultant, for example in the situation of serial seclusion episodes. If the patient is new to the service or there are concerns regarding their physical presentation then a medical review must be undertaken without delay.

If decision to seclude is made by the consultant psychiatrist, having first seen the patient, the first medical review will be the review they took immediately before authorising seclusion. A medical review within the hour will then not be necessary in this instance. This is unlikely however as the decision to seclude often in practice is made by the nurse in charge of the ward.

Where seclusion is so short that the doctor does not visit before seclusion is ended then this must be recorded on the seclusion record. The doctor should still see the patient.

Following a decision to seclude the following people should be informed, within 30 minutes of initiating seclusion or as soon as is practical:

- Consultant Psychiatrist on call or patient's Responsible Clinician (in hours)
- The duty doctor (this can be trainee psychiatrist on-call).
- Senior Manager on call with site responsibility
- Family and/or carer as agreed in care plan.

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On decision to seclude, a Seclusion Record should be commenced (Appendix A).

5.3.4 Needs and Risk Assessment

All decisions around seclusion will be clearly documented. This will include documentation of human rights considerations in the restrictive practice record.

Once the decision to seclude has been taken an assessment of the patients' needs and presenting risks should be undertaken by a registered nurse.

A visual check should be carried out to reduce availability of objects that could be used as a weapon eg shoes, belts, keys.

If staff feel that a physical search is necessary the patient's clothes may need to be searched. This should be undertaken by same gender staff if possible or at least one member of staff of the same gender must be present. Staff should refer to "Procedure for search of Patients, their belongings and the environment of care within AMH and LD inpatient facilities."

The patient should always be clothed, with the exception of belts, dressing gown cords, shoes or other items that could be used to cause self-harm, or harm to others. Where possible patients should wear their personal clothing and retain personal items if this does not compromise their safety or that of others. When appropriate disposable seclusion gowns will be available. Staff should at all times be mindful of treating the person with dignity and respect.

Where indicated and as soon as is practicable post seclusion, the patients vital signs will be recorded.

5.3.5 Medication

There is no expectation that additional medication will be given whilst a patient is in seclusion. However, where the administration of additional medication is required then oral medication should be offered before parenteral (IM) medication.

If additional oral or parenteral (IM) medication has been administered within approximately 30 minutes prior to seclusion it must be brought to the attention of the attending doctor and senior nurse attending and the details recorded clearly.

If the patient is detained under the Mental Health (Northern Ireland) Order 1986, any prescribed medication must be administered within the legal framework of that Act and in line with the BHSC Trust 'Policy and procedure for the use of rapid tranquillisation'

The nurse observer for the patient requiring seclusion must be made aware of what medication has been given, dosage and timing.

If a patient in seclusion has received medication or received emergency parenteral (IM) medication before or during seclusion then observations should be carried out in accordance with the Trust 'Policy and procedure for the use of rapid tranquillisation' and include:

- The monitoring of the patient's blood pressure, temperature, pulse, respiration, degree of movement and response to verbal or tactile simulation
- Attempts, whether successful or not, to measure the patient's vital signs must be recorded on a BP/TPR chart and in the patient's healthcare record
- A pulse Oximeter should be available
- Nursing staff should report any concerns about physical parameters immediately to the doctor on call. In the case of a medical emergency, the NIAS emergency services should be called without delay.

If a patient has been sedated then they should be monitored 'within eyesight' observation by a named registrant, until such time as a medical review indicates otherwise.

If it has been assessed as the risk being too high for staff to enter the

seclusion room, then visual observations can be used to assess patients physical state, these should be recorded. Physical observtions must commence as soon as it is safe and practical to do so.

5.3.6 Ongoing Monitoring/Observations

The aim of observation is to safeguard the patient, monitor their condition and behaviour and identify the earliest opportunity at which seclusion can be safely terminated.

A registrant nurse will be identified as an named Observing Nurse and will be within sight and sound of the patient at all times during the seclusion episode. The room should offer complete observation from the outside whilst also offering the patient privacy from others.

A seclusion record will be commenced on decision to seclude (Appendix A). A record of entries of observations will be documented on the seclusion record at least every 15 minutes. The registered nurse observing will make an entry on the seclusion form indicating the patient's condition, physical behaviour and verbal indicators if significant, for example, threats/demonstrations of insight into incident, their mood.

The Nurse in Charge should ensure that staff do not carry out constant observations for periods over 1 hour. After an hour there should be hand over to another named registrant nurse. Records must be contemporaneous.

The Observing nurse should have the ability to quickly raise the alarm for additional support via the use of a personal alarm.

It is always good practice to consider the gender of the nurse carrying out the ongoing observations, particularly if the patient has a known trauma history.

Staff who carry out observations should:

- Engage positively with patient
- Be appropriately briefed about the patient's history, background, risk factors and needs
- Be familiar with patients care plan and PBS plan and any communication or sensory needs
- Be familiar with ward, ward policy for emergency procedures and potential environmental risks
- Be able to decease/increase the level of engagement based on their judgement of the patient's individual needs and presentation.

Staff must respond immediately to any display of self-injurious behaviour that compromises patient safety.

The patient will be offered drinks, food and toilet facilities as required for their comfort. This should be noted in seclusion record.

5.3.7 Review of seclusion

Nursing review

A member of the nursing team should be available outside the seclusion room at all times during the seclusion.

A registered nurse will observe and review the patient at 15 minute intervals

Seclusion should be reviewed hourly by the Nurse in charge of the ward. Decisions and rationales should be noted on Seclusion record.

Review will be taken every 2 hours from point of seclusion by 2 registrant nurses (1 of whom was not involved in decision to seclude). Variations to this should be noted on Seclusion Record.

At any point during the 15 minute observations, if the Nurse Observer feels there is observational evidence to review seclusion this should be highlighted to the nurse in charge and facilitated as quickly as possible.

A joint review should be conducted by a consultant psychiatrist and registered nurse every 4 hours until the first MDT review has taken place.

If seclusion continues for more than 8 hours consecutively or 12 hours intermittently over a period of 48 hours, an independent MDT review will be completed by a doctor/ nurses and other professionals who were not involved in the decision to seclude or in the prior incident

Medical Review

If decision to seclude is made by the consultant psychiatrist, having first seen the patient on the ward, a seclusion review will be undertaken by a doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation

After this a joint review should be conducted by a consultant psychiatrist and registered nurse every 4 hours until the first MDT review has taken place

Following MDT Review medical reviews should occur at least twice daily in every 24 hour period. At least one review should be carried out by the patient's Responsible Clinician.

The trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews on the provision that they meet the following criteria:

- Have read this policy
- Have access to senior medical (consultant) advice at all times
- Have access to senior nursing advice at all times

- Have received training on Human Rights and Restrictive Practices.

Medical reviews should include:

- Review of patients physical and psychiatric health
- Assessment of adverse effects of medication
- Review of observations required
- Re-assessment of medication prescribed
- Assessment of risk posed by patient to others
- Assessment of risk to patient from deliberate or accidental self -harm
- Assessment of need for continuing seclusion and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive measure.
- Potential for discussion with RMO.

Night Reviews

Reviews and observations continue at night as per daytime

Sleeping patients

Wherever possible consideration should be given to end seclusion prior to the patient falling asleep.

If the patient falls asleep the seclusion episode will end and the door is unlocked. Taking account the individual needs and ability of each individual, if the patient has fallen asleep, before there has been adequate opportunity to talk about and explore with him/her the events leading up to seclusion, it must be assumed that the matter has not been adequately resolved, and it should be discussed with the patient at a suitable moment following return to usual environment.

Observations must continue as per seclusion guidelines, in particular to assess patient's presentation on awakening.

If a patient is asleep:

- the door should be opened and suitable bedding provided
- or the patient asked if they want to go to their own bedroom and seclusion will be terminated.

If the patient is awake, the doctor must attend the ward to conduct the 4 hourly review alongside the registered nurse.

Where a patient appears to be sleeping, a clinical judgement needs to be made on whether it is appropriate to wake them for a medical review. In such instances the doctor's attendance for the medical review may be replaced by a telephone review with the nurse in charge of the ward. The Trust recognises the value in allowing patients periods of uninterrupted sleep and the

potentially disturbing nature of reviews during the night. In such cases a medical review will be prioritised the next morning.

The decision to hold a telephone review needs to be agreed jointly by the doctor and nurse in charge of the ward and may only be agreed on an individual basis subject to the patient being asleep at the time the review is due. In the absence of a positive decision to have a telephone review, the default position will be that the doctor attends for the medical review.

When there are specific concerns around the physical health of the patient, the default position of the doctor attending for medical reviews should continue during the night. If the patient is asleep these reviews should be carried out in such a way that the doctor can satisfy themselves that the patient is safe and that any concerns for physical health and wellbeing can be addressed safely.

When the patient is asleep, the two hour nursing reviews should be carried out in such a way that the registered nurse can satisfy themselves that the patient is safe and there are signs of life.

It is not practical to undertake an MDT Review (senior doctor, nurses and other professionals) during night hours. This will be conducted as soon as practical.

Upon wakening, the patients' mental state must be assessed to allow an appropriate Care Plan to be identified, and/or a review of nursing supervision.

Multi-disciplinary Team Reviews

Internal Multi-disciplinary Team Reivews

The Internal Multi-Disciplinary Team should review the patient as soon as is practicable. This should be within 24 hours of seclusion commencing.

Membership of this Internal MDT will include a Responsible Clinician, the senior nurse on the ward, and staff from other disciplines normally involved in the patient's care. A Psychologist or Behaviour Therapist should be part of the review.

At weekends or public holidays the internal MDT Review should happen on the first day of return to normal working.

These reviews should evaluate and make recommendations, as appropriate, for amendments to the care plan and/or Behaviour Support Plan

The outcome of internal MDT reviews should be recorded in the patient's healthcare record.

Independent Multi-disciplinary team Reviews

If the period of seclusion continues for longer than 8hrs consecutively or 12hrs intermittently during a 48hr period then an independent MDT review should be undertaken.

This review should be undertaken by end of next working day after commencement of seclusion.

Membership of this independent MDT will include a Responsible Clinician, a senior nurse, other professionals not involved in the decision to seclude. A Psychologist or Behaviour Therapist should be part of the review.

It is good practice for this team to consult with staff involved in the decision to authorise seclusion and have access to the seclusion record.

These reviews should evaluate and make recommendations, as appropriate, for amendments to the care plan and/or Behaviour Support Plan.

The outcome of the independent MDT reviews should be recorded in the patient's record.

5.3.8 Termination of Seclusion

The patient should remain in seclusion only as long as absolutely necessary. The initial rationale with regards to "The sole aim in using seclusion is to contain severely disturbed behaviour that is likely to cause harm to others" should remain the criteria whereby the situation is assessed.
Seclusion should be terminated immediately when it is determined that it is no longer warranted. It can be ended by:

- The nurse in charge of the ward followed by consultation with the patient's Responsible Clinician or Consultant Psychiatrist on call (either in person or by telephone)
- Following an internal or independent multi-disciplinary review
- Following a Consultant medical review
- The patient falling asleep and being asked to be escorted to their room.

The door should only be opened when there is an adequate team present as deemed appropriate by the Nurse in Charge.

Opening a door for short periods does not constitute an end to seclusion but it may appropriately prompt a review of the need for its continued use.

An observation of the patient's physical, mental and psychological state, with the patient's consent, will be completed by nursing staff and any concerns referred immediately to the duty doctor or doctor on call for examination, if felt to be necessary.

The seclusion record will be completed.

Details of seclusion will be recorded in day/night report and discussed at handover periods such as safety briefs and daily report outs.

Following all episodes of seclusion there should be a post-incident review/de-brief to ensure analysis of the clinical detail, organizational learning and support for all parties involved, including patients. This should take place at relevant meetings.

Any patient who has been secluded should be supported after the event to help him or her understand why the seclusion took place. The patient will be given opportunity to discuss the events leading to the seclusion episode. The details of the discussion will be recorded in the patient's Care Plan or PBS Plan, which will be updated if required. It may be appropriate to involve Next of Kin in these discussions and this should be discussed with Next of Kin at admission.

5.3.9 Involvement of Next of Kin

Involvement of next of kin is dependent on patient's expressed wishes for next of kin involvement and capacity to consent to this sharing of information
If a patient has capacity and consents then:

Seclusion should be discussed with all next of kin on admission and their wishes regarding when they wish to be informed documented

When a patient is secluded for first time Next of Kin should be informed. This should be done in a timely but considerate manner taking into account time of day/night and their wishes as noted in the patient's care plan.

Any subsequent notification of further episodes should be agreed with the patient/Next of Kin and the agreement recorded in the patient's record, this should include the option to be involved in any post seclusion review.

If the patient has capacity and indicates they do not want the NOK informed, this will be recorded in the patient' care plan and noted in the seclusion plan

5.4 Dissemination

This policy will be disseminated by email, ward meetings and a copy available on the ward to all staff working with adults within Learning Disability Inpatient Services within the BHSCT. It will also from part of the induction process for all new staff.

5.5 Resources

All staff will be trained on use of seclusion and Human Rights and Restrictive Practices. Usage will be monitoring through data gathering and auditing of records

5.6 Exceptions

This policy refers to adult learning disability inpatient services only.

6.0 MONITORING AND REVIEW

LD services will have a robust seclusion monitoring process in order to ensure that their governance arrangements “enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions”, including use of seclusion.

The monitoring process will include a monthly audit on the compliance of the use of the policy with a report to be given to the co-director and discussed at hospital management meetings.

The levels of Seclusion will be reported in a weekly Safety Brief which will be provided to the Board of Directors. Feedback from patients, families, carers and advocates will be used to review and monitor use of the policy.

This process will be overseen by the hospital management team

The role of this group will be to:

- Monitor the adherence of seclusion to the Code of Practice and any departures from such
- Receive and analyse data relating to, monitor and report overall trends in the use of seclusion
- Monitor and report on other areas of restrictive practice as determined appropriate by each clinical division
- Review documentation for and information about the use of seclusion and alternative management strategies via multidisciplinary team feedback
- Review use of seclusion for each patient including where there is prolonged or multiple episodes of seclusion with the teams .
- Consider any staff training and education issues and make relevant recommendations
- Monitor the use of seclusion for areas of section 75
- Share and disseminate good practice
- To report 6-monthly to the wider LD service Governance Group.

Instances of seclusion should be reviewed for each individual patient, new use of seclusion, abnormal levels of seclusion, seclusion being used multiple times in course of weeks or a few months, or seclusion lasting for greater than 48 hours, or any general change in trends at individual patient level should be escalated to the hospital management team for review. This will occur at the live governance meetings.

The ward multidisciplinary team will discuss the use of seclusion through regular reports and reviews at safety briefings, daily report outs, live

governance meetings and monthly clinical improvement groups and provide information to the hospital management team.

Weekly statistical data on the use of seclusion is provided to the hospital management team.

Regular reports will be produced on the use of seclusion and presented to the Trust Board.

The policy will be reviewed on a five yearly basis.

7.0 EVIDENCE BASE / REFERENCES

Good Practice in Consent for Treatment or Examination: Implementation Guide for Health Care Professionals, DHSSPS, 2007

BPS/ Royal College “Challenging Behaviours: a unified approach”

Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;

RCN guidelines on restrictive practice

NMC Guidelines for Records and Record Keeping

Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org

‘Guidance on the Use of Restrictive Physical Interventions’ (Department of Health, July 2002);

‘BILD Mental Health Procedure Implementation Guide. Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings. National Institute for Mental Health in England. 2004;

Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005 CG25.

Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002

Safeguarding Vulnerable Adults

The Mental Health (NI) Order 1986 and its associated Code of Practice

Good Practice in Consent: Implementation Guide for Health Care Professionals

Positive and Proactive Care: reducing the need for restrictive interventions, Social Care, Local Government and Care Partnership Directorate
April 2014

Minimum standards for seclusion practice at St Charles 2018

8.0 APPENDICES

Appendix A: Seclusion Record
Appendix B: Flowchart: Deciding to seclude
Appendix C: Flowchart: Review in Seclusion

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Policy and Procedure for Use of Seclusion in Adult Learning Disability Inpatient Services** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the

responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

PP. Dr Colin Milliken _____ **Date:** 13/09/2021

Authors

_____ **Date:** 13/09/2021

Director

Appendix A

Seclusion Record/Voluntary Confinement Record

Patients name		**Date:**	
Ward		**Paris id.**	
Place of seclusion			
Legal status	**Voluntary** ☐	**Detained** ☐	**Under 18** ☐
Authorising Consultant		**Time contacted**	
Senior Manager on call with site responsibility informed		**Time contacted**	
Secluding Nurse		**Duty Doctor informed (include time contacted)**	
Next of Kin		**Time contacted/or reason recorded for not contacting.**	
Time seclusion commenced			**Duration of seclusion**
Time seclusion ended			
Accident/incident form completed		Patient ☐ Staff ☐ Other patient ☐ Incident number _____	

A Narrative of the reason for the decision to seclude the patient

B Describe briefly efforts and methods used to prevent placing patient in seclusion (include a description of PBS interventions employed, if no time to implemented state this – be descriptive)

Staff involved:

C Seclusion Plan

A written plan must be prepared immediately, the primary aim being to ensure patients safety and that the episode lasts for the shortest time.

Plan to ensure seclusion ends at the earliest opportunity

D Observations and Clinical Review Sheet (Description of patients presentation throughout the previous 15 minute period, including how the staff intervened/what the staff were doing)

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
First 15 mins after the beginning seclusion			
15 to 30 mins after beginning seclusion			
30 to 45 mins after beginning seclusion			
45 to 60 mins after beginning seclusion			

1 hour review **Time:**	
Nurse in Charge: _____	**Outcome:**

1 hour medical review **Time:**	
Signature **_____**	**Outcome:**

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
60 - 75 mins after the beginning seclusion			
75 - 90 mins after beginning seclusion			
90 - 105 mins after beginning seclusion			
105 - 120 mins after beginning seclusion			

2 hour review **Time:**	
Nurse in Charge of secluding ward: **_____**	**Independent nurse:** **_____**
Outcome:	

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
120 - 135 mins after the beginning seclusion			
135 - 150 mins after beginning seclusion			

150 - 165 mins after beginning seclusion			
165 - 180 mins after beginning seclusion			

3 hour review **Time:**	
Nurse in Charge: _____	**Outcome:**

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
180 - 195 mins after the beginning seclusion			
195 - 210 mins after beginning seclusion			
210 - 225 mins after beginning seclusion			
225 - 240 mins after beginning seclusion			

4 hour review **Time:**	
Nurse in Charge: _____	**Independent Nurse:** _____
Consultant involved in review _____	

Outcome: **Plan if seclusion is to continue:**

If seclusion lasts more than 4 hours, the Nurse in charge, Nurse and consultant will decide and document who should be involved in subsequent reviews.

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
240 - 255 mins after the beginning seclusion			
255 - 270 mins after beginning seclusion			
270 - 285 mins after beginning seclusion			
285 - 300 mins after beginning seclusion			

5 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome:	

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
300 - 315 mins after the beginning seclusion			

315 - 330 mins after beginning seclusion			
330 - 345 mins after beginning seclusion			
345 - 360 mins after beginning seclusion			

6 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome:	

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
360 - 375 mins after the beginning seclusion			
375 - 390 mins after beginning seclusion			
390 - 405 mins after beginning seclusion			
405 – 420 mins after beginning seclusion			

7 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome	

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**

420 - 435 mins after the beginning seclusion			
435 - 450 mins after beginning seclusion			
450 = 465 mins after beginning seclusion			
465 - 480 mins after beginning seclusion			

8 hour review **Time: Outcome:**	
Nurse in Charge:	**Names of others involved in review:**

E Independent MDT review

Date:

Staff involved:

F How was seclusion ended?

By NIC followed by consultation with the patient's Responsible Clinician or Consultant on call (either in person or by telephone)	
The patient falling asleep and being asked to be escorted to their room	
Following an internal or independent multi-disciplinary review	
Following a Consultant medical review	
Patient engaging with staff/ appearing with less risk (Decision by of NIC based on level of presenting risk)	

G Evaluation of patient following period of seclusion (be descriptive, include how the patient is emotionally, their demeanour, their attitude. When appropriate, discuss the incident with the patient - ask how they feel/how they think the incident could be managed differently)

Have clinical observations been completed? Yes No (if no, include reason)
Staff involved:

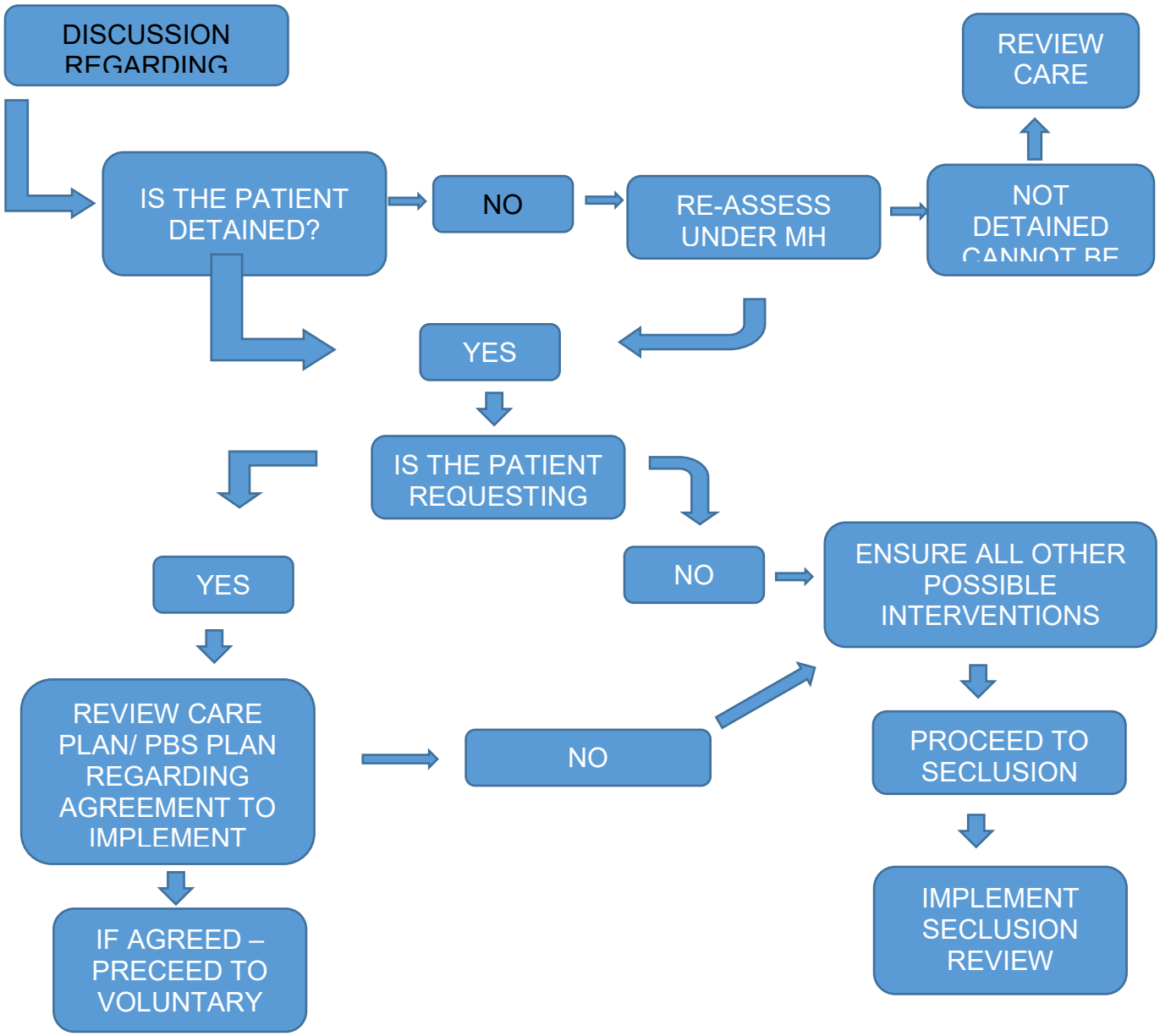
G MDT review

Date:

Staff involved:

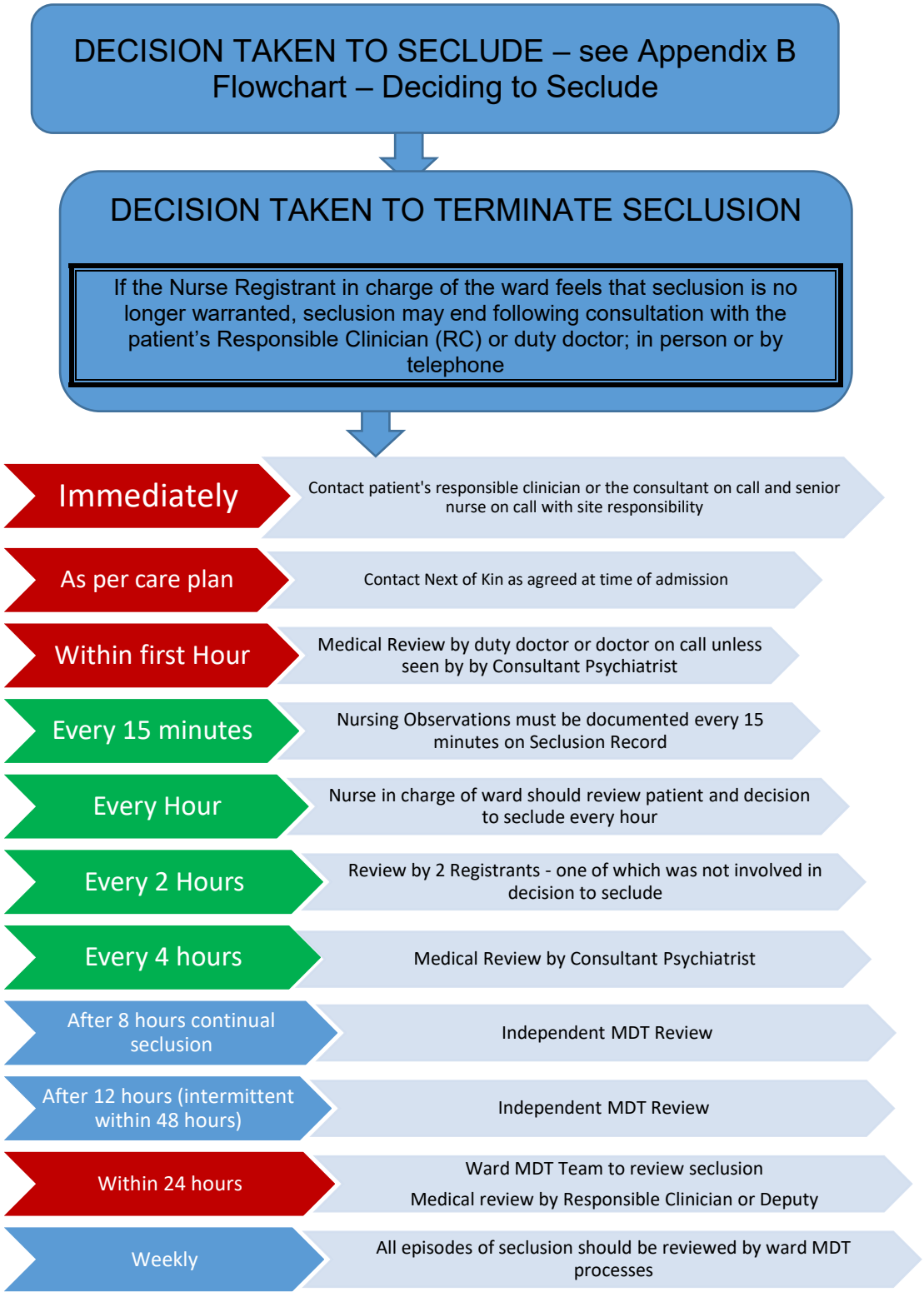
Appendix B

Flowchart – Deciding To Seclude



Appendix C

Flowchart – Seclusion Review



MAHI - STM - 105 - 436

This Certificate confirms that

Belfast Health and Social Care Trust
Muckamore Abbey Hospital

is licensed by the Crisis Prevention Institute as an

Approved Training Centre

for the provision of CPI BILD Accredited Training Programmes in

Management of Actual or Potential Aggression (MAPA®)

in accordance with the national BILD Physical Interventions Training Accreditation Scheme

Valid from 20 October 2017

by the following Certified Instructors:

[redacted]

Authorised by
Martyn Dadds
Managing Director

Certificate date: **December 2017**

CPI Inc. BILD Accredited MAPA® Approved Training Centres are required to operate strictly within the terms of the formal License Agreement with CPI Inc. at all times in order to safeguard professional standards of practice and to protect the integrity of the BILD Physical Interventions Accreditation Scheme

Please provide feedback about the performance of the Approved Training Centre to the Licensed Organisation and / or directly to CPI at euquality@crisisprevention.com or telephone 0161 929 9777

MAHI - STM - 105 - 437

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Management of Actual or Potential Aggression (MAPA®)

in accordance with the national BILD Physical Interventions Training Accreditation Scheme

Valid from 27/11/2018

by the following Certified Instructors:

[redacted]

Authorised by - **Martyn Dadds**
Managing Director

Certificate date: **November 2018**

CPI Inc. BILD Accredited MAPA® Approved Training Centres are required to operate strictly within the terms of the formal License Agreement with CPI Inc. at all times in order to safeguard professional standards of practice and to protect the integrity of the BILD Physical Interventions Accreditation Scheme

Please provide feedback about the performance of the Approved Training Centre to the Licensed Organisation and / or directly to CPI at euquality@crisisprevention.com or telephone 0161 929 9777

MAHI - STM - 105 - 438

CRISIS PREVENTION INSTITUTE™

This certificate confirms that

BELFAST HEALTH & SOCIAL CARE TRUST – KNOCKBRACKEN HEALTHCARE

Is licensed by Crisis Prevention Institute as an

APPROVED TRAINING CENTRE

For the Provision of

VERBAL INTERVENTION & SAFETY INTERVENTIONS TRAINING

Training to staff working within the organisation.

Roger Boyd (Managing Director)

Crisis Prevention Institute

Valid until: 31.12.2023

Issued on: 17.02.2023

Crisis Prevention Institute is a certified training provider under the BILD Association of Certified Provider scheme

MAHI - STM - 105 - 439

CRISIS PREVENTION INSTITUTE™

Certified instructors as of 01.01.2023

Anne Brannigan

Cormac Craig

Emma Killen

Kevin Mackel

Lee Watters

Mark Wilson

Martin McCooey

Mary McGowan

Neil Walsh

MAHI - STM - 105 - 440

Nicola Johnston

Rosalind Beattie

Rowan Frost

Sam Warren

Shelley Martin

Sheree Cassidy

Stephen Noble

CONFIDENTIAL REPORT

Positive Options
BILD Accredited MAPA® Approved Training Centre

Annual Report for:
BELFAST HEALTH AND SOCIAL CARE TRUST
KNOCKBRACKEN HEALTHCARE PARK MAPA® ATC SATELLITE CENTRE

08 January 2010

LICENSING OUTCOME:

Relicensed without Conditions

Prepared on behalf of Positive Options by:
Jeremy Boughey, General Manager

Positive Options BILD Accredited MAPA® Approved Training Centre

Annual Report

1. Introduction

1.1 This Report summarises the findings that relate to the performance of **Belfast Health and Social Care Trust – Knockbracken Healthcare Park, hereafter referred to as 'the ATC'; 'the Organisation', or 'Knockbracken'** (a Positive Options BILD Accredited MAPA® Approved Training Centre [ATC]) in meeting the requirements of the ATC License Agreement between itself and Positive Options Limited as the Licensee, and the standards and expectations of the BILD Code of Practice for the Use of Physical Interventions: A Guide for Trainers and Commissioners of Training (2006). The Report is provided on the basis of an ATC Verification and Support Visit undertaken by an Independent Assessor appointed by Positive Options to undertake the Visit on its behalf, and the ATC providing routine reports relating to MAPA® training activity under the License Agreement.

1.2 Section 3 of this Report contains the concluding decision of Positive Options about the *continued licensing* (for ATCs subject to a 3-year licensing arrangement) or *relicensing* (for ATCs subject to an annual licensing arrangement, including those transferring from a 3-year licensing arrangement at its end) of the MAPA® ATC and may or may not contain *conditions*; *recommendations*, and *considerations for best practice*; these terms are explained in Section 2, below. The decision contained within Section 3 of this Report is *informed* by the Assessor's Report to Positive Options and their opinions but is **not** wholly dependent upon the individual and/or summative views offered by the Assessor. Positive Options will consider additional factors associated with the License Agreement and the ATC's general performance against the requirements of the License. There is an expectation by Positive Options that the Management Lead for the Organisation, together with the ATC Co-ordinator will formulate a brief response to indicate the Organisation's agreement to the contents of the Report or to contest any observations that it feels to be unfair, unrepresentative or inaccurate, and to make any immediate responses to any conditions; recommendations, and considerations for best practice that are included in the Report.

1.3 The Independent Assessor's Report to Positive Options is informed by a self-assessment provided by the ATC Co-ordinator in advance of the Visit taking place, and by the Assessor 'building confidence' around the declarations contained within the assessment, through the use of objective questioning. As part of the Visit process the Assessor will review any conditions made and/or recommendations and/or considerations for best practice offered by Positive Options during any previous Annual Centre Verification and Support Visit. The Visit undertaken by the Assessor will have been in-part one of verification and in-part developmental; as such, the Assessor will have offered support and advice to the ATC Co-ordinator and any other ATC personnel that s/he met with as part of the Visit. For the purposes of brevity the Assessor's Report is **not** included although Positive Options is committed to sharing a copy of the Report upon request by the ATC Management Lead or the ATC Co-ordinator.

1.4 Positive Options will monitor the ATC's progress with any *conditions* made to the continued licensing or relicensing of the ATC and will expect the Management Lead for the Organisation or through a process of organised delegation the ATC Co-ordinator, to provide routine progress reports at routine intervals until Positive Options is assured that a condition is met.

1.5 It is expected that this Report will be shared at a senior (Board) level through the Organisation's internal governance infrastructure and any conditions made relating to the continued licensing or relicensing of the Organisation as a Positive Options BILD Accredited MAPA® ATC are given the appropriate level of attention to instruct solutions for areas of non-compliance with best practice standards issued nationally; standards that make up the BILD Code, and the licensing arrangement with Positive Options Limited.

Positive Options BILD Accredited MAPA® Approved Training Centre

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2. Terminology

2.1 The term **'recommendation'** is used in the Report in the context of a standard within the BILD Code of Practice (2006) being declared and/or assessed as being met but in the opinion of the Assessor the governance arrangements necessary to support the License Agreement could benefit from minor adjustments to enhance practice; an approach, system and/or process. The words that we generally use in this Report to prefix a recommendation will be: 'could' or 'might', 'should consider', etc. When a recommendation is made, the ATC's decision (or not) to act upon this will be reviewed by the Assessor, together with the Centre Co-ordinator at the next scheduled Annual Centre Verification and Support Visit.

2.2 The term **'condition'** is used in the Report in the context of meaning a change in practice; an approach, system and/or process that is required and essential to ensure the fidelity of BILD's Code being met or the application of MAPA® is upheld. A 'condition' will generally result from a standard being self-declared by the ATC and/or assessed by the Assessor as **not being met**, or only **part-met**. The words that we generally use in this Report to prefix a condition will be: 'should', 'must' or 'will'; 'is required to', etc.

2.3 The continued licensing of the ATC or its relicensing will be contingent upon any condition(s) required of the ATC being fully met **or** sufficient alternative assurance being provided to Positive Options that serious attempts are being made to address the issue(s) raised. Where Positive Options is **not** fully assured and it believes that the lack of assurance puts in jeopardy the safety and welfare of either/both service users or staff; Positive Options' own accreditation, and/or Positive Options professional reputation then the ATC can expect serious consideration being given by Positive Options to either suspending, or in extreme circumstances, terminating the License Agreement between the two organisations.

2.4 The phrase **'considerations for best practice'** is used in this Report in the context of strengthening the governance arrangements necessary to support the Organisation managing the MAPA® ATC License Agreement generally and in the opinion of the Assessor and/or Positive Options might benefit from minor adjustments to enhance practice; an approach, system and/or process. Suggestions made will extend beyond the BILD Code of Practice and the relationship with the Code may therefore be tangential. Typically, the 'considerations' offered in the Report will be more aligned with the developing expectations by Positive Options with regards to the MAPA® approach and its effective implementation within the Organisation. The words that we generally use in this Report to prefix a 'consideration for best practice' will be as for 'recommendations'.

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3. Visit Outcome

3.1 Details of the Visit

ATC Co-ordinator:	**Tara Patterson, Trust Advisor / Trainer for Management of Aggression**
Senior Organisational Representative:	**Ann Johnston, Senior Manager – Corporate Risk Services**
Date of Visit:	**09 November 2009**
Venue of Visit:	**Graham House, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8BH**
Independent Assessor:	**Anji Dyke**
ATC Staff Present:	**Tara Patterson, Martin McCooey – Licensed MAPA® Trainer**
License Expiry Date:	**31 December 2009**

3.2 About the MAPA® ATC

3.2.1 Since 1 April 2007 the Belfast Health and Social Care Trust assumed responsibility for services provided by Belfast City Hospital, The Royal Hospitals, The Mater Hospital, Greenpark Healthcare Trust, North and West Belfast and South and East Belfast HSS Trusts. The six Trusts which joined to form the (new) Belfast Health and Social Care Trust came together to provide an integrated and comprehensive range of health and social care for the people of Northern Ireland, and beyond. The Trust employs nearly 22,000 staff and provides services for more than 340,000 people in Belfast, and regional services to the whole of Northern Ireland. Specialist mental health services are one of a number of the broad range of clinical specialities offered by the new Trust and forms the focus of the Positive Options BILD Accredited MAPA® Approved Training Centre, described under License as the *Knockbracken Healthcare Park ATC Satellite Centre*. Its sister MAPA® ATC covered by the Trust focuses on learning disability services offered by Muckamore Hospital.

3.2.2 The Knockbracken Healthcare Park ATC configuration is one of the longest standing MAPA® ATC licensing arrangements; the first trainers were trained in 2000 and Knockbracken became one of the first ATCs authorised by Positive Options under its own BILD accreditation in December 2005. The Centre currently employs nine Licensed MAPA® Trainers (LMTs); six of these LMTs are trained to deliver training programmes in Level 1 MAPA® interventions; three LMTs are currently trained to deliver training programmes in Level 2 MAPA® interventions, although one of the three existing LMTs is currently converting to Level 1 at the time of the Visit taking place and this report being prepared. MAPA® activity within the ATC is relatively extensive totalling 150 (MAPA®) training days and 774 staff being trained in the calendar year 2009.

3.2.3 Following the 2008 Annual Centre Verification and Support Visit, the process that informs the relicensing (or not) of MAPA® ATCs, Knockbracken Healthcare Park MAPA®ATC was relicensed unconditionally although two recommendations were offered to the Organisation. The ATC was commended in nine areas relating to implementing the spirit and practices required by the BILD Code of Practice for the Use of Physical Interventions (2006) and the MAPA® ATC License Agreement. Areas of praise previously included:

- Developing use of patient-centred terminology in both policy and practice.
- The use of electronic booking systems to provide course synopsis to staff and thus helping meet pre-course information requirements as outlined in Chapter 4 of the BILD Code (2006).
- An information leaflet is available at ward/clinical level for staff and their managers.
- It is understood that there is a good relationship between the MAPA® Training Team and operational managers.
- Knockbracken appears to have a cohesive training team that is up to date with latest best practice guidance and is keen to further develop its knowledge and skills. Strong, positive leadership within the MAPA® Training Team has been reported consistently.
- There are effective relationships between the Trust and others HSC Trusts in Northern Ireland; as a longstanding MAPA® ATC, Knockbracken is often looked to as a centre of knowledge and excellence.
- There is a positive focus on evaluation, learning and improvement within the ATC; possibly the direct evaluation of the service user experience could be strengthened in the future.
- There is a strong sense of organisation within the MAPA® Training Team and good levels of confidence across the trainer group.

3.3 **Current Performance against the BILD Code of Practice for the Use of Physical Interventions (2006)**

Section	Descriptor	Compliance Level	Comments
1	Policies	Compliant	See recommendations 1, 2, and 3; 3.10 below.
2	Best Interest Criteria	Compliant	See recommendation 3; 3.10 below.
3	Techniques for Physical Intervention	Compliant	
4	Health and Safety	Compliant	
5	Course Organisation	Compliant	
6	Monitoring Performance	Compliant	See recommendation 2; 3.10 below.
7	Evaluation and Record Keeping	Compliant	
8	Professional Conduct	Compliant	See recommendations 1 and 3; 3.10 below.

3.4 **Current Performance against the Positive Options MAPA® ATC License Agreement**

Section	Descriptor	Compliance Level	Comments
3	Role of the Approved Training Centre (ATC)	Compliant	
4	Role of the ATC Co-ordinator	Compliant	
5	Role of the ATC Licensed MAPA® Trainers (LMTs)	Compliant	LMTs within Registration period: 100%

7	Use of Trademarks, Copyrighted Materials and Logos	Compliant	No evidence to contrary.
8	Certification of Course Participants	Compliant	
9	Advertising and Marketing	Compliant	No evidence to contrary.
10	Insurance and Liability	Compliant	No evidence to contrary.
11	Assignment	Compliant	No evidence to contrary.
13	Fees Payable	Compliant	No outstanding fees or aged debts of any size or significance without explanation.

3.5 **Commendable Practice**

3.5.1 In January 2009 the Centre Co-ordinator produced a leaflet supporting the Zero Tolerance campaign in Northern Ireland, in consultation with the Suzy Lamplugh Trust for all staff. The leaflet outlines the Trust's commitment to support and advise its staff with regard to personal safety, it also profiles the menu of associated training available to all.

3.5.2 Training provided to Security Staff by the MAPA® Training Team is reported to have changed (positively) the focus of the management of aggression and violence by Security Staff and enabled a more consistent approach to the use of physical interventions as experienced by service users and members of the public. The LMTs engaged in practice sessions for Security Staff were reported to include wearing security staff equipment i.e. stab vests and radio belts, in order to test and problem solve using MAPA® interventions. This approach has ensured that Security Staff can better understand the impact and implications of holding people. Positive Options heard that it was recognised that whilst being required to use such equipment, it did inhibit and limit the benefits of (Security Staff) making an assessment of physical reactions when time and space is being taken up. The method also highlighted the need to ensure that such equipment is taken into account in minimising injury to patients, service users and members of the public in crisis situations.

3.5.3 The Centre Co-ordinator and LMT present when the Assessor appointed by Positive Options to undertake the license verification on its behalf visited the Trust described a case study written from a professional perspective that is used on MAPA® learning events. We understand that the case study is then supported by the provision of diary inserts that profile a service user's perspective. This creative method of training delivery helpfully addresses the stereotyping and assumptions that are sometimes made about users of services by professionals. It provides an opportunity for discussion and debate around the personalisation and person-centred practice agendas.

3.5.4 The Assessor noted that the Centre Coordinator for the MAPA® ATC provides a letter to participants at least three weeks prior to the event taking place; we understand that the letter outlines expectations regarding safe participation; appropriate dress and attaches a health disclaimer document.

3.5.5 During the 2008 Visit the Centre Co-ordinator described a 'Managers Pack' that provided all relevant information in respect to MAPA® for ward managers. The Assessor was made aware during the 2009 Visit that the Pack has once again been updated and reissued to all operational managers to ensure that staff are appropriately prepared for participation on during MAPA® training.

3.5.6 There continues to be a strong emphasis on evaluation, learning and improvement within the MAPA® ATC although this largely relates to staff satisfaction, understanding and professional aspects relating to MAPA® and MAPA® training. The ATC is bestowed responsibility for audit relating to MAPA® physical interventions and the management of challenging behaviour; aggression, and violence. The ATC could excel its current commitment to quality and service improvement by demonstrating its assurance to the spirit of the BILD Code (2006) through the objective measurement of service user experience of the use of MAPA® in care services.

3.5.7 The Assessor made a specific observation (a commendation shared by Positive Options directly) relating to the genuine interest by the MAPA® ATC Centre Co-ordinator and the MAPA® Training Team in ensuring that MAPA® values and principles were not only firmly embedded within the training content but evident in policy and care practices. The Centre Co-ordinator and LMTs appear to utilise training intelligence advantageously to influence the development of policy and practice in the Trust's services.

3.6 Practices Requiring Immediate or Urgent Attention by the ATC

3.6.1 The Trust must progress its single policy for the use of physical interventions in the management of challenging behaviour; aggression, and violence. This matter has narrowly avoided forming a condition to relicensing on the basis of a specific existing policy that we believe is in operation in specialist mental health services. We understand that there is some dispute within the Trust's Management Team relating to the shape and tone of the (proposed) single policy and would encourage, very strongly, that the Organisation takes reasonable account of concerns voiced by the ATC Centre Co-ordinator and MAPA® Training Team about having a policy in place that directs the use of holding practices that is clear and unambiguous and is in the spirit of current societal expectations. We would also strongly recommend that the tenet of the Policy is balanced equally between meeting the therapeutic aspects of care management of service users as well as (importantly) the staff of the Trust.

3.7 Compliance with Quarterly Activity Reporting Requirements

Quarter	Submission due	Compliance with Submission	Timeliness of Submission
1: 1 Jan – 31 Mar	30 April	Yes	On-Time
2: 1 Apr – 30 Jun	31 July	Yes	On-Time
3: 1 Jul – 30 Sep	30 October	Yes	On-Time
4: 1 Oct – 31 Dec	31 January	Yes	On-Time
Summative Performance		**100%**	**100% On-Time**

3.8 Relicensing Decision

3.8.1 The ATC should be re-licensed, unconditionally, until **31 December 2010**.

3.9 Conditions to Relicensing

3.9.1 There are no conditions to relicensing Belfast Health and Social Care Trust – Knockbracken Healthcare Park as a Positive Options BILD Accredited MAPA® Approved Training Centre.

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3.10 **Recommendations**

No.	BILD Domain	Narrative Proposal
1.	**1 Policies** **8 Professional Conduct**	Following the 2007 ATC Annual Report issued to the Trust, relicensing was conditional on the Trust, together with its partners producing a single policy for the use of restrictive physical interventions in the management of challenging behaviour; aggression, and violence. We heard of progress during the 2008 Visit and formally recommended the advancement of this initiative. We understand that the development of a single policy is now significantly advanced but remained unratified at the time of the Annual Visit taking place. We therefore recommend here finalisation of the Policy before the end of the current financial year. The Trust should provide a copy of the final agreed policy to Positive Options, for information.
2.	**1 Policies** **6 Monitoring Performance**	The ATC could excel its current commitment to quality and service improvement by demonstrating its assurance to the spirit of the BILD Code (2006) through the objective measurement of service user experience of the use of MAPA® in care services.
3.	**1 Policies** **2 Best Interest Criteria** **8 Professional Conduct**	The ATC should capitalise on its success in providing useful information to staff at a clinical level about the MAPA® model and when its principles are applied by considering producing user accessible information; for example, an easy-read leaflet or fact sheet about what MAPA® is and why and how physical as well as non-physical interventions may be used to positively address and/or support challenging behaviour and the management of aggression and violence that might be attributed to mental ill health. Positive Options would be keen and interested to proof and quality assure any service user information that the ATC might wish to produce for service users, their informal carers, and visitors and the public.

3.11 **Considerations for Best Practice in Implementing the MAPA® Physical Interventions Model within the ATC Organisation**

3.11.1 There are no considerations for best practice in implementing MAPA® within the Organisation.

Name: **Jeremy Boughey** Position: **General Manager**

Signature: Jeremy Boughey. Date: 08 January 2010

CONFIDENTIAL REPORT

Positive Options
BILD Accredited MAPA® Approved Training Centre

Annual Report for:
BELFAST HEALTH AND SOCIAL CARE TRUST
MUCKAMORE ABBEY HOSPITAL MAPA® ATC SATELLITE CENTRE

08 January 2010

LICENSING OUTCOME:

Relicensed without Conditions

Prepared on behalf of Positive Options by:
Jeremy Boughey, General Manager

Positive Options BILD Accredited MAPA® Approved Training Centre

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1. Introduction

1.1 This Report summarises the findings that relate to the performance of **Belfast Health and Social Care Trust – Muckamore Abbey Hospital, hereafter referred to as 'the ATC'; 'the Organisation'; 'the Hospital', or 'Muckamore'** (a Positive Options BILD Accredited MAPA® Approved Training Centre [ATC]) in meeting the requirements of the ATC License Agreement between itself and Positive Options Limited as the Licensee, and the standards and expectations of the BILD Code of Practice for the Use of Physical Interventions: A Guide for Trainers and Commissioners of Training (2006). The Report is provided on the basis of an ATC Verification and Support Visit undertaken by an Independent Assessor appointed by Positive Options to undertake the Visit on its behalf, and the ATC providing routine reports relating to MAPA® training activity under the License Agreement.

1.2 Section 3 of this Report contains the concluding decision of Positive Options about the *continued licensing* (for ATCs subject to a 3-year licensing arrangement) or *relicensing* (for ATCs subject to an annual licensing arrangement, including those transferring from a 3-year licensing arrangement at its end) of the MAPA® ATC and may or may not contain *conditions*; *recommendations*, and *considerations for best practice*; these terms are explained in Section 2, below. The decision contained within Section 3 of this Report is *informed* by the Assessor's Report to Positive Options and their opinions but is **not** wholly dependent upon the individual and/or summative views offered by the Assessor. Positive Options will consider additional factors associated with the License Agreement and the ATC's general performance against the requirements of the License. There is an expectation by Positive Options that the Management Lead for the Organisation, together with the ATC Co-ordinator will formulate a brief response to indicate the Organisation's agreement to the contents of the Report or to contest any observations that it feels to be unfair, unrepresentative or inaccurate, and to make any immediate responses to any conditions; recommendations, and considerations for best practice that are included in the Report.

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2. Terminology

2.1 The term **'recommendation'** is used in the Report in the context of a standard within the BILD Code of Practice (2006) being declared and/or assessed as being met but in the opinion of the Assessor the governance arrangements necessary to support the License Agreement could benefit from minor adjustments to enhance practice; an approach, system and/or process. The words that we generally use in this Report to prefix a recommendation will be: 'could' or 'might', 'should consider', etc. When a recommendation is made, the ATC's decision (or not) to act upon this will be reviewed by the Assessor, together with the Centre Co-ordinator at the next scheduled Annual Centre Verification and Support Visit.

2.2 The term **'condition'** is used in the Report in the context of meaning a change in practice; an approach, system and/or process that is required and essential to ensure the fidelity of BILD's Code being met or the application of MAPA® is upheld. A 'condition' will generally result from a standard being self-declared by the ATC and/or assessed by the Assessor as **not being met**, or only **part-met**. The words that we generally use in this Report to prefix a condition will be: 'should', 'must' or 'will'; 'is required to', etc.

2.3 The continued licensing of the ATC or its relicensing will be contingent upon any condition(s) required of the ATC being fully met **or** sufficient alternative assurance being provided to Positive Options that serious attempts are being made to address the issue(s) raised. Where Positive Options is **not** fully assured and it believes that the lack of assurance puts in jeopardy the safety and welfare of either/both service users or staff; Positive Options' own accreditation, and/or Positive Options professional reputation then the ATC can expect serious consideration being given by Positive Options to either suspending, or in extreme circumstances, terminating the License Agreement between the two organisations.

2.4 The phrase **'considerations for best practice'** is used in this Report in the context of strengthening the governance arrangements necessary to support the Organisation managing the MAPA® ATC License Agreement generally and in the opinion of the Assessor and/or Positive Options might benefit from minor adjustments to enhance practice; an approach, system and/or process. Suggestions made will extend beyond the BILD Code of Practice and the relationship with the Code may therefore be tangential. Typically, the 'considerations' offered in the Report will be more aligned with the developing expectations by Positive Options with regards to the MAPA® approach and its effective implementation within the Organisation. The words that we generally use in this Report to prefix a 'consideration for best practice' will be as for 'recommendations'.

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3. Visit Outcome

3.1 Details of the Visit

ATC Co-ordinator:	[redacted], **Behaviour Nurse Specialist**
Senior Organisational Representative:	[redacted], **Hospital Services Manager**
Date of Visit:	**11 November 2009**
Venue of Visit:	**Muckamore Abbey Hospital, 1 Abbey Road, Muckamore, Antrim, BT41 6DP**
Independent Assessor:	**Anji Dyke**
ATC Staff Present:	[redacted] **– Licensed MAPA® Trainer**
License Expiry Date:	**31 January 2010**

3.2 About the MAPA® ATC

3.2.1 Since 1 April 2007 the Belfast Health and Social Care Trust assumed responsibility for services provided by Belfast City Hospital, The Royal Hospitals, The Mater Hospital, Greenpark Healthcare Trust, North and West Belfast and South and East Belfast HSS Trusts. The six Trusts which joined to form the (new) Belfast Health and Social Care Trust came together to provide an integrated and comprehensive range of health and social care for the people of Northern Ireland, and beyond. The Trust employs nearly 22,000 staff and provides services for more than 340,000 people in Belfast, and regional services to the whole of Northern Ireland. Regional specialist assessment and treatment for people with learning disabilities is provided by Muckamore Abbey Hospital which also helps to support people living regular lives in the community. The Hospital is situated three miles outside of Antrim; it opened in the late 1950s and since this time the Hospital and its facilities have continued to be developed through refurbishment and the addition of modern facilities. There is presently a major redevelopment programme underway to ensure that assessment and treatment services for people with learning disabilities are contemporary and in line with current societal expectations. In recognition of the high quality, patient-centred service that the Hospital is offered as providing Muckamore was awarded the Charter Mark for Excellence in 1998; 2001, 2004 and 2007. Its sister MAPA® ATC covered by the Trust focuses on specialist mental health services offered by Knockbracken Healthcare Park.

3.2.2 The Muckamore Abbey Hospital ATC configuration is one of the longest standing MAPA® ATC licensing arrangements; the first (Level 1) trainers were trained in 2000 and Muckamore became one of the first ATCs authorised by Positive Options under its own BILD accreditation in December 2005. The Centre currently employs ten Licensed MAPA® Trainers (LMTs); three of these LMTs are trained to deliver training programmes in Level 1 MAPA® interventions and seven LMTs are currently trained to deliver training programmes in Level 2 MAPA® interventions. MAPA® activity within the ATC is relatively extensive totalling 88 (MAPA®) training days and 474 staff being trained in the calendar year 2009.

3.2.3 Following the 2008 Annual Centre Verification and Support Visit, the process that informs the relicensing (or not) of MAPA® ATCs, Muckamore Abbey Hospital MAPA®ATC was relicensed

unconditionally although three recommendations were offered to the Organisation. The ATC was commended in five areas relating to implementing the spirit and practices required by the BILD Code of Practice for the Use of Physical Interventions (2006) and the MAPA® ATC License Agreement. Areas of praise previously included:

- Muckamore was reported to have a cohesive training team that is professional and experienced in the support of vulnerable people with a learning disability. The Assessor also reported a strong ethical and humanistic commitment to meeting the needs of people and the appropriate use of restrictive physical interventions in the management of their behaviour.
- The ATC's relationship with the 'Tell it Like it Is' Service User Group was reported to be strong and routine.
- There are effective relationships between the Trust and others HSC Trusts in Northern Ireland.
- A positive focus on audit, evaluation, learning and improvement has been developed within the ATC.
- A commitment to work with other ATCs such as Knockbracken Healthcare Park to agree a single policy for the management of challenging behaviour; aggression, and violence, and the use of restrictive physical interventions in pursuance of this.

3.3 **Performance against the BILD Code of Practice for the Use of Physical Interventions (2006)**

Section	Descriptor	Compliance Level	Comments
1	Policies	Compliant	See recommendations 1, 2, and 3; 3.10 below.
2	Best Interest Criteria	Compliant	
3	Techniques for Physical Intervention	Compliant	
4	Health and Safety	Compliant	
5	Course Organisation	Compliant	See recommendation 4; 3.10 below.
6	Monitoring Performance	Compliant	
7	Evaluation and Record Keeping	Compliant	See recommendation 4; 3.10 below.
8	Professional Conduct	Compliant	See recommendations 1, 2, and 3; 3.10 below.

3.4 **Performance against the Positive Options MAPA® ATC License Agreement**

Section	Descriptor	Compliance Level	Comments
3	Role of the Approved Training Centre (ATC)	Compliant	
4	Role of the ATC Co-ordinator	Compliant	
5	Role of the ATC Licensed MAPA® Trainers (LMTs)	Compliant	LMTs within Registration period: 100%

7	Use of Trademarks, Copyrighted Materials and Logos	Compliant	No evidence to contrary.
8	Certification of Course Participants	Compliant	
9	Advertising and Marketing	Compliant	No evidence to contrary.
10	Insurance and Liability	Compliant	No evidence to contrary.
11	Assignment	Compliant	No evidence to contrary.
13	Fees Payable	Compliant	No outstanding fees or aged debts of any size or significance without explanation.

3.5 **Commendable Practice**

3.5.1 The two Licensed MAPA® Trainers (LMTs) who deliver the training module that focuses on understanding challenging behaviour are both Behaviour Nurse Specialists.

3.5.2 The Assessor appointed by Positive Options to undertake the verification and support Visit on its behalf reported that the ATC at Muckamore took the lead for the planned transfer of a young male service user to a community setting following a hospital admission of two years duration. This transfer of care resulted in 14 staff working with and supporting the person in the community receiving a three-day tailored MAPA® training course. She heard that the training was informed by analysis of incidents and proven behaviour management strategies developed by the ATC. We understand that there was significant opposition to the transfer of this person's care to the community and a lack of belief that the young man would cope adequately. The Centre Co-ordinator offered that the young man is now living in the community successfully and that staff working with and supporting him feel that they have the skills to support him and better manage the risk behaviours that he exhibits from time to time.

3.5.3 We understand that Bank staff and students are trained alongside established clinicians and practitioners employed substantively by the Trust. We would expect this to bring benefits to bank staff and students and promote an inclusive environment of work.

3.5.4 A new addendum to the ATC's five-day MAPA® training course includes basic life support as part of the curricular ensuring an integrated approach to learning and the sharing of key messages to staff.

3.5.5 The Assessor was provided with an opportunity to see training delivery live at the time of her Visit. She reported that the training delivery that she observed was in line with expected high standards extolled by Positive Options as part of its preparation of trainers and subsequent update and reassessment programmes that existing LMTs are expected to be successful in completing. The Assessor added that participants were thoroughly engaged and engrossed in demonstrating their competence. She learnt that individual courses are designed around risk assessments and presenting behaviours within clinical service areas. It was noted that audits have been vital in refocusing and emphasising key messages to reinforce good practice. This clearly demonstrates the Hospital's commitment to delivering the spirit of the BILD Code of Practice (2006) and the practices that it expects under Section 2 (Best Interest Criteria) and Section 3 (Techniques for Physical Intervention), specifically.

3.5.6 It was observed that the ATC continues to have has a considerable amount of support in the production of monthly and quarterly internal audit reports. Whilst these are not clinical in nature the reports are compiled and produced by a specific post holder employed for the purposes of monitoring and research.

3.5.7 The Assessor was reassured that the LMTs employed within the Service meet on a routine and regular basis to ensure standardised training practices and to develop specialised and tailored learning around the needs of individual service users.

3.5.8 Overall we heard that the (new) ATC Co-ordinator is keen to modernise the ATCs administrative practices that support training and its delivery and ensure that the licensing arrangement between the Trust (Hospital) and Positive Options is fully adhered to. An anecdote offered by the Assessor in her written opinion to Positive Options following the Visit was perhaps telling of the commitment of the MAPA® Training Team to service users. She recounted that she witnessed the Centre Co-ordinator's application of values in practice when they bumped into a service user walking on the site. The Co-ordinator was reported to be respectful, sensitive and supportive to the person and for the Assessor it was a reassuring moment to see people practice what they preach. Positive Options would equally uphold such practices.

3.6 Practices Requiring Immediate or Urgent Attention by the ATC

3.6.1 The Trust must progress its single policy for the use of physical interventions in the management of challenging behaviour; aggression, and violence. This matter has narrowly avoided forming a condition to relicensing on the basis of a specific existing policy that we believe is in operation in specialist learning disability services although the MAPA® Training Team has disputed the robustness of the policy, specifically the clinical terminology used. We understand that there is some dispute within the Trust's Management Team relating to the shape and tone of the (proposed) single policy and would encourage, very strongly, that the Organisation takes reasonable account of concerns voiced by the ATC Centre Co-ordinator and MAPA® Training Team at Muckamore about having a policy in place that directs the use of holding practices that is clear and unambiguous and is in the spirit of current societal expectations. We would also strongly recommend that the tenet of the Policy is balanced equally between meeting the therapeutic aspects of care management of service users as well as (importantly) the staff of the Trust.

3.7 Compliance with Quarterly Activity Reporting Requirements

Quarter	Submission due	Compliance with Submission	Timeliness of Submission
1: 1 Jan – 31 Mar	30 April	Yes	On-Time
2: 1 Apr – 30 Jun	31 July	Yes	On-Time
3: 1 Jul – 30 Sep	30 October	Yes	On-Time
4: 1 Oct – 31 Dec	31 January	Yes	On-Time
Summative Performance		**100 %**	**100% On-Time**

3.8 Relicensing Decision

3.8.1 The ATC should be re-licensed, unconditionally, until **31 January 2011**.

Positive Options BILD Accredited MAPA® Approved Training Centre

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3.9 **Conditions to Relicensing**

3.9.1 There are no conditions to relicensing Belfast Health and Social Care Trust – Muckamore Abbey Hospital as a Positive Options BILD Accredited MAPA® Approved Training Centre.

3.10 **Recommendations**

No.	BILD Domain	Narrative Proposal
1.	**1 Policies** **8 Professional Conduct**	Following the 2007 ATC Annual Report issued to the Trust, relicensing was conditional on the Trust, together with its partners producing a single policy for the use of restrictive physical interventions in the management of challenging behaviour; aggression, and violence. We heard of progress during the 2008 Visit and formally recommended the advancement of this initiative. We understand that the development of a single policy is now significantly advanced but remained unratified at the time of the Annual Visit taking place. We therefore recommend here finalisation of the Policy before the end of the current financial year. The Trust should provide a copy of the final agreed policy to Positive Options, for information.
2.	**1 Policies** **8 Professional Conduct**	The ATC and the Trainers licensed by Positive Options to work as part of it would benefit from a literary search of extant and new professional references and national documents that would enhance the training materials currently used by the ATC to educate and train the Hospital's staff.
3.	**1 Policies** **8 Professional Conduct**	In the development of the new training suite at Muckamore Hospital by the Trust, consideration should be given by the Centre Co-ordinator to include a Resource Library (bookcase/shelf) of topical documents relating to the use of restrictive physical interventions, and a Notice Board whereby front covers of relevant documents could be made more visual for staff attending training courses.
4.	**5 Course Organisation** **7 Evaluation and Record-Keeping**	The method of course evaluation by Lead Trainers, whilst undertaken in a basic way is merely sufficient and lacking structure and the ability to dynamically interpret data. This is inconsistent with the attention given by the ATC to audit and evaluation of quantitative data. We understand that currently notes are maintained in a relatively ad-hoc way by trainers in a book kept in the training suite. Positive Options would strongly recommend that the ATC adopt use of its *Trainer's Event Evaluation Report (TEER)* which was offered to all MAPA ATCs in December 2008. The document will enable a consistent appraisal of training by the people who are charged with delivering it and the form lends itself to databasing and structured analysis.

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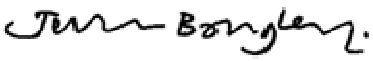
3.11 **Considerations for Best Practice in Implementing the MAPA® Physical Interventions Model within the ATC Organisation**

3.11.1 During her observation of training the Assessor appointed by Positive Options to undertake the Visit on its behalf observed that the Positive Options PowerPoint materials were not the most current versions. The LMTs employed by the Hospital described compatibility issues with their equipment and the information that is made available from the trainers' area of Positive Options website. The Centre Co-ordinator is recommended to contact Positive Options to discuss the compatibility issues to determine how this might be overcome.

Name: **Jeremy Boughey** Position: **General Manager**

Signature:  Date: 08 January 2010

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Belfast Health & Social Care Trust
Muckamore Abbey Hospital
CPI Approved Training Centre

VERIFICATION REPORT NOVEMBER 2015

LICENSING OUTCOME: RELICENSED

On the basis of the findings detailed within this report the license to operate as a CPI Approved Training Centre is granted on a rolling 12 monthly basis for a further 3 years 31 December 2018.

Distribution List:

Esther Rafferty – Service Manager
[redacted] – Behaviour Specialist and ATC Coordinator
CPI Management

1. Introduction

This report was authored on behalf of CPI Inc. by Lorraine Hilton, Director - Customer Service, Quality and Validation. It was issued on 22nd December 2015 following the Verification Visit that took place on 26 October 2015 at the Trust's Knockbracken site in Belfast. Present at the meeting were Lorraine Hilton on behalf of CPI and [redacted] on behalf of the Trust.

2. Background

The Belfast Health & Social Care Trust provide health and social care services to the population of Belfast and some specialist services to the whole of Northern Ireland. Muckamore Abbey Hospital is a CPI Approved Training Centre (ATC) and provide specialist inpatient, assessment and treatment services for people with learning disabilities and mental health needs, forensic needs or challenging behaviour.

The ATC was established in 2005 and currently has 15 certified instructors, including four recent additions in 2015. With the exception of the four new instructors all are licensed to deliver MAPA® Foundation, Advanced and Emergency programmes. The new Instructors are currently licenced to deliver the Foundation programme only. The ATC has taken the opportunity to 'upskill' some instructors with additional content as part of the annual renewal of their certification and as such 6 of the instructors are able to deliver training and consultancy in CPIs CH-3SM Holding Skills for Essential Care (CH-3) programme and 8 instructors have also recently been licensed to deliver the Dementia Capable Care: Behaviours (DDC:B) programme.

3. Executive Summary

The verification visit is undertaken on a three yearly cycle to inform the renewal of the ATC license. From the information gleaned during the discussions with the ATC Coordinator the license will be renewed on a rolling 12 monthly basis for a further three years until 31 December 2018.

The visit provides an opportunity to review the practices of the ATC against the license agreement and importantly against six criteria that are internationally recognised as key factors in reducing the use of restrictive practises within organisations which incidentally correspond to the six strategies identified in the Trust Policy i.e. leadership and governance; performance measurement; learning and development; providing personalised support; customer focus and involvement and continuous improvement.

We noted a number of areas of good practice, in particular the focus on restraint reduction and avoidance with the promotion of positive behaviour support awareness and coaching sessions; the collection, collation and analysis of incident data and the involvement of MAPA® certified instructors in incident review and support. We do not feel it necessary to impose any conditions on the relicensing of Belfast Health and Social Care Trust's Muckamore Abbey Hospital as a CPI Approved Training Centre but we have made one recommendation around the timescales in which MAPA® is delivered.

CPI understands that the instructors have other roles within services and as such we recognise that the delivery of MAPA® training is only a part of their role. Our objective is to support Certified Instructors to deliver effective workplace training to staff to support them in delivering improved outcomes for the people who use services. In the two interim years (2016 & 2017) until the next Verification Visit the ATC may request a 'Support Day'. CPI is open to suggestions as to how the ATC would like to use the support days and will consider the suitability and appropriateness of all requests. We would consider facilitating a support day in conjunction with other Trusts in Northern Ireland.

4. Good Practice

The visit highlighted a number of areas of good practice:

I. The policy supports national and international guidance with a clear focus on restraint reduction and avoidance identifying six strategic areas to support restraint reduction.
II. The collection, collation and analysis of data enables the production of monthly physical intervention reports to support active monitoring of the use of interventions by individual service and across the Trust as a whole.
III. The roll out of positive behaviour support awareness and coaching to staff is a positive step in the drive to reduce the use of restraint within services.
IV. There is a strong sense of involvement by the instructors and the ATC coordinator in actively reviewing and supporting clinical and support staff following an incident where physical interventions are used. There are also examples of support to family members with understanding behaviour and the use of restrictive physical interventions.
V. The regular meetings for certified instructors and the regional MAPA® provide an open forum for discussion, sharing good practice and peer to peer support and would be particularly valuable for the new MAPA® instructors.

5. Conditions

We use the term condition in the context of meaning a change in practise, approach or system/process that is needed to meet a requirement within the BILD Code of Practice (2014). A condition will result from a standard not being met or only partially met.

We do not feel it necessary to impose any conditions on the relicensing Belfast Health and Social Care Trust's Muckamore Abbey Hospital as a CPI Approved Training Centre.

6. Recommendations

The following recommendation is based on the discussions that took place during the Verification Visit and offered by CPI to support the ATC and the Organisation in improving an approach, a system or a process that may already exist but might benefit from minor adjustments, additions or amendments or may not yet exist but where implementation would enhance what is already there within the Organisation. It is entirely the decision of the organisational leadership whether or not to act on these recommendations.

I. In relation to the time scales in which MAPA® training is delivered we would recommend that the current duration of training is appropriate, i.e. 5 days for an initial programme and 2 days for a refresher. In the interests of restraint reduction and avoidance it is important that refresher programmes do not just focus on the holding skills.

7. Summary of Findings

Below is a summary of the discussion points in relation to the 6 key factors that strongly drive and influence restraint reduction within organisations

	Key Factor	Comments
1	Leadership and Governance	The Belfast Health & Social Care Trust has an extensive range of policies in place including a comprehensive 'Use of Restrictive Interventions for Adult and Children's Services'. The Policy sets out a framework for Restraint Reduction based on the same six strategies used in this report. As ever the key for any organisation is to ensure that policy is enacted at every level. To this end there are clear responsibilities of management and staff at all levels are clearly defined. This policy provides overarching guidance for all Trust Services which will then create their own procedural documents that outline how the policy will be implemented within the individual services. The Leadership have set out organisational mission, guiding principles and values which are articulated on the website and in literature available in services. Data regarding the use of physical interventions is collected, collated and analysed at all levels within the Trust and reported at a senior level via Risk and Governance Committee and the Joint Health& Safety Committee.
2	Performance Measurement	Incident reports have historically been made manually but electronic recording via the Datix system is now being used in most services (all by the end of 2015). A wide range of information is collected that enables the production monthly physical intervention reports. The information has recently been updated to include a specific requirement to state if MAPA® has been used. The reports enable the data to be broken down by individual services patients, the types of interventions used, length of time etc. Such data is invaluable when monitoring the use of restrictive physical interventions. The data indicates that even though restrictive interventions are still being used the level of restriction and the time patients are held is reducing. Collated incident data is escalated to senior management via Risk and Governance Committee and the Joint Health& Safety Committee. MAPA® certified instructors meet regularly and incident data and analysis is a regular discussion point. Incidents reports are monitored by the ATC Coordinator / Behaviour Specialist for accurate and appropriate completion as well as reviewing where advice, support or additional training might be required.

		The Trust has agreed to pilot the Restraint Reduction Network's self audit tool, that requires organisations to assess how they measure up to specific Restraint Reduction criteria.
3	Learning and Development	Staff are made aware of MAPA® on joining the Trust, with inclusion in induction. The MAPA® certified instructors have roles within clinical services as well as their training delivery role. Each of the wards at the hospital has a MAPA instructor on the staff team. This has many benefits, not least the ongoing support for staff who might have to use physical interventions in their service and the valuable knowledge and understanding of the services which the Instructors can bring to the delivery of training and so ensuring that training remains relevant and appropriate to staff. Training need is regularly reviewed to ensure appropriate skills are given to staff. Whilst all staff are provided with the full range of MAPA® Foundation, Advanced and Emergency skills, it has become apparent that the use of emergency skills has rapidly declined and consideration has been given to the continuation of teaching these skills on an on-going basis. All services are required to report on compliance with training requirements and there are systems in place to monitor staff attendance at training. Service Managers and staff are reminded when refresher training is due. We understand the release of staff to attend training can be problematic and options to review the time scales in which training is delivered are continually being reviewed. CPI would like to take the opportunity to remind the ATC of the importance of ensuring that training, both initial and refresher programmes, supports restraint reduction through the inclusion of the non-physical responses to challenging behaviour that are detailed in units 1 to 7 and 10 of the MAPA® Foundation programme. So, for example, CPI would recommend that for those staff that are trained with the full range of MAPA® holding skills the minimum delivery time would be 5 days for the initial programme and 2 days for a refresher. The feedback from staff following MAPA ® Training is positive with an indication that staff feel more confident in managing situations. In line with the focus on restraint reduction and avoidance the Hospital has run positive behaviour support awareness and coaching sessions. Individuals who present risk behaviour where there is likelihood that restrictive practices might be used have PBS plans developed and put in place.

4	Providing Personalised Support	The PARIS system supports the sharing of patient information between the professionals that are involved in an individual's care and treatment. We discussed the completion of comprehensive multidisciplinary risk assessments that are completed for all patients on admission. Positive Behaviour Support plans, including ways of minimising the use of restrictive practices are put in place for those patients whose behaviour may challenge. Environmental risk assessments are completed in all services and have resulted in changes to minimise the impact of negative environmental factors on people using services. Patients are encouraged to be involved the development and on-going review of their care plans.
5	Customer Focus and Involvement	We discussed the ways in which patients, families and carers are provided with information and support by the Trust. There is a complaints procedure in place and people are made aware of this through information provided on admission, literature available on site and on the Trust website. Discussions with regard to the use of MAPA® interventions are had with those who might present with challenging behaviours as part of the risk assessment process and the development of positive behaviour support plans. We understand that Keep Me Safe, Treat me with Respect leaflets are available for patients and families/carers. Patient meetings/forums and 'Tell it Like it is' questionnaires provide patients with opportunities to raise concerns and issues. Independent Advocates are available to support patients in raising concerns and issues or to ask questions about the service or the care they are receiving. MAPA® Instructors meet with parents/families and carers to inform and about what MAPA® is and importantly what it not. Patient satisfaction surveys are regularly completed. We noted the use of accessible information with the use of the Keep Me Safe leaflets and the provision of information in various formats, including BSL and ISL via the website.
6	Continuous improvement	There is acknowledgement that a key requirement for any organisation looking to reduce the use of restraint is to ensure learning takes place when an incident does occur. We were informed of the very clear pathway for incident investigation which may vary depending on the severity of the incident. All incidents are reviewed at ward level and discussed at weekly MDT meetings to

		understand the cause, review whether the response was appropriate, what might have been done differently and what needs to change to prevent a recurrence. We understand that MAPA® Instructors are often involved in incident reviews which not only supports those involved but will also ensure that training delivery remains appropriate and relevant to those attending. There are mechanisms in place to support the escalation of incident findings through levels of management and across directorates via the Governance leads and the Joint Health and Safety Committee. MAPA® certified Instructors are invited to attend a regional MAPA® Forum. The forum is made up of instructors from each of the Northern Ireland Trusts and supports the sharing of best practice and peer to peer support.

Appendix 1.

Certified Instructors currently registered at Belfast Health and Social Care Trust

Name	Current Certification Year:	Certification and qualifications:
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

*since moved to the Northern Trust but will continue to deliver training for BHSCT

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Belfast Health & Social Care Trust
Muckamore Abbey Hospital and Community Learning Disability Services
CPI Approved Training Centre

VERIFICATION REPORT NOVEMBER 2018

LICENSING OUTCOME: RELICENSED

On the basis of the findings detailed within this report the license to operate as a CPI Approved Training Centre is granted on a rolling 12 monthly basis for a further 3 years 31 December 2021.

Distribution List:

Mairead Mitchell – Interim Co-director of Learning Disability Services
[redacted] – Behaviour Specialist, ATC Coordinator and licensed MAPA Trainer
Dan Chesterman – Account Manager
CPI Management

1. Introduction

This report was authored on behalf of CPI Inc. by Lorraine Hilton, Director - Customer Service, Quality and Validation. It was issued on 27TH November 2018 following the Verification Visit that took place on 02 October 2018 at the Trust's Knockbracken site in Belfast. Present at the meeting were Lorraine Hilton on behalf of CPI and [redacted] on behalf of the Trust.

2. Background

The Belfast Health & Social Care Trust provide health and social care services to the population of Belfast and some specialist services to the whole of Northern Ireland. Muckamore Abbey Hospital is a CPI Approved Training Centre (ATC) and provide specialist inpatient, assessment and treatment services for people with learning disabilities and mental health needs, forensic needs or challenging behaviour. The ATC has recently (October 2017) been extended to incorporate Community Learning Disability Services whose staff have previously been trained in a different model of behaviour support and physical interventions.

An ATC since 2005 there are currently 14 Certified MAPA® Instructors. (See appendix 1) including four recently who have recently completed their Foundation level training for delivery in to community services. With the exception of those four all are licensed to deliver MAPA®

Foundation and Advanced programmes. In the year from October 2017 to September 2018 the ATC has delivered more than 60 classes to over 900 participants. (See Appendix 2)

3. Executive Summary

The verification visit is undertaken on a three yearly cycle to inform the renewal of the ATC license. From the information gained during the discussions with the ATC Coordinator the license will be renewed on a rolling 12 monthly basis for a further three years until 31 December 2021.

The visit provides an opportunity to review the practices of the ATC against the license agreement and importantly against six criteria that are internationally recognised as key factors in reducing the use of restrictive practises within organisations which incidentally correspond to the six strategies identified in the Trust Policy i.e. leadership and governance; performance measurement; learning and development; providing personalised support; customer focus and involvement and continuous improvement.

We were left in no doubt about the ATC's desire to reduce the use of restrictive practices and the use of physical restraint. We noted points of good practice in each of the areas mentioned above and we are pleased to note the delivery of training to community services to bring consistent approaches and messaging throughout. Whilst we do not feel it necessary to impose any conditions on the relicensing of the ATC, we have made some recommendations that may help to enhance current practice. These include raising awareness of restraint reduction by ensuring that 'reduction' rather than the 'use of' is a prominently expressed in Trust policies, procedures and literature; the development of an overarching strategy to support a reduction in the use of all restrictive practices (as opposed to just physical holding); and consider the duration of refresher training, making sure ample time is allocated to ensure that preventative strategies and non-physical interventions can be refreshed alongside the physical skills.

CPI understands that the instructors have other roles within services and as such we recognise that the delivery of MAPA® training is only a part of their role. Our objective is to support Certified Instructors to deliver effective workplace training to staff to support them in delivering improved outcomes for the people who use services. In the two interim years (2019 & 2020) until the next Verification Visit the ATC may request a 'Support Day'. CPI is open to suggestions as to how the ATC would like to use the support days and will consider the suitability and appropriateness of all requests. We would consider facilitating a support day in conjunction with other Trusts in Northern Ireland.

Additionally, CPI will hold a Certified Instructor Conference in 2019 that will provide opportunities for certified instructors to meet others share best practice and keep up to date with current and sector relevant guidance and legislation. Further information will be published soon.

4. Good Practice

The visit highlighted a number of areas of good practice:

I. We understand that over the last 12 months, MAPA® training has been rolled out to staff working in Community Learning Disability Services, ensuring that staff indifferent services are working to the same model supports a consistent approach and messaging throughout.

II. The role of the ATC Coordinator is key in ensuring the delivery of MAPA® training remains consistent, instructors are supported with regular meetings to promote their on-going development and such meetings provide for preparation and review of training, practice and peer support. This is good practice and will be an invaluable source of support for new instructors and particularly those working in the community.

III. The inclusion of a MAPA® Instructor on the staff team in inpatient services provides post training support and coaching for staff and help to embed the skills learnt in the classroom.

IV. The collection, collation and analysis of data enables the production of monthly physical intervention reports to support active monitoring of the use of interventions by individual service and across the Trust as a whole.

V. Positive behaviour support awareness and coaching to staff is a positive step in the drive to reduce the use of restraint within services.

5. Conditions

We use the term condition in the context of meaning a change in practise, approach or system/process that is needed to meet a requirement within the BILD Code of Practice (2014). A condition will result from a standard not being met or only partially met.

We do not feel it necessary to impose any conditions on the relicensing Belfast Health and Social Care Trust's Muckamore Abbey Hospital as a CPI Approved Training Centre.

6. Recommendations

The following recommendation is based on the discussions that took place during the Verification Visit and offered by CPI to support the ATC and the Organisation in improving an approach, a system or a process that may already exist but might benefit from minor adjustments, additions or amendments or may not yet exist but where implementation would enhance what is already there within the Organisation. It is entirely the decision of the organisational leadership whether or not to act on these recommendations.

I. The current policy indicates the ambitions of the Trust to reduce the use of restraint within its services, however, consideration might be given to how restraint reduction

and a reduction in the use of all restrictive practices could be made more explicit to ensure it is a key focus for Leaders and staff. At a basic level this might include referencing reducing the use of restraint in the policy title or broadening out restraint to incorporate all forms of restrictive practice.

II. Whilst there are indications that the Trust has a desire to reduce the use of restrictive practices there was no evidence of an explicit plan to do so. We might suggest that an operational group, which we understand has been set up to look at restraint reduction, could develop a specific trust-wide plan that focuses on reducing physical restraint and all restrictive practices and how such reductions might come about.

III. It is important that refresher training also includes a refresh of non-physical (as well as physical) skills in order to ensure that staff have the skills to be able to de-escalate situations and avoid getting to a point where a physical intervention might be required. To be able refresh staff in both non-physical and physical skills and adequately assess competency the Trust should ensure adequate time is allocated to refresher programmes. The CPI standard to refresh the Foundation level programme is one day and the advanced level programme, a minimum of two days.

7. Summary of Findings

Below is a summary of the discussion points in relation to the 6 key factors that strongly drive and influence restraint reduction within organisations

	Key Factor	Comments
1	Leadership and Governance	The ATC delivers MAPA® training to staff working at Muckamore Abbey Hospital and within the last year has rolled out MAPA® training to those working in Community Learning Disability Services. Included in a wide range of policies published by the Trust are 'The use of Restrictive Interventions in Adult and Children's Services' and the 'A Zero Tolerance Approach to The Prevention and Management of Aggression & Violence Towards Staff in the Workplace' which provide the guidance for Trust staff around the use of physical interventions. We understand the policy is currently under review and an updated version will be published shortly. The policy indicates an understanding of the key factors that are required for any organisation to achieve restraint reduction in its services and outline a framework based on the same six strategies used in this report. We would encourage the Trust to review the terminology and language used in the report to ensure a reduction the use of restraint is a primary focus. At a basic level this might include referencing reducing the use of restraint in the policy title or broadening out restraint to incorporate all forms of restrictive practice. See recommendation i Trust values established by the leadership, we understand after consultation with staff and the public, are articulated on the website and in literature available in services and are supported by the underpinning philosophy of the MAPA® programme. Whilst there are indications that the Trust has a desire to reduce the use of restrictive practices there was no evidence of an explicit plan to do so. We might suggest that an operational group, which we understand has been set up to look at restraint reduction, could develop a specific trust-wide plan that focuses on reducing physical restraint and all restrictive practices and how such reductions might come about. Recommendation ii
2	Performance Measurement	Since the last meeting in 2015 all services are now using the Datix system to record incidents and the use of physical interventions. The use of electronic systems enables the production of monthly physical intervention reports. The reports enable the data to be broken down by individual services patients, the types of interventions used, length of time etc. Such data is invaluable when monitoring the use of restrictive physical interventions. We understand that collated incident data is escalated to senior management via Risk and Governance Committee and the Joint Health & Safety Committee. In addition, Learning Disability Hospital management

		meet monthly to review the use of all restrictive interventions. At a ward level, the weekly multi-disciplinary team meetings provide opportunities to discuss and review incidents and revise care and support plans appropriately.
3	Learning and Development	MAPA® training forms part of the induction for staff joining the Trust. We understand that the level of training will depend on the service is which staff are working. The completion of a training needs analysis will identify whether a personal safety course (MAPA® units 1-8+10), a MAPA Foundation course or a MAPA® Advanced course is most appropriate for which staff/service. We understand that whilst Advanced level physical skills are still taught their use in practice has declined and this has resulted in fewer staff accessing this level of training. There is an acknowledgement within the Trust that training is not a one-off classroom experience but a process of on-going learning and development. In support of this, a MAPA® trainer is part of the staff team on each of the wards in Muckamore and is able to offer post training support for staff and help embed the principles and values of the training within practice. Furthermore, the instructors' first-hand knowledge and understanding of the services will be reflected in training and so ensuring it remains relevant to those accessing it. The role of the ATC Coordinator is key in ensuring the delivery of MAPA® training remains consistent, instructors are supported with regular meetings to promote their on-going development and such meetings provide for preparation and review of training, practice skills delivery, incident review, sharing best practice and peer support. Whilst it is the responsibility of the individual and their line manager to access refresher training within the appropriate time frames (annually in the case of MAPA® Training) we understand that there are systems in place remind staff and managers when training is due and to monitor attendance and compliance with training requirements. Training courses are advertised on the Trust Intranet many months in advance to ensure that services have enough time to plan rotas. We discussed the importance of the inclusion of non-physical (as well as physical) skills in refresher training to ensure that non-physical interventions are always the first option and physical interventions are only ever used as a last resort when all other options have been tried. The Trust and the ATC must ensure that adequate time is allowed for refresher training. This should be a minimum of 2-days if all advanced skills are being refreshed. This requirement is will be reinforced in new standards (Restraint Reduction Training Standards) which are due for publication in early 2019.

		In support of restraint reduction, the Trust has facilitated Positive Behaviour Support (PBS) awareness sessions for staff and some staff (behaviour specialists) we understand are to receive further training in coaching staff in relation to PBS. One of the values of the Trust support 'maximising learning and development' of staff. We understand this is done through regular supervision, and appraisals. Staff feedback is sought via the annual staff survey as well as mechanisms within services to raise issues and concerns. We understand the Trust is an Investors in People Organisation, demonstrating its commitment to the involvement of staff in all aspects of the organisation
4	Providing Personalised Support	The Trust has systems in place that support the sharing of service user information with all relevant professionals involved in their care and treatment to support good planning and decision making. We discussed the completion of comprehensive multidisciplinary risk assessments that are completed for all patients on admission. Positive Behaviour Support plans, including ways of minimising the use of restrictive practices are put in place for those patients whose behaviour may become aggressive and/or violent. Environmental risk assessments are completed in all services and have resulted in changes to minimise the impact of negative environmental factors on people using services. Patients are encouraged to be involved in the development and on-going review of their care plans.
5	Customer Focus and Involvement	The importance of involving patients and their families is recognised. Patients are encouraged to be involved in the creation of their assessments and care planning, but individuals are also encouraged to take part in initiatives that support improving service and care delivery. There is a complaints procedure in place and people are made aware of this through information provided on admission, literature available on site and on the Trust website. Discussions regarding the use of MAPA® interventions are had with those who might present with challenging behaviours as part of the risk assessment process and the development of positive behaviour support plans. We understand that Keep Me Safe, Treat me with Respect leaflets are available for patients and families/carers. In addition, MAPA® Instructors meet with parents/families and carers to inform them about what MAPA® is and importantly what it is not, and whilst no formal training is offered parents are given advice on how to keep themselves and others

		safe. Patient meetings/forums and 'Tell it Like it is' questionnaires provide patients with opportunities to raise concerns and issues. Independent Advocates are available to support patients in raising concerns and issues or to ask questions about the service or the care they are receiving. Patient satisfaction surveys are regularly completed and are used to gauge satisfaction and guide service improvement.
6	Continuous improvement	There is acknowledgement that a key requirement for any organisation looking to reduce the use of restraint is to ensure learning takes place when an incident does occur. There are processes in place to support a detailed investigation at both service and organisational level, depending on the severity of the incident. All incidents are reviewed at ward level and discussed at weekly MDT meetings to understand the cause, review whether the response was appropriate, what might have been done differently and what needs to change to prevent a recurrence. the We understand that MAPA® Instructors are often involved in incident reviews which not only supports those involved but also allows the use of anonymised but real incidents to be incorporated in to training delivery, ensuring it remains appropriate and relevant to those attending. There are mechanisms in place to support the escalation of incident findings through levels of management and across directorates via the Governance leads and the Joint Health and Safety Committee.

Appendix 1.

Certified Instructors currently registered at Belfast Health and Social Care Trust's Muckamore Abbey Hospital and Community Learning Disability Services

Full Name	CI Level	CI Status	CI since	Renewal Due	Certification	Level	Qualification
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	

***certification has yet to be activated as the invoice for attendance on the instructor certification programme remains outstanding**

Appendix 2 - MAPA® Training delivery (October 2017 – September 2018)

Account	Class Count	Account Participants	Account Hours	Customer ID	First Name	Last Name	Class Count	Instructor Participants	Instructor Hours
Belfast Health & Social Care Trust (Muckamore)	64	904	1012.50	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

APPROVED TRAINING CENTRE (ATC) LICENSING AGREEMENT

BETWEEN

Belfast Health & Social Care Trust - Knockbracken Healthcare

And

CRISIS PREVENTION INSTITUTE

Effective date of agreement: 27/11/2019

Contents

1. Parties and object of agreement

1.1. Belfast Health & Social Care Trust (Knockbracken), Knockbracken Healthcare Park, Graham House, Saintfield Road, Belfast, Antrim. BT9 9BH

1.2. Crisis Prevention Institute Suite 2, Ground Floor and First Floor, Building 2, Brooklands place, Brooklands Road, Sale, Manchester. M33 3SD

1.3. Whereas, CPI shall license Belfast Health & Social Care Trust (Knockbracken) as an Approved Training Centre (ATC) under the terms and conditions outlined in the agreement.

2. Definitions

2.1. **ATC** shall mean Approved Training Centre.

2.2. **ATC Entity** shall mean the organisation specifically authorised as an ATC under this Agreement.

2.3. **Confidential information** shall mean

I. any information related to the terms of this Agreement;
II. products, sales and customer/patient data, marketing and promotion concepts, business plans and other business information shared as a result of this Agreement, and all similar information, whether such disclosure is made in writing, orally, electronically or visually;
III. any information, idea or method which relates to the business of or affairs of either Party; and
IV. any other information that is identified as confidential by the disclosing Party at the time it is disclosed or which should otherwise be understood to be of a confidential nature.

2.4. **Effective date** shall mean the date on which the duly authorised representatives from both parties have signed this agreement.

2.5. **CPI** shall mean Crisis Prevention Institute's office in the United Kingdom

2.6. **Intellectual Property Rights** shall mean patents (including utility models), design patents, and designs (whether or not capable of registration), copyright, databases, trademarks and any other form of statutory protection of any kind and applications for any of the foregoing respectively as well as any trade secrets.

2.7. **Party or Parties** shall mean CPI, the ATC Entity, or both as required by the context

3. License

3.1. **Approved Training Centre** – The ATC Entity is licenced by CPI to use the CPI brand and logo in the promotion of CPI training programmes solely within the ATC Entity.

3.2. **CPI training programmes** - The ATC Entity is licenced by CPI to deliver, use, display and perform

3.2.1. CPI approved and certified 2-day MAPA® Non-Instructor Foundation programmes and appropriate MAPA® renewal programmes on-site at the ATC Entity

3.2.2. CPI approved and certified 5-day Non-Instructor MAPA® Advanced Physical Skills and appropriate MAPA® renewal programmes on-site at the ATC Entity;

3.3. **Limitations on License**

3.3.1. ATC Entity is not permitted to deliver CPI training to employees of third party organisations unless otherwise explicitly stated in this Agreement.

3.3.2. ATC Entity shall purchase all learner workbooks and training materials from CPI to support the delivery of CPI programmes.

3.4. **Certified Instructor (CI) Training** –

3.4.1. CPI shall offer open or onsite 5-day MAPA® Foundation Instructor Certification Programmes (ICP) for nominated ATC Entity staff to be trained as certified MAPA® instructors (CIs).

3.4.2. CPI shall offer open or onsite 5-day Advanced programmes for nominated ATC Entity staff to be trained at these levels if it is so required by the Organisation.

3.4.3. CPI shall offer open or onsite 2 and 5-day annual MAPA® Renewal programmes for nominated ATC Entity staff to be re-certified as MAPA® instructors (CIs).

3.5. **Certified Instructor Support** – CPI shall provide weekday (UK business hours of 09:00 to 17:00 hours excluding bank holidays) programme delivery and technical content support to the ATC and the CIs via its UK based Instructor Support Help Desk.

3.6. **Training Certification, Records and Database** – CPI shall provide a training recording system and database to all CIs for recording their own training delivery and the names of participants on the programmes they deliver. The system shall also enable CIs to produce certificates for attendees who have successfully passed the programmes. Training documentation is necessary and required for all CIs.

3.7. **Centre Verification Visits and Support Days –** a Centre Verification Visit will take place within the first year following the approval of the ATC Entity as an ATC and every subsequent three years. CPI will report the findings of the visit to the Organisation. In the two years between Verification Visits, CPI will offer two days (one per year) of optional support to the ATC Entity. The Support Day(s) may be used as a Centre Verification Visit if that is preferred by the ATC Entity. The support and verification visits are included in the license fee, reasonable expenses will be invoiced to the ATC.

3.8. **Website** – CPI may display the ATC Entity as an ATC on its website.

3.9. **Continued Learning –** CPI shall provide CIs with a monthly e-newsletter The Supportive Stance and a quarterly copy of the Instructor Forum – EU. All publications are in English.

3.10. **Bi-annual Conferences** – CPI holds bi-annual conferences that CIs and others are encouraged to attend. Information about these conferences is provided to all CIs well in advance of the conference for planning purposes.

3.11. **Restraint Reduction Network (RRN**) – CPI set-up and is an active member of the Restraint Reduction Network. This is an independent network, run by BILD, that brings together committed organisations providing education, health and social care, services for people who may challenge. The network, has ambitions to deliver restraint free care and support designed to make a real difference in the lives of people who may be subject to various forms of coercive or restrictive practices.

3.12. **Additional Programmes** – CPI offers additional behaviour management programmes that CIs can attend to enhance and develop their professional competence. These include Advanced and Emergency MAPA® programmes, Dementia Capable Care Behaviours (DCC:B), Holding Skills for Essential Care and Treatment (CH-3), and Autistic Spectrum Conditions (ASC).

3.13. **Research and Development** – CPI supports the organisations it works with by continuously investing in research and development to ensure its programmes reflect current thinking and practice and strives to enable training to be immediately applicable and transferable to the workplace.

4. Obligations agreed to by CPI and the ATC Entity

4.1. CPI shall licence the ATC Entity as an Approved Training Centre (ATC) on a 12-month rolling contract basis for up to three (3) years. Either party may terminate the agreement by giving 3 calendar months' notice in writing to the other party. If no notice is served the contract shall automatically roll over to the next year but in no event shall this Agreement remain in effect longer than three (3) years from the effective date. Both parties agree to review the Agreement prior to the end of the 3rd year and determine how best to renew.

4.2. The ATC Entity shall only use CPI Certified Instructors, who are up to date with their annual renewal requirements to deliver CPI training programmes.

4.3. The ATC Entity shall ensure that all CPI training programmes are delivered using CPI approved materials, including instructor manual, participant workbooks, and PowerPoint presentations.

4.4. The ATC Entity shall ensure that CPI training programmes are delivered in accordance with the BILD Code of Practice 2014 (or any subsequent publications) and all applicable local and national guidance.

4.5. The ATC Entity shall ensure that there are appropriate policies in place around the use and reduction of physical interventions within the Organisation.

4.6. The ATC Entity shall ensure that there are robust systems in place to allow staff and services users to raise concerns and make complaints.

4.7. The ATC Entity shall ensure that all CPI training that is delivered to staff is based on a current behaviour audit / training needs analysis.

4.8. The ATC Entity shall have in place systems and processes to ensure that staff knowledge and skills are refreshed and competence is reassessed annually.

4.9. The ATC Entity shall nominate a person to act as the **ATC Coordinator**. This person will:

- 4.9.1. be the main point of contact between CPI and the ATC
- 4.9.2. Ensure that certified instructors (or a nominated administrative support person) notify CPI of all training delivery via the CPI website.
- 4.9.3. Ensure that records are maintained for all CPI training programmes delivered by the ATC
- 4.9.4. Liaise with CPI to organise Verification and Support visits.
- 4.9.5. Advise CPI when Certified Instructors leave the Organisation.

4.10. The ATC Entity shall nominate a **Senior Organisational Representative** (board or equivalent level) that will:

- 4.10.1. Act as signatory to this license agreement
- 4.10.2. Provide an interface between the ATC and the senior management of the organisation for governance purposes.
- 4.10.3. Take overall responsibility for ensuring the terms of this agreement are adhered to.

4.11. The ATC Entity shall nominate a **minimum of two employees** to attend the MAPA® Instructor Certification Programme. On successful completion of the programme the attendees will be awarded Certified Instructor status. In order to remain a Certified Instructor s/he must:

- 4.11.1. Attend an appropriate renewal every 12 months
- 4.11.2. Use CPI approved and authorised training materials to deliver all MAPA® training programmes.
- 4.11.3. Notify CPI of all CPI training delivery via the documentation pages on the CPI website
- 4.11.4. Be up to date with their continued professional development
- 4.11.5. Notify CPI as soon as is reasonably practical of any change in circumstance that may impact their ability or suitability to deliver CPI Training
- 4.11.6. Only deliver CPI's training programmes to employees of the ATC Entity

4.12. The photographing, video recording or any other form of visual or auditory capture of CPI, Inc. program content (including physical techniques) is strictly prohibited. CPI, Inc. withholds the right to permit such actions on the basis of intellectual property protection under the Intellectual Property Act 2014 and the permissions of individuals under the EU General Data Protection Regulation.

4.13. CPI training programmes involving the use of restrictive physical interventions will be delivered in accordance with the recommended trainer/participant ratios outlined in the BILD Code of Practice (2014, or subsequent publications or standards). In addition to any interpretation of the BILD standard, CPI recommends that Certified Instructors should aim to deliver physical intervention training in pairs in order to maintain safe levels of instruction and supervision. In the case of Advanced and Emergency programmes it is a requirement of this agreement that two appropriately trained and certified instructors deliver the courses.

4.14. Under the terms of the license agreement CPI reserves the right to attend any MAPA® training programmes delivered by the ATC without giving prior notice in order to monitor the quality of the programme and adherence to CPI standards of delivery including use of CPI products and materials.

4.15. Any un-announced visits from CPI shall be at CPI's expense

4.16. All use of CPI brand, logo and promotional materials including artwork must be reviewed and approved by CPI in advance of their use and must conform to CPI "Copy and Style Guidance" rules. CPI agrees to review all requests under this section within ten (10) business days of the date of the request. Any failure by CPI to provide a response within that time frame shall be deemed approval for use by the ATC.

4.17. All prices shown in section 5.0 are "net" of VAT. Where applicable VAT shall be added at the prevailing rate.

4.18. All prices shown in section 5.0 are valid for 2019only and are subject to annual review plus cost of living increases.

4.19. The ATC Entity understands that CPI is committed to compliance in respect of personal data, and the protection of the "rights and freedoms" of individuals whose information CPI collects and processes in accordance with the General Data Protection Regulation (GDPR). The ATC Entity agrees that as part of this agreement, the ATC Entity is required to provide certain personal information about its employees to CPI. CPI shall manage that personal information as required by the GDPR and as outlined in its privacy notice found here *https://www.crisisprevention.com/en-GB/About-CPI/Privacy-Policy*. In addition, the ATC Entity agrees that, to the extent that personal data is shared between CPI and the ATC Entity, it shall adhere to a policy for managing such data at least as restrictive as CPI's then current policy.

5. Fees and product prices

1.	ATC Application process	**£349.00**	
2.	ATC License Fee	**£2,750.00**	annually
3.	ATC certificate	**Free of charge**	annually
4.	Certified Instructor Initial Programmes (ICP)	**£1,890**	As required
5.	Certified Instructor renewal Programmes	**£420**	Annually
6.	5- Day MAPA Advance Programmes (ICP)	**£2,590**	As required
7.	5-Day MAPA Advanced Instructor Renewal	**£1,040**	As required
8.	Verification Visit and Report	Travel and accommodation expenses where applicable	At the end of the first year and every subsequent 3 years. Optional in the 2 interim years
9.	On-site support days and Report	Travel and accommodation expenses where applicable	Optional during the 2 interim years between verification visits
10.	Telephone and email support	**Free of charge**	As required
11.	On-site consultation		As required
12.	Online validation and certification	**Free of charge**	Per programme event
13.	Quarterly Training Delivery and Participant Reports	**Free of Charge** If required	Quarterly
14.	Participant licenses (workbooks)	**To Be Advised (initial license) To Be Advised (refresher license)**	Per participant
15.	Products and resources featured in the Instructor Resource catalogue	As per catalogue	As required
16.	Use of the CPI logo	**Free of charge**	As required
17.	Membership of the Restraint Reduction Network	CPI will introduce and support the organisations application to the RRN. Fees may be payable to the RRN	

Prices are quoted exclusive of VAT
Prices are quoted for 2019 only and are subject to annual review plus cost of living increases.

The terms of payment are thirty (30) days net from the date of submission of an invoice. Interest on delayed payments accrues at the statutory interest rate set by The Secretary of State of the UK in accordance with Late Payment of Commercial Debts (Interest) Act 1998. CPI will also be entitled to the fixed Compensation arising out of late payment charge in accordance with the Late Payment of Commercial Debts (Interest) Act 1998.

6. General Term and Conditions

6.1. Notices. Any notification or written communication required by or contemplated under the terms of this Agreement shall be in writing and shall be deemed to be delivered if transmitted via Email to the Email addresses listed below. Email addresses for such notices shall be the following or such substitute addresses of which notice is given in accordance herewith:

If to CPI:	Crisis Prevention Institute, Inc. Nathan Cromer [redacted]
If to The ATC Entity:	Belfast Health & Social Care Trust - Knockbracken Healthcare Neil Walsh - [redacted]

6.2. Assignment. Neither this Agreement nor any interest in this Agreement may be assigned by either party without the prior express written consent of the other party, except either party may assign this Agreement to the successor or surviving entity in the event of a merger, acquisition or corporate restructuring.

6.3. Modification or Amendment. No amendment, change or modification of this Agreement shall be valid unless in writing signed by the parties hereto.

6.4. Headings. Headings used in this Agreement are provided for convenience only and shall not be used to construe meaning or intent.

6.5. Governing Law. The laws of the United Kingdom shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties hereto.

6.6. Disputes. The parties agree that any disputes relating to this Agreement shall be litigated in a court of competent jurisdiction situated within the United Kingdom.

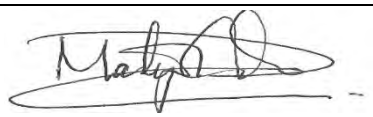
6.7. Entire Understanding. This document and any exhibits attached constitute the entire understanding and agreement of the parties with respect to the subject matter of this Agreement, and any and all prior agreements, understandings, and representations are hereby terminated and cancelled in their entirety and are of no further force and effect.

6.8. Severability. If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included. If removal of any invalid or unenforceable term affects the interpretation of any remaining terms, the remaining terms shall be construed consistent with the spirit and intent of this Agreement.

6.9. Authority. The undersigned parties represent and warrant that each has the authority to enter into this agreement on behalf of the respective parties and to bind the respective parties to the terms hereof.

Confidentiality. Each party shall hold the Confidential Information of the other party in confidence and shall not disclose the Confidential Information to third parties nor use the other party's Confidential Information for any purpose other than the purpose of this Agreement. Such restrictions shall not apply to Confidential Information which is (a) already know by the recipient, (b) becomes, through no act or fault of the recipient, publicly known, (c) received by the recipient from a third party without the restriction on disclosure or use, (d) independently developed by recipient without reference to the Confidential Information, or (e) required to be disclosed by a court or government agency.
Each Party shall cease using confidential material and information received from the other Party promptly upon cancellation of the Agreement or when that Party no longer needs the material or information in question for the purpose stated in the Agreement and, unless the Parties separately agree on the destruction of such material, return the material in question (including all copies thereof). Each Party shall, however, be entitled to retain the copies required by law or regulation.

Signed on behalf of CPI,

Name:	Martyn Dadds
Position:	Managing Director
Signature:	
Date:	27/11/2019

Signed on behalf of the ATC Entity,

Name:	Neil Walsh
Position:	Trust Advisor/Trainer Management of Aggression Team
Signature:	
Date:	18/12/2019

APPROVED TRAINING CENTRE (ATC) AFFILIATION AGREEMENT

Belfast Health & Social Care Trust (Knockbracken)

1. Parties and object of agreement

Belfast Health & Social Care Trust (Knockbracken), Knockbracken Healthcare Park, Saintfield Road, Belfast, Antrim, BT8 8BH.

1.1. Crisis Prevention Institute Suite 2, Ground Floor and First Floor, Building 2, Brooklands place, Brooklands Road, Sale, Manchester. M33 3SD

1.2. Whereas, CPI shall license Belfast Health & Social Care Trust (Knockbracken) as an Approved Training Centre (ATC) under the terms and conditions outlined in the agreement.

2. Definitions

2.1. **ATC** shall mean Approved Training Centre.

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I. any information related to the terms of this Agreement.
II. products, sales and customer/patient data, marketing and promotion concepts, business plans and other business information shared as a result of this Agreement, and all similar information, whether such disclosure is made in writing, orally, electronically or visually.
III. any information, idea or method which relates to the business of or affairs of either Party; and
IV. any other information that is identified as confidential by the disclosing Party at the time it is disclosed, or which should otherwise be understood to be of a confidential nature.

2.4. **Effective date** shall mean the date on which the duly authorised representatives from both parties have signed this agreement.

2.5. **CPI** shall mean Crisis Prevention Institute's office in the United Kingdom

2.6. **Intellectual Property Rights** shall mean patents (including utility models), design patents, and designs (whether or not capable of registration), copyright, databases, trademarks and any other form of statutory protection of any kind and applications for any of the foregoing respectively as well as any trade secrets.

2.7. **Party or Parties** shall mean CPI, the ATC Entity, or both as required by the context

3. License

3.1. **Period of License.** CPI shall licence the ATC Entity as an Approved Training Centre (ATC) on a 12-month rolling contract basis for up to three (3) years. Either party may terminate the agreement by giving 3 calendar months' notice in writing to the other party. If no notice is served the contract shall automatically roll over to the next year but in no event shall this Agreement remain in effect longer than three (3) years from the effective date. Both parties agree to review the Agreement prior to the end of the 3rd year and determine how best to renew.

3.2. The ATC Entity is licenced by CPI to use the CPI brand and logo in the promotion of CPI training programmes solely within the ATC Entity.

3.3. CPI training programmes - The ATC Entity is licenced by CPI to deliver, use, display and perform

3.3.1. CPI approved and certified MAPA® / Verbal Intervention™ or Safety Intervention™ Non-Instructor Foundation programmes and appropriate renewal programmes on-site at the ATC Entity

3.4. Limitations on License

3.4.1. ATC Entity is not permitted to deliver CPI training to employees of third-party organisations unless otherwise explicitly stated in this Agreement.

3.4.2. ATC Entity shall purchase all learner workbooks and training materials from CPI to support the delivery of CPI programmes.

3.5. Certified Instructor (CI) Training –

3.5.1. CPI shall offer open or onsite Verbal Intervention™ and Safety Intervention Foundation Instructor Certification Programmes (ICP) for nominated AC Entity staff too be trained as certified Instructors

3.5.2. CPI shall offer open or onsite Safety Intervention™ Advanced and Advanced & Emergency programmes for nominated ATC Entity staff to be trained at this level should the organisational training needs analysis deems it necessary.

3.5.3. CPI shall offer open or onsite Verbal Intervention™ and Safety intervention™ Renewal programmes for existing Instructor to be recertified.

3.6. Certified Instructor Support – CPI shall provide weekday (UK business hours of 09:00 to 17:00 hours excluding bank holidays) programme delivery and technical content support to the ATC and the CIs via its UK based Instructor Support Help Desk.

3.7. Website – CPI may display the ATC Entity as an ATC on its website.

3.8. Continued Learning – CPI shall provide CIs with a monthly e-newsletter The Supportive Stance and a quarterly copy of the Instructor Forum – EU. All publications are in English.

3.9. Bi-annual Conferences – CPI holds bi-annual conferences that CIs and others are encouraged to attend. Information about these conferences is provided to all CIs well in advance of the conference for planning purposes.

3.10. Restraint Reduction Network (RRN) – CPI set-up and is an active member of the Restraint Reduction Network. This is an independent network, run by BILD, that brings together committed organisations providing education, health and social care, services for people who may challenge. The network has ambitions to deliver restraint free care and support designed to make a real difference in the lives of people who may be subject to various forms of coercive or restrictive practices.

3.11. Additional Programmes – CPI offers additional behaviour management programmes that CIs can attend to enhance and develop their professional competence. These include Advanced and Emergency Safety Intervention™ programmes, Dementia Capable Care Behaviours (DCC: B) and , Holding Skills for Essential Care and Treatment (CH-3).

3.12. Research and Development – CPI supports the organisations it works with by continuously investing in research and development to ensure its programmes reflect current thinking and

practice and strives to enable training to be immediately applicable and transferable to the workplace.

4. Obligations agreed to by the Organisation and CPI

4.1 Requirements of Certified Instructors

	Standard	Agreed
a	The Instructor is licensed to deliver training to employees of the named organisation only	✓
b	CPI training cannot be 'sold on' for income generation or commercial gain	✓
c	Instructor certification is valid for one year from the last date of their initial certification and for 12 months thereafter, subject to annual attendance and completion of an appropriate Instructor Certification Renewal programme	✓
d	A license, that includes a Participant workbook, must be purchased for every person attending a CPI training event run by the organisation.	✓
e	All CPI training must be documented on the CPI website for validation and certification purposes	✓
f	Certified instructors must hold a current first aid certificate. As a minimum requirement this must be the Emergency First Aid at Work one day programme which includes Immediate Life Support (ILS)	✓
g	Certified instructors must be able to evidence appropriate qualifications and experience in supporting people in the sector in which they are working	✓
h	Certified Instructors must be able to evidence on going professional development and agree to make portfolios available for inspection on request (by CPI or BILD ACT)	✓
i	Certified Instructors must manage training sessions safely and professionally.	✓
j	Certified Instructors are required to complete and maintain accurate training records	✓
k	Certified Instructors are required to deliver training in accordance with the RRN Training Standards	✓
l	Certified Instructors must maintain the integrity of the training by delivering it as directed by CPI in the Instructor Guide and only the physical skills identified through the Training Needs Analysis should be delivered to participants.	✓
m	Certified Instructors must be able to evidence that they have qualifications, experience, and competence in supporting people in the sector in which they are delivering training.	✓
n	Certified Instructors delivering training with the organisation must only do so on the basis of a training needs analysis	✓

4.2 Requirements of the ATC Coordinator - The ATC Entity shall nominate a person to act as the ATC Coordinator. This person will:

	Standard	Agreed
a	Be the main point of contact between CPI and the ATC	✓
b	Ensure that certified instructors (or nominated administrative support people) notify CPI of all training delivery via the CPI website	✓
c	Ensure that records are maintained for all CPI training programmes delivered by the ATC	✓
d	Liaise with CPI to organise Verification and Support visits	✓
e	Advise CPI when Certified Instructors leave the Organisation	✓

4.3 Senior Organisational Representative (SOR) – The Organisation shall appoint an SOR (board or equivalent level). This could be the person within the organisational with Board level responsibility for Restraint reduction. They will:

4.4

	Standard	Agreed
a	Act as signatory to this license agreement	✓
b	Provide an interface between the ATC and the senior management of the organisation for governance purposes	✓
c	Take overall responsibility for ensuring the terms of this agreement are adhered to	✓

4.4 Operational Standards for Organisations

	Standard	Agreed
a	The Organisation is responsible for familiarising senior leaders and staff with the requirements of the RRN training Standards and deliver training in accordance with those standards	✓
b	CPI training has been commissioned on the basis of need identified as part of the completion of a training needs analysis (TNA) which has been undertaken and is based on an analysis of incident data and what is known about our those that use our services.	✓
c	Only physical skills that are identified as needed in the TNA should be delivered to participants	✓
d	The use of physical interventions within our organisation has been approved at Board (or equivalent) level.	✓
f	There is a Board Level (or equivalent) person responsible for restraint reduction within the organisation	✓
g	The organisation has an active restraint reduction plan in place that is reviewed and updated regularly.	✓
h	There are appropriate levels of Immediate Life Support (ILS) training for our staff and the training is in accordance with the guidelines of the UK Resuscitation Council for Immediate Life Support.	✓
i	Prior to attending any training that includes physical interventions staff have received training in primary preventative strategies as indicated in RRN standards 2.5.1	✓
j	There are options to support staff and service users who may require additional emotional support following an incident and/or a use of restraint.	✓
k	There are policies and procedures in place to monitor the use of physical interventions in order to prevent the misuse/abuse of such interventions and to promote and encourage restraint reduction planning and initiatives. These policies have been/will be shared with staff prior to attendance at this training.	✓
l	The organisation must maintain accurate and up to date training records for all staff.	✓
m	The organisation must have a policy in place for dealing with and managing concerns that might arise during the delivery of training to staff.	✓
n	Organisations must have in place effective systems to evaluate training	✓
o	All participants attending training will undergo continuous assessment throughout the delivery of the programme. Participants will be assessed on their values and	✓

	attitudes as well as their competency in meeting the learning outcomes through pre and post-test questions, group activities, verbal participation and demonstrations.	
p	Participants must attend a Refresher programme that refreshes and reassesses skills and competencies every 12 months.	✓
q	When teaching and assessing competence in restrictive physical interventions the ratio of trainers to participants must not exceed 1:12. If the class size exceeds 12 the training must be delivered by two appropriately qualified trainers. A participant cohort must not exceed 18. In addition to any interpretation of the local or national guidance or Standards, CPI recommends that Certified Instructors should aim to deliver physical intervention training in pairs to maintain safe levels of instruction and supervision. In the case of Advanced and Emergency programmes, it is a requirement of this agreement that two appropriately trained and certified instructors deliver the courses.	✓

4.5 Quality Assurance

a	An ATC Verification Visit will take place within the first year following the approval of the ATC Entity as an ATC and every subsequent three years. CPI will report the findings of the visit to the Organisation	✓
b	In the two years between Verification Visits, CPI will offer two days (one per year) of optional support to the ATC Entity. The Support Day(s) may be used as a Centre Verification Visit if that is preferred by the ATC Entity.	✓
c	The support and verification visits are included in the license fee, reasonable expenses will be invoiced to the ATC.	✓
d	CPI reserves the right to attend any CPI training programmes delivered by the ATC without giving prior notice to monitor the quality of the programme and adherence to CPI standards of delivery including use of CPI products and materials.	✓
e	Organisations must have effective internal quality assurances systems in place that support compliance with Restraint Reduction Network Training Standards	✓
f	CPI (as the Training Provider) has quality assurance processes in place that require the organisation to complete a self-assessment document. This may be followed up with requests for the provision of supporting evidence and the right to attend any CPI training programmes delivered by the Organisation with or without prior notice in order to review programme delivery in respect of adherence to CPI and RRN standards	✓
g	BILD ACT, as the certification body, may request information (via CPI) from the organisation and have the right to attend any CPI training programmes with or without prior notice in order to monitor the quality of the programme and adherence to RRN Standards	✓
h	If your organisation opts for affiliation to BILD ACT CPI will support the organisation to meet the standards, however, should actions to meet Standards remain outstanding and a resolution cannot be agreed, as a last resort, CPI has the option to revoke affiliated status. The decision will be notified to BILD ACT.	✓

4.6 The photographing, video recording or any other form of visual or auditory capture of CPI, Inc. program content (including physical techniques) is strictly prohibited. CPI, Inc. withholds the right to permit such actions on the basis of intellectual property protection under the Intellectual Property Act 2014 and the permissions of individuals under the EU General Data Protection Regulation.

4.9 All use of CPI brand, logo and promotional materials including artwork must be reviewed and approved by CPI in advance of their use and must conform to CPI "Copy and Style Guidance" rules. CPI agrees to review all requests under this section within ten (10) business days of the date of the request. Any failure by CPI to provide a response within that time frame shall be deemed approval for use by the ATC.

4.8 All prices shown in section 5.0 are "net" of VAT. Where applicable VAT shall be added at the prevailing rate.

4.9 All prices shown in section 5.0 are valid for 2023 only and are subject to annual review plus cost of living increases

4.10 The ATC Entity understands that CPI is committed to compliance in respect of personal data, protection of the "rights and freedoms" of individuals whose information CPI collects and processes in accordance with the General Data Protection Regulation (GDPR). The ATC Entity agrees that as part of this agreement, the ATC Entity is required to provide certain personal information about its employees to CPI. CPI shall manage that personal information as required by the GDPR and as outlined in its privacy notice found here https://www.crisisprevention.com/en-GB/About-CPI/Privacy-Policy. In addition, the ATC Entity agrees that, to the extent that personal data is shared between CPI and the ATC Entity, it shall adhere to a policy for managing such data at least as restrictive as CPI's then current policy.

4 Fees and product prices

1.	ATC Application process	£349.00	
2.	ATC License Fee	£3,490.00	Annually
3.	BILD ACT Affiliation	Included (standard cost £500)	Annually
4.	ATC certificate	Free of charge	Annually
5.	Certified Instructor Initial Programmes (ICP)	As Arranged with your account	As required
6.	Certified Instructor renewal Programmes	As Arranged with your account	Annually
7.	Safety Intervention Advance and Advanced & Emergency Instructor Programmes (ICP)	As Arranged with your account	As required
8.	Safety Intervention Advanced and Advanced & Emergency Instructor Renewal	As Arranged with your account	As required
9.	Verification Visit and Report	Travel and accommodation expenses where applicable	At the end of the first year and every subsequent 3 years. Optional in the 2 interim years
10.	On-site support days and Report	Travel and accommodation expenses where applicable	Optional during the 2 interim years between verification visits
11.	Telephone and email support	Free of charge	As required
12.	On-site consultation	As Arranged with your account	As required
13.	Online validation and certification	Free of charge	Per programme event
14.	Quarterly Training Delivery and Participant Reports	Free of Charge If required	Quarterly
15.	Participant licenses (workbooks)	As Arranged with your account	Per participant
16.	Products and resources featured in the Instructor Resource catalogue	As Arranged with your account	As required
17.	Use of the CPI logo	Free of charge	As required

Prices are quoted exclusive of VAT
Prices are quoted for 2023 only and are subject to annual review plus cost of living increases.

The terms of payment are thirty (30) days net from the date of submission of an invoice. Interest on delayed payments accrues at the statutory interest rate set by The Secretary of State of the UK in accordance with Late Payment of Commercial Debts (Interest) Act 1998. CPI will also be entitled to the fixed Compensation arising out of late payment charge in accordance with the Late Payment of Commercial Debts (Interest) Act 1998.

5 General Term and Conditions

5.10 Notices. Any notification or written communication required by or contemplated under the terms of this Agreement shall be in writing and shall be deemed to be delivered if transmitted via Email to the Email addresses listed below. Email addresses for such notices shall be the following or such substitute addresses of which notice is given in accordance herewith:

If to CPI:	Crisis Prevention Institute, Inc. John Murry [redacted]
If to The ATC Entity:	Belfast Health and Social Care Trust (Knockbracken) Neil Walsh [redacted] 02895042050

5.11 Assignment. Neither this Agreement nor any interest in this Agreement may be assigned by either party without the prior express written consent of the other party, except either party may assign this Agreement to the successor or surviving entity in the event of a merger, acquisition or corporate restructuring.

5.12 Modification or Amendment. No amendment change, or modification of this Agreement shall be valid unless in writing signed by the parties here to.

5.13 Headings. Headings used in this Agreement are provided for convenience only and shall not be used to construe meaning or intent.

5.14 Governing Law. The laws of the United Kingdom shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties hereto.

5.15 Disputes. The parties agree that any disputes relating to this Agreement shall be litigated in a court of competent jurisdiction situated within the United Kingdom.

5.16 Entire Understanding. This document and any exhibits attached constitute the entire understanding and agreement of the parties with respect to the subject matter of this Agreement, and any and all prior agreements, understandings, and representations are hereby terminated and cancelled in their entirety and are of no further force and effect.

5.17 Severability. If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included. If removal of any invalid or unenforceable term affects the interpretation of any remaining terms, the remaining terms shall be construed consistent with the spirit and intent of this Agreement.

5.18 Authority. The undersigned parties represent and warrant that each has the authority to enter into this agreement on behalf of the respective parties and to bind the respective parties to the terms hereof.

Confidentiality. Each party shall hold the Confidential Information of the other party in confidence and shall not disclose the Confidential Information to third parties nor use the other party's Confidential Information for any purpose other than the purpose of this Agreement. Such restrictions shall not apply to Confidential Information which is (a) already know by the recipient, (b) becomes, through no act or fault of the recipient, publicly known, (c) received by the recipient from a third party without the restriction on disclosure or use, (d) independently developed by recipient without reference to the Confidential Information, or (e) required to be disclosed by a court or government agency.

Each Party shall cease using confidential material and information received from the other Party promptly upon cancellation of the Agreement or when that Party no longer needs the material or information in question for the purpose stated in the Agreement and, unless the Parties separately agree on the destruction of such material, return the material in question (including all copies thereof). Each Party shall, however, be entitled to retain the copies required by law or regulation.

Signed on behalf of CPI,

Name:	Roger Boyd
Position:	Managing Director
Signature:	
Date:	16.02.2023

Signed on behalf of the ATC Entity,

Name:	Neil Walsh
Position:	Trust Advisor / Trainer
Signature:	
Date:	16.02.23

Belfast Health and Social Care Trust

The Roles and Responsibilities of the ATC and the Associate Instructors

Safety Intervention Team

BHSCT (Knockbracken ATC)

March 2023

ATC Managerial Responsibility

1. Manage and maintain accurate education and training records of staff attendance in relation to relevant training in eLearning Personal Safety @ Work and all Safety Intervention and Clinical Holding training

2. Manage the co-ordination and availability of trainers to deliver agreed training programmes, this includes:

- Substantive trainers and associate clinical based trainers

3. Monitor and maintain standards of training within the Trust including our satellite training sites; Shannon Clinic, Beechcroft and AMHIC. This will be done by:

- Adapting a centralised calendar agreed upon in all areas, ensuring training does not clash as reasonably practicable. This will allow a member of the corporate team to be present during training at the satellite sites to ensure effective governance and provide support

- Due to the current resources of the corporate team we aim to be available for 70% of the training in the satellite sites – the team are currently in the process of presenting a business case to improve resources

- The ATC Co-ordinator will complete a bi-annual audit of training being delivered in the satellite units in line with the RRN Training Standards 2019

4. Monitor and evaluate the impact of training on service provision and safe practice in the Trust

5. Advise on identified risk issues within the Trust relating to behaviours that challenge and/or risk behaviour, working in partnership with all professions

6. The ATC co-ordinator must be involved in the planning and processing of recruiting new trainers within the Trust, including our satellite sites. Recruitment should be a fair process in concordance with Trust Recruitment policy

7. The co-ordinator will schedule in an ATC meeting once every quarterly period as per calendar year

8. The ATC Co-ordinator will complete a bi-annual audit of training being delivered in the satellite units in line with the RRN Training Standards 2019

Associate Instructors

1. The Associate Instructors must complete their initial CPI training and attend their annual updates in order to renew their license with CPI

2. The Associate Instructors will continue to provide training in their clinical areas, in conjunction with the agreed centrailised calendar

3. The Associate Instructors will facilitate a member of the corporate team to assist them on their designated training days

4. Associate Instructors must complete a minimum of 6 days training from their last update – failure to complete this minimum requirement may result in this resource being withdrawn

5. Associate Instructors that have been allocated a roster to train a course within their own clinical areas or with the corporate team in Graham House must attend this course (unless they cannot due to unforeseen circumstances) – Safety Intervention is mandatory training and it is vitally

important to all staff and the welfare our patients that these courses are delivered

6. Associate Instructors must be available to attend ATC meetings in relation to training and other business (unless they cannot due to unforeseen circumstances)

7. Associate Instructors will log their own courses onto the CPI website. Course documentation including certificates, post-tests, evaluations, sign-in sheets and formative assessment will be scanned and sent via email to the corporate team for safe storage and logging onto HRPTS

   The Associate Instructors will be an additional resource to their wards and will be able to assist staff in identifying appropriate methods of managing patients who exhibit behaviours that challenge and/or risk behaviour and are encouraged to liaise with the Trust ATC Co-ordinator in relation to additional advice and guidance
8. The Associate Instructors role does not replace that of the manager's or the nurse in charge but should complement the roles in maintaining safe systems of work as required by the Health & Safety at Work (NI) Order 1978

9. All Associate Instructors must adhere to the ethos and standards as set out by the relevant Trust Policies and those set by the Crisis Prevention Institute (CPI)

MAHI - STM - 105 - 502

CRISIS PREVENTION INSTITUTE®

CPI *Safety Intervention*™

ADVANCED AND EMERGENCY

INSTRUCTOR GUIDE

The Crisis Prevention Institute is accredited by the International Association for Continuing Education and Training (IACET). The Crisis Prevention Institute complies with ANSI/IACET Standard, which is recognised internationally as a standard of excellence in instructional practices. As a result of this accreditation the Crisis Prevention Institute is authorised to issue the IACET CEU.

INTRODUCTION

ADDITIONAL CLASSROOM TRAINING

APPENDICES, GLOSSARY, RESOURCES

CPI *Safety Intervention*™ Advanced and Emergency

INSTRUCTOR GUIDE

Important Note to Certified Instructor

Before teaching this content, you are required to be currently certified in CPI *Safety Intervention*™ Foundation. Certified Instructors must also continue to abide by the CPI Certified Instructor Terms of Service when delivering training. Keep in mind that participants attending this course may work in environments where extreme behaviour and high-level risk are experienced frequently. Therefore, the fear and anxiety of what may happen at work may be prevalent. This is an opportunity to discuss workplace fears and how staff can work together to manage productive responses.

Although prevention is the ultimate goal in crisis management, recognise that there may be times when the higher level of risk of the situation necessitates restrictive interventions. It is important during these high-risk situations that staff continue to use their core values to drive their decision making and maintain safety for everyone involved. This course will explore ways to keep core values at the forefront of thinking, especially when using restrictive interventions.

It is important that staff choose approaches that are balanced and proportionate to the behaviour of the individual in distress. When there is physical risk, staff may need to respond with restrictive interventions. These safety interventions need to balance the risk of the behaviour with the safety and risk of the intervention. This course will explore varying levels of safety intervention and provide tools to assist in measuring risk and choosing appropriate interventions.

Interventions may be traumatic events and/or can trigger memories of past traumatic experiences for the individual in distress and for staff. How you manage a situation and your responses afterwards can have a direct impact on whether the safety intervention damages the Therapeutic Rapport between the individual and staff or lessens the traumatic experience for all involved.

Risk Behaviour can include self-injurious behaviour and can involve multiple people. It ranges from standing to seated to the floor, from isolated situations to crowded areas. It is important for staff to understand the actual risk presented at the moment, as well as the risks presented through intervention. It is staff's responsibility to determine balanced and least restrictive responses to risk behaviour and to choose safety interventions that maintain safety for all involved. In later modules, specific tools to assist in making appropriate decisions, including practising a range of safety interventions to maintain safety even in higher-risk situations, will be explored.

In certain situations, it may be necessary to use safety interventions in order to maintain the safety of an individual in distress. Communication through touch will play a large role in these situations. Consider the impact of touch during such interventions and what may be communicated. What can be done to ensure communication that is respectful and maintains core values?

CPI Guiding Philosophy

CARE

Respect, dignity, empathy, person-centred

WELFARE

Maintaining independence, choice and well-being

SAFETY

Protecting rights and minimising harm

SECURITY

Safe, effective, harmonious and collaborative relationships

Key Legislation

Policies and guidance documents which relate to my area of practice:

Authorisation and Approval Considerations for Use of Safety Interventions

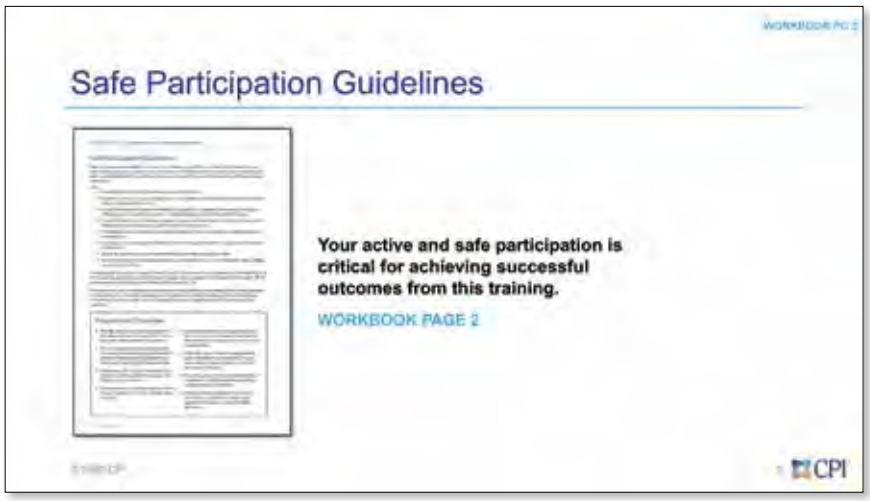
Your employer has selected this training recognising that the philosophy, lessons, and skills taught in the programme align with organisational values. Safety intervention procedures taught in this programme are based on typical behaviours and risks you may encounter at work. Balancing objectives to provide for the best possible care and welfare, while maintaining safety and security, requires ongoing consideration, study, and practice. In addition, participants in this training must remember that use of any safety intervention needs to be guided by:

- Organisational policies and procedures.
- Relevant legal and regulatory frameworks.
- Professional standards for best practice.

Please Read Carefully:
In CPI *Safety Intervention*™ training, you will be involved in practising intervention strategies. You should understand that some of these methods may involve physical contact and include risk of injury. It is important to follow the directions of the Instructor and the Safe Participation Guidelines of the programme.

CPI makes no warranty or representation that the skills, principles, and methods taught in this programme comply with all local laws, rules, regulations, and ordinances that may be applicable to persons utilising same. CPI's safety intervention principles should be used only in a manner that aligns with local laws. CPI assumes no liability for any bodily injury, loss, or damage caused by the misuse or incorrect application of the skills, principles, and methods taught in this programme, or by the illegal or inappropriate use of same, whether or not such injury, loss, or damage is foreseeable.

Slide 3



Workbook Pg 2

Safe Participation Guidelines

Your active and safe participation is critical for achieving successful outcomes from this training. At the start of the day, you are required to sign in as confirmation that you are fit to participate and that you will take responsibility for the *Care, Welfare, Safety, and Security*SM of yourself and others by adhering to these safety rules.

I will:

- Be professional and respectful of everyone in the classroom.
- Notify the Instructor of any past injuries or concerns I have about performing activities either before class or at the first opportunity.
- Accept the Instructor's guidance and follow any adaptations necessary for my safe participation, including not taking part in an activity if it compromises my safety or the safety of others.
- Follow the Instructor's directions and only perform activities when asked to do so. If for any reason I feel unable to safely participate, I will discuss it with the Instructor.
- Immediately stop any classroom activity when asked to do so, for any reason, by the Instructor or any participant.
- Not engage in any activity that is likely to disrupt learning, offend others, or cause harm or injury to self or others.
- Report all injuries and accidents immediately so a formal record can be made.
- Maintain my legal responsibilities regarding confidentiality and not share information that identifies any specific individual.

Participants will be taught a range of intervention skills and assessed for competent practice. Attendance in this event does not provide evidence that participants are competent to teach these skills to others. All CPI courses must be taught by a Certified Instructor licensed by CPI.

Participants who have any personal circumstances that may limit their participation in the course (physical or otherwise) must consult their manager prior to attendance. Where necessary, participants who may be limited in their participation must seek advice from their Occupational Health Department before attending.

Programme Objectives

Workbook Pg 2

- Describe the principles of risk assessment and risk reduction and demonstrate how to undertake a behavioural risk assessment.
- Provide a legal and professional rationale for decision making and give justification for actions made in relation to risk behaviour including the use of physical interventions.
- Assess a specific range of behaviours using the Brøset Violence Checklist to predict the likelihood of a crisis event.
- Demonstrate the use of physical interventions that are consistent with a set of physiological principles.
- Describe the warning signs associated with the adverse impact of physical interventions and identify the necessary corrective actions to minimise harm.
- Define the roles of incident manager/team leader and other team members for team interventions to ensure safety for both staff and person in distress.
- Assess risk using the *Decision-Making Matrix*℠ to determine if additional staff are needed during physical interventions.
- Assist the individual experiencing Tension Reduction to consider alternative, more appropriate behaviours using the IBERA framework.

Agenda

TRAINING COMPONENT	LEARNING INTENT	Classroom Time Needed
Module 7: Decision Making	Organise thinking regarding the prediction of risk behaviours, encouraging objective and critical analysis to determine staff approaches. Organise thinking regarding assessing extreme risk behaviours. *Participants will:* • Examine a situational or behavioural risk assessment using the Brøset Violence Checklist (BVC) based upon the individual, specific behaviours, and the prevailing risk. • Use the *Decision-Making Matrix*℠ to assess extreme risk behaviour.	60 minutes
Safety Interventions: Disengagement Skills Review and Expansion	Develop strategies to respond effectively when an individual is at the extreme Risk Behaviour Level. Build the confidence of staff in their ability to keep themselves and others safe using CPI Emergency Response and CPI Emergency Rescue disengagement skills. *Participants will:* • Review and apply the principles for disengagement to low-, medium-, and high-risk behaviours. • Review and practise applying the principles of CPI Emergency Response and CPI Emergency Rescue disengagement skills for extreme risk behaviours.	115 minutes
Safety Interventions: Holding Skills Review and Expansion	Develop strategies to respond effectively when an individual is at the Risk Behaviour Level. Build the confidence of staff in their ability to keep themselves and others safe using physical holding skills. *Participants will:* • Review and apply the principles of holding to risk behaviours. • Practise applying CPI emergency holding skills for high-risk and extreme risk behaviours and situations including: – Emergency Floor Holding – Rapid Tranquillisation – Seclusion • Demonstrate confidence in keeping themselves and others safe in a crisis situation. • Develop problem-solving skills and respond to a range of risk behaviours and situations.	420 minutes
Module 8: Post-Crisis	Use the IBERA Post-Crisis Debriefing Tool as part of the CPI *COPING Model*℠.	50 minutes
Consolidation and Learner Assessment	Consolidate participant learning from Foundation and finish any competency assessment.	120 minutes
Conclusion	Reflect on new learning and complete an action plan.	15 minutes
	Total Time	**13 hours**

Total Time 60 minutes

Time for Activities 25 minutes

Workbook Pages 3–7

Presentation Slides 4–8

MODULE 7

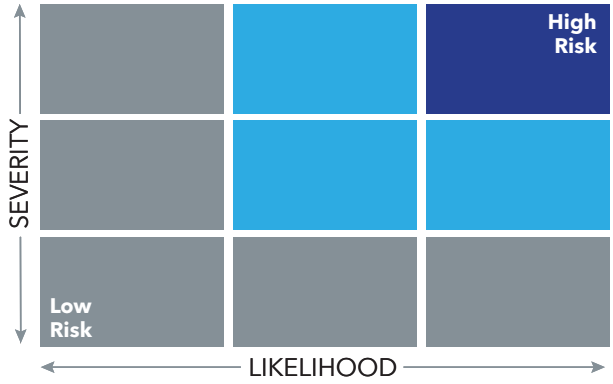
Decision Making

Having introduced the concepts of risk and decision making, you will expand on this knowledge and explore how you can assess situations or behaviours which may lead to greater levels of harm. It also will help you make decisions in relation to the use of physical interventions that may be justified and defended from a legal and professional perspective.

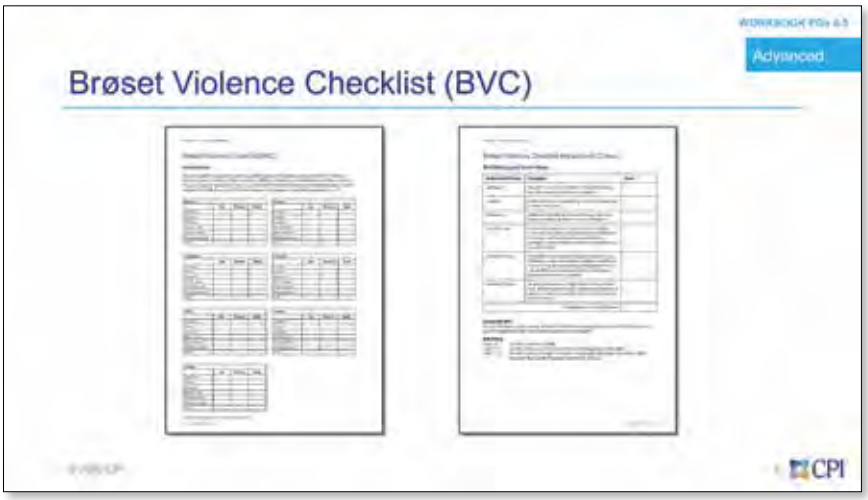
Learning Objectives

1. Undertake a situational or behavioural risk assessment based upon extreme risk behaviour using the *Decision-Making Matrix*SM.
2. Assess a specific range of behaviours using the Brøset Violence Checklist (BVC) to predict the likelihood of a crisis event so that preventive measures can be implemented to avoid escalation in the crisis cycle.
3. Reinforce the concepts of reasonable, proportionate, and least restrictive physical interventions to risk behaviour based on current legal and professional frameworks, and national or sector-specific guidelines for best practices.

*Decision-Making Matrix*SM



Slide 5



Workbook Pgs 4-5

Activity: Predicting Risk Behaviour *(25 minutes)*

Part 1: Classroom Scenario

Set Up

- Prior to this activity, direct participants to use the BVC behavioural reference terms and risk rating assessment criteria in their workbook **(Instuctor Guide Appendix 1)** as these will be needed so that:
  - Participants can assist in the first activity.
  - Participants can complete an assessment in the second part of the activity.
- Ask for two volunteers to assist you in scenario 1.
- Ask the volunteers to leave the room with you so that you can explain their roles without the other participants hearing your instructions.
- Explain that they will present a common conflict or crisis event with one person in the role of person in distress and one in the role of staff member. Explain that the activity is focused on the remaining participants as they are going to be asked to observe and assess how likely risk behaviour or violence is to occur.
- Using the BVC behavioural reference terms and risk rating assessment criteria, outline a typical conflict or crisis scenario you want them to demonstrate.

  The person in distress
  The person in distress will choose between one or more of the behavioural criteria to demonstrate during the activity. Ensure they fully understand that their role is to clearly demonstrate these behaviours as the other participants in the class are being asked to assess the risk. Ensure that the person in distress does not engage in any actual risk behaviour to the staff member or others.

  The staff member
  Explain that the staff member should approach the person in distress and attempt to use all the non-verbal and verbal skills taught within the programme. However, the focus of the activity will be on the other participants in the classroom assessing the person in distress.
- Explain to the remaining participants that they will see a typical conflict or crisis scenario demonstrated by a person in distress and a staff member.

- Explain that following the activity, you will ask participants to determine a risk rating on how likely the person in distress is to be violent in the following 24 hours.
- Ask participants to watch the scenario and write down their risk rating.


Workbook Pg 6

Participate

- Bring the person in distress and staff member back into the room and begin the activity.
- Allow the activity to run for 1–2 minutes so that the person in distress can demonstrate some of the behavioural criteria.
- Stop the activity, ensuring each participant observing the activity writes down their risk rating.
- Debrief the group on their results.

Explain

- Ask participants to give a show of hands for each risk rating (e.g., How many people gave the person in distress a small risk rating? How many gave a moderate or high risk rating?)
- Discuss with the group why there are these different perceptions and assessments.
- Ask participants what criteria they used to form their assessment decision.
  - Did they pay attention to any aspect of the individual's behaviour?
  - Did they consider any specific factors?
  - Can they explain to others how and why they reached their assessment decision?
  - What is the impact of making an accurate or inaccurate assessment decision?

Part 2: Classroom Scenario

Set Up

- Direct participants to the Brøset Violence Checklist in their workbooks and explain:
  - The behavioural criteria and examples.
  - The risk rating assessment criteria and how an assessment decision is reached.
- Ask for two new volunteers who will present a different scenario. Ask the participants to leave the room so that you can set up the scenario so the other participants cannot hear your instructions.
- Explain that they will present a different common conflict or crisis event with one person in the role of person in distress and one in the role of staff member. Explain that the activity is focused on enabling the remaining participants to assess how likely risk behaviour or violence is to occur using the BVC. Allow the volunteers enough time to work out their scenario and determine which behaviours they wish to include in the activity.
- Explain to the remaining participants that you will repeat a conflict or crisis scenario, but on this occasion, participants must determine a risk rating using the BVC.
- Ask participants to watch the scenario and write down their risk rating.

Participate

- Bring the person in distress and staff member back into the room and begin the activity.
- Allow the activity to run for 1–2 minutes so that the person in distress can demonstrate some of the behavioural criteria.
- Stop the activity, ensuring each participant observing the activity writes down their risk rating.
- Debrief the group on their results.

Explain

- Ask participants to give a show of hands for each risk rating:
  - How many people gave the risk rating small (a score of 0), meaning they did not observe any of the behavioural criteria?
  - How many people gave the risk rating moderate (a score of 1-2), meaning they did observe up to two of the behavioural criteria?
  - How many people gave the risk rating high (a score of 3 or more), meaning they did observe between 3 and 6 of the behavioural criteria?
- Discuss with the group why some participants may have reached a different risk rating, even though everyone is using the same assessment criteria.
- Establish how many people had the same risk rating (e.g., moderate) but identified different behavioural criteria. Discuss how this might happen and ask the group if they think it makes any difference to the actions staff will subsequently take.
- Ask participants to discuss the benefit of using a tool like this.

Note: *Depending on time available and how much consensus you have in terms of the participants making a similar assessment, the activity can be repeated again to ensure that everyone can accurately complete the BVC assessment.*

Brøset Violence Checklist Behavioural Criteria

Risk Rating and Score Sheet

Behavioural Criteria	Descriptor	Score
Confused	Appears obviously confused and disorientated (e.g., may be unaware of time, place or person).	
Irritable	Easily annoyed or angered (e.g., unable to tolerate the presence of others).	
Boisterous	Behaviour is overtly loud or noisy (e.g., slamming doors, shouting out when others are talking etc.).	
Verbal Threats	A verbal outburst which is more than just a raised voice, and where there is a definite intent to intimidate or threaten another person (e.g., verbal abuse, sexually or racially offensive abuse, name calling, open or veiled threats).	
Physical Threats	A definite intent to physically threaten or harm. (e.g., adopting an aggressive stance, raising a hand/arm as if to strike out, raising a foot or posturing as if to kick out, modelling or imitating a head-butt, raising an object as if to throw or smash it).	
Attacking Objects	An attack directed at an object and not an individual (e.g., indiscriminate throwing, smashing or breaking of objects or furniture, punching, kicking or headbutting walls or doors).	
Total Behaviour Criteria Observed		

Scoring the BVC
Score 0 if behaviour is not present, and score 1 if behaviour is present (only score 1 if the behaviour is present regardless of how many times the behaviour is repeated).

Risk Rating

Total = 0	The risk of violence is small.
Total = 1–2	The risk of violence is moderate. Preventive measures should be taken.
Total = 3–6	The risk of violence is high. Preventive measures should be taken. In addition, plans should be developed to manage the potential violence.

Predicting Risk Behaviour Discussion

The aim of the Brøset Violence Checklist (BVC) is to help you predict the likelihood of violence, so that you can ensure the approaches in the person's *My Safety and Support Plan* **(Instructor Guide Appendix 2)** can be implemented to avoid a crisis event.

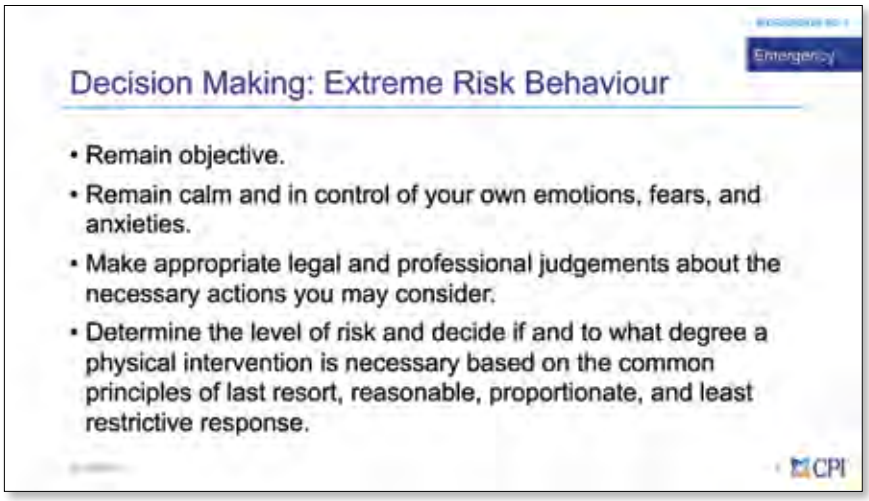
CPI recommends the BVC as it is an evidence-based, peer-reviewed assessment that has shown to be effective as a prediction tool for risk behaviour. The tool helps you use a systematic approach to assessing potential violence for a specific individual or period of time. When everyone uses the same criteria, they have an objective approach with a common understanding and language to make decisions. Assessing and predicting potential conflict and crisis behaviour will help you to implement preventive approaches and avoid or minimise the need to use restrictive interventions.

The BVC does not replace the *Decision-Making Matrix*SM for assessing risk behaviour. The BVC is for assessing the individual in the moment. It is used for when you quickly need to predict if there is a potential for violence from an individual in your immediate care. The BVC assessment allows you to immediately put in place preventive measures to avoid crisis behaviour and the use of restrictive practices. The *Decision-Making Matrix*SM still applies to crisis intervention moments and can also be used as a Post-Crisis risk assessment tool.

Use the BVC in a structured manner (e.g., assess each person every day) or when deemed necessary (e.g., for a fixed period of time if a particular individual you work with is repeatedly going through a crisis), as well as 'in the moment.' As part of the Integrated Experience, assess the person in distress and the impact of your approaches to de-escalate.

Remember to still draw on your professional knowledge, skills, and experience. When using the BVC, take account of how well you know the people you work with, and some of the behaviours that might be related to their personality or condition and not necessarily an indicator that risk behaviour is likely (e.g., a person with a neurological condition or other cognitive impairment may ordinarily be confused, boisterous, or use language that would typically be viewed as offensive or threatening). In reaching your assessment decision, you will need to consider how well you know the person and how you perceive their behaviour as a likely indicator of risk behaviour to avoid unnecessarily high and inaccurate risk ratings. Similarly, you may be so accustomed to the person and their behaviour, you could score them inaccurately low when in fact, you should be implementing preventive approaches.

Slide 6



Workbook Pg 7

Decision Making: Extreme Risk Behaviour

You have previously seen how the *Decision-Making Matrix*SM can be used to compare the variables of likelihood and severity of harm to determine the perceived level of risk ranging from low to high. Having determined the level of risk, you used this information to make decisions about your response to risk behaviour during a crisis to help you:

- Remain objective.
- Remain calm and in control of your own emotions, fears, and anxieties.
- Make appropriate legal and professional judgements about the necessary actions you may consider.
- Determine the level of risk and decide if and to what degree a physical intervention is necessary based on the common principles of last resort, reasonable, proportionate, and least restrictive response.

There may also be a situation, in specific contexts, where risk behaviours have varying potential for harm with significantly greater risks. While such events are rare, you can use the same decision-making framework to assess the specific level of risk for extreme behaviours. This can be done to assess known behaviours as well as for those in-the-moment situations.

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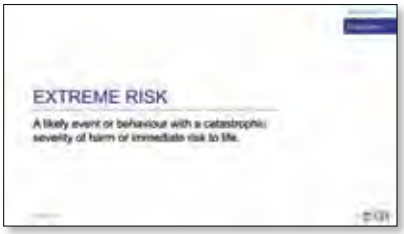
Slides 7–8



Workbook Pg 7

Decision-Making Matrix℠ and Extreme Risk Behaviour Lecture

- Refer to the *Decision-Making Matrix*℠.
- Recap how the variables for likelihood and severity of harm are used to assess risk behaviour in terms of low, medium, or high risk. Explain that while the *Decision-Making Matrix*℠ can be used to assess known behaviours as extreme, the severity of harm variable (vertical axis) can be used to form an immediate assessment.
- Point out the term Extreme Risk (which is above High Risk on the matrix). Give an example or elicit one from participants.

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- Define **Extreme Risk**.
  - A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.
- Ask participants to think about situations in their workplace (events or behaviours) that may amount to an extreme risk, and write these up on a flip chart. You may need to prompt participants to consider the different types of behaviours such as those behaviours directed toward themselves (e.g., a person in distress takes hold of your hair) as well as behaviours that are directed towards others (e.g., when a person in distress takes hold of a colleague's hair).
- Discuss with the group considerations they need to have in place when assessing a behaviour as extreme risk. This may include:
  - The potential problems that arise when an event or behaviour is labelled as extreme.
  - The need to ensure any actions arising from that assessment comply with organisational policy (authorisation and approval), legal and professional responsibilities, as well as national guidelines for best practice.

Now that you have a good idea of how to apply an objective risk assessment during risk behaviour, as well as verbal, non-verbal, and paraverbal skills, you will have a chance to practise these strategies in the next segment of the course.

SAFETY INTERVENTIONS

Disengagement Skills

Total Time 115 minutes

Workbook Pages 9–14

Presentation Slides 9–23

Advanced and Emergency Content Introduction

Previously, you learnt the importance of non-verbal, verbal, and paraverbal communication. You have also experienced the concept of Integrated Experience and how interpersonal communication can be both positively and negatively interpreted or influenced. Think about how you will use your non-verbal, paraverbal, and verbal communication to manage your behaviour as you intervene in crisis, particularly as you practise disengagement skills.

In this section, you will learn about the physiological principles in relation to extreme risk behaviours. You will learn how an Emergency Response can be applied to maximise your ability to gain a release from an extreme risk behaviour while minimising harm.

Learning Objectives

1. Demonstrate and practise a neck disengagement for high-risk behaviour.
2. Identify a range of Emergency Responses to extreme risk behaviour that may be encountered during a crisis.
3. Apply the physiological principle of Direct Pressure and Movement as a response to gain a release from a hold to the body where other physiological principles have not worked or within a catastrophic or life-threatening situation.
4. Demonstrate and practise using Emergency Responses to cause a person in distress to let go as a protective reaction when all other options have been exhausted.

Slide 11

Workbook Pg 10

Neck (High-Risk Behaviour)

Demonstrate

- Ask a participant to assist you in the role of a person in distress.
- Prompt the person in distress to stand behind you and wrap their forearm around your neck.
- Start with your *Supportive Stance*SM.
- To maximise your safety and reduce the pressure to your airway, tuck your chin and apply Hold and Stabilise.
- To reduce the person in distress' ability to impair your airway, lower your centre of gravity to maximise your position, posture, and proximity.
- Take a step back, turning your face towards the person's body, placing your shoulder behind the person in distress.
- Use Lever to create energy and movement around your front foot and hips, using your shoulder.
- As the space between you and the person in distress increases, step back to a place of safety.
- Use another participant to repeat the demonstration.

Teachable Moments

- Ensure staff immediately move to a place of safety.
- Ensure you maintain visual of the person in distress while releasing.

Tips

- Be mindful that some participants will be very sensitive or concerned about others holding their neck.
- Due to the close proximity of this activity, participants may prefer to work with people of the same gender.
- It is helpful to encourage participants to work with partners of a similar size.

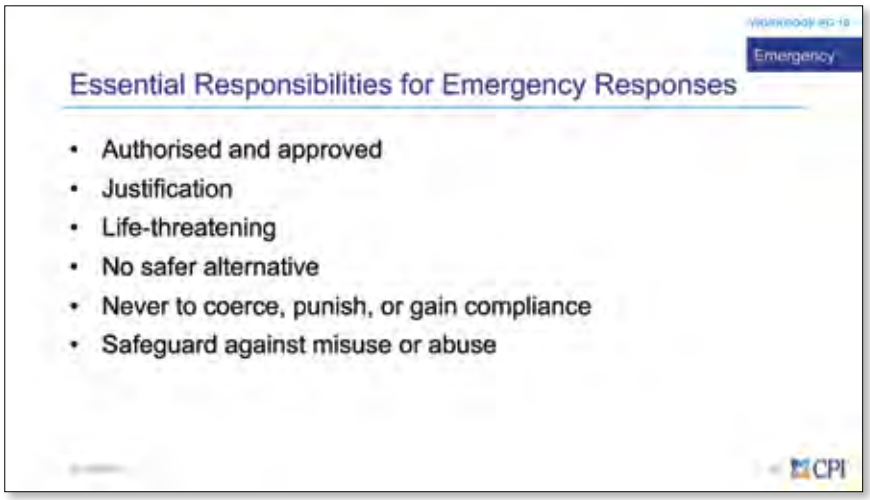
Participate

- Designate participants into two rows, with one row acting in the role of staff and one row acting in the role of the person in distress. Have the staff member face the opposite direction of the person in distress.
- Have the person in distress stand behind the staff member, placing their forearm around the staff member.
- Cue staff to adopt the *Supportive Stance*SM (remember to cue participants to think about their position, posture, and proximity).
- Cue staff to Hold and Stabilise while at the same time lowering their centre of gravity to maximise their *Supportive Stance*SM.
- Cue staff to turn their face towards the person in distress' body.
- Cue staff to create a lever with their hips and shoulders, rotating around their front foot.
- This should be repeated 3–5 times, each time increasing the speed.
- Change roles and repeat the activity.

Explain

- Emphasise that you are responding to high-risk behaviour.
- The key is to adopt the *Supportive Stance*SM simultaneously with Hold and Stabilise.
- As the staff change their *Supportive Stance*SM, ensure they turn their face towards the person in distress' body to reduce pressure to the neck/airway.
- A release is generated by creating greater momentum (energy and speed) with the hips and shoulder and movement (rotation) around a single point–the front foot.

Slide 12



Workbook Pg 10

Essential Responsibilities for Emergency Responses

- Authorised and approved
- Justification
- Life-threatening
- No safer alternative
- Never to coerce, punish, or gain compliance
- Safeguard against misuse or abuse

The goal of Emergency Responses is to gain a release from a hold while minimising harm to the person in distress.

Emergency Responses (Escape and Rescue) must be formally authorised and approved by your organisation. Refer to your organisational policy, and ensure you have explicit approval and authorisation to use these interventions within your workplace before providing any instruction.

Emergency Responses create a somatic response causing the person in distress to instinctively let go as a protective reaction. The focus of each demonstration and practise in this section is twofold:

- To reinforce the concept of risk assessment covered in Module 7.
- To develop a consistent response to extreme risk behaviour in keeping with your key legal and professional responsibilities.

Remember the *Decision-Making Matrix*SM in Module 7. You learnt to assess risk based on likelihood and severity of harm. Extreme Risk occurs when the likelihood is almost certain and severity is significant. This is known as extreme risk behaviour.

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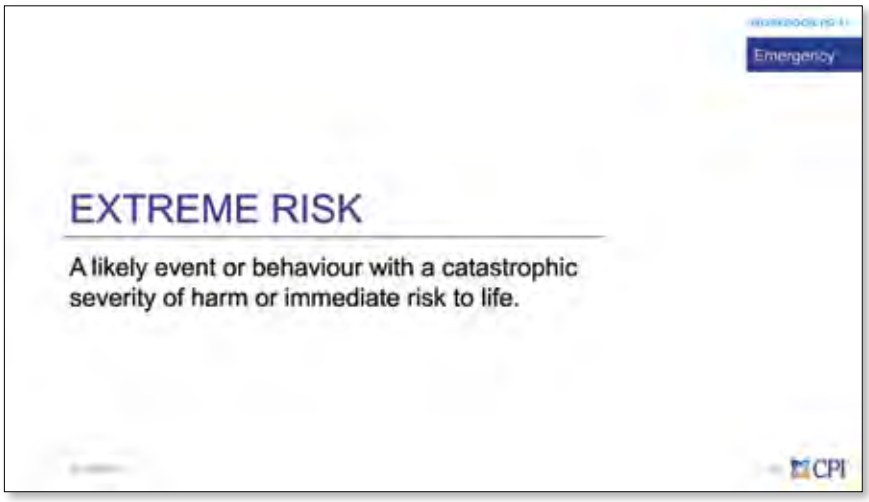
Slide 13



Workbook Pg 11

EXTREME RISK

A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

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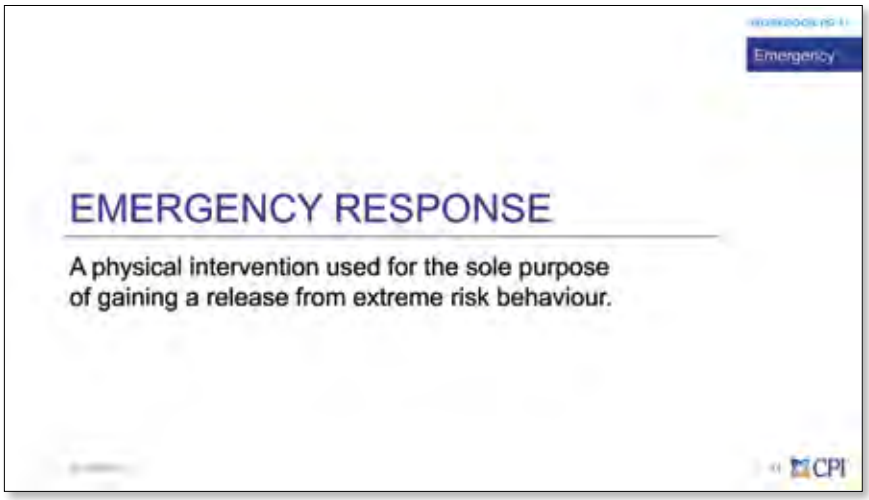
Slide 14



Workbook Pg 11

EMERGENCY RESPONSE

A physical intervention used for the sole purpose of gaining a release from extreme risk behaviour.

Example 1: Escape
A person in distress is holding you using an extreme risk behaviour, and your intention is to immediately escape to a place of safety.

Example 2: Rescue
A person in distress is holding someone else using an extreme risk behaviour, and your intention is to rescue the person and move to a place of safety.

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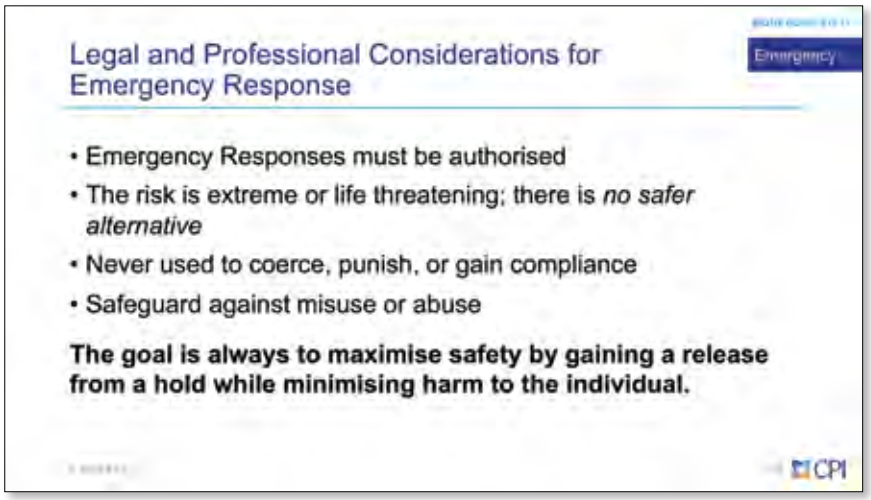
Slide 15



Workbook Pg 11

Legal and Professional Considerations for Emergency Response

Think back to the *Decision-Making Matrix*SM and the legal and professional issues related to the use of non-restrictive and restrictive physical interventions. An Emergency Response for rescue or escape should only be used after all other preventive efforts have been exhausted and you are able to justify that you meet all your legal and professional obligations. As part of your decision-making process, you should also consider:

- The use of Emergency Responses must be authorised and approved by your organisation.
- The risk is extreme or life threatening and there is *no safer alternative*.
- Emergency Responses are never used to coerce, punish, or gain compliance.
- You have recording and reporting procedures which safeguard against misuse or abuse.

Remember, for extreme risk behaviour the goal is always to gain a release from a hold while minimising harm to the distressed individual.

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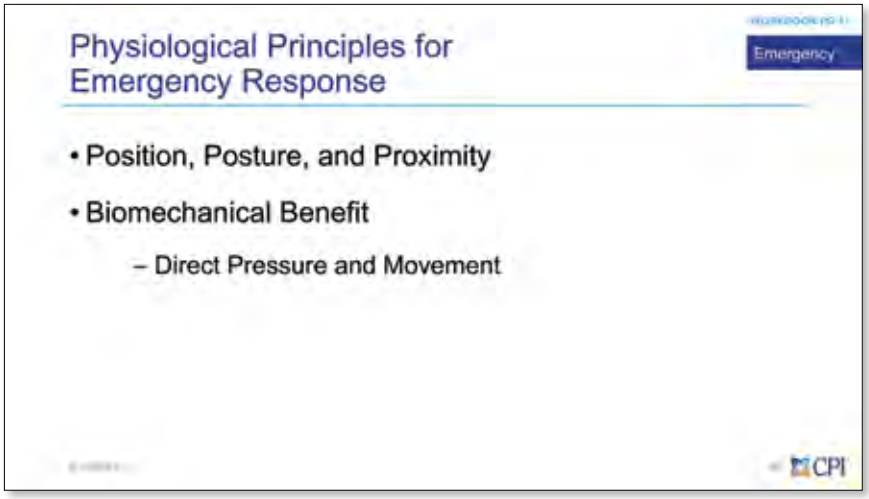
Slide 16



Workbook Pg 11

Physiological Principles for Emergency Response

The same core physiological principles of position, posture, and proximity you have practised with the *Supportive Stance*SM apply to Emergency Responses. Once you have adopted a *Supportive Stance*SM gain a release by using the principle of Direct Pressure and Movement.

Principles of Emergency Response

- Position, Posture, and Proximity
- Biomechanical Benefit
  - Direct Pressure and Movement

Click to advance to next slide.

Slides 17–21

Workbook Pg 12

Workbook Pg 13

Extreme Risk – Emergency Responses

Learning Goal

During this activity, you will apply the key Principles of Disengagement and a fourth anatomical and physiological principle for disengagement: Direct Pressure and Movement.

Assume that all preventive efforts have been exhausted and there is a legal and professional justification for the use of Emergency Responses–prior principles of disengagement have been exhausted. Situationally, you have assessed the risk behaviour as extreme with the potential for catastrophic severity of harm and/or immediate risk to life.

Demonstrate each Emergency Response in the following sequence to ensure that each participant learns how to locate the correct area of the body to apply the physiological principles.

- Thumb
- Dorsal Hand
- Upper Outer Torso
- Sternum
- Mandibular

Remember, you should only apply Emergency Responses when authorised and approved by your organisation. Applying Emergency Responses outside the context of your organisational policy may compromise you professionally and legally.

Demonstrate (Escape)

- Ask a participant to be the person in distress and to assist you in the demonstration.
- Explain to participants that you will initially demonstrate and practise the physiological principles for Emergency Responses that can be used for escape before providing everyone with the opportunity to look at how this might apply to specific extreme risk behaviours.
- Adopt the *Supportive Stance*SM (think about your position, posture, and proximity).
- Prompt the person in distress to make a fist and position them so that the remaining participants can clearly see the next actions.
- Apply the principle of Hold and Stabilise to the wrist of the person in distress and give the directive to 'let go.'
- Demonstrate Direct Pressure and Movement to the thumb to open the hand, simulating a release or escape.
- Choose another participant and repeat the demonstration, this time giving a clear instruction on how the principle of Direct Pressure and Movement is applied. Repeat the demonstration so that all participants have a clear understanding of the physiological principle.

  Note: *It is not necessary to apply the principle in full due to discomfort this may cause.*

Participate

- Designate participants into two rows, with one row acting in the role of staff and one row acting in the role of the person in distress.
- Remind participants that each behaviour scenario is Extreme Risk.
- Cue staff to adopt the *Supportive Stance*SM.
- Cue person in distress to reach forward with a closed fist. Ask the staff member to apply the principle of Hold and Stabilise, and then give the directive: 'Let go.'
- Cue the staff member to apply the principle of Direct Pressure and Movement until the person in distress opens their hand, simulating a release.
- Change roles so that each participant has been in the role of staff or the person in distress.
- Change pairs and repeat the teaching sequence so that all participants practise how to apply the principle for Emergency Response to:
  - Dorsal Hand
  - Upper Outer Torso
  - Sternum
  - Mandibular

Explain

- Remember that these are only used for extreme risk behaviour which has the potential for catastrophic/life-threatening harm.
- The purpose is to get an immediate release to allow you to get out of harm's way. If applying an emergency response doesn't create a release, reconsider other disengagement options as possible.

Thumb

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Dorsal Hand

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Upper Outer Torso

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Sternum

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Mandibular

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Demonstrate (Rescue)

- Explain to participants that you will initially demonstrate and practise the physiological principles for Emergency Responses that can be used for rescue before providing everyone with the opportunity to look at how this might apply to specific extreme risk behaviours.
- Ask two participants to assist. One will be the person in distress and one will be a staff member.
- Ask the person in distress to take hold of the staff member to simulate an assault using an extreme risk behaviour.
- Approach the person in distress from the rear or side and adopt the *Supportive Stance*[SM] (think about your position, posture, and proximity).
- Apply the principle of Hold and Stabilise to the person in distress and give the directive 'let go'. (Other suitable directives may be 'please let go'; 'open your hand'; or 'let go now.')
- Based on the specific extreme risk behaviour, demonstrate Direct Pressure and Movement to the Thumb, Dorsal Hand, Upper Outer Torso, Sternum, and Mandibular simulating a release or escape.
- Choose another two participants and repeat the demonstration, this time giving a clear instruction on how the principle of Direct Pressure and Movement is applied. It is important to repeat the demonstration so that all participants have a clear understanding of the physiological principles.

Participate

- Designate participants into groups of three with each participant in the following roles:
  - The staff member undertaking the rescue.
  - The person in distress.
  - The staff member in need of rescue.
- Remind participants that each behaviour scenario is Extreme Risk.
- Cue the person in distress to adopt an extreme risk behaviour on the staff member needing to be rescued.
- Cue the staff member intervening to apply the principle of Direct Pressure and Movement to gain a release and assist the staff member to a place of safety. Remind participants that there is no need to apply the principle in full and that they should avoid unnecessary discomfort.
- Ask each group to change roles and repeat the activity.

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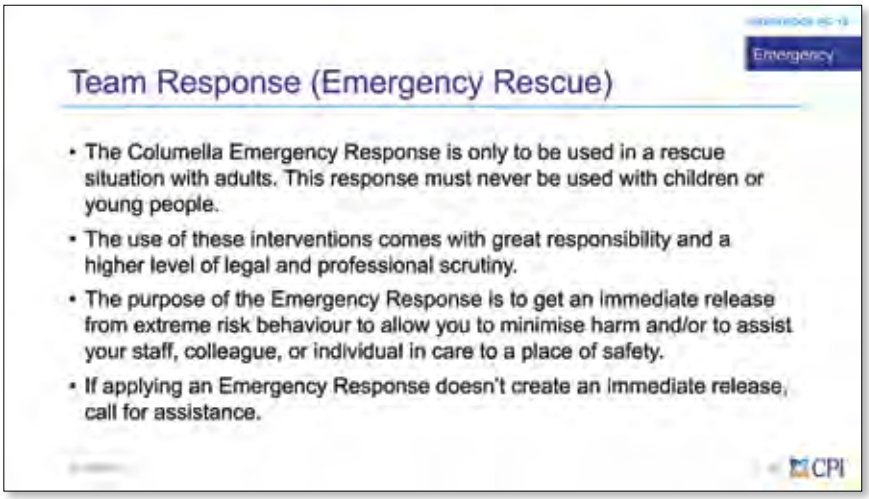
Slide 22



Workbook Pg 14

Team Response (Emergency Rescue)

You will now see how you might rescue an individual using the columella to gain a release. This is only used in a situation of extreme risk behaviour, and the columella should only be used for rescue.

Set Up

1. Get two participants, one in the role of the person in distress and one in the role of the person in a life-threatening situation (may be a staff member or another individual).
2. Establish the behavioural scenario (e.g., the person in distress is assaulting the other person and that person is unsuccessful or unable to gain a release).
3. Your role is to rescue the person and assist them to a safer place.

Demonstrate

For this demonstration, you are learning the Columella Emergency Response only to be used in a rescue situation with adults. This response must never be used with children or young people.

- Ask the person in distress to take hold of the staff member to simulate an assault using an extreme risk behaviour in a standing position.
- Acting as the rescuing staff member, approach the person in distress from behind in a *Supportive Stance*[SM] with a right hand lead.
- Apply the principle of Hold and Stabilise to the person in distress, placing your hands onto their head. Give a directive, such as, 'let go.' (Other suitable directives may be 'please let go'; 'open your hand'; or 'let go now.')
- Based on the specific extreme risk behaviour, demonstrate Direct Pressure and Movement to the columella simulating a release or escape. (The columella is the skin and cartilage between the nostrils at the base of the septum.) When demonstrating this, ensure that participants observe you moving your lead hand down the forehead and face to carefully locate the columella. Once located, apply Direct Pressure and Movement.
- Once you gain a release, move to a place of safety.
- Choose another two participants and repeat the demonstration, this time giving a clear instruction on how the principle of Direct Pressure and Movement is applied. Repeat the demonstration so that all participants have a clear understanding of the physiological principles.

Participate

- Have the group form two rows. One row is the person in distress, and the other is the rescuing staff member.
- Cue the person in distress to turn and face away (simulating extreme risk behaviour).
- Cue the staff member to apply the principle of Direct Pressure and Movement to the columella to gain a release.
- Repeat the rescue and remind participants that there is no need to apply the principle in full. Avoid unnecessary discomfort. Depending on the participants' work environment, you may choose to repeat the activity simulating extreme risk behaviour in a kneeling or seated position.

Explain

Remember that this is only used for extreme risk behaviour which has the potential for catastrophic/life-threatening harm.

- The use of these interventions comes with great responsibility and a higher level of legal and professional scrutiny, so staff who use these approaches must be able to account for their actions in the specific circumstances when Emergency Responses are used.
- The purpose of the Emergency Response is to get an immediate release from extreme risk behaviour to allow you to minimise harm and/or to assist your staff, colleague, or individual in care to a place of safety.
- If applying an Emergency Response doesn't create an immediate release, call for assistance, and continue to reconsider other disengagement options.
- Revisit the Physical Skills Review Framework after practice and ask participants to discuss the legal and professional issues and any concerns they may have about Emergency Responses.

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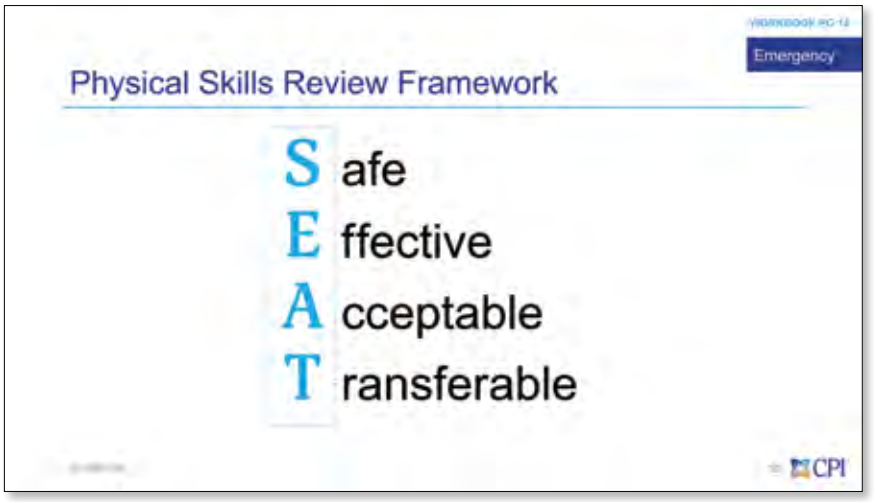
Slide 23



Workbook Pg 14

NOTE: *After teaching one, or a group of physical intervention skills, provide your class with opportunities to reflect on what they have just learnt. Encourage them to use the space in their workbook to capture relevant notes that will help them remember the safe application of the key principles.*

Physical Skills Review

When progressing through the teaching strategy, encourage participants to consider the principles, experiment with different ways to apply the skills, and reflect on the appropriateness and effectiveness of the applications using the Physical Skills Review Framework.

Safe	In what way does the specific restrictive intervention enable you to maximise safety and minimise harm?
Effective	What makes your intervention effective?
Acceptable	How would this be viewed as an acceptable response to risk behaviour?
Transferable	How can you transfer the principles back into your workplace?

SAFETY INTERVENTIONS

Holding Skills

Total Time 420 minutes

Workbook Pages 15–20

Presentation Slides 24–45

Holding Skills Prerequisites for Participants

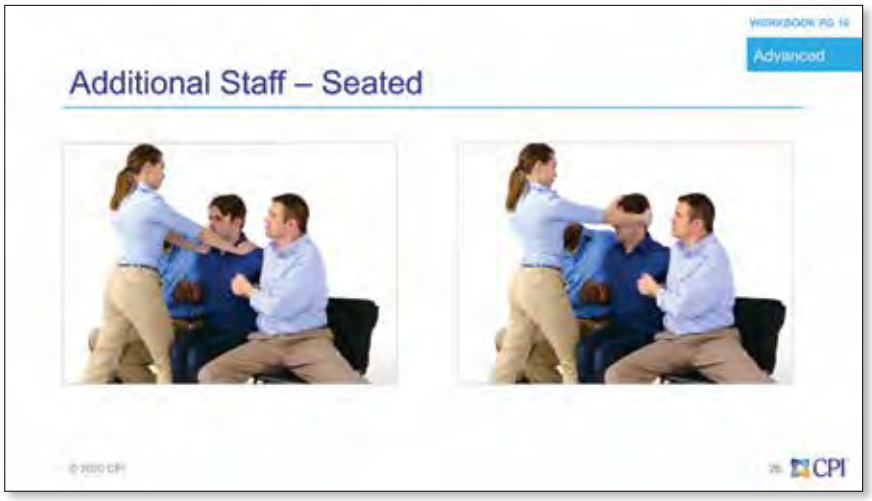
To participate in this module, participants must meet the following criteria:

Must be currently in work and physically fit and able to undertake their typical day-to-day role in the workplace. Where there are concerns about any participant's ability to undertake the physical modules in the programme, the participant must seek occupational advice before continuing so that any reasonable adjustments can be made by the Instructor.

Participants must have completed CPI *Safety Intervention*™ Foundation. Participants must not be taught any physical interventions in isolation to other modules in the programme.

Participants must demonstrate an understanding of the legal and professional issues related to the use of physical interventions.

Slide 26



Workbook Pg 16

Adding Additional Staff – Seated

Learning Goal

During a physical intervention, an individual may use their shoulders and/or head in a way that increases risk to staff and/or the person in distress. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Employ the principles outlined in the *Opt-Out Sequence*℠ when determining if additional staff are required to assist in the physical intervention.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Seated Holding through focused and dynamic practice.

15-30 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Additional Staff – Seated

Demonstrate

- Ask for a volunteer to assist you by sitting in the middle chair in the role of the person in distress.
- Ask for examples or describe to the class situations in which the addition of a third staff member may be necessary to maintain safety. These may include, but are not limited to:
  - The individual is trying to stand up and allowing this increases risk.
  - Staff are having difficulty managing the individual's energy.
  - The individual is using their head to create risk to self or others.
- Identify the potential risks of the situation and ways to reduce the risks such as:
  - Adjusting how staff are holding the individual.
  - Disengaging.
  - Adding a third staff member to support the individual's shoulders or head.
- Demonstrate supporting the shoulders first and then the head.
- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from the side, before standing in front of the person in distress, slightly off centre.
  - Posture – maintain your balance, keeping both feet on the floor.
  - Proximity – stand close enough to make contact with the individual's upper body and/or head.
- Upper Body – Shoulders
  - Cup your hands and place them on the shoulders toward the outside of the torso.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.
- Upper Body – Head
  - Place the palm of your trailing hand on the individual's forehead, remaining above the line of the eyebrows, with fingers pointing toward the crown of the head.
  - Place the palm of your lead hand behind the individual's head so that your forearm is adjacent to the individual's ears.

Instructor Note: *When seated, the individual must always be in a recumbent or upright position. Moving the individual forward into a flexed position will seriously compromise breathing and may lead to serious respiratory and cardiovascular compromise or death.*

- Lower Body
  - Place your leading leg on the outside of the person in distress' knee/thigh.
  - Limit the range of motion by applying the principles together with colleagues to maintain a high level of restriction.

Participate

Set Up

- Organise class into groups of four.
  - The Person in Distress
  - Team Members (Two)
  - Team Leader
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask team members to place the person in distress into a High Level of Restriction in a Seated Position.
- Cue team leader to enter from the side to support the shoulders.
- Remind them of the key strategies:
  - Communicate with team members.
  - Enter from side to avoid kicks.
  - Posture is upright, position is on outside of legs with close proximity to limit range of motion.
  - Place hands gently on front of individual's shoulders.
- Cue the person in distress to move shoulders and gently try to stand up.
- Ask the person in distress to sit back in the chair.
- Cue team leader to adjust their hands to support the individual's head. Remind the team leader of the principles.
  - Place one hand on individual's forehead and one hand on the back of the head above eyebrow level, ensuring neck is in mid-line position and avoiding the face and ears.
- Cue team members to disengage.
- Repeat above sequence 2 to 3 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Click to advance to next slide.

Slide 27

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Adding Additional Staff – Standing

Learning Goal

During a physical intervention, an individual may use their shoulders and/or head in a way that increases risk to staff and/or the person in distress. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Employ the principles outlined in the *Opt-Out Sequence*℠ when determining if additional staff are required to assist in the physical intervention.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Standing Holding through focused and dynamic practice.

15-30 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Additional Staff – Standing

Demonstrate

- Ask for a volunteer to assist you by standing in the role of the person in distress.
- Ask for examples or describe to the class situations in which the addition of a third staff member may be necessary to maintain safety. These may include, but are not limited to:
  - The staff are having difficulty managing the individual's energy with only two staff members.
  - The person in distress is using their head to create risk to self or others.
- Identify the potential risks of the situation and ways to reduce the risks such as:
  - Adjusting how staff are holding the individual.
  - Disengaging.
  - Adding a third staff member to support the individual's shoulders or head.
- Demonstrate supporting the shoulders first and then the head.
- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from the side, before standing in front of the person in distress, slightly off centre.
  - Posture – maintain your balance, keeping both feet on the floor.
  - Proximity – stand close enough to make contact with the individual's upper body and/or head.
- Upper Body – Shoulders
  - Cup your hands and place them on the shoulders toward the outside of the torso.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.
- Upper Body – Head
  - Place the palm of your trailing hand on the individual's forehead, remaining above the line of the eyebrows, with fingers pointing toward the crown of the head.
  - Place the palm of your lead hand behind the individual's head so that your forearm is adjacent to the individual's ears.
- Lower Body
  - Remain in a *Supportive Stance*SM maintaining your position, posture, and proximity.
  - Keep both feet on the floor and use your trailing leg to slow down any forward movement the person in distress creates.

Participate

Set Up

- Organise class into groups of four.
  - The Person in Distress
  - Team Members (Two)
  - Team Leader
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask team members to place the person in distress into a High Level of Restriction in a Standing Position.
- Cue team leader to enter from the side to support the shoulders.
- Remind them of the key strategies:
  - Communicate with team members.
  - Enter from side to avoid kicks.
  - Position on outside of legs with close proximity to limit range of motion.
  - Place hands gently on the individual's shoulders.
- Cue the person in distress to move shoulders.
- Ask the person in distress to stop moving.
- Cue team leader to adjust their hands to support the individual's head. Remind the team leader of the key points:
  - Place one hand on the individual's forehead and one hand on the back of the head above eyebrow level, ensuring neck is in a neutral position.
  - Cradle the head to your body, which will reduce the range of motion and increase safety.
  - Avoid contact with the neck, chin, face, eyes, and ears.
- Ask the person in distress to attempt to move their head gently.
- Cue team members to disengage.
- Repeat above sequence 2 to 3 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Additional Staff – Standing

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to begin in High Level of Restriction in a Standing Position without an additional person physically assisting.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to move slowly and naturally.
- The additional person will enter the situation to physically assist.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 2 to 3 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Click to advance to next slide.

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Team Intervention

Learning Goal

During a physical intervention, an individual may use their shoulders and/or head in a way that increases risk to staff and/or the person in distress. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Employ the principles outlined in the *Opt-Out Sequence*℠ when determining if additional staff are required to assist in the physical intervention.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Standing Holding through focused and dynamic practice.

15-30 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Team Intervention Activity

Demonstrate

- Ask for four volunteers. One participant will be the person in distress, two participants will be the staff holding the individual's arms, and one will be acting as the team leader/incident manager.
- Ask for examples or describe to the class situations in which staff may intervene as a team in order to maintain safety. These may include, but are not limited to:
  - The person in distress' behaviour requires team intervention for safety.
  - Fights break out between two individuals in your care.
- Identify the potential risks of the situation and ways to reduce the risks such as:
  - Adjusting how staff are holding the individual.
  - Disengaging.
- Tell participants that you will demonstrate each level of team interventions. The first demonstration is how to intervene in low-risk behaviour, the second is how to intervene in medium/high-risk behaviour, and the third is how to intervene in fights.

Demonstration 1 – Low-Level Team Intervention

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from the side.
  - Posture – maintain your balance, keeping both feet on the floor.
  - Proximity – stand close to make contact with the individual's arm.
- Biomechanical Benefits
  - Place your outside hand against the outside of the individual's nearest elbow.
  - Place your inside hand on the outside of the individual's elbow which is furthest away.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Demonstration 2 – Medium/High-Level Team Intervention

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from the side.
  - Posture – maintain your balance, keeping both feet on the floor.
  - Proximity – stand close to make contact with the individual's arm.
- Biomechanical Benefits
  - Place your outside hand against the outside of the individual's nearest elbow.
  - Place your inside hand underneath and over the inside of the individual's forearm/wrist.
  - Move to a high level of restriction. Use the inside hand to hold the inside of the individual's wrist and guide the elbow back so the outside of your body rests against the outside of the elbow.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.
  - If required, the third member of the team can approach and manage the individual's shoulders and/or head to maintain a high level of restriction.

Demonstration 3 – High-Level Team Intervention

You will learn how to intervene as a team to manage the individual's risk behaviour within the context of a fight scenario, such as two individuals fighting each other; or an individual assaulting another individual, staff, or member of the public.

Two-Staff Intervention

Lead Member of Staff

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from behind and step forward with your right leg, using your right hand to lead.
  - Posture – maintain your balance.
  - Proximity – stand close to make contact with the individual.
- Biomechanical Benefits
  - Cup your leading hand and place it over the individual's right shoulder.
  - Place the palm of your left hand behind the individual's left shoulder.
  - In one fluid movement, prompt the individual to rotate to the right by stepping back with your leading right foot, turning the individual's shoulders towards you.
  - As the individual turns, your lead hand (the outside hand) moves down the upper arm and onto the outside of the elbow.
  - Your inside hand goes underneath and over the inside of the individual's forearm/wrist.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Second Member of Staff

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from behind to the right of the lead team member.
  - Posture – maintain your balance.
  - Proximity – stand close to make contact with the individual.
- Biomechanical Benefits
  - As the individual turns to the right, use both hands to block the movement of the individual's arm.
  - Place your outside hand on the outside of the elbow and your inside hand underneath and over the inside of the individual's forearm/wrist.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Three-Staff Intervention

Lead Member of Staff (arms)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from behind and step forward with your right leg, using your right hand to lead.
  - Posture – maintain your balance.
  - Proximity – stand close to make contact with the individual.
- Biomechanical Benefits
  - Reach forward with your leading arm and place it underneath the individual's right shoulder.
  - Stand in as close as possible and place the palm of your trailing hand behind the individual's left shoulder.
  - In one fluid movement, prompt the individual to rotate to the right by stepping back with your leading foot, turning the individual's shoulders towards you.
  - As the individual turns, your lead arm remains underneath the individual's shoulder and your inside hand reaches forward to hold the individual's wrist (thumb on top, palm to the side, and fingers underneath).
  - Move the individual's arm back so that their wrist sits below their shoulder.
  - Your body goes on the outside of the elbow, and your outside hand moves over the individual's hand to maintain a high level of restriction.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Second Member of Staff (arms)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from behind and step forward with your right leg, using your right hand to lead.
  - Posture – maintain your balance.
  - Proximity – stand close to make contact with the individual.
- Biomechanical Benefits
  - As the individual turns to the right, use both hands to block the movement of the individual's arm.
  - Place your outside hand on the outside of the elbow and your inside hand on the individual's wrist (thumb on top, palm to the side and fingers underneath).
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Third Member of Staff (head)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from behind and to the right of the lead member of staff.
  - Posture – maintain your balance.
  - Proximity – stand close enough to make contact with the individual's upper body and/or head.
- Biomechanical Benefits
  - Shoulders – Cup your hands and place them on the individual's shoulders toward the outside of their torso.
  - Head – Place the palm of your trailing hand on the individual's forehead, ensuring it remains above the line of the eyebrows, with your fingers pointing towards the crown of the head. Place the palm of your lead hand behind the individual's head so that your lead forearm rests adjacent to the individual's ears.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Participate

Set Up

- Organise class into groups of four.
  - The Person in Distress
  - Team Members (Two)
  - Additional Support Member
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting in a standing position.
- Direct the group using clear verbal instructions that you used in the demo, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue the staff to intervene using a low-level team intervention.
- Watch for safety and make any appropriate adjustments.
- Cue the staff to intervene using a medium/high-level team intervention.
- Watch for safety and make any appropriate adjustments.
- Cue staff to intervene in a fight.
- Watch for safety and make any appropriate adjustments.
- Cue participants to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 3 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to begin standing, with the person in the role of third person supporting the head also acting as team leader.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to engage in risk behaviour.
- Team members should respond to the situation by continuing to physically assist the person in distress.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Click to advance to next slide.

Slides 29–30

Workbook Pg 17

Standing to Floor Transition

Learning Goal

During a physical intervention, an individual may use their shoulders and/or head in a way that increases risk to staff and/or the person in distress. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Employ the principles outlined in the *Opt-Out Sequence*℠ when determining if additional staff are required to assist in the physical intervention.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

   Instructor Note: *When seated, the individual must always be in a recumbent or upright position. Moving the individual forward into a flexed position will seriously compromise breathing and may lead to serious respiratory and cardiovascular compromise or death.*

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Seated Holding through focused and dynamic practice.

15-30 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Standing to Seated (Floor Transition)

Demonstrate

- Ask for four volunteers. Two will be the staff, one in the role of the person in distress, and one will be supporting the person in distress' shoulders.
- Ask for examples or describe to the class situations in which staff may transition to the floor in order to maintain safety. These may include, but are not limited to:
  - Slips, trips, or falls.
  - The person in distress accidentally moves to the floor.
  - The person in distress intentionally moves to the floor.
- Identify the potential risks of the situation and ways to reduce the risks such as:
  - Adjusting how staff are holding the individual.
  - Disengaging.
- Tell participants that you will demonstrate two options. The first demonstration is how the anatomical and physiological principles can be applied to a transition to the floor in a seated positon. The second demonstration shows how the anatomical and physiological principles can be applied to transition to the supine position.

Transition to the Floor in a Seated Position

- As the person in distress transitions to the floor, the team leader will approach from behind and take responsibility for the individual's safety as the team also transitions to the floor.
- Roles change where the additional staff member supporting the shoulders or head will become the team leader.

Demonstrate Supporting the Person in Distress in Role of the Team Leader

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from behind the individual.
  - Posture – maintain your balance, keeping both feet on the floor.
  - Proximity – as the individual sits down, kneel down. Maintain the *Supportive Stance*SM with your knee closest to the individual on the floor and your foot furthest away on the floor, enabling you to be balanced and stable.

Demonstrate Staff Holding the Person in Distress' Arms

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – maintain your balance, keeping both feet on the floor. As the individual moves to the floor, kneel down. Maintain the *Supportive Stance*SM with your knee closest to the individual on the floor and your foot furthest away on the floor, enabling you to be balanced and stable.
  - Proximity – as the individual sits on the floor, your knee closest to the individual maintains close contact with the individual's hip. Move close to the individual's upper body.

- Biomechanical Benefits
  - Maintain the Outside/Inside principle on the individual's arms and move close to the outside of the individual's upper body to ensure the individual remains in a recumbent position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Demonstrate Staff Holding the Person in Distress' Shoulders

- You will assume the role of team leader by remaining standing in the *Supportive Stance*SM and observing for safety and support.

Click to advance to next slide.

Transition to the Floor in a Supine Position

Demonstrate Supporting the Person in Distress in Role of the Team Leader

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain behind the individual.
  - Posture – kneel down and turn to face the individual.
  - Proximity – as the individual lies back on the floor, maintain contact by allowing the individual's head to rest on your knees.
- Biomechanical Benefits
  - Cup one hand under the nape of the individual's neck, ensuring the head and neck are in a neutral position.
  - Place the palm of your other hand onto the individual's forehead, avoiding contact with the face.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Demonstrate Staff Holding the Person in Distress' Arms

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – as the individual lies on the floor, turn and face your colleague, resting on both knees in order to maintain the *Supportive Stance*SM.
  - Proximity – maintain close contact with the individual's arms.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle by placing both your knees around the individual's elbow and your hands around the individual's wrists.
  - Ensure the individual's upper arms rest on the floor and their forearms/hands point towards the ceiling.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change volunteers and repeat the demo to reinforce the anatomical and physiological principles.

Standing to Floor Transitions

Participate

Set Up

- Organise class into groups of five.
  - The Person in Distress
  - Team Members (Two)
  - Additional Support Member
  - Team Leader
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting in a standing position.
- Direct the group using clear verbal instructions that you used in the demo, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue staff and the person in distress to transition from a standing to seated position.
- Watch for safety and make any appropriate adjustments.
- Cue the person in distress to transition from seated to lying on the floor.
- Watch for safety and make any appropriate adjustments.
- Cue the group to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 3 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to begin in High Level of Restriction in a Standing Position with additional person physically assisting.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to move slowly and naturally to the floor.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning to the floor safely.

Participate

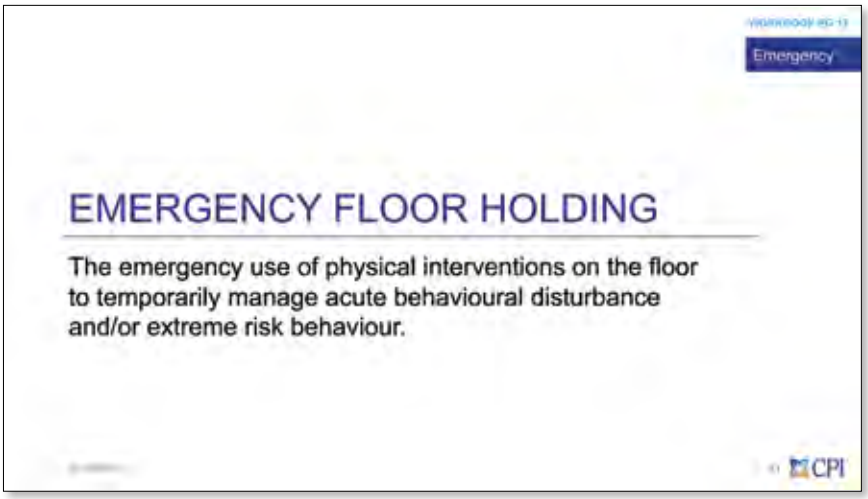
- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 3 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

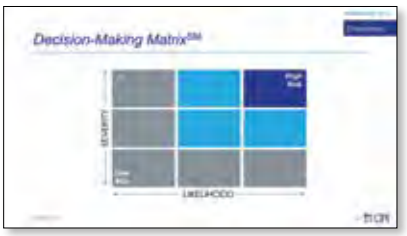
Click to advance to next slide.

Teachable Moment

- Remember to always keep the head and neck of the person in distress in a neutral position to avoid any injury.
- Avoid contact with the neck, chin, face, eyes, and ears.
- Remember that the transition is not a forced take down to the floor. Once the individual is seated or lying on the floor, follow the *Opt-Out Sequence*℠ to prompt the individual to stand, or determine if you may let go.

Slides 31–32





Workbook Pg 17

Decision-Making Matrix℠ and Extreme Risk Behaviour Lecture (for Emergency Floor Holding)

Emergency Floor Holding may be considered an option and used as a last-resort risk management response to extreme risks.

Definition: The emergency use of physical interventions on the floor to temporarily manage acute behavioural disturbance and/or extreme risk behaviour.

Example 1: Holding someone in a supine floor position.

Example 2: Holding someone in a side-lying floor position.

Example 3: Holding someone in a *Supported Prone Position*℠.

Click to advance to next slide.

Remember the *Decision-Making Matrix*℠ and how the variables for likelihood and severity of harm are used to assess risk behaviour in terms of extreme risk.

Think about situations in your workplace (events or behaviours) that may amount to an extreme risk where the person may have to be temporarily held on the floor.

Write these up on a flip chart. You may need to prompt participants to consider the different types of behaviours such as those behaviours directed toward themselves (e.g., a person in an acute behavioural crisis who repeatedly assaults others to place themselves at significant risk; a prolonged restraint where attempts to use the *Opt-Out Sequence*℠ have been unsuccessful; situations where essential prescribed medication needs to be administered without the individual's cooperation; administration of rapid tranquillisation; placement of an individual into an approved seclusion facility).

Refer back to the risks of restraint, your current professional guidance, and organisational policies. Here are some ways to minimise any risk of restraint-related deaths:

- Independent assessment of physical skills.
- Assessment of individual.
- Organisational authorisation and approval.
- Responding to medical warning signs.

Slides 33–35

Workbook Pg 18

Emergency Floor Holding

Learning Goal

During a physical intervention, an individual may use their shoulders and/or head in a way that increases risk to staff and/or the person in distress. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Employ the principles outlined in the *Opt-Out Sequence*SM when determining if additional staff are required to assist in the physical intervention.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?
2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.
3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.
4. **Can you let go?**
   Consider how adjustments may have changed the risk.

Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

Instructor Note: *This teaching sequence may only be taught as a part of the Advanced and Emergency programme.*

Click to advance to next slide.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Standing Holding through focused and dynamic practice. In addition, they should have demonstrated proficiency with the Standing to Seated learning sequence and Adding a Third Person.

30-40 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Emergency Floor Holding (Supine)

Demonstrate

- Ask for five volunteers. One in the role of the person in distress, two staff members to manage the arms, one staff member to manage the legs, and one to act as team leader.
- Emergency holding in a supine position enables you to temporarily manage extreme risk behaviour and/or acute behavioural disturbance when the individual accidentally or intentionally moves to the floor.
- Tell participants that you will demonstrate three different roles in the intervention. The first demonstration will show how the individual's head is protected, the second demonstration will show how to manage the individual's arms, and the third demonstration will show how to manage the individual's legs.

Click to advance to next slide.

Emergency Floor Holding Supine (Protecting Head, Spine & Airway)

- As the person in distress transitions to the floor, protect the head, neck, and spine. Provide constant and direct observations of the individual to maintain their welfare and safety.
- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – remain in front of the individual, by their head.
  - Posture – maintain your balance with both knees on the floor.
  - Proximity – kneel close enough to maintain contact with the individual's head.
- Biomechanical Benefits
  - Cup your hand under the nape of the neck to ensure the head and neck rest in a neutral position on your knees. Place the palm of your other hand onto the individual's forehead, avoiding any contact with the face. If necessary, place the individual's head on the floor between both knees and keep the palm of your hand on their forehead.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Floor Holding Supine (Arms)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – lie with your hips flat to the floor and support your body weight on your forearms.
  - Proximity – lie as close as possible to the individual's upper body. Hips are towards their upper body, and shoulders are towards their wrist.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle by keeping the individual's arm against the floor. The individual's arm/hand is angled towards their hips. Maintain the Inside principle with your upper body, keeping your hand on the individual's wrist (thumb on top, palm to the side, and fingers underneath).
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Click to advance to next slide.

Emergency Floor Holding Supine (Legs)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from the side.
  - Posture – lie on the floor and support your full body weight on your forearms, hips, and thigh.
  - Proximity – lie as close as possible to the individual's thighs, ensuring you are above the knee.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle by keeping your arms around the individual's thighs, ensuring your body remains against/over the individual's thighs.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change the volunteers, then repeat the demonstration ensuring you use the verbal explanations to reinforce application of the anatomical and physiological principles.

Participate

Set Up

- Organise class into groups of five.
  - The Person in Distress
  - Team Members Supporting the Arms
  - Team Member Supporting the Head
  - Team Member Supporting the Legs
- Remind class to apply the principles as demonstrated in the classroom model.

Teachable Moment

- Always keep the head and neck in a neutral position.
- Avoid contact with the neck, chin, face, eyes, and ears.

Focused Practice

- Ask participants to assume their role, starting from the transition in the supine position.
- Direct the group using clear verbal instructions that you used in the demonstration, so they may apply the anatomical and biomechanical principles for a high level of restriction.
- Cue the staff member managing the head to support the person in distress who will lie in the supine position.
- Watch for safety and make any appropriate adjustments.
- Cue the staff members managing the arms to support the person in distress transitioning to a supine position.
- Watch for safety and make any appropriate adjustments.
- Cue the staff member managing the legs to support the person in distress transitioning to a supine position.
- Watch for safety and make any appropriate adjustments.
- Cue the group to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 4 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

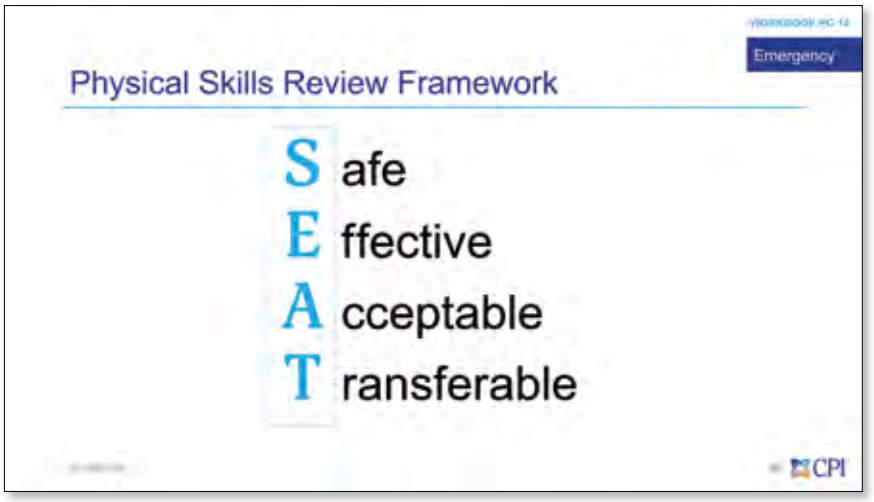
- Instruct team members to begin the transition in a supine position with additional staff members physically assisting.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to move slowly and naturally to the floor.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning to the floor safely.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Click to advance to next slide.

Slide 36



Physical Skills Review

When progressing through the teaching strategy, encourage participants to consider the principles, experiment with different ways to apply the skills, and reflect on the appropriateness and effectiveness of the applications using the Physical Skills Review Framework.

Safe	In what way does the specific restrictive intervention enable you to maximise safety and minimise harm?
Effective	What makes your intervention effective?
Acceptable	How would this be viewed as an acceptable response to risk behaviour?
Transferable	How can you transfer the principles back into your workplace?

Slide 37

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Standing to Floor Transitions

Learning Goal

During a physical intervention, the person in distress may end up kneeling or facedown on the floor. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

This transition is never a planned or forced take down. Once the individual is on the floor, employ the principles outlined in the *Opt-Out Sequence*SM. You will let go if there is no intent to hold the individual in either the kneeling or prone position on the floor.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security[SM].

   Click to advance to next slide.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Standing Holding through focused and dynamic practice.

15–30 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Standing to Kneeling (Floor Transition)

Demonstrate

- Ask for four volunteers. Two will be the staff, one will be the person in distress, and one will be supporting the person in distress' shoulders.
- Ask for examples or describe to the class situations in which staff may transition to the floor in order to maintain safety. These may include, but are not limited to:
  - Slips, trips, or falls
  - The person in distress accidentally moves to the floor.
  - The person in distress intentionally moves to the floor.
- Identify the potential risks of the situation and ways to reduce the risks such as:
  - Adjusting how staff are holding the individual.
  - Disengaging.
- Tell participants that you will demonstrate two options. The first demonstration is how the anatomical and physiological principles can be applied to a transition to the floor in a kneeling position. The second demonstration will show how the anatomical and physiological principles can be applied to transition to the prone position.

Transition to the Floor in a Kneeling Position

- As the person in distress transitions to the floor, the team leader will approach from the front and take responsibility for the individual's safety as the team also transitions to the floor.
- A third member of staff is needed in the intervention in order to minimise injury to the individual's head, neck, and spine. Demonstrate the role of the staff supporting the individual's shoulders/head.
- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – approach from the front of the individual.
  - Posture – maintain your balance, keeping both feet on the floor. As the individual kneels, kneel down to maintain your *Supportive Stance*℠. Your knee closest to the individual is on the floor and your foot furthest from the individual is on the floor to remain balanced and stable.
  - Proximity – kneel close enough to remain in contact with the individual's upper body.
- Biomechanical Benefits
  - Cup your hands and place them on the shoulders toward the outside of the torso, ensuring the individual remains in an upright position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Demonstrate Staff Holding the Person in Distress' Arms

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – maintain your balance, keeping both feet on the floor. As the individual kneels to the floor, kneel down to maintain the *Supportive Stance*SM. Put your knee closest to the individual on the floor and your foot furthest away on the floor, enabling you to be balanced and stable.
  - Proximity – as the individual kneels on the floor, your thigh and knee closest to the individual maintains close contact with the individual's hip, thigh, and knee. Move close to their upper body.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle on the individual's arms and move close to the outside of the individual's upper body to ensure the individual remains in an upright position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Transition to the Floor in a Prone Position

Demonstrate the Role of the Staff Supporting the Individual's Shoulders/Head

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain in front of the individual.
  - Posture – kneel down, maintaining the *Supportive Stance*SM with your knee closest to the individual on the floor and your foot furthest away on the floor to remain balanced and stable. As the individual moves into the *Supported Prone Position*SM, face the individual with both knees on the floor.
  - Proximity – as the individual lies on the floor, maintain close contact, allowing the individual's head to rest on your knees.
- Biomechanical Benefits
  - Move your hands from the individual's shoulders onto their head.
  - Place the palm of your trailing hand to the back of the individual's head with your forearm adjacent to the individual's ears.
  - Keep your hands in place to protect the individual's head from hitting the floor.
  - Once the individual is lying on the floor, place the individual's head onto your knees, maintaining the neck in a neutral position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Demonstrate the Role of the Staff Supporting the Individual's Arms

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – as the individual lies down, follow their movement and place their arms on the floor while remaining kneeling in order to maintain your *Supportive Stance*SM.
  - Proximity – maintain close contact with the individual's arms and lower body.
- Biomechanical Benefits
  - Prompt the individual to move their arms forward, placing your outside hand onto the outside of the individual's elbow.
  - Maintain your inside hand on the inside of the individual's wrist and prompt the individual to place their forearms flat on the floor.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change volunteers and repeat the demonstration to reinforce the anatomical and physiological principles.

Participate

Set Up

- Organise class into groups of five.
  - The Person in Distress
  - Two Team Members
  - Additional Support Member
  - Team Leader
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting in a standing position.
- Direct the group using clear verbal instructions that you used in the demonstration, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue staff and the person in distress to transition from a standing to kneeling position.
- Watch for safety and make any appropriate adjustments.
- Cue the person in distress to transition from kneeling to lying prone on the floor.
- Watch for safety and make any appropriate adjustments.
- Cue the group to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 3 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to begin in High Level of Restriction in a Standing Position with additional person physically assisting.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to move slowly and naturally to the floor.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning to the floor safely.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 3 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Teachable Moment

- Remember to always keep the head and neck of the person in distress in a neutral position to avoid any injury.
- Remember that the transition is not a forced take down to the floor. Once the individual is seated or lying on the floor, follow the *Opt-Out Sequence*℠ to prompt the individual to stand, or determine if you may let go.

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Emergency Floor Holding – *Supported Prone Position*℠

Learning Goal

During a physical intervention, the person in distress may end up lying facedown on the floor. Apply the Principles of Holding during high or extreme risk situations to minimise risk to staff members, minimise risk to the person in distress, and safely manage the behaviour.

Once the individual is on the floor, employ the principles outlined in the *Opt-Out Sequence*℠. You will let go if there is no intent to hold the individual in a *Supported Prone Position*℠.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security℠.

   Instructor Note: *This teaching sequence may only be taught as a part of the Advanced and Emergency programme.*

   Click to advance to next slide.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in Low-, Medium-, and High-Level Standing Holding through focused and dynamic practice. In addition, they should have demonstrated proficiency with the Standing to Seated learning sequence and Adding a Third Person.

30–40 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Emergency Floor Holding – *Supported Prone Position*SM

Demonstrate

- Ask for five volunteers. One in the role of the person in distress, two staff members to manage the arms, one staff member to manage the legs, and one to act as team leader.
- Emergency holding in a *Supported Prone Position*SM enables staff to temporarily manage extreme risk behaviour and/or acute behavioural disturbance when the individual accidentally or intentionally moves to the floor and cannot be managed in a supine position.
- Tell participants that you will demonstrate three different roles in the intervention. The first demonstration will show how the individual's head is protected, the second demonstration will show how to manage the individual's arms, and the third demonstration will show how to manage the individual's legs.

Click to advance to next slide.

Emergency Holding Supported Prone (Head, Spine and Airway)

- As the person in distress transitions to the floor, protect their head, neck, and spine. Provide constant and direct observations of the individual to maintain their welfare and safety.
- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain in front of the individual, by their head.
  - Posture – maintain balance with both knees on the floor.
  - Proximity – kneel close enough to maintain contact with the individual's head.
- Biomechanical Benefits
  - Cup one hand under the individual's forehead, ensuring the head and neck rest in a neutral position on your knees. Place the palm of your other hand onto the back of the individual's head.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding Supported Prone (Arms)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain at the side, slightly more forward than the person in distress.
  - Posture – lie with your hips flat to the floor and support your body weight on your forearms.
  - Proximity – lie as close as possible to the individual's upper body. Your shoulder should be above (but not touching) the individual's shoulder.
- Biomechanical Benefits
  - Place the individual's arms close to their body with their wrist directly under their shoulder ensuring their chest is off the floor. Place the outside of your upper body against the outside of the individual's elbow with your outside hand over the individual's hand.
  - Maintain the Inside principle with your inside hand around the individual's wrist (thumb on top, palm to the side, and fingers underneath).
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding Supported Prone (Legs)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from the side.
  - Posture – lie on floor and support your full body weight on your forearms,hips and, thigh.
  - Proximity – lie as close as possible to the individual's legs, ensuring you're close to the individual's feet.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle by keeping your arms around the individual's shins, and lean back towards the individual's feet.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change the volunteers then repeat the demonstration, ensuring you use the verbal explanations to reinforce application of the anatomical and physiological principles.

Participate

Set Up

- Organise class into groups of five.
  - The Person in Distress
  - Team Members Supporting the Arms
  - Team Member Supporting the Head
  - Team Member Supporting the Legs
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting from the transition in the *Supported Prone Position*[SM].
- Direct the group using clear verbal instructions that you used in the demonstration, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue the staff member managing the **head** to support the person in distress who will lie in the *Supported Prone Position*[SM].
- Watch for safety and make any appropriate adjustments.
- Cue the staff members managing the **arms** to support the person in distress transitioning to a *Supported Prone Position*[SM].
- Watch for safety and make any appropriate adjustments.
- Cue the staff member managing the **legs** to support the person in distress transitioning to a *Supported Prone Position*[SM].
- Watch for safety and make any appropriate adjustments.
- Cue the group to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 4 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to begin in the transition in a *Supported Prone Position*℠ with additional staff members physically assisting.
- Tell the class that you will begin practice with a cue. At that time, the person in distress should begin to move slowly and naturally to the floor.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning to the floor safely.

Teachable Moment

- Always keep the head and neck in a neutral position.
- Avoid contact with the neck, chin, face, eyes, and ears.
- Always ensure the individual's arms are as close as possible to their body, with their wrists positioned under their shoulder in order to raise their chest off the floor to maintain good respiratory function.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

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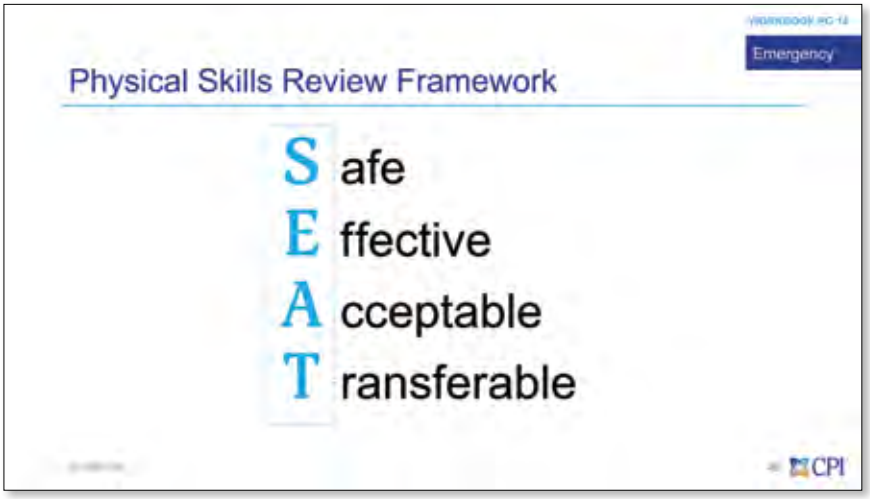
Slide 40



Physical Skills Review

When progressing through the teaching strategy, encourage participants to consider the principles, experiment with different ways to apply the skills, and reflect on the appropriateness and effectiveness of the applications using the Physical Skills Review Framework.

Safe	In what way does the specific restrictive intervention enable you to maximise safety and minimise harm?
Effective	What makes your intervention effective?
Acceptable	How would this be viewed as an acceptable response to risk behaviour?
Transferable	How can you transfer the principles back into your workplace?

Rapid Tranquillisation and Seclusion

Learning Goal

Emergency Floor Holding Side Lying is a temporary emergency position used only for the administration of rapid tranquilllisation when access to a suitable injection site is necessary. The side-lying position should never be used for any other purpose.

Employ the principles outlined in the *Opt-Out Sequence*SM.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?
2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.
3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.
4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security*SM*.

   Instructor Note: *This teaching sequence may only be taught as a part of the Advanced and Emergency programme.*

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in the *Supported Prone Position*SM.

30–40 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Rapid Tranquillisation and Seclusion Lecture

There are some circumstances or emergency situations when the immediate risk of harm to self or others presented by an individual is so extreme, an emergency floor hold is required to keep people safe.

While emergency floor holding is a temporary risk management approach, research shows that the duration of such interventions, especially when the person is held on the floor, is a key factor in restraint-related deaths. In accordance with the current evidence, a prolonged floor restraint is any intervention which exceeds 10 minutes.

As such, when involved in emergency floor holding you can implement immediate measures to avoid prolonged restraint and reduce the risk of restraint-related death.

Set Up

- Divide participants into three groups, giving each group a flip chart and pen.
- Ask each group to think about all the different approaches they have learnt during the programme which they could implement in situations when emergency floor holding is used to maintain the safety of the individual.
- Ask them to identify any other approaches they could take to ensure that they avoided or minimised the risk of restraint-related deaths.
- Ask them to identify what their options are if the restraint exceeded 10 minutes.

Participate

- Cue the participants to start the activity.
- Run the activity for about 5 minutes.
- Stop the activity and gather feedback from the participants.

Explain

- Ask a representative from each group to share their feedback.
- Reinforce key concepts from the programme (e.g., use the *Opt-Out Sequence*SM; risk assess skills and develop individualised plan; avoid *Supported Prone Position*SM where possible; ensure that there is always a team leader/incident manager to oversee the incident; time the incident) and capture on a flip chart any new or innovative ideas each group has identified.
- If not already identified, raise the issue of rapid tranquillisation and seclusion, and then proceed with slide presentation.

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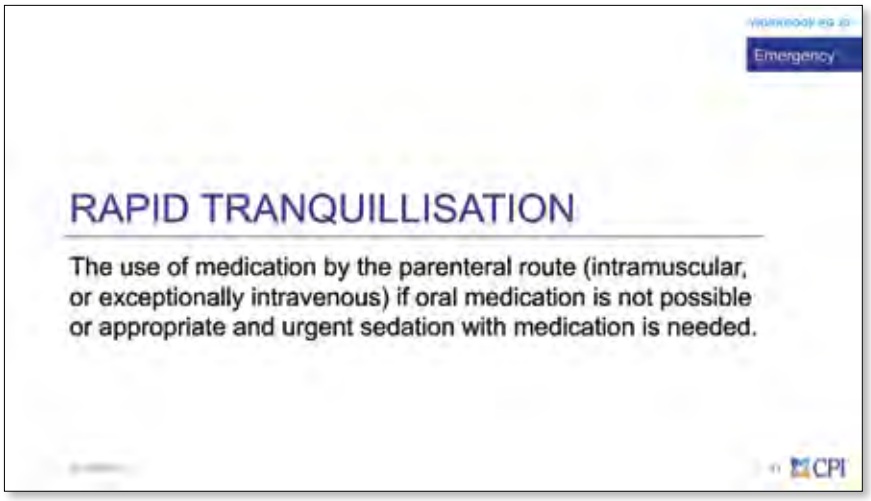

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Rapid Tranquillisation

Definition: The use of medication by the parenteral route (intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Example: The use of intramuscular lorazepam to sedate an individual with extreme behavioural disturbance.

When administering rapid tranquillisation, consider the following:

- Individual's preferences outlined in their safety and support plan/advance directive.
- Pre-existing health needs or concerns, including cardiovascular disease.
- Possible intoxication.
- Previous response to medication and known adverse reactions.
- Potential interactions with other medications or substances consumed.
- The total daily dose of medication.
- Privacy, dignity, and respect during administration.

Monitor and observe hourly for safety and side effects:*

- Pulse, blood pressure, respiration, temperature
- Level of hydration
- Level of consciousness

*Monitor every 15 minutes if maximum dose is exceeded, individual appears to be asleep or sedated, has taken illicit substances or alcohol, has known health problem, or has experienced harm as a result of physical intervention.

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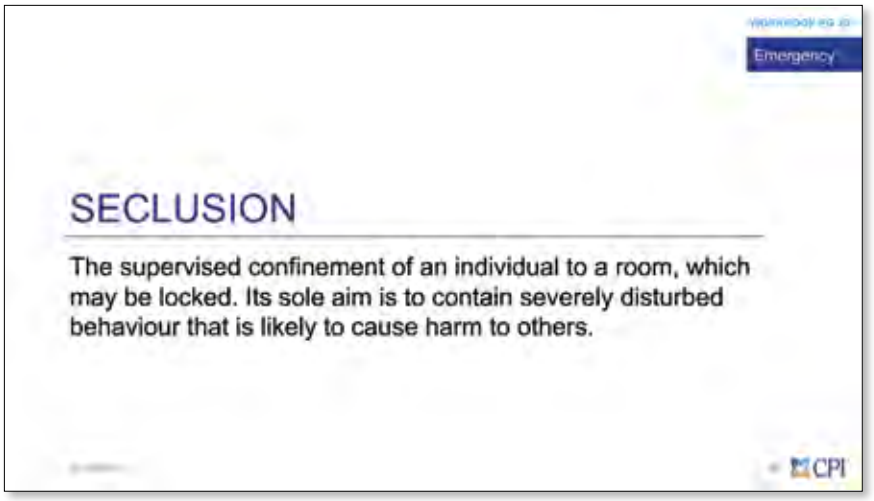
Slide 42



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Seclusion

Definition: The supervised confinement of an individual to a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

Example: When an emergency floor hold becomes prolonged and letting go is not a safe option. Staff assess the risks of continued holding are greater than moving the individual into seclusion.

When administering seclusion, consider the following:

- Can only take place in accordance with current mental health legislation.
- Used for the minimum time possible.
- Facility must be designated 'fit for purpose.'
- Maintain observation and ensure the individual's safety remains paramount.
- Subject to review and immediate post-incident debrief.

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Emergency Floor Holding for Rapid Tranquillisation

Demonstrate

- Ask for five volunteers. One in the role of the person in distress, two staff members to manage the arms, one staff member to manage the legs, and one to act as team leader (operator to administer medication).
- For the purpose of the demonstrations, you will act in the role of the sixth individual needed in the intervention to support the individual's head/shoulders.
- The demonstration is based on the assumption that attempts to administer IM medication in a standing, kneeling, or supported prone position are unsafe. A side-lying position should only be used as a transient/temporary position for the administration of medication.
- Tell participants that you will demonstrate the four different roles in the intervention. The first demonstration will show how the individual's head is protected, the second demonstration will show how to manage the individual's arms, and the third demonstration will show how to manage the individual's legs.

Emergency Floor Holding Side Lying (Head, Spine and Airway)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain in front of the individual, by their head.
  - Posture – maintain balance with both knees on the floor.
  - Proximity – kneel close enough to maintain contact with the individual's head.
- Biomechanical Benefits
  - Keep both hands on the individual's head. Keep the head and neck in a neutral position as the individual turns to one side.
  - Once the individual is lying on their side, keep one hand under the individual's head and one hand on top, ensuring the individual's head rests on your knees in a neutral position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Floor Holding Side Lying (Arms)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – remain at the side, slightly more forward than the person in distress.
  - Posture – move to a kneeling position.
  - Proximity – kneel as close as possible to the individual's arm/upper body.
- Biomechanical Benefits
  - Preparation for the turn
    - » Keep your outside hand on the wrist, placing the individual's arms down to their waist, close to their body, palm facing inwards.
    - » Place both knees above and below the elbow with your inside hand over the top.
  - Turning the individual
    - » Keep your outside hand on the individual's wrist.
    - » Reach and cup the individual's hip with your inside hand.
    - » Your colleague keeps their outside hand on the wrist.
    - » They reach and cup underneath the individual's shoulder with their inside hand.
    - » On the instruction 'please roll', turn the individual onto their side, moving in as close as possible to maintain the position so that medication can be administered.
    - » Once medication has been administered, turn the individual back into the supine position.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Floor Holding Side Lying (Legs)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – remain to the side.
  - Posture – lie on floor and support your full body weight on your forearms, hips, and thigh.
  - Proximity – stay as close as possible to the individual's legs, ensuring you are above the individual's knees.
- Biomechanical Benefits
  - Maintain the Outside/Inside principle by keeping your arms around the individual's thighs.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Participate

Set Up

- Organise class into groups of six.
  - The Person in Distress
  - Team Members Supporting the Arms
  - Team Member Supporting the Head
  - Team Member Supporting the Legs
  - Team Leader/Operator Administering Medication
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting from the transition in the *Supported Prone Position*[SM].
- Direct the group using clear verbal instructions that you used in the demo, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue the staff members managing the **head** and **arms** of the person in distress to transition from *Supported Prone Position*[SM] to side-lying position.
- Watch for safety and make any appropriate adjustments.
- Cue the staff members managing the **legs** to support the person in distress in side-lying position.
- Watch for safety and make any appropriate adjustments.
- Cue the staff member administering the medication.
- Watch for safety and make any appropriate adjustments.
- Cue the group to disengage.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 4 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

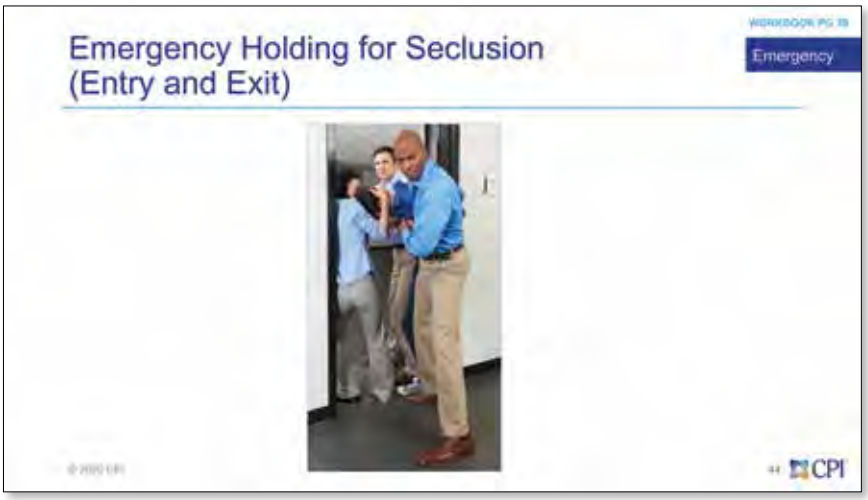
Set Up

- Instruct team members to begin in the transition from a *Supported Prone Position*[SM] to a side-lying position.
- Tell the class that you will begin practice with a cue. At that time, the staff will turn the person in distress to a side-lying position to practise administering medication.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning to the side-lying position.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Slide 44



Workbook Pg 20

Emergency Holding for Seclusion (Entry and Exit)

Learning Goal

The Emergency Holding for Seclusion is only used after all other methods have been exhausted and there is a legal and professional justification for the use of restrictive physical interventions in order to seclude an individual.

Emergency holding for entry and exit into seclusion must be in keeping with the organisation's policy and any national, international, or professional guidance.

Employ the principles outlined in the *Opt-Out Sequence*SM.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?
2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.
3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.
4. **Can you let go?**
   Consider how adjustments may have changed the risk.

Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security[SM].

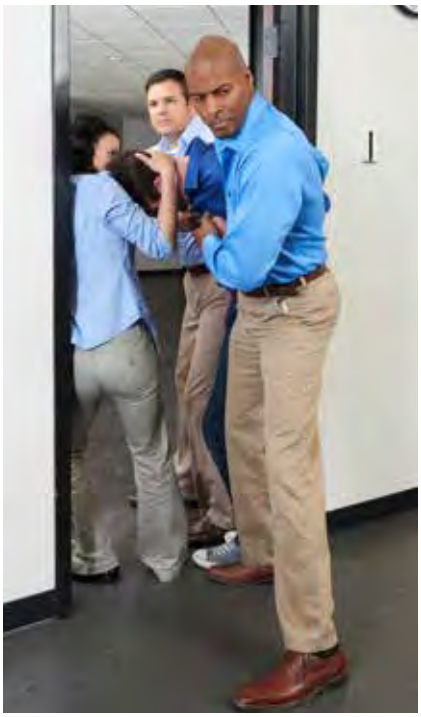
Instructor Note: *This teaching sequence may only be taught as a part of the Advanced and Emergency programme.*

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in the High Level of Restriction in a Standing Position.

30-40 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Emergency Holding for Seclusion (Entry and Exit)



Demonstrate

- Ask for five volunteers. One in the role of the person in distress, two staff members to manage the arms, one staff member to manage the legs, and one to act as team leader.
- For the purpose of the demonstrations, you will act in the role of the sixth individual needed in the intervention to support the individual's shoulders/head.
- Demonstrate each element of seclusion (entry and exit) and then how the team of staff can apply the principles collectively to keep the individual safely positioned.
- The demonstration will be based on the assumption that attempts to exit seclusion from a standing, kneeling, or seated position have been discounted as suitable interventions before considering a *Supported Prone Position*SM. (Prior to the demonstration, set up these scenarios to enable participants to problem solve how a standing, kneeling, or seated position may be considered suitable).
- Tell participants that you will demonstrate the different roles involved in the intervention, first in entry and then in exit.

Click to advance to next slide.

Seclusion Entry

- For this demonstration you will show how the individual's head is protected and how to manage the individual's arms.
- Start from a High Level of Restriction in a Standing Position.
- Have two volunteers supporting the arms.

Emergency Holding for Seclusion (Protecting the Head, Spine and Airway)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – approach from the side, before standing in front of the individual slightly off centre. Approach the door, standing with your back directly against the wall and enabling everyone to rotate around the door frame into the room.
  - Posture – maintain balance with both feet on the floor.
  - Proximity – stand close enough to make contact with the individual's upper body and/or head.
- Biomechanical Benefits
  - Place the palm of your trailing hand on the individual's forehead, ensuring it remains above the line of the eyebrows, with your fingers pointing towards the crown of the head.
  - Place the palm of your lead hand behind the individual's head, so that your lead forearm rests adjacent to the individual's ears.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding for Seclusion (Arms)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – remain at the side, next to the individual as you approach the door. Stay to the side as the team rotates into the doorway.
  - Posture – maintain your balance and ensure your outside foot provides good stability. Lean in towards the individual and move your inside foot forward to adopt a *Supportive Stance*℠.
  - Proximity – stand as close as you can, if possible maintaining direct contact with the individual's shoulder, hip, and thigh.
- Biomechanical Benefits
  - Keep your outside hand on the outside of the individual's elbow.
  - Use the movement of the individual's arm to guide the elbow back so the individual's wrist sits beneath their shoulder.
  - At the same time, move your hand from the elbow and place your body on the outside of the individual's elbow.
  - Place your inside hand on the individual's wrist (thumb on top, palm to the side, and fingers underneath).
  - The inside hand cups the wrist up towards the individual's shoulder.
  - The outside hand is placed over the top of the individual's hand as you apply all the principles together, to establish a high level of restriction.

Seclusion Exit

- For this demonstration, you will show how to disengage from the *Supported Prone Position*℠, starting with the staff member managing the individual's legs, the staff member protecting the individual's head, and the staff members managing the arms.
- Start from a *Supported Prone Position*℠.

Emergency Holding for Seclusion (Legs)

- First, use a *Supportive Stance*℠ by applying position, posture, and proximity:
  - Position – remain at the side.
  - Posture – kneel on your leg closest to the individual and place your outside foot on the floor in preparation to stand and exit.
  - Proximity – remain as close as possible to the individual's legs.
- Biomechanical Benefits
  - Stand and maintain contact with the individual's legs until you are ready to stand and exit the seclusion room.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding for Seclusion (Protecting the Head, Spine and Airway)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain in front of the individual by their head.
  - Posture – maintain balance with both knees on the floor.
  - Proximity – kneel close enough to make contact with the individual's head.
- Biomechanical Benefits
  - Prompt the individual to turn their head to one side. Keep one hand between the floor and the individual's face, and one hand on top of the individual's head.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding for Seclusion (Arms)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain to the side, facing the exit.
  - Posture – kneel on your leg closest to the individual and place your outside foot on the floor in preparation to stand and exit.
  - Proximity – kneel as close as possible to the individual's upper body/arms.
- Biomechanical Benefits
  - Face the exit and place your knee on the outside of the individual's elbow, keeping your inside hand on the inside of the individual's elbow.
  - Place your outside hand on the inside of the individual's wrist (thumb on top, palm to the side, and fingers underneath).
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change the volunteers. Then repeat the demonstration, ensuring you use the verbal explanations to reinforce application of the anatomical and physiological principles.

Participate

Set Up

- Organise class into groups of five.
  - The Person in Distress
  - Team Members Supporting the Arms
  - Team Member Supporting the Head
  - Team Member Supporting the Legs
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting with Seclusion Entry first, then practising Seclusion Exit.
- Direct the group using clear verbal instructions that you used in the demonstration, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue the staff members managing the head and arms of the person in distress to transition the individual through the doorway and into the seclusion room.
- Watch for safety and make any appropriate adjustments.
- Cue the staff members to hold the person in distress in the *Supported Prone Position*[SM].
- Cue the staff to disengage using the Seclusion Exit skills.
- Watch for safety and make any appropriate adjustments.
- Cue the activity to end.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 4 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to start with Seclusion Entry and then practise Seclusion Exit.
- Tell the class that you will begin practice with a cue. At that time, the staff will start with supporting the individual in a standing high-level restriction and move to the Seclusion Entry.
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning throughout the activity.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Slide 45

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Emergency Holding for Seclusion (Searching or Removal of Unsafe Items)

Learning Goal

The Emergency Holding for Seclusion is only used after all other methods have been exhausted and there is a legal and professional justification for the use of restrictive physical interventions in order to seclude an individual.

Emergency holding for removing unsafe clothing in seclusion must be in keeping with the organisation's policy and any national, international, or professional guidance.

Employ the principles outlined in the *Opt-Out Sequence*SM.

1. **Why are you holding the person?**
   Consider the people, the behaviour, and the environment. Have the risks changed, thus necessitating a change in intervention approach?

2. **What are the risks?**
   Consider the physical and psychosocial impact of the behaviours and the interventions.

3. **What can be done to reduce the risks?**
   Consider adjusting the level of restriction and/or changing position, posture, and proximity.

4. **Can you let go?**
   Consider how adjustments may have changed the risk.

   Instructor Note: *Assess that participants have a firm understanding of the principles as taught through the classroom models before moving on to more complex application of those principles. Additionally, ensure that participants focus on the safe application of CPI's physical intervention skills that are consistent with* Care, Welfare, Safety, and Security*SM*.

   Instructor Note: *This teaching sequence may only be taught as a part of the Advanced and Emergency programme.*

   Click to advance to next slide.

Guidelines

Prerequisite Learning:
Prior to teaching this sequence, participants should have demonstrated proficiency in the High Level of Restriction in a Standing Position.

30-40 minutes.
Time may vary significantly depending on participant proficiency, class size, and instructional approach.

Emergency Holding for Seclusion (Searching or Removal of Unsafe Items)

Demonstrate

- Ask for five volunteers. One in the role of the person in distress, two staff members to manage the arms, one staff member to manage the head, and a team leader.
- Start in the *Supported Prone Position*SM.
- The demonstration is based on the assumption that removal of unsafe clothing will take place within the context of seclusion only. In keeping with legal and professional obligations, the procedure must take place while maintaining the individual's dignity and privacy. Only clothing which is assessed as presenting a risk to the individual will be removed.

Emergency Holding for Seclusion Searching or Removal of Unsafe Items (Protecting the Head, Spine and Airway)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – kneel in front of the individual, kneel with your leg closest to the individual, and keep your outside foot on the floor.
  - Posture – kneel upright, maintaining your balance.
  - Proximity – kneel close enough to make contact with the individual's upper body and/or head.
- Biomechanical Benefits
  - Place the palm of your trailing hand on the individual's forehead, ensuring it remains above the line of the eyebrows, with your fingers pointing towards the crown of the head.
  - Place the palm of your lead hand behind the individual's head so that your lead forearm rests adjacent to the individual's ears.
  - The team leader rolls the individual's upper body clothing up beneath the individual's shoulders.
  - Placing a hand through the neck of the garment, the team leader pulls the garment forward, lifting it up and over the individual's head so it rests along the individual's shoulders.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Emergency Holding for Seclusion Searching or Removal of Unsafe Items (Arms)

- First, use a *Supportive Stance*SM by applying position, posture, and proximity:
  - Position – remain to the side, slightly further forward than the individual.
  - Posture – move to a kneeling position.
  - Proximity – kneel as close as possible to the individual's arm/upper body.
- Biomechanical Benefits
  - Keep your outside hand on the wrist, placing the individual's arms down to their waist and close to their body with palm facing inwards.
  - Place both knees above and below the elbow with your inside hand over the top.
  - Extend the individual's arm onto the small of their back and maintain the principles while the team leader removes one arm of the garment from the individual.
  - Return to the *Supported Prone Position*SM in order to enable the team leader to remove the garment from the individual's other arm.
  - Limit the range of motion, collaborating with your colleagues to maintain a high level of restriction.

Change the volunteers. Repeat the demonstration, ensuring you use the verbal explanations to reinforce application of the anatomical and physiological principles.

Participate

Set Up

- Organise class into groups of six.
  - The Person in Distress
  - Team Members Supporting the Arms
  - Team Member Supporting the Head
  - Team Member Supporting the Legs
  - Team Leader
- Remind class to apply the principles as demonstrated in the classroom model.

Focused Practice

- Ask participants to assume their role, starting in the *Supported Prone Position*SM.
- Direct the group using clear verbal instructions that you used in the demonstration, so they may apply the anatomical and biomechanical principles for a high-level restriction.
- Cue the staff members managing the head to begin removing the unsafe clothing of the person in distress.
- Watch for safety and make any appropriate adjustments.
- Cue the staff members managing the arms to remove the individual's arms from the unsafe clothing.
- Watch for safety and make any appropriate adjustments.
- Cue the activity to end.
- Rotate within groups so that each person has the opportunity to practise at each position.
- Repeat above sequence 4 to 5 times.

Dynamic Practice

After participants have demonstrated proficiency with focused practice, you may proceed with dynamic practice here or incorporate dynamic practice at a later point of the class.

Set Up

- Instruct team members to start the activity of removing unsafe clothing.
- Tell the class that you will begin practice with a cue. At that time, the staff will start in the *Supported Prone Position*[SM].
- Team members should respond to the situation by continuing to physically assist the person in distress transitioning throughout the activity.

Participate

- Cue practice.
- Watch for safety and reinforce safe application of principles.
- Repeat above sequence 4 to 5 times.
- Rotate among the teams so that each person has the opportunity to practise at each position.

Situational Role-Plays of Programme

Situational role-plays provide an opportunity for practical application of the information covered during training. Role-plays can be used effectively at this point in the programme or at the end of each section if the course is being divided into a number of training sessions.

Instructional Objectives

1. Apply the material covered in the training to a real-life situation.
2. Allow participants to experience the agitated individual's point of view.
3. Build capabilities to convey values related to *Care, Welfare, Safety, and Security*SM during interventions.

Key Points

- When setting up situational role-plays, be sure to use examples that are common within your work environment. Develop sample scenarios ahead of time.
- If at any time the situation gets out of hand, regain control by stopping the intervention. It is helpful to develop a cue word for this before the role-play begins.
- Talk about what took place and why. This is where the learning takes place.
- Without a follow-up discussion, the situational role-plays become strictly an entertainment section of the programme.
- Focus discussion on the positive aspects of the intervention. It can be easy to focus on the negative aspects, turning off the participants who were involved.
- Be sure to ask the observers for their feelings and reactions, as they will give valuable insight into the role-play.

Situational Role-Play

Learning Goal

This role-play has been adapted to incorporate a higher level of decision making for those who work in higher-risk environments. The purpose of this situational activity is not to put people on the spot, but to look at how the principles of the programme can be applied in situations that you are likely to encounter in your everyday work lives.

Set Up

- Divide the participants into groups of three or four. (If there is an odd number of participants, pair the observer and the debriefer.)
- Take aside each participant to assign and explain roles:

  Staff Member
  The person in this role is going to approach the individual and give a typical instruction (e.g., can you please come into my office because I need to talk to you about something important). Depending on the individual's reaction (which may range from full cooperation to risk behaviour), the aim of the staff member is to gain cooperation and respond to the individual using non-verbal, verbal, and paraverbal strategies. If the individual engages in risk behaviour, the staff member needs to make a rapid assessment of the risk (using the *Decision-Making Matrix*℠) and then decide upon an appropriate response.

  Person in Distress
  The person in this role should decide how to respond to the staff member. The individual may choose to fully cooperate or may decide to replicate behaviour from the Anxiety, Defensive, or Risk Behaviour levels in the *Crisis Development Model*℠. The goal is to give the staff member opportunity to apply some of the strategies from the programme. In order to ensure everyone's safety, remind this person of the Safe Participation Guidelines and ensure that the individual understands the responsibility for staff's welfare and safety, especially if risk behaviour occurs during the situational role-play.

  Observer
  The person in this role should take a note pad and pen and write down all the positive interventions they observe the staff member implementing. It is important to remind the observer to only focus on positive examples seen and heard from the programme. The observer is to highlight the specific interventions previously practised when providing feedback to the staff member.

  Debriefer
  The person in this role will use a simple debriefing tool and ask the participants to reflect back on the activity. Give them the note cards of the questions to ask the staff member and person in distress.

- Provide the debriefer with a note card of the following 'what' questions:

  What . . .

  – Was the problem/difficulty/situation?
  – Were you trying to achieve? What actions did you take?
  – Was the response or outcome to your actions?
  – Were the feelings provoked in you or others?
  – Worked and what didn't work?

So what . . .

- Does this tell you/teach you/imply or mean?
- Was going through your mind?
- Did you base your decisions and actions on?
- Other knowledge or skills did you bring to the situation?
- Is your new understanding of the situation?

Now what . . .

- Will you do (things you will repeat and the things you will change) when responding to similar situations in the future?

Participate

1. Remind participants it is their responsibility to create learning opportunities, and to maintain safety for themselves and their learning partners.
2. Cue activity to begin.
3. When the activity reaches a natural conclusion (or at the point you choose to end it with your cue word), initiate a discussion of what took place and seek feedback from participants in each group.
   - For example, you may ask everyone who was an observer to highlight some of the interventions they observed. You may ask the staff members what aspects of the programme they found easy to apply and which were more difficult. Did the role-play reach Tension Reduction? If so, how did you know it had reached this point?
4. Ask for one or two examples only so that the activity can be repeated with each group taking turns changing roles.

Explain

This activity is used to practise problem-solving skills, revisit content from the programme, and apply your knowledge of the skills learnt.

Click to advance to next slide.

Total Time 50 minutes

Time for Activities 35 minutes

Workbook Pages 21–23

Presentation Slides 46–47

MODULE 8

Post-Crisis

In this next activity you will learn additional debriefing methods to help individuals discover their own solutions after a crisis.

Learning Objectives

1. Identify a five-step, simple method of non-directive support to people who have witnessed or experienced crisis.
2. Practise debriefing individuals to help them discover their own solutions to the crisis events.
3. Build capabilities to convey values related to *Care, Welfare, Safety, and Security*℠ during interventions.

Activity: IBERA Post-Crisis Debriefing Tool – Part 1 *(20 minutes)*

Set Up

- You may choose to set up a crisis scenario involving a physical intervention as part of this activity, or ask participants to use the last physical skills activity they practised before Module 8.
- Divide participants into three roles:
  - Person in Distress (or staff member who was involved in the physical intervention). Ensure there is a mixture of both roles for the activity.
  - Staff Member
  - Observer
- Have the staff member wait outside of the room for instructions.
- Explain the role of the observer is to observe the staff member's non-verbal, paraverbal, and verbal behaviour practised throughout the programme and to provide feedback at the end of the activity.
- Explain the role of the person in distress (or staff member involved in the incident) will be to talk to the staff member about the previous crisis event including physical interventions that they were involved in.
- Ask the person in distress (or staff member involved in the incident) to raise concerns and complain about the way in which the event was handled. You may need to prompt them to think about the type of complaint or concern people in their workplace raise when physical interventions are used. You may prompt the person in distress/staff member to use some or all of the following examples in the discussion:
  - Someone was injured.
  - It was unnecessary or unjustified.
  - It could have been avoided.
  - It went on for too long.
  - There was a lack of respect and dignity, the person in distress wasn't listened to.
  - Staff were rude and abrupt.
  - Other staff/team did not intervene in a timely manner.
- Remind the person in distress (or staff member involved in the incident) that they are in Tension Reduction for this activity, so they will not escalate back into crisis behaviour.
- Explain to the staff member that they are meeting with either an individual who had been restrained or a colleague who wants to talk about an issue related to a recent restraint. Their role is to debrief and provide the person with post-incident support using all the non-verbal, paraverbal, and verbal communication skills previously used in the course.
- DO NOT give them any further information.

Participate

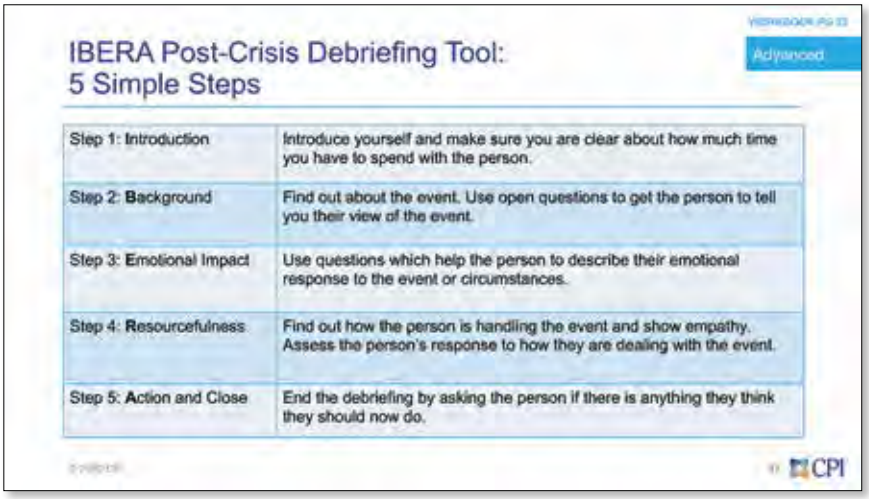
- Cue the participants to start the activity.
- Run the activity for about 5 minutes.
- Stop the activity and gather feedback from the participants.

Explain

- Ask for feedback from several of the participants, making sure to include each role.
- Did they feel the staff member was trying to justify what had happened, or did they give undivided attention? Was the staff member non-directive (i.e., didn't try to force any particular perspective or view)?
- Ask the person in distress if they felt the staff member was listening to their concerns or if they were really trying to get them to agree to a particular outcome or perspective.
- Explain that often after a crisis, there is a tendency to try and fix things for the person or provide advice or even simply provide a justification for what happened.

Click to advance to next slide.

Slide 47



Workbook Pgs 22-23

IBERA Post-Crisis Debriefing Tool: 5 Simple Steps

Remember you are not trying to 'fix' things for the person; you are simply trying to provide non-directive support after a crisis event. The aim of the framework is to help guide your discussion so that the person feels supported and can clarify how they feel about an event.

IBERA Post-Crisis Debriefing Tool: 5 Simple Steps continued

Step 1: **I**ntroduction	Introduce yourself and make sure you are clear about how much time you have to spend with the person.
Step 2: **B**ackground	Find out about the event. Use open questions to get the person to tell you their view of the event. *Tell me what happened.* *Describe what happened.*
Step 3: **E**motional Impact (i) Find out how the event is making the person feel (ii) Find out what is the key issue causing the person greatest concern	Use questions which help the person to describe their emotional response to the event or circumstances. *So how do you feel about that?* *How does that make you feel?* People may give you a lot of factual and emotional information. Remember to paraphrase to ensure you clarify that you understand what the person is saying. Ask the person to say what issue troubles them most. *What troubles you most about the event?* *What bothers you most?* *What concerns you most?*
Step 4: **R**esourcefulness	Find out how the person is handling the event and show empathy. Assess the person's response to how they are dealing with the event. *How are you handling that?* *How are you managing that?* Reflect that you understand how the person feels and how they are dealing with the event. *That must be difficult.*
Step 5: **A**ction and Close	End the debriefing by asking the person if there is anything they think they should now do. This allows you to hand the issue back to the individual and encourages the person to think of their own solutions. Avoid telling the person what they should or should not do, or how they should or should not feel.

IBERA Discussion

Providing genuine and impartial support to someone following a crisis event is a complex affair. It is important that you maintain Therapeutic Rapport in those circumstances when someone needs help.

Being able to quickly establish rapport, listen with empathy, and help the person to share and reflect their thoughts and feelings in a safe way is an essential part of Post-Crisis support.

Our tendency may be to try and avoid such difficult conversations. We sometimes fail to listen and go straight to solving the problem for the person without really understanding their unique experience and perspective.

The IBERA framework is a short and simple, person-centred debriefing tool which helps you to rationally detach and remain objective. The framework provides a series of simple prompts you can use to help the person work through their reality of the crisis, their own experience, thoughts and feelings, so you can confirm positive feelings, offer support, and reinforce their ability to self-manage.

The framework consists of five steps. When using this approach, keep to the specific structure and questions and avoid giving advice. Sometimes, people elaborate or drift into other conversations so be prepared to interrupt and redirect with another question until you get a response.

In terms of Post-Crisis support, the IBERA framework is nothing more than 'emotional first aid.' If a serious issue is disclosed during the debriefing, remember, the most appropriate solution is to refer the person to specialist support.

Introduction
Introduce yourself and make sure you are clear about how much time you have to spend with the person. The process should not take more than 5 or 10 minutes.

Background
Find out about the event. Use open questions to get the person to tell you their view of the event (e.g.,Tell me what happened. or Describe what happened.).

Emotional Impact
Use questions which help the person to describe their emotional response to the event or circumstances (e.g., So how do you feel about that? or How does that make you feel?).

People may give you a lot of factual and emotional information. Remember to paraphrase to ensure you clarify that you understand what the person is saying. To help the person focus on their main issue, ask them to say what issue troubles them most (e.g., What troubles you most about the event?, What bothers you most?, or What concerns you most?).

Resourcefulness
Assess the person's response to how they are dealing with the event (e.g., How are you handling that? or How are you managing that?).

Reflect that you understand how the person feels and how they are dealing with the event (e.g., That must be difficult for you.).

Action and Close
End the debriefing by asking the person if there is anything they think they should now do. This allows you to hand the issue back to the individual and encourages the person to think of their own solutions.

Activity: IBERA Post-Crisis Debriefing Tool – Part 2 *(15 minutes)*

Set Up

- Rotate participants so that they are in a new role.
- Have the person acting in the role of staff member wait outside the room for further instructions away from other participants.
- Explain to the observer and person in distress/staff colleague that you are going to repeat the previous activity.
- Explain that the person in distress/staff colleague will be talking to the staff member about the previous crisis event they were involved in where physical interventions were used. Ask the person in distress/staff colleague to raise concerns and complain about the way in which the event was handled. You may need to prompt them to think about the type of complaint and concern people in their workplace raise when physical interventions are used, ideally prompting the person in distress/staff colleague to use some or all of the following examples in the discussion:
  - Someone was injured.
  - It was unnecessary or unjustified.
  - It could have been avoided.
  - It went on for too long.
  - There was a lack of respect and dignity, the person in distress wasn't listened to.
  - Staff were rude and abrupt.
  - Other staff/team did not intervene in a timely manner.
- Remind the person in distress/staff colleague that they are in Tension Reduction for this activity, so they will not escalate back into crisis behaviour.
- Meet with the staff member and explain that they are meeting with either an individual who had been restrained or a colleague who wants to talk about an issue related to a recent restraint. Their role is to debrief and provide the person with post-incident support using all the non-verbal, paraverbal, and verbal communication skills previously used in the course.
- For this activity, ask the staff member to refer to the IBERA Post-Crisis Debriefing Tool in their workbook, and instruct them to follow the questions as they speak to the person in distress/staff colleague. Give them a few minutes to read the framework and explain that they can have this with them to prompt the discussions. Remind them to use all the non-verbal, paraverbal, and verbal skills practised throughout the programme.

Participate

- Ask the staff member to come into the room.
- Explain to all participants that for this activity, the staff member will be using a handout with a series of questions to help guide them through the activity. Cue the participants to start the activity.
- Run the activity for about 5 minutes.
- Stop the activity and gather feedback from the participants.

Explain

- Ask for feedback from several of the participants, making sure to include each role.
- Ask the observer to provide feedback on the staff member's non-verbal, paraverbal, and verbal communication skills.
- Did they notice anything different between this activity and the first activity?
- Ask the person in distress if they felt the staff member was listening to their concerns or if they were really trying to get them to agree to a specific outcome or perspective. Did they feel the staff member was trying to justify what had happened or did they give undivided attention? Was the staff member non-directive (i.e., didn't try to force any particular perspective or view)?

Total Time 15 minutes

Time for Activities 10 minutes

Workbook Pages 27–32

Presentation Slides 48–50

Conclusion

The purpose of the conclusion is to provide an opportunity for participants to reflect on what they learned in the course and create an action plan to apply skills in the workplace. You will also be able to celebrate their successful completion of the course and collect the evaluation.

Thank your participants for attending and participating. You may also want to share information about expectations for ongoing training (e.g., frequency of refresher classes). Share your contact information and make yourself available for follow-up questions and support.

Materials Needed

- ☐ Projector
- ☐ Participant Workbooks
- ☐ Pens/pencils for participants

Preparation Checklist

- ☐ Review Training Evaluation Form and write in any additional questions if required by your regulating bodies or professional certification boards

Slides 48–49

Workbook Pg 27

Congratulations on all you've accomplished in this training. This training introduced you to strategies for preventing escalating behaviours in persons who have experienced trauma. You also learned interventions to de-escalate crisis situations while being trauma-responsive.

Ask the group for any final questions or if they need further clarification on the content discussed in the programme.

Click to advance to next slide.

Optional Action Plan Activity *(5 Minutes)*

Purpose

To have participants reflect on what they've learned and identify opportunities for additional development.

Set Up

Throughout training, you had an opportunity to reflect on Key Takeaways from each module. You will use these to draft an action plan that identifies how you will implement what you have learned in the training in your daily practice.

Before you look at your action plan let's review trauma-informed practice and the principles of trauma-informed care. How can you use these to inform your plan? What specific goals will help ensure you are trauma-responsive in your practice?

Participate

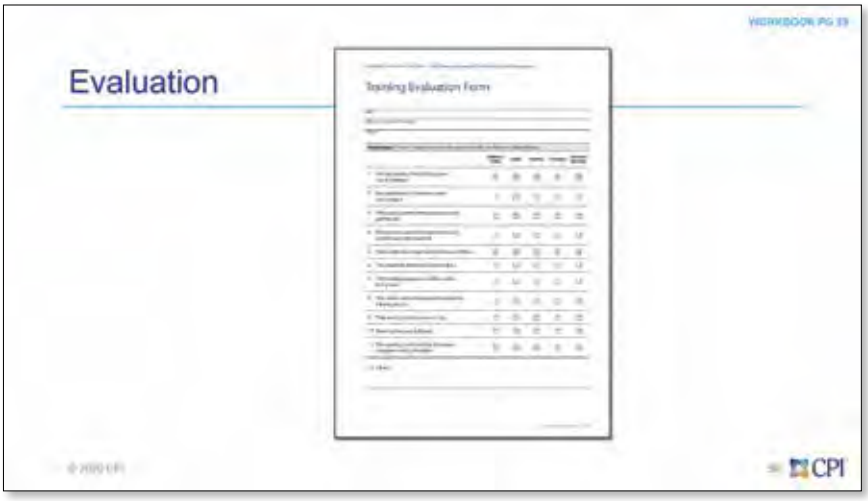
1. *Cue the activity.*
2. *Allow participants 2 minutes to begin drafting their action plan.*
3. *Once time has lapsed, assign participants into pairs and instruct them to take turns sharing their plans* (3 minutes).

Explain

The purpose of this tool is to let you reflect on what you've learned and identify opportunities for additional development. Work collaboratively with a trusted mentor, coach, or manager as you prepare your plan and work towards achieving your goals.

Click to advance to next slide.

Slide 50



Workbook Pg 29

Training Evaluation *(5 Minutes)*

Direct participants to the Training Evaluation Form in the back of their workbook. Space is provided for you to write in any additional questions if required by your regulating bodies or professional certification boards.

Instruct participants to complete the form before exiting the class. Highlight the importance of feedback to help with your future development as an Instructor and to identify any gaps in the programme materials.

Brøset Violence Checklist (BVC)

Instructions

Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well known client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Monday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tuesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saturday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

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Brøset Violence Checklist Behavioural Criteria

Risk Rating and Score Sheet

Behavioural Criteria	Descriptor	Score
Confused	Appears obviously confused and disorientated (e.g., may be unaware of time, place or person).	
Irritable	Easily annoyed or angered (e.g., unable to tolerate the presence of others).	
Boisterous	Behaviour is overtly 'loud' or noisy (e.g., slamming doors, shouting out when others are talking etc.).	
Verbal Threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person (e.g., verbal abuse, sexually or racially offensive abuse, name calling, open or veiled threats).	
Physical Threats	A definite intent to physically threaten or harm. (e.g., adopting an aggressive stance, raising a hand/arm, as if to strike out, raising a foot or posturing as if to kick out, modelling or imitating a head-butt, raising an object as if to throw or smash it).	
Attacking Objects	An attack directed at an object and not an individual (e.g., indiscriminate throwing, smashing or breaking of objects or furniture, punching, kicking or headbutting walls or doors).	
	Total Behaviour Criteria Observed	

Scoring the BVC
Score 0 if behaviour is not present, and score 1 if behaviour is present (only score 1 if the behaviour is present regardless of how many times the behaviour is repeated).

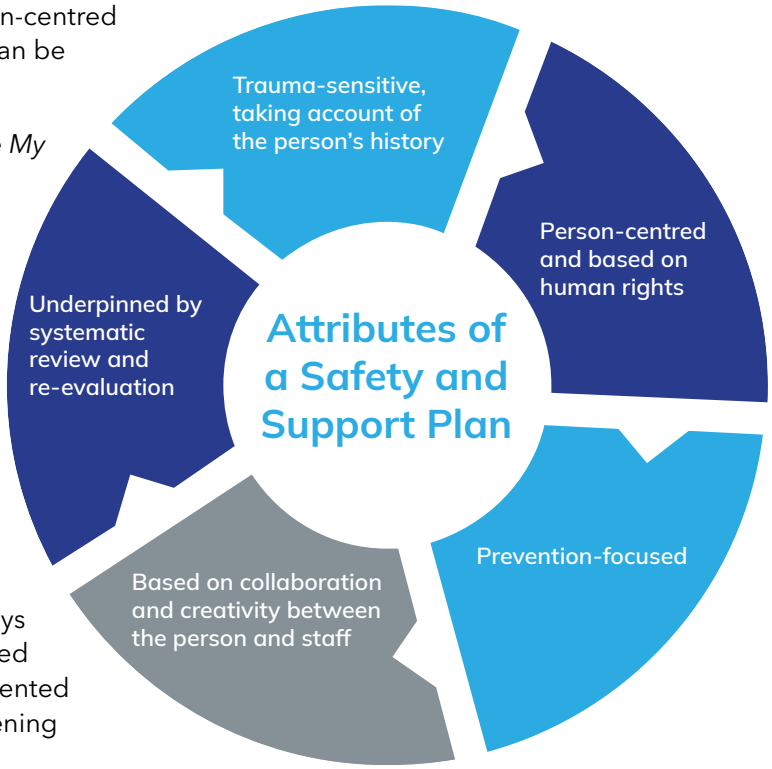
Risk Rating

Total = 0	The risk of violence is small.
Total = 1–2	The risk of violence is moderate. Preventive measures should be taken.
Total = 3–6	The risk of violence is high. Preventive measures should be taken. In addition, plans should be developed to manage the potential violence.

My Safety and Support Plan

The *My Safety and Support Plan* is an individualised plan that the person develops (with the help of staff if necessary) to ensure that potential crisis events are avoided. This should be written in easy-to-understand language so that all staff can implement the plan and provide the person with the necessary person-centred, trauma-sensitive care and support.

The plan's focus is to understand the person's history—their strengths, gifts, and abilities; their friends, family, and people that matter; the things that are important as well as the triggers that are likely to lead to crisis—so that such crisis events can be minimised and restrictive interventions avoided. Each person should have their own safety and support plan even if their behaviour is unlikely to escalate to crisis, since the plan helps staff to think about personalising the care and support they offer. The plan helps staff to avoid common conflicts and triggers that often underpin crisis events. It also enables staff to identify escalating behaviour. When staff recognise this behaviour, they can determine the appropriate person-centred interventions so that restrictive practices can be avoided.



When crisis events cannot be avoided, the *My Safety and Support Plan* ensures that staff continue to maintain a trauma-sensitive approach. Any agreed and necessary restrictive interventions continue to take account of the person's immediate needs and wishes in order to ensure that harm is minimised and to maintain the individual's *Care, Welfare, Safety, and Security*[SM].

The plan should be a 'live' document that is regularly revisited to ensure that staff understand how to provide good support to the person. The plan must always be reviewed after a crisis event has occurred so that further approaches can be implemented to prevent similar crisis events from happening again.

My Circle of Support

(The people who are important to me, my friends and the people who help and support me)

Primary Preventive Interventions

(Getting the right fit between my needs and my support)

What strengths, gifts, and qualities do I bring? *(Getting to know me)*

What is important to me? What works for me? *(What matters most to me right now, and in the immediate future: What makes for a good day; what keeps me safe and well; what keeps me active, engaged, and stimulated)*

What doesn't work for me? *(What makes for a bad day; what do I find unpleasant or distressing; what do I prefer to avoid)*

What does good care and support look like for me? *(Identify the 'best fit' in terms of the care and support I need to minimise the impact of Precipitating Factors; consider any previous traumatic events, so that the support provided is trauma-sensitive)*

Precipitating Factors/Triggers/Background Factors

(Internal and external factors which trigger or accelerate my risk or crisis behaviour)

My Precipitating Factors/Triggers *(My flash points, triggers, and common conflicts that cause my behaviour to escalate)*

Secondary Preventive Interventions

(What helps me to manage my triggers; what decelerates and de-escalates my risk or crisis behaviour)

Anxiety Level
(My known observable behaviours)

Supportive Approaches
(My calming and support strategies)

Defensive Level
(My known observable behaviours)

Directive Approaches
(My calming and support strategies)

Risk or Crisis Behaviour

(Crisis behaviour which is likely to cause harm to self or others)

Risk Behaviour Level

My risk behaviours are:

The level of risk to myself and/or others is:

My preferred strategies to minimise harm are:

Any necessary restrictive interventions staff may need to use include:

To minimise trauma and distress when using restrictive interventions, staff should:

Post-Crisis Support

(My preferred way of managing my emotions after a crisis event)

Tension Reduction
After a crisis event, I prefer to:

Therapeutic Rapport
Support from staff should include:

APPENDIX 3

Safety Interventions: Classroom Formative Assessment Record

(for Disengagement and Holding)

How to Use These Forms

Use these Assessment Records during the classroom portion of your training with Disengagement and Holding. Refer to the Participant Assessment Criteria. For each intervention taught, place a check mark to indicate competent demonstration or an X if they did not/were unable to demonstrate competence. Also indicate whether they met objectives for the Team Leader and Medical Emergency columns where they appear.

These forms are not an assessment of the participant's competence in the workplace. They only evaluate how well an individual can demonstrate the objective in the classroom setting. Photocopy the following forms and fill in participant names. Use the Notes spaces if needed.

If an individual is not able to demonstrate competency, complete the individual participant sheet for remediation options.

Give participants feedback on where they demonstrated skills effectively and where they may need more practice. You may want to provide extra practice or time based on individual needs.

Classroom Formative Assessment Record

CPI Non-Restrictive Safety Interventions: Disengagement

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

CPI *Safety Intervention*™ Advanced		X if not taught																						
				WRIST			CLOTHES			HAIR			NECK			BODY			BITE		INTERVENTIONS (1 Staff)			NECK (High Risk)
PARTICIPANT NAME		X IF ABSENT	STRIKE	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	L	M	H	
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								

PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Low Risk	Position, Posture, Proximity Hold and Stabilise	Demonstrated repeated application without instruction
Medium Risk	Position, Posture, Proximity Pull/Push	Demonstrated repeated application without instruction
High Risk	Position, Posture, Proximity Lever	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

CPI Non-Restrictive Safety Interventions: Disengagement

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →															
CPI *Safety Intervention*™ Emergency		X IF ABSENT	EMERGENCY RESPONSES												
			THUMB		DORSAL HAND		TORSO		STERNUM		MANDIBULAR		COLUMELLAR		
	PARTICIPANT NAME		Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Extreme Risk	Position, Posture, Proximity Direct Pressure/Movement	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

CPI Restrictive Safety Interventions: Holding

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →																											
CPI *Safety Intervention*™ Advanced		X IF ABSENT	TEAM LEADER	MEDICAL EMERGENCY	SEATED			STANDING			TEAM INTERVENTIONS (2 Staff)	TRANSITIONS (2 Staff)	CHILDREN HOLDS								3RD PERSON		ADVANCED TEAM INTERVENTIONS (3 staff)	TRANSITIONS (3 Staff)	STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)		STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)	
													SEATED (chair)			SEATED (floor)			STANDING									
PARTICIPANT NAME					L	M	H	L	M	H			L	M	H	L	M	H	L	M	H	SEATED	STANDING			STANDING TO SEATED	STANDING TO SUPINE	STANDING TO KNEELING	STANDING TO SUPPORTED PRONE
1																											
2																											
3																											
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7																											
8																											
9																											
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11																											
12																											
13																											
14																											
15																											

PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Low Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
Medium Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
High Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

CPI Restrictive Safety Interventions: Holding

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →																				
CPI *Safety Intervention*™ Advanced		X IF ABSENT	TEAM LEADER	MEDICAL EMERGENCY	SEATED			STANDING			TEAM INTERVENTIONS (2 Staff)	TRANSITIONS (2 Staff)	3RD PERSON		ADVANCED TEAM INTERVENTIONS (3 staff)	TRANSITIONS (3 Staff)	STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)		STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)	
					L	M	H	L	M	H			SEATED	STANDING			STANDING TO SEATED	STANDING TO SUPINE	STANDING TO KNEELING	STANDING TO SUPPORTED PRONE
	PARTICIPANT NAME																			
1																				
2																				
3																				
4																				
5																				
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10																				
11																				
12																				
13																				
14																				
15																				

PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Low Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
Medium Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
High Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

CPI Restrictive Safety Interventions: Holding

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →										
CPI *Safety Intervention*™ Emergency				EMERGENCY FLOOR HOLDING			SECLUSION			
PARTICIPANT NAME		X IF ABSENT	EMERGENCY TEAM INTERVENTIONS (3 staff)	SUPINE	SUPPORTED PRONE	RAPID TRANQUILLISATION	ENTRY	SEARCH/ REMOVAL OF UNSAFE ITEMS	EXIT
1									
2									
3									
4									
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9									
10									
11									
12									
13									
14									
15									

PARTICIPANT ASSESSMENT CRITERIA		
Range	Skill Application	Performance
Extreme Risk	Outside/Inside Principle Limit Range of Motion Direct Pressure/Movement	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

CPI Restrictive Safety Interventions

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

Participant Name:	
Skill Unassessed/Competence Not Demonstrated:	
Instructor Reason/Notes	Participant Reason/Notes
Instructor Signature	Participant Signature

NOTES:

Glossary of Terms

Abuse–any action that intentionally or unintentionally harms or injures another person; any action that falls below recognised acceptable professional codes of practice.

Civil Law-a branch of law, sometimes called non-criminal law, which relates to the rights and duties between individuals.

Codes of Professional Practice–expected levels of practice, including behaviour and values, which are adopted by professional bodies, government, and non-governmental bodies to regulate professional conduct.

Criminal Law–a branch of law that relates to crime. It regulates social conduct and determines what is threatening, harmful, or otherwise a danger to the property, health, safety, and welfare of people.

Debrief–a short-term helping process undertaken after a crisis event.

Emergency Floor Holding–may be considered an option and used as a last-resort risk management response to extreme risks.

Emergency Response–a physical intervention used for the sole purpose of gaining a release from extreme risk behaviour.

Extreme Risk–a likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

Human Rights–the basic rights and freedoms that belong to everyone regardless of gender, race, religion, ethnicity, sexual orientation, or other status and that cannot be taken away without lawful due process.

Medical Emergency–a term used during a team physical intervention as an alert for all staff to immediately let go in order to call for emergency medical assistance and to follow emergency BLS protocol.

Organisational Policy–a statement of intent implemented as a set of procedures within an organisation that have been developed and approved by senior managers and board directors to assist internal decision making so desired outcomes are achieved.

Pain Compliance–the unacceptable deliberate use of pain as a method of coercion to enforce rules or gain cooperation; the deliberate use of pain to punish, harm, or seek retribution.

Proportionate–relative, similar, or corresponding; related in degree, size, or response.

Psychosocial–the interaction between a person (their thoughts, feelings, and behaviour) and their social environment.

Rapid Tranquillisation–the use of medication by the parenteral route (intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Restraint Reduction–a strategic organisational approach to reduce the use of coercive practices and to prevent the misuse and abuse of restraint.

Safeguarding–protecting children and adults from abuse and neglect.

Seclusion–The supervised confinement of an individual to a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

Transition–movement to or from different locations or positions and/or the movement between different levels of restriction. Transitions involve changing the level of restriction (low, medium, and high); walking, sitting, standing, and negotiating doorways; responding to slips, trips, and falls.

References

Almvik, R., Woods, P., & Rasmussen, K. (2000). The Brøset Violence Checklist: Sensitivity, specificity and interrater reliability. *Journal of Interpersonal Violence, 15*(12), 1284-1296. https://doi.org/10.1177/088626000015012003

Linaker, O. M. & Busch-Iversen, H. (1995). Predictors of imminent violence in psychiatric inpatients. *Acta Psychiatrica Scandinavica, 92*(4), 250-254. ncbi.nlm.nih.gov/pubmed/8848948

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CRISIS PREVENTION INSTITUTE®

Thank you for your participation in our programme. If we can be of further assistance to you, your colleagues, or your organisation, please contact CPI.

crisisprevention.com

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CRISIS PREVENTION INSTITUTE®

CPI *Safety Intervention*™

ADVANCED AND EMERGENCY

PARTICIPANT WORKBOOK

Participant Record

Name _____ Date _____

Instructor(s) _____

CRISIS PREVENTION INSTITUTE®

crisisprevention.com

Connect with us on social media

CPI Guiding Philosophy

CARE

Respect, dignity, empathy, person-centred

WELFARE

Maintaining independence, choice and well-being

SAFETY

Protecting rights and minimising harm

SECURITY

Safe, effective, harmonious and collaborative relationships

Authorisation and Approval Considerations for Use of Safety Interventions

Your employer has selected this training recognising that the philosophy, lessons, and skills taught in the programme align with organisational values. Safety intervention procedures taught in this programme are based on typical behaviours and risks you may encounter at work. Balancing objectives to provide for the best possible care and welfare, while maintaining safety and security, requires ongoing consideration, study, and practice. In addition, participants in this training must remember that use of any safety intervention needs to be guided by:

- Organisational policies and procedures.
- Relevant legal and regulatory frameworks.
- Professional standards for best practice.

Please Read Carefully

In CPI *Safety Intervention*™ training, you will be involved in practising intervention strategies. You should understand that some of these methods may involve physical contact and include risk of injury. It is important to follow the directions of the Instructor and the Safe Participation Guidelines of the programme.

CPI makes no warranty or representation that the skills, principles, and methods taught in this programme comply with all local laws, rules, regulations, and ordinances that may be applicable to persons utilising same. CPI's safety intervention principles should be used only in a manner that aligns with local laws. CPI assumes no liability for any bodily injury, loss, or damage caused by the misuse or incorrect application of the skills, principles, and methods taught in this programme, or by the illegal or inappropriate use of same, whether or not such injury, loss, or damage is foreseeable.

Safe Participation Guidelines

Your active and safe participation is critical for achieving successful outcomes from this training. At the start of the day, you are required to sign in as confirmation that you are fit to participate and that you will take responsibility for the *Care, Welfare, Safety, and Security*SM of yourself and others by adhering to these safety rules.

I will:

- Be professional and respectful of everyone in the classroom.
- Notify the Instructor of any past injuries or concerns I have about performing activities either before class or at the first opportunity.
- Accept the Instructor's guidance and follow any adaptations necessary for my safe participation, including not taking part in an activity if it compromises my safety or the safety of others.
- Follow the Instructor's directions and only perform activities when asked to do so. If for any reason I feel unable to safely participate, I will discuss it with the Instructor.
- Immediately stop any classroom activity when asked to do so, for any reason, by the Instructor or any participant.
- Not engage in any activity that is likely to disrupt learning, offend others, or cause harm or injury to self or others.
- Report all injuries and accidents immediately so a formal record can be made.
- Maintain my legal responsibilities regarding confidentiality and not share information that identifies any specific individual.

Participants will be taught a range of intervention skills and assessed for competent practice. Attendance in this event does not provide evidence that participants are competent to teach these skills to others. All CPI courses must be taught by a Certified Instructor licensed by CPI.

Participants who have any personal circumstances that may limit their participation in the course (physical or otherwise) must consult their manager prior to attendance. Where necessary, participants who may be limited in their participation must seek advice from their Occupational Health Department before attending.

Programme Objectives

- Describe the principles of risk assessment and risk reduction and demonstrate how to undertake a behavioural risk assessment.
- Provide a legal and professional rationale for decision making and give justification for actions made in relation to risk behaviour including the use of physical interventions.
- Assess a specific range of behaviours using the Brøset Violence Checklist to predict the likelihood of a crisis event.
- Demonstrate the use of physical interventions that are consistent with a set of physiological principles.
- Describe the warning signs associated with the adverse impact of physical interventions and identify the necessary corrective actions to minimise harm.
- Define the roles of incident manager/team leader and other team members for team interventions to ensure safety for both staff and person in distress.
- Assess risk using the *Decision-Making Matrix*SM to determine if additional staff are needed during physical interventions.
- Assist the individual experiencing Tension Reduction to consider alternative, more appropriate behaviours using the IBERA framework.

MODULE 7

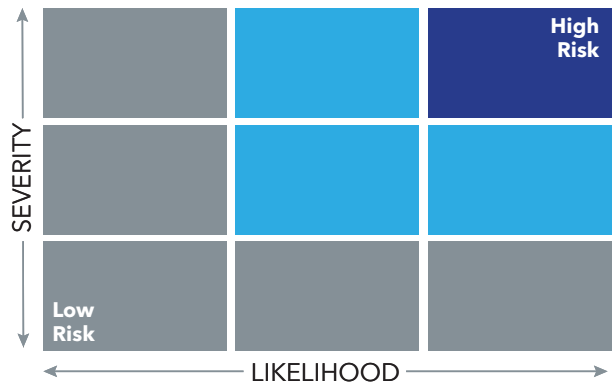
Decision Making

Having introduced the concepts of risk and decision making, you will expand on this knowledge and explore how you can assess situations or behaviours which may lead to greater levels of harm. It also will help you make decisions in relation to the use of physical interventions that may be justified and defended from a legal and professional perspective.

Learning Objectives

1. Undertake a situational or behavioural risk assessment based upon extreme risk behaviour using the *Decision-Making Matrix*SM.
2. Assess a specific range of behaviours using the Brøset Violence Checklist (BVC) to predict the likelihood of a crisis event so that preventive measures can be implemented to avoid escalation in the crisis cycle.
3. Reinforce the concepts of reasonable, proportionate, and least restrictive physical interventions to risk behaviour based on current legal and professional frameworks, and national or sector-specific guidelines for best practices.

*Decision-Making Matrix*SM



Brøset Violence Checklist (BVC)

Instructions

Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well known client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Monday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tuesday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saturday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /			
	Day	**Evening**	**Night**
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Brøset Violence Checklist Behavioural Criteria

Risk Rating and Score Sheet

Behavioural Criteria	Descriptor	Score
Confused	Appears obviously confused and disorientated (e.g., may be unaware of time, place or person).	
Irritable	Easily annoyed or angered (e.g., unable to tolerate the presence of others).	
Boisterous	Behaviour is overtly 'loud' or noisy (e.g., slamming doors, shouting out when others are talking etc.).	
Verbal Threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person (e.g., verbal abuse, sexually or racially offensive abuse, name calling, open or veiled threats).	
Physical Threats	A definite intent to physically threaten or harm. (e.g., adopting an aggressive stance, raising a hand/arm as if to strike out, raising a foot or posturing as if to kick out, modelling or imitating a head-butt, raising an object as if to throw or smash it).	
Attacking Objects	An attack directed at an object and not an individual (e.g., indiscriminate throwing, smashing or breaking of objects or furniture, punching, kicking or headbutting walls or doors).	
	Total Behaviour Criteria Observed	

Scoring the BVC
Score 0 if behaviour is not present, and score 1 if behaviour is present (only score 1 if the behaviour is present regardless of how many times the behaviour is repeated).

Risk Rating

Total = 0	The risk of violence is small.
Total = 1–2	The risk of violence is moderate. Preventive measures should be taken.
Total = 3–6	The risk of violence is high. Preventive measures should be taken. In addition, plans should be developed to manage the potential violence.

Activity: Predicting Risk Behaviour

Advanced

Part 1:

Observe a common conflict or crisis event and determine a risk rating on how likely the person in distress is to be violent in the following 24 hours.

Part 2:

Assess how likely risk behaviour or violence is to occur using the BVC.

Decision Making: Extreme Risk Behaviour

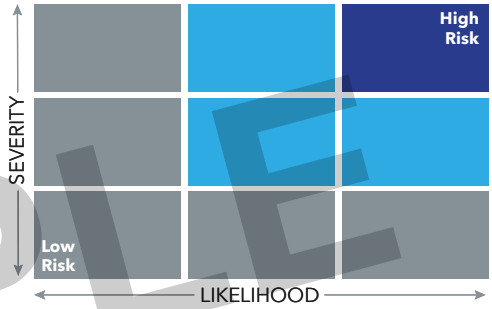
Emergency

You have previously seen how the *Decision-Making Matrix*SM can be used to compare the variables of likelihood and severity of harm to determine the perceived level of risk ranging from low to high. Having determined the level of risk, you used this information to make decisions about your response to risk behaviour during a crisis to help you:

- Remain objective.
- Remain calm and in control of your own emotions, fears, and anxieties.
- Make appropriate legal and professional judgements about the necessary actions you may consider.
- Determine the level of risk and decide if and to what degree a physical intervention is necessary based on the common principles of last resort, reasonable, proportionate, and least restrictive response.

There may also be a situation, in specific contexts, where risk behaviours have varying potential for harm with significantly greater risks. While such events are rare, you can use the same decision-making framework to assess the specific level of risk for extreme behaviours. This can be done to assess known behaviours as well as for those in-the-moment situations.

***Decision-Making Matrix*SM**



EXTREME RISK

A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

Notes

SAFETY INTERVENTIONS

Disengagement Skills

Previously, you learnt the importance of non-verbal, verbal, and paraverbal communication. You have also experienced the concept of Integrated Experience and how interpersonal communication can be both positively and negatively interpreted or influenced. Think about how you will use your non-verbal, paraverbal, and verbal communication to manage your behaviour as you intervene in crisis, particularly as you practise disengagement skills.

In this section, you will learn about the physiological principles in relation to extreme risk behaviours. You will learn how an Emergency Response can be applied to maximise your ability to gain a release from an extreme risk behaviour while minimising harm.

Learning Objectives

1. Demonstrate and practise a neck disengagement for high-risk behaviour.
2. Identify a range of Emergency Responses to extreme risk behaviour that may be encountered during a crisis.
3. Apply the physiological principle of Direct Pressure and Movement as a response to gain a release from a hold to the body where other physiological principles have not worked or within a catastrophic or life-threatening situation.
4. Demonstrate and practise using Emergency Responses to cause a person in distress to let go as a protective reaction when all other options have been exhausted.

CAUTION: The safety interventions represented in this module should only be learned and practised under the supervision of a CPI Certified Instructor. The images of these interventions shown here are intended as a point of reference and represent only a snapshot of the process required to execute the skills and principles. Any attempt to learn these skills and principles from the images or descriptions, or use them without proper instruction, may result in injury.

Neck (High-Risk Behaviour)

Advanced

Essential Responsibilities for Emergency Responses

Emergency

- Authorised and approved
- Justification
- Life-threatening
- No safer alternative
- Never to coerce, punish, or gain compliance
- Safeguard against misuse or abuse

The goal of Emergency Responses is to gain a release from a hold while minimising harm to the person in distress.

Emergency Responses (Escape and Rescue) must be formally authorised and approved by your organisation. Refer to your organisational policy, and ensure you have explicit approval and authorisation to use these interventions within your workplace before providing any instruction.

Emergency Responses create a somatic response causing the person in distress to instinctively let go as a protective reaction. The focus of each demonstration and practice in this section is twofold:

- To reinforce the concept of risk assessment covered in Module 7.
- To develop a consistent response to extreme risk behaviour in keeping with your key legal and professional responsibilities.

Emergency

EXTREME RISK

A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

EMERGENCY RESPONSE

A physical intervention used for the sole purpose of gaining a release from extreme risk behaviour.

Example 1: Escape
A person in distress is holding you using an extreme risk behaviour, and your intention is to immediately escape to a place of safety.

Example 2: Rescue
A person in distress is holding someone else using an extreme risk behaviour, and your intention is to rescue the person and move to a place of safety.

Emergency

Legal and Professional Considerations for Emergency Response

- The use of Emergency Responses must be authorised and approved by your organisation.
- The risk is extreme or life threatening and there is *no safer alternative*.
- Emergency Responses are never used to coerce, punish, or gain compliance.
- You have recording and reporting procedures which safeguard against misuse or abuse.

Remember, for extreme risk behaviour the goal is always to gain a release from a hold while minimising harm to the distressed individual.

Emergency

Physiological Principles for Emergency Response

Principles of Emergency Response

- Position, Posture, and Proximity
- Biomechanical Benefit
  - Direct Pressure and Movement

Extreme Risk – Emergency Responses

Emergency

Thumb

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Dorsal Hand

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Upper Outer Torso

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Extreme Risk – Emergency Responses continued

Emergency

Sternum

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Mandibular

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Team Response (Emergency Rescue)

Emergency

- The Columella Emergency Response is only to be used in a rescue situation with adults. This response must never be used with children or young people.
- The use of these interventions comes with great responsibility and a higher level of legal and professional scrutiny, so staff who use these approaches must be able to account for their actions in the specific circumstances when Emergency Responses are used.
- The purpose of the Emergency Response is to get an immediate release from extreme risk behaviour to allow you to minimise harm and/or to assist your staff, colleague, or individual in care to a place of safety.
- If applying an Emergency Response doesn't create an immediate release, call for assistance, and continue to reconsider other disengagement options.
- Revisit the Physical Skills Review Framework after practice and ask participants to discuss the legal and professional issues and any concerns they may have about Emergency Responses.

Physical Skills Review

Safe	In what way does the specific restrictive intervention enable you to maximise safety and minimise harm?
Effective	What makes your intervention effective?
Acceptable	How would this be viewed as an acceptable response to risk behaviour?
Transferable	How can you transfer the principles back into your workplace?

SAFETY INTERVENTIONS

Holding Skills

Holding Skills Prerequisites for Participants

To participate in this module, participants must meet the following criteria:

- Must be currently in work and physically fit and able to undertake their typical day-to-day role in the workplace. Where there are concerns about any participant's ability to undertake the physical modules in the programme, the participant must seek occupational advice before continuing so that any reasonable adjustments can be made by the Instructor.
- Participants must have completed CPI *Safety Intervention*™ Foundation. Participants must not be taught any physical interventions in isolation to other modules in the programme.
- Participants must demonstrate an understanding of the legal and professional issues related to the use of physical interventions.

CAUTION: The restrictive interventions represented in this module should only be learned and practised under the supervision of a CPI Certified Instructor. The images of these interventions shown here are intended as a point of reference and represent only a snapshot of the process required to execute the skills and principles. Any attempt to learn these skills and principles from the images or descriptions, or use them without proper instruction, may result in injury.

Additional Staff – Seated

Advanced

Additional Staff – Standing

Team Intervention

Emergency

Low-Level Team Intervention

Medium/High-Level Team Intervention

High-Level Team Intervention

Standing to Seated (Floor Transition)

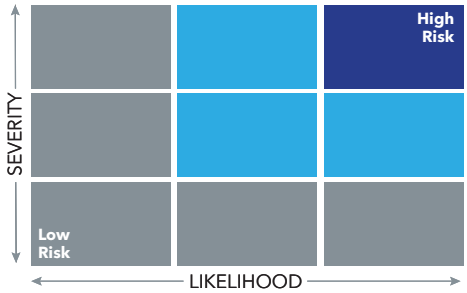
Advanced

Transition to the Floor in a Supine Position

*Decision-Making Matrix*SM and Extreme Risk Behaviour Lecture (for Emergency Floor Holding)

Emergency

*Decision-Making Matrix*SM



EMERGENCY FLOOR HOLDING

The emergency use of physical interventions on the floor to temporarily manage acute behavioural disturbance and/or extreme risk behaviour.

Emergency Floor Holding (Supine)

Emergency

Emergency Floor Holding Supine (Protecting Head, Spine & Airway)

Emergency Floor Holding Supine (Arms)

Emergency Floor Holding Supine (Legs)

Standing to Kneeling (Floor Transition)

Advanced

Emergency Floor Holding – *Supported Prone Position*SM

Emergency

Emergency Holding Supported Prone (Head, Spine and Airway)

Emergency Holding Supported Prone (Arms)

Emergency Holding Supported Prone (Legs)

Emergency Floor Holding Side Lying for Rapid Tranquillisation

Emergency

RAPID TRANQUILLISATION

The use of medication by the parenteral route (intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Example: The use of intramuscular lorazepam to sedate an individual with extreme behavioural disturbance.

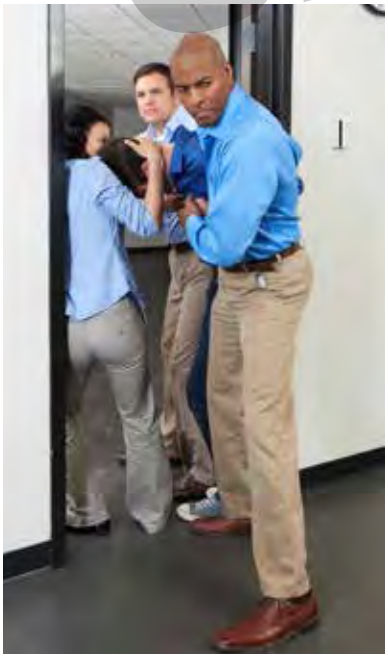
Emergency Floor Holding for Rapid Tranquillisation

SECLUSION

Emergency

The supervised confinement of an individual to a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

Example: When an emergency floor hold becomes prolonged and letting go is not a safe option. Staff assess the risks of continued holding are greater than moving the individual into seclusion.



Emergency Holding for Seclusion (Entry and Exit)

Emergency Holding for Seclusion (Searching or Removal of Unsafe Items)

MODULE 8

Post-Crisis

In this next activity you will learn additional debriefing methods to help individuals discover their own solutions after a crisis.

Learning Objectives

1. Identify a five-step, simple method of non-directive support to people who have witnessed or experienced crisis.
2. Practise debriefing individuals to help them discover their own solutions to the crisis events.
3. Build capabilities to convey values related to *Care, Welfare, Safety, and Security*℠ during interventions.

Advanced

IBERA Post-Crisis Debriefing Tool: 5 Simple Steps

Remember you are not trying to 'fix' things for the person; you are simply trying to provide non-directive support after a crisis event. The aim of the framework below is to help guide your discussion so that the person feels supported and can clarify how they feel about an event.

Step 1: **I**ntroduction	Introduce yourself and make sure you are clear about how much time you have to spend with the person.
Step 2: **B**ackground	Find out about the event. Use open questions to get the person to tell you their view of the event. *Tell me what happened.* *Describe what happened.*
Step 3: **E**motional Impact (i) Find out how the event is making the person feel (ii) Find out what is the key issue causing the person greatest concern	Use questions which help the person to describe their emotional response to the event or circumstances. *So how do you feel about that?* *How does that make you feel?* People may give you a lot of factual and emotional information. Remember to paraphrase to ensure you clarify that you understand what the person is saying. Ask the person to say what issue troubles them most. *What troubles you most about the event?* *What bothers you most?* *What concerns you most?*
Step 4: **R**esourcefulness	Find out how the person is handling the event and show empathy. Assess the person's response to how they are dealing with the event. *How are you handling that?* *How are you managing that?* Reflect that you understand how the person feels and how they are dealing with the event. *That must be difficult.*
Step 5: **A**ction and Close	End the debriefing by asking the person if there is anything they think they should now do. This allows you to hand the issue back to the individual and encourages the person to think of their own solutions. Avoid telling the person what they should or should not do, or how they should or should not feel.

Activity: IBERA Post-Crisis Debriefing Tool

Advanced

Part 1 Observer Notes

Part 2 Observer Notes

Notes

Glossary of Terms

Abuse–any action that intentionally or unintentionally harms or injures another person; any action that falls below recognised acceptable professional codes of practice.

Civil Law-a branch of law, sometimes called non-criminal law, which relates to the rights and duties between individuals.

Codes of Professional Practice–expected levels of practice, including behaviour and values, which are adopted by professional bodies, government, and non-governmental bodies to regulate professional conduct.

Criminal Law–a branch of law that relates to crime. It regulates social conduct and determines what is threatening, harmful, or otherwise a danger to the property, health, safety, and welfare of people.

Debrief–a short-term helping process undertaken after a crisis event.

Emergency Floor Holding–may be considered an option and used as a last-resort risk management response to extreme risks.

Emergency Response–a physical intervention used for the sole purpose of gaining a release from extreme risk behaviour.

Extreme Risk–a likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

Human Rights–the basic rights and freedoms that belong to everyone regardless of gender, race, religion, ethnicity, sexual orientation, or other status and that cannot be taken away without lawful due process.

Medical Emergency–a term used during a team physical intervention as an alert for all staff to immediately let go in order to call for emergency medical assistance and to follow emergency BLS protocol.

Organisational Policy–a statement of intent implemented as a set of procedures within an organisation that have been developed and approved by senior managers and board directors to assist internal decision making so desired outcomes are achieved.

Pain Compliance–the unacceptable deliberate use of pain as a method of coercion to enforce rules or gain cooperation; the deliberate use of pain to punish, harm, or seek retribution.

Proportionate–relative, similar, or corresponding; related in degree, size, or response.

Psychosocial–the interaction between a person (their thoughts, feelings, and behaviour) and their social environment.

Rapid Tranquillisation–the use of medication by the parenteral route (intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Restraint Reduction–a strategic organisational approach to reduce the use of coercive practices and to prevent the misuse and abuse of restraint.

Safeguarding–protecting children and adults from abuse and neglect.

Seclusion–The supervised confinement of an individual to a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

Transition–movement to or from different locations or positions and/or the movement between different levels of restriction. Transitions involve changing the level of restriction (low, medium, and high); walking, sitting, standing, and negotiating doorways; responding to slips, trips, and falls.

References

Almvik, R., Woods, P., & Rasmussen, K. (2000). The Brøset Violence Checklist: Sensitivity, specificity and interrater reliability. *Journal of Interpersonal Violence, 15*(12), 1284-1296. https://doi.org/10.1177/088626000015012003

Linaker, O. M. & Busch-Iversen, H. (1995). Predictors of imminent violence in psychiatric inpatients. *Acta Psychiatrica Scandinavica, 92*(4), 250-254. ncbi.nlm.nih.gov/pubmed/8848948

Notes

Action Plan – Putting it Together

Use this action plan to implement the strategies you learned in the training into your everyday practice.

Goal(s): What skills do you want to develop further? What practices do you want to stop doing?
Tasks/Action Steps: What will be done?
Structure for Accountability: What support do you need to ensure you are implementing the steps?
Evidence of Success: How will you know that you are making progress?

Notes

Training Evaluation Form

Date

Title and Location of Training

Trainer

Instructions: Please indicate your level of agreement with the statements listed below.

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1. The objectives of the training were clearly defined.	☐	☐	☐	☐	☐
2. Participation and interaction were encouraged.	☐	☐	☐	☐	☐
3. The topics covered were relevant to my profession.	☐	☐	☐	☐	☐
4. The topics covered were relevant to my professional development.	☐	☐	☐	☐	☐
5. The content was organised and easy to follow.	☐	☐	☐	☐	☐
6. The materials distributed were helpful.	☐	☐	☐	☐	☐
7. This training experience will be useful in my work.	☐	☐	☐	☐	☐
8. The trainer was knowledgeable about the training topics.	☐	☐	☐	☐	☐
9. The training objectives were met.	☐	☐	☐	☐	☐
10. Training time was sufficient.	☐	☐	☐	☐	☐
11. The meeting room and facilities were adequate and comfortable.	☐	☐	☐	☐	☐

12. Other:

Workbook ID below.
Do not write in this box.

INSTRUCTOR: Sign and distribute this card before documenting online.
For easy removal of card, please pop card from the sides.

SI CPI | Blue Card®

Name

has completed the CPI *Safety Intervention*™
Advanced and Emergency

Organisation Hours Completed

Issued Expires Instructor

For more learning opportunities
visit **crisisprevention.com.**

INSTRUCTOR: Remember to remove this card and give to participant.
For easy removal of card, please pop card from the sides.

CARE
Respect, dignity, empathy, person-centred

WELFARE
Maintaining independence, choice and well-being

SAFETY
Protecting rights and minimising harm

SECURITY
Safe, effective, harmonious and collaborative relationships

MAHI - STM - 105 - 653

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Table of Contents

Introduction

This learner resource is used with the CPI learner materials for CPI *Safety Intervention*™ training which includes the use of restrictive interventions. It is intended to aid learner reflections and group discussions, as well as reinforce key elements of the training. Throughout your training programme, your Instructor will refer to this material and direct you to specific sections as they relate to each module or each topic/subject within each module.

Each section focuses on a topic area to support your training and provides space for reflection. You may want to write down thoughts about your own practice as well as any questions you may want to ask your Instructor, other participants in your training event, or colleagues in your workplace.

01 Section | Definitions of Coercion and Restrictive Practices

Coercion

Coercion involves a range of interventions which aim to bring about cooperation from an individual who is unwilling or unable to accept care and support, in other words persuading someone to do something they do not want to do. While coercive interventions are aimed at helping people make choices in their best interests, there are ethical concerns about coercion since the typical interventions range from informal persuasion, inducements, or pressure to explicit compulsory methods and acts of force such as detention under the Mental Health Act and restrictive practices including forced medication (rapid tranquillisation), physical restraint, seclusion and external body searches.

It is important to remember that there is a subjective psychological element linked to the relationship between the individual and the care professionals. The person being coerced may feel they lack influence and control, choice, and freedom, and they may have a feeling of depersonalisation.

Restrictive Practices

A restrictive practice (or restraint) can generally be described as any approach used to restrict a person's liberty of movement, whether the person objects to such restriction or not. Considered only as a possible response to risk behaviour at the third level of the *Crisis Development Model*[SM], restrictive practices are categorised as 'Tertiary' or 'Crisis/ Reactive' Interventions. The Equality and Human Rights Commission (2019) provide a much wider definition which states:

'"Restraint" is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference, for example removing someone's walking frame to prevent them moving around'.

Restrictive practices or restraint can be much more than the use of force. The Restraint Reduction Network Training Standards (2019) divide restrictive practices into four distinct categories that may be used to manage risk behaviours.

Category A - Physical Restraint

Physical Restraint is defined by the Department of Health (2014) as *'any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.* Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

Clinical Holding is physical restraint used solely for the delivery of safe care and treatment to a person who lacks capacity to consent for such treatment. The British Society for Disability and Oral Health (2009) define clinical holding as *'the use of physical holds to assist or support a patient to receive clinical care and treatment'.*

The Royal College of Nursing (2010) provide further clarification by including the use of clinical holds as *'a suitable method of helping children and adults, with their permission, to manage a painful procedure quickly or effectively'.*

Category B - Environmental Restraint

Seclusion is a specific method of environmental restraint typically used in acute and secure mental health settings and is defined as *'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving'* (Mental Health Act 1983 Code of Practice, 2015).

The Equality and Human Rights Commission's Human Rights Framework for Restraint (2019) recognises that seclusion is enforced isolation by *'locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area'.*

Enforced isolation is also a method of environmental restraint which goes beyond formal seclusion and is sometimes described by other terms such as **Enhanced Care, Segregation, Separation, Time Out** or **Solitary Confinement**.

Long-Term Segregation is a specific form of enforced isolation involving *'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines*

that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis' (Mental Health Act 1983 Code of Practice, 2015).

Category C - Chemical Restraint

Although the use of antipsychotics and sedatives may constitute chemical restraint, especially for individuals who lack capacity to consent, **Rapid Tranquillisation** is a specific emergency form of chemical restraint and refers to *'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place'* (Mental Health Act 1983 Code of Practice, 2015).

Category D - Mechanical Restraint

Mechanical restraint involves *'the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'* (Care Quality Commission, 2015a).

Although the use of belts or cuffs is typically associated with the police and prison service, some acute mental health and forensic settings permit mechanical restraint to contain extreme violence and/or when certain individuals are admitted or transferred to and from hospital to minimise the risk of absconding.

In some settings, especially children and adults with severe intellectual disabilities, mechanical restraints (splints) may be used to minimise the impact of injury from self-harm. A range of equipment designed for another purpose may be used as mechanical restraint, so it is not uncommon to find furniture and other equipment being used to restrict a person's liberty. This includes bedrails, harnesses, belts, confusing door handles, keypads or other electrically operated entry and exit systems. These methods of restriction often go unnoticed, unreported and unrecorded by staff as these approaches are viewed as taking safety precautions rather than restrictive practices.

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

Section 02 | Legal and Professional Issues Related to the Use of Restrictive Practices

All CPI programmes that include restrictive physical interventions contain a module covering decision making, an assessment of risk and the legal, professional and ethical issues related to restrictive practices. This module enables you to make reasonable and proportionate decisions about the use of any physical intervention for the management of risk behaviour so that you can provide a sound justification for such actions if challenged by others. When deciding to use (or not to use) a restrictive intervention, your decisions and actions are judged, typically retrospectively, by many people including:

- The individual subject to restriction and their families
- Colleagues, managers, and employer
- Professional bodies
- Regulators
- Commissioners
- Courts

It is important that your decisions and subsequent actions not only reflect the key themes of decision making outlined in CPI training, but also reflect the legal and professional expectations for your field of work as there may be specific requirements, guidelines or legislation that relate to your setting or user group. Ensuring your decisions and actions reflect the current legal and professional expectations and obligations helps ensure your decisions are viewed as last resort, least restrictive, reasonable and proportionate in the circumstances, as well as justified and defendable.

Duty of Care

A Duty of Care is the legal obligation imposed on an individual requiring them to adhere to a standard of reasonable conduct while performing any act that could reasonably involve harm to others. It is the first element that must be established to proceed with any case of negligence and takes account of harm that may arise from the action taken as well as harm arising from a failure to act. Duty of Care can be viewed as a social contract between individuals and the implicit responsibilities individuals have towards others.

A three-part test establishes if a Duty of Care exists:

- Harm must be a reasonably foreseeable result of the individual's action (or lack of action).
- A relationship must exist where there is a clear expectation to uphold a Duty of Care.
- It must be fair, just and reasonable to impose such a duty.

As professionals, you have a clearly defined Duty of Care. You have a responsibility under this duty to ensure any action or failure to act in relation to risk behaviour does not cause any reasonably foreseeable harm. In so doing, you must consider the risk of harm associated with the action you take and compare this to the risk of taking no such action so that the outcome results in no harm or the least amount of harm reasonably foreseeable in the circumstances.

There is a wide range of legislation, guidance and standards which influence how restrictive practice can be used and legally justified. Below is a summary of the main reference materials which relate to legal and professional practice. As a professional working in education, health or social care settings, it is your responsibility to ensure you are familiar with the expectations and standards of conduct that influence your practice by ensuring your decisions and actions reflect the expectations of your organisation in accordance with these professional and legal requirements.

1. The Restraint Reduction Network Training Standards, 2019

The RRN Training Standards provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. They ensure that training is directly related and proportionate to the needs of specific populations. The standards outline the importance of delivering evidence-based accredited training which provides knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

The standards are mandatory for all training with a restrictive intervention component delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. They can also be applied to:

- The wider education, health and social care sectors
- Children and adult services
- The UK and internationally

2. Human Rights

United Nations Convention of the Rights of the Child, 1989; Human Rights Act, 1998; United Nations Convention of Rights of Persons with Disabilities, 2006; Equality Act, 2010
Human rights are the basic rights and freedoms that belong to every person in society from birth to death and apply regardless of where you are from, what you believe or how you choose to live your life. Your human rights can never be taken away, but they can be restricted in the interests of society.

Human Rights Act 1998: Articles 2, 3, 8 and 14
The Human Rights Act creates legal obligations for the protection of rights for all those living within a democratic society. The Act applies to all public authorities and shapes the legal duties of staff to respect and protect everyone's human rights, especially in relation to the use of lawful restraint.

Article 2 reinforces our legal Duty of Care and requires *'all reasonable steps to be taken to protect a person's right to life'* including stopping an intervention if it is likely to result in harm and/or intervening to protect a person from themselves or others where a failure to act could result in harm.

Article 3 prohibits *'torture, and inhuman and degrading treatment or punishment'* which may include different types of assault on human dignity and physical integrity as well as acts of unjustified suffering. Although under Article 3 actions which inflict a sufficient severity of pain may be considered torture, especially if undertaken *deliberately*, the use of any restrictive intervention must not cause harm (arising from either intended, negligent actions or failures to protect) amounting to degrading or ill-treatment. When deciding if any intervention is a breach of Article 3, the Court will consider the severity and intensity of suffering inflicted on an individual based on an assessment of factors including the:

- Duration of the action
- Physical and psychological impact/effects
- Sex, age, gender and health of the person
- Manner and execution of the intervention

Article 8 requires staff to involve the person in decisions about their care and treatment and to ensure that the use of any restrictive practice is the least restrictive option based on the prevailing risks.

Article 14 protects the right against discrimination and means that restrictive practices must not be undertaken on the grounds of race, ethnicity, age, gender or other status or protected characteristic.

3. Legislation relating to children and young people

Child Care Act (Ireland) 1991; Protection of Children Act, 1999; Protection of Children (Scotland) Act, 2003; The Children Act, 2004; Children (Emergency Protection Orders) Act (Northern Ireland), 2007; The Children and Young Person Act, 2008; Working Together to Safeguard Children, 2018; Children First Act (Ireland), 2015
A range of legislation provides the legal basis for how social services and other agencies deal with issues relating to children. This legislation has been introduced so that all individuals looking after children, in the home, workplace, school or other setting, are aware of how children should be looked after and legally protected.

While different legislation may give greater or lesser focus on the use of restrictive practice, there is a universal expectation that the use of any force should be a last resort, reasonable and proportionate to the circumstances. The overall aim is to protect the child or young person from harm. This range of legislation aims to make sure the care children and young people receive is well supported, of high quality and tailored to their needs while also improving their educational experience and achievements.

The Protection of Children and Vulnerable Adults Order (Northern Ireland), 2004; The Safeguarding Vulnerable Groups Act 2006; Protection of Vulnerable Groups (Scotland) Act, 2007
Legislation and guidance to safeguard vulnerable groups (children and adults) implements more stringent ways to carry out checks on those individuals who wish to work with children, the elderly or people who are classed as being in positions of vulnerability. This legislation gives employers powers, in conjunction with those bodies who oversee the checking of potential new employees, to help confirm the safety and reliability of those individuals who wish to work with those who fall under the auspice of vulnerable groups.

Education and Inspections Act, 2006; Best Practice Guidelines in the Use of Restraint (Child Care: Residential Units) (Ireland), 2006; The Use of Reasonable Force Guidelines, 2013; Behaviour and Discipline in Schools, 2015; Safe and Effective Intervention – Use of Reasonable Force and Searching for Weapons (Wales), 2013; Reducing the Need for Restraint and Restrictive Intervention, 2019
Advice for schools is intended clarify the use of force to help school staff feel more confident about using this power when they feel it is necessary, and to

make clear the responsibilities of head teachers and governing bodies in respect of this power.

Within current guidance, 'reasonable force' covers the broad range of actions that involve a degree of physical contact with pupils to control or restrain. This can range from guiding a pupil to safety by the arm through to more extreme circumstances such as breaking up a fight or where a student needs to be restrained to prevent violence or injury.

'Reasonable in the circumstances' relates to the specific event in which force is used and means using no more force than is needed based on the risks presented. 'Restraint' means to hold back physically or to bring a pupil under control and is typically used in more extreme circumstances. In accordance with guidance for schools, reasonable force cannot be used as a punishment.

Guidelines also provide advice to head teachers and school staff on developing a school behaviour policy. By law, the head teacher must set out measures in the behaviour policy which aim to:

- Promote good behaviour, self-discipline and respect
- Prevent bullying
- Ensure that pupils complete assigned work
- Regulate the conduct of pupils

The Reducing the Need for Restraint and Restrictive Intervention (2019) guidance reflects previous guidance for the adult health and social care sector published by the Department of Health in 2014 for England and Wales and states: *'Restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution, and we are particularly concerned about long-term or institutionalised uses of restrictive interventions.'*

This guidance is advisory and applies to the following settings and services:

- Local authorities, Clinical Commissioning Groups and NHS commissioned health services
- Maintained and non-maintained special schools, special academies, special free schools, special post-16 institutions and independent educational institutions
- Children's homes (including secure children's homes) and residential holiday schemes for disabled children
- Local authority and independent fostering service providers

Safeguarding

Safeguarding is the protection of children from violence, exploitation, abuse and neglect and is enshrined in Article 19 of the United Nations Convention on the Rights of the Child. Child protection systems are the means by which any organisation, or individual, is charged with the safety of children under their care. Organisations are obliged by law to inform the authorities of any suspicions they have in relation to the welfare and safety of any child. If an individual suspects sexual abuse, physical or emotional cruelty, maltreatment or instances of risk (which can include the use of restraint), they should inform the correct authorities so that a thorough and proper investigation can take place.

Child protection guidelines are designed to ensure that where such a suspicion of potential harm is raised, it is acted upon in good time and with the full cooperation of all the relevant bodies. This ensures that all agencies involved in any such investigation are fully conversant with each individual case and are also able to act in the best interests of any child or vulnerable person that may need help.

4. Legislation relating to adults

Adults with Incapacity (Scotland) Act, 2000; Mental Capacity Act, 2005; Deprivation of Liberty Safeguards, 2007; Adult Support and Protection (Scotland) Act, 2007; Mental Capacity Act (Deprivation of Liberty Amendments), 2009; Assisted Decision-Making (Capacity) (Ireland) Act, 2015; Mental Capacity Act (Northern Ireland), 2016; Liberty Protection Safeguards, 2019

Legislation related to capacity is designed to protect vulnerable people over the age of 16 around decision making based on the presupposition that every adult, whatever their disability, has the right to make their own decisions wherever possible. Where a decision is too big or complicated for a person to make, even with appropriate information and support, then mental capacity legislation requires people supporting someone without capacity to make a 'best interests' decision for them.

The Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS), which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005 to ensure that people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty. Under the Mental Capacity Act, liberty safeguards allow restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes only in circumstances where such

restrictions are in a person's best interests. As such, to deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.

Mental Health Act, 1983; Mental Health (Scotland) Act, 1984; The Mental Health (Northern Ireland) Order, 1986; Mental Health Act (Ireland), 2001; Mental Health (Care and Treatment) (Scotland) Act, 2003 Code of Practice Vol 1, 2 and 3; Mental Health Act (1983) Code of Practice, 2008; Mental Health Act Code of Practice for Wales, 2016
Mental health legislation covers the reception, care and treatment of mentally disordered persons. The Mental Health Act Code of Practice aims to provide stronger protection for patients and clarify roles, rights and responsibilities. This includes:

- Involving the patient and, where appropriate, their families and carers in discussions about the patient's care at every stage
- Providing personalised care
- Minimising the use of inappropriate blanket restrictions and restrictive interventions including medication, physical (manual) restraint and seclusion

5. Other related guidance

Framework for Restrictive Physical Intervention Policy and Practice. Welsh Assembly Government, 2005; Positive and Proactive Care, 2014; Positive and Proactive Workforce, 2014; Guidance for Designated Centres: Restraint Procedures, 2014
A range of guidance provides a framework for staff and service providers towards changing the culture and practice to ensure people who receive health and social care do so in a safe manner which promotes independence and recovery. These various documents recognise the importance of a therapeutic environment emphasising primary and secondary preventive approaches to eliminate or minimise the use of restrictive practices.

Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings (NG10), 2015
This guidance for healthcare covers the short-term management of violence and aggression in adults, young people and children. It aims to safeguard both staff and people who use services by helping prevent violent situations and providing guidance to manage them safely when they occur. Regarding the use of restrictive interventions, section 1.4 emphasises the importance of staff training and offers guidelines on the use of manual (physical), mechanical, chemical and environmental restrictions.

Care Act, 2014; Health and Social Care Act, 2008 (Regulated Activities) Regulations, 2014; Social Services and Well-Being (Wales) Act, 2014
The Care Act and related legislation sets out the statutory responsibilities for integrating care and support. It places specific responsibilities on local authorities for safeguarding so that people at risk are protected from abuse. Abuse includes the misuse and abuse of restrictive practices, coercive interventions which may lead to physical, psychological or sexual abuse, as well as neglect and acts of omission. Importantly, this legislation is designed to prevent 'organisational abuse' including poor care practices and ill-treatment.

(a) Regulation 12: Safe Care and Treatment
The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. There are inherent risks in carrying out care and treatment, especially when restrictive practices are used, so under this regulation, it is not considered to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services.

(b) Regulation 13: Safeguarding Service Users From Abuse and Improper Treatment
This regulation safeguards people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. Providers must have a zero-tolerance approach to abuse, unlawful discrimination and restraint and must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors.

(c) Regulation 20: Duty of Candour
This regulation intends to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support and providing truthful information and an apology.

College of Policing Memorandum of Understanding: The Police Use of Restraint in Mental Health & Learning Disability Settings, 2017
The memorandum sets out a national position about when police can be asked to attend incidents which occur in mental health settings, for what reasons and what can be expected of them when they do attend especially in relation to the use of restrictive practices. Circumstances which may prompt police involvement include situations with an immediate risk to life or limb, immediate risk of serious harm, hostage taking, the use of a weapon or serious damage to property.

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

03 Section | Models of Restraint Reduction

A Health Promotion or Public Health Model

Such a model can be used to eliminate or minimise restrictive practices by addressing three levels of need for people who present behaviours that challenge services or who put themselves or others at risk of harm. The health promotion model has three stages: primary prevention, secondary prevention, and tertiary intervention.

Primary Prevention (Universal Precautions)

This stage involves activities or approaches designed to impact on the incidence of a condition to reduce or alter the factors that cause it. In terms of reducing restrictive practices, primary prevention aims to reduce the likelihood of the behaviour occurring in the first instance by reducing exposure to known triggers. Primary prevention includes:

- Delivering services that focus on person-centred, trauma-sensitive care and support
- Providing positive and rewarding social environments
- Giving a structure to the day and providing meaningful occupation and activities
- Addressing health inequalities
- Improving levels of independence
- Enhancing quality of life
- Improving communication skills
- Helping people manage their own conditions by enhancing coping skills or adapting their environment
- Helping people to exercise and sleep well

Primary prevention is often part of a specific approach within an organisation and may include formalised models such as Positive Behaviour Support, Safewards, No Force First, Active Support and the Six Core Strategies. Primary prevention may also include individualised approaches such as Cognitive Behavioural Therapy, Dialectic Behaviour Therapy and other psychological interventions. Fundamentally, primary prevention is based on person-centred approaches which aim to provide the 'right fit' between the services available and the needs of the individual.

Secondary Prevention (Selected Interventions)

Secondary prevention focuses on early intervention and aims to minimise escalation in behaviour which may lead to the use of restrictive practices. Secondary interventions include:

- An assessment of the presenting behaviour so that a targeted approach can be used which may include the removal of immediate triggers
- Making changes to the environment
- Self-regulation techniques such as relaxation, breathing exercises, mindfulness and meditation techniques
- Effective verbal and non-verbal approaches such as limit setting and distraction techniques
- Reinforcement of alternative positive behaviours
- The use of appropriate medication either to address underlying psychiatric symptoms or to help alleviate anxiety

Tertiary Intervention (Indicated Interventions)

These are reactive strategies aimed at addressing the needs of individuals where primary and secondary prevention has failed in order to help the individual to regain control. Tertiary strategies can be non-restrictive or restrictive. They aim to bring about immediate behavioural change in the individual by enabling staff to manage the situation and eradicate or minimise the risks. It is important to recognise that tertiary approaches are risk management responses and not designed or intended to achieve any long-term or lasting behavioural change.

The Six Core Strategies

The Six Core Strategies were developed using the health promotion model as an organisational approach for eliminating or minimising physical restraint and seclusion and is now more widely used to eliminate or minimise all forms of restrictive practice. CPI advocates this model consisting of six elements of organisational performance.

1. Leadership

Leadership strategies include defining and articulating a vision, values and philosophy that

expect to eliminate restrictive practices where possible, minimise the use to manage risk behaviour and ensure such practices maximise safety and minimise harm. To achieve this vision, leaders need to develop and implement a targeted action plan to improve performance and hold everyone to account. Leadership includes the oversight of every event when restrictive practices are used, investigating causality, reviewing and revising policy and procedures that may instigate conflicts, and monitoring and improving workforce development based on the principles of continuous quality improvement.

2. Use of Data
This core strategy suggests that successfully reducing restrictive practices requires the collection and use of data at different levels (e.g. individual user, individual unit/department, wider service) to identify baseline measures. These include data review by unit, shift, day; individual staff members involved in events and user; as well as tracking injuries and complaints related to restrictive practices in both service users and staff.

3. Workforce Development
This strategy ensures the workforce has the knowledge and skills to deliver services based on the principles of person-centred approaches, recovery and the characteristics of trauma-informed systems of care. The purpose of this strategy is to create an environment that is less likely to be coercive or trigger conflicts and is implemented through ongoing staff training. This strategy ensures staff implement a wide range of primary prevention, person-centred approaches designed to teach users emotional self-management of symptoms and individual triggers that lead to loss of control.

4. Use of Prevention Tools
This strategy reduces the use of restrictive practices through tools and assessments integrated into organisational policy and for each user via individual safety and support plans. This strategy relies heavily on the concept of individualised approaches and includes assessment tools to identify risk for violence, universal trauma assessment, person-first, non-discriminatory language in speech and written documents, environmental changes to include comfort and sensory rooms, sensory modulation interventions, and other meaningful treatment activities designed to teach people emotional self-management skills.

5. Consumer Involvement
This fully and formally includes service users, children, families and external advocates in various roles and at all levels in the organisation to help reduce restrictive practices. It includes monitoring, debriefing, and peer support services.

6. Debriefing Techniques
This core strategy recognises the usefulness of a thorough analysis of every instance of restrictive practices. Reducing restrictive practices occurs through knowledge gained from a rigorous analysis of events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate, as much as possible, the adverse and potentially traumatising effects of restrictive practices for those involved.

How CPI Training Integrates These Approaches Into Our Training

CPI training is based on a review of the current research in best practice and teaches participants a range of interventions within the primary, secondary and tertiary model. The curriculum includes practical approaches to reduce and manage conflict to minimise restrictive practices. Should behaviour escalate, CPI *Safety Intervention*™ training includes the option of non-restrictive and restrictive tertiary/reactive strategies using a risk-based approach to ensure risk behaviour is managed as safely as possible.

In line with the Six Core Strategies, CPI programmes include a Safety and Support Plan to enable staff to work with service users to develop a person-centred, trauma-informed intervention plan which identifies everyday practices to get the 'right fit' between the individual's personal support and needs in order to avoid potential conflict and crisis situations. The Safety and Support Plan also ensures that the use of any restrictive practices is assessed and agreed individually with each service user so interventions take account of the person's characteristics, history and specific risk behaviour.

CPI Four-Stage Model
Based on a health promotion model, the CPI framework outlines a cycle of continuous assessment, intervention and learning based on Primary and Secondary preventive interventions; non-restrictive and restrictive Crisis (Tertiary) Intervention; and a fourth stage of Post-Crisis Support and Learning. This final stage helps staff implement a range of interventions to ensure that debriefing is offered to all those involved in the use of restrictive practices. This stage also ensures effective learning to prevent or minimise restrictive practices.

CPI Training and Positive Behaviour Support (PBS)
The overall aim of Positive Behaviour Support (PBS) is to improve the quality of a person's life and that of the people around them by delivering the right support to help people lead a meaningful life and learn new

skills without unnecessary restrictions. It is not simply about getting rid of problematic behaviour. PBS is a person-centred approach for providing long-term support to people who have, or may be at risk of developing, behaviours that challenge. It is a blend of person-centred values and behavioural science and uses evidence to inform decision making. PBS is based on a set of overarching values which include the commitment to providing support that promotes inclusion, choice, participation and equality of opportunity.

Fundamental to this approach is the belief that all behaviour is communication and all behaviour happens for a reason. Distress behaviour or behaviour that challenges others may be a person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life and reduce the likelihood of distress or challenging behaviour.

Positive Behaviour Support has several primary, secondary and tertiary approaches which include:

- Considering the person and their life circumstances including physical health and emotional needs such as the impact of any traumatic or adverse life events and mental illness, physical ill health or disability
- Reducing the likelihood of behaviours that challenge by creating physical and social environments that are supportive and capable of meeting people's needs
- Being proactive and preventive by teaching people new skills to replace behaviours that challenge
- Developing other skills and enhancing the opportunities people have for independent, interesting and meaningful lives
- Agreeing tertiary (crisis/reactive) strategies which help keep everyone safe if the challenging behaviour presents a risk to self or others, provided any restrictive practices agreed are the least restrictive and most appropriate to the person

One core part of PBS involves assessing the individual and their behaviour to help understand why the behaviour happens, how the behaviour has been learned and how it is maintained. This process is called functional assessment. Once the reason for the behaviour has been identified, a personal plan is co-produced with the individual and their carers and followed by everyone involved in supporting the person.

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

04 Section | Person-Centred, Trauma-Informed Care

Trauma is the experience of violence and victimisation including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disaster. This includes direct experience of the traumatic event; witnessing the traumatic event in person; learning that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or first-hand repeated or extreme exposure to aversive details of the traumatic event. The most harmful trauma experiences tend to be those perpetrated by someone close—someone well-known to the victim—and/or intentional, repeated and prolonged.

The earlier in life trauma happens, the more profound the impact on brain development. People who have experienced trauma in early childhood (sometimes called Adverse Childhood Experiences or ACEs) often struggle to self-regulate and seem to always to be in a state of high alert to protect themselves from remembered harmful experiences. This is their automatic, learned response and not signs of pathology, rather, **they are survival strategies that have helped them cope** with terrible pain and challenges. Trauma-informed care involves 'universal precautions' based on an assumption that the people who use services have a history of trauma which can present behaviourally in many ways including:

- Anxiety, depression
- Substance abuse
- Self-injury
- Eating problems
- Poor judgement and continued cycle of victimisation
- Flashbacks, nightmares and hyper-vigilance
- Terror
- Auditory hallucinations
- Difficulty with problem solving
- Aggression

Trauma-informed care focuses on 'what happened to the person' instead of 'what's wrong with the person' and helps staff understand how the person's behaviour developed, how this impacts on the person now, and how to help the person develop new coping strategies. When taking a trauma-informed approach, it is important for staff to reflect on their own behaviours and responses to individuals (what CPI calls the Integrated Experience) by being aware of how their approach may adversely impact on the person.

- **Triggers.** Staff approaches, the environment or situation may trigger self-protection responses (e.g. sights, sounds, smells, tone of voice and touches may remind the person of their trauma).
- **Flashbacks.** Situations may trigger recurring memories, feelings and thoughts associated with the trauma.
- **Traumatic stress** brings the past to the present and can trigger a response of intense fear, horror and helplessness in which extreme stress overwhelms one's capacity to cope.

CPI programmes include the use of the **My Safety and Support Plan** developed in partnership with people who have a lived experience of restraint to help services develop a person-centred, trauma-informed approach. The plan integrates some of the concepts from the Models for Eliminating or Minimising the Use of Restrictive Practices and Trauma-Informed Care to help staff work with users to personalise care and support.

The plan follows the CPI four-stage model and integrates each level of the *Crisis Development Model*℠ to guide staff to use the right approaches for the person and minimise the likelihood of risk behaviour escalating and restrictive practices being used.

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

05 Section | Lived Experience

Although the use of restrictive practices is sometimes necessary, be mindful of the impact such interventions have on the person. Not only is the event itself distressing, but restrictive practices can reinforce previous trauma in the person's life—leaving a lasting adverse impact. Although it may not be possible to eliminate all restrictive practices, it is important that such practices are trauma sensitive and aimed at maximising safety and minimising harm.

Below is a short account from a person with a history of trauma who has a lived experience of restrictive practices (to maintain confidentiality, the name of the person has been changed). Laura has a history of trauma involving physical, psychological and sexual abuse from immediate family and family associates. She spent much of her childhood in foster care and children's homes resulting in intermittent mental ill health and admission into hospital under the Mental Health Act.

I have been physically restrained and placed into seclusion many times in hospital when my mental and physical health has deteriorated. Due to a range of physical, psychological and sexual abuse I encountered in my childhood my mental health would deteriorate and, at times, I would put myself and others at risk of harm. As a consequence, I have been frequently restrained and put into seclusion.

I know staff must keep everyone safe, but I always felt that the use of restraint and seclusion became a routine part of my care—an automatic reaction by staff regardless of my behaviour. It felt like there was an expectation that I would need to be restrained and secluded. When admitted into hospital, I would beg staff not to restrain me and not to close the door and lock me in the seclusion room. I suppose it was the fear—fear from my past, fear of what was happening in the present and fear of what would happen in the future. I would become anxious about who was going to come back through the door. When would it happen? And what would they do once they came back? I was so scared, I would wet myself or vomit.

I would ask myself 'why'? Why couldn't the staff see my non-verbal distress, my silence, my tears, my fear and panic? Despite my plea not to be restrained and locked in, why did they ignore me? Why didn't they offer me an alternative; why were they so focused on achieving an outcome that was right for them but not me?

The few times I did speak, I would say, 'Please don't hurt me again tonight'. I would sit in the corner of the room. I would be good. I would be quiet and just wait . . . and wait. . . and wait. I would sit and stare at the door handle. I always knew when the insensitive, nasty or cruel staff were coming in, just by the way the door handle moved. It's easy to see the nice staff—they can't help but let you know through their behaviour, the way they look at you, the way they approach you, the way they listen, the way they smile and the way they speak.

Those events still live with me today. Unless I really must, I never sit with my back to the door. I don't like small spaces and don't like to be locked in anywhere—even everyday places you wouldn't think about such as toilets or cars. I feel very anxious when speaking to people and I'm very conscious about people's non-verbal behaviour as certain expressions remind me of my trauma history.

Please share my words and my thoughts. They are true and the events I experienced were re-traumatising and, even today through my recovery, have a massive impact on me. I am on a hiding to nothing. People like me, with a lifetime of labels are never allowed to have normal feelings like everyone else, like staff:

Staff are creative and find ways to get what they want or need. They refuse to do things on professional grounds or because of their personal views which must be respected – ***I'm manipulative and non-compliant.***

Staff raise their voice to be heard or out of frustration. They become animated out of passion or commitment – ***I'm agitated, aggressive and threatening.***

Staff get frustrated and stressed because of work or home pressures, or because of the challenges they face – ***my behaviour is simply a symptom of my deteriorating mental health.***

Staff become disheartened because of the way they have been treated by a stranger, a friend, a colleague, a manager or because they must deal with people like me every day – ***I get depressed, angry or pissed off on purpose, because of my illness or because I'm mad and bad.***

Staff behaviour and feelings are always just – ***my behaviour and feelings are always unjust*** *–* ***I have no mitigation; it's always my illness; it's always my fault.***

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

Section 06 | A Human Rights Approach to Reducing Restrictive Practices

It is important that organisations do everything they can to eliminate restrictive practices and ensure that when restrictive practices are necessary, they are 'exception events' used to manage risk behaviour. When restrictive practices are used, the aim should be to maximise safety and minimise harm.

Historically, restrictive practices in all settings have been misused so taking a human rights approach can help services ensure abuse is avoided. The organisation should provide staff, users and families with clear information regarding when restrictive practices may be used as well as specify which restrictive practices are considered acceptable.

Ensure that staff, users and families know that restrictive practices should never be used as a punishment, and never be used to force compliance with rules. The British Institute of Human Rights (2013) published a framework to help staff think about how human rights can underpin professional practice. The PANEL principles help staff consider how best to support people who present behaviours that challenge services.

Key Principle	What This Means	What This Looks Like
Participation	Enabling participation of all key people and stakeholders	Consulting with and involving people in their care and support
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights-based approach	Outlining responsibilities under the Mental Health Act and Mental Capacity Act, measuring quality of life outcomes against agreed standards
Non-Discrimination	Avoiding discrimination, paying attention to groups who are vulnerable to rights violations	Using person-centred approaches that do not discriminate, making sure staff are sensitive to culture and diversity
Empowerment	Empowering staff and people who use services with knowledge and skills to realise rights	Raising awareness through education and resources, explaining how human rights are affected by restrictive practices
Law	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying human rights implications of supporting people who challenge; considering fairness, respect, equality, dignity and autonomy

In addition to the human rights approach outlined in section 2 of this supplement, CPI can provide resources co-produced by people with a lived experience to reinforce the underpinning values of a person-centred, trauma-informed approach.

The CPI **Keep Me Safe, Treat Me With Respect** booklet and poster help explain the appropriate use of restrictive physical interventions taught within CPI programmes. Designed for service users and families, the Keep Me Safe booklet explains why and when a restrictive physical intervention may be used, when it should not be used and gives people help and advice on what to do if they feel any restrictive practice has been used unnecessarily.

Corrupted Cultures

Where restrictive practices are misused and abused, it is common to find that such practice develops within an organisation or staff team over time. Often, it is difficult to identify who, why, when and where abusive practices started, but the misuse and abuse of restrictive practices typically occurs in a 'corrupted culture'. Many people think that a corrupted culture develops because of the building services are in, so modernising buildings and changing where services are delivered is often seen as the way to prevent abusive practice. However, despite the closure of long stay hospitals, a greater focus on care in the community, integrated education, and personalised budgets, abusive practices continue to occur.

A corrupted culture is a working environment where staff adopt unethical, unprofessional and illegal action to gain benefit or to minimise harm. It develops as a result of the social values and culture within an organisation. This can be at an organisation-wide level, a team level or even individual staff level. Corrupted cultures are typically insidious, developing slowly with practice gradually becoming more and more abusive, often without the people within the organisation noticing until it becomes too late. Services that offer person-centred, trauma-informed support are less likely to develop corrupted cultures as their services and support are based on human rights and co-production. Organisations that recruit for values, train for values, coach and supervise for values and undertake performance management and disciplinary action for values are rarely corrupted.

Corrupted cultures have common characteristics and follow a similar path. This means that organisations, staff and families can look for the signs and act to identify each step so that corrective actions can be taken. Some common features include inequality and stigmatisation, isolation and a lack of external review, inexperienced workforce with low levels of knowledge and skill, poor working practices and values, poor leadership and management. A corrupted culture prioritises the needs of the workforce over the needs of users and families who access the service and authorises coercive and restrictive practices as a means of control. Examine the six steps and consider where your organisation is on this journey to corruption. Think about what you can do to raise concern so that the journey is reversed.

CPI's Five Steps to a Corrupted Culture

Step 1: Us and Them
At the start of the journey to corruption, organisations and their staff find ways to depersonalise, stigmatise and de-value the people they are there to support. Emphasis is placed on difference, and similarities are dismissed. Behaviour is negatively labelled 'deviant,' and a level of threat is reinforced to dehumanise people.

Step 2: Control
Once a difference is created ('Us and Them'), rules establish an imbalance of power. Those with power ('Us') enforce the rules. Those without power ('them') follow the rules so that rules are used to create a culture of control. Basic human rights are denied, instead creating a range of 'privileges' which have to be earned and which can be taken away.

Step 3: Do Harm
Use degrading and dehumanising language and practices in ways that those with control ('Us') would not accept. Emphasise risk as the justification for the degrading and dehumanising practices and find creative ways to manage and contain people with coercion and restrictive practices. Justify excessive restriction and approaches which may breach people's human rights on the basis that it's the only way to manage 'Them'.

Step 4: Apathy
Stand by and watch it happen because the organisational whistle blowing procedures are ineffective. Accept the fact that you are a lone voice, and no one will listen to your concerns. Become tolerant of abusive practices and find excuses to justify them. Normalise practice (e.g., 'it's the only way'; 'we have no choice'; 'you don't know how difficult these people are'; 'we support those people no one else can work with').

Step 5: Contain
Develop more ways to restrict, segregate and isolate people from their friends, families and from their wider community and society. Deny people their cultural and social heritage and strip people of their individual identities by ascribing non-human characteristics (e.g., 'she behaves like an animal; he has the strength of ten men'). Develop 'specialised services and support' that only certain staff can work in. Induct new staff to the 'culture' and remove those staff who don't conform or who challenge practice.

Personal Reflection
What have you learned? Why does this matter? What will you do differently? How will you apply this learning in your work?

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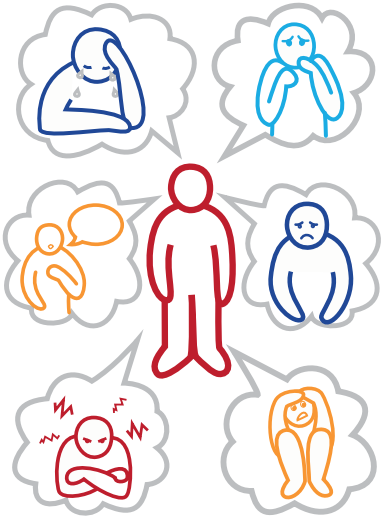
Keep Me Safe, Treat Me With Respect

An easy read guide on the use of restrictive interventions

Introduction

- If a restrictive intervention is used when you are distressed, you need to have the facts about the help and support that you receive.
- This guide provides facts that you, your family, or others may need to know.
- If you are distressed, staff need to keep you safe. They can use restrictive interventions as long as they do not breach your human rights.
- Use this guide to talk about how the use of restrictive interventions may affect you.

What happens if you become distressed?



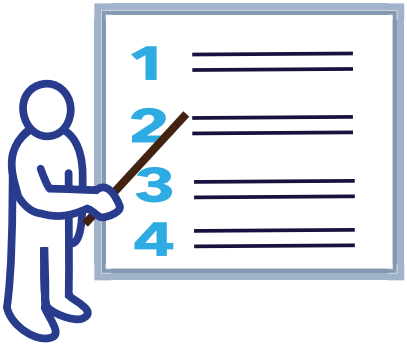
- Behaviour is what we say and do. It's how we communicate.
- When people are scared, anxious, upset, alone, or angry, these feelings can lead to a loss of control. We call this distress behaviour.
- We know that sometimes, distress is unavoidable.
- When people become very distressed and lose control, they can hurt themselves or others. Staff then have a duty of care and may use restrictive interventions to keep everyone safe.

What are restrictive interventions?

These are the actions staff are allowed to use to limit or restrict your liberty when you are distressed.

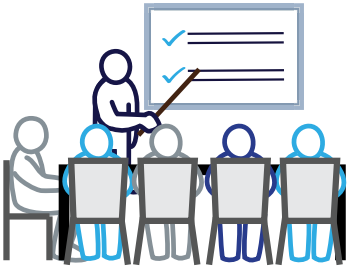
The four types are:

- **Physical:** when physical contact is made to limit or prevent your movement.
- **Chemical:** when you are given prescribed medication to reduce your distress.
- **Environmental:** when you are confined to a designated room or area to keep you away from others or to stop you leaving.
- **Mechanical:** when a device (e.g., a belt or cuff) is used to limit or prevent your movement.

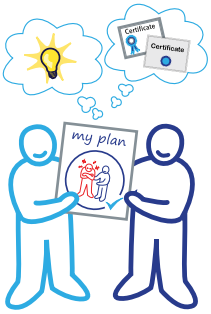


Staff will do everything to make sure the help and support you receive does not include restrictive interventions. If they do happen, it will be by exception.

What training do staff receive?

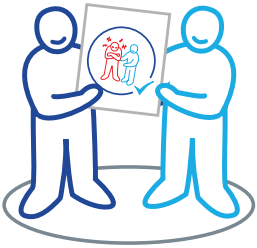


- Staff are highly skilled and experienced. They are trained to understand the causes of distress behaviour and to use a range of strategies so your distress doesn't increase.



- Staff are trained to help you manage the things that cause your distress. They can agree the help and support that you need. Then restrictive interventions can be avoided.

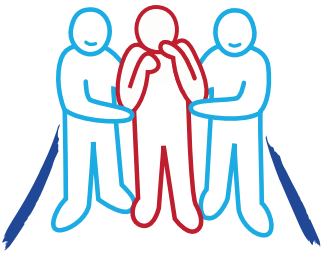
- If your distress behaviour causes harm, staff are trained to use restrictive interventions.



- Staff are trained to use the right approach for you. Staff will agree if any restrictive interventions are necessary to keep you safe.

When can staff use restrictive interventions?

- Staff are permitted to use restrictive interventions to keep you safe as long as they do not breach your human rights.

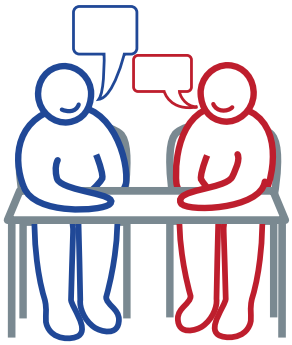


- Restrictive interventions should be:
  - A last resort
  - Least restrictive
  - Used for the shortest time possible
  - Used to maximise safety and minimise harm

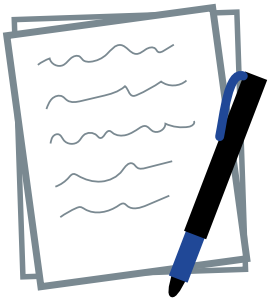
- Restrictive interventions should feel safe. They shouldn't cause pain or injury. They should never be used as a punishment or to enforce rules.

- If staff use restrictive interventions, they will always treat you with respect, dignity, and kindness.

What should happen after a restrictive intervention has been used?



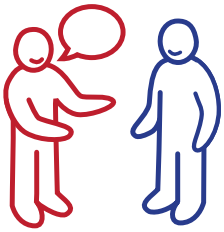
- Afterwards, someone should stay with you to make sure you are OK.



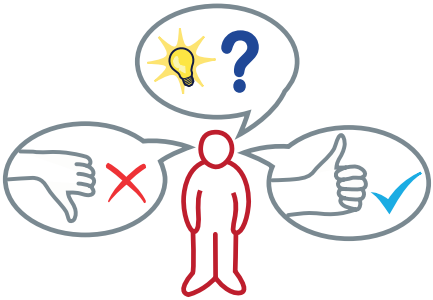
- Staff will record what happened.

- Talking helps everyone to think about improving your help and support. Then restrictive interventions can be avoided in the future.

What if I want to complain about the use of restrictive interventions?



- A member of staff is always there to listen.



- You have a right to question staff about the use of restrictive interventions.
- You have the right to complain if you feel restrictive interventions have been used in a way you think was unacceptable.

- If you are unsure who to speak to, you can seek additional help from an advocate. Advocates can get the information you need and make sure your rights are maintained.

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CPI would like to thank the REACH Project, ASIST Advocacy Services, and people with a lived experience of restrictive interventions who helped in the production of this easy read guide.

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My Safety and Support Plan

Name

Signature Date

Name of staff helping me to develop my plan

Signature Date

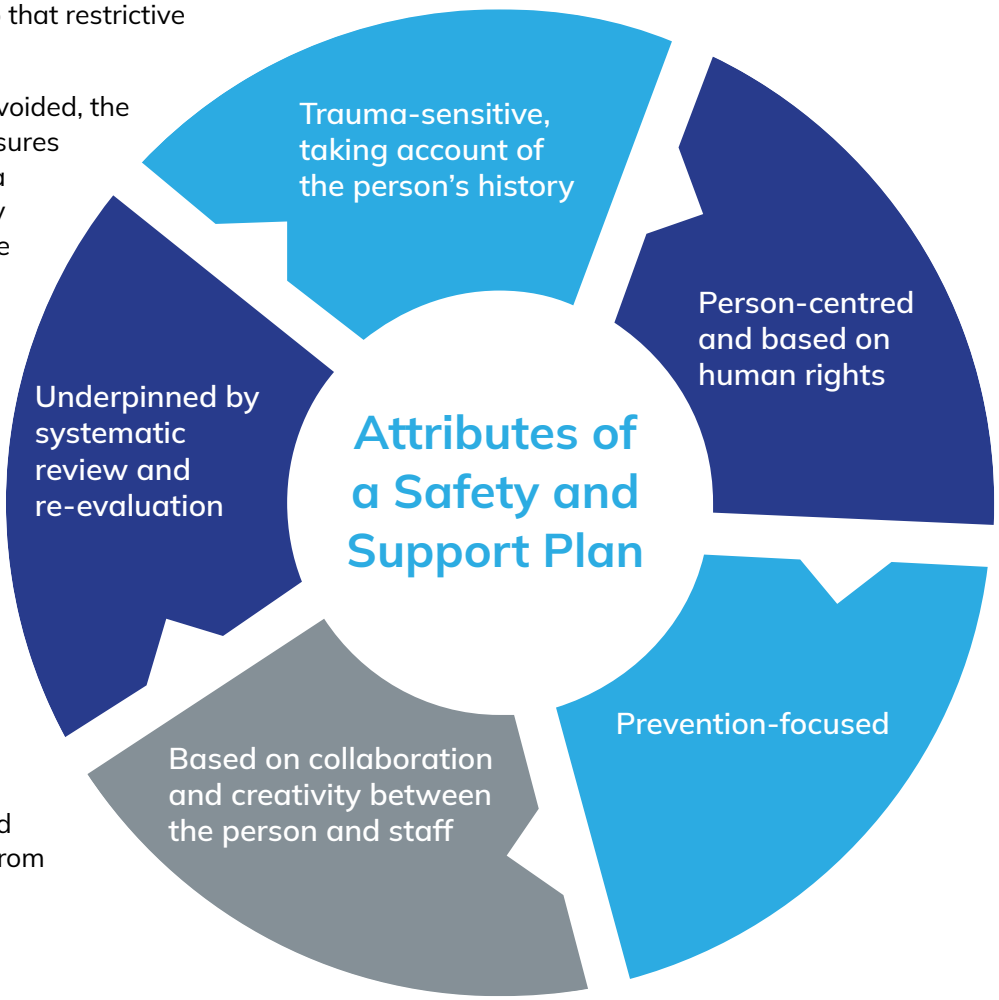
My Safety and Support Plan

The *My Safety and Support Plan* is an individualised plan that the person develops (with the help of staff if necessary) to ensure that potential crisis events are avoided. This should be written in easy-to-understand language so that all staff can implement the plan and provide the person with the necessary person-centred, trauma-sensitive care and support.

The plan's focus is to understand the person's history—their strengths, gifts, and abilities; their friends, family, and people that matter; the things that are important as well as the triggers that are likely to lead to crisis—so that such crisis events can be minimised and restrictive interventions avoided. Each person should have their own safety and support plan even if their behaviour is unlikely to escalate to crisis, since the plan helps staff to think about personalising the care and support they offer. The plan helps staff to avoid common conflicts and triggers that often underpin crisis events. It also enables staff to identify escalating behaviour. When staff recognise this behaviour, they can determine the appropriate person-centred interventions so that restrictive practices can be avoided.

When crisis events cannot be avoided, the *My Safety and Support Plan* ensures that staff continue to maintain a trauma-sensitive approach. Any agreed and necessary restrictive interventions continue to take account of the person's immediate needs and wishes in order to ensure that harm is minimised and to maintain the individual's *Care, Welfare, Safety, and Security*[SM].

The plan should be a 'live' document that is regularly revisited to ensure that staff understand how to provide good support to the person. The plan must always be reviewed after a crisis event has occurred so that further approaches can be implemented to prevent similar crisis events from happening again.



My Circle of Support

(The people who are important to me, my friends and the people who help and support me)

Primary Preventive Interventions

(Getting the right fit between my needs and my support)

What strengths, gifts, and qualities do I bring? *(Getting to know me)*

What is important to me? What works for me? *(What matters most to me right now, and in the immediate future: What makes for a good day; what keeps me safe and well; what keeps me active, engaged, and stimulated)*

What doesn't work for me? *(What makes for a bad day; what do I find unpleasant or distressing; what do I prefer to avoid)*

What does good care and support look like for me? *(Identify the 'best fit' in terms of the care and support I need to minimise the impact of Precipitating Factors; consider any previous traumatic events, so that the support provided is trauma-sensitive)*

Precipitating Factors/Triggers/Background Factors

(Internal and external factors which trigger or accelerate my risk or crisis behaviour)

My Precipitating Factors/Triggers *(My flash points, triggers, and common conflicts that cause my behaviour to escalate)*

Secondary Preventive Interventions

(What helps me to manage my triggers; what decelerates and de-escalates my risk or crisis behaviour)

Anxiety Level *(My known observable behaviours)*	**Supportive Approaches** *(My calming and support strategies)*
Defensive Level *(My known observable behaviours)*	**Directive Approaches** *(My calming and support strategies)*

Risk or Crisis Behaviour

(Crisis behaviour which is likely to cause harm to self or other

Risk Behaviour Level

My risk behaviours are:

The level of risk to myself and/or others is:

My preferred strategies to minimise harm are:

Any necessary restrictive interventions staff may need to use include:

To minimise trauma and distress when using restrictive interventions, staff should:

Post-Crisis Support

(My preferred way of managing my emotions after a crisis event)

Tension Reduction
After a crisis event, I prefer to:

Therapeutic Rapport
Support from staff should include:

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An Independent Review and Assessment of Risks Associated With the Safety Intervention Contained Within all CPI Training Programmes

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Keele University
United Kingdom

Date of Assessment
07.01.2019

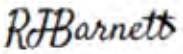
Personal Statement/Assessor Qualifications, Expertise and Experience

I am a qualified physiotherapist and currently work as a Lecturer in Physiotherapy at Keele University. In addition to this, I have a special interest in the safety aspects of safety interventions having previously trained as a Certified Instructor delivering training into NHS services and served as a member of the Restraint Advisory Board (RAB) for the Ministry of Justice (MoJ) and Youth Justice Board (YJB) between 2010 and 2012. My role within the RAB, which oversaw the development of a new restraint system for use across juvenile custodial setting called MMPR, was to give specific guidance on the physiological and anatomical safety of the physical techniques used. As a result of this work, I was asked to become a member of the Independent Restraint Advisory Panel (IRAP) within the MoJ as well as a member of YJB Serious Injuries and Warning Signs sub-committee (still a current member). I have undertaken several research projects and published peer reviewed articles around the safety of safety interventions (see bibliography), especially related to factors which are likely to increase or decrease adverse restraint-related outcomes.

I was a guideline writing member for the latest NICE guidance (NG10) published in 2015 and work as a guest lecturer at Wolverhampton University on the BSc in Restraint Reduction specialising in the anatomy and physiology of restraint.

Conflicts of Interests

I have undertaken the role of independent risk assessor to CPI since 2012 and jointly published research with Chris Stirling (CPI Senior Vice President). I am not a paid employee of CPI and I have not received any financial incentives or funding for my research from either CPI or Keele University.

Signed: 

Richard Barnett, MSc, BSc (Hons), HCPC, MHEA
Independent Risk Assessor

Assessment Moderation Panel

The assessment decision and conclusions in this report were independently moderated by the following people:

Dr Kevin Huckshorn	Assistant Hospital Administrator/Executive Director for Clinical Services at Bridgewater State Hospital, Bridgewater, MA, America.
Prof Joy Duxbury	Professor of Mental Health Nursing, University of Manchester, England.
Prof Bridget Hamilton	Associate Professor & Director, Centre for Psychiatric Nursing, University of Melbourne, Australia.
Dr Roger Almvik	Research Director, Centre for Research & Education in Forensic Psychiatry, St. Olav's University Hospital, Trondheim, Norway.
Dr Anna Bjorkdahl	Head of Clinical Development, Department of Psychiatry Stockholm South, Stockholm, Sweden.
Dr Colin Dale	Chief Executive, Caring Solutions, Consultancy for Mental Health and Learning Disability Services, Lancashire, England.
Brenda Crossley	Nurse Consultant, Crossley Hall Associates, Lancashire, England.
Ian Hall	Nurse Consultant, Crossley Hall Associates, Lancashire, England.

Risk Matrix and Descriptors

1. The methodology used in risk appraisal to determine the risk rating for each safety interventions is derived from the use of a 5 x 5 risk matrix, adapted from the NPSA 2008[3] considered with a range of other current evidence on the known risks associated with the use of restrictive safety interventionss[4-14]. The matrix provides an internationally well-recognised mechanism to provide risk ratings for adverse outcomes and comfortably fits the assessment of the restrictive safety interventions used in CPI programmes. A risk rating decision framework based upon the NPSA risk matrix further serves as a guide for Certified Instructors, Commissioning Organisations, staff and service users/families to provide a clear understanding of the risks associated with CPI restrictive safety interventions. The tables below provide descriptors for the risk variable (likelihood and consequence) as well as the overall risk rating matrix with a colour coding system for easy reference by the reader (see tables 1, 2 and 3 below).

Table 1 — Overall Risk Rating

LIKELIHOOD RATING	CONSEQUENCE				
	(a) Negligible	(b) Minor	(c) Moderate	(d) Major	(e) Catastrophic
1. Rare	(G)	(G)	(G)	(Y)	(Y)
2. Unlikely	(G)	(Y)	(Y)	(O)	(O)
3. Possible	(G)	(Y)	(O)	(O)	(R)
4. Likely	(Y)	(O)	(O)	(R)	(R)
5. Almost certain	(Y)	(O)	(R)	(R)	(R)

OVERALL RISK RATING GUIDE (colour code)			
Green (G)	Yellow (Y)	Orange (O)	Red (R)
Low Risk	Moderate Risk	High Risk	Extreme Risk

Table 2 — LIKELIHOOD Rating Descriptors

Lable	Descriptor
1. Rare	This will probably never happen
2. Unlikely	Do not expect it to happen/recur, but it is possible it may do so
3. Possible	Might happen or recur occasionally
4. Likely	Will probably happen/recur, but it is not a persisting issue
5. Almost certain	Will undoubtedly happen/recur, possibly frequently

Table 3 — CONSEQUENCE Rating Descriptors

Lable	Descriptor
(a) Negligible	Minimal injury requiring no/minor intervention or treatment
(b) Minor	Non-permanent minor injury or illness
(c) Moderate	Non-permanent moderate injury or illness
(d) Major	Major injury or long-term incapacity/disability
(e) Catastrophic	Incident leading to death or irreversible health effects

Risk Assessment for Disengagement Skills

1. The following tables summarise the risks associated with the use of the CPI Foundation Disengagements (table 4); the CPI Advanced Emergency and Rescue Responses for Adults (table 5); the CPI Foundation Disengagements for Older Adults (table 6); the CPI Foundation Disengagements for Early Years (table 7); and the CPI Foundation Disengagements for Children and Young People (table 8) based on the application of the anatomical and physiological principles which underpin these safety interventions..
2. Within each table, *Section 1* (left column) refers to the assessed risks that may apply to a service user, and *Section 2* (right column) refers to the assessed risks that may apply to staff carrying out the interventions. These tables provide information supplemental to individual risk assessments (both service users and staff) to aid in decision making in relation to the appropriateness of interventions used.

Table 4 – Risks associated with CPI Foundation Disengagements (Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Adults Application of the CPI Biomechanical Principles for Strikes (including items used as a weapon)											
Upper Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Lower Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Application of the CPI Biomechanical Principles for Low Risk Behaviour (Hold and Stabilise)											
Wrist	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Body	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Neck	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for Medium Risk Behaviour (Pull/Push)											
Wrist	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Body	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Neck	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1a	1a	2b	1a		2a	3a	3b	1a	1a
Application of the CPI Biomechanical Principles for High Risk Behaviour (Lever)											
Wrist	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Clothes	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Body	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Hair	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Neck	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Bite	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A

Table 5 – Risks associated with CPI Advanced Emergency and Rescue Responses (Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Adults Application of the CPI Biomechanical Principles for Extreme Risk Behaviour (CPI Emergency Escape Responses)											
Thumb	2b	3b	3b	1a	1a		2a	1a	1a	1a	1a
Dorsal Hand	2b	3b	1a	1a	1a		2a	1a	1a	1a	1a
Torso	2b	3b	1a	1a	1a		2a	1a	1a	1a	1a
Sternum	2b	3b	1a	1a	1a		2a	1a	1a	1a	1a
Mandible	2b	3b	1a	2b	1a		2a	3a	1a	1a	1a
Application of the CPI Biomechanical Principles for Extreme Risk Behaviour (CPI Emergency Rescue Responses)											
Nasal Columellar	2b	3b	1a	1a	1a		2a	1a	1a	1a	1a

Table 6 – Risks associated with CPI Foundation Disengagements (Older Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Older Adults Application of the CPI Biomechanical Principles for Strikes (including items used as a weapon)											
Upper Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Lower Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Application of the CPI Biomechanical Principles for Low Risk Behaviour (Hold and Stabilise)											
Wrist	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for Medium Risk Behaviour (Pull/Push)											
Wrist	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for High Risk Behaviour (Lever)											
Wrist	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Clothes	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Hair	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a

Table 7 – Risks associated with CPI Foundation Disengagements (Early Years)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Early Years Application of the CPI Biomechanical Principles for Strikes (including items used as a weapon)											
Upper Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Lower Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Application of the CPI Biomechanical Principles for Low Risk Behaviour (Hold and Stabilise)											
Wrist	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for Medium Risk Behaviour (Pull/Push)											
Wrist	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1a	1a	2b	1a		2a	3a	3b	1a	1a
Application of the CPI Biomechanical Principles for High Risk Behaviour (Lever)											
Wrist	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Clothes	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Hair	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a

Table 8 – Risks associated with CPI Foundation Disengagements (Children and Young People)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Children and Young People Application of the CPI Biomechanical Principles for Strikes (including items used as a weapon)											
Upper Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Lower Body	2b	3b	3b	1a	1a		2a	3b	3b	1a	1a
Application of the CPI Biomechanical Principles for Low Risk Behaviour (Hold and Stabilise)											
Wrist	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1b	1a	1a	1a		2a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for Medium Risk Behaviour (Pull/Push)											
Wrist	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Clothes	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Hair	2b	2a	1a	1a	1a		2a	1a	1a	1a	1a
Bite	2b	1a	1a	2b	1a		2a	3a	3b	1a	1a
Application of the CPI Biomechanical Principles for High Risk Behaviour (Lever)											
Wrist	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Clothes	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a
Hair	2b	2b	2b	1a	1a		2a	2b	2b	1a	1a

Control Measures

- Disengagement skills should only be taught and used in settings where the organisation provides explicit authorisation and approval for use, underpinned by clear policies and recording and reporting procedures which prevent misuse and/or abuse.
- When using disengagements, consideration should be given to known individual factors which may increase the residual risk rating requiring staff to moderate their response to maximise safety and minimise harm. These factors include but are not exclusively limited to considerations for age; gender; ethnicity; physical wellbeing; cognitive disabilities; psychological wellbeing including mental ill health, history of trauma and/or phobias; communication impairments; social and cultural factors; and alcohol and substance misuse (see CPI Document 'Risks of Restraint' for a detailed outline of the research on individual factors known to increase the risk of harm occurring).
- Prior to use, an individual behaviour support plan based on a person-specific risk assessment should be completed which identifies the known risk behaviours, known triggers, primary and secondary preventative approaches and the authorised and approved reactive disengagement skills. The behaviour support plan should identify any additional control measures which will maximise safety and minimise harm to the individual.
- When using disengagement skills as a response to risk behaviour, staff have an obligation to make an ongoing assessment of risk with subsequent reasonable adjustments in application by taking account of the person's behaviour and the circumstances of the event in order to maximise safety and minimise psychosocial, anatomical and physiological harm.
- Disengagements should only be considered as a response to risk behaviour and never to enforce compliance.
- Emergency escape or rescue disengagements are only suitable for adults presenting extreme risk behaviour to self or others and must only be used following organisational authorisation and approval. Emergency disengagements must never be used with children and young people, older adults or populations who may be described as frail or vulnerable.

Risk Assessment for Holding Skills

1. The following tables summarise the risks associated with the use of the CPI Foundation Holding Skills for Adults (table 9); the CPI Advanced Holding Skills for Adults (table 10); the CPI Foundation Holding Skills for Older Adults (table 11); the CPI Foundation Holding Skills for Early Years (table 12); the CPI Foundation Holding Skills for Children and Young People (table 13); and the CPI Advanced Holding Skills for Young People, which include Emergency Floor Holding (table 14). Table 15 summarises the risks associated with the use of CPI Clinical Holding Skills as they apply to typical clinical interventions for people of all ages.

2. The assessment rating for each skill set is based on the application of the CPI anatomical and physiological principles which underpin the application of these safety interventions. Within each table, Section 1 (left column) refers to the assessed risks when these interventions are applied to a service user, and Section 2 (right column) refers to the assessed risks in relation to the application of these interventions by staff.

3. These tables provide the necessary information to supplement the individual risk assessment for any individual service users who may be subject to such interventions. The information in tables can also be used by occupational health advisors when assessing the ability of employees to safely apply such interventions in the workplace as part of their employment role.

Table 9 – Risks associated with CPI Foundation Holding Skills (Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Adults Seated Holds using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles Standing Holds and Transitions using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	2b	2b	1a	1a		1a	2b	2b	1a	1a

Table 10: Risks associated with CPI Advanced Holding Skills (Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Adults Team Interventions, Moving People from Risk and Team Interventions for Fights											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Floor Transitions using Low, Medium and High Levels of Restriction (Standing to Supine)											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Floor Transitions using Low, Medium and High Levels of Restriction (Standing to Supported Prone)											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Emergency Holding Skills using High Levels of Restriction (CPI Supine Positionsm)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Emergency Holding Skills using High Levels of Restriction (CPI *Supported Prone Position*℠)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Emergency Holding Skills using High Levels of Restriction (CPI *Rapid Tranquilisation Position*℠)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Emergency Holding Skills using High Levels of Restriction (Seclusion Entry, Placement and Exit)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b

Table 11: Risks associated with CPI Foundation Holding Skills (Older Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Older Adults Seated Holds using Low, Medium and High Levels of Restriction for Distressed Behaviour of Concern											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles Standing Holds and Transitions using Low, Medium and High Levels of Restriction for Distressed Behaviour of Concern											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a

Table 12: Risks associated with CPI Foundation Holding Skills (Early Years)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Early Years Standing Holds using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles Seated Holds using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a

Table 13: Risks associated with CPI Foundation Holding Skills (Children and Young People)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Children and Young People Standing Holds and transitions using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles Seated Holds using Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	2b	2b	1a	1a		1a	2b	2b	1a	1a
Application of the CPI Biomechanical Principles Team Interventions, Moving People from Risk and Interventions for Fights											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Floor Transitions using Low, Medium and High Levels of Restriction (Standing to Floor – Seated or Supine)											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Floor Transitions using Low, Medium and High Levels of Restriction (Standing to Floor – Kneeling or Supported Prone)											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b

Table 14: Risks associated with CPI Foundation Holding Skills (Young People)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Young People Emergency Holding Skills using High Levels of Restriction (CPI *Supine Position*℠)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b
Application of the CPI Biomechanical Principles Emergency Holding Skills using High Levels of Restriction (CPI *Supported Prone Position*℠)											
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b

Table 15: Risks associated with CPI Clinical Holding Skills (Early years, Children and Young People, Adults, Older Adults)

Risk Parameter	Section 1: Application Risks to Service User						Section 2: Application Risks to Staff				
	Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)		Psychosocial	Soft tissue	Articular or bone	Respiratory (AB)	Cardiovascular (C)
Application of the CPI Biomechanical Principles: Bed/Trolley Transfer Low and Medium Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles: Upright, Recumbent, Supine and Lateral Positions Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Application of the CPI Biomechanical Principles for Specific Clinical Procedures: Oral and Nasal Sedation, Nasogastric Tube Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
High	1a	2b	2b	1a	1a		1a	2b	2b	1a	1a
Application of the CPI Biomechanical Principles for Specific Clinical Procedures: Intravenous Medication/Bloods Low, Medium and High Levels of Restriction											
Low	1a	1a	1a	1a	1a		1a	1a	1a	1a	1a
Medium	2a	2a	2a	2a	2a		2a	2a	2a	2a	2a
High	3b	3b	3b	3b	3b		3b	3b	3b	3b	3b

Control Measures

- Holding skills (physical restraint) should only be taught and used in settings where the organisation provides explicit authorisation and approval for use, underpinned by clear policies and recording and reporting procedures which prevent misuse and/or abuse.
- Prior to use, an individual behaviour support plan based on a person-specific risk assessment should be completed which identifies the known risk behaviours, known triggers, primary and secondary preventative approaches and the authorised and approved reactive holding skills. The behaviour support plan should identify any additional control measures which will maximise safety and minimise harm to the individual.
- The use of holding skills as a response to risk behaviour should be an exception event and not routine. When used as a response to manage risk behaviour, physical restraint should not typically exceed 10 minutes' duration, during which time staff should actively apply the CPI *Opt-Out Sequence*[SM] and consider non-physical alternatives to avoid prolonged use. Once 10 minutes is reached, staff should cease holding or actively seek a non-physical alternative as soon as is reasonably practicable in the circumstances.
- When using holding skills, consideration should be given to known individual factors which may increase the residual risk rating during real events requiring staff to moderate their response to maximise safety and minimise harm. These factors include but are not exclusively limited to considerations for age; gender; ethnicity; physical wellbeing; cognitive disabilities; psychological wellbeing including mental ill health, history of trauma and/or phobias; communication impairments; social and cultural factors; alcohol and substance misuse (see CPI Document 'Risks of Restraint' for a detailed outline of the research on individual factors known to increase the risk of harm).
- When using holding skills, staff have a professional and legal obligation to use the least restrictive response (i.e., the minimum level of restriction for the minimum amount of time). As part of the ongoing assessment of risk, staff must make reasonable adjustments in application, taking account of the person's on-going behaviour and the circumstances of the event in order to continue to maximise safety and minimise harm.
- When using holding skills, avoid contact with the nose, mouth or neck; do not excessively flex the upper body (i.e. bend the person forward); and do not apply pressure to the chest or abdomen as this will impair the person's airway, breathing and/or circulation, thereby increasing the likelihood of respiratory and/or cardiovascular compromise.
- When using holding skills, avoid hyper-flexing or hyper-extending joints as this will increase likelihood of pain and injury.
- Staff trained in holding skills must be able to identify and respond to medical warning signs (see CPI Document 'Risks of Restraint').
- Staff trained in holding skills should also be trained (as a minimum) in Emergency First Aid (Immediate Life Support) in order to be able to respond appropriately to adverse incidents which may occur during and/or in close proximity to the application of safety interventions.

The following documents were used to inform this risk appraisal:

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15. Barnett, R., Green, M., Price, W., & Stirling, C. (in press). *An investigation into the physiological and psychological impact of supine and side-lying physical restraint techniques.*

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CPI *Safety Intervention*™

FOUNDATION

MAHI - STM - 105 - 705

Safe Participation Guidelines

INTRODUCTION | CPI Nonviolent Crisis Intervention® Training

Safe Participation Guidelines

Your active and safe participation is critical for achieving successful outcomes from this training. At the start of the day, you are required to sign in as confirmation that you are fit to participate and that you will take responsibility for the *Care, Welfare, Safety, and Security*℠ of yourself and others by adhering to these safety rules.

I will:

- Be professional and respectful of everyone in the classroom.
- Notify the Instructor of any past injuries or concerns I have about performing activities either before class or at the first opportunity.
- Accept the Instructor's guidance and follow any adaptations necessary for my safe participation, including not taking part in an activity if it compromises my safety or the safety of others.
- Follow the Instructor's directions and only perform activities when asked to do so. If for any reason I feel unable to safely participate, I will discuss it with the Instructor.
- Immediately stop any classroom activity when asked to do so, for any reason, by the Instructor or any participant.
- Not engage in any activity that is likely to disrupt learning, offend others, or cause harm or injury to self or others.
- Report all injuries and accidents immediately so a formal record can be made.
- Maintain my legal responsibilities regarding confidentiality and not share information that identifies any specific individual.

Participants will be taught a range of intervention skills and assessed for competent practice. Attendance in this event does not provide evidence that participants are competent to teach these skills to others. All CPI courses must be taught by a Certified Instructor licensed by CPI.

Participants who have any personal circumstances that may limit their participation in the course (physical or otherwise) must consult their manager prior to attendance. Where necessary, participants who may be limited in their participation must seek advice from their Occupational Health Department before attending.

Program Objectives

- Identify and know how to respond to various levels of crisis behaviors.
- Recognize how to manage your own consistent, calm behavior in order to influence a positive outcome in a crisis situation.
- Learn strategies to strengthen nonverbal communication.
- Develop limit-setting strategies when verbally intervening to de-escalate defensive behaviors.
- Learn safety intervention strategies to maximize safety and minimize harm.
- Explore the Physical Skills Review Framework and key legal and professional considerations when using restrictive interventions.
- Explore the *Decision-Making Matrix*℠ when assessing Risk Behavior.
- Demonstrate and practice non-restrictive and restrictive interventions that are consistent with a set of physiological principles.
- Explore a framework to help guide staff and the individuals in distress through a process of re-establishing the relationship.

Your active and safe participation is critical for achieving successful outcomes from this training.

WORKBOOK PAGE 3

Introduction

All **behaviour** is a form of **communication**.

CPI Values and Philosophy

CARE

Respect, dignity, empathy, person-centered

WELFARE

Maintaining independence, choice and well-being

SAFETY

Protecting rights and minimising harm

SECURITY

Safe, effective, harmonious and collaborative relationships

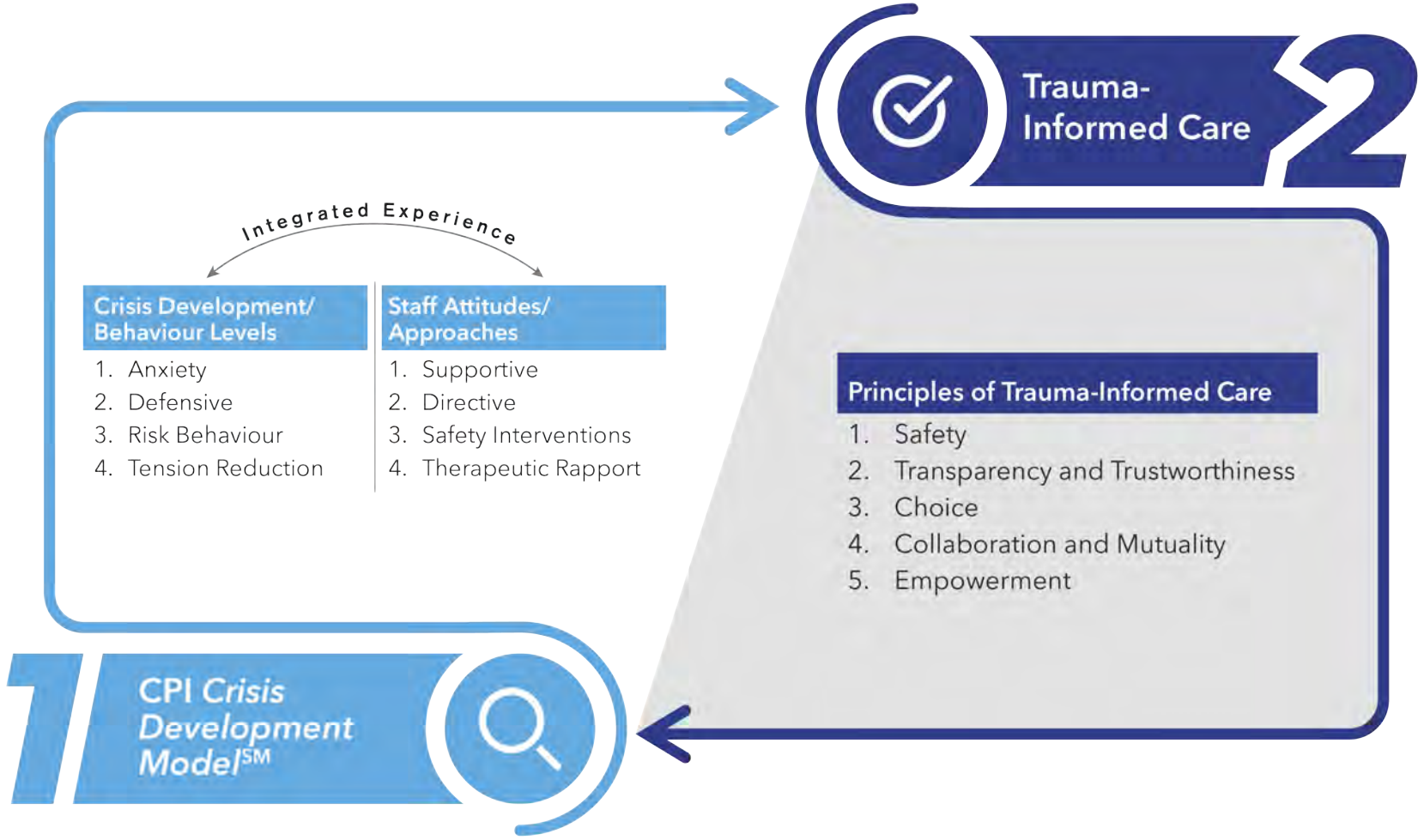
MODULE 1

The CPI *Crisis Development Model*SM

The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	4. Therapeutic Rapport

The CPI *Crisis Development Model*SM



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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	

A change in typical behaviour.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	**1. Supportive**

An empathic, non-judgemental approach.

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The CPI *Crisis Development Model*SM

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	**2. Directive**

Providing clear direction or instruction.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	

Behaviour that presents an imminent or immediate risk to self or others.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	**3. Safety Interventions**

Non-restrictive and restrictive strategies to maximise safety and minimise harm.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	

Decrease in physical and emotional energy.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	**4. Therapeutic Rapport**

Re-establish the relationship.

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The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	4. Therapeutic Rapport

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Activity: *Crisis Development Model*SM

Case Study – Choose your industry

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Activity: *Crisis Development Model*SM

Case Study – Healthcare

A patient waits to meet with a doctor. She's pacing, fidgeting with her phone, and constantly asking the receptionist where the doctor is. A nurse comes to collect preliminary information regarding her symptoms. When asked to have an X-ray taken, the patient immediately becomes verbally abusive. She refuses the procedure and argues, 'You just want to waste my time with unnecessary tests!' She belittles the nurse by calling her 'stupid' and saying, 'None of you know what you're doing.'

Continue

MAHI - STM - 105 - 722

Activity: *Crisis Development Model*SM

Case Study – Human Services

A client waits to meet with his case manager after riding the bus for over an hour. Due to his intellectual disabilities, he often becomes frustrated when trying to communicate his needs. He's pacing, fidgeting with his phone, and constantly asking the receptionist where his case manager is. The case manager arrives to discuss his support plan. While reviewing the plan, the client accuses the case manager of treating him like a baby because he feels the plan is too restrictive. The client continues screaming and making statements such as, 'You just want to control me!' and 'You can't make me!'

Continue

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Activity: *Crisis Development Model*SM

Activity Questions

- What behaviours/level of crisis did you see?
- What staff approach would you take?
- What would you say or do?

Knowledge Check

When an individual is demonstrating behaviours such as kicking and biting, they are displaying:

a. Anxiety

b. Defensive

c. Risk Behaviour

d. Tension Reduction

Knowledge Check

When an individual is demonstrating behaviours such as kicking and biting, they are displaying:

a. Anxiety

b. Defensive

c. Risk Behaviour

d. Tension Reduction

Knowledge Check

An individual is looking at the clock and pacing back and forth. What behaviour level is the person exhibiting?

a. Anxiety
b. Defensive
c. Risk Behaviour
d. Tension Reduction

Knowledge Check

An individual is looking at the clock and pacing back and forth. What behaviour level is the person exhibiting?

a. **Anxiety**
b. Defensive
c. Risk Behaviour
d. Tension Reduction

Knowledge Check

How would you respond to help an individual who is saying ‘no’ and refusing to perform a task?

a. Supportive words and attitude.

b. Call for help.

c. Provide choices with consequences.

d. Re-establish the relationship.

Knowledge Check

How would you respond to help an individual who is saying ‘no’ and refusing to perform a task?

a. Supportive words and attitude.

b. Call for help.

c. Provide choices with consequences.

d. Re-establish the relationship.

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Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

MODULE 2

Integrated Experience

Integrated Experience

Your **approach** changes **everything**.

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Integrated Experience

The CPI *Crisis Development Model*SM

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	4. Therapeutic Rapport

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INTEGRATED EXPERIENCE

Behaviour influences behaviour.

Principles of Trauma-Informed Care

- Safety
- Transparency and Trustworthiness
- Choice
- Collaboration and Mutuality
- Empowerment

Integrated Experience

What are factors that might negatively impact your ability to remain consistent and calm in your responses?

- ❑ Waking up late
- ❑ Lack of caffeine
- ❑ Not enough sleep
- ❑ Family stress
- ❑ Illness
- ❑ Trying to fit too much into one day
- ❑ Interpersonal conflicts at work
- ❑ Traffic jams
- ❑ Work dissatisfaction

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PRECIPITATING FACTORS

Factors influencing a person's behaviour.

Precipitating Factors

Understanding Precipitating Factors helps you to:

- Avoid becoming a Precipitating Factor yourself.
- Address the factors that lead to crisis situations.
- Not take crisis personally.

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RATIONAL DETACHMENT

Recognising the need to remain professional by managing your own behaviour and attitude.

Creating New Assumptions

- What is wrong with you?
- Victim
- Overreaction
- Dysfunction
- Difficult to deal with

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Rational Detachment

Observe the Behaviour

- What is the other person communicating?
- How am I responding?
- What am I expressing or conveying?
- How are they responding to me?

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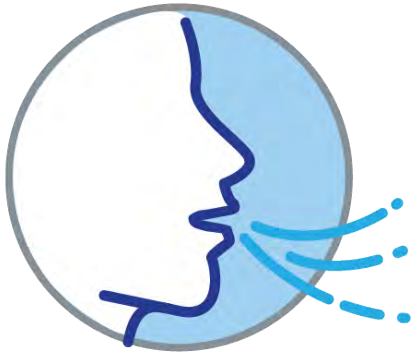
Rational Detachment Tips



Take a deep breath.

Choose your words carefully.

Ask for help.

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Activity: Identifying Triggers

Instructions:

Choose from the list below or write your own based on experiences with people you interact with. Write the factors in the **Triggers** column.

Determine how you can positively impact the Triggers. Write your responses in the **Positive Impact** column.

- Gender of staff
- Small spaces
- Touch
- Loud noises
- Emergency vehicles
- Crowded room
- Authority figures
- Limited feeling of control
- Physical appearance of staff
- Dimly lit spaces
- Noisy or stressful environment
- Memories

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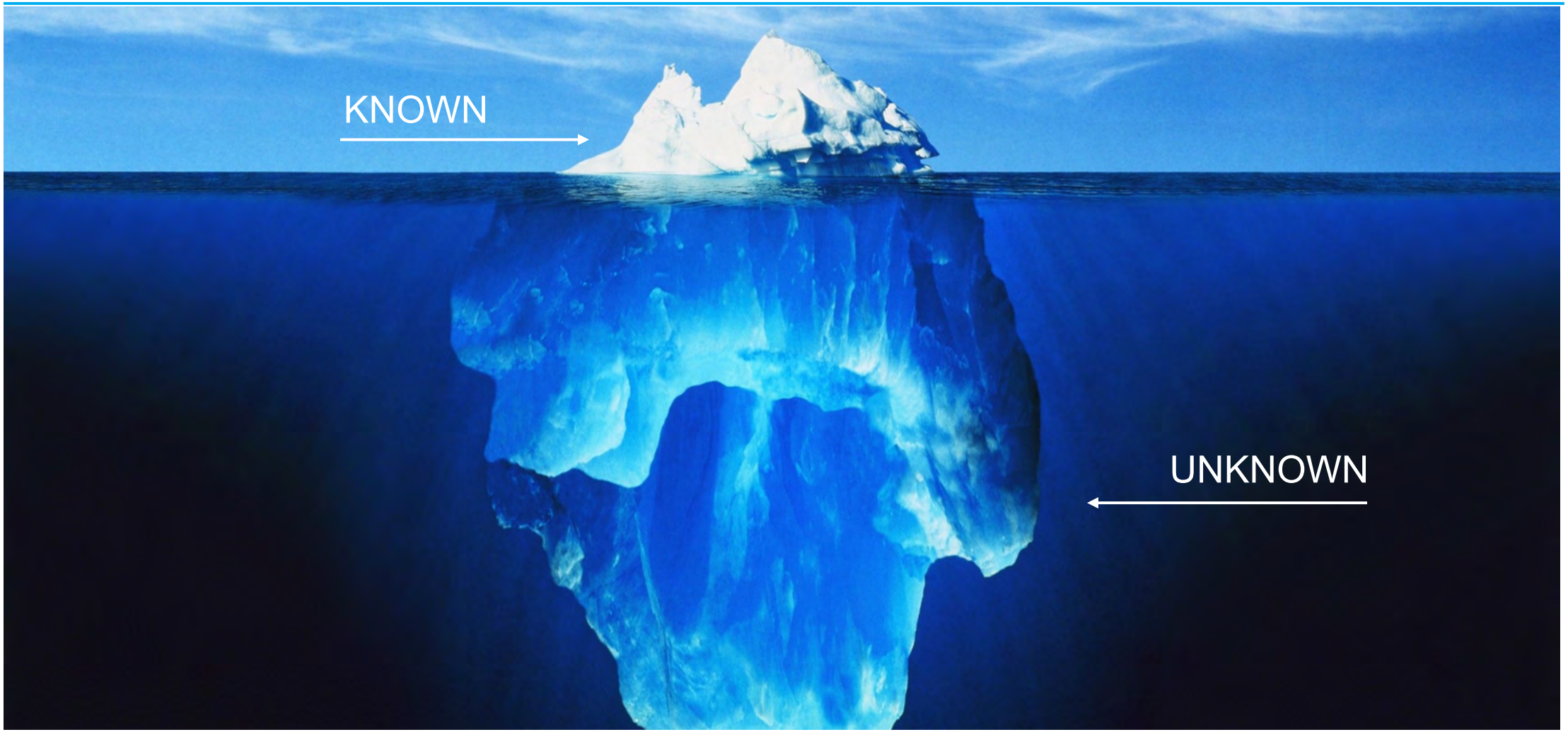
Integrated Experience



Knowledge Check

Which of the following best describes Rational Detachment?

a. The underlying reasons for behaviour

b. A staff response to calm someone

c. Maintaining your professionalism by not taking it personally

Knowledge Check

Which of the following best describes Rational Detachment?

a. The underlying reasons for behaviour

b. A staff response to calm someone

c. Maintaining your professionalism by not taking it personally

Knowledge Check

The Integrated Experience means that:

a. Change happens when you can control the behaviour
b. Behaviour influences behaviour
c. You should always match the other person's behaviour

Knowledge Check

The Integrated Experience means that:

a. Change happens when you can control the behaviour

b. Behaviour influences behaviour

c. You should always match the other person's behaviour

Knowledge Check

Precipitating Factors is a concept that refers to:

a. The underlying reasons for behaviour

b. An empathic, non-judgemental approach

c. Postures, gestures, facial expressions, and movement used to communicate

Knowledge Check

Precipitating Factors is a concept that refers to:

a. **The underlying reasons for behaviour**

b. An empathic, non-judgemental approach

c. Postures, gestures, facial expressions, and movement used to communicate

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Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

MODULE 3

Communication Skills

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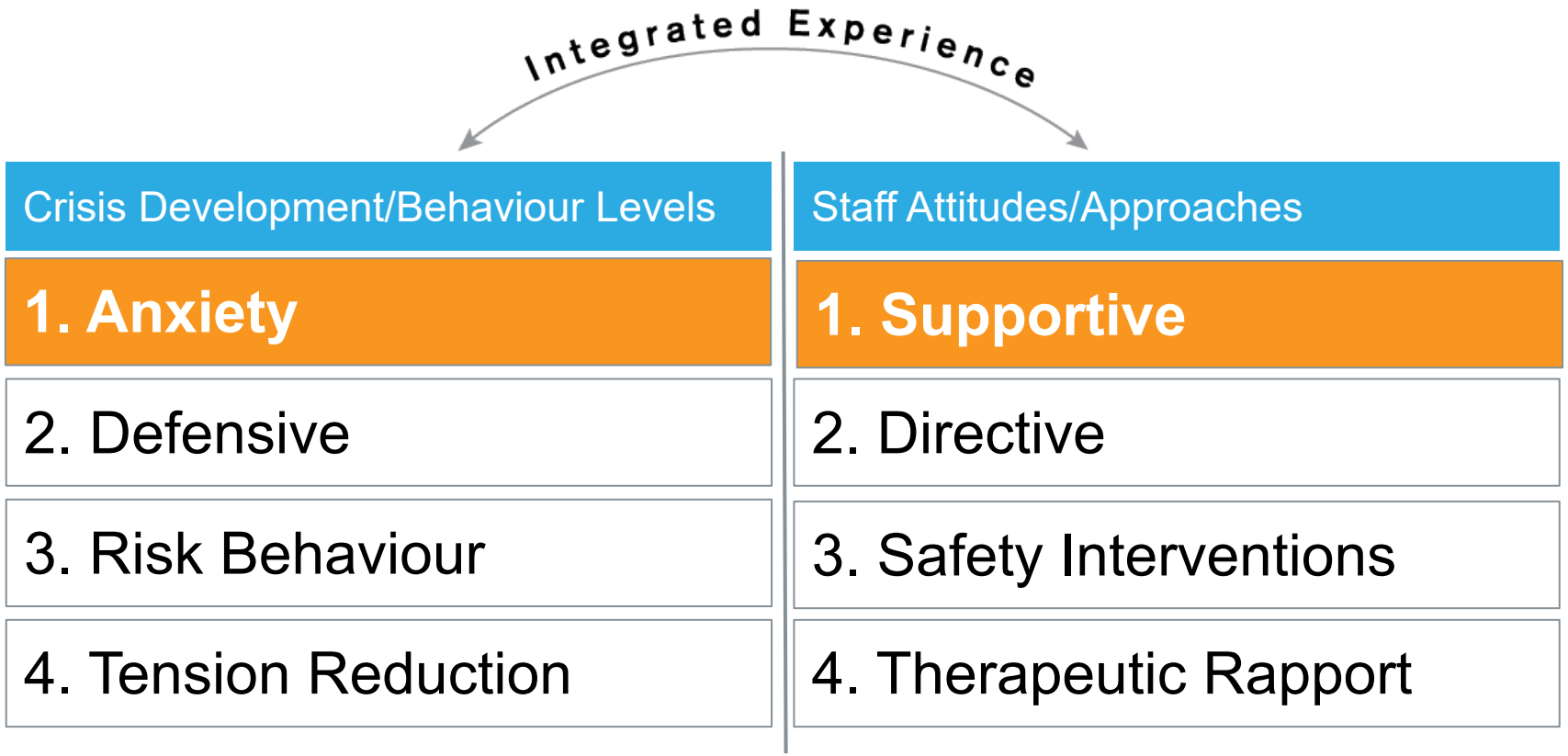
Communication Skills

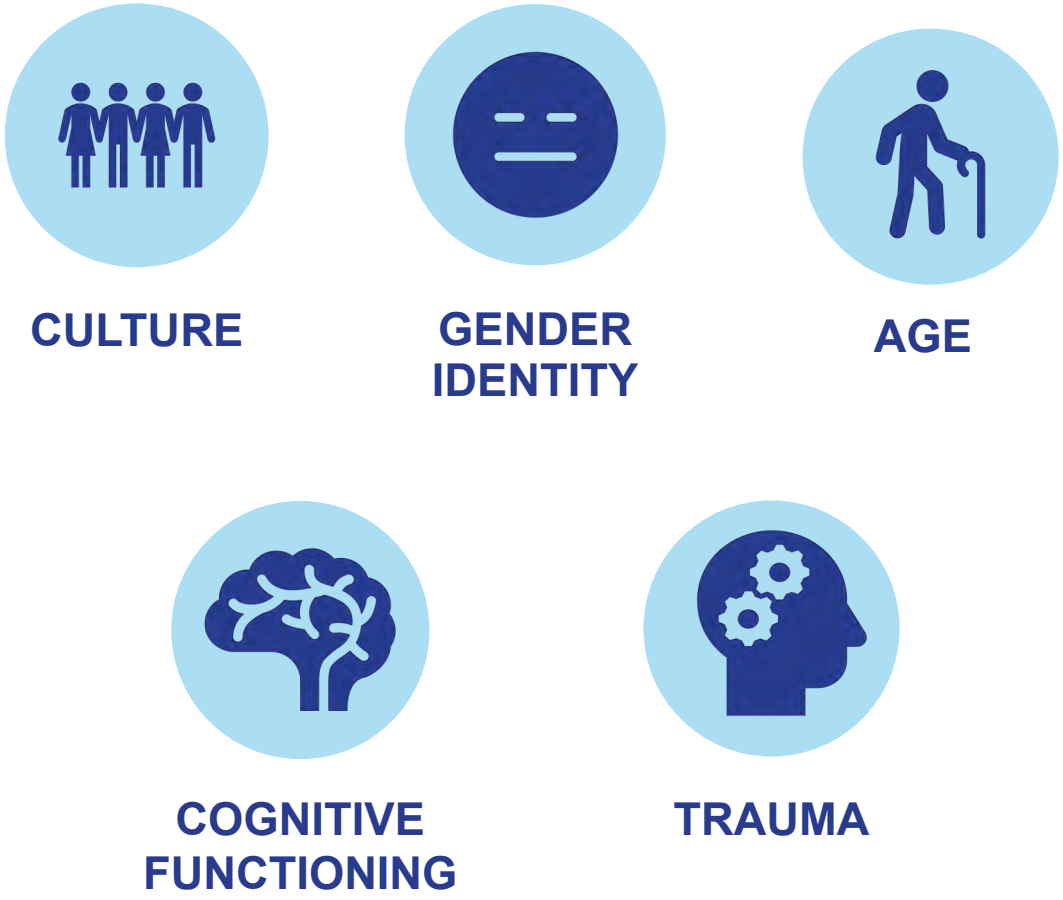
The CPI *Crisis Development Model*SM



Forms of Communication

- Verbal
- Paraverbal
- Non-Verbal

Communication Considerations



- How would you alter your communication when considering these factors?
- What about your postures or gestures?

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Verbal Communication

- Short, simple, clear
- Respectful
- Positively phrased

Instead of. . .

'You are not supposed to be in this area.'

Say. . .

'You seem lost. How may I help you?'

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Paraverbal Communication

TONE

VOLUME

RHYTHM OF SPEECH

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Paraverbal Communication Tips

- Use caring, supportive tones.
- Keep the volume appropriate to the situation.
- Deliver your message at a rate the person can process.

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Non-Verbal Communication

- Personal space
- Body language
- Communication through touch
- Listening with empathy

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Pop Question

Personal space is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

Pop Question

Personal space is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

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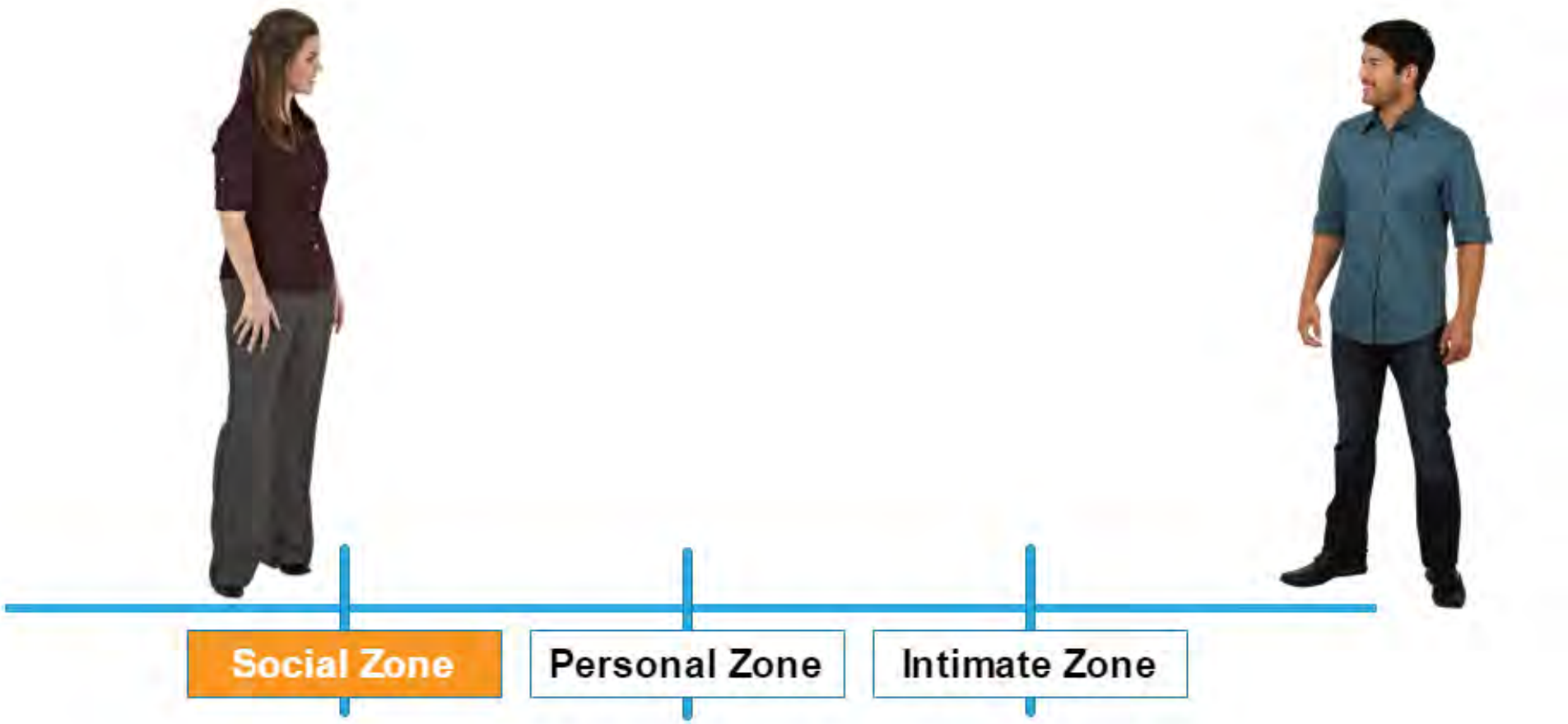
Social Zone



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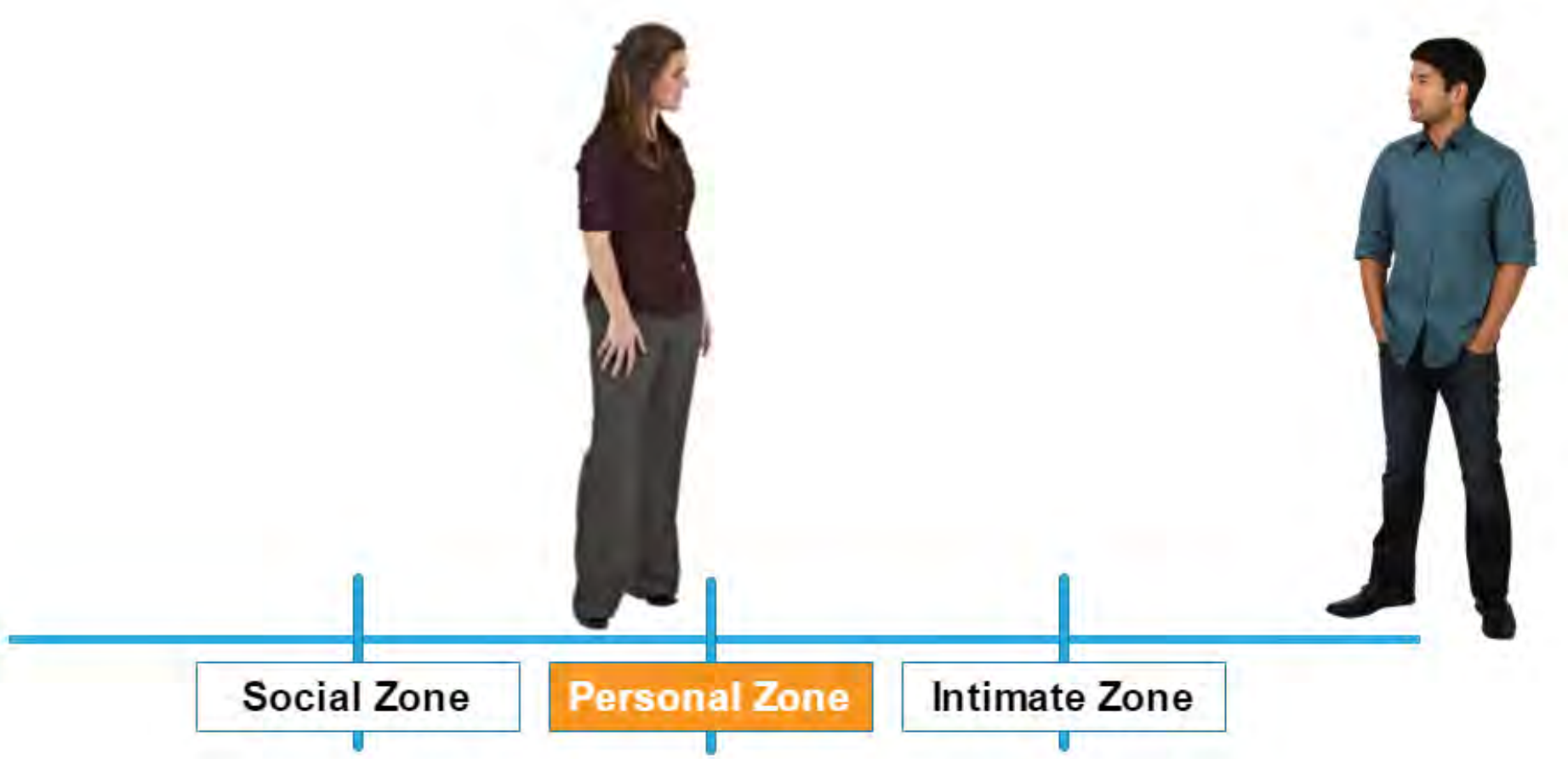
Personal Zone



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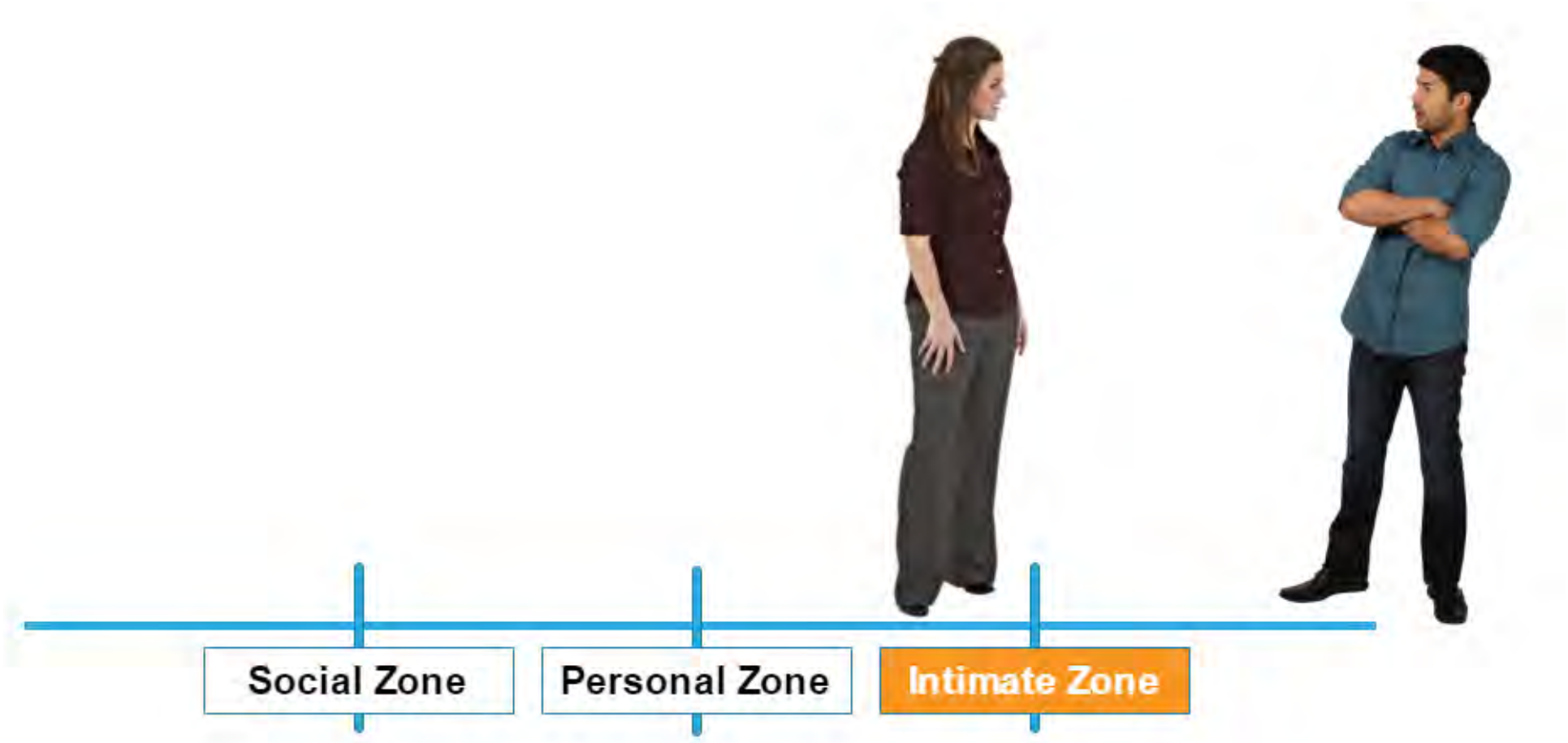
Intimate Zone



MAHI - STM - 105 - 765

Pop Question

Body language is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

MAHI - STM - 105 - 766

Pop Question

Body language is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

Communication Skills

When someone is anxious or defensive, how may their body language communicate this?

- ❑ Crossed arms
- ❑ Avoiding eye contact
- ❑ Slouching
- ❑ Fake smile
- ❑ Angling their body away from you
- ❑ Wringing hands

Communication Skills

When someone is anxious or defensive, how may their body language communicate this?

- ✓ Crossed arms
- ✓ Avoiding eye contact
- ✓ Slouching
- ✓ Fake smile
- ✓ Angling their body away from you
- ✓ Wringing hands

Pop Question

Communication through touch is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

Pop Question

Communication through touch is:

a. The postures, gestures, facial expressions, and movement used to communicate.

b. A form of physical contact that expresses feelings or emotion.

c. The distance people prefer to maintain between themselves and others.

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Communication Through Touch

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The *Supportive Stance*SM

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The *Supportive Stance*SM

Consider your position in relation to the person.

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The *Supportive Stance*SM

Be sure your posture remains non-threatening and relaxed.

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The *Supportive Stance*SM

Be sure to manage the distance between yourself and another person.

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The *Supportive Stance*SM

- Communicates respect
- Appears non-threatening
- Maximises safety

MAHI - STM - 105 - 777

Pop Question

Listening with empathy is:

a. Giving judgements and advice.

b. A way of listening and responding to another person that improves mutual understanding and trust.

c. Managing your approach in relation to the person.

MAHI - STM - 105 - 778

Pop Question

Listening with empathy is:

a. Giving judgements and advice.

b. A way of listening and responding to another person that improves mutual understanding and trust.

c. Managing your approach in relation to the person.

MAHI - STM - 105 - 779

Listening With Empathy

- Remain non-judgemental
- Give your undivided attention
- Listen to facts and feelings
- Allow time for silence and reflection
- Paraphrase what you understand

Knowledge Check

Which is a non-verbal, supportive response to a person in distress?

a. Limit setting

b. Respecting personal space

c. Downplaying the challenge

Knowledge Check

Which is a non-verbal, supportive response to a person in distress?

a. Limit setting

b. Respecting personal space

c. Downplaying the challenge

Knowledge Check

Which of the following is a paraverbal way of demonstrating support?

a. Your word choice

b. Your body language

c. Your tone of voice

Knowledge Check

Which of the following is a paraverbal way of demonstrating support?

a. Your word choice

b. Your body language

c. Your tone of voice

Knowledge Check

When demonstrating the *Supportive Stance*SM, think about your Position, Posture, and _____.

a. Power

b. Proximity

c. Personhood

Knowledge Check

When demonstrating the *Supportive Stance*SM, think about your Position, Posture, and _____.

a. Power

b. Proximity

c. Personhood

MAHI - STM - 105 - 786

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

MODULE 4

Responding to Defensive Behaviours

MAHI - STM - 105 - 788

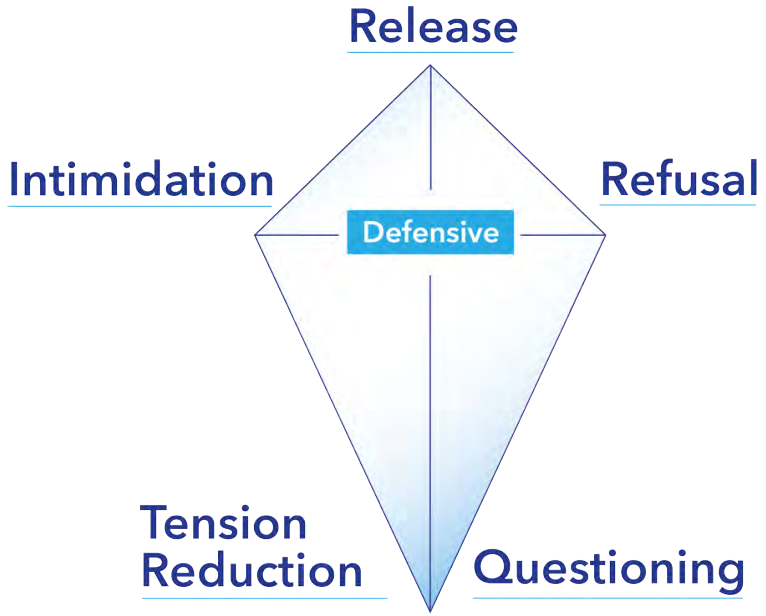
Defensive Behaviours and the *Verbal Escalation Continuum*SM

The CPI *Crisis Development Model*SM

Integrated Experience

Crisis Development/ Behaviour Levels	Staff Attitudes/ Approaches
1. Anxiety	1. Supportive
2. Defensive	**2. Directive**
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	4. Therapeutic Rapport

*Verbal Escalation Continuum*SM



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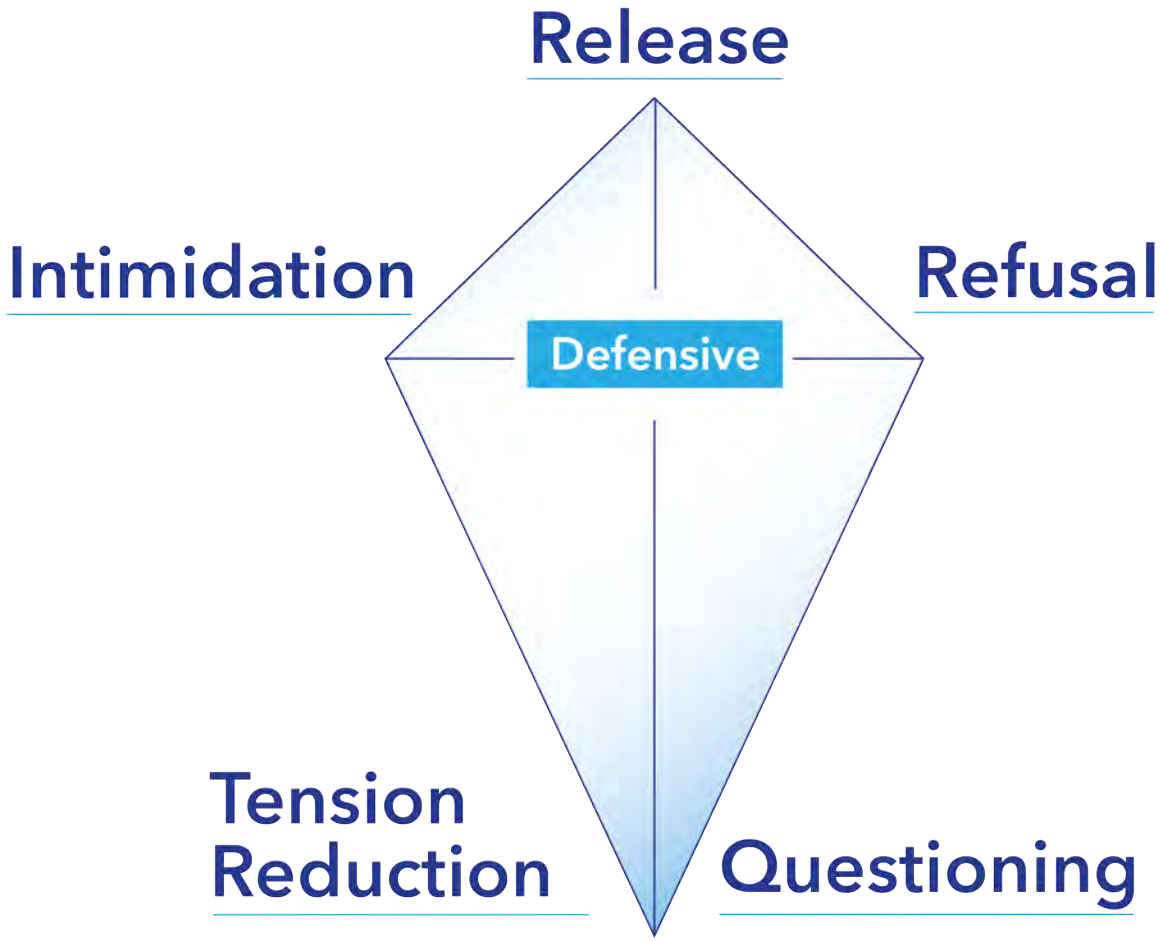
The *Verbal Escalation Continuum*SM



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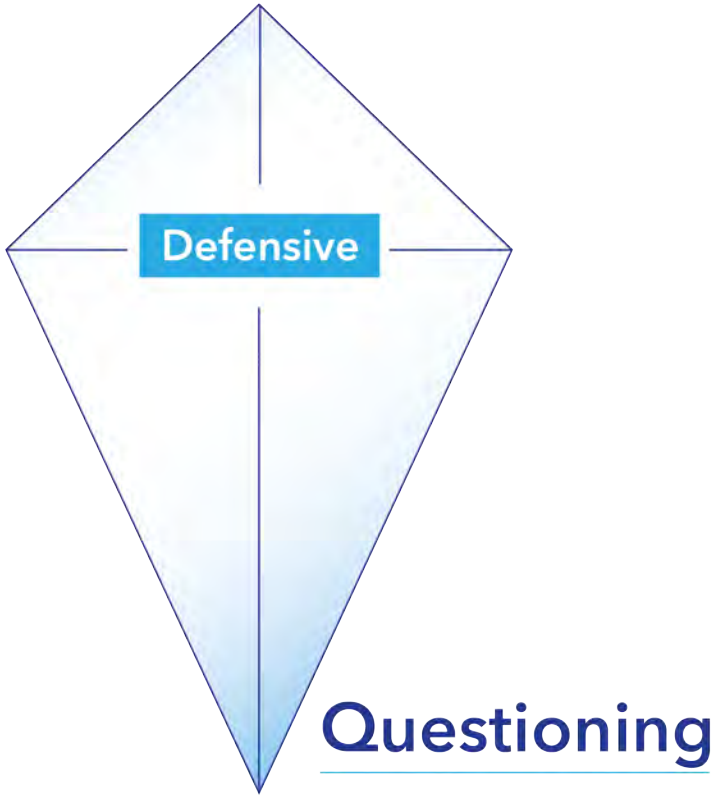
The *Verbal Escalation Continuum*SM



Questioning

INFORMATION-SEEKING

A rational question seeking a rational response.

STAFF INTERVENTION

Give a rational response.

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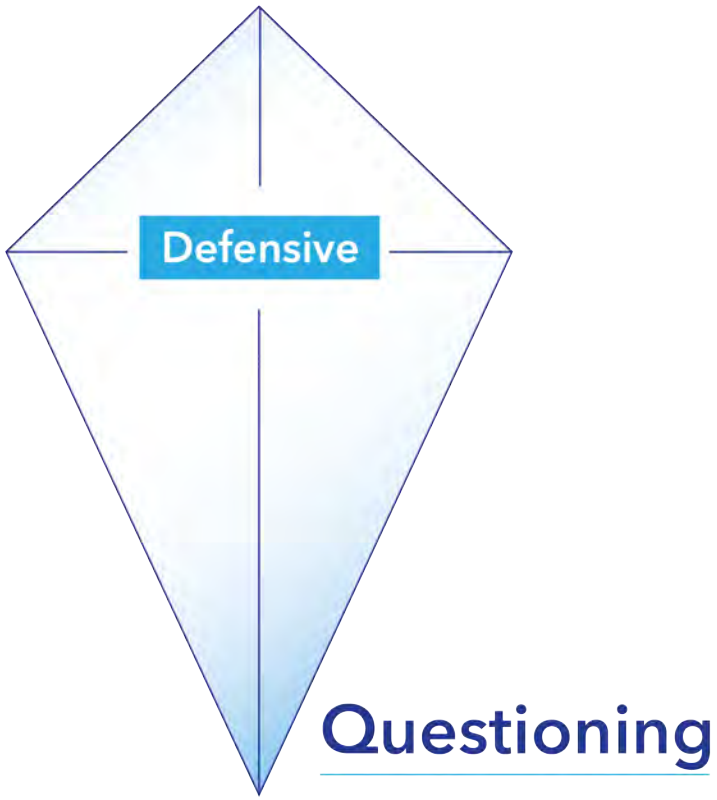
The *Verbal Escalation Continuum*SM



Questioning

CHALLENGING

Questioning authority; attempting to draw a staff into a power struggle.

STAFF INTERVENTION

Downplay the challenge. Stick to the topic.

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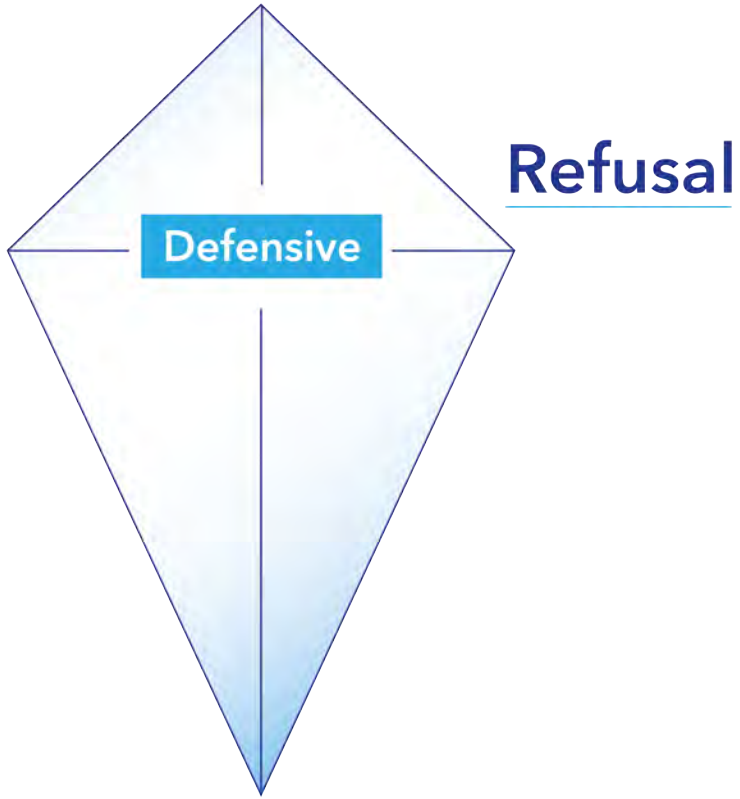
The *Verbal Escalation Continuum*SM



Refusal

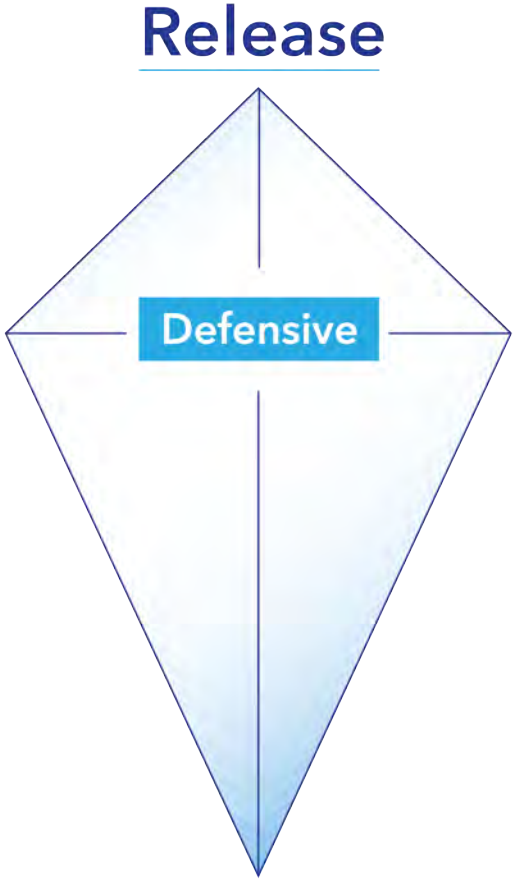
Unwillingness to cooperate or follow instructions.

STAFF INTERVENTION

Limit setting.

MAHI - STM - 105 - 793

The *Verbal Escalation Continuum*SM



Release

Verbal and emotional outburst; screaming, swearing, high-energy output.

STAFF INTERVENTION

Allow venting.

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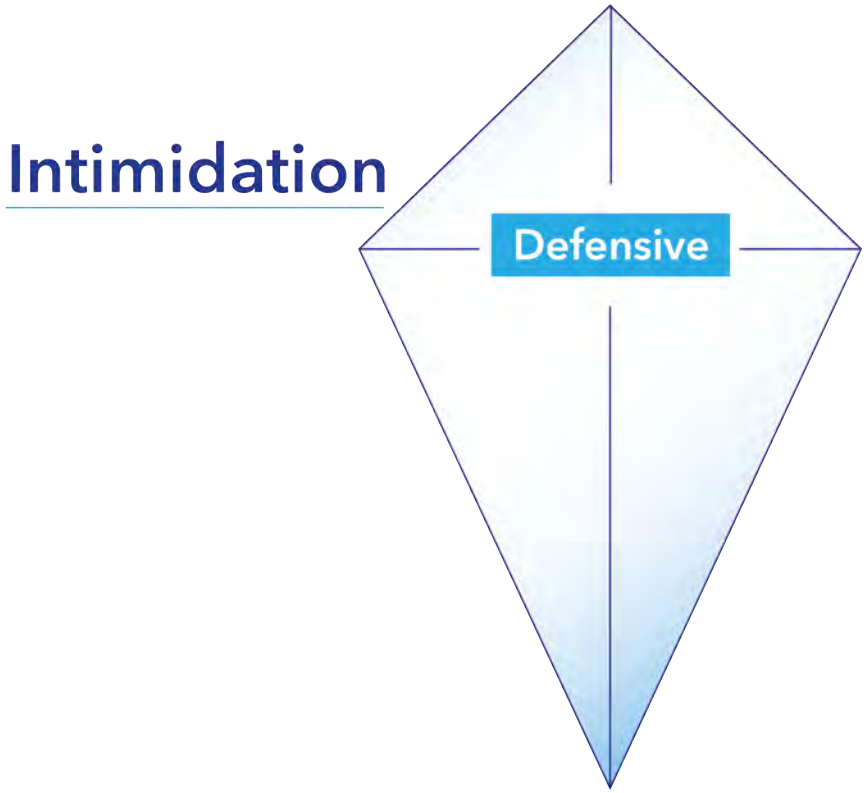
The *Verbal Escalation Continuum*SM



Intimidation

The individual is verbally and/or non-verbally threatening staff in some manner.

STAFF INTERVENTION

Take all threats seriously. Seek assistance.

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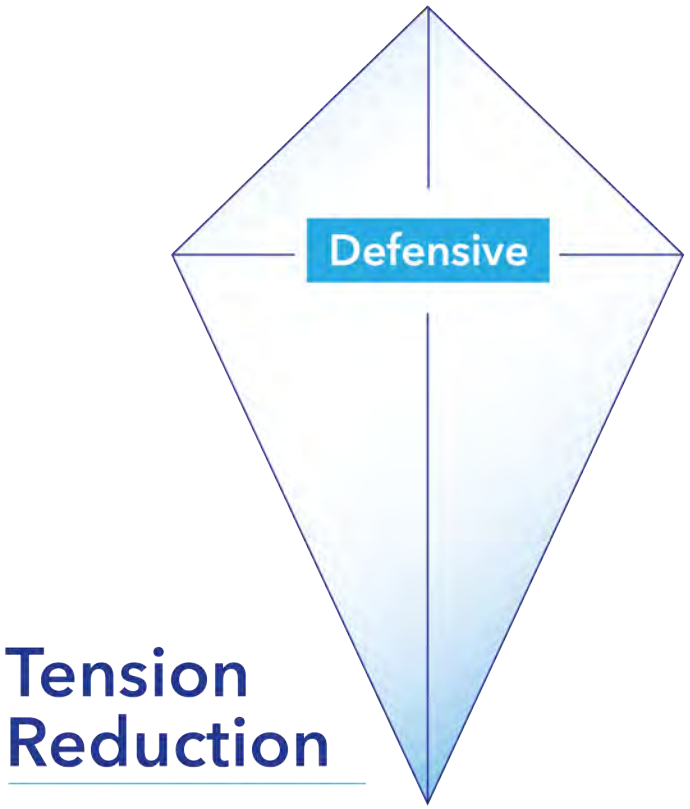
The *Verbal Escalation Continuum*SM



Tension Reduction

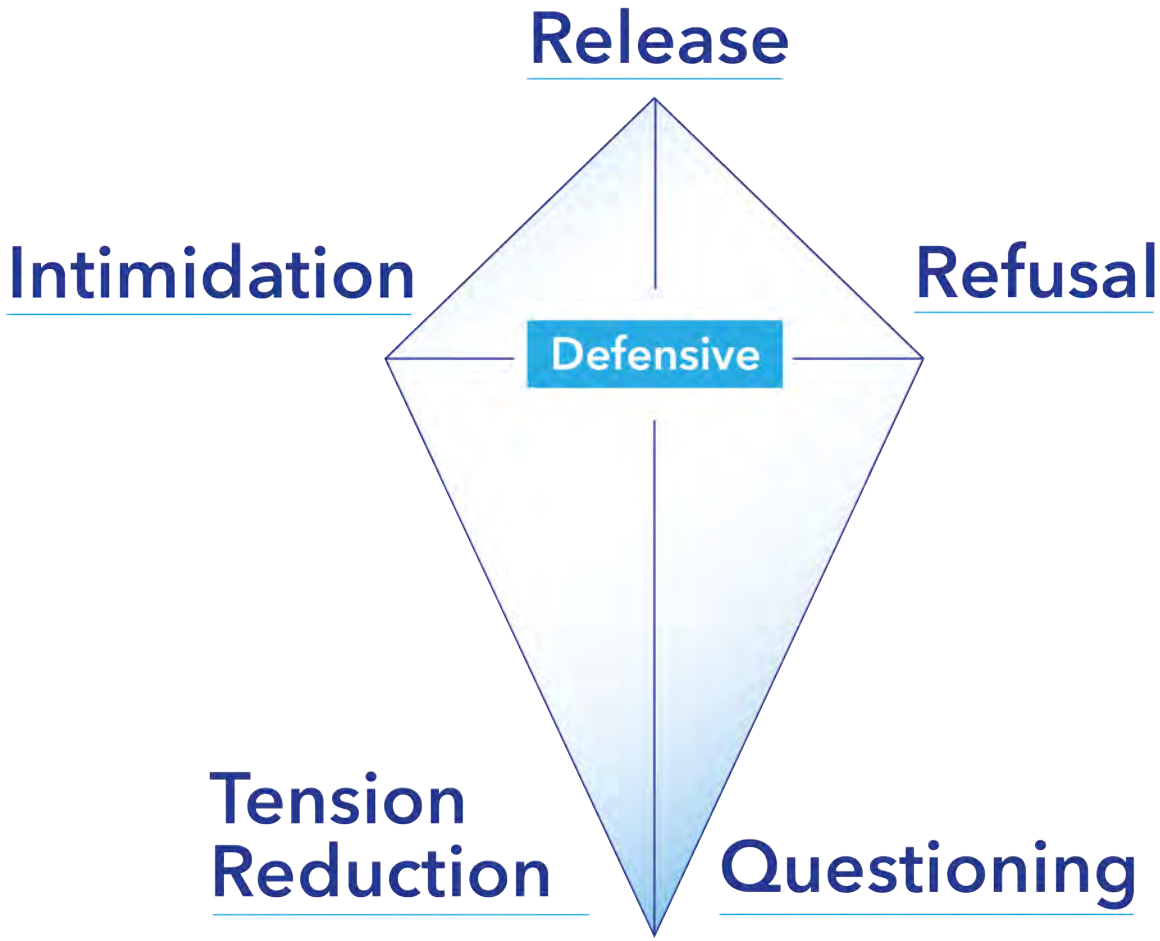
Decrease in physical and emotional energy.

STAFF INTERVENTION

Establish Therapeutic Rapport.

MAHI - STM - 105 - 796

The *Verbal Escalation Continuum*SM



MAHI - STM - 105 - 797

Activity: Identify the Defensive Behaviours

Identify the defensive behaviours and corresponding staff interventions.

MAHI - STM - 105 - 798

Activity – Example 1

Beatrice tells staff to 'just hurry up and do your damn job' and asks, 'Do you even know what you're doing?'

What is the defensive behaviour?

What is the staff intervention? Be specific. What would you say/do?

MAHI - STM - 105 - 799

Activity – Example 2

Theo becomes aggressive and makes threatening statements like ‘you better watch your back’ and ‘I’m going to mess you up.’

What is the defensive behaviour?

What is the staff intervention? Be specific. What would you say/do?

MAHI - STM - 105 - 800

Activity – Example 3

Grace grows increasingly angry before she finally stands up from her chair and starts shouting at staff, 'I'm sick of waiting! I want to see someone NOW!'

What is the defensive behaviour?

What is the staff intervention? Be specific. What would you say/do?

MAHI - STM - 105 - 801

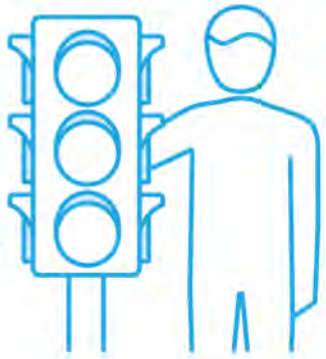
Activity – Example 4

Seth becomes increasingly agitated when asked to perform a task. Suddenly he responds, ‘No! You can’t make me!’

What is the defensive behaviour?

What is the staff intervention? Be specific. What would you say/do?

MAHI - STM - 105 - 802



LIMIT Setting

Respectful

Phrase limits in a positive way using effective non-verbal, verbal, and paraverbal skills.

Simple

Limit the number of words you use.

Reasonable

Connect the expectation to the person's circumstances and level of ability.

MAHI - STM - 105 - 803

Examples of Limit Setting

INTERRUPT AND REDIRECT

(Interrupt) 'Juan, you're shouting. **(Redirect)** Please speak quietly. Thank you.'

WHEN/THEN PATTERN

'Juan, **when** you lower your voice, **then** I'll be able to address your concerns.'

IF/THEN PATTERN

'Juan, **if** you lower your voice, **then** I'll be able to address your concerns.'

FAIL SAFE CHOICE

'Juan, would you like to talk about this now or later in private?'

MAHI - STM - 105 - 804

Framework for Planning a Difficult Conversation

PLANNING

SCRIPTING

DELIVERING

DOCUMENTING

MAHI - STM - 105 - 805

Planning

- Think about how you'll remain rationally detached.
- Consider where and when to conduct the conversation.

MAHI - STM - 105 - 806

Scripting

SCRIPTING

- Develop a written or mental roadmap of what you will say.
- Keep it factual.

MAHI - STM - 105 - 807

Delivering

DELIVERING

- Respect the dignity of the person.
- Rationally detach.
- Deliver the facts.
- Offer something.
- Listen and respond with empathy.
- Bring closure.

MAHI - STM - 105 - 808

Documenting

DOCUMENTING

- Summarise the conversation.
- Note observations.
- Objectively assess your performance.

MAHI - STM - 105 - 809

Demonstrating Consistency With Communication

- Listen to understand the other person.
- Allow time to process.
- Remain flexible; situations evolve.
- Make the conversation private if possible.
- Don’t get pulled into power struggles.

Activity: Planning a Difficult Conversation

Practise using the framework for planning a difficult conversation.

Activity Roles

Individual in Distress
Be prepared to react to the news the staff person will give you.

Staff
Deliver the script you wrote in your workbook from the previous activity.

Observer
Be ready to discuss what you saw the staff person do effectively.

Knowledge Check

Planning and practising your preferred verbal responses is important when intervening with a person demonstrating **Refusal**.

a. True

b. False

Knowledge Check

Planning and practising your preferred verbal responses is important when intervening with a person demonstrating **Refusal**.

a. True

b. False

Knowledge Check

Limits should be respectful, simple, and _____.

a. Trustworthy
b. Reasonable
c. Sane
d. Accountable

Knowledge Check

Limits should be respectful, simple, and _____.

a. Trustworthy

b. Reasonable

c. Sane

d. Accountable

Knowledge Check

'Would you like to talk about this now or later?' is an example of which type of limit setting?

a. When/Then

b. Interrupt and Redirect

c. Fail Safe Choice

d. If/Then

Knowledge Check

'Would you like to talk about this now or later?' is an example of which type of limit setting?

a. When/Then

b. Interrupt and Redirect

c. Fail Safe Choice

d. If/Then

Tips to Manage Fear and Anxiety

- Take slow, deep breaths.
- Don’t rush into the room.
- Check your perception.
- Understand what led to their behaviour.
- Get help.

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

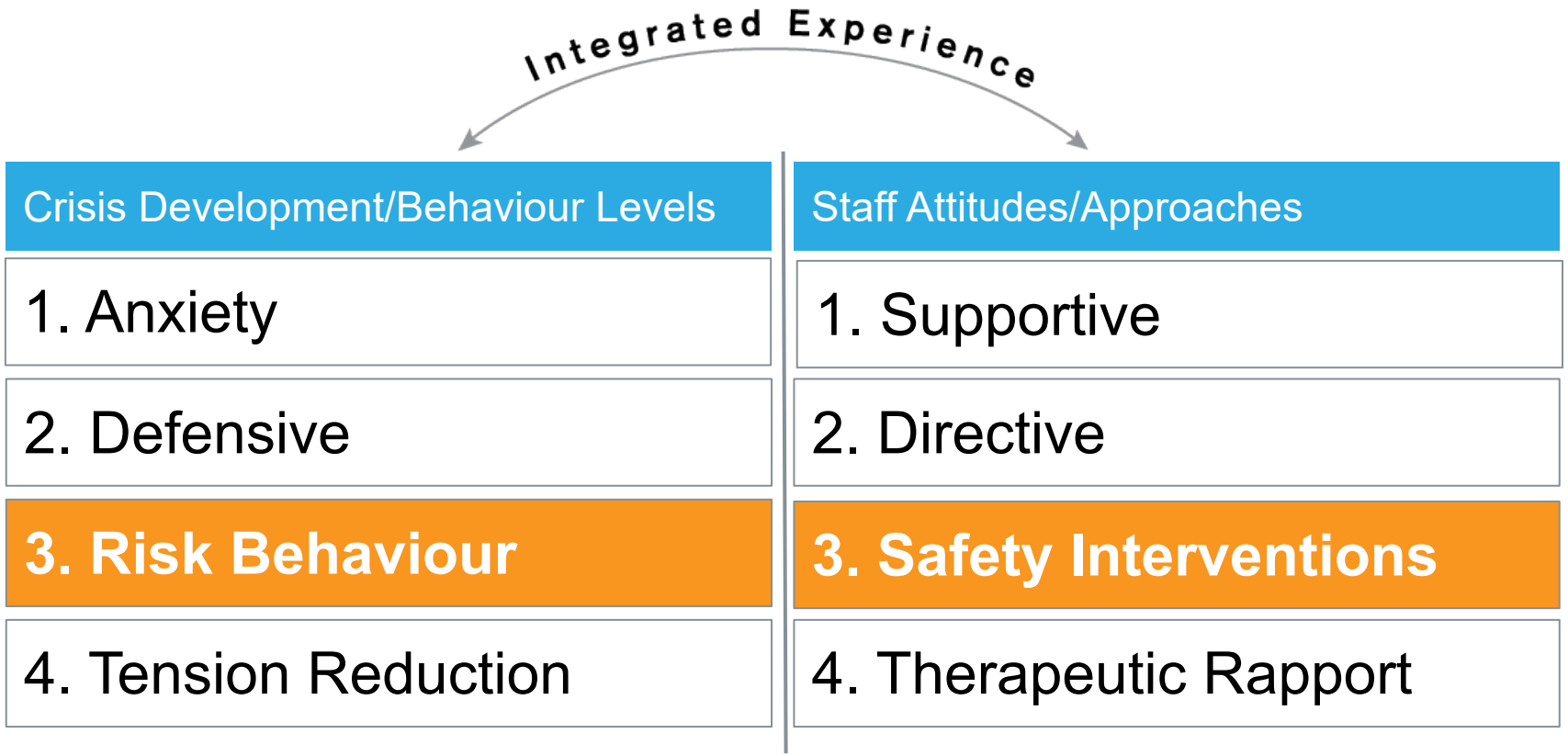
MODULE 5

Safety Interventions

MAHI - STM - 105 - 820

Safety Interventions

The CPI *Crisis Development Model*SM



Safety From Different Perspectives

KEEPING YOURSELF SAFE

KEEPING THE INDIVIDUAL IN CRISIS SAFE

KEEPING OTHERS AROUND THEM SAFE

Non-Restrictive Interventions

- Remove items that could be dangerous.
- Remove the person.
- Remove other people.
- Ask a staff member to help.
- Call for help.

MAHI - STM - 105 - 823

Activity: Coordinated and Collaborative Approach

Case Study – Choose your industry

Activity: Coordinated and Collaborative Approach

Case Study – Healthcare

In the lobby of a healthcare facility, several people wait for their appointments. Two people sitting next to each other begin arguing. One is blaming the other for their loved one being in an accident. The other individual refuses to take the blame. The argument becomes louder and more animated. A staff member approaches the people arguing to try to de-escalate the situation.

Continue

Activity: Coordinated and Collaborative Approach

Case Study – Human Services

In the day room of a treatment centre, several people are watching television, playing games, or reading. Two residents sitting next to each other begin arguing over who gets to pick the next programme to watch. The argument becomes louder and more animated. A staff member approaches them to try to de-escalate the situation.

Continue

Knowledge Check

What are some essential safety strategies for you to consider in your approach?

a. Immediately call for help no matter what.

b. Use an authoritative tone to gain compliance.

c. Remain calm and call for help.

Knowledge Check

What are some essential safety strategies for you to consider in your approach?

a. Immediately call for help no matter what.

b. Use an authoritative tone to gain compliance.

c. Remain calm and call for help.

Knowledge Check

In the event of a crisis, it's important to remove the person or relocate bystanders from the environment.

a. True

b. False

Knowledge Check

In the event of a crisis, it's important to remove the person or relocate bystanders from the environment.

a. True

b. False

Knowledge Check

When intervening with a person demonstrating Risk Behaviour, non-restrictive interventions are the first resort.

a. True

b. False

Knowledge Check

When intervening with a person demonstrating Risk Behaviour, non-restrictive interventions are the first resort.

a. True

b. False

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

SAFETY INTERVENTIONS

Disengagement Skills

MAHI - STM - 105 - 834

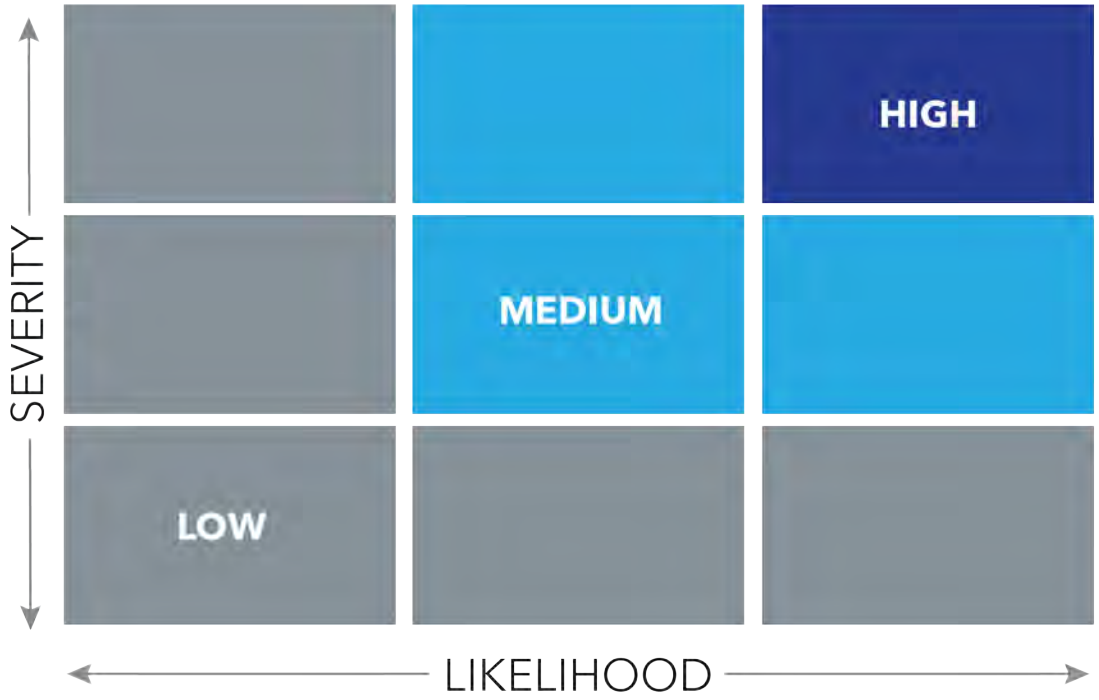
Safe Participation Guidelines

Maintaining Safety in the Training Programme

- Be professional and respectful.
- Notify the Instructor of any past injuries.
- Accept the Instructor's guidance.
- Follow the Instructor's directions.
- Stop any classroom activity when asked.
- Do not engage in disruptive activity.
- Report all injuries.
- Maintain legal responsibilities.

MAHI - STM - 105 - 835

*Decision-Making Matrix*SM



1. Position
2. Posture
3. Proximity

} *Supportive Stance*SM

Block and Move

MAHI - STM - 105 - 836

Physical Strike Intervention

Block

Move away to safety

MAHI - STM - 105 - 837

Disengagement Skills

Key Themes to Consider With Safety Intervention

- Duty of care
- Reasonable and proportionate
- Last resort and least restrictive
- Risk of doing something vs risk of doing nothing
- Human rights
- Reduce use, prevent misuse and abuse
- Risk of causing additional trauma

MAHI - STM - 105 - 838

Disengagement Skills

Key Principles

Position – Posture – Proximity

Biomechanical Benefit

Principles of Disengagement

Hold and Stabilise

Pull/Push

Lever

MAHI - STM - 105 - 839

Disengagement Skills - Wrist

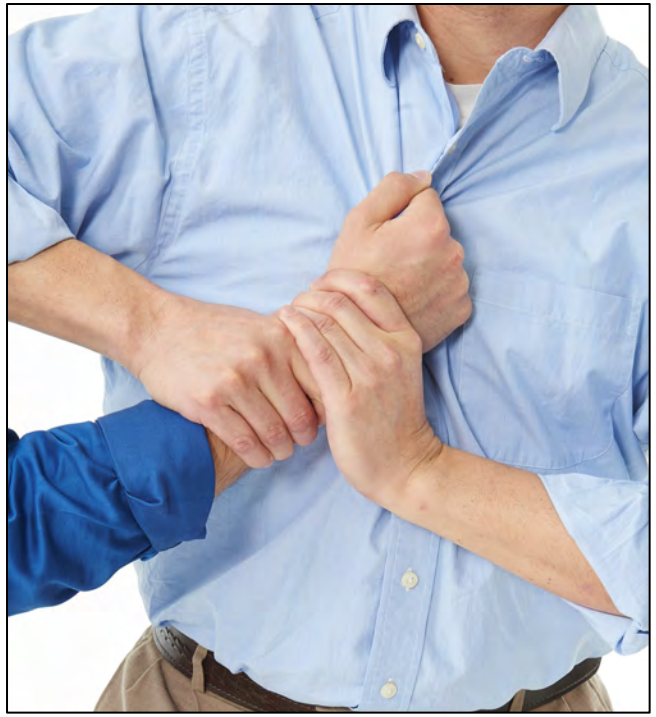
Hold and Stabilise

Pull/Push

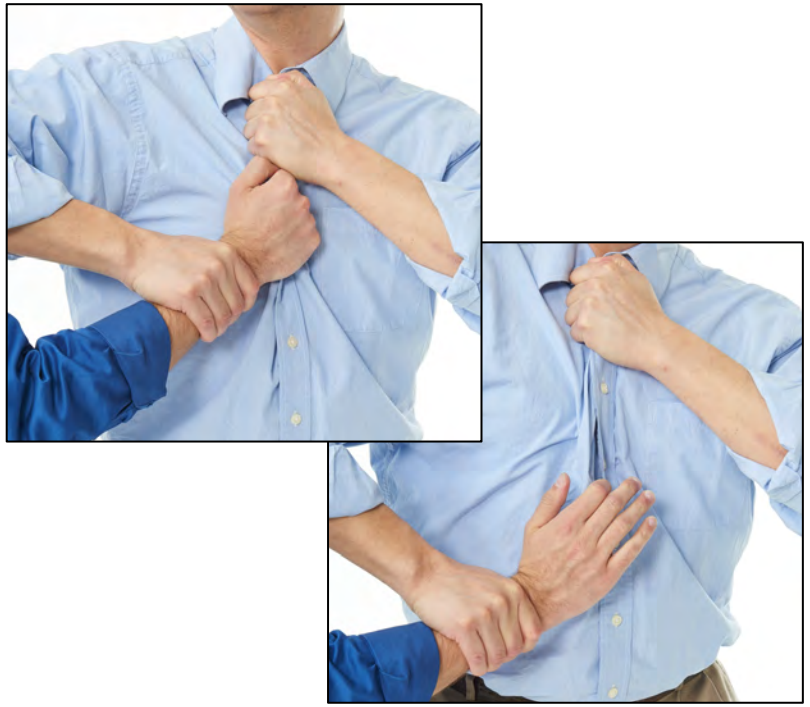
Lever

MAHI - STM - 105 - 840

Disengagement Skills - Clothing



Hold and Stabilise



Pull/Push

Lever

MAHI - STM - 105 - 841

Disengagement Skills - Hair

Hold and Stabilise

Pull/Push

Lever

MAHI - STM - 105 - 842

Disengagement Skills - Neck

Hold and Stabilise

Pull/Push

Lever

MAHI - STM - 105 - 843

Disengagement Skills - Body

Hold and Stabilise

Pull/Push

Lever

MAHI - STM - 105 - 844

Disengagement Skills - Bite

Hold and Stabilise
Pull/Push

MAHI - STM - 105 - 845

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

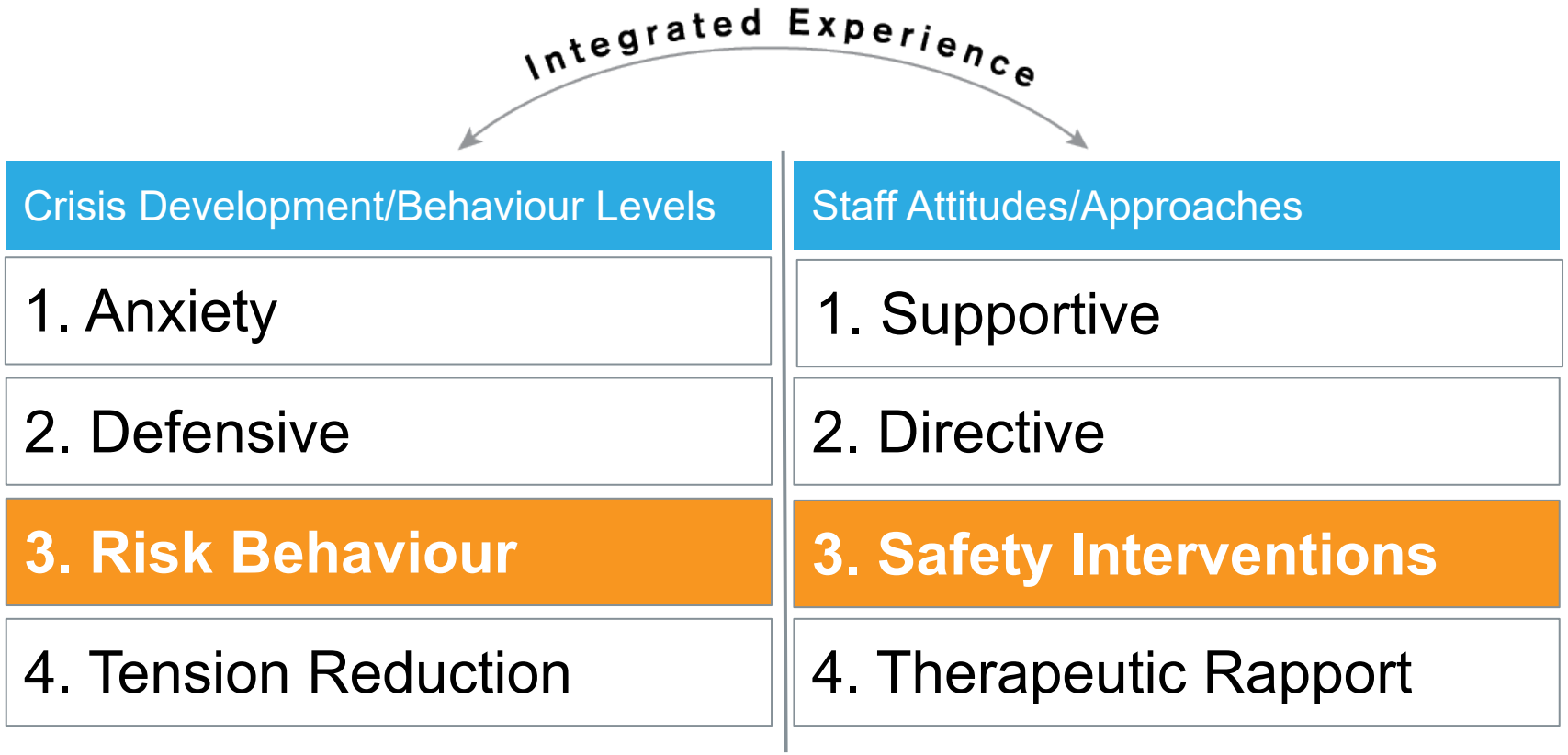
MODULE 6

Introduction to Restrictive Interventions

MAHI - STM - 105 - 847

Introduction to Restrictive Interventions

The CPI *Crisis Development Model*SM



MAHI - STM - 105 - 848

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

CPI Values and Philosophy

CARE

Respect, dignity, empathy, person-centered

WELFARE

Maintaining independence, choice and well-being

SAFETY

Protecting rights and minimising harm

SECURITY

Safe, effective, harmonious and collaborative relationships

CPI™

MAHI - STM - 105 - 850

Introduction to Restrictive Interventions

Use restrictive intervention as a last resort.

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1. Anxiety	1. Supportive
2. Defensive	2. Directive
3. Risk Behaviour	3. Safety Interventions
4. Tension Reduction	4. Therapeutic Rapport

MAHI - STM - 105 - 851

Introduction to Restrictive Interventions

When considering restrictive interventions, use them as a last resort and ensure they are:

- Reasonable
- Proportionate
- Least Restrictive

MAHI - STM - 105 - 852

RESTRICTIVE INTERVENTION

Physical holding to maximise safety and minimise harm.

MAHI - STM - 105 - 853

Legal and Professional Considerations

- Duty of care.
- Best interests.
- Reasonable and proportionate.
- Last resort and least restrictive.
- The risk of doing something and the risk of doing nothing.
- Human rights.

Restrictive Intervention

What are the foreseeable risks if I do something and the foreseeable risks if I do nothing?

Choose the option that presents the least amount of risk.

Be aware of your organisation's approved policy and the risk of restrictive interventions.

MAHI - STM - 105 - 856

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

MAHI - STM - 105 - 857

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

SAFE

In what way does the specific restrictive intervention enable you to maximise safety and minimise harm?

MAHI - STM - 105 - 858

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

EFFECTIVE

What makes your intervention effective? How well does it maximise safety and minimise harm?

MAHI - STM - 105 - 859

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

ACCEPTABLE

How would this be viewed as an acceptable response to risk behaviour?

MAHI - STM - 105 - 860

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

TRANSFERABLE

How can you transfer the principles back into your workplace?

Trauma-Responsive Practice

- Awareness of prevalence of trauma
- Use of the principles of trauma-informed care
- Listening with empathy
- Developing supportive relationships

Knowledge Check

The use of restrictive interventions for Risk Behaviour should only be considered as a last resort.

a. True

b. False

Knowledge Check

The use of restrictive interventions for Risk Behaviour should only be considered as a last resort.

a. True

b. False

Knowledge Check

Restrictive interventions include which of the following?

a. Calling for help
b. Disengagements
c. Limit setting
d. Physical holding
e. Removing items that could be dangerous

Knowledge Check

Restrictive interventions include which of the following?

a. Calling for help

b. Disengagements

c. Limit setting

d. Physical holding

e. Removing items that could be dangerous

MAHI - STM - 105 - 866

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

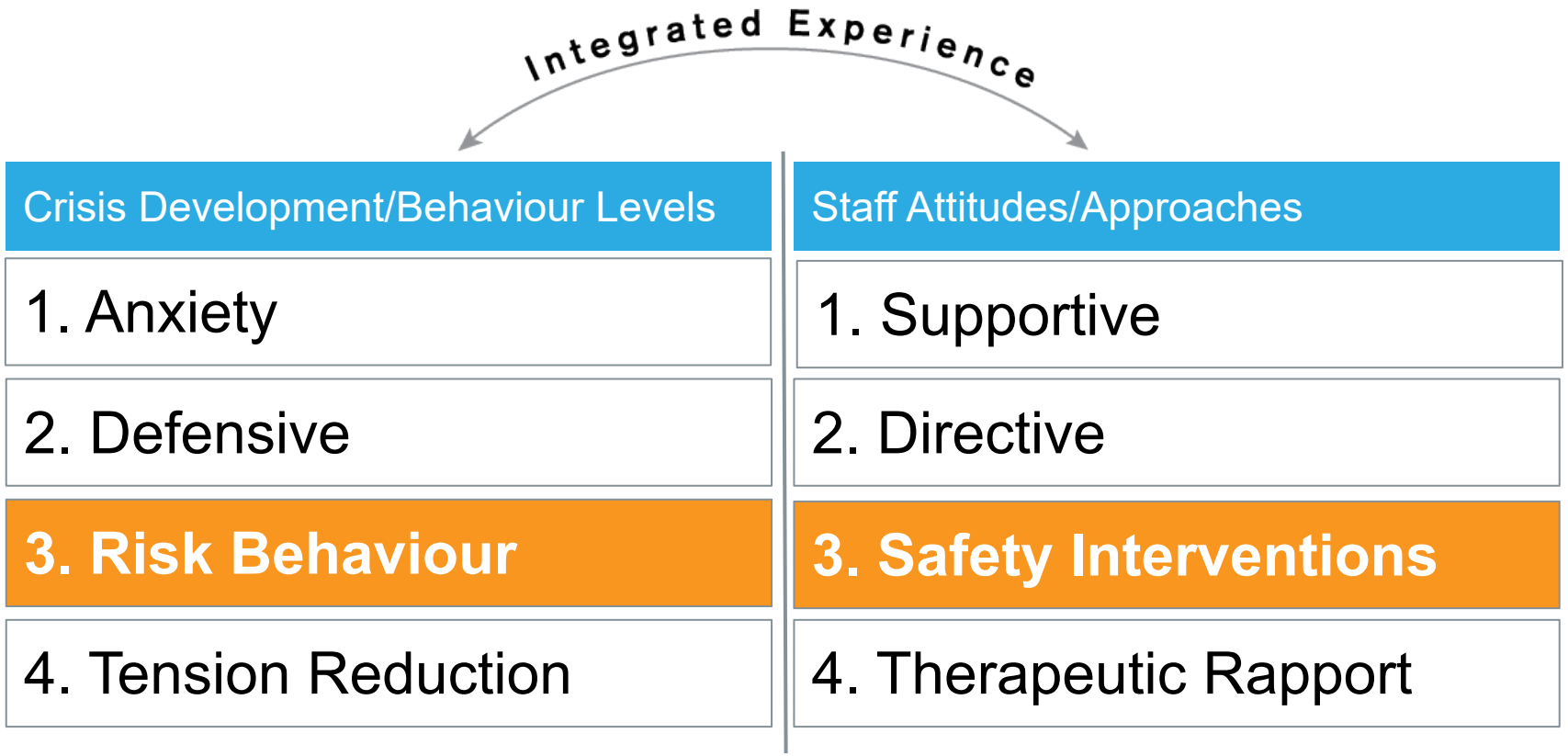
MODULE 7

Decision Making

MAHI - STM - 105 - 868

Decision Making

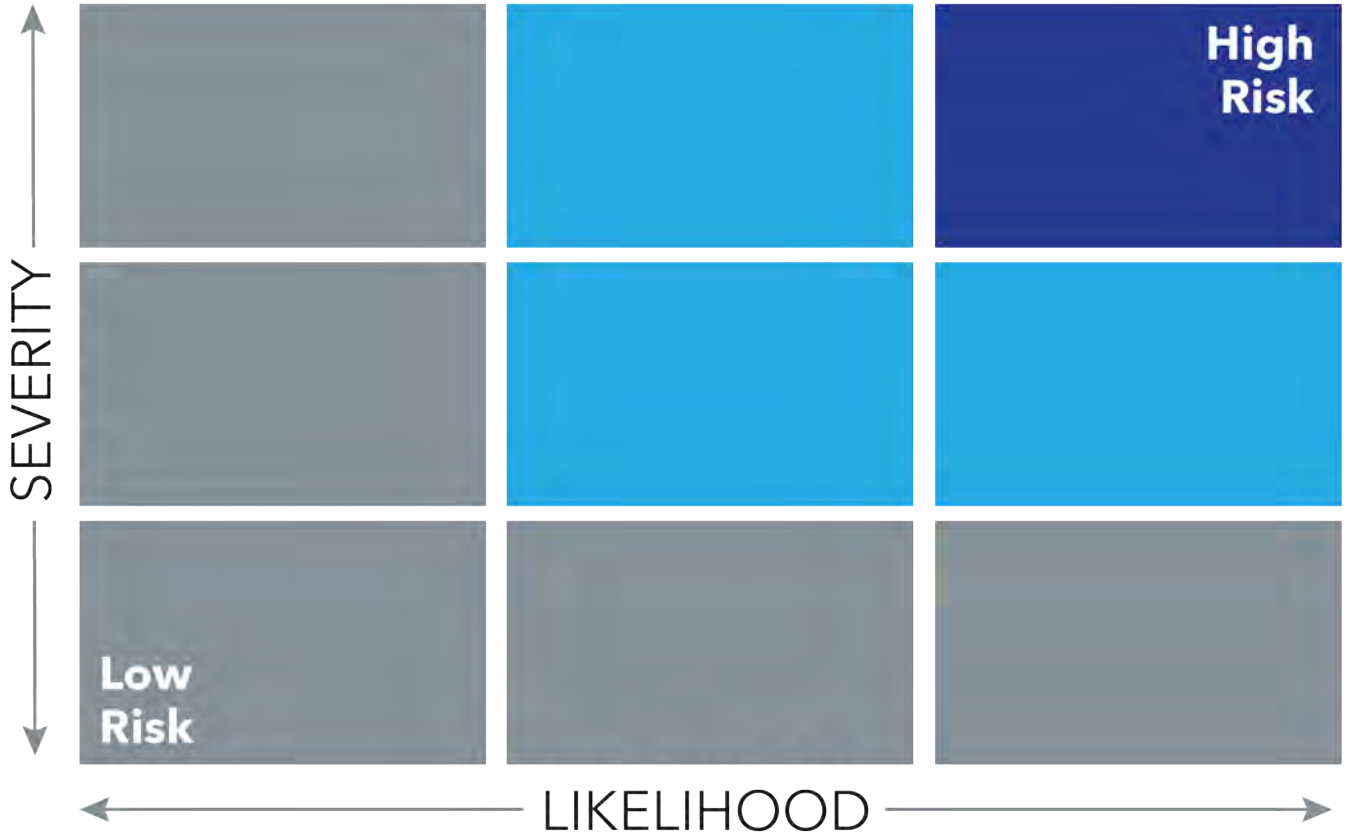
The CPI *Crisis Development Model*SM



MAHI - STM - 105 - 869

Decision Making

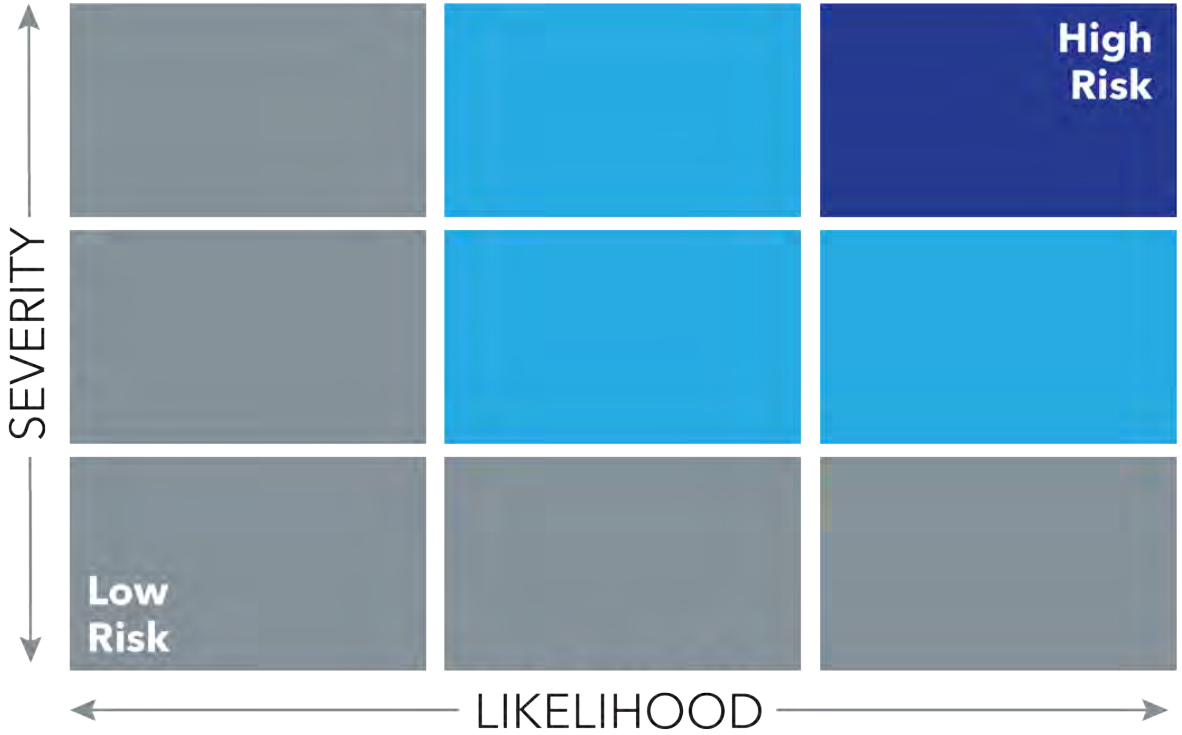
*Decision-Making Matrix*SM



MAHI - STM - 105 - 870

Decision Making

*Decision-Making Matrix*SM



Risk: The chance of a bad consequence.

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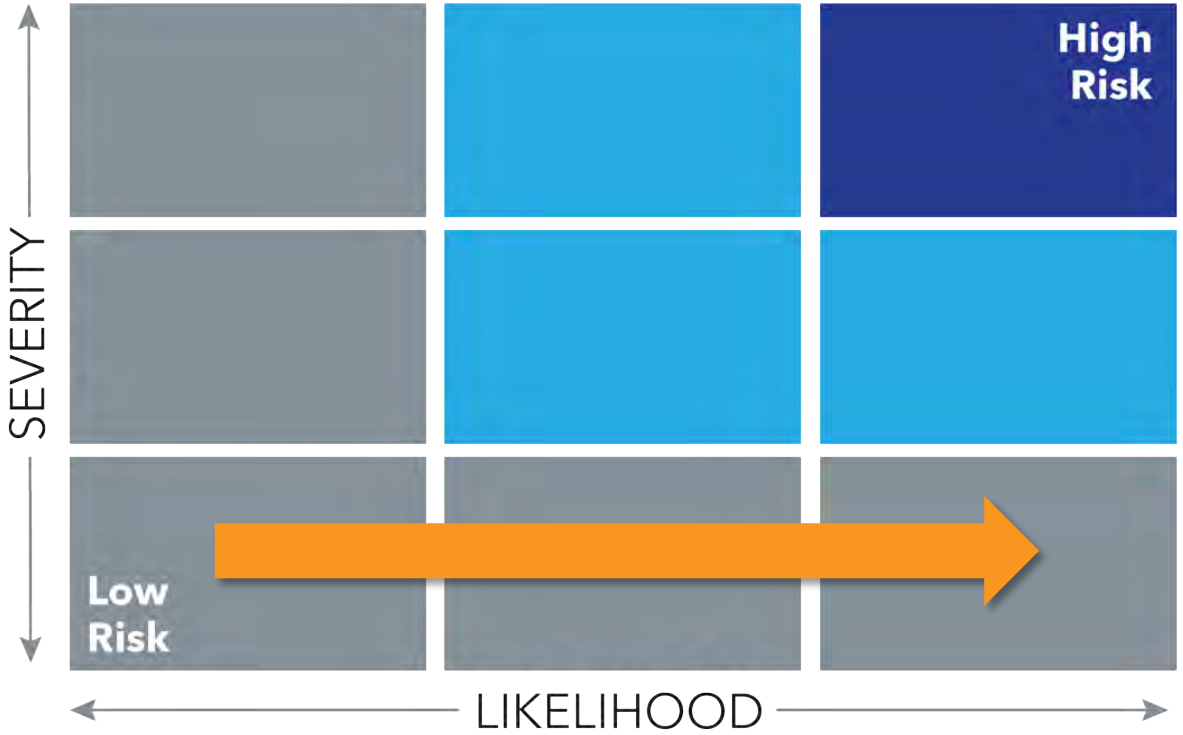
Decision Making

*Decision-Making Matrix*SM



Likelihood: The chance that an event or behaviour may occur.

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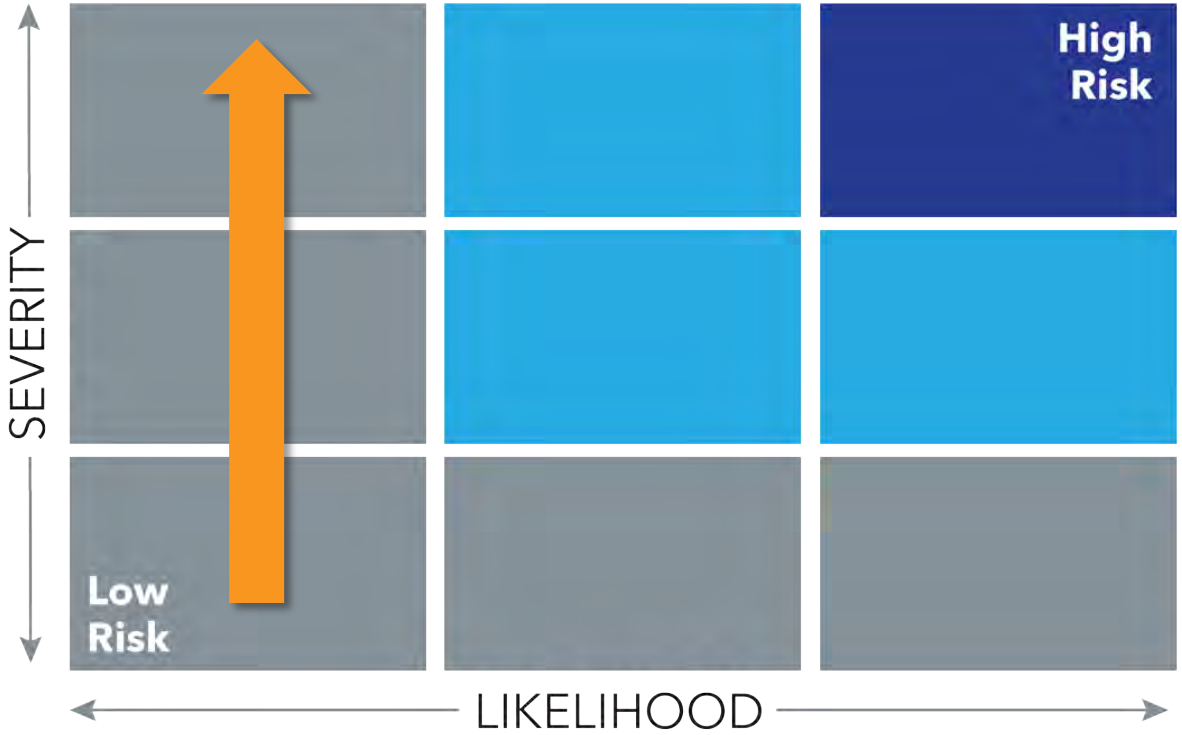
Decision Making

*Decision-Making Matrix*SM



Severity: The level of harm that may occur.

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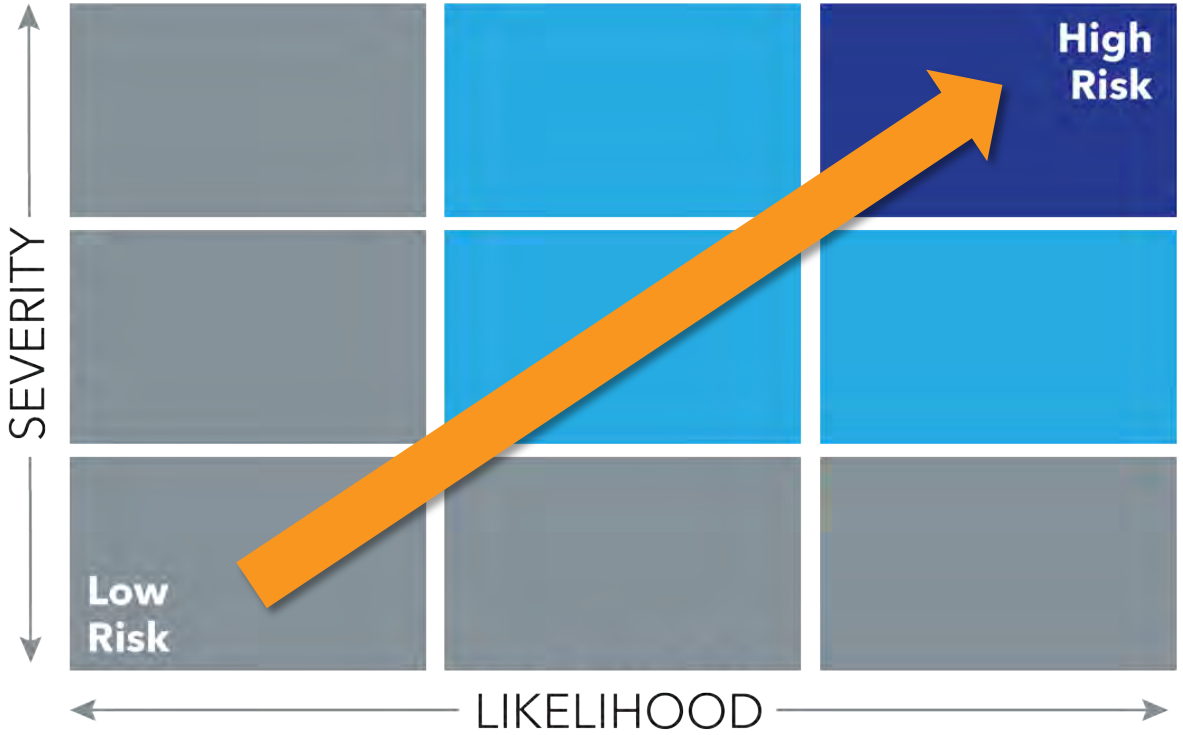
Decision Making

*Decision-Making Matrix*SM



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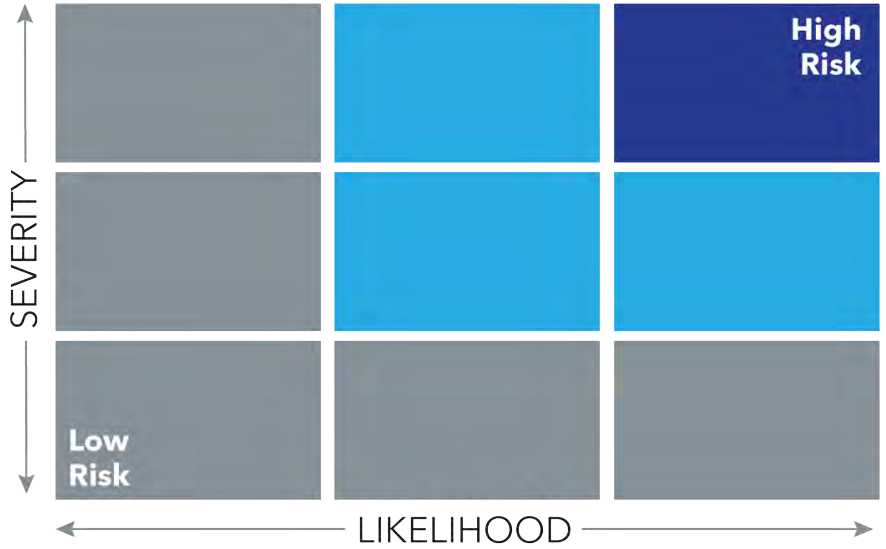
Assessing Risk Example

***Decision-Making Matrix*SM**



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Assessing Risk Example

A five-year-old boy, Henry, climbed onto a two-metre metal file cabinet.

He has good balance and is very agile.

File cabinet is against a wall and next to a desk.

Cabinet is weighed down and unlikely to fall.

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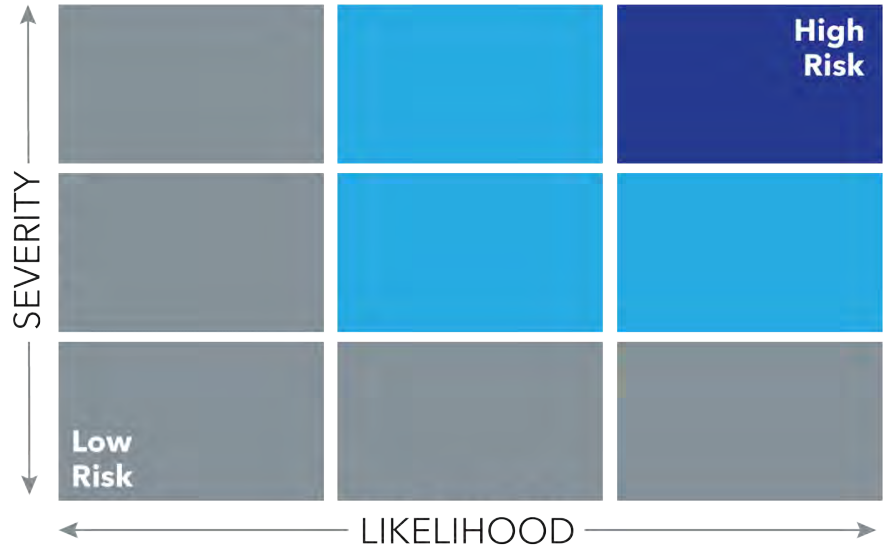
Assessing Likelihood

***Decision-Making Matrix*SM**



LIKELIHOOD of Henry falling = **Low**

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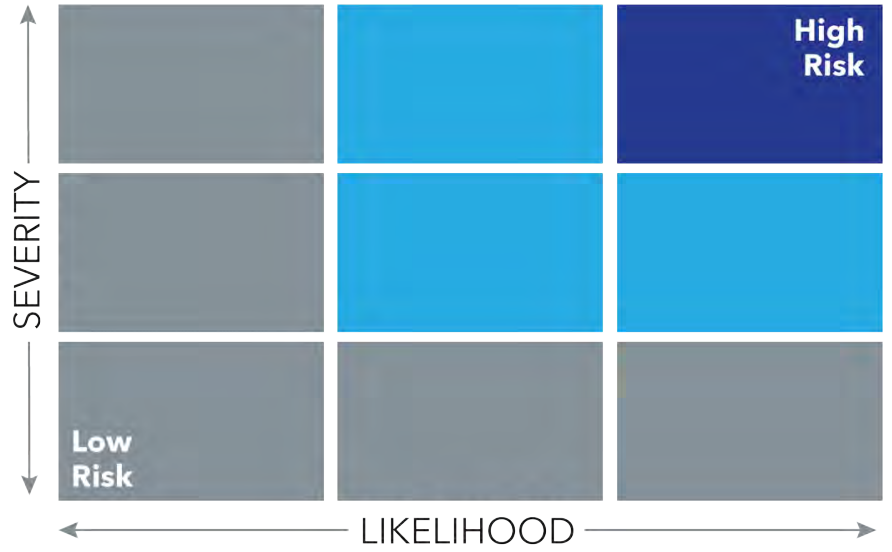
Assessing Severity

***Decision-Making Matrix*SM**



LIKELIHOOD of Henry falling = **Low**

SEVERITY of injury = **Medium**

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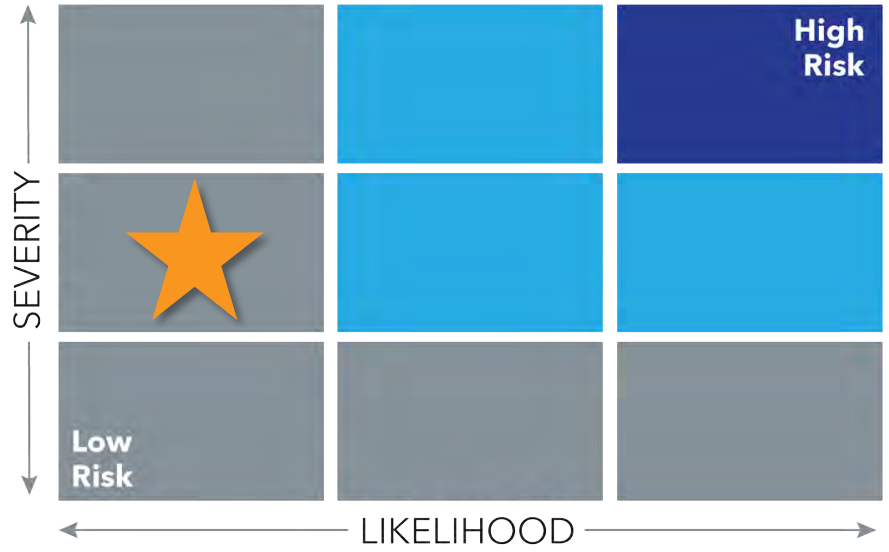
Assessing Severity

***Decision-Making Matrix*SM**



LIKELIHOOD of Henry falling = **Low**

SEVERITY of injury = **Medium**

MAHI - STM - 105 - 879

Safety Interventions

In the scenario with Henry, how may you reduce the likelihood of him falling?

How may you reduce the severity of harm?

*Decision-Making Matrix*SM

To get started, consider the following:

- No right or wrong answers.
- How may your past experiences, fear, or anxiety influence your assessment?

MAHI - STM - 105 - 881

Activity: *Decision-Making Matrix*SM Part 1

Case Study – Choose your industry

MAHI - STM - 105 - 882

*Decision-Making Matrix*SM

Case Study – Healthcare

One evening, Connie arrives in the emergency room with a badly broken arm and a black eye. This is not the first time that she has come to the emergency room with similar injuries. The staff suspects she is experiencing domestic abuse and called the police for her, but she has refused to press charges. When she is asked about how the injuries occurred this time she becomes very agitated and refuses to answer the questions or complete the necessary paperwork to be admitted. When told she cannot be treated until she completes the paperwork, she grabs scissors from behind the desk and threatens to hurt someone in the waiting room if she is not seen immediately.

Continue

MAHI - STM - 105 - 883

*Decision-Making Matrix*SM

Case Study – Human Services

Erma, 44, admits herself into a psychiatric hospital for treatment of schizophrenia with suicidal thoughts. As a child Erma was committed to a mental institution for several years. Erma has been able to manage her schizophrenia with medication. As she's checking herself in, she appears calm and rational. When a staff member comes to show her the room where she'll stay during treatment, her behaviour drastically changes. She starts screaming at the staff person, accusing them of conspiring with 'the man' to lock her up, and she refuses treatment. Erma grabs a vase from the desk, telling staff she'll throw it.

Continue

Activity: *Decision-Making Matrix*SM Part 2

- Using the previous case study example, determine appropriate Safety Interventions.
- Keep in mind your organisational policies and procedures.
- In groups, determine:
  - How may you reduce the likelihood of injury?
  - How may you reduce the severity of harm?
  - How does their history of trauma impact your decision?
- Write your responses on the flipchart paper provided.
- Be prepared to discuss.

Knowledge Check

You need to align your safety intervention with your organisational policies and procedures.

a. True

b. False

Knowledge Check

You need to align your safety intervention with your organisational policies and procedures.

a. True

b. False

Knowledge Check

The *Decision-Making Matrix*SM assesses risk based on likelihood and _____.

a. Consequence

b. Severity

c. Criminal/Civil law

Knowledge Check

The *Decision-Making Matrix*SM assesses risk based on likelihood and _____.

a. Consequence

b. Severity

c. Criminal/Civil law

Knowledge Check

If you use restrictive intervention strategies, they need to be reasonable, proportionate, and least restrictive.

a. True

b. False

Knowledge Check

If you use restrictive intervention strategies, they need to be reasonable, proportionate, and least restrictive.

a. True

b. False

MAHI - STM - 105 - 891

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

SAFETY INTERVENTIONS

Holding Skills

MAHI - STM - 105 - 893

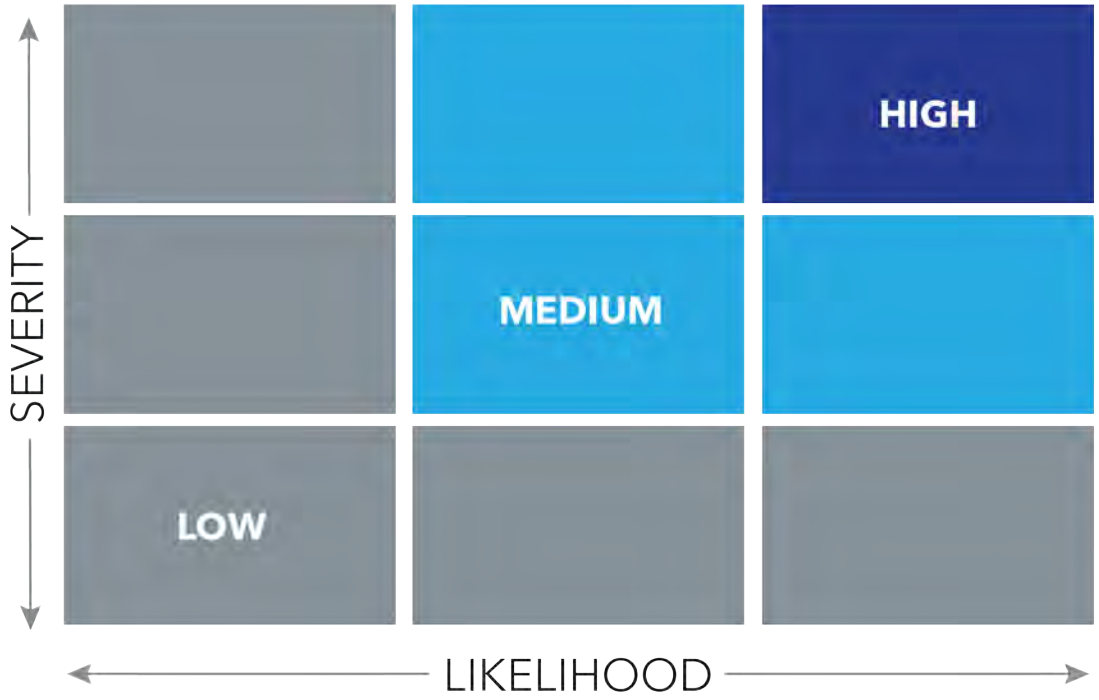
Safe Participation Guidelines

Maintaining Safety in the Training Programme

- Be professional and respectful.
- Notify the Instructor of any past injuries.
- Accept the Instructor's guidance.
- Follow the Instructor's directions.
- Stop any classroom activity when asked.
- Do not engage in disruptive activity.
- Report all injuries.
- Maintain legal responsibilities.

MAHI - STM - 105 - 894

*Decision-Making Matrix*SM



1. Position
2. Posture
3. Proximity
4. Biomechanical Benefits

} *Supportive Stance*SM

- **Outside/Inside Principle**
- **Limit the range of motion**

CPI

MAHI - STM - 105 - 895

Holding Skills - Seated

Low-Level Restriction

Medium-Level Restriction

High-Level Restriction

MAHI - STM - 105 - 896

Holding Skills - Standing

Low-Level Restriction

Medium-Level Restriction

High-Level Restriction

MAHI - STM - 105 - 897

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

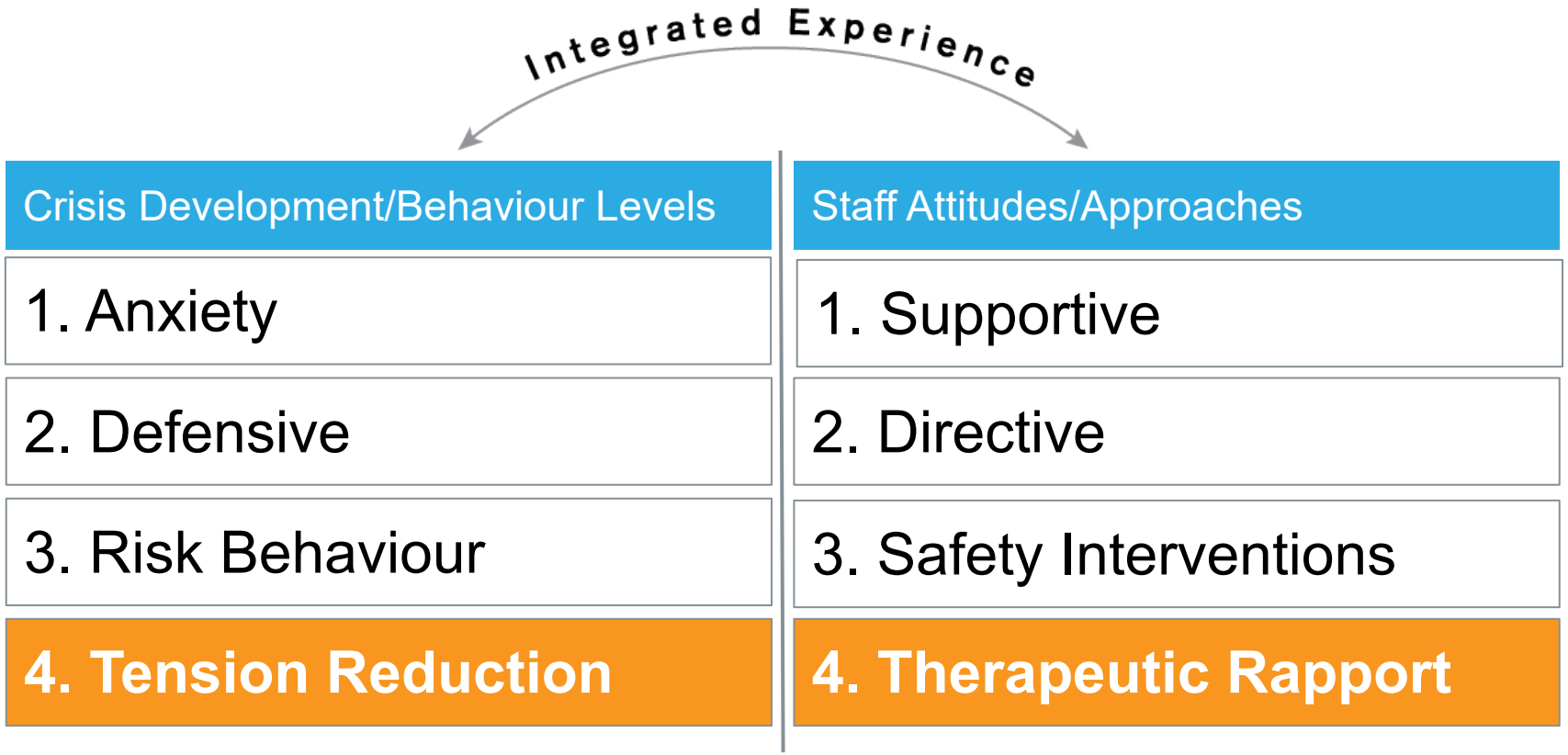
MODULE 8

Post-Crisis

MAHI - STM - 105 - 899

Post-Crisis

The CPI *Crisis Development Model*SM



Pop Question

What are physical and emotional examples that may indicate a person has reached Tension Reduction?

- ❑ Relaxed posture
- ❑ Crying
- ❑ Decrease in breathing rate
- ❑ Guilt
- ❑ Apologising
- ❑ Returning complexion
- ❑ Reduced muscle tension
- ❑ Embarrassment

Pop Question

What are physical and emotional examples that may indicate a person has reached Tension Reduction?

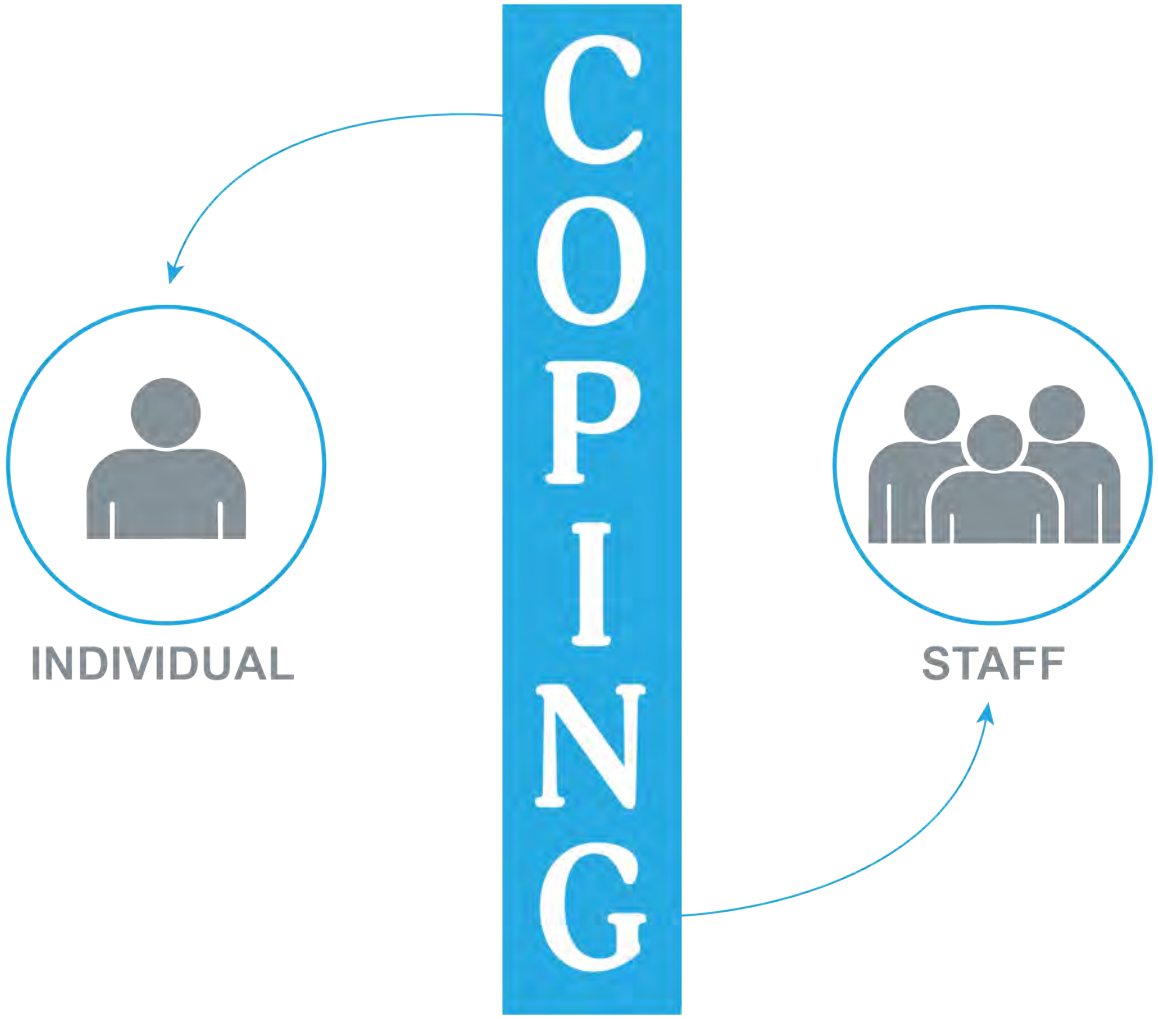
- ✓ Relaxed posture
- ✓ Crying
- ✓ Decrease in breathing rate
- ✓ Guilt
- ✓ Apologising
- ✓ Returning complexion
- ✓ Reduced muscle tension
- ✓ Embarrassment

MAHI - STM - 105 - 902

The *COPING Model*SM

Control
Orient
Patterns
Investigate
Negotiate
Give

The *COPING Model*SM



The *COPING Model*SM – Individual

Control – ensure that emotional and physical control is regained.

Example:

'I'd like to talk about what happened earlier. Do you have a few minutes?'

The *COPING Model*^{SM} – Individual

Orient yourself to the basic facts.

- What happened?
- When did it happen?
- Who else has been affected?
- Why did it happen?
- Where did it happen?

MAHI - STM - 105 - 906

The *COPING Model*SM – Individual

Patterns – Look for patterns for the behaviour.

Is this the first time the individual reacted that way or has it become a recurring event?

The *COPING Model*SM – Individual

Investigate alternatives to the behaviour.

Examples may include:

- What could you do differently next time?
- What should we do to put things right?
- What were you thinking about at the time of the incident?

MAHI - STM - 105 - 908

The *COPING Model*SM – Individual

Negotiate future approaches and expectations of behaviour.

Suggestions may include:

- *'What can we do to help you when you feel distressed?'*
- *'Is there anything you don't want us to do during these moments?'*

MAHI - STM - 105 - 909

The *COPING Model*SM – Individual

Give back responsibility; provide support and encouragement.

Example:

'I appreciate you talking with me. Do you agree with the plan that we just discussed?'

Principles of Trauma-Informed Care

- Safety
- Transparency and Trustworthiness
- Choice
- Collaboration and Mutuality
- Empowerment

The *COPING Model*SM – Staff

Control – ensure that emotional and physical control is regained by the staff person.

Start the conversation by acknowledging their feelings and then asking permission to discuss.

The *COPING Model*SM – Staff

Orient yourself to the basic facts.

Staff may have arrived at different points and observed different things. Acknowledge what you observed and prompt for more details if needed.

- What happened?
- When did it happen?
- Who else has been affected?
- Why did it happen?
- Where did it happen?

MAHI - STM - 105 - 913

The *COPING Model*SM – Staff

Patterns – Look for patterns in staff responses to the behaviour.

Review the staff response history. Are there patterns in how the team or specific staff members responded?

The *COPING Model*SM – Staff

Investigate ways to strengthen staff responses.

With team members, propose and discuss potential solutions.

What were you thinking about at the time of the incident?

What changes should be considered to help prevent future crisis events or to improve a future response?

The *COPING Model*SM – Staff

Negotiate changes that will improve future interventions. Reinforce what's working well.

Example:

'Is there anything you would have done differently?'

Discuss and gain commitment from all staff to ensure that any improvements will be made.

The *COPING Model*SM – Staff

Give support and encouragement.

Express trust and confidence in their ability to respond during the next crisis.

MAHI - STM - 105 - 917

Activity: The *COPING Model*SM

Case Study – Choose your industry

MAHI - STM - 105 - 918

Post-Crisis

Case Study – Healthcare

Zak is a 40-year-old small business owner who lives alone. He's in the emergency room after a car ran a red light and smashed into his car, nearly totaling it. The worst of Zak's injuries is a broken left wrist. Zak is frustrated that he can't open his store or work with his dominant hand. When the doctor tells Zak that he'll need a cast, he yells, 'I don't have time for this!' and pushes his chair at the doctor. After several minutes of ranting and swearing, he slumps into his chair, resigned.

Continue

MAHI - STM - 105 - 919

Post-Crisis

Case Study – Human Services

Jasmine just turned 20 and has been struggling with anorexia nervosa since she was 15 years old. After being hospitalised for respiratory issues due to malnutrition, she was admitted to an inpatient treatment programme for eating disorders. At breakfast, a counsellor confronts Jasmine about hiding food with the intent to throw it away. Jasmine throws her tray at the wall and screams at the counsellor, ‘You can’t make me eat!’ After continuing to rant for a few minutes, she curls up on the floor and starts crying, appearing inconsolable.

Continue

Knowledge Check

What is the goal when de-escalating crisis behaviour?

a. Maintain Rational Detachment.

b. Manage defensive behaviour.

c. Manage high-risk behaviour.

d. Help person reach Tension Reduction.

Knowledge Check

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a. Maintain Rational Detachment.

b. Manage defensive behaviour.

c. Manage high-risk behaviour.

d. Help person reach Tension Reduction.

Knowledge Check

When supporting an individual after a crisis, what is the first thing you should do?

a. Address medical and/or emotional needs.

b. Contact Security to file a report.

c. Take care of yourself and get back to calm.

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a. **Address medical and/or emotional needs.**

b. Contact Security to file a report.

c. Take care of yourself and get back to calm.

Knowledge Check

The *COPING Model*℠ can only facilitate a restorative conversation between staff.

a. True

b. False

Knowledge Check

The *COPING Model*℠ can only facilitate a restorative conversation between staff.

a. True

b. False

Restorative Question Framework

- What happened?
- What were you thinking about at the time of the incident?
- Who else has been affected?
- What should we do to put things right?
- How can we do things differently in the future?

MAHI - STM - 105 - 927

Final Thoughts

Review the **Points to Remember** and reflect on your **Key Takeaways** from the module.

CPI *SAFETY INTERVENTION*™ FOUNDATION

Conclusion

MAHI - STM - 105 - 929

Action Plan

Trauma-Responsive Practice

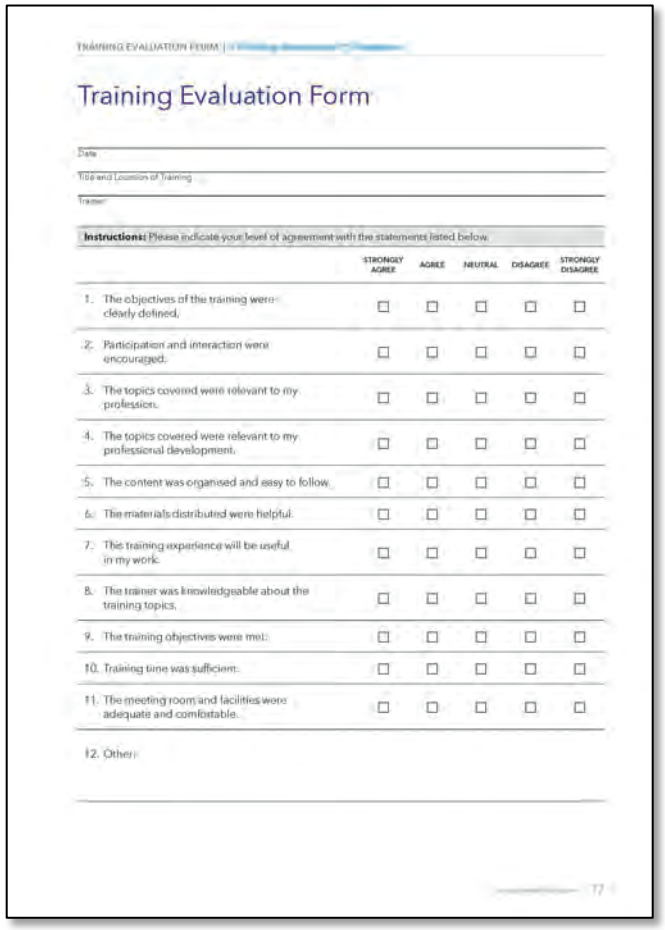
- Programming
- Environment
- Language
- Values

Trauma-Informed Care

- Safety
- Transparency and Trustworthiness
- Choice
- Collaboration and Mutuality
- Empowerment

MAHI - STM - 105 - 930

Evaluation and Classroom Test



TRAINING EVALUATION FORM

Training Evaluation Form

Date

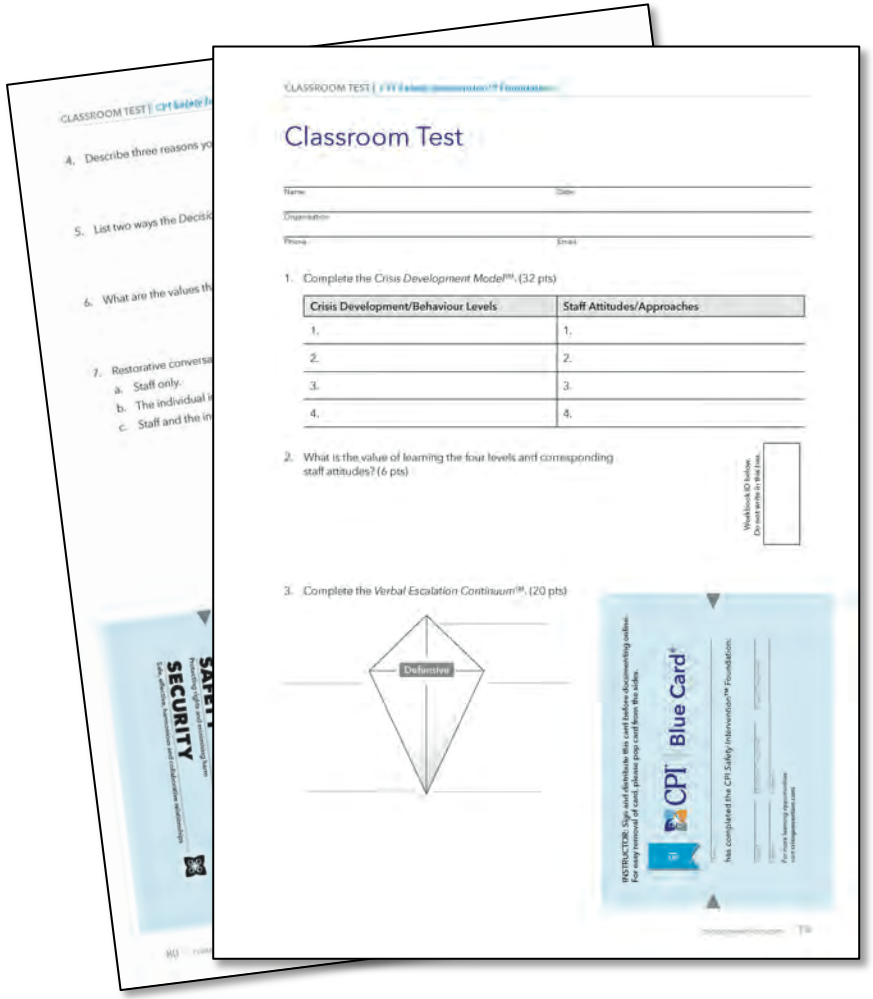
Title and Location of Training

Trainer

Instructions: Please indicate your level of agreement with the statements listed below.

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1. The objectives of the training were clearly defined.	☐	☐	☐	☐	☐
2. Participation and interaction were encouraged.	☐	☐	☐	☐	☐
3. The topics covered were relevant to my profession.	☐	☐	☐	☐	☐
4. The topics covered were relevant to my professional development.	☐	☐	☐	☐	☐
5. The content was organised and easy to follow.	☐	☐	☐	☐	☐
6. The materials distributed were helpful.	☐	☐	☐	☐	☐
7. The training experience will be useful in my work.	☐	☐	☐	☐	☐
8. The trainer was knowledgeable about the training topics.	☐	☐	☐	☐	☐
9. The training objectives were met.	☐	☐	☐	☐	☐
10. Training time was sufficient.	☐	☐	☐	☐	☐
11. The meeting room and facilities were adequate and comfortable.	☐	☐	☐	☐	☐

12. Other:



CLASSROOM TEST

4. Describe three reasons yo

5. List two ways the Decisi

6. What are the values th

7. Restorative conversa
   a. Staff only
   b. The individual i
   c. Staff and the in

SECURITY

CLASSROOM TEST

Classroom Test

Name Date

Organization

Phone Email

1. Complete the *Crisis Development Model*™. (32 pts)

Crisis Development/Behaviour Levels	Staff Attitudes/Approaches
1.	1.
2.	2.
3.	3.
4.	4.

2. What is the value of learning the four levels and corresponding staff attitudes? (6 pts)

Workbook ID (below). Do not write in this box.

3. Complete the *Verbal Escalation Continuum*™. (20 pts)

Defensive

CPI Blue Card®

INSTRUCTOR: Sign and distribute this card before discontinuing online. For easy removal of card, please pop card from the sides.

has completed the *CPI Safety Intervention*™ Foundation.

CPI

MAHI - STM - 105 - 931

CPI *Safety Intervention*™

ADVANCED AND EMERGENCY

 | ELPR20EMCCCIYPUK | 20-SIE-EP-CL-1002 | revFeb21

MAHI - STM - 105 - 932

CPI Values and Philosophy

CARE

Respect, dignity, empathy, person-centered

WELFARE

Maintaining independence, choice and well-being

SAFETY

Protecting rights and minimising harm

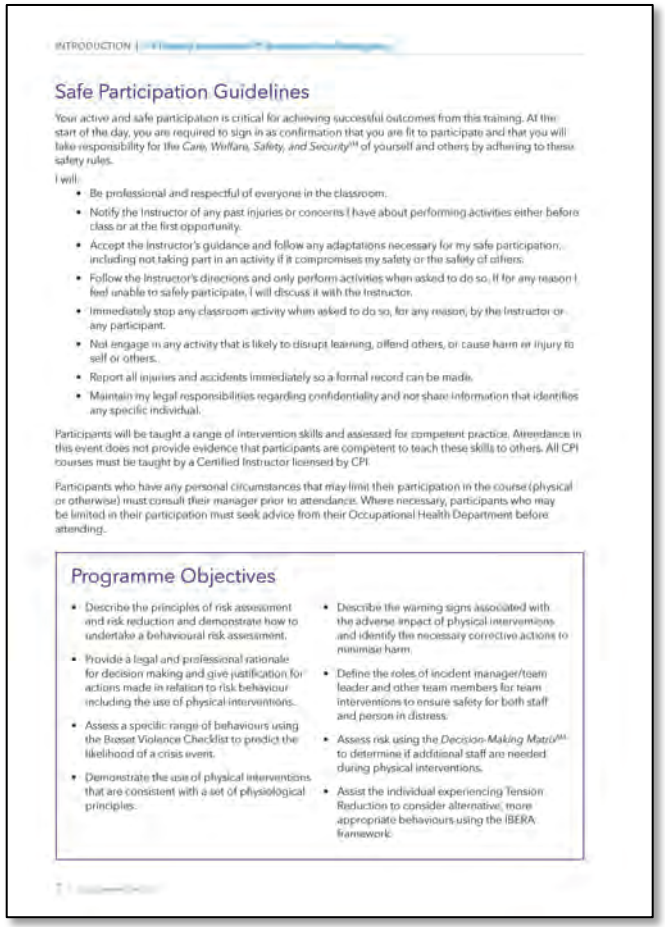
SECURITY

Safe, effective, harmonious and collaborative relationships

CPI

MAHI - STM - 105 - 933

Safe Participation Guidelines



INTRODUCTION |

Safe Participation Guidelines

Your active and safe participation is critical for achieving successful outcomes from this training. At the start of the day, you are required to sign in as confirmation that you are fit to participate and that you will take responsibility for the *Care, Welfare, Safety, and Security*™ of yourself and others by adhering to these safety rules.

I will:

- Be professional and respectful of everyone in the classroom.
- Notify the Instructor of any past injuries or concerns I have about performing activities either before class or at the first opportunity.
- Accept the Instructor's guidance and follow any adaptations necessary for my safe participation, including not taking part in an activity if it compromises my safety or the safety of others.
- Follow the Instructor's directions and only perform activities when asked to do so. If for any reason I feel unable to safely participate, I will discuss it with the Instructor.
- Immediately stop any classroom activity when asked to do so, for any reason, by the Instructor or any participant.
- Not engage in any activity that is likely to disrupt learning, offend others, or cause harm or injury to self or others.
- Report all injuries and accidents immediately so a formal record can be made.
- Maintain my legal responsibilities regarding confidentiality and not share information that identifies any specific individual.

Participants will be taught a range of intervention skills and assessed for competent practice. Attendance in this event does not provide evidence that participants are competent to teach these skills to others. All CPI courses must be taught by a Certified Instructor licensed by CPI.

Participants who have any personal circumstances that may limit their participation in the course (physical or otherwise) must consult their manager prior to attendance. Where necessary, participants who may be limited in their participation must seek advice from their Occupational Health Department before attending.

Programme Objectives

- Describe the principles of risk assessment and risk reduction and demonstrate how to undertake a behavioural risk assessment.
- Provide a legal and professional rationale for decision making and give justification for actions made in relation to risk behaviour including the use of physical interventions.
- Assess a specific range of behaviours using the Beset Violence Checklist to predict the likelihood of a crisis event.
- Demonstrate the use of physical interventions that are consistent with a set of physiological principles.
- Describe the warning signs associated with the adverse impact of physical interventions and identify the necessary corrective actions to minimise harm.
- Define the roles of incident manager/team leader and other team members for team interventions to ensure safety for both staff and person in distress.
- Assess risk using the *Decision-Making Matrix*™ to determine if additional staff are needed during physical interventions.
- Assist the individual experiencing Tension Reduction to consider alternative, more appropriate behaviours using the IBERA framework.

Your active and safe participation is critical for achieving successful outcomes from this training.

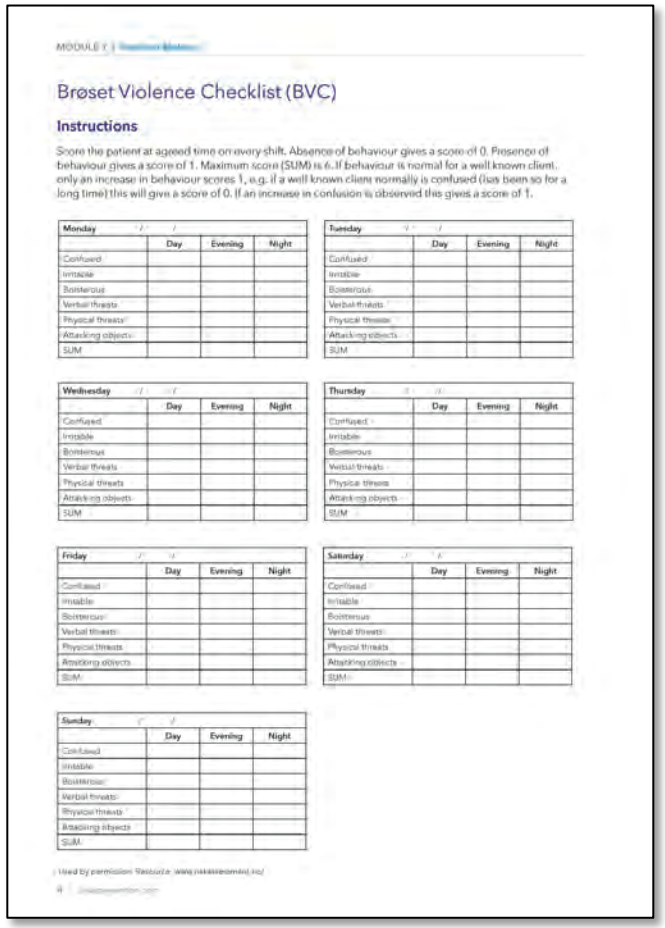
WORKBOOK PAGE 2

MODULE 7

Decision Making

Advanced

Brøset Violence Checklist (BVC)



Brøset Violence Checklist (BVC)

Instructions

Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well known client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Monday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tuesday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

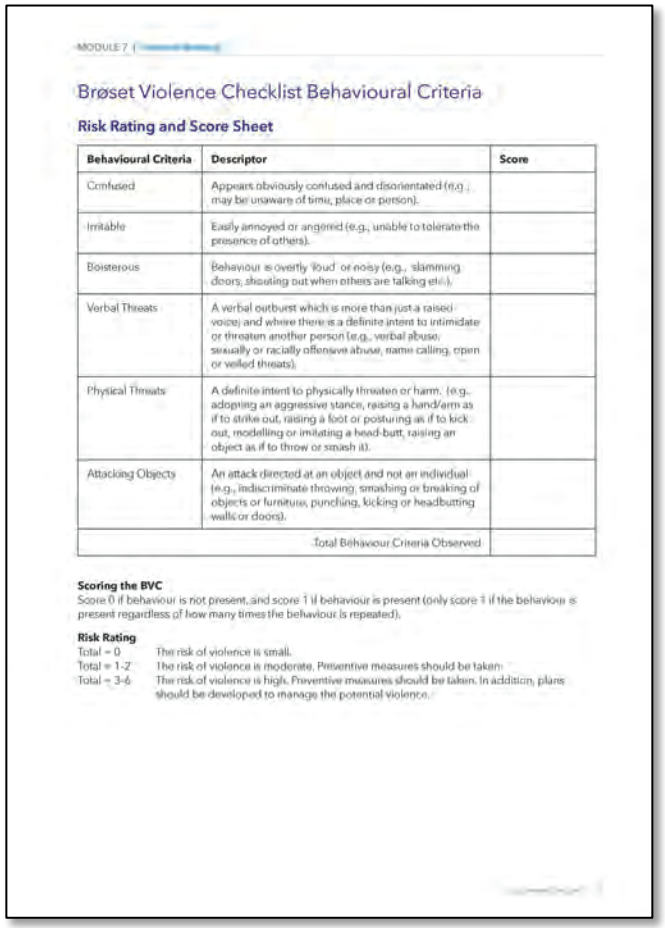
Wednesday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saturday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			



Brøset Violence Checklist Behavioural Criteria

Risk Rating and Score Sheet

Behavioural Criteria	Descriptor	Score
Confused	Appears obviously confused and disorientated (e.g., may be unaware of time, place or person).	
Irritable	Easily annoyed or angered (e.g., unable to tolerate the presence of others).	
Boisterous	Behaviour is overtly 'loud' or noisy (e.g., 'slamming doors, shouting out when others are talking etc.).	
Verbal Threats	A verbal outburst which is more than just a raised voice) and where there is a definite intent to intimidate or threaten another person (e.g., verbal abuse; sexually or racially offensive abuse, name calling, open or veiled threats).	
Physical Threats	A definite intent to physically threaten or harm. (e.g., adopting an aggressive stance, raising a hand/arm as if to strike out, raising a foot or posturing as if to kick out, modelling or imitating a head-butt, raising an object as if to throw or smash it).	
Attacking Objects	An attack directed at an object and not an individual (e.g., indiscriminate throwing; smashing or breaking of objects or furniture, punching, kicking or headbutting walls or doors).	
	Total Behaviour Criteria Observed	

Scoring the BVC

Score 0 if behaviour is not present, and score 1 if behaviour is present (only score 1 if the behaviour is present regardless of how many times the behaviour is repeated).

Risk Rating

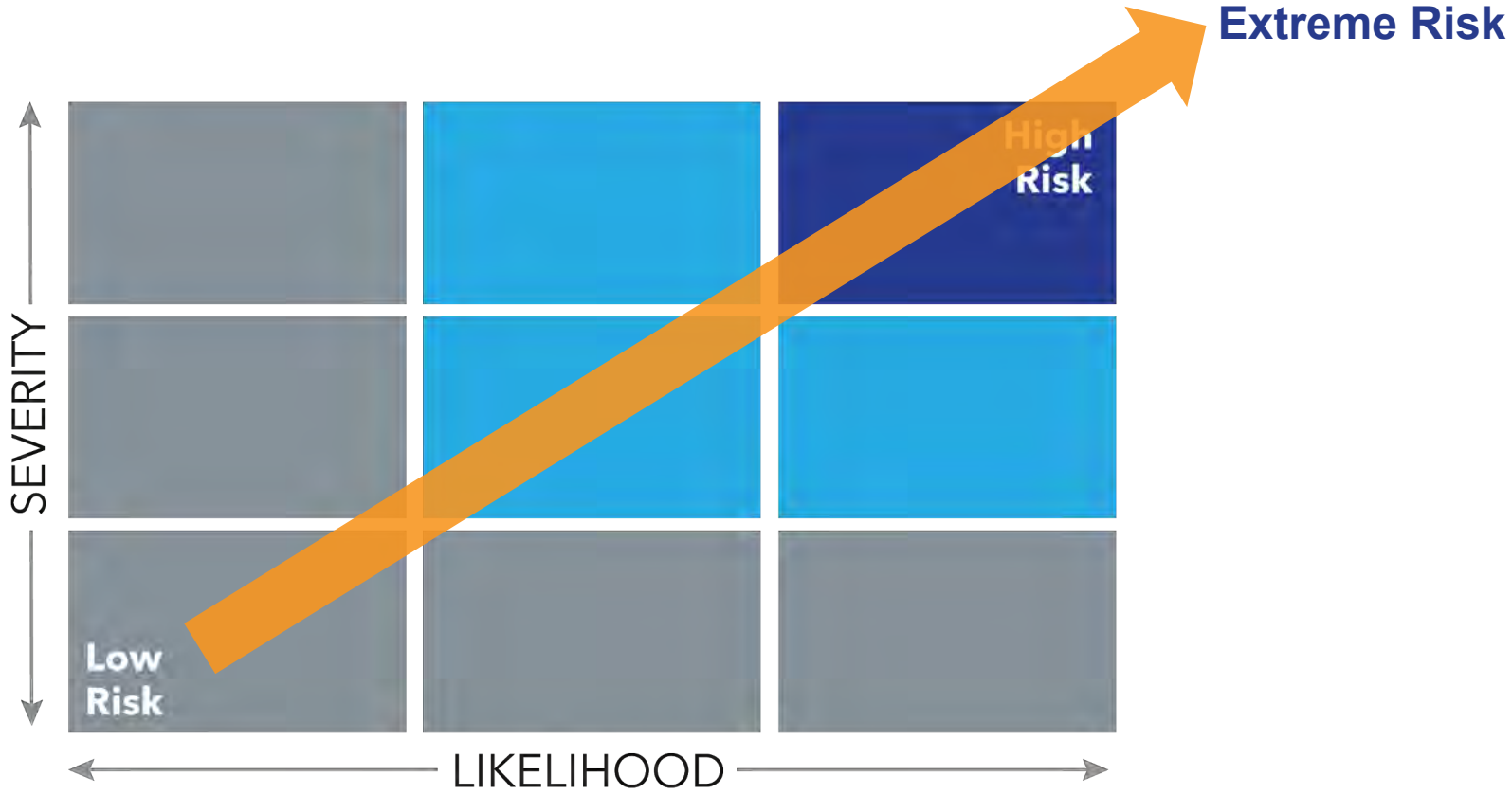
Total = 0 The risk of violence is small.
Total = 1-2 The risk of violence is moderate. Preventive measures should be taken.
Total = 3-6 The risk of violence is high. Preventive measures should be taken. In addition, plans should be developed to manage the potential violence.

Decision Making: Extreme Risk Behaviour

- Remain objective.
- Remain calm and in control of your own emotions, fears, and anxieties.
- Make appropriate legal and professional judgements about the necessary actions you may consider.
- Determine the level of risk and decide if and to what degree a physical intervention is necessary based on the common principles of last resort, reasonable, proportionate, and least restrictive response.

Decision Making

Decision-Making Matrix[SM]



EXTREME RISK

A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

SAFETY INTERVENTIONS

Disengagement Skills

MAHI - STM - 105 - 940

Safe Participation Guidelines

Maintaining Safety in the Training Programme

- Be professional and respectful.
- Notify the Instructor of any past injuries.
- Accept the Instructor's guidance.
- Follow the Instructor's directions.
- Stop any classroom activity when asked.
- Do not engage in disruptive activity.
- Report all injuries.
- Maintain legal responsibilities.

Advanced

Neck (High-Risk Behaviour)

Essential Responsibilities for Emergency Responses

- Authorised and approved
- Justification
- Life-threatening
- No safer alternative
- Never to coerce, punish, or gain compliance
- Safeguard against misuse or abuse

EXTREME RISK

A likely event or behaviour with a catastrophic severity of harm or immediate risk to life.

EMERGENCY RESPONSE

A physical intervention used for the sole purpose of gaining a release from extreme risk behaviour.

MAHI - STM - 105 - 945

Legal and Professional Considerations for Emergency Response

- Emergency Responses must be authorised
- The risk is extreme or life threatening; there is *no safer alternative*
- Never used to coerce, punish, or gain compliance
- Safeguard against misuse or abuse

The goal is always to maximise safety by gaining a release from a hold while minimising harm to the individual.

MAHI - STM - 105 - 946

Physiological Principles for Emergency Response

- Position, Posture, and Proximity
- Biomechanical Benefit
  - Direct Pressure and Movement

Extreme Risk – Emergency Responses

Thumb

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Extreme Risk – Emergency Responses

Dorsal Hand

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Extreme Risk – Emergency Responses

Upper Outer Torso

Staff Response (Emergency Escape)

Team Response (Emergency Rescue)

Extreme Risk – Emergency Responses

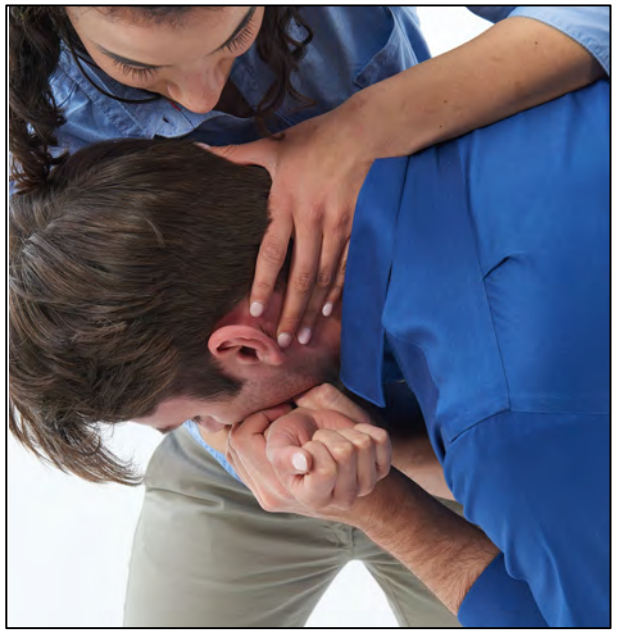
Sternum

Staff Response (Emergency Escape)

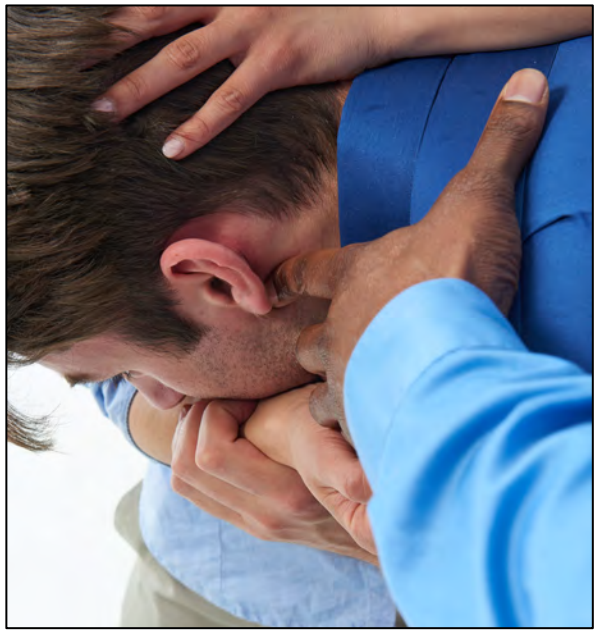
Team Response (Emergency Rescue)

Extreme Risk – Emergency Responses

Mandibular



Staff Response (Emergency Escape)



Team Response (Emergency Rescue)

Team Response (Emergency Rescue)

- The Columella Emergency Response is only to be used in a rescue situation with adults. This response must never be used with children or young people.
- The use of these interventions comes with great responsibility and a higher level of legal and professional scrutiny.
- The purpose of the Emergency Response is to get an immediate release from extreme risk behaviour to allow you to minimise harm and/or to assist your staff, colleague, or individual in care to a place of safety.
- If applying an Emergency Response doesn't create an immediate release, call for assistance.

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

SAFETY INTERVENTIONS

Holding Skills

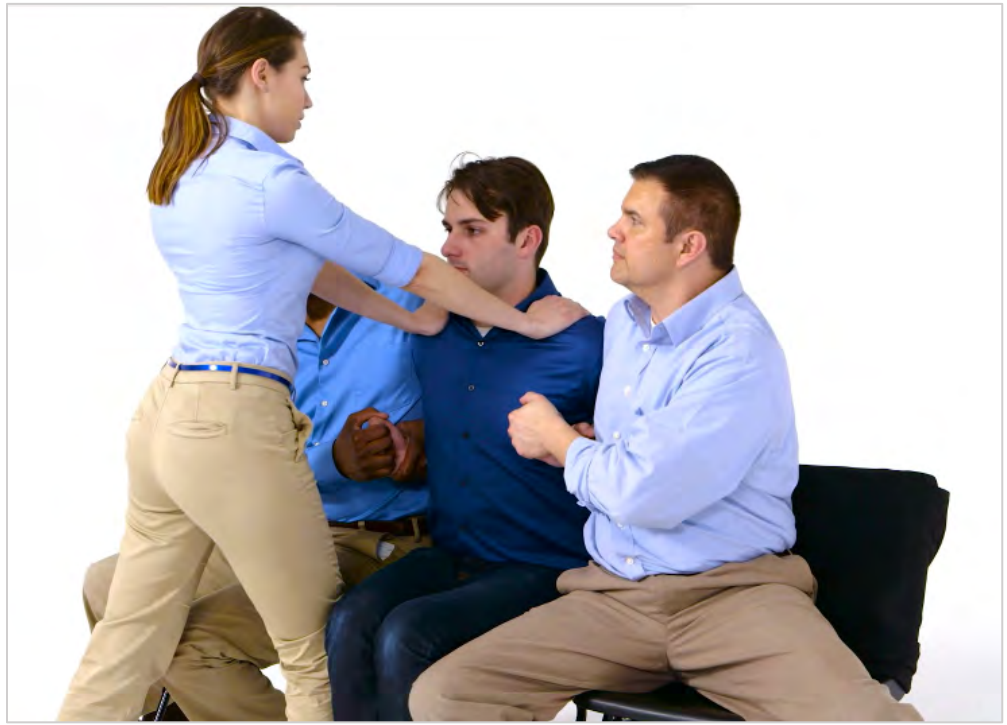
MAHI - STM - 105 - 955

Safe Participation Guidelines

Maintaining Safety in the Training Programme

- Be professional and respectful.
- Notify the Instructor of any past injuries.
- Accept the Instructor's guidance.
- Follow the Instructor's directions.
- Stop any classroom activity when asked.
- Do not engage in disruptive activity.
- Report all injuries.
- Maintain legal responsibilities.

Additional Staff – Seated



Additional Staff – Standing

Team Intervention

Low-Level Team Intervention

Medium/High-Level Team Intervention

High-Level Team Intervention

Advanced

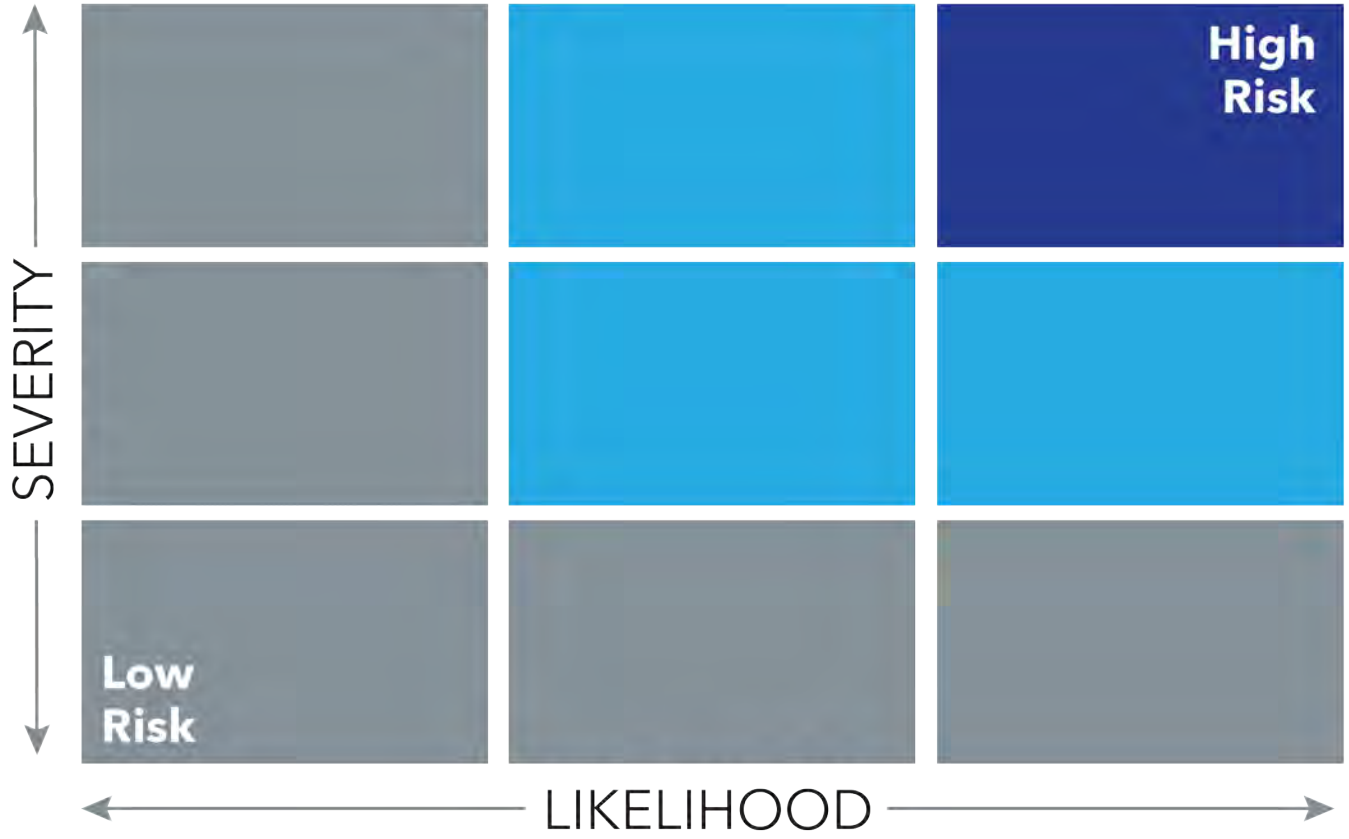
Standing to Seated (Floor Transition)

Transition to the Floor in Supine Position

EMERGENCY FLOOR HOLDING

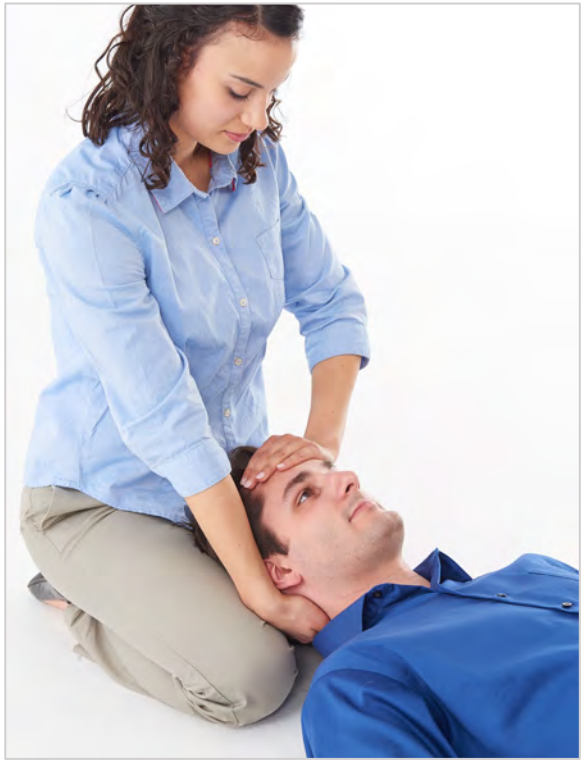
The emergency use of physical interventions on the floor to temporarily manage acute behavioural disturbance and/or extreme risk behaviour.

*Decision-Making Matrix*SM



Emergency Floor Holding (Supine)

Emergency Floor Holding (Supine)



Emergency Floor Holding Supine (Protecting Head, Spine & Airway)

Emergency Floor Holding Supine (Arms)

Emergency Floor Holding (Supine)

Emergency Floor Holding Supine (Legs)

Physical Skills Review Framework

Safe

Effective

Acceptable

Transferable

Advanced

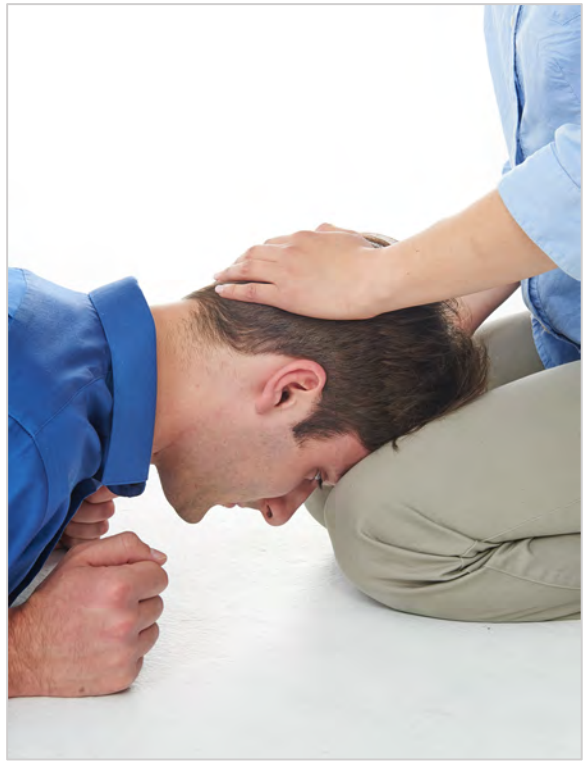
Standing to Kneeling (Floor Transition)

MAHI - STM - 105 - 968

Emergency Floor Holding — *Supported Prone Position*SM

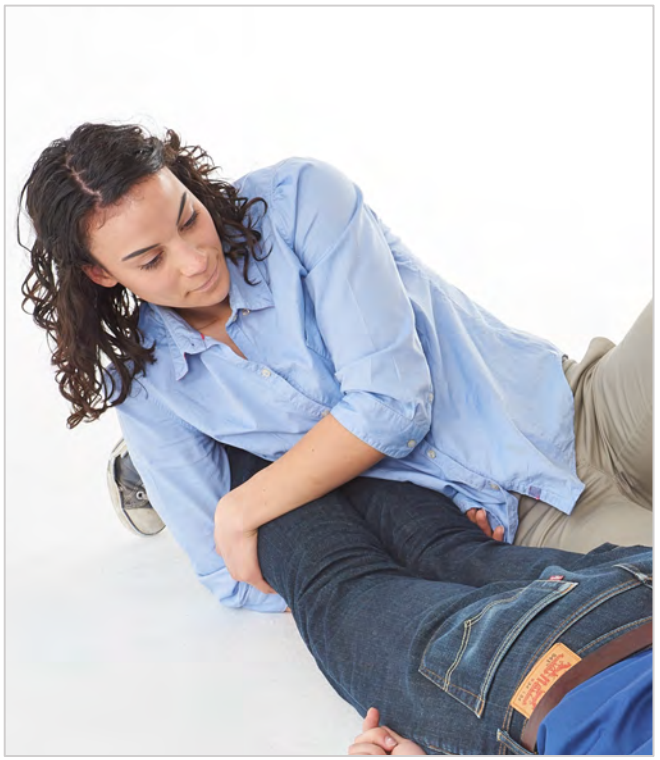
MAHI - STM - 105 - 969

Emergency Floor Holding — *Supported Prone Position*SM



Emergency Holding Supported Prone (Head, Spine & Airway)

Emergency Holding Supported Prone (Arms)



Emergency Holding Supported Prone (Legs)

Physical Skills Review Framework

S afe

E ffective

A cceptable

T ransferable

RAPID TRANQUILLISATION

The use of medication by the parenteral route (intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

SECLUSION

The supervised confinement of an individual to a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.

MAHI - STM - 105 - 973

Emergency Floor Holding Side Lying for Rapid Tranquillisation

MAHI - STM - 105 - 974

Emergency Holding for Seclusion (Entry and Exit)

MAHI - STM - 105 - 975

Emergency Holding for Seclusion (Searching or Removal of Unsafe Items)

MODULE 8

Post-Crisis

MAHI - STM - 105 - 977

Advanced

IBERA Post-Crisis Debriefing Tool: 5 Simple Steps

Step 1: **I**ntroduction	Introduce yourself and make sure you are clear about how much time you have to spend with the person.
Step 2: **B**ackground	Find out about the event. Use open questions to get the person to tell you their view of the event.
Step 3: **E**motional Impact	Use questions which help the person to describe their emotional response to the event or circumstances.
Step 4: **R**esourcefulness	Find out how the person is handling the event and show empathy. Assess the person's response to how they are dealing with the event.
Step 5: **A**ction and Close	End the debriefing by asking the person if there is anything they think they should now do.

CPI *SAFETY INTERVENTION*™ ADVANCED AND EMERGENCY

Conclusion

MAHI - STM - 105 - 979

Action Plan

Trauma-Responsive Practice

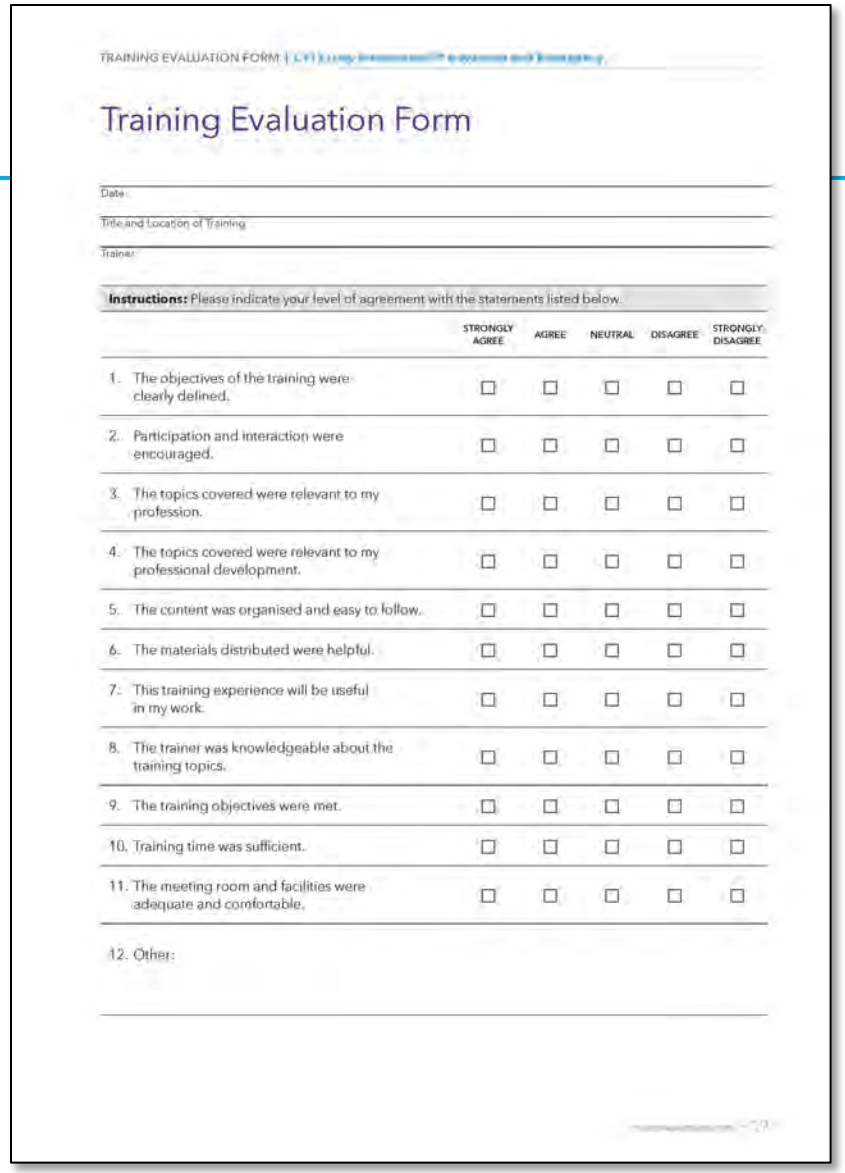
- Programming
- Environment
- Language
- Values

Trauma-Informed Care

- Safety
- Transparency and Trustworthiness
- Choice
- Collaboration and Mutuality
- Empowerment

MAHI - STM - 105 - 980

Evaluation



TRAINING EVALUATION FORM

Training Evaluation Form

Date:

Title and Location of Training:

Trainer:

Instructions: Please indicate your level of agreement with the statements listed below.

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1. The objectives of the training were clearly defined.	☐	☐	☐	☐	☐
2. Participation and interaction were encouraged.	☐	☐	☐	☐	☐
3. The topics covered were relevant to my profession.	☐	☐	☐	☐	☐
4. The topics covered were relevant to my professional development.	☐	☐	☐	☐	☐
5. The content was organised and easy to follow.	☐	☐	☐	☐	☐
6. The materials distributed were helpful.	☐	☐	☐	☐	☐
7. This training experience will be useful in my work.	☐	☐	☐	☐	☐
8. The trainer was knowledgeable about the training topics.	☐	☐	☐	☐	☐
9. The training objectives were met.	☐	☐	☐	☐	☐
10. Training time was sufficient.	☐	☐	☐	☐	☐
11. The meeting room and facilities were adequate and comfortable.	☐	☐	☐	☐	☐

12. Other:

Verbal Intervention: Classroom Formative Assessment

MAHI - STM - 105 - 981

Course Date(s): _____ Instructor(s): _____

	Participant Name	X if Absent	X if Not Taught	Applies Staff Approaches			*Supportive Stance*SM			Listens With Empathy			Verbal Intervention Approach			Comments
				SKILLED	VALUES	NEEDS PRACTICE	SKILLED	VALUES	NEEDS PRACTICE	SKILLED	VALUES	NEEDS PRACTICE	SKILLED	VALUES	NEEDS PRACTICE	
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How to Use This Form

MAHI - STM - 105 - 982

Use this Verbal Intervention: Classroom Formative Assessment during the classroom portion of your CPI training. The description of the task being evaluated is listed in the following table. Review Criteria to Meet Task. You will look and listen for participants to use the various skills they have learnt in the training. For additional criteria, refer to your Instructor Guide.

These objectives are written as a broad perspective of what you should look for, and the skilled behaviour example gives you an idea of what this might look like. This assessment is only meant to evaluate how well an individual can demonstrate the objective in the classroom setting. It is not meant to be used in the workplace.

Photocopy the following form and fill in participant names. Place a checkmark in the boxes that indicate if they were successful in meeting the objective or not. There is a column for you to write more notes if needed.

Give participants feedback on where they demonstrated skills effectively and where they may need more practice. You may want to provide extra practice or time based on individual needs.

Task During Verbal Interventon	**Criteria to Meet Task**
Applies staff approaches to different levels of crisis behaviour	• Uses supportive approaches for anxious behaviour. – Examples: listens, offers a drink or a quiet place, etc. • Uses directive approaches for defensive behaviours. – Examples: gives clear instruction, sets limits, avoids a power struggle, etc.
Demonstrates the *Supportive Stance*[SM]	• Aware of position, posture, and proximity • Approaches from the side • Stands a safe distance (leg or arm length) away and is aware of personal space
Listens with empathy	• Remains non-judgemental • Gives undivided attention • Allows time • Paraphrases
Recognises types of defensive behaviour and uses appropriate verbal intervention	• Avoids entering a power struggle • Sets limits • Allows venting • Downplays challenge • Gives a directive

Classroom Formative Assessment Record

MAHI - STM - 105 - 983

CPI Non-Restrictive Safety Interventions: Disengagement

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

CPI *Safety Intervention*™ Advanced		X if not taught																						
		X IF ABSENT	STRIKE	WRIST			CLOTHES			HAIR			NECK			BODY			BITE		INTERVENTIONS (1 Staff)			NECK (High Risk)
	PARTICIPANT NAME			L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	L	M	H	
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PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Low Risk	Position, Posture, Proximity Hold and Stabilise	Demonstrated repeated application without instruction
Medium Risk	Position, Posture, Proximity Pull/Push	Demonstrated repeated application without instruction
High Risk	Position, Posture, Proximity Lever	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

MAHI - STM - 105 - 984

CPI Non-Restrictive Safety Interventions: Disengagement

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →															
CPI *Safety Intervention*™ Emergency		X IF ABSENT	EMERGENCY RESPONSES												
			THUMB		DORSAL HAND		TORSO		STERNUM		MANDIBULAR		COLUMELLAR		
PARTICIPANT NAME			Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	
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PARTICIPANT ASSESSMENT CRITERIA		
Range	Skill Application	Performance
Extreme Risk	Position, Posture, Proximity Direct Pressure/Movement	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

MAHI - STM - 105 - 985

CPI Restrictive Safety Interventions: Holding

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →																										
CPI *Safety Intervention*™ Advanced		X IF ABSENT	TEAM LEADER	MEDICAL EMERGENCY	SEATED			STANDING			TEAM INTERVENTIONS (2 Staff)	TRANSITIONS (2 Staff)	CHILDREN HOLDS							3RD PERSON		ADVANCED TEAM INTERVENTIONS (3 staff)	TRANSITIONS (3 Staff)	STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)		STANDING TO FLOOR TRANSITIONS (Slips, Trips, and Falls)	
													SEATED (chair)			SEATED (floor)			STANDING								
PARTICIPANT NAME					L	M	H	L	M	H			L	M	H	L	M	H	L	M	H	SEATED	STANDING			STANDING TO SEATED	STANDING TO SUPINE	STANDING TO KNEELING	STANDING TO SUPPORTED PRONE
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PARTICIPANT ASSESSMENT CRITERIA		
Range	**Skill Application**	**Performance**
Low Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
Medium Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction
High Risk	Outside/Inside Principle, Limit Range of Motion	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

MAHI - STM - 105 - 986

CPI Restrictive Safety Interventions: Holding

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

X if not taught →									
CPI *Safety Intervention*™ Emergency				EMERGENCY FLOOR HOLDING			SECLUSION		
PARTICIPANT NAME		X IF ABSENT	EMERGENCY TEAM INTERVENTIONS (3 staff)	SUPINE	SUPPORTED PRONE	RAPID TRANQUILLISATION	ENTRY	SEARCH/ REMOVAL OF UNSAFE ITEMS	EXIT
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PARTICIPANT ASSESSMENT CRITERIA		
Range	Skill Application	Performance
Extreme Risk	Outside/Inside Principle Limit Range of Motion Direct Pressure/Movement	Demonstrated repeated application without instruction

Marking: Place the following mark in the appropriate safety intervention column for each participant upon successful demonstration.

✔ = Competent Demonstration and Application

✗ = Did Not Demonstrate Competence

If individual is not able to demonstrate competency, complete individual participant sheet for remediation options.

Classroom Formative Assessment Record

MAHI - STM - 105 - 987

CPI Restrictive Safety Interventions

Course Title: _____

Commissioner: _____

Course Date(s): _____

Instructor(s): _____

Participant Name:	
Skill Unassessed/Competence Not Demonstrated:	
Instructor Reason/Notes	Participant Reason/Notes
Instructor Signature	Participant Signature

NOTES:

NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

Diabetic foot problems: prevention and management

NICE guideline
Published: 26 August 2015
www.nice.org.uk/guidance/ng19

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG10 and CG119.

This guideline partially replaces CG15.

This guideline is the basis of QS208 and QS209.

Overview

This guideline covers preventing and managing foot problems in children, young people and adults with diabetes. It aims to reduce variation in practice, including antibiotic prescribing for diabetic foot infections.

See a 3-page visual summary of the antimicrobial prescribing recommendations, including tables to support prescribing decisions.

Who is it for?

- Healthcare professionals caring for people with diabetes
- Commissioners and providers of diabetes foot care services
- People with diabetes, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Care within 24 hours of a person with diabetic foot problems being admitted to hospital, or the detection of diabetic foot problems (if the person is already in hospital)

1.1.1 Each hospital should have a care pathway for people with diabetic foot problems who need inpatient care. **[2011]**

1.1.2 A named consultant should be accountable for the overall care of the person, and for ensuring that healthcare professionals provide timely care. **[2011]**

1.1.3 Refer the person to the multidisciplinary foot care service within 24 hours of the initial examination of the person's feet. Transfer the responsibility of care to a consultant member of the multidisciplinary foot care service if a diabetic foot problem is the dominant clinical factor for inpatient care. **[2011]**

1.1.4 The named consultant and the healthcare professionals from the existing team should remain accountable for the care of the person unless their care is transferred to the multidisciplinary foot care service. **[2011]**

1.2 Care across all settings

1.2.1 Commissioners and service providers should ensure that the following are in place:

- A foot protection service for preventing diabetic foot problems, and for treating and managing diabetic foot problems in the community.
- A multidisciplinary foot care service for managing diabetic foot problems in hospital and in the community that cannot be managed by the foot protection service. This may also be known as an interdisciplinary foot care service.
- Robust protocols and clear local pathways for the continued and integrated care of people across all settings including emergency care and general practice. The protocols should set out the relationship between the foot protection service and the multidisciplinary foot care service.
- Regular reviews of treatment and patient outcomes, in line with the National Diabetes Foot Care Audit. **[2015]**

1.2.2 The foot protection service should be led by a podiatrist with specialist training in diabetic foot problems, and should have access to healthcare professionals with skills in the following areas:

- Diabetology.
- Biomechanics and orthoses.
- Wound care. **[2015]**

1.2.3 The multidisciplinary foot care service should be led by a named healthcare professional, and consist of specialists with skills in the following areas:

- Diabetology.
- Podiatry.
- Diabetes specialist nursing.
- Vascular surgery.

- Microbiology.
- Orthopaedic surgery.
- Biomechanics and orthoses.
- Interventional radiology.
- Casting.
- Wound care. **[2015]**

1.2.4 The multidisciplinary foot care service should have access to rehabilitation services, plastic surgery, psychological services and nutritional services. **[2015]**

1.2.5 Healthcare professionals may need to discuss, agree and make special arrangements for disabled people and people who are housebound or living in care settings, to ensure equality of access to foot care assessments and treatments for people with diabetes. **[2015]**

1.2.6 Take into account any disabilities, including visual impairment, when planning and delivering care for people with diabetes. **[2015]**

1.3 Assessing the risk of developing a diabetic foot problem

Frequency of assessments

1.3.1 For children with diabetes who are under 12 years, give them, and their family members or carers (as appropriate), basic foot care advice. **[2015]**

1.3.2 For young people with diabetes who are 12 to 17 years, the paediatric care team or the transitional care team should assess the young person's feet as part of their annual assessment, and provide information about foot care. If a diabetic foot problem is found or suspected, the paediatric care team or the transitional care team should refer the young person to an appropriate specialist. **[2015]**

1.3.3 For adults with diabetes, assess their risk of developing a diabetic foot problem at the following times:

- When diabetes is diagnosed, and at least annually thereafter (see the recommendation on carrying out reassessments at intervals, depending on the person's risk of developing a diabetic foot problem).
- If any foot problems arise.
- On any admission to hospital, and if there is any change in their status while they are in hospital. **[2015]**

Assessing the risk of developing a diabetic foot problem

1.3.4 When examining the feet of a person with diabetes, remove their shoes, socks, bandages and dressings, and examine both feet for evidence of the following risk factors:

- neuropathy (use a 10 g monofilament as part of a foot sensory examination)
- limb ischaemia (see the NICE guideline on peripheral arterial disease)
- ulceration
- callus
- infection and/or inflammation
- deformity
- gangrene
- Charcot arthropathy. **[2023]**

1.3.5 Use ankle brachial pressure index in line with the NICE guideline on peripheral arterial disease. Interpret results carefully in people with diabetes because calcified arteries may falsely elevate results. **[2015]**

1.3.6 Assess the person's current risk of developing a diabetic foot problem or needing an amputation using the following risk stratification:

- Low risk:
  - no risk factors present except callus alone.
- Moderate risk:
  - deformity **or**
  - neuropathy **or**
  - peripheral arterial disease.
- High risk:
  - previous ulceration **or**
  - previous amputation **or**
  - on renal replacement therapy **or**
  - neuropathy and peripheral arterial disease together **or**
  - neuropathy in combination with callus and/or deformity **or**
  - peripheral arterial disease in combination with callus and/or deformity.
- Active diabetic foot problem:
  - ulceration **or**
  - infection **or**
  - chronic limb-threatening ischaemia **or**
  - gangrene **or**
  - suspicion of an acute Charcot arthropathy, or an unexplained hot, swollen foot with a change in colour, with or without pain. **[2023]**

For a short explanation of why the committee did not change the recommendations that were reviewed in 2023, and how this might affect practice, see the rationale and impact section on assessing the risk of developing a diabetic foot problem.

Full details of the evidence and the committee's discussion are in evidence review B: risk assessment models and tools for predicting the development of diabetic foot problems and foot review frequency.

Managing the risk of developing a diabetic foot problem

1.3.7 For people who are at low risk of developing a diabetic foot problem:

- continue to carry out foot assessments at their annual diabetes review
- emphasise the importance of foot care (see the section on patient information about the risk of developing a diabetic foot problem)
- advise them that they could progress to moderate or high risk. **[2023]**

1.3.8 Refer people who are at moderate or high risk of developing a diabetic foot problem to the foot protection service. **[2015]**

1.3.9 The foot protection service should assess newly referred people as follows:

- Within 2 to 4 weeks for people who are at high risk of developing a diabetic foot problem.
- Within 6 to 8 weeks for people who are at moderate risk of developing a diabetic foot problem. **[2015]**

1.3.10 For people at moderate or high risk of developing a diabetic foot problem, the foot protection service should:

- Assess the feet.
- Give advice about, and provide, skin and nail care of the feet.

- Assess the biomechanical status of the feet, including the need to provide specialist footwear and orthoses.
- Assess the vascular status of the lower limbs.
- Liaise with other healthcare professionals, for example, the person's GP, about the person's diabetes management and risk of cardiovascular disease. **[2015]**

1.3.11 Depending on the person's risk of developing a diabetic foot problem, carry out reassessments at the following intervals:

- Annually for people who are at low risk, as part of their annual diabetes review.
- Frequently (for example, every 3 to 6 months) for people who are at moderate risk.
- More frequently (for example, every 1 to 2 months) for people who are at high risk, if there is no immediate concern.
- Very frequently (for example, every 1 to 2 weeks) for people who are at high risk, if there is immediate concern.
- Consider more frequent reassessments for people who are at moderate or high risk, and for people who are unable to check their own feet. **[2023]**

1.3.12 People in hospital who are at moderate or high risk of developing a diabetic foot problem should be given a pressure redistribution device to offload heel pressure. On discharge they should be referred or notified to the foot protection service. **[2015]**

For a short explanation of why the committee did not change the recommendations that were reviewed in 2023, and how this might affect practice, see the rationale and impact section on managing the risk of developing a diabetic foot problem.

Full details of the evidence and the committee's discussion are in evidence review B: risk assessment models and tools for predicting the development of diabetic foot problems and foot review frequency.

Patient information about the risk of developing a diabetic foot

problem

1.3.13 Provide information and clear explanations to people with diabetes and/or their family members or carers (as appropriate) when diabetes is diagnosed, during assessments, and if problems arise. Information should be oral and written, and include the following:

- Basic foot care advice and the importance of foot care.
- Foot emergencies and who to contact.
- Footwear advice.
- The person's current individual risk of developing a foot problem.
- Information about diabetes and the importance of blood glucose control (also see recommendation 1.3.14). **[2015]**

1.3.14 For guidance on education programmes and information about diabetes, see the education and information section in the NICE guideline on type 1 diabetes in adults, the education section in the NICE guideline on type 2 diabetes in adults, and the sections on education and information for children and young people with type 1 diabetes and education and information for children and young people with type 2 diabetes in the NICE guideline on diabetes (type 1 and type 2) in children and young people. **[2015]**

1.4 Diabetic foot problems

Referral

1.4.1 If a person has a limb-threatening or life-threatening diabetic foot problem, refer them immediately to acute services and inform the multidisciplinary foot care service (according to local protocols and pathways; also see the recommendation on services and protocols commissioners and service providers should ensure are in place), so they can be assessed and an individualised treatment plan put in place. Examples of limb-threatening and life-threatening diabetic foot problems include the following:

- Ulceration with fever or any signs of sepsis.
- Ulceration with limb ischaemia (see the NICE guideline on peripheral arterial disease).
- Clinical concern that there is a deep-seated soft tissue or bone infection (with or without ulceration).
- Gangrene (with or without ulceration). **[2015]**

1.4.2 For all other active diabetic foot problems, refer the person within 1 working day to the multidisciplinary foot care service or foot protection service (according to local protocols and pathways; also see the recommendation on services and protocols commissioners and service providers should ensure are in place) for triage within 1 further working day. **[2015]**

Patient information about diabetic foot problems

1.4.3 Provide information and clear explanations as part of the individualised treatment plan for people with a diabetic foot problem. Information should be oral and written, and include the following:

- A clear explanation of the person's foot problem.
- Pictures of diabetic foot problems.
- Care of the other foot and leg.
- Foot emergencies and who to contact.
- Footwear advice.
- Wound care.
- Information about diabetes and the importance of blood glucose control (also see the recommendation on additional guidance on education programmes and information about diabetes). **[2015]**

1.4.4 If a person presents with a diabetic foot problem, take into account that they may have an undiagnosed, increased risk of cardiovascular disease that may need further investigation and treatment. For guidance on the

primary prevention of cardiovascular disease, see the NICE guideline on cardiovascular disease: risk assessment and reduction, including lipid modification. **[2015]**

1.5 Diabetic foot ulcer

Investigation

1.5.1 If a person has a diabetic foot ulcer, assess and document the size, depth and position of the ulcer. **[2015]**

1.5.2 Use a standardised system to document the severity of the foot ulcer, such as the SINBAD (Site, Ischaemia, Neuropathy, Bacterial Infection, Area and Depth) or the University of Texas classification system. **[2015]**

1.5.3 Do not use the Wagner classification system to assess the severity of a diabetic foot ulcer. **[2015]**

Treatment

1.5.4 Offer 1 or more of the following as standard care for treating diabetic foot ulcers:

- Offloading.
- Control of foot infection.
- Control of ischaemia.
- Wound debridement.
- Wound dressings. **[2015]**

1.5.5 Offer non-removable casting to offload plantar neuropathic, non-ischaemic, uninfected forefoot and midfoot diabetic ulcers. Offer an alternative offloading device until casting can be provided. **[2015]**

1.5.6 In line with the NICE guideline on pressure ulcers, use pressure-redistributing devices and strategies to minimise the risk of pressure

ulcers developing. **[2015]**

1.5.7 When treating diabetic foot ulcers, debridement in hospital should only be done by healthcare professionals from the multidisciplinary foot care service, using the technique that best matches their specialist expertise and clinical experience, the site of the diabetic foot ulcer and the person's preference. **[2015]**

1.5.8 When treating diabetic foot ulcers, debridement in the community should only be done by healthcare professionals with the relevant training and skills, continuing the care described in the person's treatment plan. **[2015]**

1.5.9 Consider negative pressure wound therapy after surgical debridement for diabetic foot ulcers, on the advice of the multidisciplinary foot care service. **[2015]**

1.5.10 When deciding about wound dressings and offloading when treating diabetic foot ulcers, take into account the clinical assessment of the wound and the person's preference, and use devices and dressings with the lowest acquisition cost appropriate to the clinical circumstances. **[2015]**

1.5.11 Consider dermal or skin substitutes as an adjunct to standard care when treating diabetic foot ulcers, only when healing has not progressed and on the advice of the multidisciplinary foot care service. **[2015]**

1.5.12 Do not offer the following to treat diabetic foot ulcers, unless as part of a clinical trial:

- Electrical stimulation therapy, autologous platelet-rich plasma gel, regenerative wound matrices and dalteparin.
- Growth factors (granulocyte colony-stimulating factor [G-CSF], platelet-derived growth factor [PDGF], epidermal growth factor [EGF] and transforming growth factor beta [TGF-β]).
- Hyperbaric oxygen therapy. **[2015]**

1.5.13 When deciding the frequency of follow-up as part of the treatment plan, take into account the overall health of the person with diabetes, how healing has progressed, and any deterioration. **[2015]**

1.5.14 Ensure that the frequency of monitoring set out in the person's individualised treatment plan is maintained whether the person with diabetes is being treated in hospital or in the community. **[2015]**

1.6 Diabetic foot infection

Investigation

1.6.1 If a diabetic foot infection is suspected and a wound is present, send a soft tissue or bone sample from the base of the debrided wound for microbiological examination. If this cannot be obtained, take a deep swab because it may provide useful information on the choice of antibiotic treatment. **[2015]**

1.6.2 Consider an X-ray of the person's affected foot (or feet) to determine the extent of the diabetic foot problem. **[2015]**

1.6.3 Think about osteomyelitis if the person with diabetes has a local infection, a deep foot wound or a chronic foot wound. **[2015]**

1.6.4 Be aware that osteomyelitis may be present in a person with diabetes despite normal inflammatory markers, X-rays or probe-to-bone testing. **[2015]**

1.6.5 If osteomyelitis is suspected in a person with diabetes but is not confirmed by initial X-ray, consider an MRI to confirm the diagnosis. **[2015]**

Treatment

1.6.6 Start antibiotic treatment for people with suspected diabetic foot infection as soon as possible. Take samples for microbiological testing before, or as close as possible to, the start of antibiotic treatment.

[2019]

1.6.7 When choosing an antibiotic for people with a suspected diabetic foot infection (see recommendations 1.6.8 and 1.6.9), take account of:

- the severity of diabetic foot infection (mild, moderate or severe)
- the risk of developing complications
- previous microbiological results
- previous antibiotic use
- patient preferences. **[2019]**

For a short explanation of why the committee made these 2019 recommendations and how they might affect practice, see the rationale and impact section on treatment.

Full details of the evidence and the committee's discussion are in evidence review A: diabetic foot infection: antimicrobial prescribing.

Choice of antibiotic

1.6.8 When prescribing antibiotics for a suspected diabetic foot infection in adults aged 18 years and over, follow table 1 for a mild infection or table 2 for a moderate or severe infection. **[2019]**

1.6.9 Seek specialist advice when prescribing antibiotics for a suspected diabetic foot infection in children and young people under 18 years. **[2019]**

1.6.10 Give oral antibiotics first line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics. **[2019]**

1.6.11 If intravenous antibiotics are given, review by 48 hours and consider switching to oral antibiotics if possible. **[2019]**

1.6.12 Base antibiotic course length on the severity of the infection and a clinical assessment of response to treatment. Review the need for continued antibiotics regularly. **[2019]**

Table 1 Antibiotics for mild diabetic foot infection in adults aged 18 years and over

First-choice oral antibiotic

Antibiotic	Dosage and course length
See BNF for appropriate use and dosing in specific populations, for example, people with hepatic or renal impairment, or who are pregnant or breastfeeding.	Oral doses are for immediate-release medicines.
Flucloxacillin	500 mg to 1 g four times a day for 7 days. A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take some time to return to normal, and full resolution of symptoms at 7 days is not expected. In August 2015, the upper dose of 1 g four times a day was off label. See NICE's information on prescribing medicines.

Alternative oral antibiotics for penicillin allergy or if flucloxacillin unsuitable (guided by microbiological results when available)

Antibiotic	Dosage and course length
See BNF for appropriate use and dosing in specific populations, for example, people with hepatic or renal impairment, or who are pregnant or breastfeeding.	Oral doses are for immediate-release medicines.

Antibiotic	Dosage and course length
Clarithromycin	500 mg twice a day for 7 days. A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take some time to return to normal, and full resolution of symptoms at 7 days is not expected.
Erythromycin (in pregnancy)	500 mg four times a day for 7 days. A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take some time to return to normal, and full resolution of symptoms at 7 days is not expected.
Doxycycline	200 mg on first day, then 100 mg once a day (can be increased to 200 mg daily) for 7 days. A longer course (up to a further 7 days) may be needed based on clinical assessment. However, skin does take some time to return to normal, and full resolution of symptoms at 7 days is not expected.

Table 2 Antibiotics for moderate or severe diabetic foot infection in adults aged 18 years and over

First-choice antibiotics (guided by microbiological results when available); in severe infection, give intravenously for at least 48 hours (until stabilised)

Antibiotic	Dosage
See BNF for appropriate use and dosing in specific populations, for example, people with hepatic or renal impairment, or who are pregnant or breastfeeding, and administering intravenous (IV; or, where appropriate, intramuscular) antibiotics.	Oral doses are for immediate-release medicines.

Antibiotic	Dosage
Flucloxacillin **with or without**	1 g four times a day orally **or** 1 to 2 g four times a day IV. In August 2015, the dose of 1 g four times a day was off label. See NICE's information on prescribing medicines.
Gentamicin **and/or**	Initially 5 to 7 mg/kg once a day IV, subsequent doses adjusted according to serum gentamicin concentration. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.
Metronidazole	400 mg three times a day orally **or** 500 mg three times a day IV.
Co-amoxiclav **with or without**	500/125 mg three times a day orally **or** 1.2 g three times a day IV
Gentamicin	Initially 5 to 7 mg/kg once a day IV, subsequent doses adjusted according to serum gentamicin concentration. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.

Antibiotic	Dosage
Co-trimoxazole (in penicillin allergy) **with or without**	960 mg twice a day orally **or** 960 mg twice a day IV (can be increased to 1.44 g twice a day). See BNF for information on monitoring of patient parameters. In August 2015, this was not licensed for diabetic foot infection, so was off-label. See NICE's information on prescribing medicines.
Gentamicin **and/or**	Initially 5 to 7 mg/kg once a day IV, subsequent doses adjusted according to serum gentamicin concentration. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.
Metronidazole	400 mg three times a day orally **or** 500 mg three times a day IV.
Ceftriaxone **with**	2 g once a day IV.
Metronidazole	400 mg three times a day orally **or** 500 mg three times a day IV.

Notes:

Course length is based on clinical assessment: minimum of 7 days and up to 6 weeks for osteomyelitis (use oral antibiotics for prolonged treatment).

Give oral antibiotics first line if the person can take oral medicines, and the severity of

their condition does not require intravenous antibiotics.

Review intravenous antibiotics by 48 hours and consider switching to oral antibiotics if possible.

Other antibiotics may be appropriate based on microbiological results and specialist advice.

Skin takes some time to return to normal, and full resolution of symptoms after a course of antibiotics is not expected. Review the need for continued antibiotics regularly.

Additional antibiotic choices if Pseudomonas aeruginosa suspected or confirmed (guided by microbiological results when available)

Antibiotic	Dosage
See BNF for appropriate use and dosing in specific populations, for example, people with hepatic or renal impairment, or who are pregnant or breastfeeding, and administering intravenous (IV; or, where appropriate, intramuscular) antibiotics.	Oral doses are for immediate-release medicines.
Piperacillin with tazobactam	4.5 g three times a day IV (can be increased to 4.5 g four times a day).
Clindamycin **with**	150 to 300 mg four times a day orally (can be increased to 450 mg four times a day) **or** 600 mg to 2.7 g daily IV in two to four divided doses, increased if necessary in life-threatening infection to 4.8 g daily (maximum per dose 1.2 g).

Antibiotic	Dosage
Ciprofloxacin (consider safety issues) **and/or**	500 mg twice a day orally **or** 400 mg two or three times a day IV. See Medicines and Healthcare products Regulatory Agency (MHRA) advice for restrictions and precautions for using fluoroquinolone antibiotics due to very rare reports of disabling and potentially long-lasting or irreversible side effects affecting musculoskeletal and nervous systems. Warnings include: stopping treatment at first signs of serious adverse reaction (such as tendonitis), prescribing with special caution in people over 60 years and avoiding coadministration with a corticosteroid (March 2019).
Gentamicin	Initially 5 to 7 mg/kg once a day IV, subsequent doses adjusted according to serum gentamicin concentration. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.

Notes:

Course length is based on clinical assessment: minimum of 7 days and up to 6 weeks for osteomyelitis (use oral antibiotics for prolonged treatment).

Give oral antibiotics first line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics.

Review intravenous antibiotics by 48 hours and consider switching to oral antibiotics if possible.

Other antibiotics may be appropriate based on microbiological results and specialist advice.

These antibiotics may also be appropriate in other situations based on microbiological results and specialist advice.

Antibiotics to be added if MRSA infection suspected or confirmed (combination therapy with an antibiotic listed above)

Antibiotic	Dosage
See BNF for appropriate use and dosing in specific populations, for example, people with hepatic or renal impairment, or who are pregnant or breastfeeding, and administering intravenous (IV; or, where appropriate, intramuscular) antibiotics.	Oral doses are for immediate-release medicines.
Vancomycin	15 to 20 mg/kg two or three times a day IV (maximum 2 g per dose), adjusted according to serum vancomycin concentration. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.
Teicoplanin	Initially 6 mg/kg every 12 hours for three doses, then 6 mg/kg once a day IV. See BNF for information on therapeutic drug monitoring and monitoring of patient parameters.
Linezolid (if vancomycin or teicoplanin cannot be used; specialist use only)	600 mg twice a day orally. 600 mg twice a day IV. See BNF for information on monitoring of patient parameters.

Notes:

Course length is based on clinical assessment: minimum of 7 days and up to 6 weeks for osteomyelitis (use oral antibiotics for prolonged treatment).

Review intravenous antibiotics by 48 hours and consider switching to oral antibiotics if possible.

Other antibiotics may be appropriate based on microbiological results and specialist advice.

For a short explanation of why the committee made these 2019 recommendations and how they might affect practice, see the rationale and impact section on choice of antibiotic, dose frequency, route of administration and course length.

Full details of the evidence and the committee's discussion are in evidence review A: diabetic foot infection: antimicrobial prescribing.

Advice

1.6.13 When prescribing antibiotics for a diabetic foot infection, give advice about:

- possible adverse effects of the antibiotic(s)
- seeking medical help if symptoms worsen rapidly or significantly at any time, or do not start to improve within 1 to 2 days. **[2019]**

For a short explanation of why the committee made this 2019 recommendation and how it might affect practice, see the rationale and impact section on advice.

Full details of the evidence and the committee's discussion are in evidence review A: diabetic foot infection: antimicrobial prescribing.

Reassessment

1.6.14 When microbiological results are available:

- review the choice of antibiotic **and**

- change the antibiotic according to results, using a narrow-spectrum antibiotic, if appropriate. **[2019]**

1.6.15 Reassess people with a suspected diabetic foot infection if symptoms worsen rapidly or significantly at any time, do not start to improve within 1 to 2 days, or the person becomes systemically very unwell or has severe pain out of proportion to the infection. Take account of:

- other possible diagnoses, such as pressure sores, gout or non-infected ulcers
- any symptoms or signs suggesting a more serious illness or condition, such as limb ischaemia, osteomyelitis, necrotising fasciitis or sepsis
- previous antibiotic use. **[2019]**

For a short explanation of why the committee made these 2019 recommendations and how they might affect practice, see the rationale and impact section on reassessment.

Full details of the evidence and the committee's discussion are in evidence review A: diabetic foot infection: antimicrobial prescribing.

Prevention

1.6.16 Do not offer antibiotics to prevent diabetic foot infections. Give advice about seeking medical help if symptoms of a diabetic foot infection develop. **[2019]**

For a short explanation of why the committee made this 2019 recommendation and how it might affect practice, see the rationale and impact section on prevention.

Full details of the evidence and the committee's discussion are in evidence review A: diabetic foot infection: antimicrobial prescribing.

1.7 Charcot arthropathy

Investigation

1.7.1 Be aware that if a person with diabetes fractures their foot or ankle, it may progress to Charcot arthropathy. **[2015]**

1.7.2 Suspect acute Charcot arthropathy if there is redness, warmth, swelling or deformity (in particular, when the skin is intact), especially in the presence of peripheral neuropathy or renal failure. Think about acute Charcot arthropathy even when deformity is not present or pain is not reported. **[2015]**

1.7.3 To confirm the diagnosis of acute Charcot arthropathy, refer the person within 1 working day to the multidisciplinary foot care service for triage within 1 further working day. Offer non-weight-bearing treatment until definitive treatment can be started by the multidisciplinary foot care service. **[2015]**

1.7.4 If acute Charcot arthropathy is suspected, arrange a weight-bearing X-ray of the affected foot and ankle. Consider an MRI if the X-ray is normal but Charcot arthropathy is still suspected. **[2015]**

Treatment

1.7.5 If the multidisciplinary foot care service suspects acute Charcot arthropathy, offer treatment with a non-removable offloading device. If a non-removable device is not advisable because of the clinical, or the person's, circumstances, consider treatment with a removable offloading device. **[2015]**

1.7.6 Do not offer bisphosphonates to treat acute Charcot arthropathy, unless as part of a clinical trial. **[2015]**

1.7.7 Monitor the treatment of acute Charcot arthropathy using clinical assessment. This should include measuring foot–skin temperature difference and taking serial X-rays until the acute Charcot arthropathy

resolves. Acute Charcot arthropathy is likely to resolve when there is a sustained temperature difference of less than 2 degrees between both feet and when X-ray changes show no further progression. **[2015]**

1.7.8 People who have a foot deformity that may be the result of a previous Charcot arthropathy are at high risk of ulceration and should be cared for by the foot protection service. **[2015]**

Terms used in this guideline

Diabetic foot infection

Diabetic foot infection is defined by the presence of at least 2 of the following:

- local swelling or induration
- erythema
- local tenderness or pain
- local warmth
- purulent discharge.

Mild diabetic foot infection

Local infection involving only the skin and subcutaneous tissue; if erythema, must be 0.5 cm to less than 2 cm around the ulcer (exclude other causes of inflammatory response, such as trauma, gout, acute Charcot neuro-osteoarthropathy, fracture, thrombosis and venous stasis).

Moderate diabetic foot infection

Local infection with erythema more than 2 cm around the ulcer or involving structures deeper than skin and subcutaneous tissues (such as abscess, osteomyelitis, septic arthritis or fasciitis), and no systemic inflammatory response signs.

Severe diabetic foot infection

Local infection with signs of systemic inflammatory response (such as temperature of more than 38°C or less than 36°C, increased heart rate or increased respiratory rate).

Diabetic foot problem

'Diabetic foot problem' refers to any problem affecting the feet in people with diabetes that is caused by loss of sensation (peripheral sensory neuropathy) and/or circulation problems (peripheral arterial disease).

Diabetic foot problems include:

- diabetic foot ulcers
- soft tissue infection
- destruction of the deep tissues such as heel pressure sores
- osteomyelitis (bone infection)
- Charcot arthropathy.

This guideline uses 'diabetic foot problem' throughout, because this is the term healthcare professionals will most commonly recognise for foot problems in people with diabetes. We do not mean to imply that people with diabetes should be blamed for their foot problems, and they should still be treated as individuals with their own needs, preferences and values.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Frequency of diabetic foot assessments

Based on clinical trial data and routinely collected real-world data, what is the clinical and cost effectiveness of annual foot assessments for people categorised as low risk, compared with checks every 2 years, in reducing diabetic foot problems (including ulcer, amputation and death)? **[2023]**

For a short explanation of why the committee made this recommendation for research, see the rationale section on managing the risk of developing a diabetic foot problem.

Full details of the evidence and the committee's discussion are in evidence review B: risk assessment models and tools for predicting the development of diabetic foot problems and foot review frequency.

2 Digital and emerging technologies for assessing the risk of developing diabetic foot problems

What is the effectiveness, cost effectiveness and acceptability of digital and emerging technologies for:

- assessing the risk of developing a diabetic foot problem
- helping to prevent diabetic foot problems from developing.

For example, laser doppler flowmetry, infrared thermography, and devices for measuring and providing feedback on plantar pressure. **[2023]**

For a short explanation of why the committee made this recommendation for research, see the rationale section on managing the risk of developing a diabetic foot problem.

Full details of the evidence and the committee's discussion are in evidence review B: risk assessment models and tools for predicting the development of diabetic foot problems and foot review frequency.

3 Referral criteria for the foot protection service and the multidisciplinary foot care service

When and with what criteria should people with diabetes be referred to the foot protection service or the multidisciplinary foot care service? **[2015]**

4 Education and psycho-behavioural interventions for prevention

What is the role of educational models and psycho-behavioural interventions in prevention of diabetic foot complications? **[2015]**

5 Prevention strategies for Charcot arthropathy

What strategies may be useful in the prevention of Charcot arthropathy? **[2015]**

6 Diabetic ulcer dressings

What is the clinical effectiveness of different dressing types in treating diabetic foot problems? **[2015]**

Other recommendations for research

7 Referral of people who have diabetic foot problems

Within the hospital multidisciplinary team, when is it appropriate and effective to refer people with diabetes who have foot problems to specialist services such as investigative or interventional radiology, orthopaedic or vascular services, specialist pain management

and specialist orthotics? **[2015]**

8 Prevention of diabetic foot problems

What is the effectiveness of different footwear, insoles and orthoses in the prevention of foot problems? **[2015]**

9 Review of people with diabetic foot problems

How often should people with diabetic foot problems (foot ulcers, soft tissue infections, osteomyelitis or gangrene) be reviewed? **[2023]**

For a short explanation of why the committee made this recommendation for research, see the rationale section on managing the risk of developing a diabetic foot problem.

Full details of the evidence and the committee's discussion are in evidence review B: risk assessment models and tools for predicting the development of diabetic foot problems and foot review frequency.

10 Negative pressure wound therapy for treating diabetic foot ulcers

What is the clinical effectiveness of negative pressure wound therapy in the treatment of diabetic foot ulcers? **[2015]**

11 Maggot debridement therapy for treating diabetic foot ulcers

What is the clinical effectiveness of maggot debridement therapy in the debridement of diabetic foot ulcers? **[2015]**

12 Risk stratification tools for predicting Charcot arthropathy

Which risk stratification tools can be used to predict the likelihood of Charcot arthropathy? **[2015]**

13 When to stop contact casting for acute Charcot arthropathy

When is it safe to stop contact casting in the treatment of acute Charcot arthropathy? **[2015]**

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Assessing the risk of a diabetic foot problem

Recommendations 1.3.4 and 1.3.6

Why the committee made the recommendations

All the risk assessment tools reviewed by the committee were able to predict ulcer occurrence with acceptable accuracy. There were no significant differences in classification accuracy (assessed using c-statistics) between the different risk assessment tools. When considering classification accuracy, sensitivity and specificity together, the PODUS and SIGN systems were the best. PODUS had a higher c-statistic than SIGN, but it did not report sensitivity or specificity. SIGN had the best overall sensitivity and specificity.

The committee agreed that the most important factor for an assessment tool was the ability to accurately identify people who are at high risk of developing a diabetic foot ulcer. Accurate identification allows people to be referred to appropriate services, where monitoring and preventative treatment can be started. A focus on high sensitivity over high specificity may lead to more false positives, with more people incorrectly receiving increased monitoring and referral to specialist services. However, the committee believe that this is preferable to using a system with lower sensitivity, because an increased risk of ulcer, infection and amputation is much worse than wasted resources from unnecessary monitoring or referrals. Overall, the SIGN system showed the highest sensitivity for both high-risk and combined high- and moderate-risk groups.

The committee considered recommending the PODUS clinical prediction rule because:

- evidence from the prospective cohort study was high quality
- it has higher classification accuracy than the SIGN system **and**

- it is a short and simple assessment with only 3 items, and it could be completed by primary care professionals who do not have specialist knowledge of diabetic foot care.

Despite the good evidence for the PODUS system, the committee decided not to change the 2015 recommendations, because:

- SIGN had good sensitivity and specificity (although this assessment was based on a study with a high risk of bias).
- PODUS did not include an assessment of foot deformity in its final model (in an earlier systematic review to identify the factors that most accurately predicted foot ulceration, foot deformity was rejected for being inconsistently defined). Based on their experience and knowledge of established research, the committee believe that this is an important clinical risk factor and disagreed with it being left out of the final PODUS model.
- The SIGN system is also relatively simple. It uses the same 3 items as PODUS, but also includes an assessment of foot deformity. The committee think that assessments using SIGN would only take slightly longer than assessments using PODUS, and could also be completed by primary care professionals who do not have specialist knowledge of diabetic foot care.
- SIGN is recommended by the 2015 guideline. It is well established in clinical practice, and widely recognised and understood by practitioners. If the committee recommended SIGN, existing processes could be used without issue and there would be no risk of a disruptive change to practice.
- If the committee recommended PODUS, staff would need training on how to use the new system. Several free online training courses for primary care professionals would need changing. Primary care electronic patient record systems would also need to be modified.
- There is no evidence assessing the use of PODUS in NHS practice. Given the difficulties the NHS and primary care are currently facing, the committee did not want to introduce a potentially expensive and time-consuming change in practice without clear evidence of a significant benefit. They were particularly concerned about the impact because of current low staffing levels and the time staff will need for retraining.
- NHS organisations and diabetes specialists were broadly supportive of retaining the 2015 recommendations.

The 2015 guideline recommended a modified version of SIGN that includes a check for renal disease. The committee agreed that this modification is useful and should be retained, because renal disease is a known risk factor for diabetic foot problems.

How the recommendations might affect practice

The recommendations have not changed, so no resource impact is expected.

Return to recommendations

Managing the risk of developing a diabetic foot problem

Recommendations 1.3.7 and 1.3.11

Why the committee made the recommendations

The evidence showed that 95.5% of people assessed as low risk at their first clinical assessment remained in the low-risk group at their final assessment 8 years later. The ulceration rate in the low-risk group is also very low. Given this evidence, the committee discussed reducing the frequency of foot risk assessments to once every 2 years. However, they were concerned about the impact this may have on patient care.

The annual foot assessment is not just a foot examination and risk assessment. It is also a chance to teach people how to look after their feet, and to emphasise the importance of doing so. Many people with diabetes do not have good foot care routines, or do not have foot care routines at all. They may not know what to do if they have a foot problem, or who to contact. And they may benefit from regular advice about risk factors for foot problems. Reducing the frequency of foot assessments would mean reducing the number of chances to encourage good foot care and direct people to sources of support.

The committee discussed options for providing education and support outside of foot assessments (for example, remote appointments). However, it was not clear how feasible it would be to run these extra appointments in practice. Foot assessments are currently part of the annual diabetes review, so it makes sense to continue to include the foot check and risk assessment in that appointment. There are also Quality and Outcomes Framework (QOF) indicators for annual foot examination and risk classification, which further justify

retaining the current system.

Given the risk of reducing access to education and support, the committee agreed to continue recommending annual foot assessments. They agreed that, for the recommendations to change, better evidence would be needed comparing annual and 2-yearly foot assessments. The committee therefore made recommendations for research on:

- frequency of diabetic foot assessments
- frequency of review for people with diabetic foot problems
- whether access to new technologies can improve diabetic foot assessments.

How the recommendations might affect practice

The recommendations have not changed, so no resource impact is expected.

Return to recommendations

Treatment

Recommendations 1.6.6 and 1.6.7

Why the committee made the recommendations

The committee agreed that in people with diabetes, all foot wounds are likely to be colonised with bacteria. However, for people with a diabetic foot infection, prompt treatment of the infection is important to prevent complications, including limb-threatening infections.

The committee agreed to retain the recommendation from the 2015 guideline that antibiotics should be started as soon as possible if a diabetic foot infection is suspected. The choice of antibiotic would depend on the severity of infection, although the committee acknowledged that the studies they looked at did not always differentiate between severities. The committee accepted the Infectious Diseases Society of America's definitions of mild, moderate and severe infection, and recommended that this should be taken into account when choosing an antibiotic.

The committee retained the 2015 recommendation that samples should be taken for microbiological testing before, or as close as possible to, the start of antibiotic treatment. This would allow empirical antibiotic treatment to be changed if needed when results are available.

How the recommendations might affect practice

These recommendations are consistent with current practice.

Return to recommendations

Choice of antibiotic, dose frequency, route of administration and course length

Recommendations 1.6.8 to 1.6.12

Why the committee made the recommendations

The committee agreed that in their experience, the incidence of diabetic foot infections in children and young people is rare. The mean age of participants in the evidence considered ranged from 54 to 64 years. Based on these factors, the committee included an antibiotic prescribing table for adults, but not for children and young people. They recommended that if a diabetic foot infection is suspected or confirmed in children or young people, specialist advice should be sought regarding antibiotic choice and regimen.

The evidence showed no difference in clinical outcomes for most antibiotics. But the antibiotics used in the studies were not wholly representative of UK practice, with some not being available in the UK and others not widely used. There were no differences in adverse events for many antibiotic comparisons. However, there were differences between some antibiotic classes, with lower rates of adverse effects generally for beta-lactam antibiotics.

The committee agreed that the choice of antibiotic in adults should be based on severity of infection (mild, moderate or severe) and the risk of complications, while minimising adverse effects and antibiotic resistance. This means using narrow-spectrum antibiotics first where possible, and using microbiological results, when available, to guide treatment.

The antibiotics recommended have good activity against many of the pathogens that cause diabetic foot infection, have good penetration for skin and soft tissue infections, and can be used in the different settings where treatment may take place, including ambulatory care. Based on evidence, their experience and resistance data, the committee agreed that flucloxacillin is an effective empirical antibiotic for mild diabetic foot infections (with dosing taking account of a person's body weight and renal function). The committee agreed that flucloxacillin has poor oral bioavailability and in people with diabetes who could have impaired circulation, a higher (off-label dose) of up to 1 g four times a day may be needed to adequately treat diabetic foot infection.

For adults with a moderate or severe diabetic foot infection, a choice of antibiotics (or combinations of antibiotics) should be available. This enables selection based on individual patient factors, likely pathogens, and guided by microbiological results where available. In moderate and severe infection (which includes osteomyelitis), broader cover is needed because aerobic and anaerobic bacteria may be present. Severe infections can become limb-threatening quickly so antibiotic choices with the broadest spectrum of cover are appropriate; this can be changed to a narrower-spectrum antibiotic based on microbiological results when available, in line with principles of good antimicrobial stewardship. For moderate or severe infection, the committee recommended flucloxacillin at a dose of 1 g four times a day.

Patient preference is also important, particularly for treatment that will involve a hospital stay or be prolonged. Diabetes is a chronic condition and people may have had previous foot infections, with previous courses of antibiotics, that will influence their preferences.

No evidence was identified comparing antibiotic dose, frequency or route of administration. However, the committee acknowledged that a person with a diabetic foot infection may already be on a number of other medications, and this should be taken into account when deciding on dose, frequency and route of administration of an antibiotic.

In line with the NICE guideline on antimicrobial stewardship and Public Health England's Start smart – then focus, the committee agreed that oral antibiotics should be used in preference to intravenous antibiotics where possible. Intravenous antibiotics should only be used for people who are severely ill, unable to tolerate oral treatment, or where oral treatment would not provide adequate coverage or tissue penetration. The use of intravenous antibiotics should be reviewed by 48 hours (taking into account the person's response to treatment and any microbiological results) and switched to oral treatment where possible.

The committee agreed that a shorter course was generally as effective as a longer course for adults with a mild diabetic foot infection, and a 7-day course was sufficient for most people. However, it agreed that a longer course (up to a further 7 days) may be needed for some people based on a clinical assessment of their symptoms and history. They discussed the limited evidence on antibiotic course length, which compared 6 weeks with 12 weeks in adults with diabetic foot osteomyelitis. The committee agreed that for adults with a moderate or severe diabetic foot infection (which includes osteomyelitis), a 7-day course would be a minimum, with antibiotic treatment for up to 6 weeks if they have osteomyelitis. When prolonged antibiotic treatment is given, oral options should be used and treatment should be reviewed regularly, taking into account the need for continued antibiotics. The committee discussed antibiotic choices for osteomyelitis and agreed that the empirical choices for moderate and severe diabetic foot infection are also effective empirical choices for osteomyelitis.

How the recommendations might affect practice

The recommendations aim to optimise antibiotic use and reduce antibiotic resistance.

Return to recommendations

Advice

Recommendation 1.6.13

Why the committee made the recommendation

The committee based the recommendation on their experience and safety netting advice from the NICE guideline on antimicrobial stewardship. They agreed that if symptoms worsened rapidly or significantly at any time, or did not improve within 1 to 2 days, people with a diabetic foot infection should be advised to seek medical help.

How the recommendation might affect practice

The recommendation should ensure that appropriate safety netting is in place.

Return to recommendation

Reassessment

Recommendations 1.6.14 and 1.6.15

Why the committee made the recommendations

The committee agreed that when microbiological results are available, they should be used to guide antibiotic choice. The committee recognised the complexity around interpreting microbiological results, and agreed that the quality and type of specimen should be taken into account when making decisions around whether to change an antibiotic. The committee also discussed factors that would indicate that a person with a diabetic foot infection would need to be reassessed. These included if an infection was rapidly or significantly worsening or not improving, if other diagnoses were possible, or symptoms suggested a more serious illness or condition.

How the recommendations might affect practice

These recommendations should ensure that appropriate reassessment is in place.

Return to recommendations

Prevention

Recommendation 1.6.16

Why the committee made the recommendation

The committee agreed to retain the 2015 recommendation that antibiotics should not be given to prevent diabetic foot infections. No evidence was identified for antibiotic prophylaxis and the committee agreed that antibiotic prophylaxis is not appropriate because of concerns about antimicrobial resistance. People should be advised to seek medical help if symptoms of a diabetic foot infection develop.

How the recommendation might affect practice

This recommendation is consistent with current practice.

Return to recommendation

Context

Diabetes is one of the most common chronic diseases in the UK and its prevalence is increasing. More than 4.9 million people in the UK have diabetes. Around 90% of these people have type 2 diabetes, around 8% have type 1 diabetes, and about 2% have rarer types of diabetes. By 2030, it is estimated that more than 5.5 million people in the UK will have diabetes. In England, the number of people diagnosed with diabetes increased between 2006 and 2019 from 1.9 million to 3.3 million. The life expectancy of people with diabetes is shortened by up to 15 years, and 75% die of macrovascular complications.

The risk of foot problems in people with diabetes is increased, largely because of either diabetic neuropathy (nerve damage or degeneration) or peripheral arterial disease (poor blood supply due to diseased large- and medium-sized blood vessels in the legs), or both. Peripheral arterial disease affects 1 in 3 people with diabetes over the age of 50 and can also increase the risk of heart attack and stroke. For more information, see the NICE guideline on peripheral arterial disease.

Foot complications are common in people with diabetes. It is estimated that 10% of people with diabetes will have a diabetic foot ulcer at some point in their lives. A foot ulcer can be defined as a localised injury to the skin and/or underlying tissue, below the ankle, in a person with diabetes.

Diabetes is the most common cause of non-traumatic limb amputation, with diabetic foot ulcers preceding more than 80% of amputations in people with diabetes. More than 7,000 diabetes-related amputations are reported in the UK per year. People are at higher risk of diabetes-related major and minor limb amputations if they are male, from the most deprived areas, aged over 65, or of white European family background. After a first amputation, people with diabetes are twice as likely to have a subsequent amputation as people without diabetes. Mortality rates after diabetic foot ulceration and amputation are high, with up to 70% of people dying within 5 years of having an amputation and around 50% dying within 5 years of developing a diabetic foot ulcer. This high mortality rate is believed to be associated with cardiovascular disease, and emphasises the importance of good diabetic and cardiovascular risk management. Although people of South Asian, African and African Caribbean family origin are more at risk of diabetes, there is no evidence that the prevalence of diabetic foot ulceration and amputation is higher in these subgroups than in the general population of people with diabetes in the UK.

Foot problems in people with diabetes have a significant financial impact on the NHS through primary care, community care, outpatient costs, increased bed occupancy and prolonged stays in hospital. The NHS spends at least £10 billion a year on diabetes, equivalent to 10% of its budget. Of this, 80% is spent on treating complications, and diabetic foot care is estimated to cost the NHS in England over £1 billion per year. Diabetic foot care accounts for more healthcare costs in England than breast, prostate and lung cancer combined. Much of these costs come from treating prolonged and severe ulceration.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on diabetes.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews and the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

Update information

January 2023: We reviewed recent evidence and decided that no changes were needed to our guidance on risk assessment tools for diabetic foot problems and frequency of diabetic foot reviews. Recommendations are marked **[2023]** if the evidence was reviewed.

October 2019: We have reviewed the evidence and made new recommendations on antimicrobial prescribing for adults with a diabetic foot infection. These recommendations are marked **[2019]**.

Recommendations marked **[2015]** last had an evidence review in 2015. In some cases, minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

August 2015: This guidance updates and replaces NICE guidelines CG10 (published January 2004) and CG119 (published March 2011).

Recommendations marked **[2011]** last had an evidence review in 2011.

Minor changes since publication

January 2016: Recommendation 1.3.6 has been updated to clarify the risk factors for and stratification of risk of developing a diabetic foot problem.

December 2015: Recommendation 1.3.14 has been amended to refer to the updated NICE guideline on type 2 diabetes in adults.

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Accreditation

Belfast Health and Social Care Trust

caring supporting improving together

Podiatry Department

Staff Induction/Handbook

Version 6

Date: November 2020

Review Date: April 2023

Authors: Wendy McLaughlin
Jennifer Madden
John McCarry

The Trust Vision

Our Values are important. They guide our behaviour, our attitudes, the decisions we make and what we expect of each

other. Our Staff have told us the Trust's Values are important to them and have a strong impact on how they view our organisation.

Our focus will be on embedding and living the Values throughout the Trust.

Working together

We work together for the best outcome for people we care for and support.

We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

Excellence

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes.
We deliver safe, high quality, compassionate care and support.

Openness and honesty

We are open and honest with each other and act with integrity and candour.

Compassion

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues.

We listen carefully to others to better understand and take action to help them and ourselves.

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Introduction

Belfast Trust is a Large Acute and Community Health and Social Care Trust and delivers a service to a local population of 390,000. In addition to this Belfast Trust provides some regional services to the population of Northern Ireland.

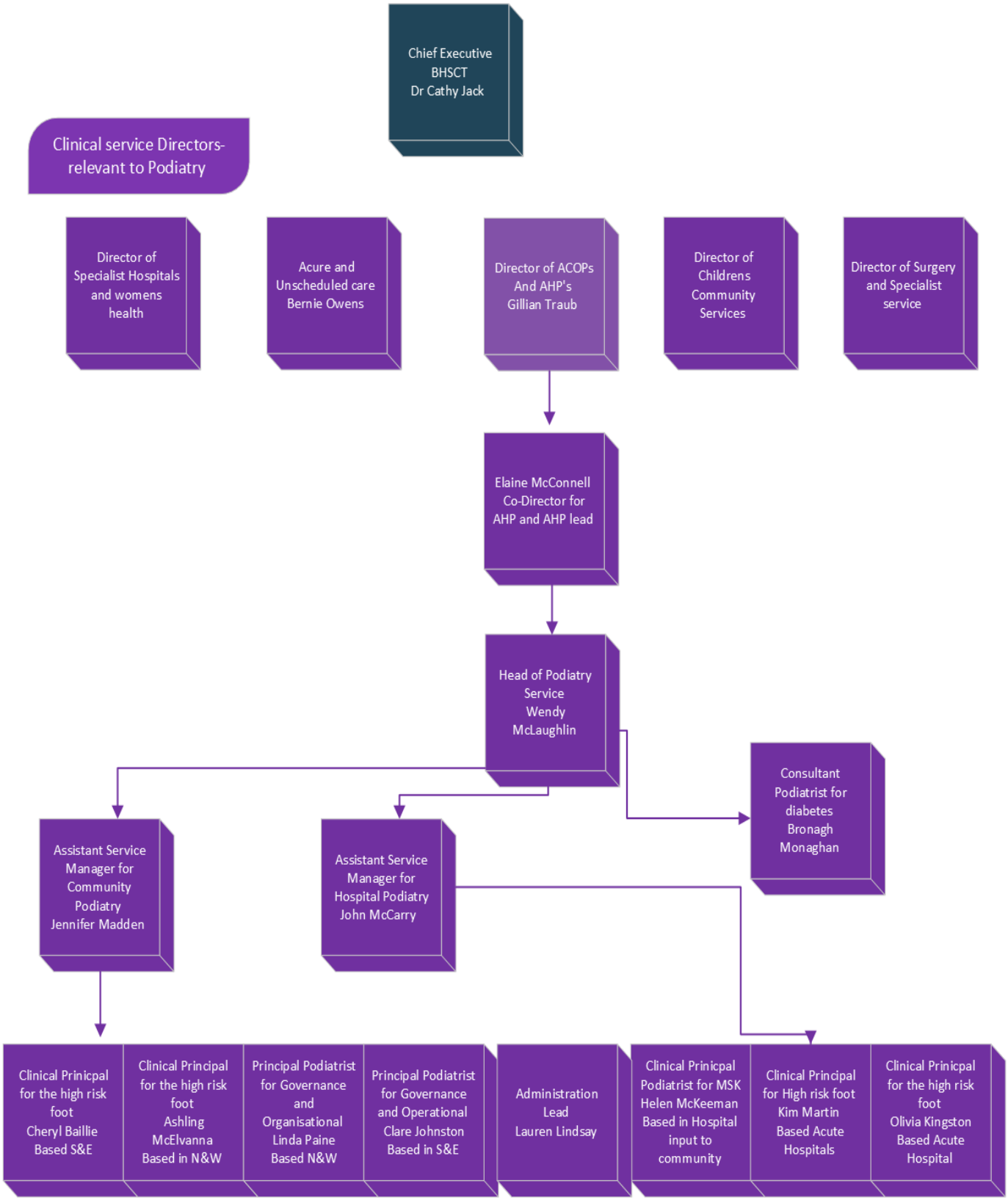
1.	Community Clinics in	Arches Health & Wellbeing Centre Bradbury Health & Wellbeing Centre Knockbreda Health & Wellbeing Centre Carlisle Health & Wellbeing Centre Shankill Health & Wellbeing Centre Beech Hall Health and Wellbeing Centre
2.	Forensic Learning Disability	Muckamore Hospital
3.	Mental Health	Acute mental Health In patient clinic BCH
4	Acute Hospitals	Royal Victoria Hospital Belfast City Hospital Mater Hospital Musgrave Park Hospital
5	ICATS	

Almost all the Podiatry service across the Trust is professional and operationally managed within the Adult Community and Older Peoples Services and Allied Health Professionals Directorate.
An ICATS service is operational managed via the Acute Services directorate and professional managed by the Professional Head of Service.

REFERRALS TO PODIATRY COMMUNITY SERVICES MADE VIA CALL MANAGEMENT CENTRE ON THE NUMBERS BELOW:

South & East – 028 90565565 / North & West - 028 90635300

Belfast Trust Structure (As relevant to Podiatry Service)



Each member of staff can approach the relevant Assistant Service Manager or in their absence the local Principal Podiatrist in relation to professional or organisational issues.

Staff members also have access to clinical leads in each clinical area in relation to the management of their specific caseloads.

Working Hours and Leave Arrangements

Working Hours

All full time podiatrists are contracted to work 37 ½ hours. Core hours of work will normally be between 8.00am and 5.30pm. Staff should agree their working hours with the relevant Assistant Service Manager. Working hour's arrangements will depend on the needs of the service and client group. Hospital working hours 8.00am to 4.30 pm

Please be aware that good timekeeping is important in all job roles.

Policies & Guidelines - Work Life Balance Flexible Working Policies and Arrangements - All Policies (sharepoint.com)

The Trust has a Family Policy Pack
Family Policy Pack Belfast Trust.doc (sharepoint.com)

Annual Leave

Each staff member will receive a leave card stating leave entitlement, which varies depending on years of service.

0- 5 years 27 days Pro Rata
5-10 Years 29 days Pro Rata
10 years + 33 days Pro Rata
25 years One off extra 5 days Pro Rata

The granting of annual leave is subject to the needs of the Podiatry service. To ensure clinic cover requests for annual leave will happen at 2 points in the year to cover Easter, Summer and Christmas holidays.

In line with the Integrated Elective Access Protocol June 2015 and to minimise disruption to clinics and patient cancellations, all leave should be requested at least 6 weeks in advance. A 6 week period of advance notice is essential for larger periods of leave. Shorter periods of leave maybe considered with shorter notice. Leave for 'peak' holiday time is planned and permitted in conjunction with other clinical team members.

Staff should request leave through the Trust annual leave system and email their Assistant Service Manager to request leave. Holiday arrangements must not be made until leave has been granted. At busy periods or when there are staff shortages leave may be rescinded.

Access NI Check on staff returning from an employment break

In accordance with the Trust's Safeguarding Vulnerable Groups Policy and the Employment Break Policy, from 1 July 2018, Managers must ensure that an Access NI Check is carried out where appropriate for any employee returning from an employment break to a regulated post.
The HR Pay & Conditions Team will inform the employee commencing an Employment Break that upon their return to a regulated post, they must inform their Manager and the HR Pay & Conditions Team at least six weeks prior to their agreed return date in order to have an Access NI Check processed.
Managers should be aware that failure to have a satisfactory Access NI Check in advance of the employees agreed return date will result on their return to work being deferred.
Managers should also ensure that any employees currently on an Employment Break must have an Access NI check carried out prior to their return.
If you have any questions or for more information re: Access NI Checks please contact:
HR Pay & Conditions Team, 5th Floor, McKinney House, Musgrave Park Hospital
Tel: 028 906 35678

Statutory leave

10 days statutory leave are allocated on a pro rata basis. Part-time staff are asked to calculate this at the beginning of each year and the insert the number of hours leave entitlement in the appropriate section of the electronic leave card.

Carrying of leave

All staff should make the effort to use their annual leave entitlement within the leave year. Annual leave should only be carried in exceptional circumstances and approval must be sought from your Assistant Manager/Principal Podiatrist. A maximum of 1 week pro rata will be considered.

Any leave in addition to this will be lost, if not taken within the leave year.

Reporting sick absence

When reporting sick leave staff must phone their relevant Assistant Service Manager on the morning of the 1st day of sickness and on the morning of their return to work.

Policies & Guidelines - Attendance Protocol policy - Management of - All Policies (sharepoint.com)

Staff must also contact relevant staff in their location/area prior to the time of their first appointment.

Please note that staff will be required to speak with their Assistant Service manager, this may require the assistant manager contacting staff at home. It is important that assistant managers have access to a telephone number. Text messages are not an acceptable method to contact your manager.

Certification requirements for Sick Leave

Calendar Days	Form of Certification
1-7	Trust Self Certificate Form is required to cover illness from 1st to 7th calendar day. (If a Medical certificate is received on the 1st day of absence then a Trust Self Certificate is not required).
8	Days and onwards Medical Certificate required from GP
Return Date	Final signing off certificate from GP. (If episode of absence was covered by a GP certificate)

If staff are sick for a longer period of time they are expected to keep in regular contact with their Assistant Service Manager.

All staff will be required to complete a return to work interview with their line Manager after every period of sickness.
All staff will be referred to have an Occupational Health appointment when they have been off more than 3 times in the last 12 months or have been off for more than 20 days in a single episode of sick.
Possible formal warnings for more than 3 episodes of sickness

Overtime/ Time in Lieu

If work is required outside normal working hour's e.g. Career talk, talk to voluntary groups, evening clinic staff should have discussed and agreed this with their Assistant Service Manager prior to agreeing to the work and lieu time arranged as appropriate. If staff has had to work extra hours this should be marked on 'time in lieu' card in hours.
Time in Lieu must be taken within 4 weeks of the work being undertaken.

When working outside normal working hours each staff member should be aware of the risks of lone working and organise support as required in AHP risk assessment.

Working Time Regulations

The Working Time Directive was implemented in Northern Ireland by the Working Time Regulations (Northern Ireland) 1998 (SR 1998 No.386) on 23 November 1998. The regulations created measures to protect the safety and health of workers.
The stated aim of the Working Time Regulations is to 'improve health and safety at work' by introducing minimum rules for employees relating to daily and weekly rest periods, rest breaks, annual leave entitlements, length of working and on night work.
Full information regarding Working Time Regulations can be provided by Human Resources Governance Equality and Improving Working Lives Sector.
Key Aspects Relevant to Podiatry Service:

- An entitlement to 11 consecutive hours rest in each 24-hour period
- A right to a rest break of at least 20 minutes if the working period is longer than 6 hours

Staff should be aware that this applies to their job in Belfast Trust and any other paid employment so if they are working in 2 organisations (Dual Employment) they should ensure they comply with this directive.
A Dual employment form is included and should be completed if appropriate

Salary Statement

Staff will be able to view their salary statement on HRTPS on a monthly basis. It is important that all staff check their own salary statement and in particular the hours for which they are being paid to ensure this is correct. If there are discrepancies please contact payroll directly and inform your Assistant Podiatry Manager/Line Manager.

Understanding Your Pay Slip

The guidance below will assist and support staff to understand their payslip including the layout of a typical pay statement. It clarifies the processes around payroll and sets out the deadlines for submission of claims & timesheets.
The majority of staff within Belfast Trust no longer receive a posted payslip. These should be accessed online via Employee Self Service. These are usually available two days before pay day.
In order to view your payslip you must first log onto Employee Self Service. Select ESS, select home, and select payslip from the quick link section to the right of the screen. This will allow you to access your full payslip.

If you require assistance with logging on to Employee Self Service, please email HRPTSSecurityTeam@belfasttrust.hscni.net with your name, staff number and National Insurance Number.

All new staff will receive a posted payslip for their first salary, and all subsequent payslips should be accessed through Employee Self Service. Employees on long-term leave, such as maternity leave, adoption leave or long term sick leave will have their payslips posted to their home address until they return to work. Posted payslips arrive no later than the day after payday. If you are expecting a posted payslip and do not receive one, please contact the Payroll Shared Services Centre (PSSC). The PSSC can be contacted on 028 9536 2190 or via payroll.ssc@hscni.net

If you require your payslip for a mortgage or finance application you can print this directly from ESS. These do not need to be requested from Human Resources or the PSSC.

Checking My Payslip

Why is it important to check my Payslip?

It is your responsibility to check the information shown on your payslip regularly. You must notify your line manager immediately if you feel your pay is incorrect.

What to do if your pay is incorrect?

If your pay is incorrect please contact your line manager in the first instance. They may be able to rectify the issue on your behalf and can advise if all paperwork that can affect your pay has been submitted (e.g. timesheets). Your line manager will liaise with the PSSC who will take the appropriate action to either pay any money owed to you or recoup an overpayment in accordance with the Regional Overpayment Policy.

What to do if I have more than one post?

For each post you will have a different staff number and separate HRPTS log on details to allow two separate payslips to be generated. For example, if you have a substantive post as a Band 5 Nurse and a Bank post you will have two staff numbers and two payslips. You will require a separate login to access each one on Employee Self Service.
You should check all of your payslips each month to ensure they are correct.
What information do PSSC need when they are contacted?
PSSC will need your staff number in order identify you on the system. If you have more than one post please ensure you identify which post the issue relates to. It is useful to provide a record of any shifts the issue relates to, including dates and times. 11

It is important to note that the PSSC will be unable to process requests for payment without written approval directly from your line manager.

What to do if I have issues with my Tax Code?

Each individual member of staff is allocated a Tax Code by HM Revenue & Customs (HMRC). It is important that you check your Tax Code regularly, particularly at the beginning of each financial year (April) to ensure the code is correct.
If you have any queries regarding your tax code you should contact HMRC in the first instance on 0300 200 3300. Please ensure when contacting HMRC that you have your National Insurance Number at hand. Neither the Trust nor PSSC can amend tax codes or advise regarding the accuracy of these as they are put in place by HMRC.

Your Information

Your personal data is held for the purposes of your employment and for payroll on the HRPTS system. This includes your name, address, bank details, and next of kin. It is your responsibility to ensure any changes to this personal information is updated immediately using Employee Self Service. This is particularly important for those details that might affect the payment of your salary (e.g. bank details).
For the small group of staff who do not have access to Employee Self Service, your personal information should be amended through your line manager. They will submit a contract change form through Manager Self Service. For these staff, when bank details need to be amended this can be done by emailing Payroll.ssc@hscni.net In the subject line enter ‘’Change of Bank Account Details’’.
If you wish to change your bank details by post the address is:
BHSCT Payroll Section, Payroll Shared Service Centre, 16 College Street, Belfast, BT1 6BT

Payroll Deadlines

It is the responsibility of staff and their managers to ensure that the information submitted in accordance with the required time scales. Claims / requests received after the specified deadline will be processed in the next month/pay period.

These deadlines are for

- Timesheets (both Excel forms or manual on call forms)
- Travel claims
- Requests to enrol into or opt out of the HSC pension scheme
- Changes to voluntary deductions, such as Union membership fees
- Medical / Dental claims for WLI or APAs

Information affecting the weekly and fortnightly payroll should be submitted by 12 noon on a Thursday.

Changes for monthly paid staff must be submitted by Line Managers by the deadlines outlined in the table below. These dates are set in place to allow the relevant Human Resources team to process, approve and send the change to the PSSC for them to make the necessary change in time for payroll.

Departmental Information

Contact Information/ Delegation of Responsibility in the absence of Assistant Service manager.

When the Assistant Service Manager is on annual leave staff should bring all issues to other Podiatry staff within their area – principal podiatrists /clinical leads who will advise you re managing the issue.

		Head of Podiatry Service Belfast HSC Trust
Podiatry Services Manager	Wendy McLaughlin	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
	Community Podiatry/FPT	
Assistant Podiatry Manager for Podiatry in Community	Jennifer Madden Carlisle Health and Wellbeing Centre 40 Antrim Rd Belfast BT15 2AX	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
Principal Podiatrist for Governance North & West	Linda Paine Beech Hall Health & Wellbeing Centre 21 Andersonstown Road Belfast BT11 9AF	Telephone: [redacted] Mobile: Email: [redacted]

Principal Podiatrist for Governance & Operational South & East	Clare Johnston Arches Health Centre Westminster Ave North Belfast BT4 1NS	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
Principal Podiatrist in High risk N&W	Ashling McElvanna Beech Hall Health & Wellbeing Centre 21 Andersonstown Road Belfast BT11 9AF	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
Principal Podiatrist in High risk S&E	Cheryl Baillie Arches Health Centre Westminster Ave North Belfast BT4 1NS	Telephone: [redacted] Mobile: [redacted] Email: [redacted]

Acute Hospitals Podiatry /MDFT

Assistant service Manager for Podiatry in Acute Hospitals	John McCarry Royal Victoria Hospital Grosvenor Rd Belfast BT12 6BE	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
Consultant Podiatrist for diabetes	Bronagh Monaghan Royal Victoria Hospital Grosvenor Rd Belfast BT12 6BE	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
Principal Podiatrist	Kim Martin Royal Victoria Hospital Grosvenor Rd Belfast BT12 6 BE	Telephone: [redacted] Mobile: [redacted] Email: [redacted]

Principal Podiatrist	Olivia Kingston Royal Victoria Hospital Grosvenor Rd Belfast BT12 6 BE	Telephone: [redacted] Mobile: Email: [redacted]
Principal Podiatrist Musculoskeletal	Helen McKeeman Belfast City Hospital Lisburn Road Belfast BT9 7AB	Telephone: [redacted] Mobile: [redacted] Email: [redacted]
	Administration	
Podiatry Administrative Manager	Lauren Lindsay Arches Health Centre Westminster Ave North Belfast BT4 1NS	Telephone: [redacted] Mobile: [redacted] Email: [redacted]

Absence of Podiatry Head of Service

When the BHSCT Podiatry Professional Head of Service is on leave Assistant Service Managers will undertake the essential managerial duties.

Important managerial issues should be discussed with an Assistant Service Manager or AHP Co − Director Elaine McConnell

Badges

An identity card with photograph will be supplied to all staff. Name badges and/or identity badges should be worn at all times.

Staff must have completed an Identity Card Request Form before attending one of the venues below:

Musgrave Park Hospital

ID Badges for MPH staff, contact the Security Department on 02890638744 between 9am & 5pm to arrange an appointment.

Belfast City Hospital

Car Parking Office, Donegall Road Multi-storey Car Park. Monday from 10am to 12pm. Tel: 028 9504 3434.

Royal Victoria Hospital

Elliott Dynes Building Tel: 028 90634242 to arrange an appointment.

Mater Hospital

Fairview Building N&W Community, Tuesday 10.30am-12.30pm Mater staff, Wednesday 10.30am-12.30pm.

Muckamore Abbey Hospital

Contact Michael McBride in the General Nursing Office for an appointment Tel: 028 9504 6038.

S&E Community & Knockbracken

For ID badges, contact the Security Department on Tel: 02890638744 between 9am & 5pm to arrange an appointment.

Dress Code and Uniform

All staff must adhere to the Policies & Guidelines - Dress Code and Uniform policy - All Policies (sharepoint.com)
All Podiatrists must wear the agreed Trust uniform when treating patients

Requirements	Rationale	Regional Dress Code Policy	
1	The Trust has adopted a 'Bare from the Elbows' position. White coats are not to be worn In the hospital setting, long sleeved clothing such as suit jackets, cardigans, fleeces or sweaters must be removed before the delivery of direct patient care. In the community setting, long sleeved clothing such as cardigans, fleeces or sweaters must be removed or sleeves rolled up, before the delivery of direct patient/client care.	Cuffs become heavily contaminated and are more likely to come into contact with patients. Cuffs may act as a vehicle for transmitting infection. Long sleeves or cuffs prevent effective hand washing.	Wear short-sleeves or roll the sleeves to elbow length before carrying out clinical procedures.

2	Loose clothing that may easily become contaminated or entangled / entrapped in equipment should not be worn. Neck ties, if worn, must be tucked in between the 3rd and 4th button on the shirt during clinical procedures. IDs should not come into contact with the patient/client whilst delivering direct care. Trust lanyards, if worn, must be secured, only carry an ID and changed/cleaned regularly.	This type of clothing may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection. To prevent cross infection and for the health and safety of the wearer.	Clinical staff who do not wear a uniform should not wear any loose clothing such as unclipped ties, draped scarves, necklaces and similar items.
3	Staff should ensure that long hair is fixed securely above the collar.	Hair hanging over the patient when delivering direct patient care may be a source of contamination. Staff who have to constantly touch or fix their hair may risk contamination to themselves or to their patients. Patients generally prefer to be treated by staff with tidy hair and a neat appearance.	All staff working in clinical areas should secure long hair.
4	Staff must not wear ANY jewellery including wrist watches, rings or necklaces whilst on duty.	Hand/wrist jewellery can harbour micro-organisms and reduces compliance	Wrist or hand jewellery must not be worn by clinical staff when performing hand hygiene

5	Staff must not wear nail varnish or false/gel nails whilst on duty and nails must be kept short and clean at all times.	Long and/or dirty nails can present a poor appearance and long nails are harder to keep clean. False nails and chipped nail varnish harbour micro-organisms and can reduce compliance with hand hygiene	Clinical staff should keep finger nails short and clean. Clinical staff must not wear false nails or nail varnish for direct patient care
6	Footwear, worn in the clinical areas should be suitable for purpose and comply with the relevant health and safety requirements. Shoes should be enclosed and have low heels. -'Croc-like', 'mesh weave' or canvas shoes must not be worn. -they must be impervious to moisture and wipeable -Theatre footwear must be appropriate to the theatre environment and easily cleaned.	Croc-like', 'mesh weave' and canvas shoes must not be worn as they do not protect the wearer from fluid spills and 'sharps'.	Footwear worn in the clinical areas should be suitable for purpose, protect the feet and comply with the relevant health and safety requirements.
7	All male staff must be either clean shaven or beards and moustaches kept clean, neatly trimmed or rolled and tucked. In some circumstances beard nets or snoods will be necessary. Beards must not interfere with fit testing and to safely wear an FFP3 face mask.	Beards may be a source of contamination. Staff who constantly touch their beards risk contamination to themselves or to their patients. Beards/unshaven skin prevents a close fit when wearing an FFP3 mask, thus endangering the member of staff. Patients generally prefer to be treated by staff with a neat appearance.	

Non – Uniform Staff Dress Code

- All staff should take a sensible and safe approach to dress, appearance, cleanliness and personal hygiene. Clothing, including uniforms, must be clean, neat and tidy.
- All staff working in a clinical area must be 'Bare Below the Elbows'. This helps to facilitate effective hand hygiene. One plain band ring may be worn. http://www.npsa.nhs.uk/cleanyourhands
  (A clinical area is defined as an area where a clinical intervention takes place i.e., 'any area where a patient is seen and/or treated – e.g. Wards; Hospital and community settings; Outpatients' Departments; Radiology; Emergency Department'.)
- Staff entering some ward/department areas, not to specifically work in the area, may also be asked to be bare below the elbows. This is applicable in areas of high risk were patients are very vulnerable to infection or where there is an outbreak situation.
- All staff must dress in a manner that is likely to inspire public confidence and promote a professional and positive image of the Trust.
- Denim jeans/leisure wear are not appropriate for work unless agreed by line manager for specific reasons.
- Staff must, at all times during the course of their working day, have available the approved identification name badge/ID and clip holder provided by the Trust.
- Lanyards, if worn, must only be used to hold an ID badge. The lanyard must be replaced if it becomes visibly stained/dirty and every 6 months.
- Clothing and appearance should not deliberately cause offence to the public or to people who come in to contact with, or use, Trust services. Clothing should be modest, non-offensive and should not contain remarks that are contrary to Trust values of respecting staff and service users and/or comments that contravene equality and human rights law e.g. remarks that are racist, sectarian, homophobic, disablist etc. or provocative, sectarian, sexist, or racist remarks.
- Clothing should not display slogans or logos relating to drugs, alcohol or tobacco, or demonstrate sponsorship of such products. It is not acceptable to wear clothing that over exposes parts of the body, e.g. stomach, chest, thighs, etc., or that is transparent or see through.
- Clothes that are visibly soiled or have come into contact with animals, spilt food, rubbish, garden waste or other contaminants should never be worn to work.
- Clothing must be appropriate to the nature of the work undertaken and not restrictive or hinder good movement and posture.
- All staff should wear footwear that is safe and suitable for the duties undertaken and comply with the relevant health and safety requirements. (e.g. Flat, toes and heels enclosed during moving and handling). Footwear should provide good grip and stability. In accordance with Health and Safety (Health and Safety at Work (Northern Ireland) Order 1978 No. 1039 (N.I. 9) Sections 2 and 3).
- Protective clothing should always be available and worn in accordance with the relevant procedures and after carrying out a risk assessment.

- Visible tattoos should not be offensive to others and should not contain imagery that is contrary to Trust values of respecting staff and service users and/or comments that contravene equality and human rights law e.g. remarks that are racist, sectarian, homophobic, disablist etc. If they are deemed to be offensive, they should be appropriately covered. New tattoos are open wounds therefore; they require to be covered with a waterproof dressing until healed/not weeping. 'Clingfilm' does not constitute a waterproof dressing.
- Tattoos on large areas of skin that are exposed during the course of a working day, such as forearms, must be healed/not weeping or have extensive scabbing before returning to work, therefore staff should attain these when off-duty or on holiday. This applies particularly to staff working in clinical areas and to those who are food handlers.
- All staff must comply with the Trust No Smoking policy. Reference: Department of Health, Social Services & Public Safety (2008) Regional Dress Code Policy and Recommendations on Staff Changing Facilities for Northern Ireland [Online]. Available at: http://www.dhsspsni.gov.uk/dresscodepolicy.pdf
- A code of dress projects a positive image and while it recognises the diversity of cultures, religions and disabilities of Trust staff, it gives priority to those issues, which promote health and safety, security and infection control.
- There is a standard dress code policy for all Trust staff regardless of whether or not a uniform is worn.
- The dress code policy applies to all BHSCT staff, employed by, or contracted on behalf of BHSCT, including students and others on placement in Trust facilities.

IT

An email account, access to Paris and ECR will be set up by the Assistant Service Manager.
Please read Policies & Guidelines - ICT Security Policy - All Policies (sharepoint.com)
Further information regarding data protection is on page16.

Driving for Work –Travel Expenses

Staff should be aware of their responsibilities under the Policies & Guidelines - Driving for Work - Policy and Procedural Arrangement relating to - All Policies (sharepoint.com)

Travel expense forms should be completed using HRPTS. Car park tickets can be claimed for locations other than your base clinic – these needs to be submitted manually.

Car Insurance

Car insurance should be checked to ensure that a business cover is available to carry patients or equipment if required.

Domiciliary Visits/Lone Working

All staff should be aware of Trust's policy and procedure arrangements relating to Policies & Guidelines - Lone Working - Policy on - All Policies (sharepoint.com)

If undertaking a domiciliary visit, details of visit and if possible expected time of return should be available to a member of staff responsible - Buddy system to check up if the staff member does not return i.e. address, length of appointment, contact details. Staff must speak with their Assistant Service Manager for specific instructions in their area.

Staff must ensure they have identification with them for all domiciliary visits.

Please also read the lone working risk assessment

During visits staff must please be aware the clients' home is their working environment and they are entitled to ask patients/relatives to stop smoking or remove animals from rooms.

Private Calls

Calls from the department phones should only be used privately in urgent situations and should be kept to a minimum.

Podiatry Service Objectives and staff responsibilities

Objectives for our service and teams are updated each year and shared with all staff.

Roles and responsibilities of the post

A Job description is available and roles and responsibilities of the post will be discussed at induction

Membership of HCPC (Health Care Professional Council)

All Podiatrists are required to be members of HCPC in order to work in the Health Service in the UK and are required to comply with HCPC standards. Staff must provide evidence of membership at appointment and as requested at regular intervals. Membership is renewed on a 2 yearly basis. Staff are advised that they are responsible to ensure this is kept up to date. Failure to do this will result in the member of staff being asked to take leave immediately

and receive no pay until the registration is updated and unpaid disciplinary action will be considered.

Note:

Particularity vulnerable times are

1. When a staff member changes address
2. If a staff member pays by direct debit and changes their bank account
3. If staff pay by direct debit at re registration staff must ensure that they also sign and return forms.
4. During prolonged periods of special leave e.g. Maternity leave, Career Break

When a member of staff changes their name e.g. on marriage they must practise and sign clinical notes and work related correspondence under their original name until their name is changed on the HCPC register.

HCPC Documentation

https://www.hcpc-uk.org/

All Podiatrists are expected to comply with the Code of Conduct Performance and Ethics and meet the *Standards of Proficiency* as defined by the HCPC.

- https://www.hcpc-uk.org/standards/standards-of-continuing-professional-development/
- https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/

Standards of Proficiency

All Podiatrists are expected to comply with professional standards/guidelines outlined in HCPC. Staff are required to familiarise themselves with these standards.

- https://www.hcpc-uk.org/standards/standards-of-proficiency/reviewing-the-standards-of-proficiency/download-the-revised-standards-of-proficiency/

Standards of Conduct, performance and ethics

- https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf

Professional Indemnification Guidance for AHP staff

In July 2014 legislation was introduced by the UK Government which requires all HCPC registrants (other than social workers in England) to have a professional indemnity arrangement in place as a condition of their registration with HCPC.

Additional information for registrants can be found at:http://www.hcpc-uk.org/Assets/documents/1000476773851HCPCProfessionalindemnity.pdf
The arrangement must provide appropriate cover - this means appropriate to a registrant's own practice, taking into account the nature and extent of its risks. This means that the HCPC will be able to ask registrants and applicants to complete declarations about their professional indemnity arrangements. They will also be able to take appropriate action where a registrant does not have a professional indemnity arrangement in place, or where a professional indemnity arrangement does not provide appropriate cover.
This change is part of the rolling HCPC re-registration programme.
Where staff are working within HSC organisations it is recognised that as long as they are working within their organisation's agreed policies and standards of practice their professional indemnification would be provided by their employer, this will include extended scope practitioner roles as outlined in their job descriptions.
It is important to note that HSC organisations only indemnify staff for work done as part of their contract and if they undertake any private work outside of this role, they will be required to hold separate insurance / professional indemnification.
Staff are advised to review their own personal arrangements and seek advice where necessary from their professional body, trade union, insurer or defence organisation in preparation for this change.

Policies, Procedures and Guidelines

Trust General and HR Policies and Guidelines

Staff are required to adhere to Trust General and Human Resources Policies and Guidelines.

Policies and Procedures (sharepoint.com)

Podiatry Department Policies, Procedures and Guidelines

Podiatry Departmental protocols/procedures/guidelines are available on MS Teams

GRP-Podiatry Team - Home (sharepoint.com)

Staff are required to adhere to these and also contribute to the review of existing or development of further procedures/guidelines.

Reporting of Accidents and Incidents

All staff should be aware of their responsibility within the Trust's Adverse Incidents Policy and Procedures.
These should be reported using DATIX immediately an incident occurs.

Datix: BHSCT Incident Report Form (belfasttrust.local)
Incident Reporting (sharepoint.com)
Serious Adverse Incidents (SAIs) (sharepoint.com)

Risk Management/ Assessment

Risk assessments are carried out on a regular basis. Staff are required to be alert to risk to patients or themselves and take appropriate action/inform their Line Manager immediately if a risk is identified.

Staff should read Policies & Guidelines - Risk Management Strategy - All Policies (sharepoint.com)the and should familiarise themselves with the Podiatry department risk registers. Staff should also read the risk assessments relevant to their area of service and ensure that they complete the controls to reduce the risk for staff/patients.

Note : Expectant mothers are required to inform their line manager immediately to allow and individual risk assessment to take place. – please read Policies & Guidelines - New and Expectant Mothers - Policy and Procedural Arrangements Relating to - All Policies (sharepoint.com)

Disciplinary and grievance procedures

Procedures can be found on the Loop

Equality Harassment and Bullying

Staff should be aware of their responsibilities regarding the Policies & Guidelines - Conflict, Bullying and Harassment in the Workplace - Policy and Procedure - All Policies (sharepoint.com)

Freedom of information Act

All staff should be aware that following the 'Freedom of Information Act' all information is discoverable.

This includes written information and e-mails. Staff should therefore take care when writing these documents.

Data Protection /Confidentiality

Staff should be aware and adhere to Trust Policies and to the HCPC standards of conduct performance and ethics. Policies & Guidelines - Data Protection and Protection of Personal Information - Policy on - All Policies (sharepoint.com)

Helpful information - Keeping your data secure

- Key issues from the Trusts Information Security Guidelines
- Treat Patient/Client information as if it were your own
- Never share user names and password
- Never send unprotected personal information via email
- Never divulge confidential information without authority
- Lock PCs when not in use or unattended
- Do not try to access information unlawfully
- All documentation and correspondence should be considered business documentation
- Encrypt, Encrypt, Encrypt – All laptops, USB sticks, emails, confidential files....
- If case files or personal/professional data are mislaid this must be reported to line manager immediately. A thorough search must be completed and then an incident IR1 form filled out.

Personal Use of Social Media

As a Trust employee it is important to be aware that posting information or views about the Trust cannot be isolated from your working life. You should therefore keep your personal use of social media as separate as possible from your professional life.

You should never do any of the following:

- Share confidential information online
- Post inappropriate comments about a staff member, patient or client. This includes discussion of work-related issues, conversations about patients and complaints about colleagues.
- Use social media sites to bully or intimidate a member of staff.
- Use social media in any way which is unlawful
- Accept a friends request from a patient or client who you *only know* through your professional work
- Use a trust email to log on to social media sites

Staff should be aware of their responsibilities using social media sites.

Policies & Guidelines - Social Media Policy - All Policies (sharepoint.com)

Consent to Treat

All staff are required to take verbal (noted in Paris Podiatry notes) or written consent for assessment. Some specific procedures require written consent please see Trust policy and staff must speak to their line manager regarding requirement for written consent in their area of work.

Record Management

Staff should be aware of the Trust's records management policy Policies & Guidelines - Records Management Policy - All Policies (sharepoint.com)

Clinical notes should be kept according to the Podiatry service Record Keeping Guideline and the Trust Record Policy
Record audit –all files are audited regularly using the Department audit checklist which is part of the annual audit programme for the Department.

N.B Staff should only use abbreviations as per Trust/Podiatry

Policies & Guidelines - Podiatry abbreviations (extended list) - All Policies (sharepoint.com)

Case File Retrieval

Many Podiatry files are stored outside the Trust. Staff should speak to their line manager regarding the system of file retrieval.

No case file should be sent by Royal Mail or Internal Post. Files should be hand delivered or if this is not possible staff should speak to their Team leader for advice.

Transport of Case Files

Transport of case files should be kept to a minimum. If files are required for domiciliary visits only the files for that session should be taken to the visits. Files for other patients seen during the session should be locked out of sight in the boot of your car.

Health and Safety

There are Health & Safety induction leaflet and checklist should be completed by staff member/line manager at induction.

Health and Safety Induction Checklist.doc (sharepoint.com)

Staff should be aware of their responsibilities under Belfast Trust's general Health and Safety Policy. Policies & Guidelines - General Health and Safety Policy - All Policies (sharepoint.com)

Environment

Environmental audits take place regularly. All staff should be aware of their working environment and address issues, which could lead to Health and Safety issues. Staff should comply with the Trust's de-clutter programme and should ensure all risks regarding slips, trips and falls are removed or identified immediately to their line manager.

All staff should be aware of the Trusts Smoke Free Policy and Management of Alcohol and Drugs in the Workplace.
Policies & Guidelines - Smoke free policy - All Policies (sharepoint.com)
Policies & Guidelines - Alcohol and Drugs in the Workplace policy - Prevention and management - All Policies (sharepoint.com)

Health and Safety audits will take place according to the schedule in your location.

Equipment

The Trust has a significant amount of equipment within the Podiatry department.

Staff should speak to their line manager regarding safe use, decontamination, reporting faults, cleaning and storing of equipment or requesting new equipment. Staff should be aware of the Trust's Policies & Guidelines - Medical Devices Procedures and Guidelines - All Policies (sharepoint.com)

If equipment is to a member of staff it is their responsible to ensure training and written instruction regarding its use is up to date and to keep a record of the equipment/ training given, as well as maintenance and recording of faults.

Display Screen Equipment

All staff should be aware of the Trust's Policies & Guidelines - Display Screen Equipment (DSE) - Policy and Procedural Arrangements - All Policies (sharepoint.com)

All staff must also complete a DSE Self Assessment Form
Display Screen Equipment (DSE) - Appendix 1 - self assessment form.docx (sharepoint.com)

Allergies

Staff should ensure they take note of any staff or client/patient allergies and should be aware if any food/product used could cause a reaction. In dealing with an allergic reaction basic training is available as part of Basic Life Support.

Latex Sensitivity

Podiatry department in Belfast Trust uses non latex gloves. However, staff may find there are latex gloves in other wards and departments and should not use these if they have a latex allergy, sensitivity, or latex induced asthma.

Please read Policies & Guidelines - Latex Sensitisation - Arrangements Relating to the Prevention and Management of - All Policies (sharepoint.com)

COSHH (Control of Substances Hazardous to Health)

Assessments are being carried out for the department and are available on Sharepoint
Our department COSHH assessors are Jim Markey and Stephen Ferguson

Please read Policies & Guidelines - Control of Substances Hazardous to Health - (COSHH) policy - All Policies (sharepoint.com)

First Aid

All staff should be aware of the Policies & Guidelines - First Aid at Work policy - All Policies (sharepoint.com)

Photography

Any member of staff using photography should be aware of Policies & Guidelines - Photography - Digital and video imaging of Service Users Consent and Confidentiality, Copyright and Storage - All Policies (sharepoint.com)

Zero tolerance

The trust has a policy of zero tolerance of aggression against staff.
Staff should inform their line manager immediately and fill in an Incident report on DATIX appropriate. Specific training is available for vulnerable areas.

Please read Policies & Guidelines - Zero Tolerance Approach policy - Prevention and Management of Aggression and Violence Towards Staff In The Workplace - All Policies (sharepoint.com)approach to Prevention and Management of violence and aggression

Waste Management

All staff must ensure they dispose of waste appropriately; Clinical waste must be disposed of in yellow bags. Follow Trust Personal Protective Equipment (PPE) procedure guidelines.

Staff should read the Policies & Guidelines - Waste policy - All Policies (sharepoint.com)

Complaints, Concerns and Compliments

All Staff should be aware of their responsibilities under Policies & Guidelines - Comments, Concerns, Complaints and Compliments -Policy and Procedure for the Management of - All Policies (sharepoint.com)Complaints leaflets are located in waiting areas/treatment rooms throughout the Trust.

The Trust has a Complaints Handling Training. All complaints should be discussed and dealt with promptly with your Team Leader.

Staff Supervision and Development

Staff Meetings

Locality staff meetings occur monthly and Department staff meetings occur two times per year, normally June and December

Podiatry Location meetings are held monthly. Date, time and venue will be arranged and circulated by the relevant Assistant Service Manager. If staff members are unable to attend any meeting, they must notify the relevant assistant podiatry manager. Staff are expected to attend one of the monthly location meetings.

If any matter is causing concern or worry to staff members the relevant Assistant Service Manager will ensure that time is made available for discussion.

Supervision

Individual and group supervision are implemented in the department according to the. New staff members will be allocated a supervisor at induction.

Course Attendance

Staff should ask their supervisor how to access the ILMS system and also please ensure they set up their Assistant Service Manager as the person to approve these courses.
Approval for course attendance should be sought from the Assistant Service Manager.

Trust in house courses can be booked through the ILMS System on the Trusts Loop
Other courses require completed study leave form with course details, agenda, study leave form etc. should be sent to Assistant Service Manager

Any course where there is a financial cost also requires Podiatry Service Manager's signature. Apply via HRPTS

Any course outside of Northern Ireland needs a Co-Director's signature.
If the course falls on a weekend or bank holiday the staff member will not be allowed lieu time unless their attendance at the course has been specifically requested by Manager.
A note should be kept of such training and a record is kept within Podiatry staff file.

Staff should be aware the Trust has an Policies & Guidelines - Study Assistance Policy - All Policies (sharepoint.com)

In-service Training (Incorporated in Team meetings)

Meetings are currently being organised within the Department/Team, at which members of staff should report on courses they have recently attended or present information from recent articles.

Student Training

The education supervision of students is an important part of NHS work. Staff will be expected to take students on a regular basis. Students should receive induction information at the start of their placement regarding confidentiality, record keeping, professional conduct, clinical standards/expectations, Health and Safety and general clinical and service orientation into the service.

It should be noted that patients have a right to choose whether or not to take part in student training. Verbal consent should be sought and this should be noted in the Paris notes.

Library

Queens University Belfast Medical library is available to NHS staff.

SDR

Staff Development Review (sharepoint.com)

All Trust employees take part in this annual development review. A profile of required skills for your particular job from the Knowledge and Skills Framework. This, along with staff member's job description, will outline their roles and responsibilities.

Mandatory Training

See Trust's Mandatory Training Policy and Podiatry Mandatory Training requirements

Statutory & Mandatory Training (sharepoint.com)

Podiatry Mandatory Training Requirements

Name _____

Subject	How Often	Who	How	Contact	Date of completion
Adverse Incident reporting	One off	All staff	Trust Hub E Learning	Trust E Learning	
Anaphylaxis	Annual	All Staff	HSC E Learning	www.hsclearning.com	
ANTT	Every 2 years	All Staff	Podiatry Trained assessor	Trained Podiatry ANTT Assessors	
Attendance Management	Once	Specific staff	HRTPS Learning portal	HRTPS Ciaran McDonald	
Adult Basic Life Support	Annual	All Staff	HSC E Learning on successful completion please book face to face via HRPTS	www.hsclearning.com	
Child Safeguarding	Every 2 years	All staff	Virtual training	https://cec.hscni.net	
Complaints management	One off	All staff	Online training Click link to complete	http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Complaints/Complaints-Training.aspx	
Corporate Welcome	One off	All Staff	1ST day of new appointment	HR & Line Manager	
COSHH awareness	Every 3 years	All staff	E Learning Trust Hub	Trust E Learning	
Data Protection 2019 (GDPR) Awareness	Every 3 years	All Staff	E Learning Trust Hub	Trust E Learning	
Display Screen Equipment Awareness	Once	All staff	HSC E Learning	www.hsclearning.com	

Equality, good relations and human rights	5 yearly	All staff	HSC E learning	www.hsclearning.com	
Fire Safety	Annual	All Staff	HRPTS MS team training event	HRPTS Fire Safety Awareness via MS Teams	
Health and safety Awareness	Once	All staff	E Learning_Trust Hub	Trust E Learning	
Health Surveillance	Annual	All staff	Trust MS Teams form	Form will be sent individually to each staff member to complete	
HIV awareness	One off	All staff	HRTPS Learning portal	HRTPS Learning portal	
Infection control for clinical staff	Every 2 years	All Staff	E Learning Trust Hub	Trust E Learning	
IRMER Training	Every 3 years	Specific staff	Trust Hub E Learning	Trust E Learning	
Local Induction	One off	All staff	Provided on appointment	Line Manager	
Management of Aggression	Every 2 years	All Staff	HRTPS Learning portal	Contact Eileen Tiffney	
Manual Handling Awareness	Every 2 years	All Staff	E Learning Trust Hub Poster_Moving&Handling_InstructionalVid	This will take you automatically to HSC learning site	
Mental Capacity Training Deprivation of Liberty	Every 2 years	All staff Podiatrist level 3	HSC Learning	http://mca-learning.health-ni.gov.uk/level3/	
Medical Devices	Every 3 years	All Staff	E Learning Trust Hub	Trust E Learning	

Prevention of Pressure Ulceration Adults	Every 2 years	All staff	E Learning Trust Hub	Trust E Learning	
Recruitment and Selection	Every 3 years	Specific staff	HSC E Learning	www.hsclearning.com	
Vulnerable Adults safeguarding	Every 2 years	All Staff	Virtual training	https://cec.hscni.net/	
Supervision	One off	All staff	HSC E Learning	www.hsclearning.com	

Basic Life Support with D-Fib

Training is provided within the Trust. This training is arranged via LMS on a yearly basis - all staff must attend this training and this will be monitored according to Trust Policy.

Adult and Child Safeguarding

Adult and Child Safeguarding training is provided by the Trust and is required in all clinical areas. Staff should ask their manager. Staff should be aware of Trust guidelines when working with small children.

Adult Safeguarding on The Loop (sharepoint.com)

Adult, Community and Older People's Services - BHSCT-Adult-safeguarding-policy-and-procedure.pdf - All Documents (sharepoint.com)

Policies & Guidelines - Safeguarding Children and Young People who Attend Adult Services for Admission, Care or Treatment - Caring for and - All Policies (sharepoint.com)

Policies & Guidelines - Child protection - Regional core child protection policy and procedures - All Policies (sharepoint.com)

Business Continuity Planning

The Trusts Emergency Preparedness Arrangements outlines the responsibilities of staff in the event of a major incident or emergency. Additional guidance can be found in the BHSCT Business Continuity Framework on the Trust Intranet Business Continuity (sharepoint.com)

Fire Safety Training

All staff should be aware of their responsibilities under the Policies & Guidelines - Fire Safety Policy - Statement and Procedural Arrangements including procedure for the Management of Oxy Acetylene - All Policies (sharepoint.com)
Fires lectures held online. Each staff member should attend these sessions on an annual basis and a record kept of attendance. If a member of staff misses this training, a session should be booked using ILMS

All staff should check location of fire doors on their first day in each clinic and should fit into fire evacuation drills in each location as arranged by Site Manager.

Gifts and Hospitality

All staff should read and adhere to the Trusts Gifts & Hospitality Policy.
Please note: "Offers of cash or cash equivalents (e.g. Lottery Tickets, Gift Vouchers or Gift Cheques) made by suppliers, contractors, service users or their relatives to individual officers of the Trust should be declined. Instead the supplier, contractor, service user or relative should be made aware of the range of endowment and gift (E&G) funds which are managed by the Trust to receive cash donations for general and specific purposes."
Any queries in relation to this should be raised with Podiatry Assistant Manager/Line Manager in the first instance.

Infection Prevention Control

Staff must wear appropriate Personal Protective Equipment when completing clinical tasks e.g. gloves, mask, apron and visor where appropriate
There are a number of policies pertaining to IPC

Policies & Guidelines - Aseptic Non Touch Technique (ANTT) - All Policies (sharepoint.com)
Policies & Guidelines - Hand hygiene policy - All Policies (sharepoint.com)

Decontamination of reusable invasive medical devices

Please read Policies & Guidelines - Decontamination of reusable invasive medical devices - All Policies (sharepoint.com)

Manual Handling

All staff should be aware of the Manual Handling (sharepoint.com)
There is a manual handling team within the Trust. All staff are required to go on basic back care training. Further training depends on specific duties of you

job, and decided by the manual handling team. No member of staff is to move patients / heavy equipment without the appropriate training.

Staff using children's seating should only use this during treatment sessions.

Manual Handling risk assessments are being completed for the Department and all staff should ensure that they read these and carry out the actions – staff should ask their Line Manager

Any staff member involved in moving/handling patients should inform their line manager immediately if they have back problems.

Our Department Representative is Linda Paine. Please contact Linda if you have any concerns/queries regarding Manual Handling.

Occupational Health and Staff Care

Occupational Health - Home (sharepoint.com)

Staff care can offer you immediate telephone counselling support, or arrange for you to meet face to face with a counsellor in a convenient and anonymous setting. We offer a short-term (up to 4 sessions), future-focused approach to counselling.

Care line 0800 731 3674

Contact Occupational Health Staff Care for more information.
Counselling is available for Trust Staff – Please contact staff Care.

Occupational Health 2nd Floor McKinney House Musgrave Park Hospital	028 9504 0401

Staff should be aware of Trust's policy on the

Policies & Guidelines - Stress, Health and Well Being - Management of - All Policies (sharepoint.com)

Staff may also be required to complete an individual Stress Risk Assessment Form

Human Resources and Organisational Development - INDIVIDUAL STRESS RISK ASSESSMENT.pdf - All Documents (sharepoint.com)

Professional Body –Royal College of Chiropodists and Podiatrists

Podiatrists are often members of Royal College of Chiropodists and Podiatrists this is a personal choice.

However HCPC Guidelines state
"If you are a registrant, you now have to make sure that you have a professional indemnity arrangement in place as a condition of your registration with us"
Other methods of professional indemnity are available.

Trade Union leads are David McKeown / Gary Monteith

Royal College of Podiatry provide union representation but there are a number of union available to HSC staff.

Useful Contact Numbers

IT Helpdesk	0800 587 3878
Human Resources	028 9504 8836
Employee Relations	028 9504 8918 028 9504 9067

Finance Contact information

Email Address	Usage	Maintained by
Payroll.ssc@hscni.net	General Queries	Service Team
Monthly_timesheet.ssc@hscni.net	Monthly timesheets & Adjustments	Support Team
Weekly_timesheet.ssc@hscni.net	Weekly Timesheets & Adjustments	Support Team

Fortnightly_timesheet.ssc@hscni.net	Fortnightly timesheets & Adjustments	Support Team
Travel_claims.ssc@hscni.net	Travel Claims & Receipts	Support Team
Dutyofcare.ssc@hscni.net	Duty of care information	Support Team
Sick_certs.ssc@hscni.net	Sick Returns and scanned copies of sick certificates	Support Team
TSR_Pension.ssc@hscni.net	All staff for Pension Estimates, TSR Figures, Retirements only	Payroll Team

Forms to be completed at Induction

Checklist	Given By	Date	Employee Signature
General Department Induction Version 6			
Local Induction / Departmental Orientation			
Departmental Orientation			
Name Badge Ordered			
Email Account Requested			
PARIS			
Podiatry Staff Directory Provided			
Annual Leave Calculate and Card Given			
Personal File Front Sheet Completed			
Health and Safety induction information given			
Mandatory Training – Level Required Identified (See Sheet)			
List of Policies and Guidelines to read given with Completion Date			
Dual Working (working Time Directorate)			

Local Induction/ Departmental Orientation

	Tick When Done
• HRPTS Registration	
• Structure of the Sector Team/Reporting Structure	
• Local Operational Procedures relevant Procedure identified	
• Clinical Guidelines relevant Guidelines identified	
• Job description/ KSF outlines	
• Supervisors identified and arrangements discussed	
• Key links in other Departments	
• Specific start and finish times	
• Lunch times/ tea breaks	
• Discussion/Filling in dual employment form	
• Travel claim – procedure/form	
• Training needs identified	
• Local Team/Sector Objectives	
• Car parking/transport arrangements	
• Lone Working/ Domiciliary Arrangements	
• Fire evacuation procedures	
• Local fire officers identified	
• Phone system	
• PC/ IT orientation/access	
• Photocopier	
• Coffee/lunch facilities	
• Panic buttons/ personal safety/ security arrangements	
• Location of - HYPO Boxes - First Aid - PPE Equipment - Resuscitation Equipment	
• Security Arrangements/ Location Keys etc.	
• Emergency Phone Number	

File Sheet (for front of each Personal File)

Podiatry Department

Name:

Home Address

Contact Phone Number

HCPC Number

Years of Service for Leave Entitlement

National insurance No

Base

Belfast Health and Social Care Trust

Working Time Regulations

Dual Employment Form

In accordance with the Working Time Regulations, the Trust must ascertain the number of hours per week worked by staff. This includes hours worked in other jobs and for other employers.

The Trust does not wish to debar you from additional employment. The information is required to ensure compliance with the Regulations.

Please complete the following details and return them to your Manager:

Information in relation to employment with Belfast Health & Social Care Trust.

Name: _____

Grade: _____

Location: _____

Staff Number: _____

Hours per week: _____

Secondary Employment details.

Employer Name & Address:

_____
_____

Grade: _____

Hours per week: _____

Signature: _____ Date: _____

It is important to advise your Manager if you take up additional employment after this date.

MAHI - STM - 105 - 1080

hpc health professions council

Standards of proficiency

Chiropodists / podiatrists

Contents

Foreword

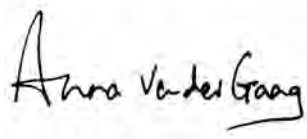
I am pleased to present the Health Professions Council's standards of proficiency.

We first published the standards of proficiency when our Register opened in July 2003. We began to review them in October 2005 to look at how they were working and to check whether they continued to reflect current practice as experienced by registrants, employers, educators and others. The review was led by a professional liaison group (PLG), which included members of our Council, as well as representatives from professional bodies and patient groups. We also held a formal consultation on the draft proposed standards. The review process and consultation produced extremely valuable feedback and we are grateful to all those who gave their time to help us in shaping the standards that follow.

We made a small number of changes to the previous standards, mainly to reflect developments in education, to clarify our intentions and to correct any errors or omissions. We also revised the introduction to explain more clearly the purpose behind the standards, especially in relation to registrants who specialise or move into non-clinical areas of practice.

I am confident that the standards are both fit for purpose and reflect current thinking in relation to safe professional practice across the professions.

These standards are effective from 1 November 2007 and were revised in September 2009.



Anna van der Gaag
Chair

Introduction

This document sets out the **standards of proficiency**. These are the standards we have produced for the safe and effective practice of the professions we regulate. They are the minimum standards we consider necessary to protect members of the public.

You must meet these standards when you first become registered. After that, every time you renew your registration you will be asked to sign a declaration that you continue to meet the standards of proficiency that apply to your scope of practice.

We also expect you to keep to our **standards of conduct, performance and ethics**, which are published in a separate document.

The standards of proficiency in this document include both generic elements, which apply to all our registrants, and profession-specific elements that are relevant to registrants belonging to one of the professions we currently regulate. The **generic standards are written in black**, and the **profession-specific standards are written in blue** to help you distinguish between them.

The generic standards explain the key obligations that we expect of you. Occasionally, we have pointed out specific elements of those key obligations. We have not attempted to create exhaustive lists of all the areas that each generic standard covers; we have simply highlighted specific elements where we consider this to be helpful.

A note about our expectations of you

The standards of proficiency play a central role in how you can gain admission to, and remain on, the Register and thereby gain the right to use the protected title(s) of your profession.

It is important that you read and understand this document. If your practice is called into question we will consider these standards (and our **standards of conduct, performance and ethics**) in deciding what action, if any, we need to take.

The standards set out in this document complement information and guidance issued by other organisations, such as your professional body or your employer.

Your scope of practice

Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself.

We recognise that a registrant's scope of practice will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain clinical area or with a particular client group, or a movement into roles in management, education or research.

Your particular scope of practice may mean that you are unable to continue to demonstrate that you meet all of the standards that apply for the whole of your profession. As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice you should be certain that you are capable of working lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training and experience.

Meeting the standards

It is important that our registrants meet our standards and are able to practise lawfully, safely and effectively. However, we don't dictate how you should meet our standards. There is normally more than one way in which each standard can be met and the way in which you meet our standards might change over time because of improvements in technology or changes in your practice. As an autonomous professional you need to make informed, reasoned decisions about your practice to ensure that you meet the standards that apply to you. This includes seeking advice and support from education providers, employers, colleagues and others to ensure that the wellbeing of service users is safeguarded at all times.

In particular, we recognise the valuable role played by professional bodies in representing and promoting the interests of their members. This often includes guidance and advice about good practice which can help you meet the standards laid out in this document.

Service users

We recognise that our registrants work in a range of different settings, which include clinical practice, education, research and roles in industry. We recognise that different professions sometimes use different terms to refer to those who use or who are affected by their practice and that the use of terminology can be an emotive issue.

We have tried to use a term in the generic standards which is as inclusive as possible. Throughout the generic standards we have used the term 'service users' to refer to anyone who uses or is affected by the services of registrants. Who your service users are will depend on how and where you work. For example, if you work in clinical practice, your service users might be your patients or your staff if you manage a team. The term also includes other people who might be affected by your practice, such as carers and relatives. In the profession-specific standards, we have retained the terminology which is relevant to each individual profession.

These standards may change in the future

We have produced this new version of our standards after speaking to our stakeholders about how the standards were working and how relevant they were to registrants' practice.

We will continue to listen to our stakeholders and will keep our standards under continual review. So we may make further changes in the future to take into account changes in practice.

We will always publicise any changes to the standards that we make by, for instance, publishing notices on our website and informing professional bodies.

Expectations of a health professional

1a Professional autonomy and accountability

Registrant chiropodists / podiatrists must:

1a.1 be able to practise within the legal and ethical boundaries of their profession

– understand the need to act in the best interests of service users at all times

– understand what is required of them by the Health Professions Council

– understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing

– be aware of current UK legislation applicable to the work of their profession

1a.2 be able to practise in a non-discriminatory manner

1a.3 understand the importance of and be able to maintain confidentiality

1a.4 understand the importance of and be able to obtain informed consent

1a.5 be able to exercise a professional duty of care

1a.6 be able to practise as an autonomous professional, exercising their own professional judgement

– be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem

– be able to initiate resolution of problems and be able to exercise personal initiative

– know the limits of their practice and when to seek advice or refer to another professional

– recognise that they are personally responsible for and must be able to justify their decisions

1a.7 recognise the need for effective self-management of workload and resources and be able to practise accordingly

1a.8 understand the obligation to maintain fitness to practise

– understand the need to practise safely and effectively within their scope of practice

– understand the need to maintain high standards of personal conduct

– understand the importance of maintaining their own health

– understand both the need to keep skills and knowledge up to date and the importance of career-long learning

1b Professional relationships

Registrant chiropodists / podiatrists must:

1b.1 be able to work, where appropriate, in partnership with other professionals, support staff, service users and their relatives and carers

– understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team

– understand the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals

– be able to make appropriate referrals

1b.2 be able to contribute effectively to work undertaken as part of a multi-disciplinary team

1b.3 be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relatives and carers

- be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5[1]
- understand how communication skills affect the assessment of service users and how the means of communication should be modified to address and take account of factors such as age, physical ability and learning ability
- be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others
- be aware of the characteristics and consequences of non-verbal communication and how this can be affected by culture, age, ethnicity, gender, religious beliefs and socio-economic status
- understand the need to provide service users (or people acting on their behalf) with the information necessary to enable them to make informed decisions
- understand the need to use an appropriate interpreter to assist service users whose first language is not English, wherever possible
- recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of care even in situations of personal incompatibility

1b.4 understand the need for effective communication throughout the care of the service user

- recognise the need to use interpersonal skills to encourage the active participation of service users
- understand the need to empower patients to manage their foot health and related issues and recognise the need to provide advice to the patient on self-treatment where appropriate

[1] The International English Language Testing System (IELTS) tests competence in spoken and written English. Applicants who have qualified outside of the UK, whose first language is not English and who are not nationals of a country within the European Economic Area (EEA), have to provide evidence that they have reached the necessary standard. We accept a number of other tests as equivalent to the IELTS examination. Please visit our website for more information.

The skills required for the application of practice

2a Identification and assessment of health and social care needs

Registrant chiropodists / podiatrists must:

2a.1 be able to gather appropriate information

2a.2 be able to select and use appropriate assessment techniques

– be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment

2a.3 be able to undertake or arrange investigations as appropriate

– be able to conduct neurological, vascular, biomechanical, dermatological and podiatric assessments in the context of chiropody and podiatry

2a.4 be able to analyse and critically evaluate the information collected

– be able to interpret physiological, medical and biomechanical data in the context of chiropody and podiatry

2b Formulation and delivery of plans and strategies for meeting health and social care needs

Registrant chiropodists / podiatrists must:

2b.1 be able to use research, reasoning and problem-solving skills to determine appropriate actions

– recognise the value of research to the critical evaluation of practice

– be able to engage in evidence-based practice, evaluate practice systematically and participate in audit procedures

– be aware of a range of research methodologies

– be able to demonstrate a logical and systematic approach to problem solving

– be able to evaluate research and other evidence to inform their own practice

2b.2 be able to draw on appropriate knowledge and skills in order to make professional judgements

– be able to change their practice as needed to take account of new developments

– be able to demonstrate a level of skill in the use of information technology appropriate to their practice

– know and be able to interpret the signs and symptoms of systemic disorders as they manifest in the lower limb and foot with particular reference to:

  – diabetes mellitus

  – rheumatoid arthritis and other arthropathies

  – cardiovascular disorders

  – dermatological disorders

  – infections

  – neurological disorders

  – renal disorders

  – developmental disorders

  – malignancy

2b.3 be able to formulate specific and appropriate management plans including the setting of timescales

– understand the requirement to adapt practice to meet the needs of different groups distinguished by, for example, physical, psychological, environmental, cultural or socio-economic factors

2b.4 be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely and skilfully

– understand the need to maintain the safety of both service users and those involved in their care

– ensure patients are positioned (and if necessary immobilised) for safe and effective interventions

- be able to use a systematic approach to formulate and test a preferred diagnosis, including being able to:
  - carry out mechanical debridement of nails and intact and ulcerated skin
  - prescribe foot orthoses
  - make and use chair-side foot orthoses
  - administer relevant prescription-only medicines, interpret any relevant pharmacological history and recognise potential consequences for patient treatment
  - apply local anaesthesia techniques
  - carry out surgical procedures for skin and nail conditions
  - use appropriate physical and chemical therapies
- be able to use basic life support skills and to deal safely with clinical emergencies
- know and be able to apply the key concepts which are relevant to safe and effective practice as a supplementary prescriber (this standard applies **only** to registrants who are eligible to have their names annotated on the Register)

2b.5 be able to maintain records appropriately

- be able to keep accurate, legible records and recognise the need to handle these records and all other information in accordance with applicable legislation, protocols and guidelines
- understand the need to use only accepted terminology in making records

2c Critical evaluation of the impact of, or response to, the registrant's actions

Registrant chiropodists / podiatrists must:

2c.1 be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly

– be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care

– be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user

– recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes

– be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately

2c.2 be able to audit, reflect on and review practice

– understand the principles of quality control and quality assurance

– be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures

– be able to maintain an effective audit trail and work towards continual improvement

– participate in quality assurance programmes, where appropriate

– understand the value of reflection on practice and the need to record the outcome of such reflection

– recognise the value of case conferences and other methods of review

3a Knowledge, understanding and skills

Registrant chiropodists / podiatrists must:

3a.1 know and understand the key concepts of the bodies of knowledge which are relevant to their profession-specific practice

- understand the structure and function of the human body, relevant to their practice, together with knowledge of health, disease, disorder and dysfunction
- be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process
- recognise the role of other professions in health and social care
- understand the theoretical basis of, and the variety of approaches to, assessment and intervention
- understand, in the context of chiropody and podiatry:
  - anatomy and human locomotion
  - histology
  - physiology
  - immunology
  - podiatric orthopaedics and biomechanics
  - systemic and podiatric pathology
  - podiatric therapeutic sciences
  - behavioural sciences
  - foot health promotion and education

3a.2 know how professional principles are expressed and translated into action through a number of different approaches to practice, and how to select or modify approaches to meet the needs of an individual, groups or communities

3a.3 understand the need to establish and maintain a safe practice environment

– be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these

– be able to work safely, including being able to select appropriate hazard control and risk management, reduction or elimination techniques in a safe manner in accordance with health and safety legislation

– be able to select appropriate personal protective equipment and use it correctly

– be able to establish safe environments for practice, which minimise risks to service users, those treating them, and others, including the use of hazard control and particularly infection control

– know the correct principles and applications of disinfectants, methods for sterilisation and decontamination, and for dealing with waste and spillages correctly

– be aware of immunisation requirements and the role of occupational health

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hcpc health & care professions council

Standards of proficiency

Chiropodists / podiatrists

Contents

Foreword

We are pleased to present the Health and Care Professions Council's standards of proficiency for chiropodists / podiatrists.

We first published standards of proficiency for chiropodists / podiatrists when our Register opened in July 2003. We published revised standards in 2007. We review the standards regularly to look at how they are working and to check whether they continue to reflect current practice in the professions we regulate.

These new revised standards are a result of our most recent review of the standards of proficiency. As a result of the first stage of the review, and the results of a public consultation, we have revised our generic standards which apply to all the professions we regulate. The revised standards are now based around 15 generic statements. This new structure means that we can retain the standards which are shared across all the professions we regulate, whilst allowing us more flexibility in describing the detailed standards which are specific to individual professions.

The profession-specific standards for chiropodists / podiatrists included in this document were developed through the input of the relevant professional bodies and the views of all stakeholders during a further public consultation. The review process and consultation produced valuable feedback and we are grateful to all those who gave their time to help us in shaping the new standards.

We have made a small number of changes to the standards overall, mainly to reflect developments in education and practice, to clarify our intentions and to correct any errors or omissions. We have also made some minor changes to the introduction, in particular to explain the language we use in the standards.

We are confident that the standards are fit for purpose and reflect safe and effective professional practice in chiropody and podiatry.

These standards are effective from 1 September 2013.

Introduction

This document sets out the standards of proficiency. These standards set out safe and effective practice in the professions we regulate. They are the threshold standards we consider necessary to protect members of the public. They set out what a student must know, understand and be able to do by the time they have completed their training, so that they are able to apply to register with us. Once on our Register you must meet those standards of proficiency which relate to the areas in which you work.

We also expect you to keep to our standards of conduct, performance and ethics and standards for continuing professional development. We publish these in separate documents, which you can find on our website.

The standards of proficiency in this document include both generic elements, which apply to all our registrants, and profession-specific elements which are relevant to registrants belonging to one of the professions we currently regulate. The generic standards are written in **bold**, and the profession-specific standards are written in plain text.

We have numbered the standards so that you can refer to them more easily. The standards are not hierarchical and are all equally important for practice.

A note about our expectations of you

You must meet all the standards of proficiency to register with us and meet the standards relevant to your scope of practice to stay registered with us.

It is important that you read and understand this document. If your practice is called into question we will consider these standards (and our standards of conduct, performance and ethics) in deciding what action, if any, we need to take.

The standards set out in this document complement information and guidance issued by other organisations, such as your professional body or your employer. We recognise the valuable role played by professional bodies in providing guidance and

advice about good practice which can help you to meet the standards laid out in this document.

Your scope of practice

Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself.

We recognise that a registrant's scope of practice will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain area or with a particular client group, or a movement into roles in management, education or research.

Every time you renew your registration, you will be asked to sign a declaration that you continue to meet the standards of proficiency that apply to your scope of practice.

Your particular scope of practice may mean that you are unable to continue to demonstrate that you meet all of the standards that apply for the whole of your profession. As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice, you should be certain that you are capable of working lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training or gaining experience, before moving into a new area of practice.

Meeting the standards

It is important that you meet our standards and are able to practise lawfully, safely and effectively. However, we do not dictate how you should meet our standards. There is normally more than one way in which each standard can be met and the way in which you meet our standards might change over time because of improvements in technology or changes in your practice.

We often receive questions from registrants who are concerned that something they have been asked to do, a policy, or the way in which they work might mean they cannot meet our standards. They are often worried that this might have an effect on their registration.

As an autonomous professional, you need to make informed, reasoned decisions about your practice to ensure that you meet the standards that apply to you. This includes seeking advice and support from education providers, employers, colleagues, professional bodies, unions and others to ensure that the wellbeing of service users is safeguarded at all times. So long as you do this and can justify your decisions if asked to, it is very unlikely that you will not meet our standards.

Language

We recognise that our registrants work in a range of different settings, which include direct practice, management, education, research and roles in industry. We recognise that the use of terminology can be an emotive issue.

Our registrants work with very different people and use different terms to describe the groups that use, or are affected by, their services. Some of our registrants work with patients, others with clients and others with service users. The terms that you use will depend on how and where you work. We have used terms in these standards which we believe best reflect the groups that you work with.

In the standards of proficiency, we use phrases such as 'understand', 'know', and 'be able to'. This is so the standards remain applicable to current registrants in maintaining their fitness to practise, as well as prospective registrants who have not yet started practising and are applying for registration for the first time.

These standards may change in the future

We have produced these standards after speaking to our stakeholders and holding a formal public consultation.

We will continue to listen to our stakeholders and will keep our standards under continual review. Therefore, we may make further changes in the future to take into account changes in practice.

We will always publicise any changes to the standards that we make by, for instance, publishing notices on our website and informing professional bodies.

Standards of proficiency

Registrant chiropodists / podiatrists must:

1 be able to practise safely and effectively within their scope of practice

1.1 know the limits of their practice and when to seek advice or refer to another professional

1.2 recognise the need to manage their own workload and resources effectively and be able to practise accordingly

2 be able to practise within the legal and ethical boundaries of their profession

2.1 understand the need to act in the best interests of service users at all times

2.2 understand what is required of them by the Health and Care Professions Council

2.3 understand the need to respect and uphold the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing

2.4 recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of care even in situations of personal incompatibility

2.5 know about current legislation applicable to the work of their profession

2.6 understand the importance of and be able to obtain informed consent

2.7 be able to exercise a professional duty of care

3 be able to maintain their fitness to practise

3.1 understand the need to maintain high standards of personal and professional conduct

3.2 understand the importance of maintaining their own health

3.3 understand both the need to keep skills and knowledge up to date and the importance of career-long learning

4 be able to practise as an autonomous professional, exercising their own professional judgement

4.1 be able to assess a professional situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem

4.2 be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately

4.3 be able to initiate resolution of problems and be able to exercise personal initiative

4.4 recognise that they are personally responsible for and must be able to justify their decisions

4.5 be able to make and receive appropriate referrals

4.6 understand the importance of participation in training, supervision, and mentoring

5 be aware of the impact of culture, equality and diversity on practice

5.1 understand the requirement to adapt practice to meet the needs of different groups and individuals

6 be able to practise in a non-discriminatory manner

7 understand the importance of and be able to maintain confidentiality

7.1 be aware of the limits of confidentiality

7.2 understand the principles of information governance and be aware of the safe and effective use of health and social care information

7.3 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users or the wider public

8 be able to communicate effectively

8.1 be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, colleagues, and others

8.2 be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5[1]

8.3 understand how communication skills affect assessment and engagement of service users and how the means of communication should be modified to address and take account of factors such as age, capacity, learning ability and physical ability

8.4 be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others

8.5 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs

8.6 understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions

8.7 understand the need to assist the communication needs of service users such as through the use of an appropriate interpreter, wherever possible

8.8 recognise the need to use interpersonal skills to encourage the active participation of service users

8.9 understand the need to empower patients to manage their foot health and related issues and recognise the need to provide advice to the patient on self-treatment where appropriate

[1] The International English Language Testing System (IELTS) tests competence in the English language. Applicants who have qualified outside of the UK, whose first language is not English and who are not nationals of a country within the European Economic Area (EEA) or Switzerland, must provide evidence that they have reached the necessary standard. Please visit our website for more information.

9 be able to work appropriately with others

9.1 be able to work, where appropriate, in partnership with service users, other professionals, support staff and others

9.2 understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team

9.3 understand the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals

9.4 be able to contribute effectively to work undertaken as part of a multi-disciplinary team

10 be able to maintain records appropriately

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols, and guidelines

10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines

11 be able to reflect on and review practice

11.1 understand the value of reflection on practice and the need to record the outcome of such reflection

11.2 recognise the value of case conferences and other methods of review

12 be able to assure the quality of their practice

12.1 be able to engage in evidence-based practice, evaluate practice systematically and participate in audit procedures

12.2 be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care

12.3 be aware of the role of audit and review in quality management, including quality control, quality assurance, and the use of appropriate outcome measures

12.4 be able to maintain an effective audit trail and work towards continual improvement

12.5 be aware of, and be able to participate in, quality assurance programmes, where appropriate

12.6 be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user

12.7 recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes

13 understand the key concepts of the knowledge base relevant to their profession

13.1 be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process

13.2 recognise the role of other professions in health and social care

13.3 understand the structure and function of health and social care services in the UK

13.4 understand the concept of leadership and its application to practice

13.5 understand the theoretical basis of, and the variety of approaches to, assessment and intervention

13.6 understand the structure and function of the human body, together with knowledge of health, disease, disorder and dysfunction relevant to their profession

13.7 understand, in the context of chiropody and podiatry:

- anatomy and human locomotion
- behavioural sciences
- foot health promotion and education
- histology

- immunology
- pharmacology
- physiology
- podiatric orthopaedics and biomechanics
- podiatric therapeutic sciences
- systemic and podiatric pathology

14 be able to draw on appropriate knowledge and skills to inform practice

14.1 be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy, or other actions safely and effectively

14.2 be able to gather appropriate information

14.3 be able to select and use appropriate assessment techniques

14.4 be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment

14.5 be able to formulate specific and appropriate management plans including the setting of timescales

14.6 be able to conduct neurological, vascular, biomechanical, dermatological and podiatric assessments in the context of chiropody and podiatry

14.7 be able to use a systematic approach to formulate and test a preferred diagnosis

14.8 be able to use basic life support skills and to deal safely with clinical emergencies

14.9 be able to change their practice as needed to take account of new developments or changing contexts

14.10 know and be able to interpret the signs and symptoms of systemic disorders as they manifest in the lower limb and foot with particular reference to:

- cardiovascular disorders
- dermatological disorders
- developmental disorders
- diabetes mellitus
- infections
- malignancy
- neurological disorders
- renal disorders
- rheumatoid arthritis and other arthropathies

14.11 be able to carry out the following techniques safely and effectively:

- administer relevant prescription-only medicines, interpret any relevant pharmacological history and recognise potential consequences for patient treatment
- apply local anaesthesia techniques
- carry out mechanical debridement of intact and ulcerated skin
- carry out surgical procedures for skin and nail conditions
- make and use chair-side foot orthoses
- manage nail disorders
- prescribe foot orthoses
- use appropriate physical and chemical therapies

14.12 be able to undertake or arrange investigations as appropriate

14.13 be able to analyse and critically evaluate the information collected

14.14 be able to interpret physiological, medical and biomechanical data in the context of chiropody and podiatry

14.15 be able to demonstrate a logical and systematic approach to problem solving

14.16 be able to use research, reasoning and problem solving skills to

determine appropriate actions

14.17 recognise the value of research to the critical evaluation of practice

14.18 be aware of a range of research methodologies

14.19 be able to evaluate research and other evidence to inform their own practice

14.20 be able to use information and communication technologies appropriate to their practice

15 understand the need to establish and maintain a safe practice environment

15.1 understand the need to maintain the safety of both service users and those involved in their care

15.2 be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting and be able to act in accordance with these

15.3 be able to work safely, including being able to select appropriate hazard control and risk management, reduction or elimination techniques in a safe manner in accordance with health and safety legislation

15.4 be able to select appropriate personal protective equipment and use it correctly

15.5 be able to establish safe environments for practice, which minimise risks to service users, those treating them and others, including the use of hazard control and particularly infection control

15.6 know how to position or immobilise patients correctly for safe and effective interventions

15.7 know the correct principles and applications of disinfectants, methods for sterilisation and decontamination, and for dealing with waste and spillages

15.8 be aware of immunisation requirements and the role of occupational health

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hcpc health & care professions council

Your duties as a registrant

Standards of conduct, performance and ethics

Contents

Foreword

I am pleased to present the Health and Care Professions Council's standards of conduct, performance and ethics.

We first published the standards of conduct, performance and ethics when our Register opened in July 2003. We began to review them in July 2006 to make sure that they continued to be fit for purpose and meet the expectations of the public, registrants and other stakeholders. The review was led by the Conduct and Competence Committee. We also held a formal consultation process on the draft standards. The review process and consultation produced extremely valuable feedback and we are grateful to everyone who gave their time to help us in shaping the standards that follow.

As part of that consultation process, we agreed some broad principles which have influenced the standards laid out in this document.

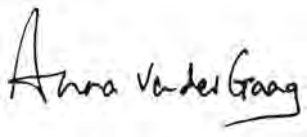
We decided that the standards should:

- focus, where possible, on providing guidance to registrants, based on our expectations of their behaviour;
- be based on over-arching principles with some more detail on important points (with more detailed guidance available elsewhere, if necessary);
- apply to all registrants (as far as possible), including those involved in direct practice, management, education, research and roles in industry; and
- be written in broad terms to be able to take account of changes in best practice, technology, the law and wider society in the future.

We made a number of changes to the previous standards, mainly to set out our aims more clearly or to correct any mistakes. We also revised the introduction to focus less on the role of the standards in fitness to practise procedures and we added more information on how registrants can use and meet the standards.

I am confident that the standards are both fit for purpose and reflect both professional and public expectations of the behaviour of registrants.

These standards were adopted in July 2008. Some minor changes were made to them on 1 August 2012, when we became the Health and Care Professions Council. The revised standards apply from that date.



Anna van der Gaag
Chair

Your duties as a registrant

The standards of conduct, performance and ethics you must keep to

1 You must act in the best interests of service users.

2 You must respect the confidentiality of service users.

3 You must keep high standards of personal conduct.

4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

5 You must keep your professional knowledge and skills up to date.

6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

7 You must communicate properly and effectively with service users and other practitioners.

8 You must effectively supervise tasks that you have asked other people to carry out.

9 You must get informed consent to provide care or services (so far as possible).

10 You must keep accurate records.

11 You must deal fairly and safely with the risks of infection.

12 You must limit your work or stop practising if your performance or judgement is affected by your health.

13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.

14 You must make sure that any advertising you do is accurate.

This document sets out the standards of conduct, performance and ethics we expect from our registrants. The standards also apply to people who are applying to become registered.

If you are registered, you must make sure that you are familiar with the standards and that you keep to them. If you are applying to be registered, you will be asked to sign a declaration to confirm that you have read and will keep to the standards once you are registered.

We also publish standards of proficiency, which are standards we use to make sure the professions we regulate work safely and effectively. We set these standards at a level we think is necessary to protect members of the public.

What we expect of you

The standards of conduct, performance and ethics play an important role in helping us make decisions about the character of the people who apply to our Register, and also in cases where we decide whether someone is fit to practise.

It is important that you read and understand this document. If someone raises concerns about your practice, we will consider these standards (and our standards of proficiency) when we decide whether we need to take any action. Please see the back of this document for more information about how we use the standards when we consider concerns raised about registrants.

The standards and your practice

The standards are written in broad terms and designed to apply to all registrants as far as possible. **However, we recognise that some of the standards may not apply to all the professions that we regulate or to the practice of some registrants**. The standards that might not directly apply to all registrants include standard eleven, which says that 'You must deal fairly and safely with the risks of infection'.

If we receive a complaint about you, the fitness to practise panel will consider the individual circumstances of the case (for example, the profession you work in and your scope of practice).

Meeting the standards

It is important that you meet our standards and are able to practise safely and effectively. We also want to make sure that you maintain high standards of personal conduct and do not do anything which might affect the public's confidence in you or your profession. However, we do not dictate how you should meet our standards.

Each standard can normally be met in more than one way. The way in which you meet our standards might change over time because of improvements in technology or changes in your practice.

As an autonomous and accountable professional, you need to make informed and reasonable decisions about your practice to make sure that you meet the standards that are relevant to your practice. This might include getting advice and support from education providers, employers, professional bodies, colleagues and other people to make sure that you protect the wellbeing of service users at all times.

In particular, we recognise the valuable role professional bodies play in representing and promoting the interests of their members. This often includes providing guidance and advice about good practice, which can help you meet the standards in this document.

Making informed and reasonable decisions

We often receive questions from registrants who are concerned that something they have been asked to do, a policy, or the way in which they work might mean that they cannot meet our standards. They are often worried that this might have an effect on their registration.

If you make informed, reasonable and professional judgements about your practice, with the best interests of your service users as your prime concern, and you can justify your decisions if you are asked to, it is very unlikely that you will not meet our standards.

By 'informed', we mean that you have enough information to make a decision. This would include reading these standards and taking account of any other relevant guidance or laws. By 'reasonable', we mean that you need to make sensible, practical decisions about your practice, taking account of all relevant information and the best interests of the people who use or are affected by your services. You should also be able to justify your decisions if you are asked to.

Language

Our registrants work in a range of different settings, which include direct practice, management, education, research and roles in industry. We have tried to use terms which are as broad as possible and which everyone can understand.

Throughout these standards, we have used the term 'service user' to refer to anyone who uses or is affected by a registrant's services. Who your service users are will depend on how and where you work. For example, if you work in clinical practice, your service users might be your patients. In some circumstances, your service users might be organisations rather than individuals. The term also includes other people who might be affected by your practice, such as carers and relatives.

We have used the phrase 'care or services' in most places in this document to describe the different work that registrants carry out. Where appropriate to the standard we have used the word 'treatment'.

Changing these standards in the future

We produced these standards after speaking to our stakeholders about how the standards were working, how they were seen and how relevant they were to registrants' practice. We also made some minor changes (to the language but not the principle of the standards) when we became the Health and Care Professions Council.

We will continue to listen to our stakeholders and review our standards. We may make changes to the standards in the

future to take account of changes in practice or public and professional expectations.

Contact us

If you are not sure how to interpret the standards, you should write to our Director of Policy and Standards at the following address.

Policy and Standards Department
The Health and Care Professions Council
Park House
184 Kennington Park Road
London
SE11 4BU

Email: policy@hcpc-uk.org

The standards of conduct, performance and ethics

1 You must act in the best interests of service users.

You are personally responsible for making sure that you promote and protect the best interests of your service users. You must respect and take account of these factors when providing care or a service, and must not abuse the relationship you have with a service user. You must not allow your views about a service user's sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you deal with them or the professional advice you give. You must treat service users with respect and dignity. If you are providing care, you must work in partnership with your service users and involve them in their care as appropriate.

You must not do anything, or allow someone else to do anything, that you have good reason to believe will put the health, safety or wellbeing of a service user in danger. This includes both your own actions and those of other people. You should take appropriate action to protect the rights of children and vulnerable adults if you believe they are at risk, including following national and local policies.

You are responsible for your professional conduct, any care or advice you provide, and any failure to act. You are responsible for the appropriateness of your decision to delegate a task. You must be able to justify your decisions if asked to.

You must protect service users if you believe that any situation puts them in danger. This includes the conduct, performance or health of a colleague. The safety of service users must come before any personal or professional loyalties at all times. As soon as you become aware of a situation that puts a service user in danger, you should discuss the matter with a senior colleague or another appropriate person.

2 You must respect the confidentiality of service users.

You must treat information about service users as confidential and use it only for the purposes they have provided it for. You must not knowingly release any personal or confidential information to anyone who is not entitled to it, and you should check that people who ask for information are entitled to it.

You must only use information about a service user:

– to continue to care for that person; or

– for purposes where that person has given you permission to use the information or the law allows you to do so.

You must also keep to the conditions of any relevant data-protection laws and always follow best practice for handling confidential information. Best practice is likely to change over time, and you must stay up to date.

3 You must keep high standards of personal conduct.

You must keep high standards of personal conduct, as well as professional conduct. You should be aware that poor conduct outside of your professional life may still affect someone's confidence in you and your profession.

4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

You must tell us (and any other relevant regulators) if you have important information about your conduct or competence, or about other registrants and health and care professionals you work with. In particular, you must let us know straight away if you are:

– convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution;

– disciplined by any organisation responsible for regulating or licensing a health or social care profession; or

– suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.

You should cooperate with any investigation or formal inquiry into your professional conduct, the conduct of others, or the care or services provided to a service user, where appropriate. If anyone asks for relevant information in connection with your conduct or competence, and they are entitled to it, you should provide the information.

We can take action against you if you are convicted of a criminal offence or have accepted a police caution. We will always consider each case individually to decide whether we need to take any action to protect the public.

However, we will consider rejecting an application for registration, or removing you from the Register if you are already registered, if you are convicted of a criminal offence or accept a police caution that involves one of the following types of behaviour.

- Violence
- Abuse
- Sexual misconduct
- Supplying drugs illegally
- Child pornography
- Offences involving dishonesty
- Offences for which you received a prison sentence

This is not a full list. We will always look at any convictions or cautions we find out about, and we have arrangements in place to be told about convictions and cautions involving registrants.

5 You must keep your professional knowledge and skills up to date.

You must make sure that your knowledge, skills and performance are of a good quality, up to date, and relevant to your scope of practice.

You must be capable of meeting the standards of proficiency that apply to your scope of practice. We recognise that your scope of practice may change over time.

We acknowledge that our registrants work in a range of different settings, including direct practice, management, education or research. You need to make sure that whatever your area of practice, you are capable of practising safely and effectively.

Our standards for continuing professional development link your learning and development to your continued registration. You also need to meet these standards.

6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

You must keep within your scope of practice. This means that you should only practise in the areas in which you have appropriate education, training and experience. We recognise that your scope of practice may change over time.

When accepting a service user, you have a duty of care. This includes the duty to refer them to others for care or services if it becomes clear that the task is beyond your own scope of practice. If you refer a service user to another practitioner, you must make sure that the referral is appropriate and that, so far as possible, the service user understands why you are making the referral.

In some circumstances, a person is entitled to be referred to another practitioner for a second opinion. In these cases, you must accept the request and make the referral as soon as you can.

If you accept a referral from another practitioner, you must make sure that you fully understand the request. You should only provide the care or services if you believe that this is appropriate. If this is not the case, you must discuss the referral with the practitioner who made the referral and, as appropriate, the service user, before you provide any care or services.

7 You must communicate properly and effectively with service users and other practitioners.

You must take all reasonable steps to make sure that you can communicate properly and effectively with service users. You must communicate appropriately, cooperate, and share your knowledge and expertise with other practitioners, for the benefit of service users.

8 You must effectively supervise tasks you have asked other people to carry out.

People who receive care or services from you are entitled to assume that you have the appropriate knowledge and skills to provide them safely and effectively. Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice.

You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely or effectively, you must not force them to carry out the task anyway. If their refusal raises a disciplinary or training issue, you must deal with that separately, but you should not put the safety or wellbeing of the service user in danger.

9 You must get informed consent to provide care or services (so far as possible).

You must explain to service users the care or services you are planning to provide, any risks involved and any other possible options. You must make sure that you get their informed consent to any treatment you do carry out. You must make a record of the person's decisions and pass this on to others involved in their care. In some situations, such as emergencies or where a person lacks decision-making capacity, it may not be possible for you to explain what you propose, get consent or pass on information. However, you should still try to do all of these things as far as you can.

A person who is capable of giving their consent has the right to refuse to receive care or services. You must respect this right. You must also make sure that they are fully aware of the risks of refusing care or services, particularly if you think that there is a significant or immediate risk to their life.

You must keep to your employers' procedures on consent and be aware of any guidance issued by the appropriate authority in the country you practise in.

10 You must keep accurate records.

Making and keeping records is an essential part of providing care or services and you must keep records for everyone you treat or for whom you provide care or services. You must complete all records promptly. If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries.

You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user.

You must protect information in records from being lost, damaged, accessed by someone without appropriate authority, or tampered with. If you update a record, you must not delete information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).

11 You must deal fairly and safely with the risks of infection.

You must not refuse to treat someone just because they have an infection. Also, you must keep to the rules of confidentiality when dealing with people who have infections. For some infections, such as sexually transmitted infections, these rules may be more restrictive than the rules of confidentiality for people in other circumstances. We discussed confidentiality in more detail earlier in this document.

You must take appropriate precautions to protect your service users and yourself from infection. In particular, you should protect your service users from infecting one another. You must take precautions against the risk that you will infect someone else.

This is especially important if you suspect or know that you have an infection that could harm other people. If you believe or know that you may have this kind of infection, you must get medical advice and act on it. This may include the need for you to stop practising altogether, or to change your practice in some way in the best interests of protecting your service users.

12 You must limit your work or stop practising if your performance or judgement is affected by your health.

You have a duty to take action if your physical or mental health could be harming your fitness to practise. You should get advice from a consultant in occupational health or another suitably qualified medical practitioner and act on it. This advice should consider whether, and in what ways, you should change your practice, including stopping practising if this is necessary.

13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.

You must justify the trust that other people place in you by acting with honesty and integrity at all times. You must not get involved in any behaviour or activity which is likely to damage the public's confidence in you or your profession.

14 You must make sure that any advertising you do is accurate.

Any advertising you do in relation to your professional activities must be accurate. Advertisements must not be misleading, false, unfair or exaggerated. In particular, you should not claim your personal skills, equipment or facilities are better than anyone else's, unless you can prove this is true.

If you are involved in advertising or promoting any product or service, you must make sure that you use your knowledge, skills and experience in an accurate and responsible way. You must not make or support unjustifiable statements relating to particular products. Any potential financial reward should not play a part in the advice or recommendations of products and services you give.

Fitness to practise

When we say someone is ‘fit to practise’, we mean that they have the skills, knowledge, character and health to practise their profession safely and effectively.

We consider concerns raised about registrants by members of the public, employers, professionals, the police and other people and take action to protect the public. This can include cautioning a registrant, placing conditions on their registration, suspending them from practice or, in the most serious cases, removing them from the Register.

When we consider a concern about a registrant, we take account of whether the standards have been met when we decide whether we need to take any action to protect the public. We will also take account of any guidance or codes of practice produced by professional bodies.

You can find more information about the fitness to practise process in our brochures How to raise a concern and What happens if a concern is raised about me?. These brochures are available to download from our website or you can contact us to ask for a copy.

Glossary

You may not be familiar with some of the terms we use throughout this document, so we have explained them below.

Accountable

As an accountable professional, you will be responsible for the decisions you make and you may also be asked to justify them.

Autonomous

As an autonomous professional, you make your own decisions based on your own judgement.

Delegate, delegation

When a registrant asks someone else (such as a colleague, student or support worker) to carry out a task on their behalf.

Fit to practise

When someone has the skills, knowledge, character and health to do their job safely and effectively.

Informed consent

When a service user has all the necessary information in a format they can understand so that they can make an informed decision about receiving care or a particular service.

Referral

When a registrant asks another practitioner to provide care or services to a service user which are beyond the registrant's scope of practice or, where relevant, because the service user has asked for a second opinion.

Scope of practice

The area or areas of a registrant's profession where they have the knowledge, skills and experience to practise safely and effectively.

Service user

Anyone who uses or is affected by the services of registrants.

Standards for continuing professional development

Standards which link a registrant's ongoing learning and development with their continued registration.

Standards of proficiency

Standards which set out what individuals should know, understand and be able to do, in order to practice safely and effectively. Applicants must meet these standards to become registered.

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hcpc health & care professions council

Your duties as a registrant

Standards of conduct, performance and ethics

Contents

Registrants must:

- promote and protect the interests of service users and carers;
- communicate appropriately and effectively;
- work within the limits of their knowledge and skills;
- delegate appropriately;
- respect confidentiality;
- manage risk;
- report concerns about safety;
- be open when things go wrong;
- be honest and trustworthy; and
- keep records of their work.

About us

We are the Health and Care Professions Council (HCPC), a regulator set up to protect the public. To do this, we keep a register of professionals who meet our standards for their professional skills, knowledge and behaviour. The people on our register are referred to as 'registrants'.

About this document

This document sets out the standards of conduct, performance and ethics. The standards set out, in general terms, how we expect registrants to behave.

We currently regulate the following 15 professions.

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Speech and language therapists

Our registrants work in a range of different settings, which include direct practice, management, education, research and roles in industry. They also work with a variety of different people, including patients, clients, carers and other professionals.

In this document we have tried to use terms which everyone can understand. Some terms which have a specific meaning in this guide are explained in the glossary at the end of this booklet.

What the standards mean for different groups

Service users, carers and the public

If you are receiving care, treatment or other services from one of our registrants, or you might do so in the future, the standards will help you to understand how our registrants should behave towards you. The standards will also be helpful if you are a carer.

On the rare occasions that something goes wrong, anyone can raise a concern through our fitness to practise process (see page 11). We can take action when there are serious concerns about a health and care professional's knowledge, skills or behaviour.

We use the standards of conduct, performance and ethics to help us decide whether we need to take action to protect the public.

Registrants and applicants

If you are registered with us, you must make sure that you are familiar with the standards and that you continue to meet them. If you are applying to be registered, you will need to sign a declaration to confirm that you will keep to the standards once you are registered.

As a registrant, you are personally responsible for the way you behave. You will need to use your judgement so that you make informed and reasonable decisions and meet the standards. You must always be prepared to justify your decisions and actions.

Making informed and reasonable decisions might include getting advice and support from colleagues, education providers, employers, professional bodies, trade unions or other people. In particular, we recognise the valuable role professional bodies play in representing and promoting the interests of their members. This often includes providing guidance and advice about good practice, which can help you meet the standards.

Students

The standards also apply to you if you are a student on an HCPC-approved programme. We have published another document, 'Guidance on conduct and ethics for students', which sets out what the standards mean for you.

1. Promote and protect the interests of service users and carers

Treat service users and carers with respect

1.1 You must treat service users and carers as individuals, respecting their privacy and dignity.

1.2 You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided.

1.3 You must encourage and help service users, where appropriate, to maintain their own health and well-being, and support them so they can make informed decisions.

Make sure you have consent

1.4 You must make sure that you have consent from service users or other appropriate authority before you provide care, treatment or other services.

Challenge discrimination

1.5 You must not discriminate against service users, carers or colleagues by allowing your personal views to affect your professional relationships or the care, treatment or other services that you provide.

1.6 You must challenge colleagues if you think that they have discriminated against, or are discriminating against, service users, carers and colleagues.

Maintain appropriate boundaries

1.7 You must keep your relationships with service users and carers professional.

2 Communicate appropriately and effectively

Communicate with service users and carers

2.1 You must be polite and considerate.

2.2 You must listen to service users and carers and take account of their needs and wishes.

2.3 You must give service users and carers the information they want or need, in a way they can understand.

2.4 You must make sure that, where possible, arrangements are made to meet service users' and carers' language and communication needs.

Work with colleagues

2.5 You must work in partnership with colleagues, sharing your skills, knowledge and experience where appropriate, for the benefit of service users and carers.

2.6 You must share relevant information, where appropriate, with colleagues involved in the care, treatment or other services provided to a service user.

Social media and networking websites

2.7 You must use all forms of communication appropriately and responsibly, including social media and networking websites.

3 Work within the limits of your knowledge and skills

Keep within your scope of practice

3.1 You must keep within your scope of practice by only practising in the areas you have appropriate knowledge, skills and experience for.

3.2 You must refer a service user to another practitioner if the care, treatment or other services they need are beyond your scope of practice.

Maintain and develop your knowledge and skills

3.3 You must keep your knowledge and skills up to date and relevant to your scope of practice through continuing professional development.

3.4 You must keep up to date with and follow the law, our guidance and other requirements relevant to your practice.

3.5 You must ask for feedback and use it to improve your practice.

4 Delegate appropriately

Delegation, oversight and support

4.1 You must only delegate work to someone who has the knowledge, skills and experience needed to carry it out safely and effectively.

4.2 You must continue to provide appropriate supervision and support to those you delegate work to.

5 Respect confidentiality

Using information

5.1 You must treat information about service users as confidential.

Disclosing information

5.2 You must only disclose confidential information if:

- you have permission;
- the law allows this;
- it is in the service user's best interests; or
- it is in the public interest, such as if it is necessary to protect public safety or prevent harm to other people.

6 Manage risk

Identify and minimise risk

6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.

6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.

Manage your health

6.3 You must make changes to how you practise, or stop practising, if your physical or mental health may affect your performance or judgement, or put others at risk for any other reason.

7 Report concerns about safety

Report concerns

7.1 You must report any concerns about the safety or well-being of service users promptly and appropriately.

7.2 You must support and encourage others to report concerns and not prevent anyone from raising concerns.

7.3 You must take appropriate action if you have concerns about the safety or well-being of children or vulnerable adults.

7.4 You must make sure that the safety and well-being of service users always comes before any professional or other loyalties.

Follow up concerns

7.5 You must follow up concerns you have reported and, if necessary, escalate them.

7.6 You must acknowledge and act on concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.

8 Be open when things go wrong

Openness with service users and carers

8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:

- informing service users or, where appropriate, their carers, that something has gone wrong;
- apologising;
- taking action to put matters right if possible; and
- making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects.

Deal with concerns and complaints

8.2 You must support service users and carers who want to raise concerns about the care, treatment or other services they have received.

8.3 You must give a helpful and honest response to anyone who complains about the care, treatment or other services they have received.

9 Be honest and trustworthy

Personal and professional behaviour

9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession.

9.2 You must be honest about your experience, qualifications and skills.

9.3 You must make sure that any promotional activities you are involved in are accurate and are not likely to mislead.

9.4 You must declare issues that might create conflicts of interest and make sure that they do not influence your judgement.

Important information about your conduct and competence

9.5 You must tell us as soon as possible if:

- you accept a caution from the police or you have been charged with, or found guilty of, a criminal offence;
- another organisation responsible for regulating a health or social-care profession has taken action or made a finding against you; or
- you have had any restriction placed on your practice, or been suspended or dismissed by an employer, because of concerns about your conduct or competence.

9.6 You must co-operate with any investigation into your conduct or competence, the conduct or competence of others, or the care, treatment or other services provided to service users.

10 Keep records of your work

Keep accurate records

10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.

10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services.

Keep records secure

10.3 You must keep records secure by protecting them from loss, damage or inappropriate access.

Fitness to practise

When we say someone is ‘fit to practise’, we mean that they have the skills, knowledge, character and health they need to practise their profession safely and effectively.

We can consider concerns which members of the public, employers, professionals, the police and other people raise about a registrant’s fitness to practise. When we are deciding whether we need to take any action against a registrant to protect the public, we look at whether the registrant has met these standards.

You can find out more information about our fitness to practise process in our brochures ‘How to raise a concern’ and ‘What happens if a concern is raised about me’. You can download these from our website at www.hcpc-uk.org, or you can phone us on 020 7840 9806 to ask for a copy.

Glossary

Apologising

Making it clear that you are sorry about what has happened. The HCPC does not regard an apology, of itself, as an admission of liability or wrongdoing.

Carer

Anyone who looks after, or provides support to, a family member, partner or friend.

Care, treatment or other services

A general term to describe the different work that our registrants carry out.

Colleague

Other health and care professionals, students and trainees, support workers, professional carers and others involved in providing care, treatment or other services to service users.

Conduct

A health and care professional's behaviour.

Consent

Permission for a registrant to provide care, treatment or other services, given by a service user, or someone acting on their behalf, after receiving all the information they reasonably need to make that decision.

Delegate

To ask someone else to carry out a task on your behalf.

Disclose

In these standards, this refers to making a formal decision to share information about a service user with others, such as the police.

Discriminate

To unfairly treat a person or group of people differently from other people or groups of people. This includes treating others differently because of your views about their lifestyle, culture or their social or economic status, as well as the characteristics protected by law – age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

Escalate

To pass on a concern about a service user's safety or well-being to someone who is better able to act on it, for example, a more senior colleague, a manager or a regulator.

Ethics

The values that guide a person's behaviour or judgement.

Practitioner

A health and care professional who is currently practising in their profession.

Refer

To ask someone else to provide care, treatment or other services which are beyond your scope of practice or, where relevant, because the service user has asked for a second opinion.

Scope of practice

The areas in which a registrant has the knowledge, skills and experience necessary to practise safely and effectively.

Service user

Anyone who uses or is affected by the services of registrants, for example, patients or clients.

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THE SOCIETY OF CHIROPODISTS AND PODIATRISTS GUIDELINES ON MINIMUM STANDARDS OF CLINICAL PRACTICE

VERSION 3.0

APRIL 2003

Appendix 1

GUIDELINES ON MINIMUM STANDARDS FOR ACCOMMODATION

CONTENTS

Introduction

In 1989 the Scottish Group of Chiropody Service Managers agreed a minimum data set for clinical premises. This was based on a data set developed by chiropody managers in the then SouthEast Thames Region, to whom grateful acknowledgment is made.
These were adopted by the Society for advice to Health Service Managers. They are included in this document for information only.
Apart from data sheets for a Chiropody clinic, this document includes data sheets for a Casting/fitting room and a Machine/Manufacturing room, which are becoming essential parts of a Trust Chiropody Service.

GENERAL CONSIDERATIONS

External

1. Catchment area
2. Existing and planned population to be served
3. Existing local services/possible transfer
4. Parking
5. Public transport facilities
6. "Dropping off zone", for use by ambulance or private car
7. Sign posting
8. Provision of ramps

Internal
The clinic should be: -

1. On ground floor unless there is a lift
2. Near the main entrance
3. Near the Waiting room/area
4. Near reception facilities

The Waiting area should be: -

1. Near the Clinic and Reception
2. Near Toilets, including disabled
3. Furnished with a range of seating to suit all ages
4. Fitted with notice boards etc., for Health Education material

1 ROOM DATA SHEET: CHIROPODY CLINIC

DEPARTMENT: CHIROPODY

ROOM: CHIROPODY SURGERY

1 . PLANNING CONSIDERATIONS

1.1 The patient may be ambulant, with or without a walking aid, or in a wheelchair and may or may not require to be transferred to the treatment chair for the treatment.
Clinical procedures performed by the chiropodist
Partial dressing or undressing of the patient with or without assistance.
Work surfaces
Coat hanging
Telephone
Storage of equipment and supplies
Casting/pattern procedures
Waste Plaster of Paris collection

1.2 OCCUPANCY PRESSURE

Up to four

1.3 RELATIONSHIP TO OTHER ROOMS

Near waiting area/reception
Near casting/fitting room

1.4 SPECIAL CONSIDERATIONS

Sited on ground floor (unless lift)

2. BUILDING ELEMENTS

2.1 FINISHES

Wall - washable clinical finish
Ceilings - fire retardant
Floor - sealed seam, non-slip vinyl, coved skirting
Tiled splashback to sink and drainer

2.2 WINDOWS AND DAYLIGHT

Daylight essential
Privacy control
Solar control if necessary

2.3 DOORS

Wheel chair access/protected

3 MECHANICAL SERVICES

3.1 DESIGN CHARACTER
Clinical

3.2 ENVIRONMENT
Temperature: *18°-20°C*
Ventilation: Natural/mechanical

3.3 MEDICAL GASES
Nitrous Oxide (Cryotherapy unit) spare cylinder to be kept near clinic.
Liquid Nitrogen, Oxygen (resuscitation) as per Trust policy.

4. ELECTRICAL SERVICES

4.1 LIGHTING
Fluorescent, colour corrected

4.2 COMMUNICATIONS
Telephone point
Computer point (as per Trust policy)

4.3 CLOCKS
Sweep second hand

GROUP A ITEMS

Items usually supplied and fitted by the contractor
A.1 Socket outlets, switched, 13 amp as required
A.2 Floor standing cupboards with work surface and up stand as required
A.3 Floor standing cupboard housing stainless steel sink with drainer, low elbow taps with mixer and plaster trap
A.4 Telephone outlet
A.5 Wall mounted cupboards (lockable) as required
A.6 Patient call system
A.7 Vent Axia (or other mechanical ventilation system)
A.8 Curtain track (for changing cubicle)
A.9 Hooks for patients' clothing
A.10 Mirror
A.11 Window blinds as required
A.12 Kneehole work top at desk top level

GROUP B ITEMS

Items supplied by the Trust and fitted by the contractor, having a permanent or semipermanent location

B.1 Soap dispenser
B.2 Paper towel dispenser
1. Leaved
2. Roll
B.3 Large Grab Handle (on wall in changing area)
B.4 Clock with sweep hand
B.5 C.S.S.D. pack storage rack
B.6 Built in Chiropody Unit (or see group C unit)

GROUP C ITEMS

Items supplied by the Trust and having a significant effect on space and/or structural requirements, generally put in place by the Trust

C.1 Chair - Chiropody patient's, electro-hydraulic, adjustable for height, tilt and backrest
C.2 Chair - Chiropodist's, swivel, height adjustable on castors
C.3 Cabinet, Chiropody with:
1. Examination light, colour corrected
2. Drill with dust extraction
C.4 Autoclave, short cycle with drying cycle. Electric. Approved by S.H.H.D./C.S.A.
C.5 Cryosurgery Unit:
Either - Nitrous Oxide with i) Various tips
ii) Venting kit
iii) Size 'F' cylinder
iv) Cylinder trolley
Or - Liquid Nitrogen i) Various tips
ii) Dewar (as dictated by Trust policy)
C.6 Ultrasonic instrument cleaning unit
C.7 Foot rest, portable, variable height
C.8 Plastazote Oven
C.9 Sack holder, enclosed, foot operated
C.10 Chairs, stacking, plastic (2)
C. 11 Filing cabinet/record cabinet
C. 12 Locker or equipment for staff clothing and valuables

GROUP D ITEMS

Additional items of equipment for specialist units/main centres

D.1 Biothesiometer
D.2 Electro-surgery Unit
D.3 Ultrasonic Therapy Unit
D.4 Doppler Vascular Flow Indicator
D.5 Ultra Violet Cabinet (instrument storage)

GROUP E ITEMS

Items supplied by Trust and put in place by the Trust

E.1 Three sets of Chiropody instruments including Burrs. Autoclavable (per chair)
E.2 Autoclavable instrument trays
E.3 Cotton wool jars with lids
E.4 Debris tray, plastic
E.5 Shoe horn, long handled
E.6 Magnifying Lens
E.7 Syringe, cartridge, self aspirating, stainless steel
E.8 Resuscitation equipment (as per Trust policy)
E.9 Tuning fork, Middle 'C', Gardner Brown 128Hz
E.10 Neurological Hammer (buck), with attachments for sharp/soft touch
E. 11 Heel raise, plastic
E. 12 Dust pan, stainless steel, long handled
E. 13 Brush, long handled (for above)
E. 14 Curtains for dressing cubicle

ROOM DATA SHEET: CASTING/FITTING ROOM

DEPARTMENT: CHIROPODY

ROOM: CASTING/FITTING

1. *PLANNING CONSIDERATIONS*

1.1. The patient may be ambulant, with or without a walking aid, or in a wheelchair and may or may not require to be transferred to the couch for the procedure

Casting/pattern procedures performed by:

ii) Chiropodist
iii) Technician
iiii) Foot-care assistant

Partial dressing/undressing of patient with or without assistance
Clinical procedures (minor)
Storage of materials
Work surfaces
Hand washing/waste plaster collection
Coat hanging
Telephoning

1.2 OCCUPANCY PRESSURE

Up to four

1.3 RELATIONSHIP TO OTHER ROOMS

Next to machine/manufacturing room
Near Chiropody clinic

2. BUILDING ELEMENTS

2.1 FINISHES
Wall - washable clinical finish
Ceilings - fire retardant
Floor - Sealed seam, non-slip vinyl, coved skirting
Tiled splashback to sink and drainer

2.2 WINDOWS AND DAYLIGHT
Daylight preferable
Privacy control

2.3 DOORS
Wheelchair access, protected

3 MECHANICAL SERVICES

3.1 DESIGN CHARACTER
Clinical

3.2 ENVIRONMENT
Temperature 18°C
Ventilation: Mechanical/Natural

3.3 MEDICAL GASES
None

4. ELECTRICAL SERVICES

4.1 LIGHTING
Fluorescent

4.2 COMMUNICATIONS
Telephone

4.2 CLOCKS
Sweep Second

GROUP A ITEMS

Items usually supplied and fitted by the contractor

A.1 Socket outlets, switched 13 amp as required
A.2 Floor standing cupboards with work surface (scratch resistant) and upstand as required
A.3 Floor standing cupboard housing stainless steel sink with drainer, low elbow taps with mixer and plaster trap
A.4 Wall mounted cupboards (lockable) as required
A.5 Telephone outlet
A.6 Vent Axia
A.7 Hooks for patients' clothing
A.8 Mirror
A.9 Solar control (as required)
A.10 Shelving (as required)
A. 11 Notice board
A. 12 Curtain track

GROUP B ITEMS

Items supplied by the Trust and fitted by the contractor, having a permanent or Semi-permanent location

B.1 Soap dispenser
B.2 Paper towel dispenser
    1. Leaved
    2. Roll
B.3 Clock with sweep hand
B.4 Curtain

GROUP C ITEMS

Items supplied by the Trust and having a significant effect on space and/or structural requirements, generally put in place by the contractor put in place by the contractor

C.1 Couch - variable height (for patient use)
C.2 Chair - chiropodist's, swivel, height and backrest adjustment, on castors
C.3 Drying cabinet, electric
C.4 Plaster of Paris agitator, electric
C.5 Chairs, stacking, plastic
C.6 Sack holders, foot operated, enclosed

GROUP D ITEMS

Items supplied by the Trust and put in place by the Trust

D.1 Scissors/shears
D.2 Plaster knife
D.3 Plaster spatula
D.4 Hole punch
D.5 Rubber mixing bowls
D.6 Large plastic bowl
D.7 Plastic dustbin (for storage of Plaster of Paris)

D.8 Plastic scoop
D.9 Dustpan & Brush/vacuum cleaner
D.10 Sundry instruments (for replacing dressings)
D.11 Neurological hammer (buck)
D. 12 Curtains for dressing cubicle
D. 13 Debris tray, plastic

ROOM DATA SHEET: MACHINE/MANUFACTURING ROOM

1. *PLANNING CONSIDERATIONS*

1.1 This room is a non-patient area used for the manufacture of orthotic and prosthetic devices
Manufacturing processes carried out by:
ii) Chiropodist
iii) Technician
iiii) Foot-care assistant
Storage of Flammable Substances
Storage of Materials
Work surfaces
Coat hanging

1.2 OCCUPANCY PRESSURE
Up to three

1.3 RELATIONSHIP TO OTHER ROOMS
Next to casting/fitting room
Not near any area where noise could have a detrimental effect

2. *BUILDING ELEMENTS*

2.1 Wall and ceiling, washable, clinical finish
Floor, seamed vinyl, non-slip with covered skirting
Tiled splashback over sink

2.2 WINDOWS AND DAYLIGHT

2.3 DOORS
Wheelchair access (for easy access of large equipment)

3. MECHANICAL SERVICES

3.1 DESIGN CHARACTER
Laboratory

3.2 ENVIRONMENT
Temperature 18°C
Ventilation: Mechanical and natural
Recommended air change 21 vol/24hr

3.3 *MEDICAL GASES*
None

4 ELECTRICAL SERVICES

4.1 LIGHTING
Fluorescent

4.2 COMMUNICATIONS
None

4.3 CLOCKS
Sweep second hand

4.4 *SAFETY PRECAUTIONS*
Cut off switch for scourer and all abrasive wheels (2)
Precautions as laid down in local Health & Safety Regulations
Protection of Eyes Regulations, 1974
Abrasive Wheels Regulations, 1970

4.5 SPECIAL CONSIDERATIONS
Possible need for 3-phase power supply
Scourer installation made through an isolator and fuse of not less than 30 amp capacity, positioned on or near the machine and near door
Scourer must be earthed

GROUP A ITEMS

Items usually supplied and fitted by the contractor

A.1 Socket outlets, switched, 13 amp, as required
A.2 30 amp three phase power supply to scourer, with cut off switches as required
A.3 Floor standing cupboards with work surface (scratch resistant) and upstand as required with sink and plaster trap, mixer taps
A.4 Wall mounted cupboards (as required)
A.5 Mechanical ventilation system
A.6 Hooks for clothing
A.7 Shelving as required
A.8 Fume cupboard

GROUP B ITEMS

Items supplied by the Trust and fitted by the contractor having a permanent or semi permanent location

B.1 Soap dispenser
B.2 Paper towel dispenser
1. Leaved
2. Roll
B.3 Clock with sweep second hand
B.4 First aid box

GROUP C ITEMS

Items supplied by the Trust and having a significant effect on space and or structural requirements, generally put in place by the Trust

C.1 Scourer, band or wheels, electric with dust extraction
C.2 Oven, large (minimum capacity 80 litres), temperature range 50°C-250°C
C.3 Vacuum former, electric
C.4 Band saw electric
C.5 Polisher, electric, bench mounted or attached to scourer
C.6 Cutting wheel, bench mounted or attached to scourer (for cutting sheet materials)
C.7 Shoe stretcher
C.8 Plaster agitator, electric

GROUP D ITEMS

Items supplied by the Trust and put in place by the Trust

D.1 Heat gun, electric
D.2 Water bath, electric
D.3 Plastic storage containers (for latex)
D.4 Sundry instruments
D.5 Heavy duty shears
D.6 Staple gun
D.7 High stools
D.8 Health and Safety Regulation notices

Acknowledgments

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Division of Podiatric Medicine, School of Biological & Health *Sciences,*
University of Westminster,
Highland Heath Board,
Scottish Group of Chiropody Service Managers,
SouthEast Thames Region Chiropody Managers Group.

HEALTH BUILDING NOTE
Local Healthcare Facilities

Chiropody/podiatry

Surgery

4.86 Patients are seated in a chair which allows the feet to be elevated. The chiropodist needs to access the feet from the foot of the chair and from either side. Space is therefore required for an instrument trolley. Good adjustable fixed or mobile lighting is required. Hand-washing facilities, also facilities for the disposal of clinical and other waste, are required. (A small sterilizer/autoclave may also be necessary.)

Store

4.87 Storage facilities are required for small items of equipment, stationery and dressings etc. The size of the store will largely depend on the extent to which pre-sterilized pads are used. Lotions for topical application may be stored either here or in the clean utility room.

Community psychiatric services

Office

4.88 Small office facilities are required where a community psychiatric nurse (CPN) and other members of the community mental health team can write up/type in patient records and complete administrative tasks. The office should accommodate an office workstation with VDT and keyboard.

4.89 A larger multi-person office, equipped with workstations and computers, is required, where staff can write up notes and complete their administrative tasks.

Interview room

4.90 Access to a small interview room is required, where a CPN or other member of the community mental health team can interview a patient in private. See also paragraph 4.36 above.

Group room

4.91 If the general group room is intensively used, a separate room will be required where members of the psychiatric team can meet patients as a group. Such a group may be involved in discussion or activities. The room needs to be comfortable, and designed to allow as much flexibility of use as possible. The room does not require any special furniture.

Store

4.92 A store may be required for stationery, small items of equipment and health promotion materials, if suitable space cannot be shared. (Drugs and injection equipment will be stored in the clean utility room.) This space may also be used for the storage of any items of furniture from the room described in 4.91 above, when these items are not being used.

Social services

Group room

4.93 Social services staff may require the provision of a group room if suitable facilities within the local healthcare resource centre cannot be accessed because of time tabling or other difficulties. This space may be shared with, or double as, the Community Psychiatric Group Room-see paragraph 4.91 above. (See also paragraph 4.36)

Additional office

4.94 An additional office with workstations may be required if there is a large social services workload in the local healthcare resource centre.

Store

4.95 A small general-purpose store may be required if storage elsewhere in the centre cannot be shared.

Physiotherapy

Patients' changing facilities

4.96 Some patients will need to change for treatment. They will require the privacy of changing accommodation for this. Others may be directed into individual treatment cubicles or into the exercise area. During treatment patients may need to move form one area to another. Adequate circulation space is also needed for the movement of patients in wheelchairs or using walking aids. A toilet must be provided which is suitable for use by disabled persons.

Treatment cubicle

4.97. Treatment carried out in the cubicles may include traction and a range of electrotherapy modalities. This area should b easily accessible from the staff base and the patients' changing accommodation. There should be access to hand-washing facilities and water for treatments in the treatment cubicle area. The cubicles require adequate space for a couch, chair and mobile equipment, also a shelf for small equipment. Provision is required for the hanging of outdoor clothes. Cubicles may need to be large enough to enable traction apparatus or large electrotherapy equipment to be used. A welded steel mesh may be required above, behind and/or alongside the treatment couches, to enable pulleys or other equipment to be attached. Secure storage is required for small items of equipment, such as portable electrotherapy appliances.

Exercise area

4.98 Active treatment of patients will be undertaken in the exercise area with individual patients or groups of patients. It is helpful if exercise rooms have an open aspect to courtyard gardens but retain a degree of privacy. The treatment may involve equipment necessitating ample allocation of space. Some items of equipment are free-

2.0 Chiropody/podiatry

Chiropodist/podiatrists are trained to diagnose and treat foot conditions, undertake surgical procedures under local anaesthetic, carry out biomechanical assessments and to diagnose, prescribe and manufacture appropriate orthosis.

Surgery

Surgery accommodation will be determined by the population to be served and by the frequency of clinics. It is recommended that one fully functional surgery should be available for every 1,000 elderly persons in the population.

The surgery should be located on the ground floor close to the main entrance. Easy access for non-able bodied persons is essential.

A schedule of accommodation for chiropody surgery services is contained in HBN 36 Volume 1.

Orthotics Suite

The accommodation for orthotics is additional to the chiropody accommodation described in HBN 36 volume 1. A schedule of accommodation for the orthotics suite has therefore been included at the end of this supplement.

An orthotics suite is required for the assessment of gait patterns and the manufacture of suitable orthotics and/or foot appliances. The suite should comprise:

Assessment room

An assessment room is necessary for the biomechanical assessment of the patient before and after fitting with appropriate orthotic devices. Easy access by non-able bodied patients is essential.

Equipment should include:

- An electro-hydraulic patient treatment couch;
- Operator stool – swivel with adjustable height and back;
- Medical treadmill;
- Tractographs;
- Goniometres;
- Video camera;
- Musgrave footprint;
- Measuring tapes;
- x-ray illuminator;
- full length mirror;
- wall hooks;
- curtain tracking;
- work surfaces at standing level;
- storage cupboards and drawers under work units.

Plaster room

A plaster room is necessary for taking casts of feet and follow up plaster-of-Paris mouldings and adjustments. Adequate storage space is necessary to allow for the drying and storage of positive casts of patients' feet.

The plaster room should adjoin the main workshop and grinding room. There should be an adequate supply of stainless steel sunken sinks with double drainer, mixer tap and plaster-of Paris settlement trap.

Work surfaces should be washable and continuous at standing height. Storage space in the form of cupboards and drawers under work units should be provided. Adjustable shelving is required to facilitate the drying of positive foot casts.

Equipment should include:

- Plaster-of-paris grinder;
- Plaster-of-paris trimmer;
- Plaster-of-paris vibrator;
- Adequate receptacles for mixing plaster-of-paris;
- Receptacles for disposals of discarded plaster-of-paris.

Grinding room

A grinding room is essential for the cutting and grinding of a variety of materials using potentially hazardous machinery.

The grinding room should adjoin the main workshop and plaster room. A soundproof, shatterproof viewing window should adjoin the main workshop area. An emergency call button is required.

All work surfaces should be washable and continuous at standing height. Storage space is required in the form of cupboards and drawers under work units. Adjustable wall-mounted shelving is required for storing square metre thermoplastic sheets.

Equipment should include:

- Various bench grinding machines suitably positioned;
- Adequate extraction and silencer systems on all grinding machines;
- A band saw.

Central Workshop

A workshop is required for the moulding and baking of a variety of materials and the manufacture of orthotic devices. Patient access is not necessary. The workshop should adjoin the grinding room and plaster room. A soundproof, shatterproof viewing window into the grinding room should be provided.

A hand wash basin is required, as well as a stainless steel sunken sink with double drainer, mixer tap and plaster-of-paris and wax trap.

A large, central worktable at standing level height should be provided. Washable, continuous work surfaces are also required.

Other equipment should include:

- Vacuum forming machinery;
- Fume cupboard;
- Latex dipping tank;
- Hot air oven;
- Bench presses;
- Flammable liquids cupboard;
- Hot air gun;
- Infra-red light
- x-ray illuminator;
- electrical clock with second hand;
- heat resistant gloves;
- shoe stretcher;
- devels level;
- high level stools with high back rest.

Materials store

A store is required for the large and bulky materials used in the manufacture of orthotics. The store should be located adjacent to the central workshop.

Equipment store

A store is required for general equipment used in the chiropody/orthotics unit.

Minor operating facilities

GPs should have the option of purchasing this service locally rather than going through the acute sector. Minor surgical procedures on the feet may be carried out in a major treatment room. Further guidance on major treatment rooms is contained, together with a schedule of accommodation, in HBN 36 volume 1.

Optional accommodation for chiropody/podiatry

Manager's office
Chiropodists' office
Administrative office
Plaster store

A schedule of accommodation for administrative spaces is provided in HBN 36 volume 1.

8.0 Schedules of accommodation

Orthotics Suite

		1 Technician		3 Technicians	
Activity Space	Space Area	Qty	Total Area	Qty	Total Area
Reception		1	6.00	1	6.00
desk/office/records		1	7.00	1	7.00
Waiting area	27.0	1	27.00	2	54.00
Assessment Room	16.0	1	16.00	2	32.00
Plaster room					
Nett Total			56.0		99.0
Planning		5%	2.8	5%	5.0
Sub-Total			58.8		104.0
Engineering		3%	1.8	3%	3.1
Circulation etc		25%	14.7	25%	26.0
Total			75.3		133.1
Departmental Totals			**75**		**135**

Orthotics Suite

Essential Complementary Accommodation

Activity Space	Space Area	Planning	Sub-Total	Engineering	Circulation	Total Area
Grinding room – small	13.5	0.7	14.2	0.4	3.5	18.0
Grinding room – large	27.0	1.4	28.4	0.9	7.1	36.5
Central Workshop – small	27.0	1.4	28.4	0.9	7.1	36.5
Central Workshop – Large	54.0	2.7	56.7	1.7	14.2	72.5
Materials store	15.0	0.8	15.8	0.5	3.9	20.0

Optional Accommodation and Services

Activity Space	Space Area	Planning	Sub-Total	Engineering	Circulation	Total Area
Equipment store	15.0	0.8	15.8	0.5	3.9	20.0
Plaster store	2.5	0.1	2.6	0.1	0.7	3.5

Appendix 2.

Guidance on safety of Electrical Equipment

Portable Appliance Testing

How often should portable electrical appliances be tested?

A lot of people seem to think there are specific regulations for the portable electrical appliance testing. This is not the case although testing has derived from Regulation 10 of *Electricity at Work Regulations 1989*. Good working practice will dictate that a visual check should be made of all the work equipment before it is initially put into use. See box below for guidance on frequency of testing.

Type of Equipment	**Testing required**
Battery-operated, less than 20 volts	None
Less than 50 volts, low voltage desk light And telephone equipment	None
IT equipment, e.g. PC's VDU's, Photocopiers, fax machines rarely moved	Formal inspection every 2-4 years, tested ever 5 years (Unless double insulated)
Double insulated (DI) equipment, not Hand Held, moved occasionally e.g. fans, Slide Projectors	Inspected every 2-4 years
Hand held DI equipment	formal visual inspection every 6 months – 1 year, testing required
Earthed equipment (Class 1) Electric kettles, patient chairs Possibly other podiatry equipment	formal visual inspection 6 months-1 year. Testing every 1-2 years
Cables, leads, plugs connected to any Of above equipment plus extension leads	Formal visual inspection 6 months – 4 years. Formal testing every 1-5 years depending on equipment

Appendix 3

ERGONOMICS AND EQUIPMENT

Study of the relationship between people and the furniture, tools, and machinery they use at work. The object is to improve work performance by removing sources of muscular stress and general fatigue: for example, by presenting data and control panels in easy-to-view form, making office furniture comfortable, and creating a generally pleasant environment.

Operator posture:
There have been a number of attempts to define "correct" posture for working with a display screen, but few people have attempted to define a “correct” posture for podiatric practice. The definition of “correct” posture has therefore been taken from those attempts to define the posture related to working with computer screens. Some suggest that the achievement of an upright seated stance is best. It is, however, a ***misconception to believe that any single seated position can or should be maintained*** throughout the working day.

The inability to vary posture is a source of mental and physical fatigue. A rough comparison can be made between the tiredness experienced by a long-distance driver and that which affects somebody who sits all day at a display screen, or in front of patients. To continue the analogy, how many drivers will not make adjustments to a car seat position set by someone else? Compare this with the number of people who appear content to sit at an adjustable workstation without making any changes, and this includes podiatrists who fail to utilise the range of adjustability in either their own operator’s chairs or those of the patient treatment couch.

Postural fatigue cannot be eliminated by adopting one "perfect posture", but may instead be reduced by regular changes of position and active muscular work which assists the blood circulation. Employees should be actively encouraged to contribute to their own comfort by these frequent postural variations.

Workstation equipment (which includes that equipment supplied as a workstation in podiatric practice) should be correctly placed and adjusted to allow easy freedom of movement within a range of comfortable positions. Workers should in no circumstances be forced to adopt constrained postures or exert effort at the extremes of reach in order to overcome shortfalls in the design or capability of the workstation.

Workstation design:

A workstation can be defined as any set of furniture that is supplied to allow a person to carryout their prescribed work pattern. In terms of podiatry the workstation can then be viewed as comprising:

- The operators chair
- The patients chair
- The work unit
- The accessories such as directional light fitting
- Waste bin

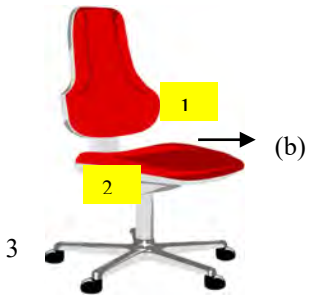
The design of the workstation should therefore minimise operator fatigue during the clinical sessions.
Thus movements which could induce stress or musculo-skeletal tiredness from the design and layout or inherent characteristics of the equipment should be submitted to a risk assessment and risk analysis.

Seating in our workplace needs to be safe but also suitable for the tasks that we do. Unsuitable seating may cause podiatrists to adopt awkward postures, which may lead to discomfort, back pain and upper limb disorders. For example, if podiatrists do not have chairs for themselves, which are fully adjustable, then inadequate postures may be adopted. In time this may lead to poor posture and lower back problems or work related upper limb disorders. This can be costly to employers but it is more costly to us as practitioners. Seating should meet the requirements of the task and the individual. This section sets out some questions you may wish to ask when undertaking a risk assessment in terms of seating for practitioners.

- Is the chair comfortable for the intended period of use?
- Is the lower back adequately supported?
- Is the upholstery sufficiently supportive and comfortable?
- Are the edges sufficiently padded and shaped to prevent uncomfortable pressure on the thighs?
- Does the chair have adequate types and ranges of adjustment?
- Is the height adjustable to allow work to be carried out at elbow height?
- Does the backrest adjust sufficiently in height and depth to allow the user to gain adequate support?
- Are armrests suitable for the task and workstation/unit? Doubtful whether any practitioners chair would require armrests.
- Are there special user requirements?
- Are there special task requirements?

Employers require ensuring adequate training in use of seating and posture while using it. Train individuals on how seating can be adjusted to meet their needs and those of the tasks. Ask individuals if they have any special seating requirements and take action to improve comfort and safety. Ensure seating is adjusted to the individual in respect of e.g. seat height, backrest position, lumbar support. Ensure worker is not perched on the edge of their seat. Maintain the seating in proper working condition and ensure adjustment mechanisms and wheels are freely working.

Good practice.



1. Backrest – should give firm support to the lower and middle back. Height adjustment of the backrest is recommended unless the backrest is high, providing complete support. (b) Adequate space for the buttocks, usually with a gap between seat and backrest. Backrests which tilt, or whose angle is adjustable, will improve support for the back in a range of working positions.

2. Seat needs to adjust in height, the size of the seat should be wide enough to seat big people comfortably, and deep enough to support the legs of tall people, but not so deep that short people cannot use the backrest. The front edge of the seat should be well rounded over and padded to prevent digging into the thighs.

3. Mobility: Swivel-action chairs provide flexibility when the podiatrist requires undertaking a variety of tasks, and moving around. The chair should allow freedom to alter position rather than the podiatrist. Ensure the castors do not slide away too easily when the podiatrist rises or sits down. Ensure also that they are kept free of clinical waste materials, which may limit their freedom of movement. There are different types of castors for different floor types: ensure the correct type is used on hard floors.

Adjustability: controls should be easy and convenient to use from a sitting position. The controls should be strong and reliable. Gas lift chairs have their own special risks associated with their use. Nobody weighing more than 100kg (16 stone) should use one, unless it is designed specifically to accommodate heavier people. The chair must be well maintained. Podiatrists tend to undertake precision work requiring concentration. This type of work tends to cause the podiatrist to lean forward and adopt a tense position especially in the shoulder and neck muscles. Chairs with a forward-tilting seat and backrest help avoid this problem and are recommended for this type of work.

Patients Chair:

As important as our own seating, we need to ensure that the height and position of the patient's chair is adjusted to ensure suitable height for the various tasks to be performed by ourselves. We need to remember that a good patient's chair is adjustable in height, rake and that where individual legrests are available that these can be altered for position also.

Patient's chair should be height adjustable. The height from minimum floor height should be the smallest possible to allow the patient into and out of the chair without incidence. The height should then be adjustable to allow maximum height possible for the podiatrist to work on plantar lesions without unacceptable bending.

The back should be collapsible for emergency use as quickly as possible. The back and seat should be tiltable where possible to allow extra height to be attained and an angle to allow access to the plantar aspect of heels wherever possible to avoid the podiatrist undue strain or stress on the lower back or neck muscles.

Individual, split legrests, fully adjustable, are preferable as again this allow greater freedom of movement of the patient by the podiatrist to allow easier access to lesions without undue stress.

The exact requirements in terms of height and adjustability will be determined by a risk assessment. A number of factors will be required:

- Height of operator
- Types of work and tasks to be performed
- Duration of tasks
- Health requirements of individual practitioners i.e. specific postural problems

Unit:

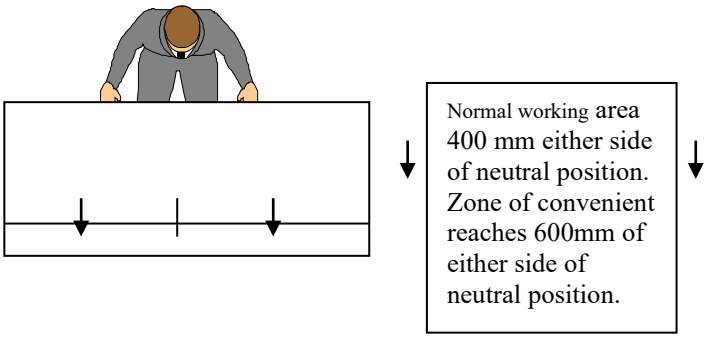
The workstation design should be based on a careful assessment of all aspects of the job, along with any special needs of the individual practitioner. There is a need to ensure that each task can be carried out safely, comfortably and as efficiently as possible.

A well-designed workstation should allow the practitioner to be seated at a comfortable height and position in relation to their tasks. Work and equipment that is frequently used should be placed within easy reach and should avoid awkward stretching or bending, or twisting which could lead to back pain or injury. The height of the patient's chair and the operators seat should ensure that the scalpel work could normally be done at elbow level or below to prevent tiredness from constant raising of the forearm. Some high-precision tasks requiring close hand-eye coordination may

require a higher hand position. However, if such work is to be carried out for any length of time, special arrangements may be required to support the arms.

Lifting even light objects should be kept to a minimum when seated as this can place a strain on the back.

Consideration also requires to be made of the level of work surfaces and relationship to podiatrists working. This is also required when positioning a waste bin. If the placing of these objects is considered carefully undue twisting and bending could be avoided. The work surface should therefore be at a level similar to that of the elbow of the practitioner. This may be in the region of 660-1,000mm's. The podiatrist should then use the maneuverability of the operator's chair to gain access to either the waste bin or the unit work surface. Where units contain low level drawers then these should only be used to house infrequently used items as the twisting and bending to gain access to these items may cause poor posture and fatigue or lower back pain.



If a job such as podiatry involves a series of tasks, the work items can be arranged in a semicircle around the worker rather than in a single straight line. A swivel chair must be provided so that all points on the semicircle can be reached from a sitting position. It is easier and quicker for the work to be at close hand.

Appendix 3a

Safety and the Practice Environment

It is the responsibility of each member to ensure the practice is equipped and maintained, and procedures are in place, to assure health, safety and welfare for patients, staff and visitors

The premises must be in current compliance with any U.K. and European requirements including:

- The Health and Safety at Work etc. Act 1974, and any regulations applicable to the practice environment e.g. Management of Health and Safety at Work Regulations (1999), Control of Substances Hazardous to Health Regulations (1999), Electricity at Work Regulations 1989 etc.
- Ionising Radiation Protection Regulations 1999

Potentially hazardous equipment used for examination and treatment is to be serviced and inspected by a qualified technician for safety, efficacy and where applicable, calibrated for accuracy as specified by manufacturer, government guidelines, or every five years

An equipment service record should be kept setting out the servicing for every potentially hazardous piece of equipment used to examine, treat or render any service to patients

Deficiencies in equipment require to be brought up to standard. Hazards must be corrected immediately and other deficiencies corrected within 21 days

Policy statements, procedure and equipment manuals are to be kept on site in office manuals, and must be available at all times (where applicable)

The member will be certificated in C.P.R. every three years (currently) and support staff should be encouraged to seek certification

Hazardous materials are to be stored in a specific, safe, controlled area.

Hazardous materials are to be labelled, and detailed current handling instructions must be reviewed, initialled annually and kept in the health and safety manual.

Written "sharps" policy and procedures are to be kept in the health and safety manual

Pharmaceutical and clinical supplies must be inspected for expiry dates and disposed of appropriately where necessary

Appendix 4

The Society of Chiropodists & Podiatrists
Control of Substances Hazardous to Health

Category(number of Coshh)Hazards

Substances used in (name of practice)

Hazards

Precautions

Contingency plans

Date of original COSHH assessment ..... Reviewed .....

Appendix 5

First Aid

General:

The Health and Safety (First Aid) Regulations 1981 place a general responsibility on employers (Trust or private practitioners) to provide *appropriate* first aid facilities. If a lone worker sustains a minor injury, he or she may be able to use a first aid box or phone for help. However, a more serious injury may mean that the worker cannot help him or herself or use the telephone.

First aid arrangements and contents of the first aid box and provision of a first aid room are based on the premise of a suitable and sufficient risk assessment being made by the employer (Trust or private practitioner).

First aid boxes:

First aid boxes should be provided within the workplace to ensure that there are adequate supplies for the nature of the hazards involved. All boxes should contain at least the minimum supplies, which are required under law. Only specified first aid supplies should be kept. No creams, lotions or drugs, however seemingly mild, may be kept in these boxes.
The location of first aid boxes and the name of the person responsible for their upkeep should be clearly indicated on notice boards throughout the workplace. First aid boxes should display the following information:
(a) The name of the person responsible for their upkeep
(b) The nearest location for further supplies
(c) The contents of the first aid box and replenishing arrangements
(d) The location of the accident book.

First aid boxes should be maintained and restocked when necessary by Authorised personnel. These personnel should be aware of the procedure for re-ordering supplies.

Portable first aid kits:
Portable first aid kits may be made available for those members of staff who are required to work away from the normal workplace, where access to facilities may be restricted. Examples of these circumstances include:
(a) Work with potentially dangerous tools and machinery away from base location
(b) Staff travelling abroad on business
(c) Staff travelling in vehicles on a regular basis, e.g. podiatrists on domiciliary visits regularly
(d) Staff whose work takes them to isolated or remote locations
(e) Staff participating in sporting or social events arranged or supported by the Trust.

First aid/recovery room:
This may be provided to assist first aiders when administering treatment. Access to the first aid room is obtainable from Authorised personnel. All staff, especially new recruits, should be made aware of the location of the first aid room, if one is available. This room must only be used for the rendering of first aid during or after illness. The location of the first aid room should be been arranged so that corridors and lifts, etc

are large enough to allow for a stretcher, wheelchair or carrying chair to be used safely and easily.

Recording accidents:
All accidents must be recorded, however minor. The Trust or private practice should provide an accident book in which all incidents must be noted. The accident book should be housed in a central location, details of which should be displayed on first aid boxes.

It is the responsibility of employees to ensure that they complete an entry in the accident book as soon as possible after the injury has occurred. Where the injured person is unable to enter his or her account into the accident book, the first aider or witness (where relevant) should enter details on the employee's behalf. Where an accident results in admittance to hospital, or inability to continue work, the relevant manager must be informed immediately.

For the purposes of maintaining first aid supplies, first aiders should keep a record of those supplies that are used, by whom and for what reason.

Safe system of work:

The following arrangements should be followed in order to ensure that suitable and sufficient provision of first aid personnel and equipment is available at the workplace.

1. First aid personnel must inform the Trust when their training certification period is nearing expiry.
2. Management should ensure that employees are familiar with the identity and location of their nearest first aider and first aid box.
3. The name(s) and location(s) of first aid personnel and equipment should be displayed on the first aid box, on the door of the first aid room (if applicable) and on notice boards.
4. **Ensure that information displayed on notice boards, the first aid room and first aid boxes is updated to reflect any changes in location or changes in appointed personnel which may take place.**
5. Ensure that the contents of each first aid box are regularly checked to establish that supplies are sufficient to meet requirements.
6. Order replacement supplies immediately after equipment has been used.
7. Ensure that there is easy access to first aid equipment and the first aid room at all times.
8. Summon professional medical assistance where necessary.
9. Ensure that details of all accidents are reported and entered into the accident book.

Where employees regularly work away from their base, portable first aid kits should be provided by the Trust or private practice. Where work is being carried out at the premises of a third party, employees should ensure that they are made familiar with the first aid arrangements applicable there and should follow these.

Suggested list for contents of a first aid box:

Where ***no special risks*** have been identified from ***the risk assessment***, a **minimum stock** of first-aid items would include:

- a leaflet giving general guidance on first-aid (e.g. HSE leaflet Basic advice on first aid at work);
- 20 individually wrapped sterile adhesive dressings (assorted sizes) appropriate to the type of work;
- two sterile eye pads;
- four individually wrapped triangular bandages (preferably sterile);
- six safety pins;
- six medium sized individually wrapped sterile unmedicated wound dressings (approximately 12 cm x 12 cm)
- two large sterile individually wrapped unmedicated wound dressings (approximately 18 cm x 18 cm)
- One pair of disposable gloves.

First-aid kits for **travelling workers** (i.e. staff who frequently carryout domiciliary visits) would ***typically*** contain:

- a leaflet giving general guidance on first-aid (e.g. HSE leaflet Basic advice on first aid at work);
- six individually wrapped sterile adhesive dressings
- one large sterile individually wrapped unmedicated wound dressings (approximately 18 cm x 18 cm)
- two triangular bandages
- two safety pins
- individually wrapped moist cleansing wipes
- one pair of disposable gloves

Appendix 6

CLINICAL ABBREVIATIONS

General Terminology

A/	Apex, eg A/2 = apex of 2nd toe
B/F	Both Feet
C/O	Patient complains of
O/E	examination
R/	Right Foot
L/	Left Foot
ID	Interdigital area eg ID½
GHG	General health good
F/	Feet
H	Haemorrhage

Anatomical Terminology

Ant.	Anterior
Post.	Posterior
Superi	Superior
Inf.	Inferior
Med.	Medial
Lat.	Lateral
pl.	Plantar
Dor.	Dorsal
J	Joint
MTPJ	Metatarso-phalangeal joint
IPJ	Interphalangeal joint
Met. Head.	Metatarsal head
Dist.	Distal
Prox.	Proximal

Nails

O/H	Corn under the nail plate
O/C	Onychocryptosis
O/G	Onychogryphosis
O/X	Onychauxis
O/P	Onychophosis
PNA	Partial Nail Avulsion
TNA	Total Nail Avulsion
Sub Ung.	Sub-ungal

Skin Pathologies

VP	Verucca pedis
HD	Hard corn
Hmill	Seed corn
H Molle	Soft corn
H Vasc	Vascular corn
HNV	Neuro-vascular corn
pp	Pressure point
CPMA	Callus plantar metatarsal area
CPD/1	Callus plantar digital area of first toe

Padding

SCF	Semi-compressed felt
SR	Sponge rubber
FW	Fleecy web
PMP	Planar metatarsal pad
Pl Cush	Plantar cushion
TG	Tube gauze
TF	Tube foam
OCP	Oval Capacity pad
IDW	Interdigital wedge
Cres.	Crescent cut out

Miscellaneous

HG	Hypergranulation tissue
OA	Osteoarthritis
RhA	Rheumatoid Arthritis
TYPE1	Type 1 diabetes mellitus – insulin dependent
TYPE2	Type 2 diabetes mellitus – medication/ insulin dependent
MODY	Maturity onset diabetes in the young
HAV	Hallux Abductovalgus
HL	Hallux Limitus
HR	Hallux Rigid

APPENDIX 7

In November 2001, the Department of Health published their document *Good Practice in Consent Implementation Guide: consent or examination or treatment.* *www.doh.gov.uk/consent*.

The principles encompassed in this document are those that the Society of Chiropodists and Podiatrists has upheld in its Minimum Standards of Clinical Practice and continue to underpin podiatric practice.

The Society of Chiropodists and Podiatrists recommends that all Chiropody/Podiatry departments within NHS/Care Trusts and Independent Health Care Provider organisations, to include Private Practice, develop and record policies for patient consent, based on the Department of Health November 2001 Guidance and those additional Society recommendations, and that they advise all employees of these policies, and the requirement to uphold them.

Principles of Consent:

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore central to all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health professionals and patients.

Patients may indicate their consent non-verbally, (for example by offering their arm for their pulse to be taken), orally, or in writing. For consent to be valid, the patient must;

- Be competent to take particular decisions.
- Have received sufficient information on which to make a decision for a particular treatment intervention.
- Not be acting under duress.

Whilst these initial principles form part of the basis of consent either verbal or non-verbal, there are specific treatment interventions where the Society of Chiropodists and Podiatrists have a professional recommendation for written consent, within the criteria for informed consent.

Provision of Information:

The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their problem/condition and about possible treatments and their risks and benefits, including the risk/benefits of doing nothing.

The Society of Chiropodists and Podiatrists recommends that written information to support verbal information be developed by NHS Trust/PCT's and all other practitioners, where potential negative outcomes, adverse reactions, or high cost interventions may result from the treatment undertaken or advised.

Examples of such interventions, which may carry a negative outcome, adverse reaction or other are;

- **Non resolution of verrucae within an expected time frame or following a particular treatment intervention which may be recommended as a successful treatment protocol.**

- **Excessive, or unexpected scarring following such treatment.**
- **Severe or adverse reactions to any treatment protocol.**
- **The alternative suggestion of no treatment where adverse reactions may be an outcome.**
- **Where any and all suggested treatment protocols for assessed foot, gait problems, may have a high financial cost to the individual patient.**

Consent is often wrongly equated with a patient's signature on a consent form. The signature is evidence that the patient has given consent, but is not proof of valid consent. A patient must be given detailed information of the procedure to be carried out, to include alternative procedures and any and all risk factors involved. Having been given this information, there is no legal bar to the procedure being carried out, where the individual understands all the issues involved, if they are unable to sign a consent form.

It is not proposed that written consent be required for all treatment interventions, as
it is rarely* a legal requirement to seek written consent, **but it is "good practice and the recommendation of the Society of Chiropodists and Podiatrists" to do so if the following apply:**

- The treatment or procedure is complex, involves significant risks, (the term "risk" is used to refer to any adverse outcome, including those which health professionals would describe as "side effects" or "complications".
- The procedure involves general/regional anaesthesia or sedation.
- Providing clinical care is not the primary purpose of the purpose of the procedure. (see following guidance on this issue).
- There may be significant consequences for the patient's employment, social or personal life.

*The Mental Health Act 1983 (under review) and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances.

The Society of Chiropodists and Podiatrists recommends that informed written consent is required where the administration of local analagesia, or any other injectable substance may be required as an element of a treatment regime, or the treatment itself.

<u>Clinical photography and conventional or digital video recordings.</u>

- **Photographic and video recordings made for clinical purposes, form part of the patient record. Although consent to recordings such as X rays is implicit in the patient's consent to procedure, health professionals should always ensure that they make clear in advance if any photographic or video recording will result from that procedure.**

- Photographic and video recordings, which are made for the treatment and assessment of a patient, must not be used for any other purpose other than the care or the audit of such care without the express consent of the individual or

the personal with parental responsibility for the patient. The exception is below.* (see marked).

- Photographic and video recordings, made for treating or assessing a patient, and from which there is no possibility of a breach of confidentiality where the individual concerned cannot be recognised, may be used within a clinical setting for educational purposes without direct patient consent, as long as the policy for this procedure is well publicised.

- If a video recording or photographic record is made of a patient for educational, research, or publication purposes, written consent must be obtained from the responsible adult, or the individual concerned, initially to make the recording, and then to use it for the purpose identified. Patients must know that they are free to stop any recording when they wish and are entitled to view the recording before they give consent to its use. If patients decide that they do not wish the recording to be used, it must be destroyed. Patients must fully understand the use for which recordings may be made and give informed consent for that process. Where recordings are made with a therapeutic use intended, and then placed in the public domain it may not be possible to withdraw them.

It is recommended that individuals involved in research and educational environments research the DOH guidance document for further details and requirements.

12 Key Points: The Law in England.

- Before you examine, treat or care for adult competent patients, you must obtain their consent.
- Adults are always assumed to be competent unless demonstrated otherwise.
- If you have doubts about their competence you need to be sure that the individual can understand the information given to them, and make a decision on a treatment based on this. Unexpected decisions do not prove that the patient is incompetent, but may indicate they need more information on the procedure.
- Patient's may be able to make decisions on their health care, even if unable to make other decisions.
- The giving of consent is usually a continual process, where there are any doubts, you should always check that the patient wishes you to continue care provision.
- Where children require treatment, consent must be obtained before examination and treatment is provided. Those aged 16/17 are presumed competent to give their own consent. Younger children, who understand the procedure can also give consent, (it is recommended that parents will be involved in the information and consent process. If a competent child consents to a treatment, a parent **cannot** override that consent. Legally, a parent can consent if a competent child refuses, but it is rare like such a circumstance will arise.
- It is always better for the person actually treating the patient to seek the consent. It is acceptable for another individual to seek the consent if one is incapable of carrying out the procedure in question, or if the individual has been trained to seek consent for procedures.
- Patients need sufficient information before they can decide whether to give their consent, examples are those of the benefits of the proposed treatment and **alternative** treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a way that they understand, their consent may not be valid.
- Consent must be given voluntarily, not under duress or undue influence.
- Consent may be written, verbal or oral. A signature on a form itself is not valid, the point of the form is to record the patient consent and the information on the procedure on which to base a decision to proceed. There are legal exceptions, which have been identified above. **The Society of Chiropodists and Podiatrists recommend that informed, written consent is required where local analgesia or any other injectable substance is either an element of the treatment, or the treatment itself. It is also recommended that Trusts and other organisations devise their own consent policies, (see introduction).**
- Competent adult patients are entitled to refuse treatment, even when it would clearly benefit them. *The only exception relates to the Mental Health Act 1983.* (currently under review, refer to current DOH guidance for further detail).
- No-one can give consent on behalf of an incompetent adult. Treatment may be provided if it would be in the best interest of the patient. Best interests include a host of issues and do not relate solely to the outcome of the treatment.

- If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment under certain circumstances, the practitioner must abide by that refusal.

The guidelines identified above are the guiding principles of "good and best practice" for consent as identified by the Department of Health November 2001, until their revision, recognised by the Society of Chiropodists and Podiatrists. As a recognised standard, individual practitioners and others, to include NHS/Trust Managers and Heads of Service should be advised, that these standards will be the recognised level for issues relating to consent where professional standards may be challenged.

EJF
29th Oct 2002

Appendix 8

Patient Assessment Protocol

The following data should be entered on the patient's record card during the initial consultation.

1. Patient's Personal Details.	Name & Title Address Date of Birth Telephone Number Type of work
2. History of Chief Complaint.	
3. Medical History.	
4. Drug History.	
5. Surgical History.	
6. Patient Assessment.	Vascular- arterial, venous & lymphatic, Neurological- motor, sensory & automatic. Functional. Skin.
7. Podiatric Diagnosis.	
8. Treatment Plan.	
9. Prognosis.	

Patient Health Record

The patient health record must include the following

- The patient's name and address
- The date of each of the patient's visits to the member
- The name and address of the primary care physician and any referring health professional
- A history of the patient
- Reasonable information about every examination performed by the member and reasonable information about every clinical finding, diagnosis and assessment made by the member
- Reasonable information about every order made by the member for examinations, tests, consultations or treatments to be performed by any other person
- Every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals..
- Reasonable information about all significant advice given by the member and every pre and post-operative instruction given by the member
- Reasonable information about every post-operative visit..
- Reasonable information about every referral of the patient by the member to another health professional, service or agency
- Reasonable information about every procedure that was commenced but not completed, including reasons for the non-completion
- A copy of every written consent
- Any radiographs taken by or on behalf of the member

In addition, the patient record should

- Include complete and up to date information
- Be legible
- Be written in permanent black ink
- Have all corrections initialled/signed and dated
- Use a clear and logical format
- Have a glossary available if abbreviations are used
- Be secured and kept together
- Be recorded at the time
- Identify the author
- Conform to institutional/Trust policies where applicable

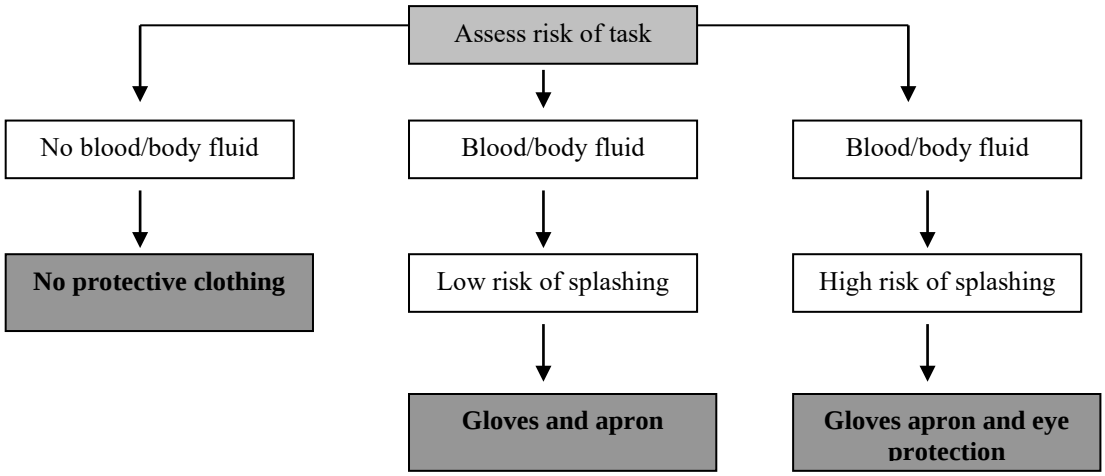
Appendix 9.

Use of gloves and Risk Assessment

Natural latex rubber (NRL) has been in use as gloves in the medical and industrial environments for over 100 years, yet it is only within the last 10 years that the issue of NRL protein allergy has come to the attention of the medical and scientific communities. One significant factor or reason for this change may be the sudden and dramatic increase in demand for these products with the advent of the HIV pandemic, which saw the same dramatic rise in glove manufacturers due to the implementation of Universal precautions. These Universal Precautions were instituted in 1987 and mandated that all health-care workers ***who came in contact with body fluids*** should wear gloves (our italics). The USA Centers for Disease Control did advise taking precautions with all patients. However, their advice **did not prescribe the use of clothing such as aprons, gloves and eye protection for all procedures**; rather, health-care workers were advised to ***assess the risk*** in each situation. This is something, which has been largely ignored and gloves usage as a universal precaution as been instigated without the risk assessment.
Latex gloves should only be used as infrequently as possible and airborne latex proteins, which are particularly problematic should be reduced by using powder-free gloves whenever possible.

Key precautions to prevent latex sensitisation.	**Manner in which to achieve precautions**.
Be aware of risks of latex sensitisation	Undertake a risk assessment of all procedures
Avoid the use of powdered latex gloves where possible	Undertake risk assessment of glove types - policy on gloves
Ascertain the allergenicity of the products being used	Ask suppliers for Medical Safety Data Sheets and information on gloves
Do not accept cheapness as a reason for using certain gloves - they may be highly allergenic	Cost should not be the presiding factor in glove choice.
Report any irritation that may be related to glove use to an occupational health department immediately	Develop communications with occupational health department. Policy on incidence reporting of occupational health problems.
Wash hands after removing gloves	Policy and procedures, audit of handwashing techniques
Avoid the use of oil-based emollients	Policy on moisturisers and hand care
Determine the local policy on latex sensitisation	Communication with Infection Control staff
Use latex gloves only if it is absolutely necessary to do so.	Risk assessment strategy and glove protocol.

This table can then be further interpreted into a flow chart making the risk assessment simplified.



(Adapted from Wilson & Breedon, 1990, and Dof H 1990.)

The effect of latex sensitivity is not just of concern to health-care workers but to the patients whom they treat. Health-care staff therefore has a duty of care as well as a responsibility to their patients and themselves to be aware of and informed about latex sensitisation and to practice in such a manner as to minimise the risks.

What are the reactions associated with latex gloves?

These can briefly be divided into the following categories:

a) Irritant Contact Dermatitis
b) Allergic Contact Dermatitis (Delayed type hypersensitivity)
c) Immediate Reactions (Immediate Type IgE Mediated Hypersensitivity)
    i) Contact Urticaria/systemic reactions
    ii) Anaphylactic reactions

Irritant Contact Dermatitis: is a non-allergic skin rash usually associated with dry, flaky skin with papules, cracks or sores. The aetiology is often that of repeated or prolonged contact of sweat from under gloves. The frequent use of gloves may aggravate a pre-existing atopic hand dermatitis. Manufacturing variations may also lead to residual amounts of accelerators, preservatives or vulcanising agents being left on the glove. These additives can cause irritation but may cause a contact allergic dermatitis.

Allergic Contact Dermatitis: is a skin condition caused by a cellular immune response activated by repeated contact with the allergen. A rash may develop 48-96 hours after exposure, usually from the tip of the fingers to where the glove ends at the wrist. This is delayed hypersensitivity reaction. With time the skin will become dry, red, crusted with sores and blisters. Once this allergic response has been initiated, exposure to even small amounts of the allergen may result in recurrence. Rubber chemicals added through the manufacturing process are the most frequent cause of this type of dermatitis. These chemicals include accelerators, anti-oxidants, anti-microbials,

emulsifiers, dispersing agents and stiffeners. The more common sensitizers or allergens are thiurams and carbamates. Both of these are accelerators speeding up the vulcanisation process or curing. Sensitisation appears to occur more easily through already damaged skin. Thus if a podiatrist has a pre-existing irritant dermatitis (skin rash) this may predispose to the development of allergic contact dermatitis. Thus staff who have hand dermatitis would be advised not to have direct skin contact with latex.

Immediate Allergic Reactions: or an antibody or class of antibodies known as IgE mediates hypersensitivity reactions, which quickly recognise the specific allergen from previous exposure. The allergen within latex gloves is thought to be that of a protein component leached from the natural latex.

These proteins have also been known to adsorb into the glove powder, which then may become airborne. Thus exposure to such airborne particles may help explain the eye, nose and respiratory symptoms. The route of exposure, the amount of the latex allergen and the sensitivity of the individual will result in differing reactions.

i) Contact Urticaria/systemic reactions - may develop local itching, or discomfort with hives within 5-60 minutes after putting on latex gloves. Exposure to airborne latex allergens may produce itchy eyes, conjunctivitis, eyelid swelling, rhinitis, shortness of breath or asthma, dizziness and tachycardia. Once removed from the allergen symptoms usually disappear within 30 minutes to 2 hours.

ii) Anaphylactic reactions - includes the above symptoms with the addition of low blood pressure.

Appendix 9b

Risk Assessment Record

Practitioner: **Address of Practice assessed:**

Ref No:	**Circulation**
Subject (e.g. task or work operation)	
Population involved:	
Persons especially at risk	
Assessor:	
Name:	
Designation:	
Signature	
sessment:	
Reason (initial, following accident, etc)	
Date due for review:	
Key sources of information (legislation, ACOP, Guidance Notes etc)	

Likelihood	**Severity**	**Risk Rating**	**Priority**
1. Low (seldom)	**1. Slight (off work for up to 3 days)**	**1**	**no action**
2. Medium (frequently)	**2. Serious (off work for over 3 days)**	**2**	**Low priority action**
3. High (certain or near certain)	**3. Major (death/major harm)**	**3 or 4**	**Medium priority action**
		6	**High priority action**
		9	**Urgent action**

Appendix 10

SAFE DISPOSAL OF CLINICAL WASTE

HSC endorsed the practical guidance published by the Health Services Advisory Committee entitled 'Safe Disposal of Clinical Waste'. Since then The Society has taken guidance on the interpretation of these guidance notes from a number of sources including the HSE and independent Inspectors from the HSE. This guidance is published in accordance with their interpretation of the Regulations as they currently stand.

The development of policies and procedures for the safe disposal of clinical waste generated by Health Care practitioners irrespective of the site, is a management responsibility (or in the case of the private practitioner their sole responsibility). The Safe Disposal of Clinical Waste comes under the auspices of the Health & safety at Work etc. Act 1974.

The key to any policy, which is to be effective, is the proper identification and quantification of risk – that is a suitable and sufficient risk assessment should be carried out.

This guidance also encompasses the requirements under the Environmental Protection Act 1990.

The Safe Disposal of Clinical waste comes under the Regulations of COSHH (1988 and as amended 1994) which requires specifically a risk assessment. The categories of clinical waste described below are the foundation to that risk assessment and while the level of risk may vary both within and between groups suitable control measures must be adopted and adhered to as appropriate for each group.

Group A
All human tissue, including blood (**whether infected or not**), and all related swabs and dressings. Soiled surgical dressings, swabs and other soiled waste from treatment areas. (Our embolden and underlining)

Group B
Discarded syringe needles, cartridges, broken glass and any other contaminated disposable sharp instrument or items.

Group C
Microbiological cultures and potentially infected waste from pathology departments and other clinical or research laboratories.

Group D
Certain pharmaceutical products and chemical waste.

Group E
Items used to dispose of urine, faeces and other bodily secretions or excretions assessed as not falling within group A.

Disposal options.

All wastes in Group A & B **MUST** be incinerated. (Our embolden and underlining)

Within the written Health & Safety policy of a Trust or Industrial centre employing podiatrists, a policy for the safe disposal of clinical waste should form part of that general policy.

Framework for policy.

- Identification of categories of clinical waste (easy all clinical waste we generate will be either Group A or B, with occasional Group D)
- Means or methods for segregation – Sharp's boxes, yellow sacks, waste containers provided by commercial firm)
- Specification of containers/enclosures to be used (guidance from NHS and BS offices – Sharps containers BS7320; Recommended colours to BS 381C:1988 – Yellow standard colour ref.: No 309)
- Storage
- Transport
- Handling before storage
- Training needs
- Personal protection
- Accidents and incidents (reporting, investigation and follow-up)
- Spillage's
- Final disposal

Sharps containers should be sealed when ¾ full (or at intervals as specified in the local assessment or agreement by the accredited waste disposal contractor: this may be weekly or less regularly dependent on amount of waste generated by the practitioner). Sharps should be disposed of intact (i.e. needles and syringes) unless a safe method of resheathing and removing needles is specified. SCP recommends disposal intact). Sharps containers should be labelled before removal and should not be put into yellow bags.

Yellow sack containing Group A waste should be held in sack holders at the point of generation. The sacks should be replaced daily or when ¾ full. Contents should not be transferred loose from container to container. The sacks when full should be sealed with a purpose made tie or closure or tying off the neck if light weight. Sacks should be labelled if not already coded, informing of where the waste was generated.

Storage

Clinical waste containers (sharps boxes or yellows sacks) may require storing prior to final disposal. It should not however be stored or accumulate in corridors, wards or surgeries.

The storage areas should where reasonably practicable, be reserved for clinical waste only, should be secure, totally enclosed and well drained, impervious hard standing. Only authorised persons should be able to gain entry. The store should be kept locked when access is not needed. Protective equipment for dealing with disposal and spillage should be available. They should be well lit and ventilated and clearly labelled.

Training.

All staff required to handle and move clinical waste should be adequately trained in safe procedures, and in dealing with spillage's or other incidents for their work activities. A record of such training should be kept. Written local procedures should be available. The training should include as a minimum:

- Risks associated with clinical waste
- Segregation
- Storage
- Spillage's procedures
- Accident procedures
- Protective clothing

NHS and Private Practices – disposal systems

Safe disposal of waste is the responsibility of the practitioner, nursing home owner or centre management. The domestic waste collection **SHOULD NOT** be used for clinical waste irrespective of where it is generated.
Options for disposal are:

- Local authority special collection and disposal service for clinical waste
- Independent contractor to local hospital incinerator
- Independent contractor to local authority facilities
- Independent contractor to contractor's incinerator
- Practitioner taking waste by arrangement to local hospital incinerator.

Sharps

Health care staff including podiatrists who treat patients at home should remove any sharps that they generate in appropriate containers for disposal via their employers clinical waste disposal system.

There is no confusion as far as HSE are concerned. Any waste generated by a podiatrist (i.e. toenail clippings, callous, swabs etc.). is Group A waste and as such must be disposed of through the channel designated for clinical waste. It is against the Regulations and is a breach of the COSHH regulations and HSWA if it is left to normal domestic waste. Any one or any Trust found to be advising that the waste can be treated as domestic waste is in direct contravention of current legislation and may be prosecuted if HSE were to investigate or hear of the policy.

Appendix 11.

Lasers and Classification

The word laser is an acronym for Light Amplification by Stimulated Emission of Radiation.

Lasers are grouped into 4 main classes and two subclasses i.e. 1, 2 3A, 3B and 4 as defined in BS EN 60825-1. These classes are based on the degree of hazard to persons, taking into account potential damage to the eye and skin. Class 1are considered essentially safe and class 4 the most hazardous, requiring strict safety procedures and policies. Surgical lasers are predominantly in Class 4.

Serious risk of injury, in particular to the eye of either patient or practitioner, may result from a lack of protective devices or measures, the use of faulty laser devices, misdirected beams or inappropriate laser control settings.
The probable mechanisms which laser induces damage are similar for all body systems. These may involve thermal, mechanical and chemical processes. The degree to which any of the above mechanisms are responsible for tissue damage is related to the energy absorbed by that tissue (Tissue Absorption Coefficient) plus certain physical parameters of the irradiating source. The most important of these parameters are: wavelength, duration, beams size at the target and power.
(For more information on potential tissue damage practitioners are advised to read the Medical devices Agency booklet Guidance on the safe use of lasers in medical and dental practice ISBN 1 85839 488 0)

Hazards.

The use of lasers produces hazards or danger to the patient, the practitioner and any other third party or support staff while the laser is in use.

Patient: Two sources of danger – Over exposure or misdirected beams are main hazards. Other dangers may be from inappropriate use or inadequate maintenance and validation schedules.

Staff: Hazardous exposure to eyes, and or skin either from a direct beam, reflection from the target site or walls and equipment.

Indirect effects: Inhalation of laser plume smoke from tissue destruction if a destructive laser is used.
Fire within the operating area through misdirected beam, or contact with non-target areas.
Practitioners should be aware of the lasing medium in use with their devices and apply appropriate COSHH assessment

Practitioners should also be aware of Maximum Permissible Exposure (MPE's) limits and consult the required documentation (see BS EN 60825-1). Those using lasers need also to be aware of the Nominal Ocular Hazard Distance (NOHD) which the subsequently portray the Laser Controlled Area.

Where a laser of Class 3A or greater are employed within a Trust or practice a Laser Protection Adviser (LPA) requires to be appointed, and their duties are comparable with those of a Radiation Protection Adviser. The duties of the LPA are matters such as hazard analysis and risk assessment for the sites where lasers are used, especially those of Class 3A, 3B and 4. In order to help with local supervision and ensure designated rules are being adhered to a Laser Protection Supervisor (LPS) should also be appointed. This person may be the practitioner using the laser or another member of staff who is closely involved with the work.

A Class 3B or 4 laser should only be used by an authorised person and a register should be kept of those designated authorised users for each site. These authorised users should sign demonstrating that they understand and accept the local rules. Any person using a laser should have underwent training necessary to ensure they understand their responsibilities to themselves and other persons with whom they work.

Lasers intended for use on patients are powered medical devices and come under the Medical Devices Directive (CE marking) and the supplier should issue purchasers with all relevant information including conformity to standards.

Legal Requirements.

Health & Safety at Work etc. Act 1974 places a general duty on employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees. In particular this includes the provision of safe equipment, systems of work and working environment. Effective training, instruction and training are necessary to meet that requirement. They also require ensuring the safety etc. of people other than employees, which includes patients and visitors. Employers should also consult the Registered Homes Act 1984 to ensure their laser installation meets the requirements if this legislation.

There are no specific statutory requirements for training of users of lasers other than the general requirements of s.2 of the Health and Safety at Work Act 1974 and regulation 11 of the Management of Health and Safety at Work Regulations 1992. However, BS EN 60825: 1992 (which replaces British Standard BS 7192: 1989) states that only persons who have received adequate training should be allowed to use class 3A, 3B and class 4 laser systems.

Environmental implications.

The reflective properties of work surfaces and walls should be taken into account when deciding on the suitability of an area as a controlled laser zone. The walls of the treatment area are normally taken as the boundary of the controlled area, but occupancy and activity levels of those within the area should be subject to control and safe systems of work. Where a class 3 laser is used which has a diverging beam then a curtained cubicle may be acceptable. However, advice should be sought from the local Laser Protection Officer/Supervisor. Warning signs conforming to BS EN 60825-1 should be provided at the entrance to the controlled area. In some instances the signs may be illuminated in which case they must be interlocked with the laser. It is not always necessary to fit a door interlock switch but to use a safe working practice.

Personal Protective Equipment (PPE).

Within the Regulations governing Health & Safety (i.e. The Management of Health & Safety at Work Regulations 1994, the Guidance on Regulations; Personal Protective Equipment at Work 1992 there is a hierarchy of control systems in which PPE is a 'last resort'.
The operator and patient should use eye protection, and any other persons within the area designated at risk. Protective eyewear should indicate the type of laser, which is to be used and the optical density of the filter. Applicable safety standards are those of BS EN 207 and 208.

All class 3B or 4 should be equipped with a warning device indicating radiation is being emitted.

Lasers should be used in accordance with a strict maintenance programme, which addresses the following areas:

- Calibration to a defined schedule
- Servicing and maintenance based on the manufacturer's recommendations
- Footswitches, cables and connectors should be readily identifiable, checked and maintained
- Pre-checks as defined by local rules.
- Lasers require calibrating and re-calibrating following repair and maintenance. Further advice can be found in HEI 98 (Health Equipment Information) November 1990, Management of Medical Equipment and Devices.

Classification.

BS EN 60825-1:1994 group's lasers into the four categories previously mentioned. As class or group number increases, the maximum output allowable increases. An Accessible Emission Limit (AEL) is specified for each class.

Class 1
Class 1 are devices which are inherently safe, in which the MPE level cannot be exceeded.

Class 2
Class 2 emits low power in the visible band (400-700nm) and operates either continuous mode or repetitively pulsed mode
Class 3A
Are devices regarded as safe for viewing with the unaided eye because maximum power and radiance are limited

Class 3B
Emit in any part of the electro-magnetic spectrum from 180nm to 1mm. Direct intrabeam viewing is always hazardous. Viewing diffuse beams is normally safe. Restricted to an upper limit of 0.5 W for CW lasers and radiant exposure from pulsed variety must be less than $10^5 Jm^{-2}$.

Class 4
High power outputs exceeding those of class 3B and their emission is in any part of the electro-magnetic spectrum from 180nm to 1 mm. This beam is capable of igniting flammable materials.

Each Class 3B and 4 should have a key-operated master control which should be removable and inoperable when the key is removed.
Class 3B and 4 should give a visible 'laser ready' warning if able to emit radiation when firing switch is activated (BS EN 60601-2-22)
There should also be a visible or audible warning when these classes are used and emitting radiation.

In most cases Podiatry uses the **Low Level Laser Therapy** units which emit at the red end of the spectrum or just into the infrared spectrum. These usually fall into the category of **3B**.

Appendix 12

CE MARKING AND REGISTRATION ORTHOTICS
MEDICAL DEVICES DIRECTIVE

EC Directive 93/42/EEC
The Medical Decises Agency advise that where the manufacture of a device is part of the normal professional activities and the clinical responsibility of the practitioner, then they are not part of the regulations and do not need to be registered.

Practitioners and laboratories who manufacture custom-made devices need to register.

Devices made or manufactured by podiatrists will be Class 1 (generally regarded as low risk) and are covered by rules 1-4. However there may be some devices – Scotch cast devices or those of a similar nature and intent or devices such as insoles which are used on Diabetic ulcers which may conform to Class IIb because of rule 4. However on the whole these devices will be manufactured by a podiatrist, for a patient and will not be placed on the market. Thus, they may not be required to be CE marked. The podiatrist may still require to register.

Because the majority of devices manufactured by podiatrists will be custom-made devices falling into Class 1 the only route of conformity to declare their status will be by the podiatrist declaring conformity.

Podiatrists produce a number of different devices, which can be termed custom made. However a Podiatrist will need to register for them all.

Silicone devices are moulded around a patient's toe and remain in place to hold the toe straight. As such this is part of normal professional activity and does not require to be registered, although the manufacturer of the silicone putty may have to register.

Overleaf is a list of pads, orthotics and other custom made devises and an interpretation as to which may require to be registered:

Register	No need to Register.
Orthotics manufactured by the podiatrist in their own premises.	Clinical padding
Casted functional foot Orthoses	Clinical strapping to alleviate strains
Casted foot Orthoses if manufactured by the podiatrist in house	Orthodigital silicone devices
Simple insoles made and manufactured to a prescription in house	Nail braces
Scotch cast boots	Alterations to prescription devices (alterations to devices manufactured previously by podiatrist
Other casted boot types for alleviation and treatment of diabetic or neuropathic ulcers	Alterations to custom made devices i.e. addition of wedges or posts
Simple casted alginate digital devices	Alterations made to over the counter insoles or pre manufactured and purchased devices
	Devices supplied by a podiatrists but not manufactured by them
	Alterations to above devices.
	Footwear alterations

If the podiatrist makes a prescription, manufactures a device but not at the chairside then they require to register for each device they may make. If they are not registered for a device at the time, they will require doing so in the future to keep themselves within the letter of the law and the Medical Directive.

Basically, if a device is made at the chairside the podiatrist does not have to be registered. If the device is not classed as chairside then they require to be registered to make or manufacture that device if they work in private practice.

Where a podiatrist makes a prescription and sends that prescription off to a third party, the third party requires to be registered and possibly to CE mark the devices.

Where a podiatrist makes a prescription, takes a cast of the patient, and sends the cast and prescription off to a third party then the third party requires to be registered.

If in doubt as to whether a device or a podiatrist requires to be registered it is safer to register the device and the podiatrist than not to.

The above are interpretations of the legal requirements but this represents the Society's view. It should not be regarded as an authoritative statement of the law or as having any legal consequence. Only the courts can give an authoritative statement. It follows that those affected should not rely on the statement but should reach their own decisions in conjunction with their lawyers and other professional advisers. The Society does not accept liability for any errors, omissions or misleading or other statements in the statement, whether negligent or otherwise.

Appendix 13

THE DATA PROTECTION ACT 1998

The EC Data Protection Directive (95/46/EC) was adopted on 24th October 1995. Article 1 of the Directive requires Member States to "protect the fundamental rights and freedoms of natural persons and in particular their right to privacy with the respect to processing of personal data".

As a result the Data Protection Act 1998, "An Act to make new provision for the regulation of processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information", came into force on 1st March 2000, and repealed the Data Protection Act 1984. **These regulations extend to include paper records.**

All members of the Society of Chiropodists and Podiatrists must comply with the eight Data Protection principles of the Data Protection Act 1998.

Definitions;

Data, (including manual data/relevant filing systems) means information which;

- Is being processed by automatically operated equipment in response to instructions to retrieve such information.
- Is recorded with the intention that it can be processed by means of such equipment.
- Is recorded as part (or with the intention that it should form part) of a relevant filing system (i.e. any set of information relating to individuals to the extent that although not processed or retrieved automatically), forms part of a structured system where the information is retrievable.

Manual Data covered by the Act;

Non -automated information may be found in a variety of different media, paper files, rollerdex, or non-automated microfiche.

For the Act to apply, the manual information must fall within the definition of "data" within the Act, and includes information, which is recorded as part of a "relevant filing system" or with the intention that it should form part of a "relevant filing system". The term "relevant filing system" means:-

"any set of information relating to individuals to the extent that, although the information is not processed by means of equipment operating automatically in response to instructions, the data is structured and stored by reference to individuals, in such a way that specific information relating to an individual is readily accessible".

For manual data to apply, there must be a set of information about individuals which is structured in such a way that specific information about an individual is readily accessible. When auditing manual records you should assess the information and the way it is structured, rather than whether it is in itself a file or filing system.

Personal Data;

Personal Data means data which relates to a living individual who can be identified;

- From the data, or
- From the data and other information, which is in the possession of, or is likely to come into the possession of, the data controller, (NHS Trust or other Health Body i.e. Private Practice), and which includes any expression of opinion about the individual, and indication of the intervention of the data controller in respect of the individual, (i.e. medical referral).

Processing;

Processing in relation to information or data, means obtaining, recording or holding of information or data, (personal data or similar), or carrying out any operation or set of operations on information or data, including;

- Organising or adapting the information, (patient records and treatment record).
- Retrieval, consultation, or use of the information or data.
- Disclosure of the information or data, (referral on to another).
- Alignment, combination, blocking, erasure or destruction of data.

Data Subject;

Is the individual who is the subject of the personal data, (patient, or employee)?

Data Controller;

Is that person who, (alone or with partners, members of a department, and others) determines the purpose and the manner in which personal data is to be processed.

Data Processor;

A data processor in relation to personal data, is someone who (other than an employee of the Data Controller, i.e. not a receptionist directly employed by a practice), processes data on behalf of the data controller, such as a data agency or similar.

Recipient.

The recipient under this Act;

- means any person to whom the data is disclosed, including any person (such as an employee of a practice), for whom this data might be required for processing purposes, (updating patient records or filing), but does not include any person to whom disclosure of information, as a result of, or with a view to, a particular inquiry relating to any legal implications or action.

Third Party;

The Third Party in relation to personal data means any person other than;

- The patient.
- The practitioner or practice.
- The data processor.

NOTIFICATION;

The Data Protection Commissioner maintains a public register of data controllers.
Each register entry includes the name and address of the data controller, and a general description of the processing of personal data by a data controller.
Notification is the process by which a data controller's details are added to the register

The Data Protection Act 1998 requires every data controller who is processing data to notify, unless they are exempt.

Failure to notify is a criminal offence.

REQUIREMENTS FOR NOTIFICATION;

Every data controller who is processing data must notify unless they are exempt.

Exemptions are possible for;

- processing of personal data for personal, family or household affairs, (including recreational purposes).
- data controllers who only process personal data for the maintenance of a public register.
- data controllers who only process personal data for any one, or all of the following purposes for their own business;
  - staff administration
  - advertising, marketing and public relations
  - accounts and records.

MANUAL RECORDS AND NORIFICATION;

There is no requirement to notify manual records which come within the scope of the Data Protection Act 1998.

You can choose to notify them voluntarily.

HOW TO NOTIFY;

Notification can be made either through the Internet, or by telephone.
Notification helpline 01625 545 740. (correct at December 2000).Every notification must be accompanied by a fee of £35.00 (VAT nil).The period of notification is one year.

THE DATA PROTECTION PRINCIPLES.

1. First Principle.

Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless;

- **At least one of the conditions in Schedule 2 is met, and**
- **In the case of sensitive data, at least one of the conditions of Schedule 3 is also met.**

Sensitive Personal Data means personal data consisting of information relating to:
a) the racial or ethnic origin of the data subject,
b) their political opinions,

c) their religious beliefs or other beliefs of a similar nature,
d) whether they are a member of a trade union,
e) their physical or mental health or condition,
f) their sexual life,
g) the commission or alleged commission by them of any offence, or
h) any proceedings for any offence committed or alleged to have been committed by them, the disposal of such proceedings or the sentence of any court in such proceedings.

Relevant Schedule 2 Provisions;

- *consent of the data subject*
- *necessary for performance of a contract with the data subject*
- *legal obligation*
- *to protect vital interests of the data subject*
- *to carry out public functions*
- *to pursue legitimate interests of the controller unless prejudicial to interests of the data subject*

Relevant Schedule Provisions;

- *explicit consent of the data subject*
- *to comply with employers legal duty*
- *to protect vital interests of the data subject or another person*
- *carried out by certain non-profit bodies*
- *the information has been made public by the data subject*
- *in legal proceedings*
- *exercising legal rights*
- *to carry out public functions*
- *for medical purposes*
- *for equal opportunities monitoring*
- *as specified by order*

2. Second Principle

Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be processed in any manner incompatible with that purpose or those purposes.

3. Third Principle

Personal data shall be adequate, relevant and not excessive in relation to the purpose or for the purpose for which they are processed.

4. Fourth Principle

Personal data shall be accurate and, where necessary, kept up to date.

5. Fifth Principle

Personal data processed for nay purpose or purposes, shall not be kept for longer than is necessary for that purpose or purposes.

6. Sixth Principle

Personal data shall be processed in accordance with the rights of data subjects under this Act.

7. Seventh Principle

Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against personal loss or destruction of, or damage to, personal data.

8. Eighth Principle

Personal data shall not be transferred to a country or a territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

INDIVIDUAL'S RIGHTS

The Act gives rights to individuals in respect of personal data held about them by others. The rights are;

1. **Right of subject access**
2. **Right to prevent processing likely to cause damage or distress**
3. **Rights to prevent processing for the purpose of direct marketing**
4. **Rights in relation to automated decision taking**
5. **Right to take action for compensation if the individual suffers damage by any contravention of the Act by the data controller**
6. **Right to make a request to the Data Protection Commissioner for an assessment to be made as to whether any provision of the Act has been contravened**

The right of subject access

Upon making a request in writing and paying a fee, an individual is entitled;

- To be told by the data controller whether they, or someone else on their behalf is processing that individual's personal data,
- If so, to be given a description of;
  a) the personal data,
  b) the purposes for which they are being processed, and
  c) those to whom the they are, or may be disclosed,
- to be told, in an intelligible manner of;
  a) all the information which forms any such personal data. This information must be supplied in permanent form by way of a copy, except where the supply of such a copy is not possible, or would involve disproportionate effort or the data subject agrees otherwise. If any of the information in the copy is not intelligible without explanation, the data subject should be given an explanation of that information, e.g. where the data controller holds the information in coded form which cannot be understood without the key to the code, and
  b) any information as to the source of those data (in some instances the data controller is not obliged to disclose such information where the source of the data is, or can be identified as, an individual, unless the other individual consents to the disclosure, or it is reasonable in all the circumstances to supply the information without consent), and
- where a decision significantly affecting a data subject is, or is likely to be, made about them by fully automated means, for the purpose of evaluating matters about them such as their performance at work, their creditworthiness, their reliability or their conduct, they are entitled to be told of the logic involved in that process. The data controller is not required to do this where the information in question constitutes a trade secret.

Subject access to information.

An individual may access their personal information by submitting a written request and fee to a data controller.

A maximum time limit of 40 days applies to compliance with the original request where accompanied by the fee payable.

A stipulated maximum fee for access to data has been set by the Data Protection Commissioner. This fee is recognised to include **all** administration costs incurred.

Fees for access to data may not exceed:
£10.00p for data stored electronically.
£50.00p for data stored manually.

SOCIETY OF CHIROPODISTS AND PODIATRISTS GUIDANCE RECOMMENDATIONS; DATA PROTECTION ACT 1998.

It is accepted that compliance with Minimum Standards for Clinical Practice, would indicate that all patient records, to include paper records, fall within the description of data, and are structured in such a way as to be easily retrievable and updated, and as such, fall within the requirements of the Data Protection Act 1998.

Where electronic systems are used to store patient information, to include treatment records and/or records of appointments, it is a legal requirement that all Members of the Society of Chiropodists and Podiatrists comply with the notification requirement of the Data Protection Act 1998.

Where patient information, to include treatment records and records of appointment, is stored manually in paper format, there is no requirement for notification within the data protection Act 1998. The principles of the Act must, however be upheld.

Those Members practising within a Group Partnership arrangement must ensure that the Group Partnership complies with any requirement of notification as indicated by the Data Protection Act 1998 and uphold the principles of the Act.

Lone and single practitioner Members of the Society of Chiropodists and Podiatrists, must ensure their compliance with the principles of, and requirements for, notification as identified by the Data Protection Act 1998.

Note that the information and recommendations outlined in this document constitute a legal requirement under the EC Data Protection Directive (95/46/EC) effective 1st March 2000.

CONTACT INFORMATION.

Data Protection information helpline; 01625 545745

Website; www.dataprotection.gov.uk

Appendix 14

Guidance on Decontamination of equipment prior to inspection, service or repair

Adapted from HSG (93) 26 and Decontamination Guidance July 1999 Version 1.0 NHS Estates.

Summary

Risk Control Systems (RCS) include a Risk Control hierarchy involving the introduction of workplace precautions. Safe systems of work are one aspect of a RCS. Such a system should be implemented to protect all staff, including those not employed within the Health Service from transmission of infection from medical devices. Medical and laboratory equipment, consumables and materials used in the treatment, diagnosis and care of patients and other equipment, which come into contact with patients or their body fluids are classified as medical devices. Items may include nail drills, handpieces, electrosurgical units, electrotherapy equipment.

Guidance.

A safe system of work is a procedure, usually written down, describing how a task is to be carried out in a way (s) which reduces or minimises the risks associated with the task. For example, before sending a nail drill for service or repair, there requires a procedure to ensure that the handpiece is decontaminated and sterilised before an external agent can undertake the service. The procedure or safe system of work might also include how the nail drill itself can be decontaminated also.

This guidance outlines the

- Legal requirements;
- Features of an appropriate system of work;
- The documentation necessary.

Failure to comply with these legislative requirements in respect to medical devices and other equipment being presented for inspection, service or repair without documentation to indicate their contamination status, would leave a practitioner or health authority liable to prosecution.

Legislation.

The Health and Safety at Work, etc. Act, 1974 places a number of duties upon employers. One of which is to ensure the health, safety and welfare of others not in their employment and who might be affected by activities, which are carried out by the employer.

In addition, the *Control of Substances Hazardous to Health (COSHH) Regulations (1988, 1999)* is applicable both to chemical hazards and biohazards. Furthermore, European Directives on protection against biological agents and the *Management of Health and Safety at Work Regulations 1992* are also applicable.

Employers must conduct their activities in a manner as to ensure that, as far, as is reasonably practicable; people not in their employ are not exposed to such risks. The Management of Health and Safety at Work Regulations (1992) place a statutory duty of co-operation between employers. e.g. the Health Service and its contractors, to

provide each other with clear communication in Health and Safety matters including any hazards associated with the transfer of material or equipment.

The guidance here relates particularly to microbiological hazards, as this is most likely in podiatry although chemical or electrical hazard may be potential hazards also.

Guidance on a safe system of work

Anyone (either internal maintenance or external consultants) who inspect, service, repair or transports medical, podiatric or laboratory equipment, either on hospital/Trust/private premises or in their own premises has a right to expect that medical devices and other equipment have been appropriately treated/decontaminated. This procedure should remove or minimise the risk of infection or other hazards.

Appropriate documentation is required from the owner/user to indicate the contamination status of the item. The documentation should be provided to the appropriate authority undertaking the service, repair or inspection.

However, suppliers of equipment also have responsibilities to provide suitable and sufficient information on the compatibility of the particular medical devices or equipment with suitable methods and agents to allow decontamination.

HC (91) 33 gives some guidance on decontamination and although it is general guidance, it requires interpretation in the light of particular local rules or situations. All items intended for inspection, service, repair or transportation should be provided with a declaration of contamination status.

There are some occasions, (for example when the condition of an item is the subject of complaint or investigation) that may be altered or influenced by a decontamination process. The investigator in this instance may wish the item **not** to be decontaminated. In this case, advice of the investigating body is sought and, if the item is to be dispatched from the hospital/private practitioner premises the following procedure should be adopted:

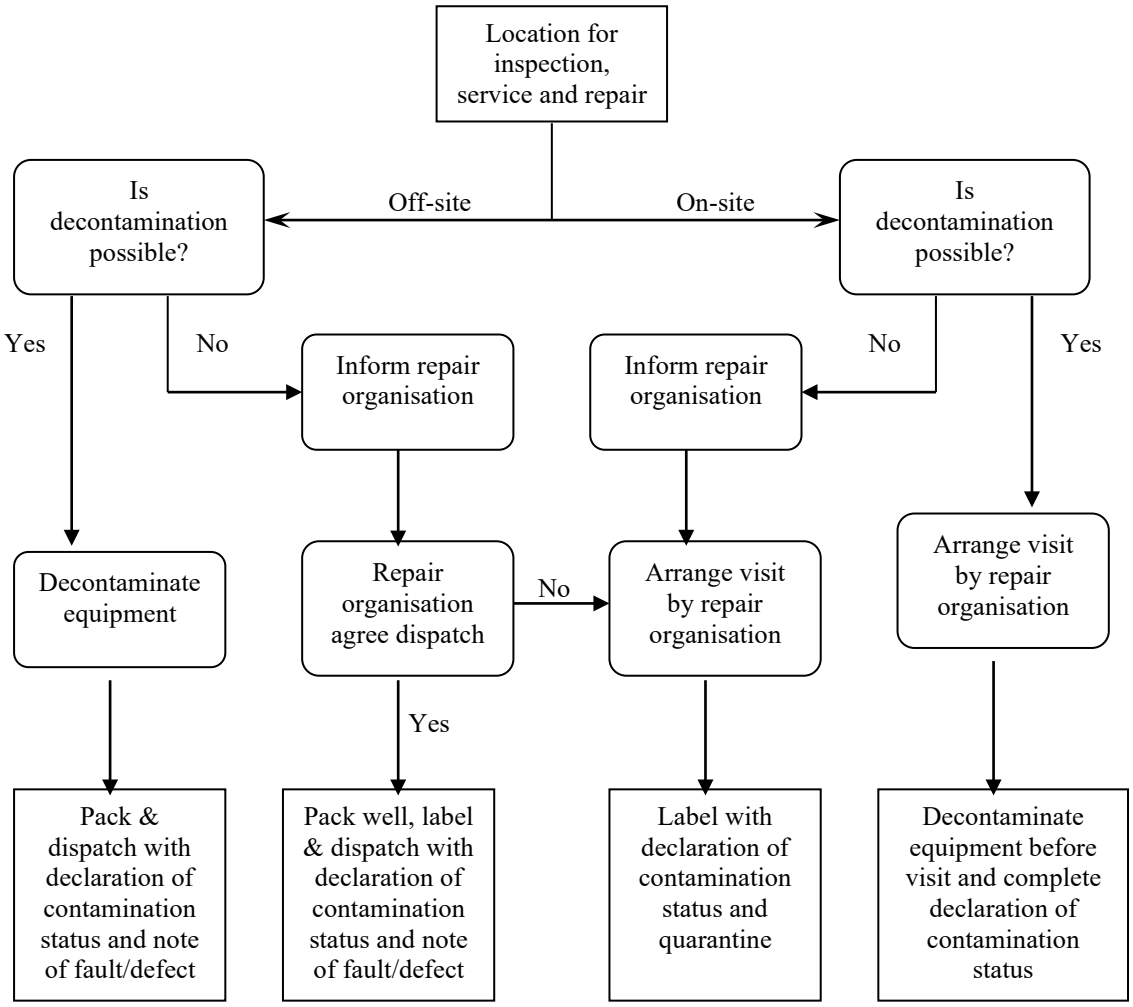
- Prior warning should be given to the intended recipient
- The condition of the item should be clearly labelled so that it can be determined prior to opening of the inner packaging
- The packaging should be sufficiently robust to withstand transport
- The packaging should ensure the content of the inner pack couldn't contaminate the outer one.

Additionally, agreement of any carrier used to transport a contaminated item may be required. Advice of the proposed carrier should be sought to enable the practitioner to package the medical device as required by the particular carrier.
The above procedure applies to items, which are not subject to investigation but cannot be decontaminated before inspection, service or repair.

Further Information on methods of packaging is contained in the Classification, Packaging and Labelling of Dangerous Substances Regulations (1984) Carriage of Dangerous Goods (Classification, Packaging and Labelling) and Use of Transportable Pressure Receptacles Regulations (1996) and further information from the Mailguide (1992)*.

*Royal Mail, Mailguide: a comprehensive guide to mail services, October 1992

Flowchart 1
Decontamination of equipment for repair, service or inspection



DECLARATION OF CONTAMINATION STATUS

Prior to the Inspection Servicing, Repair or Return of Medical and Laboratory Equipment

TO:

Make and Description of Equipment:

Mode/Serial/Batch No:

Authority's Ref. or Order No:

Recipient's Service or Returns Authorisation Reference or Contact Name:

Tick box A if applicable, Otherwise complete all parts of B providing further information as requested or appropriate.

A. This equipment/item has not been used in any invasive procedure or been in contact with blood, other body fluids, respired gases, or pathological samples. It has been cleaned in preparation for inspection, servicing, repair or transportation.

B. 1. Has this equipment/item been exposed internally or externally to hazardous materials as indicated below?

Provide further details here

YES/NO Blood, body fluids, respired gases, and pathological samples

YES/NO Other biohazards:

YES/NO Chemicals or substances hazardous to health:

YES/NO Other hazards:

2. Has this equipment/item been cleaned and decontaminated? **YES/NO**

Indicate the methods and materials used:

If the equipment/item could not be decontaminated, please indicate why:

Such equipment must not be returned/presented without the prior agreement of the recipient whose reference or contact name must be given above.

3. Has the equipment/item been suitably prepared to ensure-safe handling/transportation? **YES/NO**

I declare that I have taken all reasonable steps to ensure the accuracy of the above information, In accordance with HSG (93) 26.

Authorised signature	Unit
Name (printed)	Dept Position)
Tel no	Date

Appendix 15

The Ionising Radiations Regulations 1999 (S.I 1999 No 3232) replace the Ionising Radiations Regulations 1985 (S.I 1985 No 1333), except for the requirement for special hazard assessments (regulation 26 IRR85) and related provisions and the Ionising Radiations (Outside Workers) Regulations 1993 (S.I 1993 No 2379). The regulations come into force on January 1 2000 except for the requirement on prior authorisation which takes effect from 13 May 2000.

The Ionising Radiations Regulations 1999 (IRR99) come into force on 1 January 2000 and will implement most of the revised Basic Safety Standards Directive (96/29/Euratom) and replace the Ionising Radiations Regulations 1985 (IRR85).

The Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R) (Statutory Instrument 2000 No 1059) revoke and replace the Ionising Radiation (Protection of Persons Undergoing Medical Examination and Treatment) Regulations 1998 (POPUMET). These came into force on 13 May 2000 except for Regulations 4(1) and 4(2) which became effective from 1 January 2001.

These Regulations are wider than previous regulations covering exposure for medical diagnosis, or treatment, as part of occupational health surveillance, part of a screening programme, volunteers in medical, biomedical, diagnostic or therapeutic research and medico-legal procedures. The Regulations require the employer (or private practitioner) to have written procedures for medical exposures and to ensure they are complied with. The Regulations also require employers (or private practitioners) to ensure that whoever undertakes medical exposures undertake continuing education and training after initial qualification.

The new addition to these Regulations is the need for justification by the practitioners or referring clinician for medical exposure. There is also a requirement for clinical audit within the radiography procedures.

The referrer is responsible for providing sufficient clinical information, which would enable the justification of the medical exposure. They should ensure the completeness and accuracy of all data relating to the patient's condition. The referrer should be aware of the patient's medical history, presenting complaint, relevant past history and previous radiation exposure relevant to the condition being investigated.

Further Guidance for those undertaking radiography and Ionising Radiation can be found at:

http://www.legislation. hmso.gov.uk/si/si2000/20001059.html

which gives details of the Statutory Instrument

or http://www.doh.gov.uk/irmer.html

where details of the Ionising Radiation (Medical Exposure) Regulations 2000 can be found.

These are also available as pdf. Files on the Society's Virtual Learning Centre at http://www.scpod.org/vlc

Appendix 16. Decontamination quality assurance check list

Checkpoint	Yes	No	N/A
Was mechanical cleaning used for this set of instruments?			
If you answered no to the above statement, was manual cleaning used for this set of instruments?			
Were all instruments in this set immersed?			
Were grossly soiled and contaminated instruments placed in water below 35ºC with no detergent			
Were this set of instruments cleaned adequately?			
Were all instruments checked for quality of manual/mechanical cleaning?			
Were all instruments in this set rinsed after cleaning?			
Were all instruments dried prior to sterilization?			
Did the sterilizer reach sterilizing temperature?			
Did the sterilizer stay at the sterilizing temperature for the required period of time?			
Did the sterilizer reach the optimum pressure?			
Were the instruments removed from the sterilizer and used immediately?			
Were the instruments checked for integrity and maintained before subsequent use?			
Were the instruments from the sterilizer clearly segregated from contaminated instruments?			

Further information is available from the SCP in their renewed Statement on Decontamination of Surgical Instruments.

References

1. Department of Health – Controls Assurance Standard – Decontamination of re-usable medical devices

2. The purchase, operation and maintenance of benchtop steam sterilizers DB9605, MDA, 2nd impression 1996

3. The validation and periodic testing of benchtop vacuum steam sterilizers, DB9804, MDA 1998

4. Guidance on the purchase, operation and maintenance of benchtop vacuum steam sterilizers DB2000 (05), MDA 2000.

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6 Sterilization, disinfection and cleaning of medical devices and equipment: guidance on DECONTAMINATION from the microbiology advisory committee to Department of Health Medical Devices Agency. Department of Health, 1996.

7. Health Service Circular HSC 1999/178 Variant Creutzfeldt – Jakob Disease (vCJD): Minimising the risk of transmission. NHS Executive, 1999.

8. Single use medical devices: implications and consequences of reuse DB2000 (04). MDA 2000.

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10 Council directive 93/42/EEC (The Medical Devices Directive) Annex 1, 13.6h

12 Health Technical Memorandum 2030 – Washer – disinfectors. The Stationery Office, London 1997. (Published in 3 volumes)

13. Health Technical Memorandum 2010 – Sterilization. HMSO, London 1994 – 1997. (Published in 6 volumes)

14. Pressure Systems Safety Regulations 2000, Statutory Instrument 2000 No. 128. The Stationery Office, London

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THE SOCIETY OF CHIROPODISTS AND PODIATRISTS GUIDELINES ON MINIMUM STANDARDS OF CLINICAL PRACTICE

1.0 INTRODUCTION;

This document has been revised to reflect the current standards that affect Chiropodial/Podiatric clinical practice and accepted professional clinical standards. It should be noted**,** that, in recognition of the devolved status of the United Kingdom into the Four Home Countries, every effort has been made to ensure that the guidance and mandatory elements of it, reflect individual countries and their respective legislation, where this has been clearly identified.

It is beholden on each member to uphold the Law of their individual Home Country. If is it perceived that this may be in direct conflict with the Minimum Standards of the Society of Chiropodists and Podiatrists, that individual member must seek advice from the Professional Body.

1. The Society of Chiropodists and Podiatrists has a commitment to review professional standards and guidelines on an annual basis. This document forms the context of the most recent professional guidance based on Department of Health and other Professional Bodies, which reflect on elements of Chiropodial/Podiatric clinical practice.
2. Changes in legislation and acceptable standards of practice in respect of this legislation are included in this document.
3. Members are advised that this document should be used in conjunction with The Society Guidance notes on Health and Safety at Work.
4. It is beholden on all State Registered Chiropodists to uphold these Minimum Standards of Clinical Practice. Failure to uphold Minimum Standards of Clinical Practice may have the potential to affect the outcome of any legal action against a practitioner, and may invalidate their Indemnity insurance. Issues of "good practice" have not been tested in a Court of Law, members are therefore advised that failure to uphold the Minimum Standards of Clinical Practice may lead to adversarial claims for which they may be personally liable. (Professional Code of Conduct May 2001).

GENERAL NOTE;

As stated, this Guidance has been produced in response to current legislation and issues relating to "best practice". Mandatory elements of the Guidance have been produced in an emboldened format to assist the Chiropodist/Podiatrist in identifying those areas, which**, are required by legislation and/or accepted codes of practice.** ** where text is underlined the Society recommends members pay particular attention in the absence of a legal precedent**.

It is beholden on the practitioner to carry out a risk assessment based on their clinical practice and the Society Guidance on Health and Safety at Work, to ensure compliance with safe practice.

They must also be aware of, and comply with, all Health and Safety Regulations, Department of Health Guidance, Fire regulations, and First Aid procedures, which may apply to premises outside their normal clinical area, in which they may also practice.

(NB. It should be noted that hereafter reference to The Society of Chiropodists and Podiatrists may be written in full, or as "The Society". Both terms of reference are interchangeable and do not detract from any statements made.

Where other bodies are identified, they will be stated in full in initial text reference with abbreviations identified for further identification.)

1.1 CLINICAL SKILLS

1. Chiropodists/Podiatrists who have qualified with the Society of Chiropodists and Podiatrists Diploma, or a degree which is recognised by the Society for the award of membership are also eligible for registration by the Health Professions Council 2002
2. The Society considers that its members have a professional and ethical obligation to provide a service to patients commensurate with this level of training and that members should undertake a commitment to continuing professional and clinical development.

GENERAL PRINCIPLES

1. The patient is acknowledged and respected as an individual.
2. The patient is provided with relevant written and verbal information.
3. Communication with carers, when involvement in the patient's management is considered appropriate, should respect the wishes of both patient and carer.
4. Communication with other chiropodists/podiatrists should ensure continuity of effective patient care and facilitate the use of available clinical expertise.
5. Chiropodists/Podiatrists, where appropriate, should work as members of the multi-disciplinary team caring for the patient
6. Communication links should exist between the practice and other members of the health care team involved in the care of the individual patient.
7. **Clear, accurate and up to date patient records should be maintained.**
   - Records must describe all elements of the consultation.
   - **Records must be maintained in accordance with accepted procedures and current legislation.**
   - The assessment process must provide sufficient information to formulate a treatment plan using a clinical reasoning process.
   - The practitioner must maintain written evidence of treatment plans and objectives.
8. Patients will be given information about the chiropodial/podiatric treatment proposed. The chiropody/podiatry practice shall have sufficient space, facilities and equipment to meet its professional and managerial needs and to ensure that staff and patients are provided with a comfortable and **safe** environment.
9. Treatment areas should offer privacy and comfort.

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1.2 SURGERY PREMISES

Room data sheets, giving full information on the minimum standards recommended for accommodation, can be found at Appendix 1. Guidance on the safety of electrical equipment can be found in Appendix 2.

Minimum Equipment List

The following is the minimum equipment considered by the Society to be required for safe practice:

1. **Sufficient lighting.**
2. Extra directional lighting/lamp. Preferably colour corrected.
3. **Hand washing facilities.**
4. **Sufficient ventilation**.
5. **Autoclave,** within easy access, and ultrasonic cleaner**.**
6. Cleaning equipment.
7. Provision of suitable instruments.
8. **Operator's chair**. (Recommendations on type included in Appendix 3.)
9. Drill - dust extracting.
10. Non - carpeted floors, preferably with splashback, skirtings and welded seams.
11. Operator's work unit, or trolley with suitable surface for decontamination.
12. Patient's chair with adjustable height and leg rests, with a collapsable back.
13. **Appropriate storage facilities as required by health and safety regulations**.
14. **First aid kit.**
15. **Waste collection and disposal facilities to include sharps disposal**.
16. Telephone or emergency call system.

Additional advice on types of equipment where recommendations on design are applicable has been included in Appendix 3.

For general guidance on Safety and the Practice Environment see Appendix 3a.

1.3 STORAGE OF DRUGS

The purpose of this statement is to ensure that **all drugs are kept in the approved manner**. These precautions should also be followed for the storage of needles and syringes.

1. **All flammable products must be stored in a metal cupboard, separate from other drugs and dressings.**
2. **All drugs, needles and syringes must be stored in a locked cupboard**.
3. **All medical gases are stored in accordance with Health and Safety regulations.** Refer to the Society Guidance on Health and Safety.
4. **COSHH regulations apply**. (A sample COSHH assessment is included in Appendix 4).

First Aid

There are no mandatory items which must be included in a first aid box. A **risk assessment** should be carried out on premises and the workplace to identify potential risks. The Health and Safety Executive (HSE) have issued a recommended list of contents. Where no special risks have been identified from a risk assessment, a minimum stock of suggested items for a first aid box is outlined in Appendix 5.

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2.0 PATIENT

Patient Privacy

The purpose of this section is to ensure that individual patient privacy and dignity is respected.

1. Practitioners must acknowledge, social, cultural, religious, and gender issues, relevant to their patient. It may be necessary, in certain circumstances, to ensure that a chaperone is present during any examination, and or treatment.
2. All patients attending for treatment must be afforded the maximum privacy possible within the clinical environment, whilst dressing or undressing. Auditory and visual privacy from third parties should be afforded to all patients, wherever possible.

Safety

The purpose of this statement is to reinforce the responsibility of individual practitioners to ensure the health, safety and welfare of their patient is assured at all times.

1. Comprehensive guidance is set out in the Society's Guidance notes on Health and Safety at Work. The Society considers it is essential that practitioners undertake regular updating in resuscitative techniques. An annual update on resuscitative procedures is strongly recommended, supported by documentary evidence of participation. It is also recommended that individual members acknowledge any requirements and developments relating to CPD on this issue.

2. A telephone must be available to summon assistance in the event of a clinical emergency.

3. **All human tissue, whether infected or not, and all related swabs and dressings, soiled surgical dressings, swabs and other soiled waste from treatment areas are classified by the HSE as Group A Waste**. These should be placed in yellow waste sacks for incineration. Clinical waste generated by practitioners should not be disposed of through the domestic waste system.

Refer to the section on disposal of clinical waste for specific guidance.

2.1 CONFIDENTIALITY

The purpose of this statement is to maintain the confidentiality of all information relating to patients.

1. **All patient records, to include paper and electronic format are subject to the regulation of the Data Protection Act 1998. (The Information Commissioner, previously known as the Data Protection Registrar, advises that registration is a legal requirement where film or video recordings of patient assessment are retained).**
2. **All practitioners are advised, that if patient records are stored in an electronic format, the practitioner or practice, is required to comply with the notification requirements indicated by the Data Protection Act 1998. If an electronic system is used for patient management, or video and digital films of patients are retained, practitioners must register with the Information Commissioner, even if paper records are used. See Appendix 13.**
3. **"Paper records" must be stored in a locked area, which does not allow access by unauthorised persons**. It is recommended that metal storage facilities be used to minimise fire hazards and ensure safe storage of records in the event of a fire.
4. Practitioners must be aware of patients' rights of access to treatment records in accordance with the **Data Protection Act 1998** and the **Access to Medical Records Act 1990**, and should maintain records in an appropriate fashion. Judgmental statements of a personal nature should not be made.
5. Changes in patient medical and personal information should be recorded on their records at regular intervals. These changes should be dated and signed. (See Appendix 8).

Records

The purpose of this statement is to ensure that clear, accurate and up to date records are maintained.

1. The writing must be legible and in <u>black ink</u>**.** A record must be made at the time of treatment, and any subsequent corrections to the entry must be signed and dated.
2. A clear and logical format must be used. Where blank spaces appear, they should be scored through. All attendances and entries must be <u>dated</u> and <u>signed</u>. **It is a legal requirement that all patient records are retained for a period of eight (8) years after that patient's last appointment. Records relating to children and to young people must be kept until the patient's twenty-fifth birthday, or for eight years after the last entry, if that is longer.**

Wherever possible, practitioners should utilize systems that prevent records being altered after the event.

Abbreviations

The purpose of this statement is to identify a list of standard abbreviations that will be accepted for use within clinical records.

The Society maintains a list of clinical abbreviations, which it recognises when used within clinical records. No other abbreviations will be recognised unless the individual practice or department, maintains its own document list on which this abbreviation appears. Records of a complex nature should be written in longhand**.** A copy of accepted abbreviations are recorded in Appendix 6.

2.2 CONSENT

Informed consent for assessment/examination of any individual, should be obtained prior to commencing any treatment. The practitioner should explain the nature and purpose of any procedure, to include potential risks, alternative treatment regimes, and expected outcomes.

In November 2001, the Department of Health issued "Good Practice in Consent Implementation Guide: consent to examination or treatment". This guidance document supports all prior recommendations relating to consent for treatment identified within Minimum Standards of Clinical Practice. The guidance identifies 12 key points, which are recognized in the Four Home Countries, England, Northern Ireland, Scotland and Wales.

Whilst this guidance states it is rarely* a legal requirement for written consent for treatment**, it is recommended as " good practice"** that written consent is obtained for those procedures where the treatment or the procedure are complex, may involve significant risks, (the term "risk" to include any potential adverse outcome that may be described as a "side effect or complication"), or the procedure involve general or regional anaesthesia, or sedation.

The Society of Chiropodists and Podiatrists recommends that written consent be obtained where local anaesthesia is to be administered to carry out any clinical procedure, and where any other injectable substance may be an element of, or the treatment regime.

The Society of Chiropodists and Podiatrists recommends that all verbal advice and information provided to patients to inform any decision to agree or refuse to proceed with a treatment intervention, should be supported by written information. This is particularly important where treatment interventions may involve a negative outcome, adverse reaction, or may involve the individual in potential high cost treatment interventions.

It should be noted that where legal/disciplinary issues may be involved, The Society will use The Minimum Standards and "its" interpretation of the Minimum Standards of the practice and professional behaviour of those Members in Chiropodial/Podiatric practice, in any case brought against a Member of The Society of Chiropodists and Podiatrists. (Professional Code of Conduct 2001).

These are the minimum requirements for clinical practice..

*Refer to Appendix 7 for detailed information on consent and recommended guidance.

TREATMENT OF MINORS.

Children and their parents require informed and detailed information relating to any clinical procedure required for care before any decision to proceed with treatment. This process follows previous guidance outlined for all patient care.

Where children are competent* to give consent for themselves, you should seek consent directly from them. Consent may be deemed to be verbal, where it is recognised the child under the age of 16 understands the procedure and outcome. **The Society recommendation for written consent for those procedures previously identified, must be upheld.**

It is however good practice to involve a parent or guardian in the decision.

The Society of Chiropodists and Podiatrists recommends that no child under the age of 16 years, be assessed for clinical care in the absence of a parent or legal guardian.

Once children reach the age of 16, they are presumed in law to be competent to give consent for their own medical interventions. This means that in many respects they should be treated as adults – if a signature on a consent form is necessary, they can sign for themselves.

Where a child has learning disabilities, it must not be assumed that they are not competent to make their own decisions concerning care, where this information has been presented to them in a clear manner, and if they are supported through the process. If a child of 16 or 17 is not competent to take a particular decision, then a person with parental responsibility can take that decision for them, with the involvement of the child. **Once children reach the age of 18, no-one else can take decisions on their behalf.**

The Society recommends that NHS Trusts, PC/T's, Care Consortia, and other Specialist Departments involved in the care of those with Learning Disabilities and, or Mental Health problems, devise specific protocols and guidance for employees based on current Department of Health Guidance for Consent, and The Mental Health Act 1983 (under review).

*Refer to Appendix 7 for more detailed information on competence and the treatment of children.

Assessment

The purpose of this statement is to ensure that all patients attending for their initial appointment with a practitioner are subject to a primary assessment of their need.
A member shall perform an assessment for each patient seen in clinical practice and establish a management plan based on the assessment.

1. On initial attendance at a practice, the attending chiropodist/podiatrist should complete or confirm all clerical details on the Patient Record Card.
2. A clinical assessment must be made of the patient. Use may be made of the format shown in the Patient Assessment Protocol, (Appendix 8)
3. An initial assessment record should include pertinent information gathered from the patient's history and relevant clinical findings.
4. On completion of the assessment, a diagnosis should, wherever possible, be made of the presenting conditions, a treatment plan suggested, and possible outcomes agreed with the patient.
5. Required tests, referrals and/or consultations should be recorded.
6. All diagnostic indicators and past medical history must be identified in the clinical record, together with the treatment plan
7. It is recommended that regular re-assessment of treatment protocols and the patient's current medical status is carried out.
8. The patient record should be reviewed periodically and amended where there is a change in health status, with appropriate signature and date recorded.

2.3 MANAGEMENT

Treatment areas should provide privacy, security and comfort.
The condition, treatment plan, and prognosis shall be discussed with, and explained to the patient.

No member should:

- Treat or attempt to treat a problem or condition which the member recognises, or should have recognised, is beyond their experience, scope, or competence.
- Provide treatment, which they know, or should have known, would be harmful, or which is inappropriate to meet the needs of the patient.

Consultation with, and/or referral to another health professional, should be made when the patient's condition is beyond the member's scope of practice, or where the member deems the referral/consultation to be in the best interest of the patient.
A member shall take into account the personal and social circumstances of the patient before advising on treatment planning.
The treatment plan shall be reviewed periodically.

2.4 ADMINISTRATION OF INJECTABLE SUBSTANCES (INCLUDING LOCAL ANAESTHESIA)

It is recommended that a minimum of one registered practitioner be present, one who has the skills and clinical expertise appropriate for the procedure to be undertaken.
This is a recommendation for the minimum number of qualified personnel.
The presence of others, and their level of competence, is an issue for **risk assessment** relating to the nature of the procedure, and those risk factors affecting the patient.

A member will always administer an injectable substance for which they are trained, using a safe technique.

To achieve this the member should:

- Administer the injectable substance, only if they have gained a qualification to do so, this qualification being recognised by the Professional Body.
- Convey suitable and sufficient information to the patient, and obtain written consent before administering an injectable substance. (see Appendix 7).
- Be proficient in the procedures relating to clinical emergencies. The member must attend an update in CPR at intervals designated by the Professional Body.
- Ensure needles, syringes and substances to be injected are sterile, and not contaminated.
- Always follow criteria for safe Infection Control.
- Not discharge the patient from the clinic following administration of an injectable substance, until the patient and/or the member are convinced no adverse reactions or complications are likely to occur.
- In all cases where an injectable substance is administered, the dosage, quantity, site, effectiveness, and the presence or absence of adverse reactions, must be recorded in detail.
- The disposal of sharps, including needles, syringes and vials, must be in accordance with the Guidelines on Minimum Standards of Clinical Practice.
- Any emergency kit and oxygen supply where available, must be maintained in good order in the clinical suite.
- **If the emergency kit and/or oxygen supply is used, the chiropodist/podiatrist MUST be trained in its use, this training being certificated and updated on a regular basis.**

Where individual clinicians have access to oxygen for clinical emergencies, they must have undertaken appropriate training in recognition of the use of oxygen in clinical emergencies and its administration. They should also be able to demonstrate their participation in such training and regular refresher training.

(Adrenaline, (epynephrine), is not legally available for purchase by all practitioners. Those members who are employed by NHS Trusts, PCT's and Special Trusts, are generally protected by a Patient Group Directive.

The Society of Chiropodists and Podiatrists recommends that all members who administer injectable substances must be trained in Basic Life Support (BLS) and be able to demonstrate involvement in a recognised training programme.

Where available, possible and an employee obligation, members should participate in annual updates in BLS. (It should be noted that many, if not all NHS Trusts, PCT's etc. and Special Trusts require all clinical practitioners to participate in annual BLS update training).

July 2002

Recommendation accepted by SCP Council.

"In the light of the advice received from the Resuscitation Council (UK), the Advanced Life Support (ALS) course was not the most appropriate to meet the needs of podiatrists, and the Immediate Life Support (ILS) course has been launched to meet the needs of health care providers who could use more advanced skills than those provided by Basic Life Support (BLS) training.

SCP Council accepted that suitably trained podiatrists, (those who have completed an ILS course) can administer adrenaline in a life saving situation. (eg anaphylaxis). However, podiatrists cannot be legally supplied with adrenaline, but they may administer it in a life threatening clinical situation where they have received appropriate, recognised training in its use. Members must be able to demonstrate participation in such training and regular participation in refresher courses. Otherwise practitioners must resort to Basic Life Support (BLS) and a facility to summon the emergency services.

It is recommended, but not mandatory, that oxygen therapy is available and that the necessary training in its use has taken place.

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3.0 CONTROL OF CROSS INFECTION

Antiseptic Procedures

The purpose of this statement is to ensure that the risk of infection to a patient is reduced to a minimum.

1. Appropriate antiseptic procedures must be followed when preparing the patient for treatment, and post operatively.
2. Surgery staff must be thoroughly instructed in the handling and disposal of instruments and clinical waste, to avoid cross infection, injury from instruments, or injury from sterilising apparatus.
3. **It is essential that items sent for repair should be decontaminated where appropriate, or adequately decontaminated. If this is not possible, these items should be suitably labelled so that any potential risk is apparent.** If in any doubt of the correct procedure, it is recommended that practitioners contact the relevant supplier or agent, or their Infection Control Department for advice. (Refer to Society Guidelines 1998 and 2001).
4. The current interest in blood borne diseases should not obscure the fact that the prevention of cross infection via instruments or formites contaminated with other pathogens, demands strict and appropriately applied aseptic and antiseptic procedures.
5. It is recognised that not all chiropodial/podiatric procedures need to be carried out under aseptic conditions. However, **it is a requirement that all instruments are subjected to a decontamination process by the approved methods described below, prior to, and immediately following treatments.**
6. **The wearing of disposable gloves during treatment, should be related to a risk assessment.**
7. Where appropriate, chiropodists/podiatrists should wear a plastic apron, **and where suitable, and sufficient risk assessment demonstrates the need,** disposable gloves. In those cases where the **risk assessment** has demonstrated the likelihood of splashing of blood or other exudates may occur, the wearing of a suitable face mask and eye protection is advised.
8. All surfaces and equipment, which may come into contact with body fluids, should be protected by water repellent laminate or equivalent.
9. Cuts or abrasions on hands or other exposed parts of the body must be covered with waterproof dressings.
10. These guidelines should be used as minimum standards for the control of cross infection. It is essential that practitioners familiarise themselves with local guidelines, available from their local Infection Control Officer.

3.1 DECONTAMINATION OF SURGICAL INSTRUMENTS

N.B. Where numbers are identified in the text, refer to Appendix 16 for reference details.

All re-usable surgical equipment **must** be decontaminated to a high standard to minimise the risk of cross infection between patients. The Department of Health (DoH) issued a Controls Assurance Standard [1] for the decontamination of reusable medical devices – which sets out **minimum** standards for decontamination. That Standard is intended to apply to all those who use and reprocess reusable medical devices. Practitioners should have equipment and procedures that ensure all re-usable medical devices are properly decontaminated before use and that the risks associated with decontamination facilities and processes are adequately managed.

Members of the Society perform a wide variety of procedures. This guidance is intended for individual practitioners, practicing in the primary healthcare, private or commercial sectors. It sets out the Society's practical guidance on the decontamination process and the way that practitioners can comply with the Standard. It **does not** apply to podiatric surgery. Members who practice in the acute (secondary) care sector should be covered by the Trusts' overall decontamination policy document, which should embody the Controls Assurance Standard. However, the Society advises such members to check that the Trusts' decontamination policy **is** consistent with the Standard. The Trust's infection control team should be able to advise on this.

Decontamination is the combination of cleaning and either, or both, disinfection and sterilization that render a reusable medical device safe to handle or to re-use on another patient. Thorough cleaning is a prerequisite for disinfection and sterilization, as residual tissue and other deposits can protect infective organisms from destruction by the disinfectant or sterilant. Generally, manual cleaning is less consistent and effective than mechanical processes, which therefore, are preferred and recommended.
Sterilization **must** be carried out in a suitable steam sterilizer that has been maintained and validated to ensure it will sterilize effectively. (Disinfection may not reduce the level of microbial contamination to the same extent as sterilization.)

The DoH recommends that wherever possible, re-usable medical devices be reprocessed in centralised sterile services departments (SSDs) e.g. CSSD, TSSU, HSDU etc, which specialise in decontamination using validated equipment and can generally be relied upon to deliver sterilized products consistently. Where a SSD service is not easily obtainable, benchtop steam sterilizers can provide a convenient alternative. However, they **must** be maintained and tested in line with the guidance on maintenance, validation and periodic testing of benchtop steam sterilizers that has been issued by the MDA [2, 3, 4, 5]
The Society **requires** members to undertake steam sterilization as the method of sterilization within the decontamination process.

Guidance on decontamination

Decontamination is defined as the combination of processes that removes or destroys contamination and thereby prevents micro-organisms or other contaminants reaching a susceptible site in sufficient quantities to initiate infection or other harmful response. It comprises cleaning, disinfection and sterilization or, commonly in primary care, cleaning and sterilization. It is an essential process to make a re-usable medical device safe to handle or to re-use on another patient. Therefore **all** surgical instruments that are used in the clinical environment must be decontaminated **without exception**. It is unacceptable to decontaminate only instruments that come into direct patient contact. All instruments and instrument trays that have been taken into a treatment area **must** be decontaminated before being re-used.
All stages of the decontamination process should be in accordance with best practice, documented and controlled. The process should be reviewed periodically to ensure it continues to be effective, and the review should be documented. The person who has overall managerial responsibility for the organization/practice is responsible for all matters concerning decontamination of reusable medical devices.

Devices designated for single-use must not be re-used under any circumstances [7,8].

Used devices should be decontaminated immediately after use, or as soon as is reasonably practicable, to minimise the growth of micro-organisms on them, and minimise the risk of cross infection. Any that cannot be cleaned immediately should be immersed in cold water to prevent coagulation when contamination dries. Use of hot water, or disinfectant can also cause protein coagulation. Coagulated protein is difficult to remove and may impede effective decontamination of the device. The practicability of decontaminating a medical device is determined by its design, and the problems of decontaminating the device therefore should be considered at the acquisition stage.

Acquisition of Surgical Instruments

Organisations / members should have a written policy for the acquisition of devices. This should help to ensure the devices are fit for the intended purpose, are compatible with existing equipment and can be decontaminated using processes that are available within the practice/organisation. Practitioners should review their instruments and replace any they would have difficulty adequately decontaminating.

Storage and transportation of used devices

If used instruments have to be stored prior to decontamination, (e.g. after domiciliary visits and before returning to base) they should be stored wet to prevent coagulation of proteinaceous deposits, and in an area that is accessible only to authorised people (i.e. staff). The instruments should be packed securely so as to minimise the possibility of contact with anyone in the event of a road traffic accident. The normal small instrument containers commonly in use are sufficient for this practice. The instruments should be

stored for as little time as possible after use to minimise the growth of micro-organisms on them, and minimise the risk of cross infection.

Cleaning

Cleaning is a process that physically removes contamination but does not necessarily destroy micro-organisms. Thorough cleaning is an essential pre-requisite to ensure effective disinfection and/or sterilization because the presence of organic matter and other deposits on medical devices can protect infective organisms from inactivation by the disinfectant or sterilant.
Mechanical cleaning processes are preferred and recommended as the minimum standards of clinical practice by the Society because, generally, they are more effective and consistent than manual cleaning. They also reduce handling by staff carrying out the reprocessing, thereby reducing the potential for injury and risk of infection from contaminated devices.

Devices **must** be inspected to ensure they are clean, before they are put in the sterilizer**.**

Mechanical cleaning

Benchtop washer - disinfectors provide automated, pre-programmed cycles that can be validated. They are becoming available at an economical price, and have the advantage of providing disinfected devices, which minimises the infection risk to staff prior to sterilization of the devices.

Ultrasonic cleaning baths are available in a wide range of sizes and can provide a convenient and effective method for cleaning small numbers of instruments. Before instruments are processed in an ultrasonic bath, gross soiling should first be removed in cool water (below 35^{o} C). The liquid in the bath should be changed frequently but after filling, or replenishing the bath, it should be operated for a few minutes to de-aerate the solution. If this is not done, air bubbles may form on the devices being processed, and impair the effectiveness of the process. Detergents and other chemicals should be those specified by the manufacturer of the mechanical cleaner or specified in local guidance/policy documents.
The effectiveness of mechanical cleaning equipment requires it to be maintained, validated and tested periodically. That work should be carried out by competent, qualified people that the manufacturer or a competent contractor should be able to provide.

Manual cleaning

Manual cleaning of items should only be undertaken when other mechanical methods are inappropriate or unavailable [6]. To minimise the risk to personnel undertaking manual cleaning, splashing and the creation of aerosols **must** be avoided at all times. Appropriate facilities should be available and protective equipment should be worn at all stages of the manual cleaning process.
Facilities

Practitioners should, where practicable, have a segregated area / room for decontaminating equipment, which is accessible only by trained staff, and have a documented flow system as described below. That should minimise the risk of contamination to other staff and patients etc and minimise the risk of re-contaminating equipment that has been decontaminated.

The area to be used for manual cleaning should, where reasonably practicable, be dedicated for the purpose and not shared with other activities. It should be equipped with:

- A dedicated sink (not a wash hand-basin), or other suitably sized receptacle which is used solely for manually cleaning devices,

- A second sink (not hand wash basin) or other suitably sized receptacle for rinsing devices,

- A drainage surface.

Equipment

- Personal Protective Equipment for staff undertaking manual cleaning e.g. gloves, eye protection, face masks, waterproof aprons. A first aid kit and eye wash bottle should also be available nearby in case of sharps injuries or splashing into eyes.

- Detergents specified by the device manufacturers (enzymic detergent can be advantageous).

- Cleaning materials recommended by the device manufacturers e.g. brushes/cloths etc, which are single use or are routinely decontaminated as specified in a documented local policy.

- A clean, disposable, absorbent, non-shedding clothe for hand-drying items, or a mechanical drying facility (e.g. a drying cabinet).

Immersion Method

Check that it is safe to immerse the device.

a) Fill the clean sink or receptacle with water below 35ºC. Wearing protective clothing, dismantle or open the instrument to be cleaned (where appropriate) and remove gross soiling by brushing, wiping, agitating and irrigating the item while it is submerged, taking care to ensure it remains under the surface of the water at all times to prevent the creation of aerosols. Remove the item, drain it and then rinse it by submerging, and agitating, it in clean water in the second sink.
b) Clean the first sink or receptacle and refill with water and detergent at the dilution, and if possible at the temperature specified by the detergent manufacturer and/or local

documented policy/procedures. It is important to use detergents as close as possible to the temperature recommended for maximum efficiency. Enzymic detergents can be inactivated if the solution is too hot.

c) Fully immerse the item in the solution in order to displace trapped air and to ensure contact with all surfaces of the item being cleaned.

d) Brush, wipe, agitate, irrigate, the item to dislodge and remove all remaining visible soil, again taking care to ensure the item remains under the surface of the water at all times to prevent the creation of aerosols.

d) Remove the item from the sink and drain any excess detergent before rinsing it thoroughly by submersion and agitation in clean water in the second sink.

f) Remove and drain the item ensuring it is not re-contaminated.

g) Dry using the preferred method.

h) Complete any necessary documentation to record the item being processed and the method and solutions employed.

If either the cleaning solution or the rinse water becomes obviously soiled or contaminated, it should be changed and the process repeated.

Non-immersion manual cleaning should be used where items, e.g. electrical and electronic equipment, may be compromised by submersion in aqueous solutions. All items should be cleaned strictly in accordance with manufacturer's instruction.

Sterilization

All podiatric instruments **must** be steam sterilized after cleaning. The recommended cycle is 134 - 137°C for a minimum holding time of 3 minutes but cycles with other time-temperature relationships are permissible. Gravity displacement (i.e. non-vacuum, or traditional) benchtop sterilizers (Little Sister® types) from which air is passively displaced by steam are suitable, but only for processing devices that are **not** wrapped and are **not** hollow (e.g. cannulated items) [2, 3, 4, 5].

Guidance on the purchase of benchtop sterilizers is available from the SCP and in MDA bulletins DB9605[2] and DB2000 (05) [4], which are currently being revised and amalgamated into a single document DB2002 (06) [5].

If devices are wrapped (including pouches) they cannot be sterilized reliably in a gravity displacement sterilizer. Wrapped devices **must** be sterilized only in a sterilizer that has an effective vacuum air-removal stage, and which has been validated for the intended load.

For podiatric surgery, instruments should be sterile at the point of use, and the instruments for such procedures should be obtained from a SSD whenever possible or alternatively be sterilized immediately before use.

The effectiveness of sterilization depends on sterilizing conditions being achieved consistently. It is dependent on the application of quality assurance principles, which require the sterilizer to be maintained, validated and tested periodically. Information on the testing and validation of benchtop steam sterilizers has been published by DoH [2, 4 13].

The water in a benchtop steam sterilizer should be changed as frequently as practicable. The minimum standards of clinical practice **require** sterile water for irrigation. Instruments once sterilized, should be used immediately or within a maximum time period of 3 hours after sterilization.

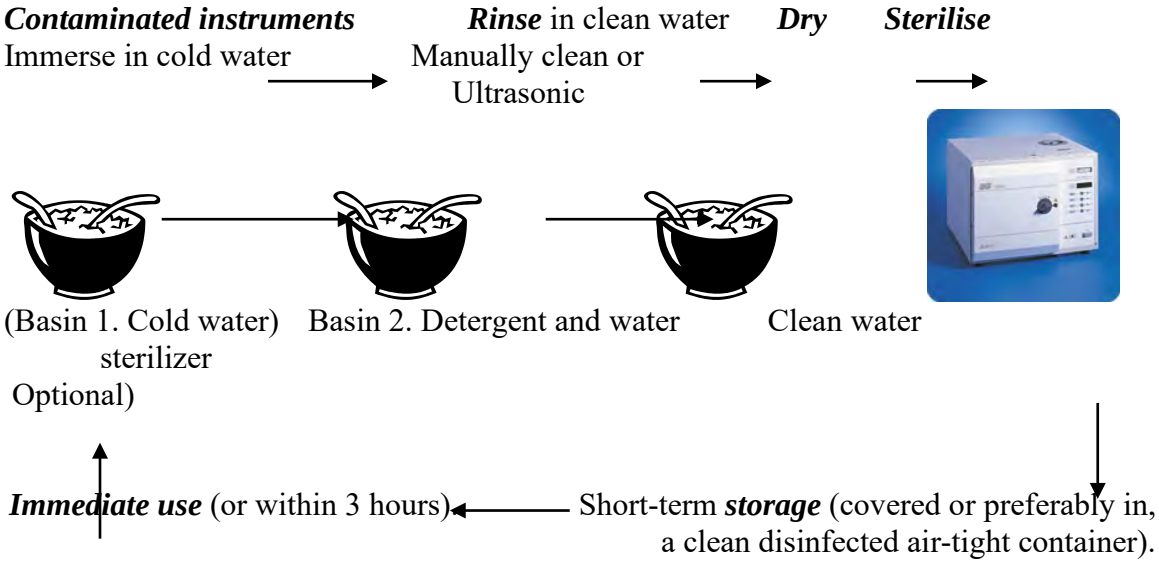
Inspection of instruments.

Inspection of instruments is important to ensure they remain within specification and will operate safely and effectively. That inspection should be carried out during the decontamination process – preferably after sterilization to minimise the risks of infection from sharps injuries, and also to check whether damage or deterioration (e.g. stiff joints on nippers etc) has occurred during sterilization. It is the responsibility of the practitioner to carry out the inspection and confirm the instruments are fit for use.

Prevention of re-contamination

It is important to segregate used devices from those that have been reprocessed, to prevent cross infection. This is most easily achieved in primary care by having a flow system (see diagram below) that gives the maximum easily achievable physical separation between the contaminated and sterilized devices. Great care should be taken to prevent recontamination of the sterilized devices e.g. through transfer via contaminated gloves during manual handling. Sterilized devices should only be moved with sterilized forceps that are used solely for that purpose.

Flow diagram of decontamination process.



Storage, packing and transport.

If the devices are to be stored after decontamination, the areas designated for storage and distribution should afford adequate protection and environmental conditions that prevent deterioration and contamination of the product i.e. it should be clean, dry, well ventilated and secure.
Instruments processed in a benchtop non-vacuum autoclave must not be wrapped (because they might not be sterilized) and should be used as soon as possible within a 3 hour period. They may be stored in a clean, disinfected, dry, airtight container but should be used within 3 hours, and must be used on the day they were sterilized.
Where devices are to be transported outside of the clinical unit (e.g. on domiciliary visits) it is essential to pack them so as to prevent damage to delicate surgical instruments, and to prevent contamination, during transit. Placing instruments in sterilization bags **after sterilization** should provide protection both against physical damage and recontamination.

Traceability

Where reasonably practicable there should be a system that enables sets of surgical instruments to be traced after use on a patient, through the decontamination processes, storage, distribution, to their use on the next patient. This is important and is relevant to both the primary and secondary care sectors, so that relevant patients can be identified in the event of exposure to a potential infection risk. Traceability systems are now available that should enable practitioners to trace instruments sets, but at present it is not possible to trace most individual instruments, as they do not normally carry unique markings.

NOTE: practitioners should not mark instruments because that could make them more difficult to clean, and might lead to mechanical failure.]

3.2 GLOVED TECHNIQUE

The purpose of this statement is to help minimise the risk of cross infection between practitioner and patient.

1. If, after a suitable and sufficient **risk assessment** has demonstrated the need, it is recommended that treatments involving non-sterile technique should be carried out wearing disposable gloves. The **risk assessment** must include the assessment of risk to the practitioner of the material of which the glove is made. In the event of a glove being punctured it must be replaced. **Gloves should not be worn for more than one patient.**
2. All aseptic and sterile procedures should be carried out using sterile single use disposable gloves. **These must only be used for single procedures**.

Refer to Appendix 9 for guidance on the use of gloves and Appendix 9a for risk assessment.

Scalpel Blades

The purpose of this statement is to ensure that the patient and operator are safeguarded from cross infection from blades.

1. **A sterile scalpel blade is a single use device.**
2. Each treatment requiring the use of a scalpel will require the use of a sterile blade.
3. All used blades will be contaminated and should be removed from the scalpel handle by means of an appropriate blade remover to avoid injury to the operator and patient, and be placed in a suitable container for disposal in the approved manner.
4. It is recommended that a sterile blade is not fixed to a scalpel handle until, or unless required as part of the treatment regime

Refer to Section 3.4 on disposal of sharps.

3.3 DISPOSAL OF CLINICAL WASTE

The purpose of this statement is to ensure that all waste identified as clinical waste under the **Controlled Waste Regulations 1992**, is disposed of in a **safe and appropriate** manner in compliance with the Regulation. All human tissue, including blood (whether infected or not), and all related swabs and dressings, soiled surgical dressings, swabs and other soiled waste from treatment areas are defined as Group A clinical waste, and must be disposed of following the **Health and Safety at Work Act 1974, (HSWA)** and **COSHH Regulations 1999.** See Appendix 10 for classifications of clinical waste.

1. It is the responsibility of the practitioner to ensure that all clinical waste is collected separately from domestic waste for **safe** and suitable disposal by an approved contractor.
2. **The clinical waste must be placed in an appropriate container as specified by the Health and Safety Commission.**
3. All receptacles for clinical waste must be disposed of when no more than ¾ full.
4. A new receptacle must be used for each working day.
5. Practitioners are advised, where appropriate, to select a suitably sized receptacle for their daily clinical practice.

Disposal of Domiciliary Waste

Clinical waste generated in a patient's own home as a result of treatment by practitioners or their employees should be dealt with by the person providing the service or treatment. Employers of podiatrists and private practitioners have a duty to ensure that clinical waste generated as a result of their treatment of a patient or treatment by their employees is disposed of safely. Employers also have a duty under the HSWA and Environmental Protection Act (EPA) to ensure safe and proper disposal. Employers' policies should have clear detailed arrangements for this disposal. Disposal should be via the employers' normal own systems, or by special arrangement with the local collection authority. Clinical waste collected in this way should not enter the domestic waste system.

Where it is the policy of a Trust, or where the clinician has conducted a suitable and sufficient risk assessment, and where the clinical waste produced by the practitioner is of a small amount and is not infected, (small amount is defined as the amount that a patient would normally produce themselves), then the waste may be disposed of through the household waste system. Where the clinician's assessment deems the waste to be infected (or possibly infected) then that waste generated **must** be disposed of in a safe manner, which is by disposal through a clinical waste system. That disposal can either be by safe removal in a yellow bag by the clinician from the patient's premises, contained in a suitable leak proof container, and returned for disposal to a central disposal area, or by collection by the Trust, or by arrangement with a local authority. The clinicians assessment of risk cannot be overridden by the Trust or an employer, unless the employer has conducted a suitable and sufficient risk assessment for each and every situation at the time of treatment.

Suitable leak proof containers should be provided with tight fitting lids for transporting the waste from the home to a suitable storage area. Lockable containers **may** be needed.

3.4 DISPOSAL OF SHARPS

The purpose of this statement is to ensure that all used sharps (needles, blades etc.) **are disposed of in the appropriate manner in accordance with Health and Safety Regulations.**

1. It is the responsibility of the employer and/or practitioner, to ensure that safe systems of work for handling sharps/scalpel blades is adhered to by all employees.
2. It is the responsibility of the employer/practitioner to ensure that all blades are removed from instruments by use of a suitable blade remover device.
3. The removed sharps must be placed in an **appropriate, marked sharps container which conforms to BS7320. This container must be stored in a safe place and disposed of, when no more than three quarters full, using an approved contractor.**
4. **Needles and disposable syringes are single use devices and should be used accordingly.**
5. It is recommended that contaminated needles are not removed from disposable syringes. **The syringe with needle should be disposed of in an appropriate sharps container.** Where dental style syringes are used, an appropriate needle guard system should be used.
6. Practitioners must be able to demonstrate evidence of **approved disposal methods** as identified in the Society of Chiropodist and Podiatrists "Guidelines on Health and Safety at Work".

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4.0 NAIL AND CUTANEOUS SOFT TISSUE SURGERY

The member should make every effort to ensure a satisfactory post-operative result, and reduce the risk of complications.

1. The operating environment must be prepared in accordance with best practice Infection Control standards.
2. Clean equipment and sterile instruments must be used.
3. An appropriate pre-operative assessment must be performed prior to surgery.
4. Patients must be informed of the purpose and nature of the treatment, and the risks involved, in such a way as to be able to decide to undergo the recommended surgery.
5. All surgical fees should be discussed, recorded, and fully explained to the patient prior to the surgery. Any related services requiring an additional fee should be listed, and any time limit on inclusive post –operative visits should be stated.
6. The patient should be given a post-operative instruction sheet, which must be reviewed verbally to avoid any misinterpretation.
7. The information sheet should provide details of 24 hour contact numbers for help and assistance.
8. The member must have the education and experience relative to the procedure being performed.

5.0 RADIATION HAZARDS

Practitioners using equipment emitting ionising radiation, must ensure that they are certificated under the current (1999/2000) Ionising Radiation Regulations, **and that their equipment and premises comply with current regulations.** All practitioners using such equipment, should ensure that all ancillary staff are **fully conversant with safety procedures** while the equipment is in use. See Appendix 15.

The National Radiological Protection Board provides, for a fee, model rules, which can be completed by a practice as appropriate, and advice on safe use of such equipment. Further information can be obtained from The National Radiological Protection Board.

Refer to any relevant guidance produced by the Faculty of Podiatric Surgery/ College of Podiatrists.

6.0 USE OF LASERS

Regulations covering the medical and surgical use of lasers came into effect on October 1st 1984. From that date, in order to provide a safeguard for the public, the range of premises which have to be registered with Health Trusts/ Boards, under the above Act, includes, clinic, consulting rooms and other places where Class 3B and Class 4 lasers are used for medical and surgical purposes. Details of usage of lasers and their classification are covered in Appendix 11.

Further guidelines on the use of lasers can be found in the Society of Chiropodists and Podiatrists Guidelines on Health and Safety at Work.

SURGERY

Guidance on standards specific to podiatric surgery may be obtained from the Faculty of Podiatric Surgery.

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7.0 PRESCRIPTION OF ORTHOTIC DEVICES

The purpose of this statement is to ensure that comprehensive, detailed information is included in the prescription format, to ensure that the appropriate orthotic device is manufactured for the patient, and to the practitioner's requirements.

1. All prescriptions must include detailed and clear information required by the manufacturer, to ensure suitability and accuracy of the completed orthotic device.
2. The dates of casting, measurement, manufacture, and issue of any orthotic device must be recorded in the patient treatment record.
3. A copy of the completed prescription form must be attached to the patient treatment record.
4. The prescription must include clear and detailed information, to include;
    - assessment and diagnosis
    - prognosis
    - description of required device
    - specification of materials and method of manufacture
    - evaluation of outcome

MANUFACTURE OF ORTHOTIC DEVICES

The purpose of this statement is to ensure compliance with current legislation and directives, and to ensure safe working practice and correct use of equipment and appropriate materials, for the manufacture of all orthotic devices.

1. **Individual practitioners who may manufacture, or make up orthotic devices must be aware of, and comply with, current legislation and EC Directives**. Refer to the Society Statement on C E marking, Appendix 12.
2. Practitioners who use external manufacturing agencies and suppliers, must ensure that these agencies are working in accordance with current legislation and EC Directives.

PREMISES USED FOR THE MANUFACTURE OF ORTHOTIC DEVICES

The purpose of this procedure is to ensure safe working practices and storage of materials in relation to **COSHH legislation** and **Health and Safety at Work legislation**. (See Appendix 1). Further guidance can be found in the Society Guidance on Health and Safety, Health and Safety in Laboratories (Orthoses) Podiatry.

All personnel involved in the manufacture and production of orthotic devices must **receive appropriate and adequate training in the safe use of each piece of equipment** and materials used in the manufacturing process.

APPENDICES

1. Accommodation Standards.
2. Guidance on Safety of Electrical Equipment.
3. Ergonomics and Equipment.

3a Safety and Practice Environment

4. COSHH Assessment format.
5. First Aid.
6. Clinical Abbreviations.
7. Consent for Treatment.
8. Patient Assessment Protocol.
9. Guidance on the Use of Gloves / Risk Assessment.
10. Categories of Clinical Waste.
11. Lasers and Classification.
12. Society Statement on C E Marking.
13. Data Protection Act 1998
14. Decontamination Procedures
15. Radiation Hazards
16. Decontamination quality assurance checklist

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Clinical Standards

Standard 1
Patient Confidentiality

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 1 - Patient Confidentiality

Where patients entrust you with sensitive information relating to their health, and other matters, as part of their treatment, they do so in confidence. It is essential that this confidence is maintained; save in limited circumstances information provided should not be disclosed in a form that might identify the patient without his or her consent. This Standard should be read in conjunction with Standard 2 – Consent, Standard 5 - Record Keeping and the HCPC's guidance on confidentiality.

It is important that patients are informed that in order to receive the continuity and quality of care that they would expect to receive, and to comply with professional obligations, the information that they give will be recorded. You should also inform them that the information may be shared with other members of the healthcare team involved in their care, which on occasions may include other healthcare professionals. A written record of discussions should be kept in the patient records. Due to the General Data Protection Regulations 2018 (GDPR) all practices are required to provide information to patients about the way in which their personal data will be processed. This should be provided in the form of a Privacy Notice. The ICO's website provides helpful guidance on what must be included in such a notice and the College also has a section on their website including a template Privacy Notice: **https://membersarea.cop.org.uk/podiatric-practice/private-practice-resources-area/gdpr**

Sharing information with others

Patients need to be made aware that they have the right to object to the sharing of information with other members of the healthcare team i.e. another podiatrist, GP, physiotherapist.

Whenever disclosing information, for example when writing to a colleague, you should let the patient know what is happening and that information will be disclosed, for example 'I am writing to your General Practitioner to let them know that you have peripheral neuropathy as a result of your diabetes'. When seeking express consent for disclosure, you must make sure that the patient is

given enough information on which to base their decision. They will need to know the reasons for the disclosure and the likely consequences of the disclosure. You should explain how much information will be disclosed and to whom it will be given.

It is important to be transparent so that the patient has an opportunity to raise any objections and will not be taken by surprise. This will help to avoid complaints. This discussion and outcome should be documented in the patients notes.

Where patients are unable to give consent

Where a patient is unable to give consent because they lack capacity to consent, then information should only be disclosed if it is in the patient's best interest and then only as much information as is needed to support their care. Each situation needs to be judged on its merits and great care taken to avoid breaching confidentiality or creating difficulties for the patient. Decisions to disclose, and the justification for disclosure, should be recorded in the patient's notes. You may need to take into account previously expressed wishes and be informed by the views of relatives or carers as to the likely wishes of the patient. Members should be aware of their obligations under the Mental Capacity Act 2005 (updated 2007). For those practising in Scotland, members should be aware of the provisions contained within the Adults with Incapacity (Scotland) Act 2000(see separate College guidance on Mental Capacity in Scotland 2019) and for those in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016.

If a patient objects to a disclosure

Where a patient objects to information being shared with other health professionals involved in their care, you should explain how disclosure would benefit the continuity and quality of care. If their decision has implications for the proposed treatment, it will be necessary to inform the patient of this. Ultimately, if they refuse you must respect their decision, even if it means that for reasons of safety you must limit your treatment options. You should record their decision along with details of your discussions within their clinical notes.

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Disclosure in the public interest

In exceptional circumstances it may be in the public interest to disclose information received in confidence without consent. For example, information about a serious crime. It is important that confidentiality should only be broken in this way in exceptional circumstances and then only after careful consideration so that you can justify your actions and the possible harm to the patient if you did not disclose the information. Theft, fraud or damage to property would generally not warrant a breach of confidence.

Children and Vulnerable Adults

Where there is a concern around a child or vulnerable adult, you must act at all times in accordance with national and local policies, see Standard 3 Safeguarding Children and Vulnerable Adults.

Keeping patient information physically and electronically secure

Patients have the right to expect that information about them will be kept secure and protected from unauthorised access. It is therefore important to ensure that the storage and movement of records within the healthcare setting does not put the confidentiality of patient information at risk.

The following principles should be adhered to for patient records on paper:

- in clinic all patient records, with the exception of those of the patient being seen, should be positioned so that no one can read them or access them;
- patient records should be returned to the filing system as soon as possible after use;
- patient records should be stored securely within a lockable filing cabinet within the clinic or offices; and
- the filing cabinet should be locked and secured when not in use.

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So far as computer held patient records are concerned the following principles should also be adhered to:

- Your computer/electronic device that holds patient information/records needs to be password protected to enter the computer itself.
- The program/system that you are using to store patient data also needs to be password protected.
- always log-out of any computer system when work on it is finished;
- do not leave a monitor unattended and logged-in;
- do not share logins and passwords with other people. If other people need to access records, then appropriate access should be organised for them;
- avoid using short or familiar passwords;
- passwords should never be written down; and
- use a password-protected screen-saver to prevent casual viewing of patient information by others.

For further information please visit the ICO website and download their 'A Practical Guide to IT security – Ideal for the small business'.
https://ico.org.uk/media/for-organisations/documents/1575/it_security_practical_guide.pdf

When undertaking domiciliary visits it is important that patient records are not left on view therefore they should be placed in the boot ideally in a lockable box. Only the patient's record(s) which are needed should be taken into a patient's home. Notes should never be left in the car overnight. Please see Standard 12 – Domiciliary Podiatry Care.

Discussing cases in public

Many improper disclosures are often unintentional. You should not discuss patients where you can be overheard. It may at times be pertinent to discuss cases with colleagues for professional reasons (to gain advice, share experience and knowledge, or clinical supervision) but care must be taken to

ensure that others do not overhear these conversations. Generally, in these situations there is no need to name the patient concerned – so don't, just in case you are being overheard.

Staff and Students

The contracts of all employees and associates, even those who arenot directly involved with patients, but who have access to or handle clinical records should contain clauses that emphasise the principles of confidentiality and state that disciplinary action could result if these principles are not met.

If students, as part of their clinical placement have access to confidential information about patients, it is important that they are informed of the importance of confidentiality during their induction. Any breaches of confidentiality by a student should be brought to the attention of their placement supervisors who should report the incident to the Head of School.

Clinical Audit

Access to clinical notes may be necessary for clinical audit, however where any data is collected it should be made anonymous at the earliest opportunity so as to reduce the risks of inappropriate disclosure and to protect patient confidentiality. Although patients may be supportive of clinical audit they may not always be aware that this may mean someone having access to their notes. Due to this you may wish to explain about clinical audit within your Privacy Notice.

Disclosure in connection with litigation

You must not disclose information to a solicitor or officer of a court without the patient's express consent or an appropriate court order. For further information see Standard 5 – Record Keeping.

Disclosure to a Statutory Body

If you are referring concerns about a previous treatment to a statutory body, for example the Health and Care Professions Council, you must seek the patient's consent before disclosing identifiable

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information. If this is not practicable then you should contact the regulatory body, which will advise you on whether the disclosure is justified in the public interest or for the protection of other patients. If you are contacted by the HCPC please contact the Professional Support Officers immediately for advice **professionalsupport@cop.org.uk.**

Disclosure to the Police

The police have no automatic right of access to health records. An obligation to disclose records to the police will arise when the police have obtained a court order for disclosure. In the absence of such an order the controller may have a discretion to disclose the records voluntarily in the public interest. However, before making a voluntary disclosure the controller should give the matter careful consideration and seek appropriate advice. The police should provide you with sufficient information about the nature of the matter which they are investigating to allow you to make a reasoned decision.

In the absence of a specific requirement there must be either explicit patient consent or a robust public interest justification for disclosure. Ultimately, the Courts decide what is or isn't in the public interest.

However, if a podiatrist has been threatened or attacked in some way by a patient and feels they need to report this to the police then they may disclose the name and address of the patient where necessary to seek legal advice or report the matter to the police, but the patients' medical condition should not be disclosed.

Disclosure to the Inland Revenue

The Inland Revenue do not have automatic rights to access patient records. However, if you record financial information in the patient records it renders them a financial document which they do have the right to access. However, the patient's confidentiality also should not be over ridden putting practitioners in an awkward situation. Therefore, you MUST NOT record financial information within patients records. See Standard 5 – Record Keeping.

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When disclosing information

You must make sure that anyone to whom you disclose personal information understands that it is given to them in confidence, which they must respect.

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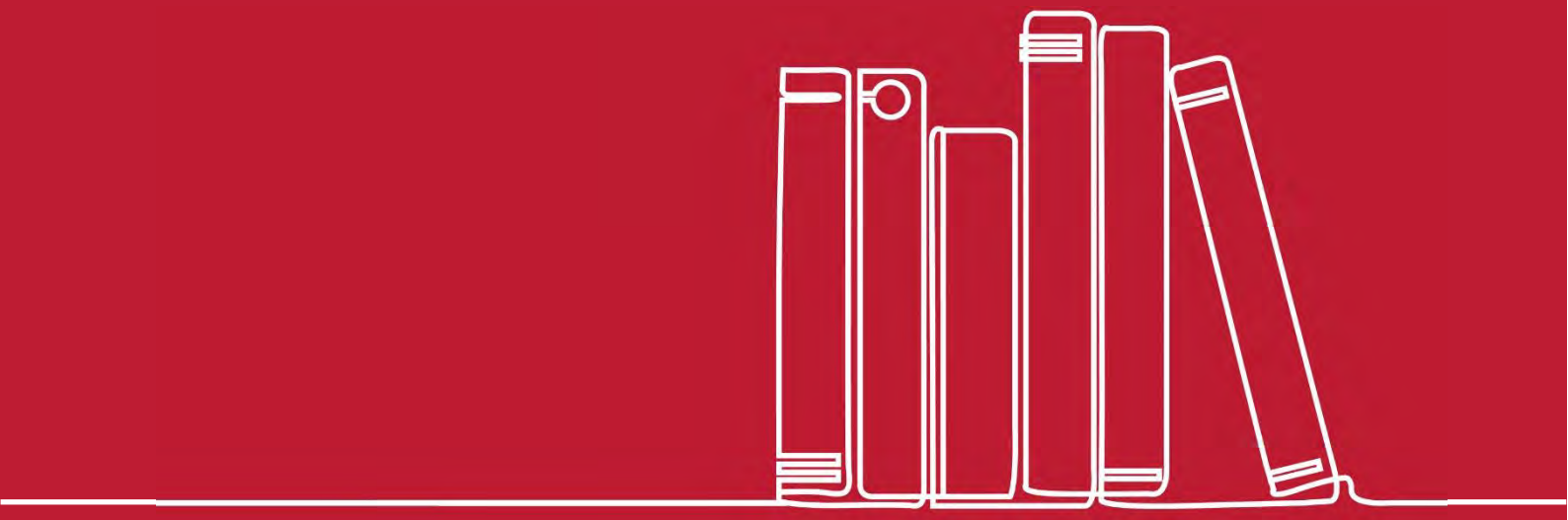
Clinical Standards



Standard 2
Patient Consent

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 2 - Patient Consent

Consent is at the heart of the relationship of trust between patient and practitioner. Before embarking on any examination or treatment, you must be satisfied that your patient, or somebody with authority to do so on their behalf, has given their valid consent to the procedure you are about to undertake.

In this guidance, aimed at podiatrists, chiropodists and assistant practitioners practicing in the UK, we summarise the key principles of consent in order that they can be incorporated into your day to day practice.

The law governing consent varies across the nations of the United Kingdom, particularly where issues of capacity are concerned. It is therefore important you understand how the law applies in the area where you work.

Key Points

- Podiatrists are legally, professionally and ethically obliged to obtain informed consent prior to examining patients or undertaking investigations or treatment.
- Signed consent should be obtained prior to initial treatment.
- Adults (aged 18 and over) are assumed to have capacity to consent.
- Young adults of 16 or 17 years of age can consent to treatment. Their entitlement to refuse treatment which is in their best interests is more complex.
- Persons aged 15 and younger can give consent to treatment in their best interests if they are 'Gillick competent' (see page 7).
- When the patient lacks capacity, or is not competent to consent, treatment can be provided in the patient's best interests subject to requirements detailed below.
- Consent will only be valid if it is informed and freely given by an individual who has capacity to consent.

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- Patients should receive the information they require to support their decision making in a format which is clear and easily understood.
- Patients must be given sufficient time to consider their decision before treatment is provided. The amount of time required will be proportionate to the significance of the decision to be made.
- Patients are free to withdraw their consent at any time.
- The consent process must be supported by clear, contemporaneous and accurate records which should include details of the information provided with respect to diagnosis, prognosis, treatment options (including no treatment), risks and benefits of the proposed treatment and the reasonable alternatives, concerns or questions raised by the patient and their reasons for choosing their preferred option.
- Even when informed consent was obtained a failure to maintain adequate details of the decision-making process will leave registrant's vulnerable if the validity of consent is challenged.
- A signed consent form is not proof of informed consent. It is one aspect of the recording of a patient's consent.
- A failure to obtain informed consent exposes practitioners to a real risk of criminal or civil liability and to a risk of action against their registration by the Health and Care Professions Council (HCPC) your regulatory body.

Introduction

The process of shared decision-making is about enabling patients to make choices which are right for them. People's attitudes vary on issues such as the amount of risk or pain they are prepared to accept so it is important that you provide information in a balanced and unbiased manner and without trying to influence the patient unduly. As clinicians we must recognise that different patients will make different choices in apparently similar situations. What is important is that patients are enabled to make the choice which best reflects their own goals and values.

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Clinicians should obtain informed consent before carrying out any examination, investigations or treatment. A failure to obtain a patient's consent before conducting an examination, undertaking investigations or carrying out treatment could lead to civil or criminal liability or to action being taken against you by the HCPC or the College's Conduct Committee.

The Professional Obligation

The HCPC Standards of Conduct, Performance and Ethics contains professional obligations to protect and promote the interests of service users; communicate appropriately and effectively and keep records of their work. Each of those professional obligations is engaged in the consideration of patient consent. Please see the HCPC website for further information:

http://www.hcpc-uk.co.uk/standards/standards-of-conduct-performance-and-ethics/

The Legal Obligation

Treating a patient without obtaining informed consent may lead to a civil claim for damages or criminal proceedings for assault or more serious criminal offences. At present the most authoritative statement of what the law of informed consent requires is contained in the Supreme Court judgment in the case of *Montgomery v Lanarkshire Health Board*.

The practitioner is under a duty to take reasonable care to ensure that the patient is aware of:

1. Any risks involved in any recommended treatment.
2. Any reasonable alternative or variant treatments.

A risk is when:

3. a reasonable person in the patient's position would be likely to attach significance to the risk; or
4. the practitioner is or should reasonably be aware that the particular patient would be likely to attach significance to it.

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Consent is also relevant to the use of personal data and/or confidential information, but those issues fall outside the scope of this document. Please see the College's Standards on Standard 1 - Confidentiality and Standard 5 - Record Keeping.

Consent at the initial consultation

Due to the litigious nature of health care today, it is strongly advised to obtain signed consent at the patient's first treatment when undertaking general Podiatry care. This could be alongside a medical questionnaire that is filled out by the patient (and checked by the Podiatrist), or this could be a separate consent form. This is so that the patient can confirm they understand they are to be treated by a Podiatrist who may use sharp instruments. This is on top of the express consent from the patient for each treatment described below.

The College has template consent forms available at:

https://membersarea.cop.org.uk/podiatric-practice/private-practice-resources-area/patient-resources

Types of Consent

Practitioners must obtain the patient's consent for any examination, investigations or treatment. Patients can give consent either verbally or in writing. Silence does not constitute consent. In the past many practitioners relied on the patient's actions as indicating their "implied consent" to treatment e.g. where a patient removed footwear to facilitate an examination. This approach risks misunderstandings going unnoticed. Having explained your intentions to the patient it is a simple matter to ask whether they have understood and to confirm their agreement. This must be recorded in the patient notes. Reliance on implied consent must be avoided.

Whether consent is obtained verbally or in writing, you must maintain a written record of when and how consent was obtained in the patient notes.

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Recording Consent

A record of relevant discussions in respect of diagnosis, options, risks and benefits, must be included in the clinical record in respect of all examinations, investigations, treatments. Any questions or concerns which the patient has expressed should be recorded in the patient record. When patients choose between alternatives you should explore the reasons for their choice and record them.

A signed consent form is only one part of the overall evidence that informed consent has been obtained. It is not a substitute for an appropriate entry in the clinical record. Courts are alert to the possibility that patients may sign forms without reading or understanding them.

Where procedures are invasive and/or carry significant risks patients must be asked to sign a consent form. This includes the following:

- All invasive procedures
- Any treatment requiring local anaesthesia
- Any treatments involving caustics, cryotherapy, dry needling and alternative therapies or treatments which use substances that a patient may have a reaction to.
- All verrucae treatments
- All injections of medicines
- Acupuncture
- Where a student, or someone in training situation is to undertake the procedure
- A procedure which may cause particular pain, discomfort or bleeding e.g. the enucleation of a large and very deep corn.

Special considerations arise in relation to clinical photography and video recordings and the question of consent in respect of those matters is addressed in Standard 5 on Record Keeping.

When completed, consent forms should be kept with the patient's notes. In the case of computerised records, you can scan the signed consent form and save it on the electronic patient record. The original will then need to be treated as confidential waste (See Standards on Disposal of Waste and Record keeping). Generally, as with all records, they should not be altered. Any changes

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to the form, made after the form has been signed, should be initialled and dated by both the patient and the podiatrist. The reasons for the amendment should be recorded in the clinical notes.

Some electronic patient record systems also have the facility to obtain a digital signature from the patient which is then embedded into an electronic consent form. This is perfectly acceptable as long as the patient can see what they are signing for and the form can be printed should you notes get requested at any time.

Consent is a process. Patients may withdraw consent after they have signed a consent form and therefore you should check before commencing treatment to confirm that the patient has not had a change of mind and note this in the record.

What form should I use for written consent?

Where written consent is sought the College has produced template consent forms for members to use. There are six consent forms, two for each of the following situations;

- consent for investigation and treatment.
- consent for photography or video recording.
- consent for examination and treatment by a student or someone in training situation.

There are forms for use where a patient is able to give consent himself or herself and forms for young persons under the age of 18. In the case of the latter, both the parent/guardian and the young person should sign the form, where you judge that the young person is able to understand what is being said. These forms can be found in on the College's website:

https://membersarea.cop.org.uk/podiatric-practice/private-practice-resources-area/patient-resources

Who can give consent?

Before relying on consent, you must be satisfied that the person providing consent is entitled to do so. This is usually a straightforward issue. All persons aged 18 or above (16 in Scotland) are assumed

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to be competent to either give or refuse consent. That presumption may be rebutted if there is evidence that the individual lacks capacity (see below).

At the ages of 16 and 17 competent individuals may give valid consent to medical treatment which is in their best interests without parental approval. Parental involvement should be encouraged particularly for important medical decisions such as potential painful procedures. If a person aged 16 or 17 years lacks capacity to give consent or has chosen to leave it to their parents to give consent, then parental consent will be required before the treatment is given.

A young person aged 15 or under, may give valid consent to medical treatment without their parents' consent provided they understand the treatment and what it involves. The practitioner must satisfy themselves that the young person is able to understand the risks and benefits as well as the options available to them. This is known as being "Gillick competent" after the legal case which determined the principles.[1] Where a person under 16 does not meet this test i.e. because they are not able to understand the treatment, what it involves and the options available to them, they will not be able to give consent and parental consent will be required before the treatment is given.

When treating a child or young person who has capacity to consent it is prudent to explore the possibility of involving their parent or guardian in the process. Where a young person has capacity, you will need their consent to disclose confidential clinical information to their parent/guardian.

In the context of private treatment, a separate issue arises in relation to agreeing to the costs of treatment.

Refusals of consent

A competent adult is entitled to withhold their consent to treatment for any reason or none. Their decision must be respected. You must take care to make an appropriate note of the discussions

[1] Gillick v West Norfolk and Wisbech AHA [1986] AC 112. In Scotland the relevant provisions are set out in the Age of Legal Capacity Act 1991.

which you have had with the patient, any advice or recommendations which you have made and their decision including any reasons which they have given for their decision.

Young Person's 17 and younger

If a young person aged 17 or younger refuses consent to treatment this might be capable of being overridden by an adult with parental responsibility if the treatment is considered in the patient's best interests. In Scotland it is likely that neither parents nor the courts are entitled to override a competent young person's decision.

Treating a patient who has refused consent presents a variety of clinical, ethical and legal challenges. It is a decision which requires careful consideration and should not be undertaken without obtaining legal advice appropriate to the region in which you are practicing. It is difficult to envisage scenarios where treatment could not reasonably be deferred. The urgency with which advice should be sought will depend on the clinical presentation. You should consider whether the involvement of other healthcare professionals would assist in resolving the matter.

Where a patient refuses a particular intervention, you may continue to provide alternative treatment to which they have consented, if that is appropriate.

Who can give parental consent?

Only people with 'Parental Responsibility' may give consent on behalf of persons under the age of 16. 'Parental Responsibility' is a legal term with a strict meaning.[2] Not all parents have parental responsibility for their children, for example, unmarried fathers do not automatically have such responsibility if they are not named on the birth certificate, although they may acquire it.

It is always advisable to enquire of the adult accompanying a child whether they have Parental Responsibility and to record details of the individual providing consent, and their relationship to the young patient, in the clinical records. You should seek advice if it is unclear whether the individual

2 The definition of Parental Responsibility is set out in legislation and differs between England and Wales and Scotland.

providing consent has Parental Responsibility. A relative, nanny or childminder would not normally have parental responsibility and thus would not normally be able to provide consent. Where necessary you should defer treatment in order to ensure that valid consent is obtained.

Where written consent is obtained the form must be signed by the person whose consent is being relied upon. This needs to be fully informed consent and therefore should be done face to face. On the rare occasion the consenting adult is not able to be present i.e. they work abroad, you must have had an appropriate discussion with them providing the relevant information and affording them the opportunity to ask questions and this must be detailed in the notes. You should also have done due diligence to confirm who it is that you are corresponding with and that they have the right to give consent for the patient involved.

What is the test for Capacity?

The test for capacity is decision specific and involves a requirement that the individual can understand the information, which is relevant to the decision to be made, can retain the information for long enough to use or weigh it and can communicate their decision. At any given time, an individual may have capacity to make some decisions but not others.

If you are concerned that a patient aged 16 or over does not have capacity, you should not rely on their consent to provide treatment. You should defer treatment and seek further information to assist in determining whether they have capacity. You should consider taking legal advice and liaising with other healthcare professionals who may be better placed in determining whether the patient has capacity.

Lack of Capacity and Best Interests

If a patient lacks capacity because they do not have the ability to understand and weigh up the information needed to make an informed decision, for example due to dementia, you should first consider whether the patient has made a an arrangement which permits a third party to consent on the patient's behalf. Such an arrangement may be in the form of a Lasting Power of Attorney for Health and Welfare (or similar) or arise from the decision of a court to appoint an individual for that

purpose. Members should be aware that the terminology for different types of Power of Attorney in Scotland differs to that in England. For more information about mental capacity in Scotland see our related guideline:
https://membersarea.cop.org.uk/api/documentlibrary/download?documentId=56

If a patient lacks capacity, you may still treat the patient if the treatment would be in their best interests. To decide if the treatment is in the patient's best interests, you should determine the patient's likely preferences by discussing the procedure with the patient's relatives, carers and friends. However, it is important to appreciate that the patient's relatives, carers and friends cannot give consent on the behalf of the patient; they can only assist in determining the patient's best interests by indicating the patient's likely preferences based on previous experience. Where the proposed treatment is invasive particular care should be taken. Where possible you should liaise with the patient's GP and seek their views on whether the proposed treatment is in the patient's best interests.

If the information from relatives, carers and friends indicate that had the patient been competent to give consent, they would have refused treatment, then you should not treat the patient. If this places the patient at risk, then with the consent of the relative, carer or friend, you should refer the matter to the patient's General Practitioner or hospital Consultant, whichever is appropriate.

Where a decision to provide treatment is taken on the basis that this is in the patient's best interests then you should record in the patient's notes the reason for this decision and the information upon which it was based. A note should also be made of whom you consulted when making this decision. It would not be appropriate to complete a written consent form, if this had otherwise been indicated.

When treating patients in a care or nursing home it is your responsibility not the homes to confirm the patient's capacity or lack there of and any power of attorneys they may have. The home may be able to provide a signed document that the power of attorneys has given them permission to consent to routine medical treatment but you need to check that this document applies to podiatry care and document it in your patient records. If the patient does have a power of attorney and they

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have not given the home permission to make medical decisions, they must be contacted so that they can give consent to treatment and sign any appropriate consent forms. If the home will not allow you to contact the power of attorney initially ask them to contact them with your details so you can speak to them directly. Ideally you should meet the power of attorney(s) at least once face to face, however, if this can not be done i.e. they do not live in the area, then you should still have a verbal conversation with them and then post information/consent forms to them by record delivery both ways. All of this should be documented in the patient's record.

For further information see the Mental Capacity Act 2005 or the Adults with Incapacity (Scotland) Act 2000 or Mental Capacity Act (Northern Ireland) 2016.

What if there is a communication problem?

If the reason that someone cannot understand is because they cannot speak English then you should allow them to be accompanied by an interpreter. Ideally the interpreter should be independent, and you must have regard to the risk that where a family member acts as an interpreter they may be exercising undue influence over the patient. If the reason that someone cannot understand is because they cannot hear, you should explore alternative means of communication.

What if I work in the NHS – do I have to follow these guidelines?

If you work within the NHS your Trust will have their own policy and probably use the Department of Health consent forms. If this is the case, you should follow your Trust's guidance.

Who can seek consent?

It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question. You must make an appropriate note of your discussions with the patient so that others involved in the patient's care can see the basis on which the patient's consent has been obtained.

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Where another practitioner has taken the patient's consent it remains the operating practitioner's responsibility to ensure that valid informed consent has been obtained before commencing treatment. You must review the records of the previous discussions, check the patient's understanding and confirm their consent prior to undertaking the investigation or treatment.

The timing of consent

Consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends. Patients should never be rushed into making a decision. However, for most podiatric practice (non-invasive and low risk procedures) it would be acceptable to provide treatment immediately after discussing it and obtaining consent. The exception being where it is advisable that signed written consent is sought (see above), in such situations it is recommended that consent should be sought in advance of the day of treatment, wherever practicable (particularly for nail surgery) and that information is given to the patient in written format and recorded in the patient's notes.

However, you can use your own clinical judgement as to whether it is beneficial to the patient to proceed on the same day. For example, a bleb of local anaesthetic being used to remove a very painful nail spicule, or verrucae treatment which may be in the best interest of the patient that this was consented for at the time of treatment rather than waiting until the next day.

If a course of treatment is recommended i.e. a course of salicylic acid verruca treatment, you do not need to complete a new consent form at each visit. The consent form signed at the beginning of the treatment which states the planned course will suffice, however, practitioners need to be aware of how many treatments the patient has consented to i.e. if they consent to 4 treatment specifically you must get them to sign a new form on the 5th treatment. You must also confirm the patient's consent verbally at each attendance and make an appropriate entry in the clinical records. If you change the treatment to a different method e.g. cryotherapy a new consent form needs to be signed and the reasons for the change in approach should be documented in the clinical notes.

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Practitioners should consider ways in which relevant information can be provided to patients in advance of their appointment. It may be possible to provide the patient with relevant information i.e. leaflets, in writing at the same time as confirming their appointment arrangements.

What information should be given to the patient?

If the patient's consent is to be valid, it is important that they first have sufficient information so that they may make a genuinely informed decision.

When seeking consent, you should inform the patient of the working diagnosis and explain why treatment is being proposed, what it is intended to achieve and what would happen if nothing were done. You should also explain the available treatment options, the likely success rates and the risks, if any, of each option and provide information about the costs involved. You should explain the likely recovery period and any restrictions which will apply during the recovery phase. The information should take account of the patient's own circumstances, e.g. risks may be higher for diabetic patients. You must also take account of the patient's desired outcome. Where local anaesthesia will be used you should also explain what they could expect to feel after the procedure, when they will be able to drive and go back to work/school.

For surgical procedures you should inform the patient how the success rates compare to national statistics, where they exist. Patients will also need to be informed about the effects on foot function generally, and whether having surgery may affect the patient's occupation, lifestyle or choice of footwear.

The following is not an exhaustive list, but many patients will be interested in the following types of information:[3]

[3]An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

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- The diagnosis including any uncertainty about the diagnosis.
- The nature and purpose of proposed investigation or treatment and the material risks.
- The consequences of no investigation/treatment.
- The reasonable alternatives or variant options, their comparative risks and benefits and likely success rates including the likelihood and seriousness of potential risks.
- The potential side-effects and complications including pain, infection or loss of function
- Recovery periods and post treatment restrictions.
- The costs of treatment.

While infection may be a rare complication of podiatric treatment its consequences may be devastating. Whenever undertaking procedures in which the skin may be breached the risk of infection must be included in the discussion with the patient. This would also apply if you accidently cut the patient during the course of your normal treatment.

The information provided must be tailored to the needs of the particular patient. The podiatrist will need to have relevant information about the patient's home circumstances, mobility, hobbies, transport, and employment. Recording those discussions will assist in demonstrating that you have facilitated the patient in making an informed choice which reflects their individual circumstances.

You should bear in mind that the timing of procedures may be of significance to the patient. A promising young athlete will want to think carefully about the timing of an elective procedure such that the recovery period does not interfere with crucial training or competition. Equally patients may need to plan around work commitments, childcare arrangements or a range of other personal considerations.

The patient must understand the professional status and qualifications of the individual who will be performing the procedure. It is essential that the patient understands that the practitioner is a podiatrist or podiatric surgeon and is HCPC registered or is being seen by an appropriately trained assistant practitioner (podiatry assistant). Where a procedure may be performed by a student or by

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a clinician under supervision, then the patient should be informed at the time the appointment is made and appropriate consent forms signed.

Uncertainty

It is important that patients have an understanding of elements of uncertainty in the available information, whether it relates to the diagnosis or the effectiveness of available treatment options.

How should the information be provided?

The process of consent requires a dialogue with the patient. It may be sufficient for information to be given verbally but it is best to provide written information (for example a leaflet) to supplement those discussions, in particular for treatment types requiring written consent (see above). Information should always be presented as simply and clearly as possible. The clinical notes must record the nature of the information provided including what information leaflets were provided and details of any additional sources to which the patient has been directed such as reputable websites.[4] Where a specific leaflet is given, then the title and version of the leaflet should be documented in the patient record. A copy of all versions of the leaflets should be kept by the podiatrist in case the patient records are ever requested, and that version is needed.

What should I do if the patient does not want to know what is involved?

There may be occasions when a patient would rather not know about certain aspects of the treatment and ask you not to tell them. In such circumstances it is important to ask if they have any particular worries or concerns about the treatment.

[4] "… the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form." *Montgomery v Lanarkshire.*

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Encourage the patient to ask anything they wish about the diagnosis or proposed treatment. If you feel it appropriate you may always suggest that they have a chat with their General Practitioner or bring a family member or friend to the next appointment. If they refuse information about the risks and benefits or certain aspects of their treatment, their decision should be respected and documented in the notes.

What should I do if the patient wants more time to consider things?

If the patient expresses a wish for more time to consider their decision, or you suspect that they would like, or would benefit from more time, then arrange another appointment. An exception may arise in the management of the at-risk foot. In such circumstances you should explain to the patient the possible consequences of delaying treatment. If they still refuse, offer to make an appointment with an appropriate medical practitioner for the following day or direct them to emergency services if appropriate. Consider arranging immediate antibiotic cover if clinically indicated. You should ensure that you maintain a detailed record of the discussions and advice in the patient's record.

What if the patient has a living will or advanced directive?

The detailed arrangements for "living wills", advanced decision making, and the appointment of surrogate decision makers vary between the regions. Before relying on an advanced decision or the consent of a surrogate decision maker you should satisfy yourself that they are valid in the area where you are practicing. If in doubt you should seek advice. More information can be found at **https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/**.

www.cop.org.uk

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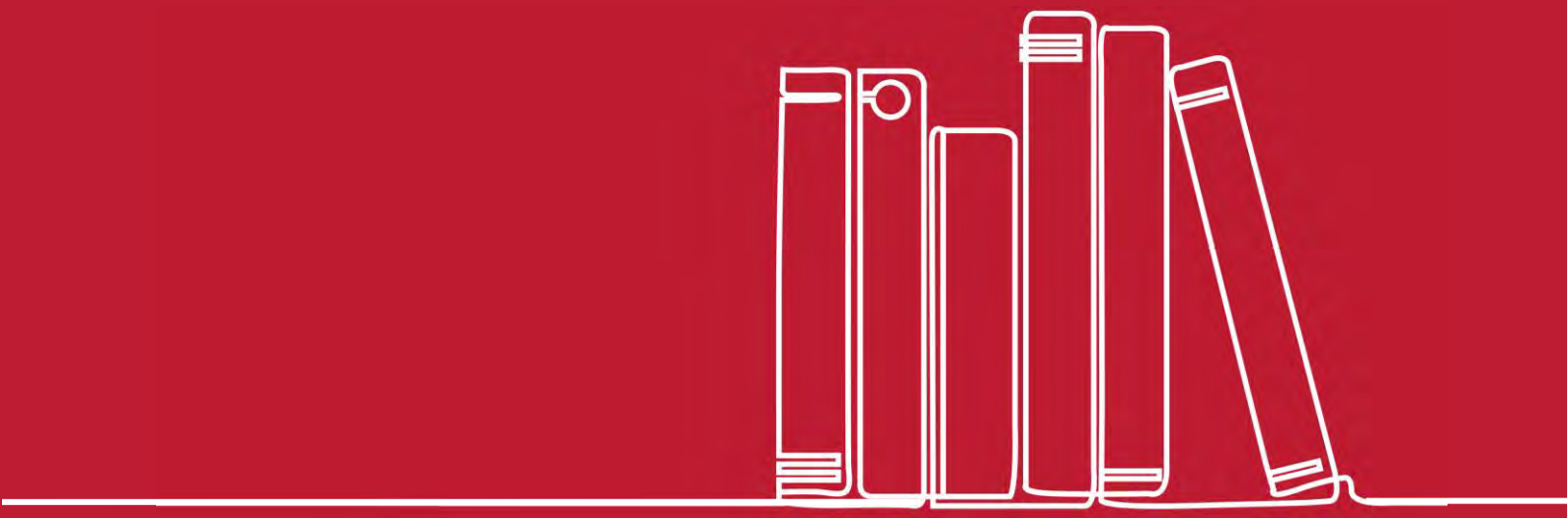
Clinical Standards



Standard 3
Safeguarding Children and Vulnerable Adults

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 3 – Safeguarding Children and Vulnerable Adults

Introduction

The safety and welfare of children and vulnerable adults has become an issue of increasing public concern. These guidelines should be consistent with the more comprehensive procedures that operate in NHS Trusts, which members are required to abide by. Their purpose is to offer guidance to members in the private and voluntary sector where a child or vulnerable adult safeguarding policy may not exist.

All practitioners and staff coming into contact with children or vulnerable adults should be aware of these policies considering that child and vulnerable adult safeguarding is an overall awareness of a child's or vulnerable adult's welfare across all aspects of the practice.

Ensure that all staff and volunteers recognise their duty and feel able to raise concerns about poor and unsafe practices concerning children/vulnerable adults and that those concerns are addressed sensitively and effectively in a timely manner.

If you are a private practitioner we recommend having a Safeguarding Statement within your practice for staff to follow (see Appendix A).

Local Authority contact numbers should be sought and used in conjunction with this document. These contact details will be found via your Local Authorities website.

Consent for the treatment of young persons and vulnerable adults is explained within Standard 2 - Consent.

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For clarity a vulnerable adult is any person aged 18 years or over, who is, or may be, unable to take care of themselves or are unable to protect themselves against significant harm or exploitation. This may be because they have a mental health problem, a disability, visual or hearing problems, are old and frail or have some form of illness. A young person is anyone under the age of 18.

When treating a young person or vulnerable adult

Sometimes, the parent may not wish to be in the room during treatment, for example nail surgery. In this situation, they must be in the room when the proposed treatment is discussed and have consented to the proposed procedure. If they subsequently decide to leave the room, you may only proceed if you are chaperoned, preferably by another adult known to the child remaining in the room.

Removal of Clothes for physical examination

There are times when a clinical examination or treatment will require the removal of certain items of clothing. Where this is necessary you will have to carefully consider the justification for making such a request. No request should be made where the proposed test or reason for removing clothing does not inform or direct the diagnosis or treatment. Clothing should only be removed with prior consent.

Preventing unsuitable people working with children and vulnerable adults

The practice needs to operate safe recruitment practices including ensuring appropriate Disclosure and Barring checks (DBS) and reference checks are undertaken. Further information on obtaining these checks can be found in the Private Practice Handbook.
https://membersarea.cop.org.uk/api/documentlibrary/download?documentId=58

The practice will ensure that any disciplinary proceedings against staff relating to child and/or vulnerable adult safeguarding matters are concluded in full even when the member of staff is no longer employed at the practice and that notification of any concerns is made to the relevant authorities and professional bodies and included in references where applicable.

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What to do if you are worried that a young person or vulnerable adult is being abused

Abuse may be physical, sexual or emotional abuse or neglect: What is important is that appropriate action is taken whenever a young person up to the age of 18 years or a vulnerable adult is suspected of being abused. What action you take will be dependent on the type of abuse, and the following is offered as a guide:

Categories of Abuse

When children or vulnerable adults are suffering from physical, sexual or emotional abuse, or may be experiencing neglect, this may be demonstrated through the things they say (direct or indirect disclosure), through changes in their appearance and their behaviour.

Physical abuse

The first step should be to enquire about any injuries that have aroused your concern, by speaking with the young person/vulnerable adult.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child/vulnerable adult. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child who they are looking after. This situation is commonly described using terms such as; fabricated and induced illness or Munchausen's Syndrome by proxy. Self-harm also comes under the category of physical abuse.

If you are satisfied with the information, a note should be made of the incident in your clinical notes, and the General Practitioner informed in writing. This is so that the General Practitioner will be alerted if there is a pattern of repeated incidents or injuries.

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Emotional Abuse and Neglect

Emotional Abuse:

Emotional Abuse is the persistent emotional ill-treatment of a child/vulnerable adult such as to cause severe and persistent adverse effects on the child's emotional development or the vulnerable adult's emotional health. It may involve conveying to children/vulnerable adult that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age of developmentally inappropriate expectations being imposed on children. It may involve causing the individual frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child/vulnerable, though it may occur alone.

Neglect:

Neglect is the persistent failure to meet a child's/vulnerable adult's basic physical and/or psychological needs, likely to result in the serious impairment of the person's health or development. It may involve a parent or carer failing to provide adequate food, shelter, and clothing; failure to protect the individual from physical harm or danger, the failure to ensure access to appropriate medical care or treatment. It may also include neglect, or unresponsiveness to, a child's basic emotional needs.

If you suspect emotional abuse or neglect you should record the reasons for your concern in your patient records.

Sexual abuse

Sexual abuse usually comes to light in a different way to physical abuse or neglect. Often there may be a change in a child's/vulnerable adult's behaviour or personality. The most usual way, however, is for the person to confide in someone, typically a health worker, teacher or volunteer.

If this happens to you, you should listen to the person and explain that you will report the issue, so

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that it is dealt with. It is important that you do not discuss the incident with the young person or vulnerable adult so as not to 'contaminate evidence'.

Financial abuse

This is mainly related to vulnerable adults and is a type of exploitation. It usually involves a relative, career, visitor or friend committing theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or misusing property, possessions and benefits.

If you suspect any of these types of abuse have occurred, you MUST report it to the appropriate authorities including their GP and social services.

Dealing with a Disclosure

Dealing with a disclosure from a child or vulnerable adult, and a safeguarding case in general, is likely to be a stressful experience. The member of staff /volunteer should, therefore, consider seeking support for him/herself and discuss this with the designated members of staff.

If a child or vulnerable adult discloses that he or she has been abused in some way, the member of staff/ volunteer should:

- Listen to what is being said without displaying shock or disbelief.
- Accept what is being said.
- Allow the person to talk freely.
- Avoid asking leading questions.
- Reassure the person but not make promises which might not be possible to keep.
- Not promise confidentiality.
- Reassure the person that what has happened is not their fault.
- Listen rather than ask questions.
- Stress that it was the right thing to tell.
- Not criticise the alleged perpetrator.

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- Explain what has to be done next and who has to be told.
- Make a written record (see Standard 5 - Record Keeping).
- Non-action is not an option in child and vulnerable adult protection. You must act immediately: do not assume someone else will.
- Liaise with Social Services.

Reporting suspected safeguarding issues

If you suspect a child or vulnerable adult is being abused or is at risk in some way it is best to try and ascertain the facts with them (or their guardians if you feel this will not put them in anymore danger).

You can report your concerns to the person's GP and/or social worker. Local authorities have social workers who deal specifically with cases of abuse. Call your local council and ask for the Adult Protection or Safeguarding Coordinator. You can also speak to the police about the situation. Some forms of abuse are crimes, so the police will be interested.

You can also contact Action on Elder Abuse **https://www.elderabuse.org.uk/**, and for children you can contact the NSPCC **https://www.nspcc.org.uk/**. If the person is in danger or needs medical attention, call the emergency services.

If you are concerned about the safety or well-being of someone living in a care home, you can contact the Care Quality Commission (CQC) in England by going to **www.cqc.org.uk**. In Wales you can contact the Care and Social Service Inspectorate by going to the **www.cssiw.wales.gov.uk**. In Northern Ireland you can get further information from **www.NIdirect.gov.uk**. In Scotland you can contact The Care Inspectorate **http://www.careinspectorate.com/**.

For specific information on what to do to report child abuse and your legal requirements please visit: **https://www.nspcc.org.uk/what-you-can-do/report-abuse/what-if-suspect-abuse/**

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Appendix A

[Insert Practice Name] Safeguarding Children and Vulnerable Adults Statement

[Insert Practice Name] believes that it is always unacceptable for anyone to experience abuse of any kind and recognises its responsibility to particularly safeguard the welfare of all children, young people and vulnerable adults, by a commitment to practice and behaviour which protects them.

We recognise that:

- The welfare of the child/young person/vulnerable adult is paramount.
- All patients, regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have the right to equal protection from all types of harm or abuse.
- Working in partnership with children, young people, vulnerable adults and their parents/guardians, carers and other agencies is essential in promoting patient welfare.

The purpose of the policy:

- To provide protection for the children, young people and vulnerable adults who receive [Insert Practice Name] services, including the children of adult patients or users.
- To provide staff, associates and students with guidance on procedures they must adopt in the event that they suspect a child, young person or vulnerable adult may be experiencing, or be at risk of, harm.

This policy applies to all staff, including the practice manager, paid staff, associates, volunteers and sessional workers, agency staff, students or anyone working on behalf of [Insert Practice Name] within a premise which is the responsibility of the practice.

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We will seek to safeguard children, young people and vulnerable adults by:

- Valuing all people as individuals, listening to and respecting their wishes and needs.
- Adopting child and vulnerable adult protection guidelines, confidentiality guidelines and the code of conduct of The College of Podiatry and The Health and Care Professionals Council for all staff, students, associates and volunteers.
- Recruiting staff and volunteers safely, ensuring all necessary DSB checks are made.
- Sharing information about child and vulnerable adult protection and good practice with children, parents, patients, carers, staff, associates and volunteers.
- Reporting information about concerns with agencies who need to know, and involving parents, children, patients' family and carers appropriately.
- Providing effective management for staff and volunteers through supervision, support and training.

We are also committed to reviewing our policy and good practice annually.

Practice Owner/Managers' Signature: _____

Adopted on: _____

Reviewed date: _____

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Clinical Standards

Standard 4
Delegation and Supervision

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 4 – Delegation and Supervision

Delegation

If you elect to delegate a task, or temporarily transfer the care of a client or patient to a podiatry assistant or assistant practitioner, you are responsible for the outcome.

You must ensure that **you as the podiatrist** have appropriately **assessed the patient** and that the person to whom you have delegated:

1. Understands what is expected of them and has a clear written treatment plan with expected outcomes with target dates.
2. Has the knowledge, skills and recognised qualification or experience to carry out what you have asked them to do safely and effectively.
3. Is appropriately supervised.
4. Is aware of when and under what circumstances the patient should be referred back for a reassessment.
5. Is able to refer the patient back to you or another Podiatrist without delay, if they are uncertain or concerned in any way as to the patient's changed health status or their response to the treatment being provided.

If they tell you that they are unwilling or unable to carry out a particular task or to continue with the care of a particular patient, you must not endanger the patient by forcing them to do so. You should explore the reasons and identify any training issues before making any decisions as to what to do.

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Supervision

Delegated work should regularly be reviewed in line with the agreed treatment plan. The appropriate level of supervision can only be defined in terms of the knowledge and skill of the podiatry assistant or assistant practitioner, according to the guidance in table 1 below. For assistants operating at level E, it will not be necessary for them to work in the same location as the supervising podiatrist but a podiatrist must be available by phone.

Table 1 - Supervision of Assistant Practitioners and Podiatry Assistants

Level	Description of theoretical knowledge	Description of technical and operative skills	Appropriate supervision
A	Having to ask or be told what to do.	Podiatrist showing: Assistant helping.	Direct supervision
B	Aware of what to do, but not really knowing what to do.	Assistant undertaking the work: with the podiatrist helping.	
C	Confident in their underpinning knowledge but not able to demonstrate that knowledge in the clinical setting.	Assistant doing the work: with a podiatrist overseeing their work.	Indirect supervision
D	Understands what to do and able to do it.	Assistant doing: with Podiatrist available within the clinical environment.	Proximal supervision
E	Able to develop their knowledge and build on it during practice.	Assistant doing: with Podiatrist available for advice either on the premises or directly contactable.	

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Clinical Standards

Standard 5
Patient Record Keeping

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 5 - Patient Record Keeping

Patients' records should be relevant, factual, consistent, and accurate. They should be signed and dated and made as soon as possible after the event which they record. They should not contain information which would surprise the patient. Relevant information should be provided to the patient directly during the consultation.

These guidelines should be used in conjunction with Standard 2 - Patient Consent. Furthermore, practitioners who are employed should have regard to any relevant local guidance issued by their employer.

What should be recorded?

It is essential that the patient record identifies the problem and records details of the facts presented by the patient, together with any observations, examinations and tests undertaken by the podiatrist. The diagnosis, or a differential diagnosis, needs to be recorded with details of any actions taken or of any decisions made and any information on how the diagnosis was reached.

Patient's demographics, medical and surgical history and medication should be checked annually and records updated as appropriate. However, it is further recommended that patients are asked verbally on each visit about changes to medication/medical history and any records are updated as appropriate to reflect those changes, this is especially important prior to undertaking any invasive procedures.

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When making the patient records in relation to your assessment it is recommended that the SOAP format is used:

S. Subjective **O. Objective** **A. Assessment/Action** **P. Plan**

Whichever format is used it is essential that all patient notes (no matter how regularly the patient attends) include the following:

1. Date of the appointment. It is best practice to also include the time of the appointment. This may be especially useful if the patient is to be seen by several healthcare practitioners in one day.

2. **S (subjective):** What the patient is complaining of or their presenting problem.

   Record the patient's current condition as they describe it to you. This section usually includes the patient's chief complaint or reason for attending, in their own words. This can be indicated with "C/O" ("complaining of").
   Includes:
   - Onset (when and mechanism of injury – if applicable).
   - Chronology (better or worse since onset, episodic, variable, constant, etc.).
   - Quality (sharp, dull, etc.).
   - Severity (usually a pain rating).
   - Modifying factors (what aggravates/reduces the complaint – activities, postures, drugs, etc.).
   - Additional symptoms (un/related or significant symptoms to the chief complaint)
   - Treatment (has the patient seen another provider for this issue?).

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3. **O (objective):** Your observations document objective findings about the patient's status. This can be indicated with "O/E" ("on examination").
   Including:
   - Findings from physical examinations, such as abnormalities including location, including which foot, location on the foot and sizes of any lesions.

4. **(A) Assessment:** Your assessment
   - This records your assessment of the problem putting together the patient's presentation and your findings. It should include a diagnosis, or a differential diagnosis.
   - Measurements/results, from a biomechanical examination or gait analysis for example.

5. **(A) Action:** Where treatment is provided you must record details of that treatment. Records of treatment should include details of the following;
   - Recommended treatment options which were discussed, including no treatment.
   - The risks and benefits and any contraindications discussed.
   - The costs where applicable.
   - Any post-treatment restrictions and the anticipated recovery period.
   - A record of the patient's consent.
   - The nature of the treatment provided;
   - The technique used;
   - The site or sites treated;
   - Details of any agents or medicaments used such as local anaesthetics, including details of the strength and quantity;

6. **P (Plan):**

   This should include the following;

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- The arrangements which have been made for follow-up or a record of the decision to discharge the patient.
- Any advice you have given the patient, including 'safety netting' advice (document if you have also given written advice, for example a leaflet about proposed treatment).
- After care instructions.
- Also include any anticipated/expected outcomes of the treatment.
- The plan should be reviewed with the patient at each visit until discharge or resolution.

7. In paper records, you must sign following each entry. If your notes are electronic you need to be able to 'lock' the notes. You should be able to produce an audit trail of access and amendments so as to demonstrate the integrity of electronic records.

8. If written information is given to the patient i.e. a leaflet to explain a particular treatment, then this should be documented in the notes along with the title of the leaflet or identifying number. It is not enough to write – '*Information leaflet given'* but would need to state for example '*Cryotherapy leaflet version 2 given'*. A copy of these leaflets and versions should be kept by the podiatrist incase the notes are requested in the future.

9. Any telephone conversations or email correspondence should be recorded in the patient's notes (excluding appointment bookings/reminders).

It is important to recognise that the absence of certain findings or symptoms is relevant information and should be recorded. This can also help to demonstrate that the relevant information was sought and negative answers were given. For example, where a Medical History form is used the layout should be such as to require the patient to record an answer to each question. The form should be reviewed by the clinician and any ambiguities or missing answers should be explored with the

patient and the relevant information should be recorded.

How should they be recorded?

The records need to be clear, unambiguous and written in terms that a patient or guardian could easily understand. They should not contain unnecessary jargon. Whilst it is acknowledged that abbreviations are useful, it would be best to use long hand as much as possible. Where abbreviations are used, they should follow the approved list in Standard 6 - Abbreviations.

All communications with patients should be conducted in a professional manner and this should be reflected in the tone and content of communications. The content must be accurate and you must be able to justify what you have recorded. Text messaging and social media conversations tend to reduce the degree of formality and should not be used to communicate with patients. It is advised to have these conversations via phone or appropriately secure email (recording the content in the notes).

Paper Records

Paper records should be consecutive with each page numbered. Each page should bear the patient's name and identifying number (should there be one). Each entry should be dated, timed and signed with the name of the author being printed alongside their first signature in the patient's records. Records must be written legibly in dark ink and never in pencil. Any alteration or correction must be dated and signed in such a manner that the original entry can still be clearly read on a photocopy. You should not leave blank spaces between entries in the records. Any blank spaces should be scored through, to prevent subsequent amendments.

Computer Records

Computerised records are acceptable and offer many advantages. However, it is essential to use a system which can reliably identify the practitioner who created or updated a record through unique user login and identification. The system or application software must have an audit trail function

that will show any alterations and reliably attribute them to an identified user. When patient's records are stored electronically, a secure data back-up system should be in place and in daily use.

Your computer/electronic device that holds patient information/records must have access controls. The program/system that you are using to store patient data also needs to have access controls such as password protection. This is an area where practitioners may require independent technical advice.

For further information on IT security please visit the ICO website (www.ico.org.uk) and download their '*A Practical Guide to IT security* – Ideal for the small business'.

What should not be recorded?

Patient records must never contain irrelevant speculation, offensive subjective statements or opinions regarding the patient. This is unacceptable.

Also, if you are in private practice, you should keep your records of payments separate from the clinical record. There may be circumstances where third parties, such as HMRC, require access to such financial records where it would not be appropriate to also disclose confidential clinical records.

What should be included in the patient records?

Correspondence from the patient, other healthcare professional's referrals or reports and consent forms are traditionally seen as part of the patient record. However, anything that contains patient information, in any media, that has been created or gathered as part of the clinical consultation forms part of the patient records. This includes video recordings or images taken during the consultation, including x-rays. All these records must be retained for an appropriate period in accordance with the Data Controller's retention policy.

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What about auditing patient records?

Poor records can make it difficult to defend our member when there is a complaint, whether to the practice or the regulator, or a claim of negligence. It is therefore advisable to audit records on a **regular basis**. This will assist with identifying any weaknesses in your current practice. To assist with this an audit tool can be found in Annex A.

What happens where a student treats a patient?

Where a pre-qualification student provides a treatment they should write up the notes. However, the practitioner who supervises the treatment must countersign the notes and make a supplementary note if necessary. Consent would also need to be obtained from the patient to be treated by a student. A record of that consent must be retained.

What can I do if I want to present a case study?

Post-graduate studies frequently require students to present case studies. In such situations you should not include the patient's notes, or make reference to the patient by name or by reference to any other personal identifiers. It is important that the patient is not identifiable from the information provided.

How long should they be kept?

Each practice should have a policy on the retention of personal data which explains how the retention period will be calculated. The practice's Privacy Notice which is provided to patients will need to include information on the retention period.

The HCPC has not published any guidance on retention periods. The ICO's current guidance on retention recognizes the role played by professional guidelines and makes the following observation:

"*There are various legal requirements and professional guidelines about keeping certain kinds of records – such as information needed for income tax and audit purposes, or information on aspects*

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of health and safety. If an organisation keeps personal data to comply with a requirement like this, it will not be considered to have kept the information for longer than necessary."[1]

The ICO Guidance also refers to agreed industry practices.[2] Practitioners may be assisted by guidance issues by the Information Governance Alliance [IGA].

Records should be subject to appraisal once the minimum retention period has been reached and should be destroyed if retention is no longer necessary. A record of the decision to destroy the record should be retained.

The IGA Guidance identifies a number of types of records with what it describes as "standard" retention periods including:

- Adult health records – 8 years following last attendance.
- Children's records – the patient's 25th or 26th birthday[3].
- For mentally disordered patients (within the meaning of the Mental Health Act 1983) 20 years after their last treatment.

Practitioners should have contingency arrangements in place for the management of their records in the event of their death or incapacity. Those arrangements must ensure that records remain secure and are accessible to patients so ensure they can continue their care elsewhere. The notes can then either be retained for the relevant retention period or returned to the patient.

[1] HMRC produce a guide on record keeping for tax purposes which addresses retention periods. It can be accessed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377656/rk-bk1.pdf
[2] The Information Governance Alliance has produced a Code of Practice for the management of health and social care records. It is likely to be accorded considerable weight by the ICO or the Courts. That Guidance includes a Schedule of minimum retention periods for different types of records.
[3] Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday.

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How should they be stored?

Patient records may be stored manually or held on computer. However they are stored, patients have the right to expect them to be stored securely, protected against unauthorised access and in a manner that they can be easily retrieved if necessary. You can elect to scan previous clinical records and store them electronically. The scanning process must be adequately quality assured to ensure that all relevant documents have been scanned.

As discussed above computers must subject to appropriate access controls and backed up on a daily basis.

How should clinical records be disposed of?

(A) Ensuring confidentiality and security

Patient records are confidential and at the end of the appropriate retentions period they should be destroyed to an international standard.[4] The IGA Code of Practice indicates that "*They can be incinerated, pulped or shredded (using a cross cut shredder) under confidential conditions*." This means you can get a confidential waste company to dispose of them in this manner. It is important to keep auditable records of the destruction of hardware such as computers, hard drives and back-up tapes.

(B) Criminal offences relating to waste disposal

In addition to the specific data protection considerations, anyone who produces, stores or disposes of waste must take all reasonable steps to ensure that waste is managed properly. This duty of care is imposed under section 34 of the *Environmental Protection Act 1990.* A breach may lead to prosecution. The onus is on the person disposing of waste to ensure that the person who takes control of that waste is licensed to do so. The Environment Agency operates a telephone based free and instant Waste Carrier Validation Check. The online version can be accessed here:

[4] See BSIA EN15713:2009 – Secure Destruction of Confidential Material

https://environment.data.gov.uk/public-register/view/search-waste-carriers-brokers

You must obtain and keep a waste transfer note in respect of any waste which you pass to a third party for disposal.

When you do dispose of records you should keep a note of what documents you have disposed of. This may be a simple excel spread sheet which has the patients initials, date of birth, date of distruction and waste transfer note number on it so you can verify what you have disposed of when if it was ever queried.

ICO Registration and Fees

Data Controllers may be required to pay a fee to the ICO. The amount of the fee depends on a range of factors and there are certain exemptions. Details can be obtained from the information commissioner may:
https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-fee/

Access to health records

Key Points:

(1) Decisions about access requests should be made by the Data Controller or their nominated individual e.g data protection lead.
(2) The identity of the requestor must be known;
(3) The right to access is not absolute;
(4) You must consider:
    (a) The 'serious harm' test; and.
    (b) The rights of third parties.

The *Data Protection Act 2018* [DPA 2018] and *General Data Protection Regulation* [GDPR] give every living person the right to apply for access to his or her health records. The patient is not required to give reasons for their request. Requests must be made in writing and can be submitted electronically. Where a practitioner who is not the Data Controller receives a request for disclosure of records they should pass that request to the Data Controller e.g their employer. The Data Controller will need to be satisfied as to the requestor's identity before making any disclosure. Data Controllers who are responsible for processing health records should have a procedure in place for dealing with subject access requests. That procedure must take account of the special provisions related to health records set out in the DPA 2018 including the '*Serious Harm Test*'.

The 'Serious Harm' Test

The Controller should consider whether the data has already been seen or is within the knowledge of the data subject. Where they are not satisfied that is the case they must consider whether the disclosure to the data subject 'would be likely to cause serious harm to the physical or mental health of the data subject or another individual'. Where the Data Controller is not a registered healthcare professional (e.g an NHS Trust) they must obtain the opinion of an 'appropriate health professional'[5] that the Serious Harm Test is not met before any disclosure is made. In order to satisfy the requirements of the DPA 2018 the clinician whose opinion is obtained will usually be the principle treating clinician.

Where the Serious Harm Test is met in respect of any aspect of the data it cannot be disclosed in response to a Subject Access Request.

Disclosure does not automatically follow from a decision that the Serious Harm Test is not met. The Controller must still take account of the other qualifications on the right to access such as the rights of third parties.

[5] As defined in Schedule 3 Part 2 paragraph 2

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The Rights of Third Parties

Health records frequently contain mixed personal data. Whilst the data of the patient will predominate there may also be personal data of the clinicians who have contributed to the patient's care and information about relatives, carers or other third parties.

The rights of those individuals must be considered before a decision is made about disclosing some or all of the health record to the patient (data subject). Where the third party in question is a clinician who contributed to the record the Controller's task is made easier by the DPA 2018 which provides an assumption of reasonableness in relation to disclosure.

In respect of other third parties the DPA 2018 requires the Controller to consider whether disclosure is reasonable. In doing so the Controller is required to have regard to all the relevant circumstances, including:

a. the type of information that would be disclosed,
b. any duty of confidentiality owed to the other individual,
c. any steps taken by the Controller with a view to seeking the consent of the other individual,
d. whether the other individual is capable of giving consent, and
e. any express refusal of consent by the other individual.

These considerations also apply where the disclosure would identify the third party as the source of information.

Right to access a child's health record

A person with parental responsibility can make a Subject Access Requests on behalf of their children who are too young to make their own request. A young person aged 12 or above is generally considered mature enough to understand what a Subject Access Request is. They can make their own request and would need to provide their consent to allow their parents to make the request for them. However, the Data Controller must use their judgement to decide whether a particular young person aged 12 or above is mature enough to make their own request as they do not always have

the maturity to do so.

Access to the Health Records of a deceased person

Professional obligations of confidence survive the death of a patient.[6] In relation to deceased patients, the Access to Health Records Act 1990 provides rights of access to "the patient's personal representative and any person who may have a claim arising out of the patient's death." The Act does not provide a right of access to any records which were made before the commencement of the Act.[7] The Act imposes a number of limitations on the right to access records, some of which are addressed further below.

The practice has the right to deny or restrict access if it believes that disclosure would cause serious harm to the physical or mental health of any other person, or would identify a third person.

Requests from Solicitors

Solicitors often ask for copies of health records. Where they do so you must ask them to submit a written request. Ordinarily, this should be accompanied by an authorisation signed by the patient, their representative or, in the case of a deceased person, the executor who may also be a next of kin. However, you may accept a request from a solicitor without a signed authorisation from the patient where you are satisfied that the request is made by solicitors acting for the patient who have been instructed by the patient to make the request.

If the records have been destroyed

If the records have been destroyed after the recommended retention period, the applicant must be informed upon request.

[6] Bluck v Information Commissioner and Epsom and St Helier University NHS Trust, Information Tribunal 2007 WL 4266111
[7] 1 November 1991

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Time limit for response

For Subject Access Requests under the General Data Protection Regulation there is time limit of 30 days within which the Data Controller must provide information on action taken to respond to the request. This period can be extended in certain circumstances.

Charging for clinical records

No fee can be charged for providing a patient with copies of their health records under a Subject Access Request, save in limited circumstances which will rarely apply in practice.

Patient requests to amend clinical records

If a patient feels information recorded on their health record is incorrect, they can request that the records are amended. Where the Controller refuses to do so the patient could complain to the Information Commissioner [ICO], who may determine that any erroneous information must be rectified, blocked, erased or destroyed. Request for amendment can usually be dealt with by including an annotation in the record setting out the patient's position.

Patient requests for deletion of clinical records

The '*right to be forgotten*' has been subject to much discussion since the landmark CJEU judgment in the case of *Google Spain*. The GDPR provides Data Subjects with a right to erasure but that is a qualified right and is only available in certain circumstances. It is difficult to envisage circumstances in which it would require the erasure of a patient's clinical records before the end of the retention period.[8] However, this is a developing area of law.

Practitioners should not agree to erase clinical information in response to a Data Subject's request without seeking legal advice from the College.

[8] Guidance for GP Data Controllers published by the BMA notes: "it is extremely difficult to envisage the circumstances when this right would apply to medical records."

Disagreement over access clinical records

If the applicant is unhappy with any aspect of the response to a Subject Access Request, try and resolve this locally. If this is not possible you can refer the matter to the College of Podiatrists. The alternative is to seek independent legal advice.

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Annex A

Select the records of 10 patients that attended the practice in the last twelve months, at random. Answer yes ‘Y’ or no ‘N’ to the following on each set of notes. Where a question is not relevant to a particular record enter ‘N/A’.

Put the total number of ‘Y’ in the total box for each question. It would be expected that members will score in excess of 8 ‘Y’s for questions.

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Audit of Patient Records

		Set of patient notes: 1	2	3	4	5	6	7	8	9	10	Total of Y's
1.	Do the clinical notes clearly state the following in a logical format:											
	a. Patient's Name and dates of each appointment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	b. Why the patient has attended the clinic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	c. Description of examination and its findings including relevant negative findings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	d. Diagnosis or differential diagnosis with reasons											
	e. The treatment carried out including site and details of technique used	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	f. Plan including follow-up arrangements and any 'safety netting' advice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Is the patient's medical history complete with no blank gaps and showing that it has been updated prior to any treatment and no less than every 12 months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Are the patient notes legible?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Is there a record of the patient's consent, including details of the discussion underpinning that consent i.e Goals, options, risks and benefits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Is the patient note signed after each entry or can the podiatrist be identified on computerised notes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Are abbreviations kept to a minimum and only College approved abbreviations used?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Are the records written in dark ink or able to be printed?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Audit of Patient Records

		Set of patient notes: 1	2	3	4	5	6	7	8	9	10	Total of Y's
8.	Is each of the pages numbered or can the record be printed in chronological order?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Are any errors crossed out with one line and signed so that they are still legible; or are errors on computerised records clearly mark as such and still visible?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	For patients with diabetes is there evidence of an annual diabetic check present?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Is there a record of any advice given, including advice in respect of after-care or self-management, with details of any advice leaflet issued to the patient including the title of the leaflet?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	No payment information is included on the patient record?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	Are records kept securely when not in use (paper or electronic)?											☐ Y or N

We would expect question 13 to be answered 'Y' in all cases.

Podatrists Name..... Signed ..... Date .....

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Clinical Standards

Standard 6
Clinical Abbreviations

For further information:
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Standard 6 – Clinical Abbreviations

General Terminology

A/	Apex, eg A/2 = apex of 2nd toe
B/F	Both Feet
C/O	Patient complains of
DPP	Dorsalis Pedis Pulse
F/	Feet
/F	Foot
GHG	General Health Good
H	Haemorrhage
ID	Interdigital area e.g. ID1/2
L/	Left
O/E	On examination
Pt	Patient
PTP	Posterior Tibial Pulse
R/	Right

Anatomical Terminology

Ant	Anterior
Dist	Distal
DIPJ	Distal Interphalangeal Joint
Dor	Dorsal
Inf	Inferior
IPJ	Interphalangeal joint
J	Joint
Lat	Lateral – away from the midline of the body or a structure e.g. the leg
PIPJ	Proximal Interphalangeal Joint

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Pl	Plantar
Post	Posterior
Prox	Proximal
Med	Medial – towards the midline of the body or a structure e.g. the leg
Met Head	Metatarsal head
MTPJ	Metatarsophalangeal joint
STJt	Sub Talar Joint
Superi	Superior

Nails

O/C	Onychocryptosis
O/G	Onychogryphosis
O/H	Corn under the nail plate
O/M	Onychomycosis
O/P	Onychophosis
O/X	Onychauxis
PNA	Partial Nail Avulsion
Sub Ung	Subungual
TNA	Total Nail Avulsion

Skin Pathologies

CPCA	Callus Plantar Calcaneal Area
CPD	Callus Plantar Digital Area e.g. CPD1 of first toe
CPMA	Callus Plantar Metatarsal Area
enuc	Enucleated
HD	Hard corn
H Mill	Seed corn
H Molle	Soft corn
HNV	Neuro-vascular corn

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H Vasc	Vascular corn
PCA	Plantar Calcaneal Area
PD	Plantar Digital Area
PMA	Planter Metatarsal Area
PP	Pressure point
TP	Tinea Pedis
VP	Verruca pedis

Padding

Cres	Crescent cut out
EVA	Ethyl Vinyl Acetate
FF	Fleecy Foam
FW	Fleecy web
HDEVA	High Density EVA
IDW	Interdigital wedge
LDEVA	Low Density EVA
MDEVA	Medium Density EVA
OCP	Oval Capacity pad
Pl Cush	Plantar cushion
PMP	Plantar metatarsal pad
SCF	Semi-compressed felt
SpR	Sponge rubber
TF	Tube foam
TG	Tube gauze

Biomechanical terms

AAFF	Adult Acquired Flat Foot
AB	Abduction

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AD	Adduction
Calc	Calcaneus
E	Eversion
EXT	External
Fib	Fibula
HAV	Hallux Abductovalgus
HL	Hallux Limitus
HR	Hallux Rigidus
IN	Inversion
INT	Internal
LLd	Limb length difference
Met	Metatarsal
MTJ	Mid Tarsal Joint
MLA (ILA)	Medial (Inner) Longitudinal Arch
NCSP	Neutral Calcaneal Stance position
NORM	Normal
POSn	Position
PTTD	Posterior Tibial Tendon Dysfunction QOM Quality of Motion
RCSP	Relaxed Calcaneal Stance Position
RECUv	Recurvatum
ROM	Range of Motion
STJ	Subtalar Joint
Tib	Tibia
Var	Varum
Val	Valgum

Pathologies

CPR	Cardio Pulmonary Resuscitation
CVA	Cerebral Vascular Accident (Stroke)

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DM	Diabetes Mellitus
DVT	Deep Vein Thrombosis
Hep	Hepatitis
HIV	Human Immunodeficiency Virus
MI	Myocardial Infarction
MODY	Maturity onset diabetes in the young
MRSA	Methicillin Resistant Staphylococcus Aureus
OA	Osteoarthritis
PVD	Peripheral Vascular Disease
RhA	Rheumatoid Arthritis
TIA	Transient Ischaemic Attack
TYPE1	Type 1 diabetes mellitus – insulin dependent
TYPE2	Type 2 diabetes mellitus – medication/insulin dependent

Miscellaneous

Appt	Appointment
bd	Twice a day
BP	Blood Pressure
B.S.	Blood Sugar
CT Scan	Computer Tomography
Dept.	Department
DNA	Did Not Attend
DOB	Date of Birth
Drsg	Dressing
ECG	Electro Cardio Graph
EEG	Electro Encephalograph
FV	Failed Visit
FTA	Failed to Attend
HG	Hyper-granulation tissue

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Hx	History of
IV	Intravenous
MRI	Magnetic Resonance Imaging
N/A	Not Applicable
NAD	No Abnormality Detected
od	Once Daily
OPD	Out Patient Department
POP	Plaster of Paris
PR	Per rectum
PRN	As Required
PTC	Patient to Contact
Px	Prescribed
qds	4 times per day
RTA	Road Traffic Accident
RTI	Road Traffic Incident
RTC	Road Traffic Collision
Rx	Prescription
SC or	
Sub Cut.	Sub cutaneous
SR	Self-Referral
SWFB	Salt water foot bathPT
tds	Three times daily
Temp	Temperature
Tx	Treatment
VCG	Verbal Consent Gained (you must then detail what the consent is for)
Yr	Year
#	Fracture

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Professions

A+E	Accident and Emergency
AP	Assistant Practitioner (Podiatry)
CPN	Community Psychiatric Nurse
DN	District Nurse
FCA	Foot Care Assistant
GP	General Practitioner
HV	Health Visitor
HCA	Health Care Assistant
OOH	Out of Hours service
OT	Occupational Therapist
PA	Podiatry Assistant
Physio	Physiotherapist
PN	Practice Nurse
Pod	Podiatrist
Pod Ass	Podiatry Assistant
SALT	Speech and Language Therapist
SHN	School Health Nurse
SN	Staff Nurse
Sis	Sister
SS	Social Services
SW	Social Worker

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Clinical Standards

Standard 7
Single Use Instruments with Podiatry

For further information:
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Email: professionalsupport@cop.org.uk

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Standard 7 – Single Use Instruments within Podiatry

Single use instruments or devices should only be used in accordance with the manufacturer's instructions and disposed of immediately after the procedure. **They must NOT be used again for any reason or left with the patient for re-use.**

Specifying a medical device as single use is the responsibility of the manufacturer of the device, and they will be labelled accordingly. Once removed from the packaging there may be no labelling on the device itself. It is therefore important that these devices are clearly segregated from re-usable devices of similar appearance to ensure of its disposal after the procedure.

Single use instruments should not be reused. If the device is reused, this is done at the practitioner's own risk, as they will not be covered by the College's Professional Indemnity Insurance.

Single used instruments should be disposed of in appropriate clinical instrument disposal tubs which look like large sharps bins. These are available from clinical waste contractors and a waste transfer note will be given when the bins are collected once full.

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Clinical Standards

Standard 8
Decontamination of Reusable Instruments

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Standard 8 – Decontamination of Reusable Instruments

Introduction

Patients have the right to expect to be treated in a safe, clean environment and to know that any reusable instrument has been decontaminated according to the level of clinical risk encountered. The prevention and control of healthcare acquired infections must be a high priority for all members, and should be embedded into everyday practice, for everyone working within the clinical environment.

These guidelines are to help achieve an appropriate standard for the decontamination of reusable podiatry instruments that come into direct contact with the skin. Members, however, should undertake an independent risk assessment to satisfy themselves that their practice is legal, safe and effective. Compliance with these guidelines should help to achieve this.

The guidelines are not intended for members undertaking podiatric surgery. It is expected that all podiatric surgeons will use instruments that have been through an accredited central sterilisation unit, when performing invasive procedures.

Decontamination

Decontamination is the combination of processes which includes cleaning, disinfection and sterilisation to render a reusable item safe for further use. There should be systems in place to ensure:

- Reusable medical devices are decontaminated in accordance with manufacturer's instructions and current guidelines;

- It is best practice to ensure instruments are tracked through the decontamination process in order to ensure that it has been carried out effectively; and
- If you are employed by the NHS, then you will need to follow local policy.

Members are encouraged to display the College's poster outlining the decontamination process within the area that they undertake the decontamination of reusable instruments (see Appendix A).

Arrangements should be fit for purpose

The reprocessing of reusable podiatry instruments should be performed in dedicated facilities and outside the immediate patient environment. Where this is not practical, then decontamination may be undertaken within the clinic. If you are moving premises or undertaking a major refurbishment of your current practice, you should make moving decontamination outside the immediate clinical area a priority.

The layout of the decontamination area should reflect the progression of instruments from dirty instruments, to cleaned instruments and then sterilised instruments. Equipment used to decontaminate podiatry instruments should be fit for purpose and validated according to the manufacturer guidelines. For autoclaves this normally needs to be done annually. There should be a dedicated sink for hand washing only. Where manual cleaning is performed (see below) there should ideally be two sinks – a 'dirty sink' for the washing of used instruments, and a 'clean sink' for rinsing of washed instruments. Where a separate 'clean sink' is not practical in the short-term a separate bowl may be used for scrubbing instruments however the dirty water needs to be poured directly down the drain (not the plug hole of the hand washing sink). When cleaning/processing instruments gloves and apron should be worn.

Cleaning of instruments

Effective cleaning of instruments is an **essential** prerequisite before sterilisation. The principal methods currently available for cleaning reusable podiatry instruments include:

- Manual cleaning (scrubbing).
- Manual cleaning, combined with ultrasonic cleaner; or
- Manual cleaning with an automated washer-disinfector;

Manual cleaning (scrubbing) of used instruments is mandatory. The College recommends, wherever possible, that automated methods such as washer disinfector or ultrasonic cleaners are used following manual cleaning. Whichever method is adopted, it is essential that it is seen as a prerequisite to sterilisation and that the instruments are checked to ensure that they are free of debris and visible contaminates before being sterilised. Used devices should be decontaminated **immediately** after use, or as soon as is reasonably practicable, to minimise the growth of micro-organisms on them, and minimise the risk of cross infection. Any that cannot be cleaned immediately should be immersed in cold water to prevent coagulation when contaminated materials dry and become encrusted. Use of hot water, or disinfectant can also cause protein coagulation, which is difficult to remove and may impede effective decontamination of the device.

Manual Cleaning: Scrubbing of instruments

Manual cleaning is governed by a separate protocol (see appendix B). To minimise the risk to personnel undertaking manual cleaning, splashing and the creation of aerosols must be avoided at all times. Practitioners should also take care when manual cleaning instruments that have a sharp edge or point not to cause a sharps injury. Appropriate facilities should be available and protective equipment should be worn at all stages of the manual cleaning process. Scrub instruments using a brush with soft plastic bristles. To minimise aerosol risk, you should scrub under water in a filled bowl/sink. Do not scrub under running water. If the water is heavily soiled, change the water and repeat the cleaning procedure. Wash brushes with detergent and hot water after each use to

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remove visible soil and store dry and head up. Brushes should be autoclaved at the end of each session or ideally be single use. Personal Protective Equipment must be worn by staff undertaking manual cleaning e.g. gloves, eye protection, face masks, waterproof aprons. A first aid kit and eye wash bottle should also be available nearby in case of sharps injuries or splashing into eyes.

Ultrasonic Cleaners

Ultrasonic cleaners may be used. This follows manual cleaning. It is important that the correct cleaning fluid is used in the ultrasonic cleaner; in accordance with manufacturer's instructions. The ultrasonic cleaner should have a cover/lid to minimise the risk of aerosol contamination of the atmosphere. The ultrasonic cleaner's water should be emptied at the end of the day down the dirty sink, or sooner if it appears to be heavily contaminated. It should then be rinsed out and cleaned, ready for fresh water and cleaning fluid to be added when it is next used. Good maintenance is essential. For safety reasons, ultrasonic cleaners ideally should not be used within the clinical environment.

Cleaning using a washer disinfector

Using a washer-disinfector is the preferred method for cleaning podiatric instruments because it offers the best option for control and validation of cleaning. Washer disinfectors are less labour intensive and have less health and safety implications. They are, however, more expensive and require additional space and so may not be possible in all situations.

Rinsing, inspection and care of instruments

Instruments cleaned in an ultrasonic cleaner or by hand should be rinsed thoroughly to remove residual debris and detergent, in a dedicated sink or bowl. This step may be omitted if a washer disinfector is used.

Whichever cleaning method is used, all instruments should be checked after cleaning, to ensure that they are clean, functional and in good condition. If there is any residual debris remaining on the instruments following cleaning, the instruments must undergo another cycle of cleaning. Occasional use of a lubricant may be required for moving parts; a non-oil-based lubricant should be used to avoid interfering with the sterilisation process.

Where the instruments are to be sterilised in a:

- vacuum autoclave, they should be dried using a disposable non-linting cloth before being wrapped, if it is intended to sterilize them wrapped; or
- non-vacuum autoclave, or unwrapped in a vacuum autoclave, they should be sterilised as soon as possible after cleaning to avoid air-drying, which can result in corrosion and microbial growth.

Sterilisation

The College accepts the use of bench top autoclaves for the sterilisation of podiatry instruments. The autoclave should be:

- Used in accordance with the manufacturer's instructions and any safety requirements; and
- Installed, commissioned, validated and maintained appropriately in compliance with the manufacturer's instructions.

All steam sterilisers are subject to the Pressure Systems Safety Regulations 2000 and must be examined periodically by a competent person.

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The below methods are acceptable for routine podiatry care:

Instruments are regarded as **sterilised and therefore clinically clean** when they

- have been cleaned, inspected and have undergone sterilisation unwrapped (in any type of steriliser) and are stored in a manner designed to limit environmental recontamination. By undergoing the sterilisation process, the chain of potential microbial cross-infection between patients is broken. Instruments intended for nail surgery and wound management should be used as soon as possible, after allowing time for the instruments to cool down.

Instruments are considered to be **sterile** when they

- have been cleaned, inspected and then wrapped before being sterilised in a steriliser designed to process wrapped instruments (e.g. a vacuum steriliser); to maintain sterility, these instruments must be stored with the wrapping intact until immediately before use;

Or

- are bought as sterile single-use items and used in accordance with manufacturers' instructions. (i.e. used immediately on removal from the sterile pack and used only once).

Instruments for Podiatric Surgery and Nail Surgery must be sterile.

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Storage and use of decontaminated instruments

Sterilised instruments processed in a non-vacuum steam steriliser stored for later use must be:

- Stored in a clean, disinfected, dry airtight container or in sterilised lidded instrument trays.
- Instruments stored in trays or loose must be sterilised for each clinical session.
- Single use sealed instrument pouches may be used (instruments must be dried thoroughly by the autoclave drying cycle before opening the door as microbiological contamination can occur through wet/damp packaging. If drying cycle not available a disposable non-linting cloth may be used). Immediately after removal from the steriliser, instruments should be aseptically wrapped using suitable sealed view packs. This could be achieved by the use of forceps, clean gloves or any other appropriate process. In addition, the entire tray may be placed within a sealed pack for storage purposes.
- Instruments stored in pouches may be stored for up to 1 year. Following this the instruments must be reprocessed and stored in new pouches.
- All pouches must be labelled with date of sterilisation and expiry dates
- A stock rotation system must be used. 'First in first out'.
- Expiry dates must be checked and documented on a regular basis.
- If the pouch becomes wet or damaged the instruments must be sterilised again.
- Instruments sterilised in a non-vacuum autoclave, intended for nail surgery and wound management should be used as soon as possible, after allowing time for the instruments to cool down.
- Instruments must never be sterilised within pouches with this type of autoclave

Sterilised instruments processed in a vacuum autoclave stored for later use must be

- Sterilised within pouches designed for this type of autoclave only.

- Instruments sterilised in pouches may be stored for up to 1 year within a clean container.
- All pouches must be labelled with date of sterilisation and expiry date.
- A stock rotation system must be used.
- Expiry dates must be checked and documented on a regular basis.
- If the pouch becomes wet or damaged the instruments must be sterilised again.

Recommendations for the use of benchtop sterilisers

Printer

It is not a legal requirement to have a printer or data logger attached to the autoclave; however, it is advisable as this can assist with the tracking of instruments and fulfil your daily testing requirements. For this the College recommends that all members, when purchasing a new autoclave, select a model that has a data logger or printer attached. It is advisable that the printouts from the autoclave are scanned electronically or photocopied and then filed in chronological order within your log book – this is due to the issue of the ink from the printout fading in time. You need to keep your records the same amount of time as you are required to keep the patient records. This is currently for an adult is 8 years after the patient's last appointment. For children and young person under the age of eighteen, it is until their 25th (twenty-fifth) birthday. Or, for mentally disordered persons (within the meaning of the Mental Health Act 1983), the required time is for 20 years after their last treatment.

Temperature

Sterilisation should be performed at the highest temperature compatible with the instruments in the load. For podiatry instruments and equipment, the College states that autoclaves reach a temperature of 134-137^{o}C for three minutes.

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Water

Change the water in the reservoir of benchtop steam sterilisers regularly using distilled water. This should be done on a daily basis. Where invasive procedures such as nail surgery, wound management, or blunt dissection are undertaken, members must use freshly prepared distilled or reverse osmosis (RO) water, or sterile water for irrigation.

Used water when emptied from the reservoir should be disposed of via the dirty sink, so as not to contaminate the clean sink.

Loading of instruments

Where instruments have a lumen a vacuum autoclave is necessary. A vacuum autoclave also permits the sterilisation of wrapped instruments, this can be advantageous in some circumstances, but is not necessary where wrapped or lumen items are not being sterilised.

Instruments in a non-vacuum autoclave must be loaded in such a manner to allow sufficient circulation of steam and therefore adequate sterilisation (see Appendix C).

Testing

All autoclaves should be installed following the supplier or manufacturer guidelines, to ensure that it is safe to operate and that it functions within predetermined parameters. Some manufacturers recommend commissioning of an autoclave before first use. If this is the case it must be recorded in your logbook.

Validation and Maintenance of benchtop sterilisers

In addition to commissioning all autoclaves need to be validated annually and maintained according to the manufacturer's instructions by a test person qualified to maintain benchtop sterilisers.

Each autoclave must have a logbook (file) in which details of the maintenance, validation, faults, modification and routine testing are recorded. The logbook should be kept up-to-date and kept in close proximity to the benchtop steriliser.

User testing

Testing is an integral part of ensuring the benchtop steriliser consistently performs to the operating parameters set during the machine's commissioning and maintenance. Failure to comply with the regular testing of the autoclave could compromise safety, may have legal implications, as well as possible implications for your professional indemnity and pressure vessel insurance.

Daily and weekly checks are required, and observation recorded on a form such as that suggested in Appendix D, which should be stored with the autoclave logbook. Each day checks must be performed to ensure that the benchtop steriliser holds the target sterilisation temperature and pressure for the specified time, that the chamber and shelves are clean and free of debris and that the rubber door seal is clean, using a damp non-linting cloth.

The test can be performed with a load in the chamber but should be conducted with the same or similar load every time. If the autoclave fails to hold any of the target sterilisation temperature and pressure for the specified time, repeat the test and, if it fails again, call the maintenance contractor.

For vacuum benchtop sterilisers, it is necessary to undertake a weekly air pressure leak test. It is therefore advisable that any vacuum autoclave has an automated air pressure leak test. Additionally, it is necessary to undertake a daily Bowie-Dick-type test pack, so as to ensure adequate steam penetration.

Pressure vessel insurance

As part of the College membership you have third party insurance for your autoclave; this will cover you if the autoclave injures a patient in some way or similar. It does not cover you for damage to

the building or break down of the machine therefore you may wish to gain other insurance for these eventualities.

Training and Safety

It is important that anyone who is undertaking the decontamination of instruments within podiatry as part of their continuing professional development keeps up to date with an acceptable standard for decontamination. Also, that they read the manufacturer's instructions for any equipment and also safety information sheets for any chemicals that they may use.

It is important to undertake COSHH assessments on any chemicals used and to adhere at all times to the manufacturer's safety recommendations. Suitable personal protective equipment, eye and mouth protection, gloves and waterproof apron should be worn at all times when decontaminating instruments.

For ease of reference a checklist of the competencies for a person undertaking the decontamination of instruments is provided in Appendix E.

List of appendices

A Overview of decontamination process (wall poster)
B Manual cleaning protocol
C Loading of instruments for sterilisation in a non-vacuum autoclave
D User testing record forms
E List of competences
F Instrument Traceability Systems

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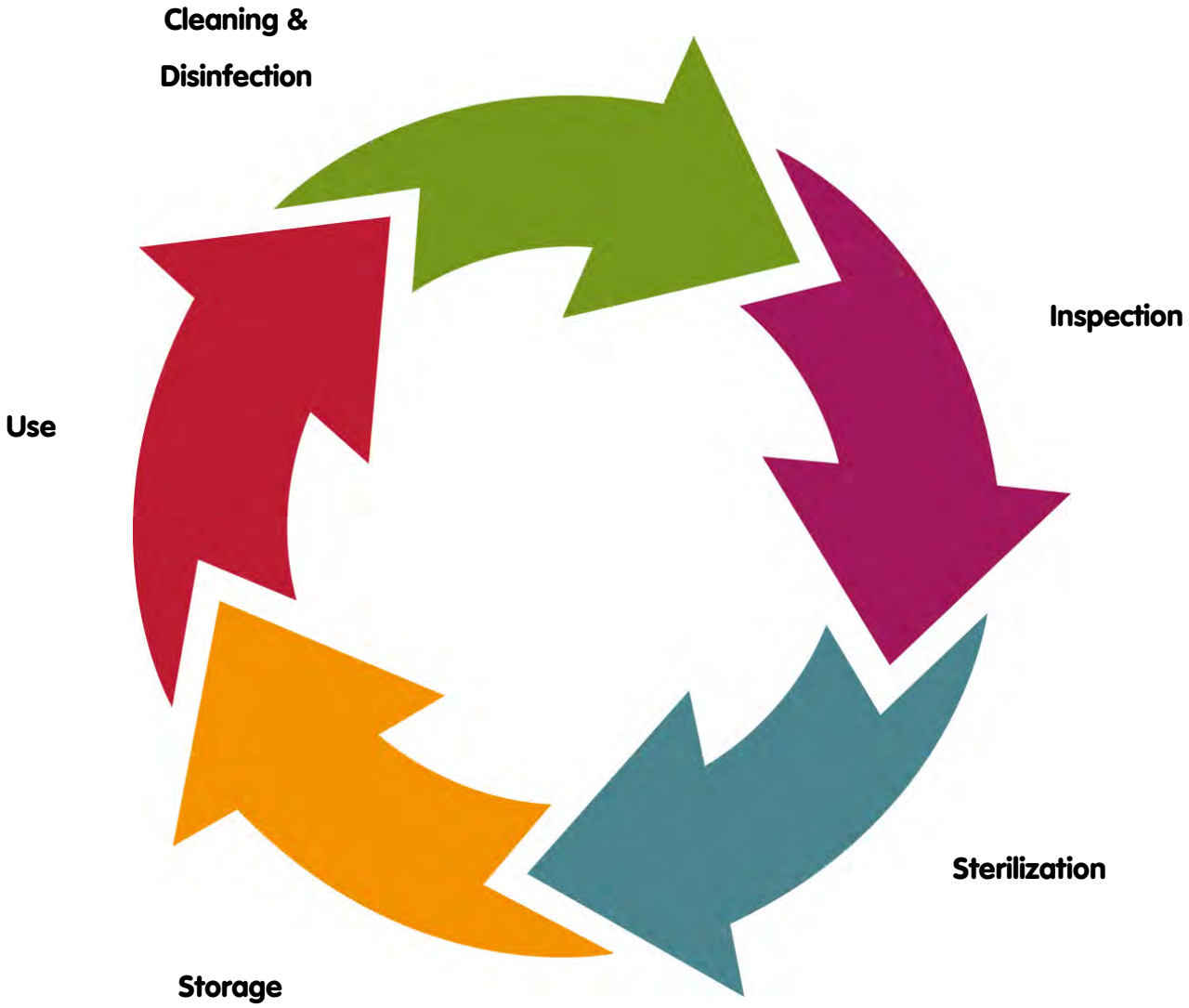
Appendix A

Decontamination Process



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Appendix B

Manual Cleaning of Instruments

Check that it is safe to immerse the device (not for electrical equipment).

1. Fill the clean sink or receptacle with water below 35°C.

2. Wearing protective clothing, dismantle or open the instrument to be cleaned (where appropriate) and remove gross soiling by brushing, wiping, agitating and irrigating the item while it is submerged, taking care to ensure it remains under the surface of the water at all times to prevent the creation of aerosols.

3. Scrub instruments using a brush with soft plastic bristles. Wash brushes with detergent and hot water after each use to remove visible soil and store dry and head up. Brushes should be autoclaved at the end of each session or ideally be single use.

4. Remove the item, drain it and then rinse it by submerging, and agitating, it in clean water in the second sink.

5. Remove and drain the item ensuring it is not re-contaminated.

6. Dry using the preferred method.

If the water becomes obviously soiled or contaminated, it should be changed and the process repeated.

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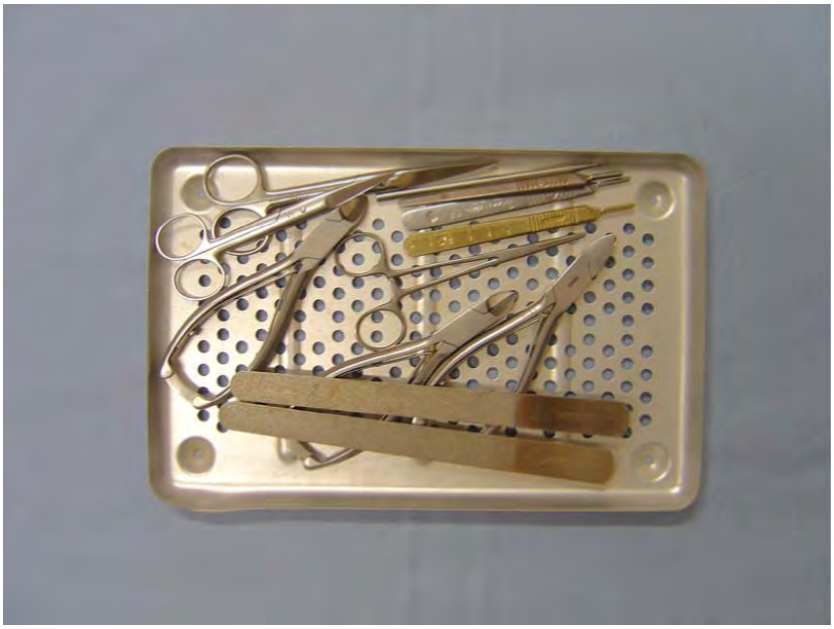
Appendix C

Photographs showing how to, and how not to load a tray of instruments for sterilisation in a non-vacuum autoclave.



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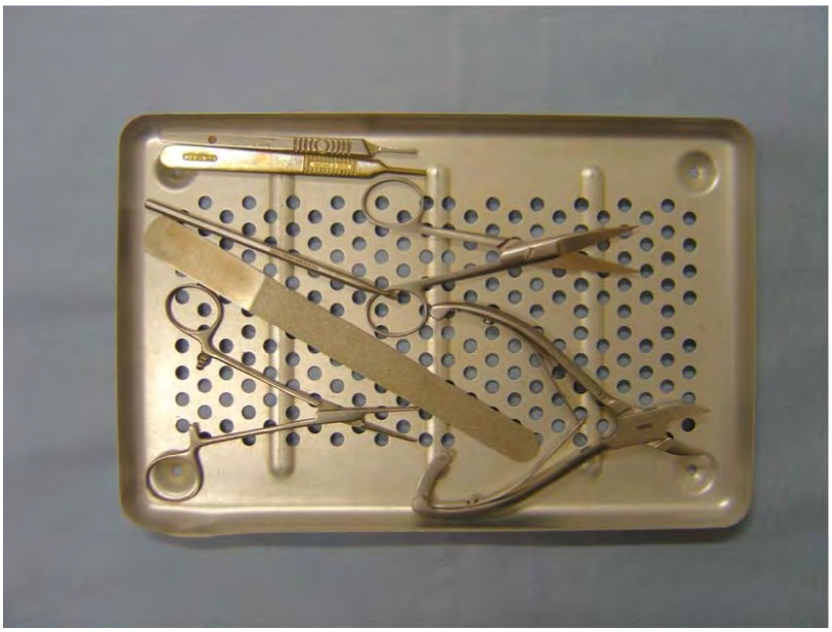

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Appendix D

User Testing of Benchtop Sterilisers

(non-vacuum autoclave)

Record Sheet

Daily Tests

Date:							
Cycle number:							
Max Holding Temperature:							
Min holding Temperature:							
Pressure during holding temp:							
Total time at holding temp:							
Testers Initials:							
CHECKED CHAMBER							
CHECKED DOOR SEAL							
CHANGE WATER							

Weekly tests

		Comments	**Tester Initials**
Door seal secure	Yes/No		
Door safety device functioning correctly	Yes/No		

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Appendix E

A checklist of competencies for persons undertaking the decontamination of reusable podiatry instruments.

1. To understand the importance of proper decontamination of reusable podiatry instruments to reduce the risks of cross infection.
2. To be aware of the need to keep dirty and clean instruments separate and of the importance of maintaining a process that achieves a 'one-way' trip from the dirty to clean area, that avoids dirty water being splashed onto sterilised instruments, or onto work surfaces on which cleaned and sterilised instruments will be laid.
3. To be able to locate and understand the COSHH assessment forms for chemicals used in the decontamination of instruments.
4. To identify appropriate protective equipment/clothing and understand when to use it when decontaminating instruments.
5. To know what actions to take should a 'Sharps injury' occur and why urgent action is necessary.
6. To be trained in the use of an eye wash kit in the event of a splash contaminating an eye.
7. To be competent in the use of automated cleaning equipment and the use of benchtop sterilisers.
8. To be aware of the difference between detergents and disinfectants and the role of each in the decontamination processes and the consequences of using a disinfectant in the cleaning process.
9. To understand the rationale for keeping the lid closed when the ultrasonic cleaner is in use, and for changing the water daily or sooner if it appears to be heavily contaminated.
10. To understand the principles of manually cleaning instruments and that this is mandatory.
11. To know how to safely load instruments in the autoclave for proper sterilisation.

12. To understand why sterile water for irrigation is recommended and why *freshly* distilled water is an acceptable alternative
13. To be aware of the importance of changing the water in the autoclave daily and the consequences of not doing so.
14. To be able to undertake daily and weekly user tests for benchtop sterilisers and know how and where to record the results
15. To know whom to contact and what to do in the in the event of a cycle failure for bench top sterilisers.
16. To know how to record the information required for tracing instruments through the decontamination process.

Appendix F

Instrument Traceability Systems

Date	Time	Autoclave Number	Cycle number	Cycle Outcome	Tray Number	Patient Identification Number	Attach Print Out
			0001	Pass Fail	---------- ---------- ---------- ----------	---------- ----------	
			0002	Pass Fail	---------- ---------- ---------- ----------	---------- ----------	
			0003	Pass Fail	---------- ---------- ---------- ----------	---------- ----------	
			0004	Pass Fail	---------- ---------- ---------- ----------	---------- ----------	
			0005	Pass Fail	---------- ---------- ---------- ----------	---------- ----------	

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Clinical Standards

Standard 9
Infection Control

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Standard 9 - Infection Control

Background

Healthcare associated infections are caused by a wide range of microorganisms. They can be transmitted from one person to another but are often carried by the patients themselves, and have taken advantage of a route into the body provided by an invasive procedure.
Healthcare workers, family members and carers are also at risk of acquiring infections when caring for patients. Healthcare workers specifically are at an increased risk of infection from blood borne viruses. Many of the people who engage with healthcare have increased susceptibility to infection due to a number of risk factors including:

Recommended treatment options which were discussed, including no treatment.

- Extremes of age
- Being immunocompromised
- Poor nutrition
- Underlying medical conditions
- Medication
- Incontinence
- Surgical procedures
- Indwelling medical devices such as urinary catheters
- Wounds
- Living in shared accommodation
- Having frequent contact with healthcare facilities

Healthcare-associated infections can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life.

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As well as causing unnecessary illness, and potentially death, infections delay recovery and adversely affect quality of life and are a cost burden. Avoidable infections related to care are not only potentially damaging to a practitioner's reputation, they may also lead to litigation.

Patient safety is a cornerstone of care, and preventing healthcare-associated infections is a priority. All patients have a right to expect certain standards when accessing healthcare, and not to be exposed to unnecessary risks.

Under Health and Safety at Work Legislation employers must put in place measures to protect staff from such risks, and staff must co-operate with these to protect themselves and others.

Practitioners need to understand the risk of cross infection. Risk assessments determining possible routes of transmission of infectious agents must be carried out. These risks must be mitigated through the implementation of effective infection prevention and control measures, such as those described in this document. These are an essential part of high quality care and contribute to the safety of patients, healthcare staff and others.

Infection Control Policy

All practitioners and their staff:

- Must be aware of the policy and have sufficient training and resources to implement it.
- Understand and follow the Infection Control Guidance which aims to reduce the risk of transmission of infection to patients, staff and others, from the work being carried out
- Co-operate with measures required to prevent the spread of infection
- Ensure that wherever care is delivered they have available appropriate supplies of:
- materials for hand decontamination

- sharps containers
- personal protective equipment
- Complete CPD on Infection Prevention and Control as required for HCPC registration (Registered staff) as per CPD guidelines.
- Provide relevant information on Infection Prevention and Control (IPC), including information on hand hygiene, to patients and carers if requested

Podiatrists should make the Infection Control Policy available for patients and other stake holders to view if requested; and take part in any audit of the policy which may be undertaken by managers/practice leads.

Podiatrists must undertake risk assessments for specific procedures and for specific cases of infection, to inform where additional infection control measures need to be put in place. These will be properly documented and reviewed. Advice on risk assessment can be found;

- in the College's Health and Safety handbook
- from the Professional Support Officers and the Health, Safety and Wellbeing Panel
- from documentation on the Health, Safety and Wellbeing section of the College website and via the Professional Standard.

Other relevant policies must also be followed e.g. decontamination, waste management
Any queries about Infection Control Policy should be directed to the Health, Safety and Wellbeing Panel via the Professional Support Officers **professionalsupport@cop.org.uk**.

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Standard Precautions

Standard precautions should be followed at all times.

Standard Infection Control Precautions (SICPs) must be put in place to reduce the risk of transmission of micro-organisms during healthcare activities. They are necessary to ensure the safety of patients, health care workers and visitors to healthcare settings/environments.

Standard Precautions developed from Universal Precautions, which were first introduced to prevent the spread or transmission of blood borne pathogens to healthcare providers. Standard Precautions now incorporate the necessary elements to prevent the transmission of a wide range of infectious agents, not only to healthcare personnel but also to patients and others.

As we cannot tell who might carry infectious micro-organisms Standard Precautions must be used whenever and wherever health care is being provided.

Standard Infection Control Precautions cannot prevent infection transmission from all infectious agents, and where specific infectious agents are suspected or known additional transmission-based precautions may be required (e.g. droplet precautions for preventing the spread of influenza).

The Standard Infection Control Precautions include:

- Hand decontamination
- Use of Personal Protective Equipment (PPE)
- Occupational Exposure Management including sharps
- Safe disposal of clinical waste
- Correct dealing with spillages of blood and body fluids
- Management of the Healthcare Environment
- Management of Equipment.

- Safe Care of Linen including Uniforms

Hand Decontamination

"Hand hygiene, a very simple action, remains the primary measure to reduce healthcare associated infection and the spread of antimicrobial resistance, enhancing patient safety across all settings" (WHO 2005)

To prevent the spread of healthcare associated infection, it is vital for those providing care to decontaminate their hands at all the right times, and in the correct way.

Other infections, endemic in the community, are also commonly spread through direct or indirect contact, mediated by hands. So good hand hygiene, by everybody is an important way of preventing spread.

When

Everyone should decontaminate their hands:

- Before starting work and before going home
- After using the toilet
- Before eating and handling preparing food
- After handling pets
- After handling raw food
- After any cleaning activities
- After potential contact with body fluids
- After handling refuse and clinical waste

  When hands look or feel dirty

During patient care hands must be decontaminated according to the 5 Moments Model

1. Clean your hands immediately before touching a patient.
2. Clean your hands immediately after touching a patient or their immediate surroundings (including footwear and orthotics).
3. Clean your hands immediately before an aseptic technique.
4. Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
5. Clean your hands after touching any object or furniture in the patient's immediate environment before leaving – even if the patient has not been touched.

What With

Alcohol Hand rub

The effective use of alcohol based hand rubs will both remove transient, and reduce the number of resistant, micro-organisms. They are a practical and acceptable alternative to hand washing with soap and water in most situations.

Therefore alcohol hand gel (conforming to current British standards), should be available at all points of care and can be used except:

- where there is potential for the spread of alcohol-resistant organisms (e.g. Clostridium difficile or other organisms that cause infectious diarrhoea)
- Where hands are contaminated with dirt/organic matter/body fluids
- When hands have become "sticky" with residue from the product

In all these cases hands should always be washed with soap and water.

However, if soap and water is not available, using alcohol hand gel is preferable to nothing in all situations

There are some risks associated with alcohol gels and rubs which include:

- Ingestion and eye exposure
- Skin irritation
- Fire

Therefore, a local risk assessment should be undertaken that ensures placement of alcohol hand rub at the point of care, and minimises any risks associated with use.

Soap and Water

Washing with plain soap and water mechanically removes transient micro- organisms. It is sufficient for

- routine daily activities and
- Most clinical and social care tasks

It is the way to decontaminate hands when:

- They are visibly soiled with dirt/organic matter
- They are potentially contaminated with body fluids (e.g. after going to the toilet)
- When looking after/contact with patients/people suffering from vomiting or diarrhoea/*Clostridium difficile* infection
- After several consecutive applications of alcohol hand rub, when a sticky residue will build up

Soap should be provided in a dispenser and bar soap should not be used.

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Antiseptic Solutions

Antiseptic solutions include:

- Chlorhexidine gluconate
- Povidone Iodine

These reduce resident as well as removing/destroying transient micro-organisms. They may offer a prolonged effect, and carry on killing and inhibiting micro-organisms for a time after application They are not necessary for most clinical activity, but may be advised for some invasive procedures, in outbreak situations, and for surgical hand decontamination and highly invasive procedures. Alcohol hand rub can also be used following hand washing with soap and water, in place of antiseptic solution/antimicrobial soap, when a higher level of skin disinfection (e.g. before an aseptic task) is required.

How

To ensure that hands can be effectively decontaminated, podiatrists providing direct patient care should be:

- bare below the elbow (Local policy may allow a plain wedding band, if this is the case the band should be moved during hand hygiene to allow the area beneath it to be decontaminated)
- Have short, clean fingernails with no nail polish, false nails or polish
- Cover any cuts and abrasions with a waterproof dressing
- They should not use nail brushes

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NHS
National Patient Safety Agency

Your 5 moments for hand hygiene at the point of care

1	**BEFORE PATIENT CONTACT**	**WHEN?** Clean your hands before touching a patient when approaching him/her **WHY?** To protect the patient against harmful germs carried on your hands
2	**BEFORE AN ASEPTIC TASK**	**WHEN?** Clean your hands immediately before any aseptic task **WHY?** To protect the patient against harmful germs, including the patient's own, from entering his/her body
3	**AFTER BODY FLUID EXPOSURE RISK**	**WHEN?** Clean your hands immediately after an exposure risk to body fluids (and after glove removal) **WHY?** To protect yourself and the healthcare environment from harmful patient germs
4	**AFTER PATIENT CONTACT**	**WHEN?** Clean your hands after touching a patient and her/his immediate surroundings when leaving the patient's side **WHY?** To protect yourself and the healthcare environment from harmful patient germs
5	**AFTER CONTACT WITH PATIENT SURROUNDINGS**	**WHEN?** Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched **WHY?** To protect yourself and the healthcare environment from harmful patient germs

Adapted from WHO World Alliance for Patient Safety 2006

cleanyourhands® campaign

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Hand Washing (With soap and water or antiseptic solution and water)

An effective handwashing technique involves three stages: preparation, washing and rinsing, and drying. Preparation requires wetting hands under tepid running water before applying liquid soap or an antimicrobial preparation. The hand wash solution must come into contact with all of the surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 10–15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly before drying with good quality paper towels.
An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination. If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation an occupational health team or GP should be consulted. Follow the instructions on page 11.

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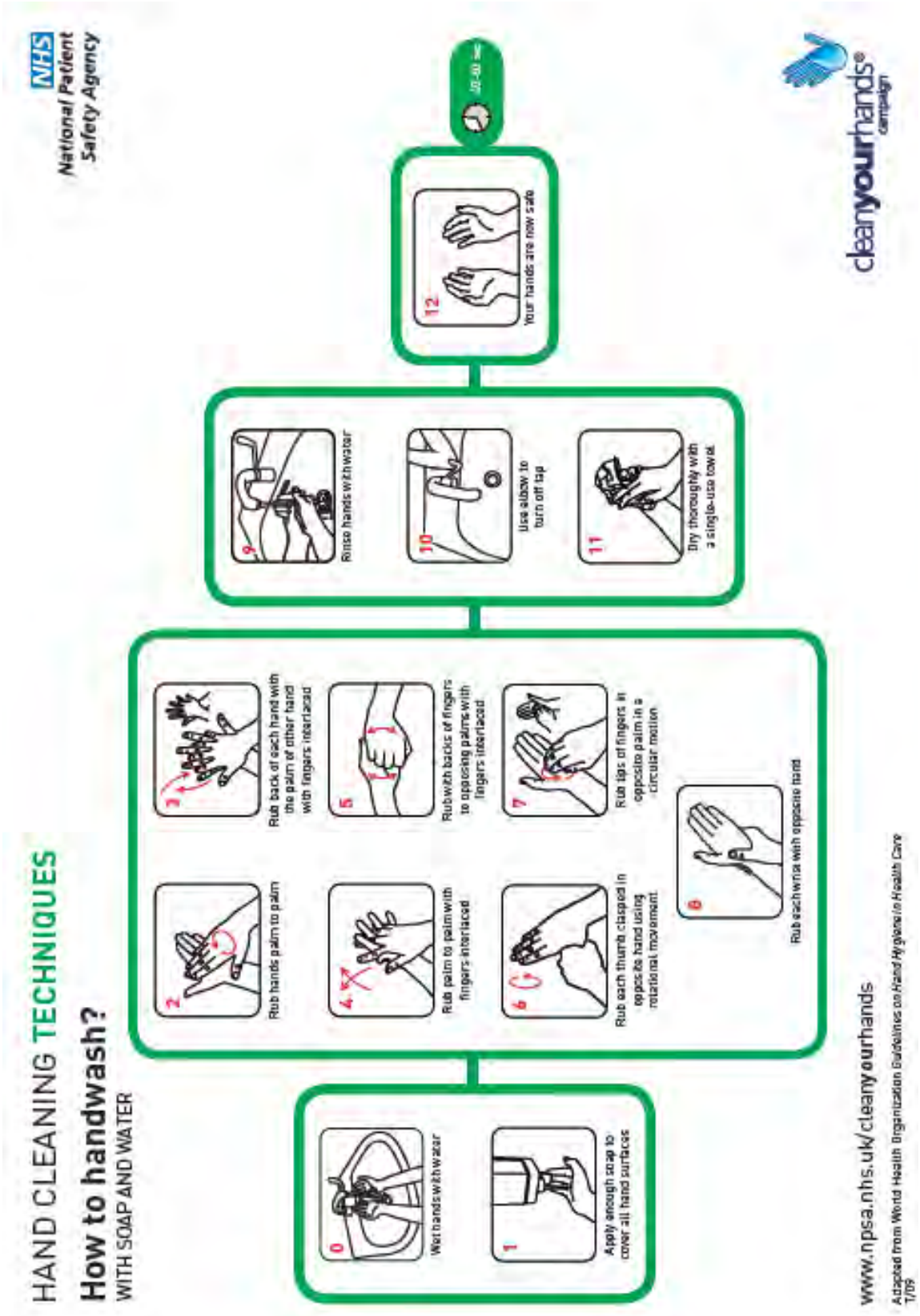

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Hand Decontamination (with alcohol hand rub)

When decontaminating hands using an alcohol hand rub, hands should be free from dirt and organic material. The hand rub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry. Follow the instructions on Page 13.

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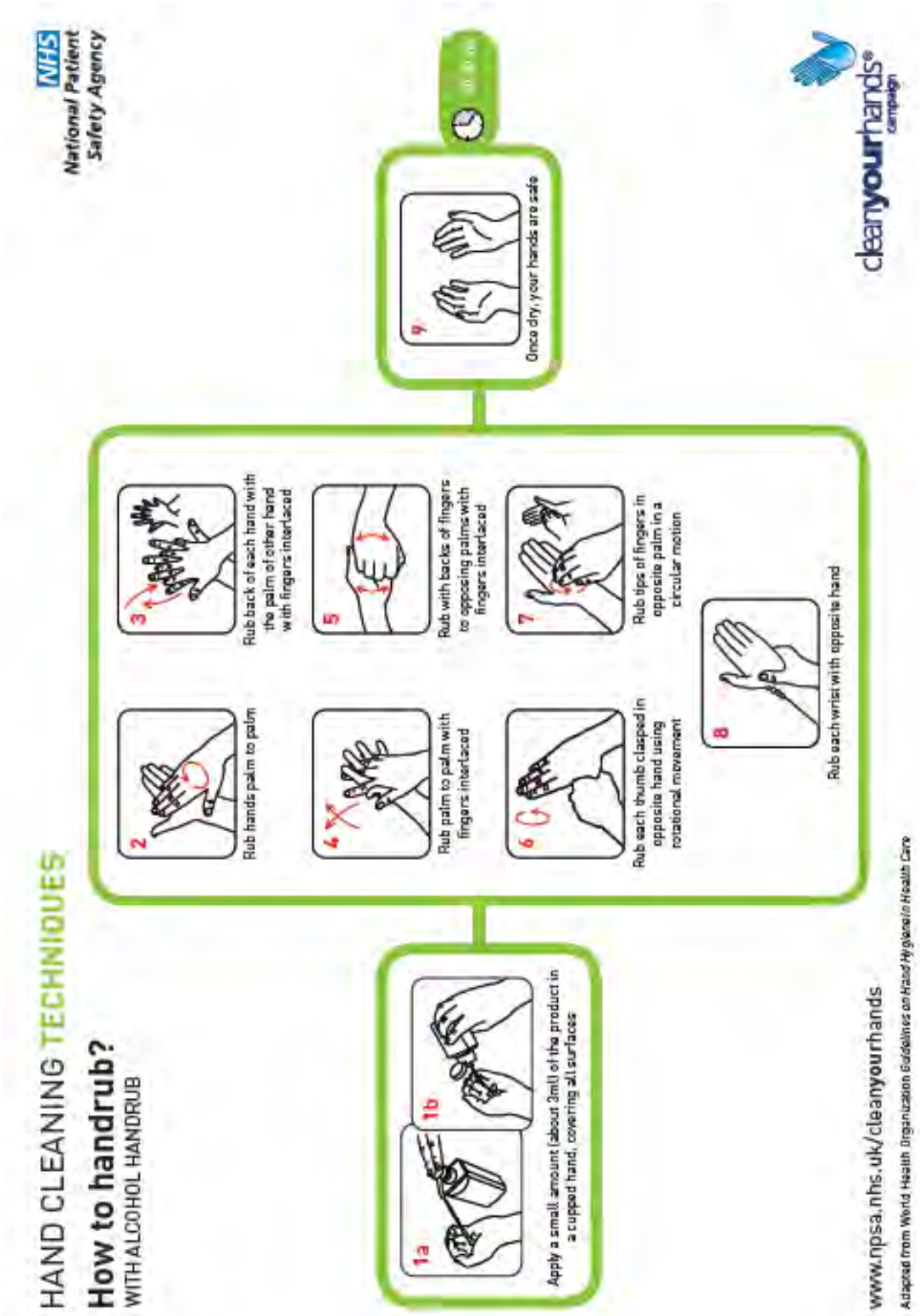

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Hand Drying

Hands should be dried thoroughly using good quality paper hand towels. Dispose of paper towels into a hands free domestic waste bin.

In domiciliary settings ask the patient to provide a clean towel at every visit or take disposable paper towels into the home.

Reusable cotton towels must not be used in clinical areas.

Surgical Hand Decontamination

Use an approved antiseptic hand cleanser from a dispenser and carry out hand hygiene process for at least 2-3 minutes or as per manufacturer's instructions

Or:
Wash with plain soap and water followed by 2 applications of alcohol hand rub
Include wrists and forearms
Dry hands with sterile paper towel

Hand Health

An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination.

If a particular product used for hand decontamination causes skin irritation an occupational health specialist or suitable medical practitioner should be consulted.

Where

Hands should be washed at designated hand wash basins which must not be used for other activities.

Clinical hand wash basins

- Should have wrist, elbow, foot or movement sensor operated non-touch tap systems- if they do not, taps should be turned off after hand washing using a paper towel
- Should incorporate mixer taps or thermostatic mixer valves
- Should not have a plug or overflow
- The water jet should not discharge directly over the drainage hole
- Hand hygiene solutions should be available at the sink and preferably be wall mounted
- Liquid soap should be provided in sealed disposable cartridges, which are not refilled.
- Dispensers should have clean nozzles and be in good working order
- There should be information at hand wash basins to remind staff how to decontaminate hands effectively.

Personal Protective Equipment (PPE)

In healthcare exposure to micro-organisms and chemicals cannot be completely removed so PPE is used to manage the risk.

PPE includes:

- Gloves
- Aprons/gowns
- Face, mouth/eye protection, e.g. masks/goggles/visors.

PPE must be used where there is a risk that a healthcare worker may come into direct contact **with blood or other body fluids, non- intact skin, mucous membranes or contaminated equipment**.

Which PPE is required should always be decided following an assessment of the risk of contamination of the healthcare workers' clothing and skin by the patients' blood, body fluids, secretions or excretions and the risk of transmission of infection to the patient (see below).

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Use of PPE according to Risk

Low Risk	Moderate Risk	High Risk
No risk of contact with blood and body fluids	Risk that clothing or skin will be contaminated with blood and body fluid	Risk that eyes, clothing or skin will get splashed with blood and body fluids
PPE not required	Apron and gloves	Eye and face protection, water repellent gowns and gloves

Most PPE is single use and should not be re-used.

The use of PPE such as gloves does not negate the need for hand hygiene. Hand hygiene should be performed before donning and immediately after removal/disposal of PPE.

Under the COSHH Health and Safety at Work Act COSHH regulations. All PPE must be:

- Adequate
- Effective
- Suitable
- Marked to PPE Directive 89/686/EEC CE
- Selected, used, maintained, tested correctly by trained people, with appropriate records kept
- Stored correctly

Accordingly, all PPE must be:

- Appropriate for the task/purpose
- suitable for the person using/wearing it with a selection of sizes available
- Available at the point of use
- Stored off of the floor, in a clean, dry area
- Dispensed directly from the original box/container
- In date and undamaged (PPE that is damaged during use should be removed immediately (safety permitting) and replaced
- Removed immediately following a procedure
- Disposed of immediately after use in the appropriate waste stream

It must not

- interfere with the task
- Be reused for a different patient/client/procedure/area (It may be necessary to change PPE such as gloves and aprons between tasks on the same patient/client to prevent unnecessary cross-contamination).
- Be a source of further contamination, e.g. by being removed and left on surfaces.
- Put on and removed in the correct order (see below)

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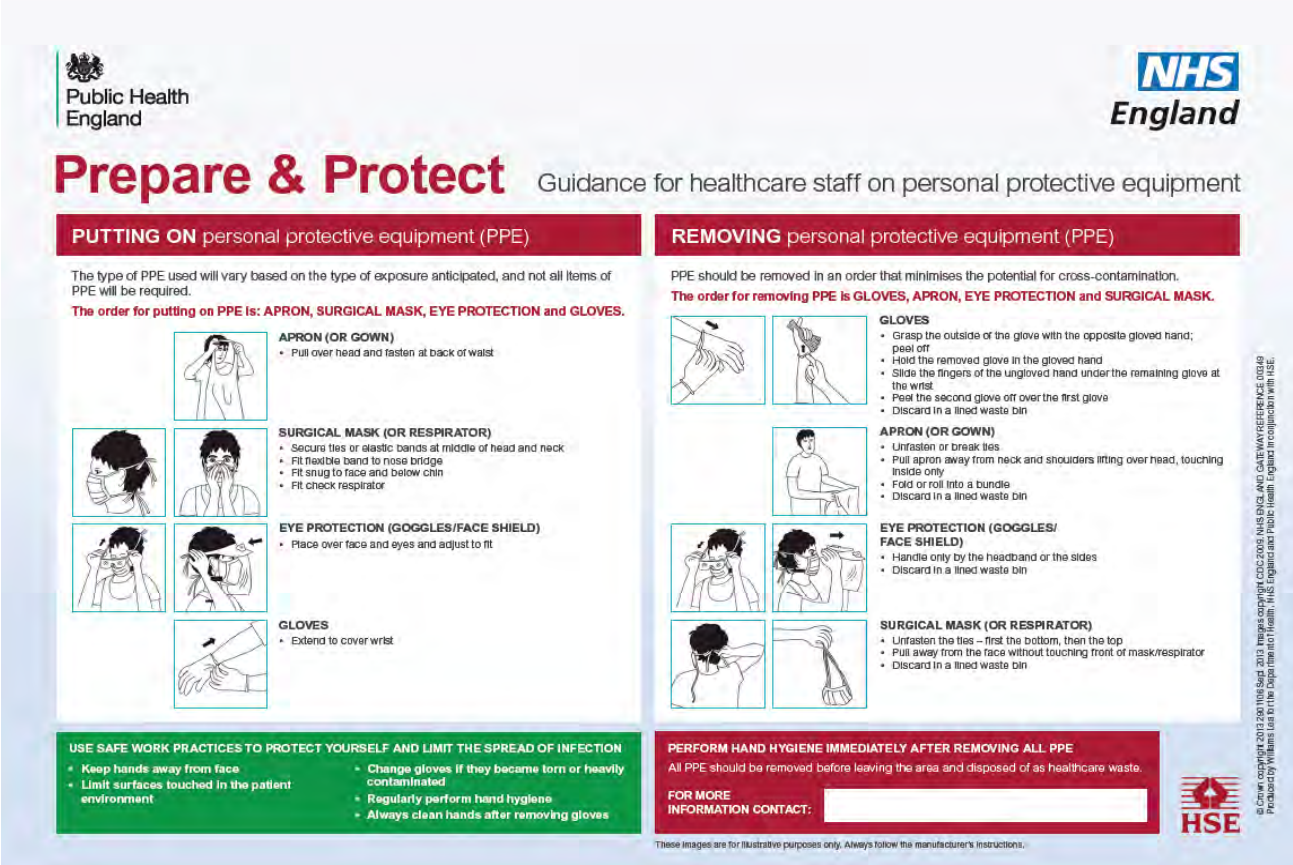

Gloves

Gloves act as a physical barrier to prevent contamination by blood and body fluids, chemicals and micro-organisms. However the integrity of any glove cannot be taken for granted, and staff should be aware that complete protection or contamination prevention of their hands cannot be guaranteed.

Prolonged use of gloves can increase the risk of occupational dermatitis because of exposure to the substance or chemicals used to manufacture gloves.

Therefore healthcare workers must undertake a risk assessment to decide if they need to wear gloves, and if so, which ones to use.

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As for all PPE use, glove use should be based on a risk assessment of all potentially risky tasks.
This assessment should consider the potential for contact/contamination with blood/body fluids.
Following risk assessment:

Gloves are not usually required where there is no potential for contact/contamination with blood or body fluids
But
Are required for any procedure where exposure to blood/other body fluids may occur.
In practice, this means that podiatrists would normally need to wear single use disposable gloves for:

- All activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions
- All activities involving the use/handling of sharp or contaminated instruments where the risk of exposure to blood or bodily fluids is high.
- All invasive procedures
- All contact with sterile sites and non-intact skin or mucous membranes

Gloves may also need to be worn where treatment is being given to patients who are being nurses/cared for under contact precautions, due to infection risk. This should be communicated to the podiatrist by the medical staff/organisation implementing these precautions.

Podiatrists may need to use sterile gloves during clean/aseptic procedures.
Gloves must comply with the relevant standards.

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Gloves intended to protect the patient and those intended to protect the wearer, come under two different sets of regulations.

- Gloves worn as PPE must meet the Personal Protective Equipment Regulations (1992) and carry a CE mark (must conform to EN420 and also to EN374 if chemical protection is required)
- Gloves used for patient protection are not classified as PPE, and are certified under medical devices regulations (must conform to EN455).

All gloves used for direct patient care:

- must conform to current EU legislation by being CE marked as medical gloves for single use and
- Be appropriate for the task

Sterile gloves should be worn during aseptic non-touch techniques where key parts/sites might be touched during the procedure

To protect the wearer:

- Do not use polythene gloves for clinical interventions.
- Latex gloves may cause sensitivity/allergic reactions. If latex gloves are used ensure they are powder free and that latex gloves are available for treatment of patients/use for staff who have sensitivity to latex (A risk assessment must be carried out). It is recommended that nitrile gloves are used instead of latex.

Gloves must be:

- Put on immediately before an episode of patient contact or treatment
- Removed as soon as the activity is completed

- They may need to be changed several times, and hands decontaminated, during an episode of patient care, depending on the tasks being undertaken.
- Torn, punctured or otherwise damaged gloves should not be used and should be removed immediately (safety permitting) if this occurs during a procedure.
- Removed with care to prevent contamination of hands and clothing.
- Disposed of immediately after used into the correct waste stream following risk assessment.

Hand hygiene should be performed immediately after the removal and disposal of gloves.

Gloves are single use and must never be decontaminated.

Aprons and Gowns

A plastic disposable apron should be worn for close contact with patients if there is a risk that clothing may be exposed to blood, body fluids, or potentially infectious debris.

Wear a long-sleeved fluid-repellent gown if there is a risk of extensive splashing of blood, body fluids, secretions or excretions onto skin or clothing.

Disposable plastic aprons or gowns must be:

- Single use for one procedure or one episode of direct patient care
- Removed immediately following use (avoid touching the front outside surface during removal) and disposed of into the correct waste stream following risk assessment.

Face Masks and Eye Protection

Face masks and eye protection must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes.

Respiratory protective equipment, for example a particulate filter mask (FFP), must be used when clinically indicated.

A risk assessment should be undertaken to determine the level of protection required.

A splash proof surgical mask, with eye protection if required, is usually sufficient to protect healthcare workers from the risk of infections transmitted through droplet and splashes.

However healthcare workers may be exposed to potentially infectious particles in the air. There is some evidence that podiatrists may be exposed to airborne particles containing micro-organisms when filing/drilling nails, and an FFP respirator would be recommended to mitigate this risk. The HSE recommends that any FFP used to protect from potentially infectious micro-organisms meets the FFP3 standard. All FFP masks must be FiT tested by a competent person and FiT checked before use.

Goggles should be used to prevent splashing, or contamination of the eyes. This would include contamination by dust which may contain micro-organisms during drilling. Staff should not assume that spectacles will provide adequate protection.

Goggles must 'wrap around' the eye area to ensure side areas are protected.

They should either be single use or decontaminated after use according to manufacturers' instructions.

A face shield/visor may be considered, in place of a surgical mask and goggles, where there is a higher risk of splattering of blood/other body fluids.

Face protection must not be touched while being worn and must be removed promptly after use, avoiding contact with the front surface. Remove using the straps/ear loops/goggle legs only

(manufacturers' instructions where given should be followed). Turn masks inwards after removal for disposal.

Practitioners should use devices such as pocket masks to protect against exposure during mouth-to-mouth resuscitation

Safe Use and Disposal of Sharps and Management of Exposure to Blood borne Viruses

Exposure to potentially infectious body fluid/blood may be caused by:

- A cut or puncture of the skin by a contaminated sharp (blade, needle)
- Through exposure of broken skin to body fluid/blood
- Bites which break the skin and draw blood.

Such exposure may result in the transmission of blood borne viruses such as HIV, Hepatitis B (HBV) and Hepatitis C (HCV). Infection with these pathogens may be serious. Even where no infection is acquired, the emotional impact of such an injury may be severe and they have the potential to result in costly litigation.

Transmission of Blood borne virus requires inoculation of an infectious dose of infected body fluid into a susceptible recipient. The infecting dose may be as low as a visible drop of blood. However, individual factors affect the risk of transmission.

The following body fluids are considered as high-risk for the transmission of blood borne viruses:

- blood and blood products
- cerebrospinal fluid
- semen and vaginal secretions
- peritoneal fluid
- pericardial fluid
- synovial fluid

- pleural fluid
- amniotic fluid
- breast milk
- any other body fluid containing visible blood
- any unfixed organs or tissues

In relation to blood-borne infections urine, faeces, vomit, sweat, tears, skin and sputum are not considered high risk unless visibly blood-stained.

Risk is dependent on the prevalence of the viruses in the population and on the transmission rate - it is higher for HBV and HCV than for HIV.

The risk of transmitting blood borne viruses from patients to staff is greater than from staff to patients. Unfortunately, inoculation (sharps) and exposure injuries to healthcare staff are common. There is no evidence that BBVs can be transmitted by blood contamination of intact skin, by inhalation or by faecal-oral contamination. A simple injury, which does not break the skin or does not involve the inoculation of body fluids, is unlikely to lead to the transmission of infection. There is a smaller risk of transmission from splashes to eyes, nose or mouth with infected blood or body fluid.

BBVs are potentially transmissible by a human bite through mucous membrane exposure if the bite breaks the skin of the person bitten.

Thankfully most sharps injuries and other exposures to blood and body fluids are preventable.

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Percutaneous (often called Sharps) Injuries

The highest risk of transmission of blood borne viruses from patients to healthcare staff is via percutaneous exposure. In the UK a small, but significant number of health care workers, have developed potentially life-threatening diseases because of a sharps injury. Since the late 1990s at least seventeen health care workers have contracted Hepatitis C, and there have been five documented cases of HIV transmission (HPA, 2008 and 2010).

All of these transmissions occurred following percutaneous exposure.

Percutaneous exposure results from inoculation with a sharp instrument such as a scalpel blade or needle, used in clinical care, which may have been contaminated with blood, or a "high-risk" body fluid. However, lancets, razors, scissors, test tubes and even fragments of bones or patients' teeth can also cause sharps injuries.

The risk of infection following percutaneous injury caused by a contaminated needle is:

- one in three for hepatitis B;
- one in 30 for hepatitis C
- one in 300 for HIV (HPA 2008)

And will depend on a number of factors, which include:

- whether the device was previously in the patient's vein or artery;
- how infectious the patient is at the time of the injury.
- the depth of the injury
- the type of sharp used

Injuries involving hollow bore needles contaminated with appreciable amounts of blood carry the most risk.

Injuries which are caused by sharp devices occur:

- during use
- after use, before disposal
- during disposal
- after disposal

Injuries may affect cleaners and other staff handling waste after disposal if sharps are not disposed of properly.

Injuries have also been caused by sharps left in vehicles used by healthcare staff.

Mucocutaneous Injuries

Involve contamination of mucous membranes (eye, mouth, nose), or of broken skin with blood, or another “high-risk” body fluid.

Although Transmission of BBVs may result from mucocutaneous exposures, the risk is much lower than that associated with percutaneous injuries. The risk of acquiring HIV after a single mucocutaneous exposure is less than one in 2000.

However, these incidents happen more frequently than percutaneous exposure.

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Minimising the Risk of Occupational Exposure to Blood borne Virus

Preventing exposure incidents is best achieved through risk assessment and application of a hierarchy of controls.

- Follow safe systems of work (see below)
- **Risk assess and use appropriate personal protective equipment (PPE)** where there is any risk of contact with body fluids (See earlier above section on PPE) where there is any risk of contact with body fluids
- When providing care, closed-toed shoes should be worn to avoid contamination with blood or other body fluids or potential injury from sharps.
- Have Hepatitis B vaccination if at risk of exposure
- Use and dispose of sharps safely

Use and Disposal of Sharps

- Risk assess all tasks involving the use of sharps, putting in place any additional measures required to prevent injury
- Minimise unnecessary use of sharps
- Use sharps safety devices if a risk assessment has indicated that they will provide safer systems of working for healthcare workers, carers and patients.
- Use gloves when using sharps
- Needles must not be bent or broken before disposal and must not be recapped.
- Never try and retrieve items from a sharps bin
- Use the appropriate sized bin for the sharps that you are using and for the number of sharps you are likely to produce

Sharps:

- Should be handled as little as possible.
- Must not be passed directly from hand to hand
- Must be discarded immediately by the person generating the sharps waste into a sharps container conforming to current standards

Sharps containers must:

- Comply with UN and British standards
- Be assembled properly
- Be labelled properly
- Be kept in a safe position that
    - Is accessible at the point of care when in use
    - allows for safe disposal of sharps
    - avoids spillage i.e. using a bracket so it can not tip
    - is not accessible to the public
    - is out of the reach of children
- Only be used for the disposal of sharps
- Not be filled above the fill line
- Must be disposed of when the fill line is reached
- Must be temporarily closed when not in use
- Should be disposed of every 3 months even if not full
- Is sealed after use and not emptied into larger bins or put into waste bins or bags

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Transport of sharps

Transport used sharps as little as possible.

Do not keep unnecessary supplies of sharps in your car.

Make sure that sharps bin are transported in a secure way, to prevent spillage, boxes must be kept upright and secured during transport. This can best be achieved by carrying the box in a suitable, marked, secondary container.

Check the container /boot at the end of each session to ensure no sharps have been dropped or spilled in the vehicle.

If sharps have been spilled, do not use the affected area and, if necessary, the whole vehicle until made safe.

Contaminated vehicles should be cleared as soon as possible without compromising safety, e.g. using a torch, a special tool / device to avoid hand contact, and Personal Protective Equipment (PPE), being wary of sharps hidden in crevices and fabrics.

Remember - failing to take adequate precautions to protect oneself and others from the risk of sharps injury is potentially a criminal offence under health and safety legislation.

Immunisation

Hepatitis B vaccine is highly effective in reducing occupational Hepatitis B transmission.

Hepatitis B vaccination is recommended for healthcare workers who may have direct contact with patients' blood or blood-stained body fluids. This includes any staff that are at risk of injury from blood-contaminated sharp instruments – see the College's standard on immunisation.

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Protecting patients

Any practitioners undertaking an exposure prone procedure (EPP), must have had the necessary tests and immunisations to enable them to undertake the procedure with the minimum of risk to themselves and others.

(Exposure prone procedures (EPPs) are those where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These procedures include those where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all time. ***This will not apply to general podiatry practice).***

There is no requirement for testing of healthcare workers not undertaking EEPs for blood-borne viruses. However, if healthcare workers think that they have been exposed to BBV, then they have a professional duty of care to patients to seek medical advice on the need to be tested for blood-borne viruses. If they are subsequently found to be infected, they should get specialist medical advice on the need to modify their working practices to protect patients.

Sharps Injuries and management

Sharps injuries must be immediately dealt with. Please see Chapter 11 Sharp Injuries guideline for specific information on how to manage a sharps injury.

Waste Disposal (See Waste Guidelines for more information)

Healthcare waste must be:

- Segregated immediately by the person generating the waste into appropriate colour-coded storage or waste disposal bags or containers which are compliant with current national legislation

- Labelled, stored, transported and disposed of in accordance with current national legislation

Management of The Environment

Micro-organisms persist in the environment and the design and the condition of the healthcare environment and of fixtures and fittings is important in infection control.

When premises are being upgraded or built infection should be a consideration. Further information about building and fixtures and fittings is available from the College's standard on environment of clinical practice.

Clinical areas should be kept tidy and clutter free to allow effective cleaning and prevent accumulation of dust.

Surfaces that are not smooth, impervious and intact can harbour bacteria and prevent effective cleaning. Environmental surfaces, fixtures and fittings and furnishings in clinical areas and areas used to store clinical supplies, should have easy-to- clean, smooth impervious surfaces, be water-resistant and preferably tolerate disinfection with hypochlorite solutions 1000ppm.

Work surfaces and hard floors should be smooth-finished, intact, durable, of good quality, washable, should not allow the pooling of liquids and be impervious to fluids.

Carpets are not recommended in clinical areas or where they are likely to be contaminated with body fluids.

Curtains in treatment areas should be disposable or cleaned when soiled or periodically.

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Environmental Cleaning

Cleanliness is intrinsically linked to infection prevention and control. A clean, well ordered environment provides the foundation for excellent infection control practice to flourish (NPSA 2009) All parts of the healthcare environment must be visibly clean but good cleaning ensures that things not only look clean but that they are clean.

It is recommended that cleaning is carried out based on the NHS Cleaning Specifications, and that cleaning standards are audited on a regular basis to ensure standards are maintained.

Practitioners should ensure that cleaners

- Use national guidance on healthcare colour-coding.
- Have received training in cleaning a healthcare environment which includes infection prevention and control and safe handling of waste and sharps
- Have adequate personal protective equipment available to them
- Comply with the "Control of Substances Hazardous to Health Regulations 2002' (COSHH)
- Store cleaning equipment in a separate designated area
- Have adequate and suitable hand-washing facilities

Different spaces require different types and frequencies of cleaning depending on the activities carried out in those spaces. See below for suggested cleaning frequencies.

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Element	Standard	Minimum Cleaning Frequency		
		High-risk ***Public thoroughfares and toilets Sterile supply areas Minor surgery***	**Significant-risk** ***Clinic rooms, treatment rooms, attached toilets and staff areas***	**Low-risk** ***Administrative areas, record and storage areas***
Clinical equipment	All parts visibly clean	One full clean daily and between every patient use	One full clean daily and between every patient use	
Medical gas equipment	All parts visibly clean	One full clean daily	One full clean daily	
Switches/sockets	Visibly clean	Daily	Daily	Weekly
Walls	Visibly clean	Check daily Dust weekly Wash yearly where required and as practicable	Check daily Dust weekly Wash yearly where required and as practicable	Check weekly Periodically wash where required and where practicable.
Ceiling	Visibly clean	Dust monthly Wash yearly where required and as practicable	Dust monthly Wash yearly where required and as practicable	Periodically wash where required and where practicable.
Doors	Visibly clean	Full clean daily	Full clean daily	Full clean weekly
Internal glazing	Visibly clean and smear free	Check clean daily Full clean weekly	Check clean daily Full clean weekly	Full clean weekly
External glazing	Clean	Full clean every 3/6 months	Full clean every 3/6 months	Full clean every 3/6 months

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Element	Standard	Minimum Cleaning Frequency		
		High-risk ***Public thoroughfares and toilets Sterile supply areas Minor surgery***	**Significant-risk** ***Clinic rooms, treatment rooms, attached toilets and staff areas***	**Low-risk** ***Administrative areas, record and storage areas***
Mirrors	Clean and smear free	Full clean daily	Full clean daily	Full clean weekly
Radiators	Visibly clean	Full clean daily	Full clean daily	Full clean monthly
Ventilation grills, extract and inlet	External part of grill visibly clean	Weekly	Monthly	Monthly
Hard floors	Complete floor Inc. edges and corners should have a uniform shine and be visibly clean	Clean daily Wet mop daily Machine clean weekly Strip and reseal yearly if reqd	Clean daily Wet mop daily Machine clean monthly Strip and reseal yearly if reqd	Clean weekly Wet mop weekly Machine clean quarterly Strip and reseal every 2 years if reqd
Soft floor	Complete floor Inc. edges and corners should be visibly clean. Should have a uniform appearance and an even colour with no stains/watermarks	Clean daily Shampoo every 6 months Where required and as practicable.	Clean daily Shampoo every annually Where required and as practicable.	Clean weekly Shampoo every 2 years Where required and as practicable.
Electrical items	Visibly clean	Dust daily Clean monthly	Dust daily Clean monthly	Dust and clean Monthly
Personal IT equipment	Visibly clean		Wipe daily	Wipe weekly
Shared IT equipment	Visibly clean		Wipe after use	Wipe after use

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Element	Standard	Minimum Cleaning Frequency		
Cleaning equipment	Visibly clean	After each use	After each use	After each use
Low surfaces	Visibly clean	Daily	Daily	Weekly
Chairs	Visibly clean	Weekly	Weekly	Weekly
Tables	Visibly clean	Daily	Daily	Weekly
Patient couches	Visibly clean	Wash daily Decontaminate between each patient	Wash daily Decontaminate between each patient	N/A
Trolleys	Visibly clean	Wash daily Decontaminate between each patient	Wash daily Decontaminate between each patient	N/A
Hand wash containers	Visibly clean	Daily	Daily	Daily
Waste bins	Visibly clean	Daily Deep clean weekly	Daily Deep clean weekly	Daily Deep clean weekly
Curtains and blinds (clinical)	Visibly clean and be able to be taken down to be washed or made of a material which is wipe clean or replaceable	Clean, change or replace 6 monthly	Clean, change or replace yearly	Clean, change or replace twice yearly
Toilets	Visibly clean	Twice daily	Daily	Daily
Sinks	Visibly clean, free from build-up of scale and other deposits	Twice daily	Daily	Daily

Most areas can be cleaned plain detergent and warm water, but a suitable disinfectant (chlorine releasing) should be available for cleaning body fluid spills or where a deeper level of decontamination is required.

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National colour coding scheme

For cleaning materials and equipment in primary care medical and dental premises

All practices are recommended to adopt the colour code below for cleaning materials. All cleaning items, for example, cloths (re-useable and disposable), mops, buckets, aprons and gloves, should be colour coded.

Red **Sanitary areas including sinks in sanitary areas**	**Blue** **General areas, e.g. waiting rooms and consulting rooms (including sinks in general areas)**
Green **Kitchens**	**Yellow** **Treatment and minor operation rooms**

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Management of Patient Equipment

(See Decontamination Guidelines for Decontamination of Instruments)

Equipment used for the care of patients is a potential source of infection, and must be decontaminated appropriately between uses (unless single use in which case it must not be re-used) and stored so as to prevent contamination.

It must be:

- stored clean and dry (not on the floor, and not in an area with dirty equipment or where decontamination takes place)
- checked for cleanliness prior to use, e.g. when being removed from storage
- decontaminated appropriately, according to risk assessment and manufacturer's instructions, and:
    - On a routine, documented schedule
    - Between uses (always)
    - When visibly dirty
    - Immediately when spillages or contamination with blood/other body fluids has occurred

The level of decontamination required will depend on the use of the equipment and the level of contamination.

There are three levels of decontamination:

- Cleaning
- Disinfection
- Sterilisation

The table below is a guide on the level of decontamination required according to risk.

Minimal Risk	Surfaces that will not come into direct contact with patients	**Cleaning and drying adequate**
Low Risk	Surfaces and equipment that come into contact with intact skin	**Cleaning and drying adequate**
Intermediate Risk	Items in contact with intact mucous membranes, or diseased or damaged skin, or items that are heavily contaminated with virulent or readily transmissible pathogens or substance or items to be used on highly susceptible Immuno-compromised patients	**High-level disinfection or sterilisation required**
High Risk	Equipment that enters sterile cavities or vascular systems, or is in contact with a break in the skin or mucous membrane	**Sterilisation required**

Equipment that may have been contaminated with blood or body fluids (other than urine) should be disinfected with a chlorine releasing agent.

It is important to note that neither disinfection nor sterilisation can take place without prior cleaning. Consequently, where disinfection is required items must first be cleaned, using detergent and dried. (Unless a product which can demonstrate it achieves both, such as a Universal Wipe is used).

Alcohol is a disinfectant and will only work effectively on clean items.

Wipes can be useful for cleaning and decontamination of small areas of the environment and for equipment, but it is important to make sure that the wipe being used will decontaminate to the level required and that a proper method is used to prevent recontamination. Where detergent wipes are used, items/areas must also be dried.

It is always important to follow manufacturer's instructions and COSHH data sheets and have risk assessments in place where chemicals are being used.

When undertaking decontamination of equipment

- Use personal protective equipment (PPE)
- Take account of hand hygiene

Second-hand equipment

All instruments and items of equipment must be decontaminated correctly before being sold, lent or repaired and this should be documented.

Orthotics

Used orthotics must be decontaminated before being sent to the laboratory, they should not be sent if they pose a risk of transmission of infection. Discuss any concerns with the laboratory before sending.

Spillages of bodily fluids

If blood/bodily fluids are spilled, the spillage should be dealt with as soon as possible.

Only staff trained in the correct procedure should manage blood and other body fluid spillages, practitioners should ensure they know the procedures and how to undertake them and provide education and training to any staff members potentially involved in the management of blood and body fluid spillages.

Appropriate personal protective equipment (e.g. single-use disposable gloves and plastic apron) should always be worn when dealing with blood and other body fluid spillages.

Blood and body fluid spillages should be directly treated with a chlorine releasing agent such as sodium hypochlorite. (Except for urine spillages which should **not** be directly treated using a chlorine releasing agent such as sodium hypochlorite).

Products (e.g. chlorine releasing solutions/granules) for management of blood and body fluid spillages should always be carefully prepared and used in accordance with manufacturer's instructions, data sheets and COSHH assessments.

Contaminated soft furnishings and carpets that cannot withstand chlorine releasing agents should be cleaned with a solution of detergent and warm/tepid water followed by steam cleaning.

If it is not possible to use either of these methods, it may be necessary to dispose of contaminated soft furnishings.

Procedure

Gather required equipment and put on PPE

For urine

Soak up as much as possible using paper towels (a gelling agent can be used), clean the area with a detergent solution, then rinse the surface. **Do not use chlorine releasing agents on urine.**

For blood and body fluids other than urine

Soak up excess fluid using paper towels, then cover area with

- sodium dichloroisocyanurate granules

- or
- with paper towels and gently flood with a 10,000 part per million solution
- of a chlorine releasing agent

Leave for the required amount of time (follow manufacturer's instructions).
Scoop up the debris with paper towels and dispose in clinical waste.
Wash with detergent and water and dry.

Small spills e.g. drops of blood can be wiped away with a disposable towel soaked in disinfectant (containing 10,000ppm), followed by washing with detergent.
Commercially available spill kits/packs can also be used

Respiratory hygiene/ Cough etiquette

Respiratory hygiene was added to SICPs following the global influenza pandemic.
Respiratory hygiene and cough etiquette should be applied as a standard infection control precaution at all times.

The measures include:

- Covering nose and mouth with disposable single use tissues when sneezing, coughing, wiping and blowing noses
- Disposing of any used tissues into a waste bin
- Washing hands with soap and water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions
- Keeping contaminated hands away from the mucous membranes of the eyes and nose

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Other Measures

Transmission based precautions

Patients who have specific infections, with a known route of transmission, may need to be managed with additional precautions (Standard Precautions always apply).

An example would be patients being nursed with contact/barrier precautions in a hospital setting. Advice should be sought from the Infection Prevention Control Team at the hospital/care setting where the patient is resident, before treatment is provided.

Where patients are under isolation precautions, or resident in wards/homes closed due to outbreaks, treatment should only be provided following a risk assessment which considers the need for treatment and the risk of cross infection. This risk assessment should be undertaken with the advice of the IPC team or applicable public health organisation.

Patients who have gastro-intestinal infection should be managed using enteric precautions. Patients with active symptoms of GI infection should not visit clinics, until 48 hours after resolution of symptoms.

Patients who are known to be colonised with MRSA or other potentially transmissible resistant organisms, which could cause infection in vulnerable people, should wherever practicable/possible be seen at the end of the day and enhanced cleaning put in place. (Or at the end of domiciliary caseloads).

Specimens

A specimen is a body substance, such as blood, sputum, pus, urine or faeces, taken from a person for the purpose of analysis. The aim of which is to identify micro-organisms that cause disease and to provide direction for appropriate treatment.

Specimens, if not handled and transported safely, can pose a risk of infection to others, including transport personnel.

Transport regulations require three layers of packaging for specimens in transit:

- a primary receptacle (the pot, vial or tube)
- a secondary packaging (the clear plastic bag)
- a leak proof outer packaging with appropriate cushioning and labelling
- including the symbol 

The outer container used for carrying specimens to pathology laboratories must be secure and conform to relevant regulations and guidelines including "The Health and Safety at Work Act (1974)", "Control of Substances Hazardous to Health Regulations" (2002) "The Carriage of Dangerous Goods (Classification, Packaging and Labelling) and the use of Transportable Pressure Receptacles Regulations 1996" and "The Transport of Infectious Substances" (2011).

The purposes of transport infectious substances are classified as either Category A or Category B.

Specimens which require transport will normally fall into the Category B group. However, it is important to be aware of Category A specimens.

Category A	Category A specimens are those from a patient who has or may have a serious disease, which can be readily transmitted from one individual to another either directly or indirectly, and for which effective treatment and preventative measures are not usually available. They include new and emerging organisms and require additional arrangements for transport (see appendix 1). For further guidance on transporting these types of specimens, contact the Health Protection Agency or the receiving laboratory.

	This category does not include MRSA or *Clostridium difficile*
Category B	Infectious substances that do not meet the criteria for inclusion in Category A. This includes most specimens and samples of excreta, secreta, blood and its components, tissue and tissue fluid swabs, and body parts being transported for purposes such as research, diagnosis, investigational activities, disease treatment or prevention.

Fridges which may be used for storage of specimens must not be used for the storage of medicines or food.

Judicious use of Antimicrobials

Infections which are resistant to antimicrobials are likely to be one of the biggest challenges to healthcare in the future.

Infection control and judicious use of antibiotics work together to help meet this challenge.

Use of antibiotics also puts patients at increased risk of *Clostridium difficile* infection.
Prescribers and users of antimicrobials have a responsibility to do so judiciously, and must not use them unnecessarily or irresponsibly.

Antimicrobial choice should be based on microbiology and the narrowest effective spectrum should be used.

Local guidelines should be followed where available.

Skin preparation

Skin preparation aims to reduce microbial burden before treatment.

The best way of reducing this burden is to ensure that patient's feet are cleaned with soap and water before treatment.

Podiatrists should undertake a risk assessment before deciding on the skin preparation they choose. This should take account of:

- Patient hygiene (many preparations have reduced activity in the presence of dirt and organic matter)
- Sensitivities, allergies and acceptability to patients
- Residue which might affect treatment e.g. moisturisers in skin wipes may leave a film that affects the use of a blade on skin)
- Type of procedure being undertaken (A 2% chlorhexidine in alcohol preparation would be recommended before an invasive procedure)

Uniform

Uniform or clothing that can be washed at least 60 degrees and ironed should be worn for direct patient care.

Uniform should only be donned within the workplace and not worn whilst travelling to and from work, except when doing domiciliary visits.

Clean workwear should be worn every day. It should be changed if it becomes heavily soiled or contaminated.

Work wear should be changed as soon as possible after patient care activities and not worn for other activities outside of the care environment.

It should be washed on a cycle that washes at 60 degrees for at least 10mins within its cycle after every day's clinical work.

It should be washed separately from other clothing and ironed.

Dirty uniforms should be transported in a plastic bag to prevent contamination.

Tops should be short sleeved and neck ties other than bow ties should not be worn.

Shoes should be closed in and protect the feet from possible sharps injury.

Staff Health

Professional staff have a responsibility to protect patients and others through appropriate vaccination. This includes having routine childhood vaccinations (or catching up) having seasonal flu vaccination and hepatitis B vaccination (for further information see Vaccination Guideline). Podiatrists and their assistants who have potentially infectious illness, including flu symptoms should not work with patients until they are no longer infectious.

Anyone with potentially infectious gastro-intestinal disease should not come to work until they have been symptom free for 48hrs.

Aseptic technique

An aseptic technique ensures that only uncontaminated equipment and fluids come into contact with susceptible body sites.

Asepsis reduces the risk of an infection developing as a result of a procedure being undertaken. It should be used during any clinical procedure that bypasses the body's natural defences, this includes all invasive procedures including wound care.

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An aseptic technique involves specific actions and procedures performed under controlled conditions. The ability to control conditions will depend on the setting where the procedure takes place, but the principles remain the same:

- the area where the procedure takes place should be as clean as possible
- minimise air disturbance in this area during the procedure e.g. avoid sweeping, using a fan, having building work going on
- perform hand hygiene prior to and during the procedure as required (see 5 Moments)
- use sterile equipment
- use a non-touch technique (utilise sterile gloves/forceps if required) to ensure that sterile parts are not contaminated

Domiciliary Visits

Working in patient's homes can be challenging when it comes to managing infection prevention and control risks.

Specific risks should be assessed and documented. The podiatrist should manage the environment as best as they can, to manage any risks, and patients and carers should be given information and advice so that they can help to provide the most suitable environment.

The podiatrist must ensure that they have a safe, clean area from which to deliver treatment.
The use of a wipe able procedure tray is recommended. Instruments and other clinical items should not be put on the floor/beds etc.

Equipment taken in and out of patient's homes should be kept to a minimum, and decontaminated between visits.

Domiciliary and drill cases and bags should be able to be decontaminated, be visibly clean and be decontaminated after every domiciliary session, or before if contaminated/dirty.

Patients should be asked to remove any pets removed before treatment takes place.

Patients should be asked to provide suitable hand hygiene consumables. If they are unable to do so the podiatrist should consider carrying a small supply of paper towels/soap in a dispenser.

Alcohol hand gel should be carried so that it is available at the point of care.

Personal Protective Equipment should be carried so that it is kept clean and undamaged. Gloves should be dispensed directly from the original container and not kept in pockets etc.

In some circumstances and following risk assessment the use of additional PPE may be required e.g. overshoes.

Communication

While bearing in mind patient confidentiality, others involved in a patients care should be informed of risks from infection.

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Clinical Standards

Standard 10
Waste Management

For further information:
The College of Podiatry, Quartz House, 207 Providence Sq, Mill Street, London SE1 2EW
Email: professionalsupport@cop.org.uk

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Standard 10 – Waste Management

Duty of Care

All podiatry practices have a legal responsibility to ensure that any waste you produce is handled safely and in accordance with current waste legislation. This Duty of Care means the practitioner is responsible for the correct assessment, segregation and disposal of the waste they produce. If the waste you generate in the course of your clinical practice, should be collected by a waste contractor, then Under the Duty of Care regulations you can only legally give your waste to disposal contractors registered with the Environment Agency, the Scottish Environmental Protection Agency or Environment and Heritage Service (Northern Ireland).

The assessment of waste

The Podiatrist should assess the type of waste that they produce and classify it accordingly. Please see Annex A for assistance. Please also see Standard12 - Domiciliary Podiatry Care.

Disposal of single use instruments

Use appropriate orange lidded sharps bin for the disposal of single use instruments.

Disposal of medicines

Medicines such as expired drugs and Local Anaesthetic cartridges should be disposed of via pharmaceutical waste bins which normally have blue lids.

Disposal of Chemicals

Chemicals need to be disposed of in chemical waste bins. Depending on the amount and type of chemical to be disposed of there are various solutions for their disposal we would suggest discussing your requirements with your waste contractor. Phenol is considered cytotoxic and therefore needs to be disposed of in a purple lidded bin.

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Disposal of Confidential Waste

When you come to disposing of your clinical records they must be treated as confidential waste and taken away in a confidential waste bin or bag by a confidential waste contractor. These are usually the same people as who deals with your clinical waste but they can be separate. Please check with your contractor as to whether they wish you to pre-shred your records or not. Records with confidential information must not be disposed of in any other way otherwise you may be committing a criminal offence. More information can be found in the College's Standard 5 - Record Keeping.

Hazardous Waste Regulations

The Hazardous Waste Regulations require business producing hazardous waste to register with the Environment Agency. However, chiropody and podiatry practices which generate less than 500kg of hazardous waste in any twelve-month period are exempt, and so do not need to register.

It is possible that clinical waste companies may challenge this view; however, it is you as the producer of the waste that classifies your clinical waste.

Pre acceptance Audit

From July 2012, the Environment Agency imposed a new legal requirement to ensure that podiatrists carry out audits of their clinical waste before it can be accepted at disposal sites. If you do produce hazardous/infectious waste you have two options:

1. You may undertake the audit and collect the data yourself. However, the procedure is complex and the Environment Agency recommends that you understand what is required before doing so as it may not be sufficient and not accepted at a site in accordance with its environmental permit.
2. You can use a clinical waste company to provide you with an online or paper audit tool that will simplify and guide you through the process. Pre-acceptance audit tools are available

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from most clinical waste companies a charge may be made for this service but is usually included in the price.

The audit is valid for 5 years.

Storage of Clinical Waste

Waste awaiting collection from a licensed collector should be kept separate from other commercial waste. Waste awaiting collection by the waste disposal contractor should be stored in a locked cupboard/area which cannot be accessed by the public or pests. Under no circumstances should you leave clinical waste bags on the street for collection even if they are due to be collected that day.

Blades, syringes and other sharp objects must be disposed of in a sharp safe box. All Podiatry premises must have provision for the correct and safe disposal of sharps. You have a 'duty' to take all reasonable measures to ensure that no un-authorised persons can interfere with clinical waste prior to collection.

Keeping your own records

It is essential that you keep a record of your clinical waste transactions, and you may either pay the waste disposal contractor to do this for you, or you can keep a copy of your Waste Transfer Notes, with parts A, B and C completed, see below.

You should keep records for at least two years, so that you can provide them if asked by the Environmental Agency, Waste Collection Authorities or the Scottish Environmental Protection Agency.

Waste Transfer Note

A Waste Transfer Note is a written description of the waste that is passed from one person to another person and is filled in and signed by both persons involved in the transfer.

Normally a standard format is used; see Annex B, the producer of the waste describes the waste in part A, and gives their details in part B. Part C is completed by the person collecting the waste and D by the person or company that finally disposes of, or incinerates the waste.

Who provides the waste transfer note is not important so long as it contains the right information and a copy is kept.

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Appendix A

Chart to assist with clinical waste management/classification

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Name of bag	Definition	To use for	Disposal	Recycle
Black bags 	Mixed municipal waste.	• Domestic waste, • Commercial waste, • Confidential shredded waste	Land fill by Council	Yes can be recycled
Tiger stripe bags 	Waste whose collection and disposal is not subject to special requirements in order to prevent infection, e.g. dressings, linen, disposable clothing, diapers. Human hygiene waste and non-infectious dressings.	• Offensive-non infectious • Hygiene waste-non infectious • Gloves, Nails and Skin which is not contaminated with infectious material.	Land fill by Council	Yes may be recycled
Orange bags 	Waste whose collection and disposal is subject to special requirements in order to prevent infection. Soiled dressings.	• Potentially infectious • Known infectious waste i.e. potentially infectious nail and skin material, dressings from wounds that are known to be infectious.	Incinerator by waste collector Consignment note	Cannot be recycled
Yellow bags 	Body parts and organs including blood bags and blood products.	• Anatomical waste Other infectious waste which requires disposal by incineration	Incinerator by waste collector Consignment note	Cannot be recycled
Bins 	For the disposal of sharps, single use instruments, chemicals, confidential waste, pharmaceutical waste etc.	• Orange lid – single use instruments • Yellow lid - sharps • Blue lid – pharmaceutical • Purple lid – cytotoxic • Other bins are available	Incinerator by waste collector Consignment note	Cannot be recycled

Please note The above coloured bags may not be available in all areas of the country, there are regional variations. Councils at present may not collect tiger striped bags.

Any Health and safety queries can be directed to the Health, Safety and Wellbeing Panel at the College via **professionalsupport@cop.org.uk** and information relating to waste can be found on the College website in the Health and Safety section.

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Annex B: Duty of care: waste transfer note example

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Section A: Description of waste

Please describe:

European Waste Catalogue number:

The waste contains

☐ Clinical waste ☐ Pharmaceutical waste

How is the waste contained?

☐ Sack ☐ Sharps box ☐ Other

Section B; Name of Podiatrist and Practice details – transferor

Podiatrist:

Practice name and address:

☑ The producer of the waste

Name of your unitary authority:

Section C: Person collecting the waste – transferee

Full name:

☐ The holder of waste disposal licence

Name of company:

Licence number:

Issued by:

☐ Registered waste carrier

Registration number

Issued by

Are you:

☐ Waste collection authority
☐ Waste disposal authority (Scotland)
☐ Waste collection authority Authorised for transport purposes

Section D: The transfer - destination

Address of transfer or collection point:

Broker who arranged this transfer if applicable

Name:

Address:

Date of transfer:

Transferor's signature:

Transferor's signature

Name:

Representing:

Name:

Representing:

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Clinical Standards

Standard 11
Management of Sharps and Exposure Incidents

For further information:
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Standard 11 – Management of Sharps and Exposure Incidents

Introduction

These guidelines are directed mainly at those working within Private Practice as members working in the NHS should adhere to their local NHS guidelines. This guideline is specifically about managing the sharp injury itself; further discussion on preventing sharps injuries and handling sharps is discussed in Standard 9 Infection Control which is available on the COP website.

The same principles apply regardless of who is injured; the patient, podiatrist, co-worker or member of the public.

Types of occupational exposure

The guidelines identify three types of occupational exposure risks in health care settings and they are:

- Sharps injuries that break the skin;
- Exposure of broken skin to blood or other high-risk bodily fluid; and
- Exposure of mucous membranes, including the eye, to blood or other high-risk bodily fluid.

A list of high-risk bodily fluids can be found in Appendix A.

Practice safely

Within podiatric practice, occupational exposures mainly occur where there is a failure to follow recommended procedures, including the safe handling and disposal of needles, syringes and blades. These guidelines are therefore a timely reminder to follow safe practice and to highlight the importance of maintaining your protection against Hepatitis B, by keeping your vaccinations up to date (please see Standard 14 – Immunisations for Podiatrists).

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The immediate management of a sharps injury

In the event of an Exposure Incident as prophylaxis is most effective when started as early as possible after injury, action must be taken immediately following any incident. Staff should not continue with clinics/visits, once patient safety is ensured, until they have performed first aid, received advice and given Post Exposure Prophylaxis if needed.

The following procedure must be followed when dealing with a sharp's injury/exposure.

Carry our First Aid immediately

For skin/tissues injuries

Gently encourage bleeding. Do not scrub or suck the area.

Wash/irrigate with soap and warm running water. Do not use disinfectants or alcohol.

Cover the area using a dry dressing.

For eye and mouth injuries

Remove contact lenses if worn (do not replace).

Irrigate/rinse with copious amounts of water or using washout kit.

Do not swallow the water which has been used for mouth rinsing.

As soon as possible inform your manager and occupational health department if appropriate. Seek assistance at Accident and Emergency Department if in private practice or if occupational health department is closed. Following inoculation of contaminated blood/high risk body fluids there may be a need to arrange for bloods to be taken from the source patient, this will entail obtaining informed consent. Blood should not be taken from the source by the affected member of staff.

Complete incident report form or use College form to document details.

(See Appendix B)

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Assess the risk of exposure to a blood borne virus

If the exposure involved fresh blood/body fluid and the client is known or suspected to be a carrier of either HIV and/or Hepatitis B virus then arrange for an immediate prophylaxis by attending the nearest Accident and Emergency Department. Do not delay.

Transmission of HIV, Hepatitis B and Hepatitis C as a result of sharps injury and mucosal splash exposure has been well documented. The risk of transmission following a sharps injury involving blood from an infected source is approximately 3/1000 for HIV, 1/30 for Hepatitis C and 1/3 for a high-level carrier of Hepatitis B. The risk associated with stale blood is much lower.

There is no risk of HIV transmission where intact skin is exposed to HIV infected blood.

Administration of prophylaxis, if required

There is good evidence to show that the risk of HIV transmission following high-risk exposure can be reduced by at least 80% with the use of the appropriate anti-viral prophylaxis. The reason for prompt action is that for optimal efficacy, prophylactic antiretroviral drugs should be commenced as soon as possible after the incident and ideally within the hour of exposure.

If you feel you may have been exposed to Hepatitis B infected blood post-exposure prophylaxis should also be considered, again you should attend your nearest Accident and Emergency Department, unless you work in the NHS and other arrangements have been made.

Next steps:

Ascertain and record the following information

In order that the likely risk can more properly be assessed after the immediate assessment, it is important that certain information is collected and recorded. To assist, a pro-forma is provided in Appendix B. It is important that where the bodily fluid source is known that this information is kept confidential and only shared with the healthcare workers involved in the administration of your

prophylaxis treatment. The information should not be disclosed to other parties, without the consent of the person who is the source of the body fluid; for example, patient, podiatrist, co-worker or member of the public.

The incident should also be recorded in the patient's notes.
It may be that the healthcare worker, dealing with your prophylaxis treatment, may arrange for a designated doctor to approach the source person to ask for their informed agreement to HIV testing. This approached should not be undertaken by anyone other than the designated doctor and especially not by yourself.

Baseline blood tests

If you work in the NHS or have an accidental injury insurance scheme you may need to take baseline blood samples for storage. Check with your employer or insurers for their specific requirements if appropriate.

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Appendix A

High and low risk body fluids

High Risk

Blood

Blood stained saliva Cerebrospinal fluid

Semen

Synovial fluid

Vaginal secretions

Low Risk

Urine

Faeces

Saliva

Vomit

(All “low risk” bodily fluids should be regarded as “high risk” if visibly contaminated by blood)

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Appendix B

Details of Blood Borne Virus Exposure

Time and date of the injury	
Was the skin punctured?	
If yes; by what instrument?	
How did the injury occur?	
Was fresh blood involved?	

If body fluid source is known

Name of client:	
Date of Birth:	
Address:	
Client GP:	
GP Address:	
HIV, Hepatitis B or C status; if known	

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Clinical Standards

Standard 12
Domiciliary Podiatry Care

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Standard 12 – Domiciliary Podiatry Care

Clinical Treatments

When undertaking domiciliary care, the onus will be on you to undertake a risk assessment as to whether you can safely undertake the proposed treatment in the domiciliary setting. Invasive procedures should only be undertaken in exceptional circumstances, and then only after following the decision chart in Appendix A. It is not advisable to perform nail surgery in a domiciliary setting. However if after following this decision chart and assessing risk you elect to undertake an invasive procedure, such as nail surgery, then you must document your reasons in the clinical notes.

It is important that your domiciliary practice has a health and safety policy. It should be specific to your practice and reviewed quarterly, this should include details of your;

- Infection control procedures
- Decontamination procedures
- Hand washing procedure
- Use of chemicals and medicines
- Risk assessments and procedures
- Environmental assessment procedures

Patient Privacy

Clients should always be afforded their dignity and have their confidentiality protected and for this reason never be treated in communal areas but always in private. The patient should always be left in a safe position and shoes and socks etc reapplied as appropriate.

When carrying out Domiciliary treatments you are a guest as well as a Healthcare professional in a patients home, therefore this should reflect in your professional behaviour at all times. It is essential

to inform the patient of your name, title and clinic details when arriving this is especially important on the first visit. Time keeping and duration of appointment should be discussed prior to the appointment as should cost of treatment.

Record keeping

Patients have the right to expect information about them to be kept secure and protected from unauthorised access. It is therefore important to ensure that only the clinical notes of the clients that you are about to visit are in the car; placed in a position where they are not in view from passers-by and that the car doors are locked at all times. Clinical notes should never be left in the car overnight.

The patients record should be updated on each visit, the practitioner should record details of treatment or advice given, as well as medical history and medication etc. Any patient advice given should be explained clearly to the patient, the practitioner should document this in the patient record and the patients understanding of the treatment and advice given. Time for record keeping is essential practice management, it should ideally be written at the patient appointment. You should **not record information about payments** on the patient record card, as this will also render them a financial document, giving the Inland Revenue an entitlement to see the records, so compromising patient confidentiality.

Domiciliary bag

The domiciliary bag should be professional in appearance, well organised and set up for a clean/dirty system of working. It should portray the correct professional image for your practice and the Profession. It is therefore important that it is properly maintained and cleaned after every use. It is important that the bag contains separate compartments for the storage of clean and dirty instruments, which should never be mixed.

To keep the size and weight of the domiciliary bag to a minimum and so reduce the risks of future musculoskeletal injury it is important to decide what medicaments and consumables you need to

carry. It is always possible to store extra supplies/or infrequently used items in the car. The practitioner will need to check their car or home insurance policy to see if domiciliary equipment is covered on the policies, a separate policy may be needed.

Domiciliary instruments

It is essential your practice has a Decontamination policy, which includes detail of your method of sterilisation. See Standard 8 Decontamination of Reusable Podiatry Instruments.

Storage of sterilised instruments

Sterilized instruments processed in a non-vacuum steam sterilizer stored for later use must be:

- Stored in a clean, disinfected, dry airtight container or in sterilized lidded instrument trays.
- Instruments stored in trays or loose must be sterilized for each clinical session.
- Instruments can be placed in single use sealed view instrument pouches (instruments must be dried thoroughly by the autoclave drying cycle before opening the door as microbiological contamination can occur through wet/damp packaging. If drying cycle not available a disposable non-linting cloth may be used).
- Instruments stored in pouches may be stored for up to 1 year. Following this the instruments must be reprocessed and stored in new pouches.
- All pouches must be labelled with date of sterilization and expiry dates
- A stock rotation system must be used. 'First in first out'.
- Expiry dates must be checked and documented on a regular basis.

Instruments must never be sterilized within pouches with this type of autoclave

Sterilized instruments processed in a vacuum autoclave stored for later use must be

- Sterilized within pouches designed for this type of autoclave only.
- Instruments sterilized in pouches may be stored for up to 1 year.

- All pouches must be labelled with date of sterilisation and expiry date.
- A stock rotation system must be used.
- Expiry dates must be checked and documented on a regular basis.

Single use /disposable instruments should never be reused; they should be disposed of according to the manufacturers' advice. They should not be left with patients for reuse.

Clinical waste

Where only non-infected nail clippings and skin scale are produced as a result of your work, and then no more than the client would have previously produced had they cared for their own feet then, after due risk assessment, it may be disposed of through the household waste system.

However, any infected tissue or bodily fluids, soiled dressings or swabs and scalpel blades must be regarded as clinical waste. Unless there are arrangements for the disposal of clinical waste from the premises, all clinical waste must be collected and transported back to your clinic and disposed of through your clinical waste system.

Blades should be transported in a sharps safe box, other clinical waste must be bagged in the appropriate coloured bag and placed in a suitable leak proof container with a tight fitting lid and secured within the boot of your car. The container should be clearly labelled 'clinical waste'. Once back at the clinic, any clinical waste should be removed and disposed of in accordance with the guidelines on disposal of clinical waste.

Infection Control

The correct clinical clothing and protective equipment, should be worn dependent on risk and Procedure, see Standard 10 – Waste Management. It is an essential requirement of clinical practice that hands are washed between patients. However, because of the nature of domiciliary work it is recommended that hands are cleaned with an alcohol-based hand rub both before and immediately after each treatment. If this is done within the sight of your client it will encourage confidence, even

though you may be wearing gloves when providing the treatment.

It may also be is advisable to carry paper towels for hand drying if using the householder's hand washing facilities, bar soap is not recommended or shared towels.

Portable equipment

For the protection of both yourself and your client all portable equipment used on domiciliary treatments should be regularly serviced and maintained in accordance with the manufacturer's guidance. Electrical equipment should be visually checked every six months and inspected by an electrician competent to undertake portable appliance testing every year.

Unsafe environments

You need to risk assess the household environment. If it is, in your judgement, unsafe for you to treat your client, for example inadequate lighting or poor hygiene, you should decline to treat the client, unless your concerns can be addressed. It is you who will be accountable, not your client, if your actions cause harm to your client.

Furniture

If it is necessary to move furniture to enable safe treatment, it is important to return any item moved to its original position after the treatment and before leaving. This is particularly important when visiting someone with impaired vision.

Family pets

Always difficult, but you should ask for family pets, for examples dogs and cats to be removed from the room whilst you provide treatment. An exception can be made for any guide dog.

Your safety /lone working

When undertaking domiciliary visits always inform someone who you plan to visit and what time you expect to be back. Always inform that person, when you return or if you are delayed. This is for

your own protection. It is always advisable to carry a mobile phone. Leaving such a list with a 'trusted' colleague would not be regarded as a breach of confidentiality.

Please also see our 'Lone Working' guideline in the Health and Safety section on the website.

If you are employed please also see your employers Lone Working Policy if they have one.

Vulnerable Adults

When visiting vulnerable adults it is often good practice to book or arrange your visit to coincide with carers or family or friends, this should be part of your risk assessment and management strategy.

Podiatrists must have knowledge of the Mental Capacity Act and in the course of their practice have due regard to the act and its implications. Podiatrists must comply with the Mental Capacity act principles and code of practice, and when the situation arises must be able to test for capacity and act in the patient's best interest. This must always be documented in the patient record, as well the steps you took to assess for Capacity. Please see the Standards on Record Keeping and Consent. It is best practice to always seek verbal consent from the patient prior to treatment as they may not have booked the appointment.

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Appendix A

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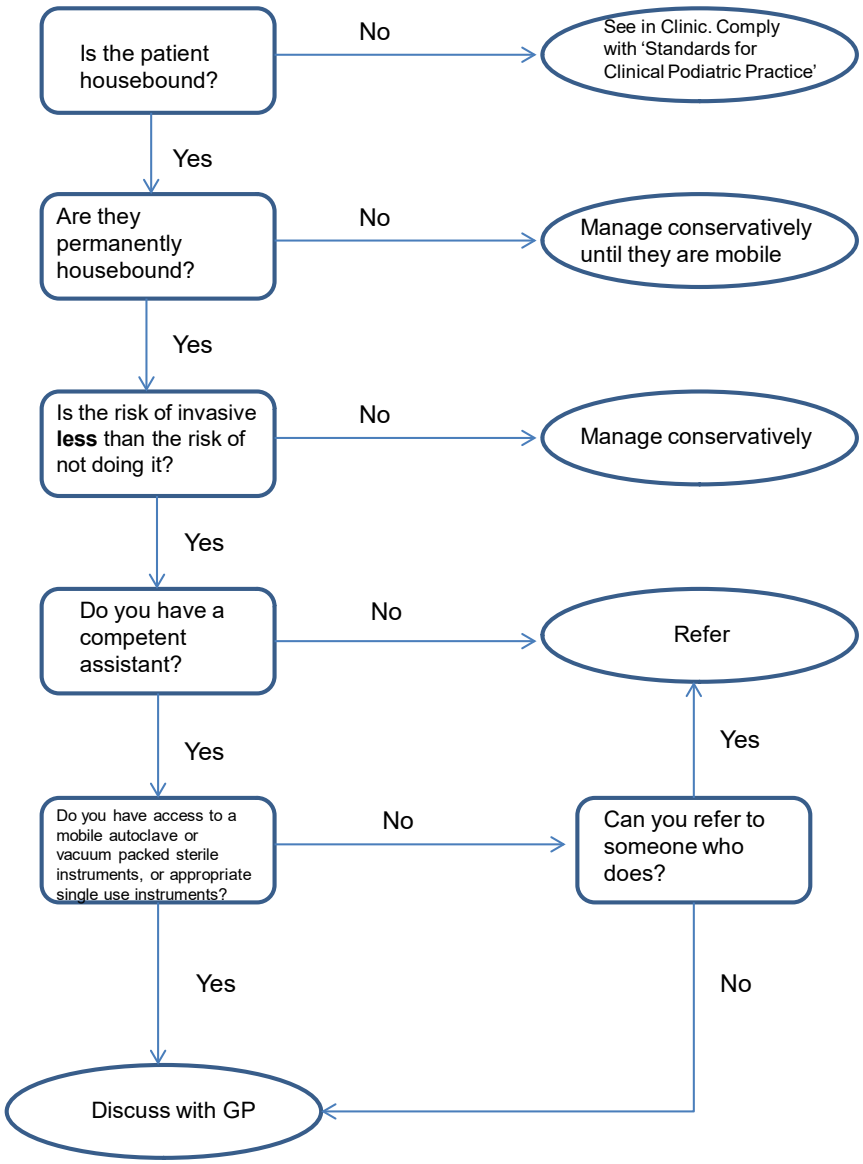
Decision Tree for Invasive Procedure i.e. Nail Surgery in a domiciliary setting



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Clinical Standards

Standard 13
Clinical Environment

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Standard 13 – Clinical Environment

This is the standard for how the clinical environment should be set up for podiatric use.

The clinic room should be of sufficient size to, at a minimum, allow the unimpeded movement of a patient, assisted by the podiatrist or career, from the door to the changing chair and couch without risk of injury or trips. This includes patients in wheelchairs and bariatric persons. The room should be laid out in such a way that in case of emergency the podiatrist can exit the room freely to seek help or safety. There should be sufficient free space around the treatment couch to facilitate CPR if necessary. Appendix A is a diagram of suggested room layout.

Shared premises

Practitioners who share premises or share a clinical room with other practitioners or allied health practitioners, must have a shared policy for decontaminating equipment and all be responsible for the setting up, the continued maintenance of an infection control document, suitable for all practitioners using the facilities.

Decontamination requirements relating to Practice Accreditation

The College recommends that all practitioners participate in the Practice Accreditation scheme, details of which can be found on the Practice Accreditation area of the College's website. The process of Accreditation is a means of complying with decontamination standards. Practice Accreditation theory and preparation contributes towards CPD activity as it defines and consolidates the carrying out of effective safe, clinical practice. It can also be a valuable business and advertising tool. It was designed to comply with legislation which in the future may require practitioners to register with the appropriate agency.

Nail drills for podiatric use

The podiatrist should operate and use the nail drill according to the manufacturer's instruction. The correct protective equipment e.g. masks should be sourced, after completion of the required risk

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assessment to ascertain and safely eliminate the associated nail dust/vapour risk posed to the practitioner, patient and the clinical environment. You should read the College guidance on the use of nail drills found on the website.

Although PAT testing is not a legal requirement the College recommends that it is undertaken annually for the practitioners and patients safety. A record should be maintained of the yearly PAT testing.

Cleaning frequencies, and renewal of extraction bags must be documented and allocated responsibility to designated, fully trained staff. Lumen parts must be processed in a vacuum autoclave. The drill and hand pieces must be appropriately decontaminated according to the manufacturer's specifications.

Environmental / Clinic layout

The following standards are recommended for clinical environments for podiatric practice. The area should be simple and uncluttered:

1. The treatment room should be of adequate size for scope of practice. If sharing premises all should be involved in the infection control policy.
2. Privacy should be assured; conversations in the room should not be easily overheard.
3. The room should be well-stocked for purpose of treatments.
4. The room should reflect thermal comfort. The HSE recommend a minimum working temperature of 16C. Age concern recommend room temperature of between 18-21C for the elderly.
5. The room should have good general lighting, natural or artificial.
6. There should be an adjustable directional light.
7. The flooring should be impervious, non-slip and ideally with splash-back skirting capable of being cleaned and disinfected. If splash back skirting is not suitable then a washable floor

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with sealant to the edges of the room would suffice. Under **no circumstances** is carpet a suitable flooring for a clinical room.

8. Walls and ceilings should be dry and free from cracks or visible defects.

9. The examination couch, operator chair and workstation should have an intact impervious cover and be capable of being cleaned and disinfected and should be adjustable. If a secondary chair is provided at the side of the patient couch for friends/family this should also be capable of being disinfected but does not need to be adjustable. Consideration should be made for bariatric patients/family.

10. Work surfaces should be impervious and capable of being cleaned with disinfectants.

11. There should be a designated and accessible hand washing basin with sensor or lever operated mixer taps providing hot and cold water.

12. Antiseptic hand washing solution and/or alcohol hand rub should be available in wall mounted containers.

13. Liquid soap and paper towels should be available in wall-mounted containers.

14. A sharps bin container should be accessible in the treatment room above waist height and preferably fixed to the wall.

15. Pedal operated waste bins with the appropriate clinical waste bag should be available. A separate household waste bin with bag should also be available so you can segregate your waste appropriately.

16. There should be a designated area for the decontamination of instruments, ideally in a separate room or clean/dirty areas clearly defined.

17. There should be two sinks (or a sink and a dedicated bowl) for the cleaning of used instruments prior to disinfection. This is separate to the handwashing sink, therefore you will need 3 sinks or 2 sinks and a bowl within your clinic room, unless you have a specific decontamination room.

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18. There should be secure facilities for the hanging of clothing and keeping of valuables. Either in the clinic room or within the building you are working in.

19. The room should be well ventilated; windows can be opened if it is safe to do so. If air conditioning is in operation it should be serviced regularly to assure safe air quality. The primary cause of air conditioning and Legionnaire's Disease contamination is poor maintenance and design. One of the most effective means of protecting the system from contamination, and therefore protecting you and the occupants of the building from Legionnaire's Disease is by installing a system that uses air-cooled refrigerant. This avoids water mist or aerosols associated with water-based systems which means that the system carries absolutely zero risk of Legionella contamination. When a water-based system is used, the system should undergo regular maintenance checks and should be cleaned regularly in order to prevent the build-up of the algae, rust, sludge and scale that can provide the perfect environment for the Legionella bacteria to flourish. Ventilation should be to the outside of building; it must be without risk to public.

20. Employers are required, by law, to either display the HSE-approved health and safety law poster within the building; or provide each of their workers with the equivalent leaflet (available as a free download - Health and Safety Law - What you need to know

Storage of medicines, needles, flammable liquids

All medicines, needles, syringes and flammable liquids should be stored in accordance with the Control of substances Hazardous to Health (COSHSH), risk assessment and manufacturers guidance.

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The College recommends:

1. All flammable products must be stored in a metal cupboard, separate from other dressings and medicines.
2. All medicines for access and supply to patients including needles and syringes must be kept in a locked cupboard.
3. The environmental conditions of the areas designed for storage, patient care or distribution should ensure the integrity of all materials/products. It should be clean, well, ventilated and secure.
4. The storage environment should provide adequate protection to prevent contamination or deterioration of the practitioner's stock.
5. Stock should be used and processed on a first in first out rotational system.
6. A designated person should control the record keeping reordering and checking of expiry dates.
7. Patients (especially the elderly, vulnerable or children) should not be in a position whereby chemicals, drugs, syringes or needles are accessible, are left alone without such items being securely stored. This is particularly important when carrying out domiciliary treatments.
8. All medical gases should be stored in accordance with the conditions specified in the risk assessment, in accordance with manufacturers' and suppliers' advice. Medical gases must be kept at the optimum environmental condition, dependent on the properties of the particular gas.
9. It is essential that if detergents and disinfectants are diluted correctly, they should never be mixed. They should always be used according to the manufacturer's instructions. If they contain alcohol or any other flammable substance they should be stored in a fireproof container.
10. When using solvents there should always be adequate ventilation and solvents should not be used in the patient vicinity.

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11. A First Aid kit, resuscitation mouthpiece and eye wash emergency kit should be available in case of burns, anaphylaxis, needle or eye slashing injury. See Standard 11- Management of sharp and exposure injuries.

Any injuries or accidents involving needles, syringes, chemicals etc. must be recorded in an accident book and dealt with appropriately.

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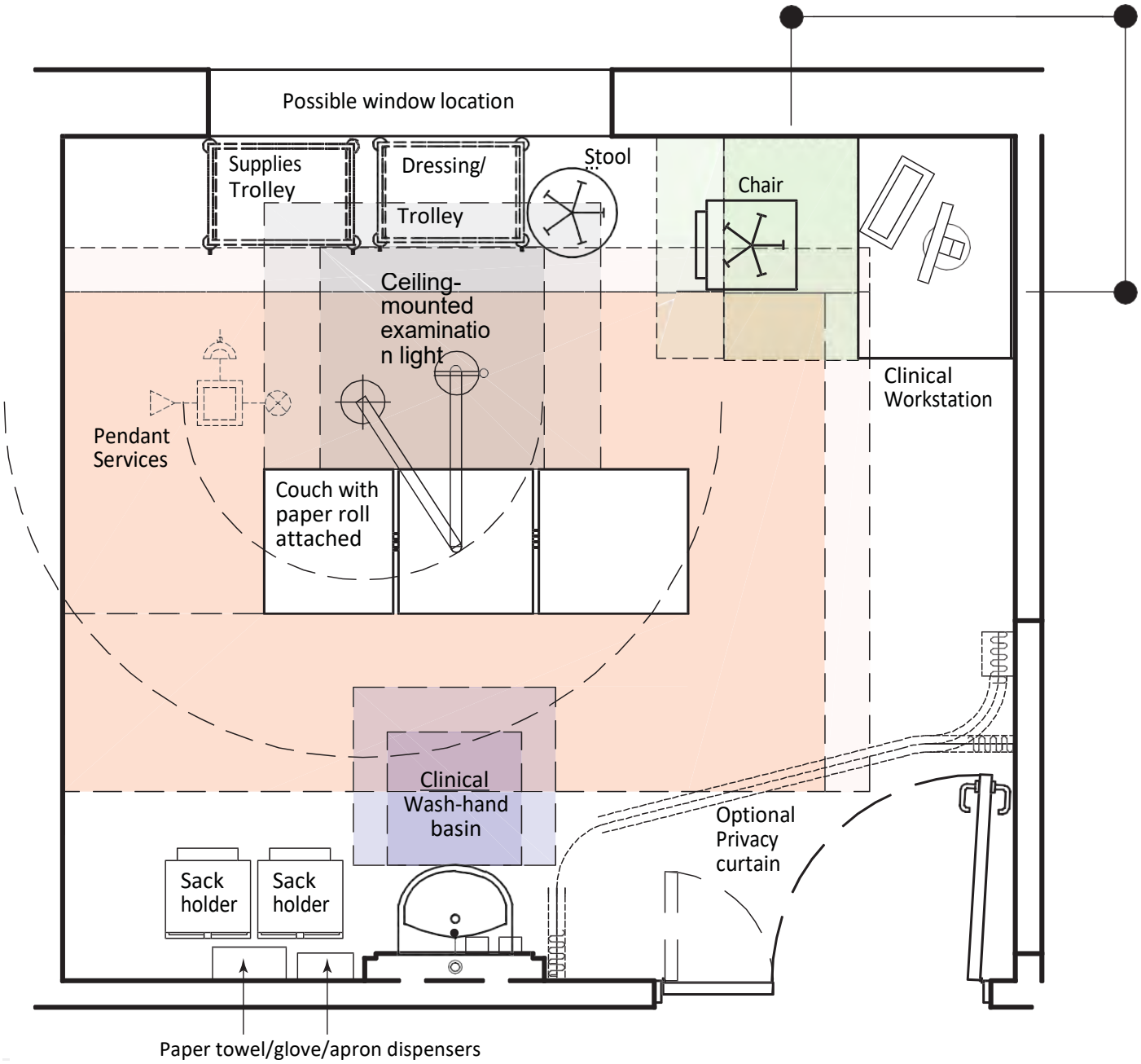
Appendix A

Suggested layout of clinic room

Treatment room: all-round couch access



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Clinical Standards

Standard 14
Immunisations for Podiatrists

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Standard 14 – Immunisations for Podiatrists

As healthcare professionals the individual Podiatrist has the responsibility of ensuring they have immunity against diseases.

Health professionals and immunisation practitioners can keep up to date with developments in the field and updates to the Green Book through regular Vaccine Update newsletters.

Routine vaccination

All Podiatrists should be up to date with their routine immunisations, e.g. tetanus, diphtheria, polio and MMR. The MMR vaccine is especially important in the context of the ability of healthcare staff to transmit measles or rubella infections to vulnerable groups. While healthcare workers may need MMR vaccination for their own benefit, they should also be immune to measles and rubella in order to assist in protecting patients. Satisfactory evidence of protection would include documentation of having received two doses of MMR or having had positive antibody tests for measles and rubella.

Selected vaccines

BCG

BCG vaccine is recommended for healthcare workers who have close contact with infectious patients. It is particularly important to test and immunise staff working in maternity and paediatric departments and departments in which the patients are likely to be immunocompromised, e.g. transplant, oncology and HIV units (see Chapter 32 of the green book on TB).

Hepatitis B

Hepatitis B vaccination is recommended for healthcare workers who may have direct contact with patients' blood or blood-stained body fluids. This includes any staff who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten by patients.

Antibody titres for hepatitis B should be checked one to four months after the completion of a primary course of vaccine. Such information allows appropriate decisions to be made concerning post-exposure prophylaxis following known or suspected exposure to the virus.

Influenza

Influenza immunisation helps to prevent influenza in staff and may also reduce the transmission of influenza to vulnerable patients. Influenza vaccination is therefore recommended for healthcare workers directly involved in patient care, who should be offered influenza immunisation on an annual basis.

Varicella

Varicella vaccine is recommended for susceptible healthcare workers who have direct patient contact. Those with a definite history of chickenpox or herpes zoster can be considered protected. Healthcare workers with a negative or uncertain history of chickenpox or herpes zoster should be serologically tested and vaccine only offered to those without the varicella zoster antibody.

Reference:

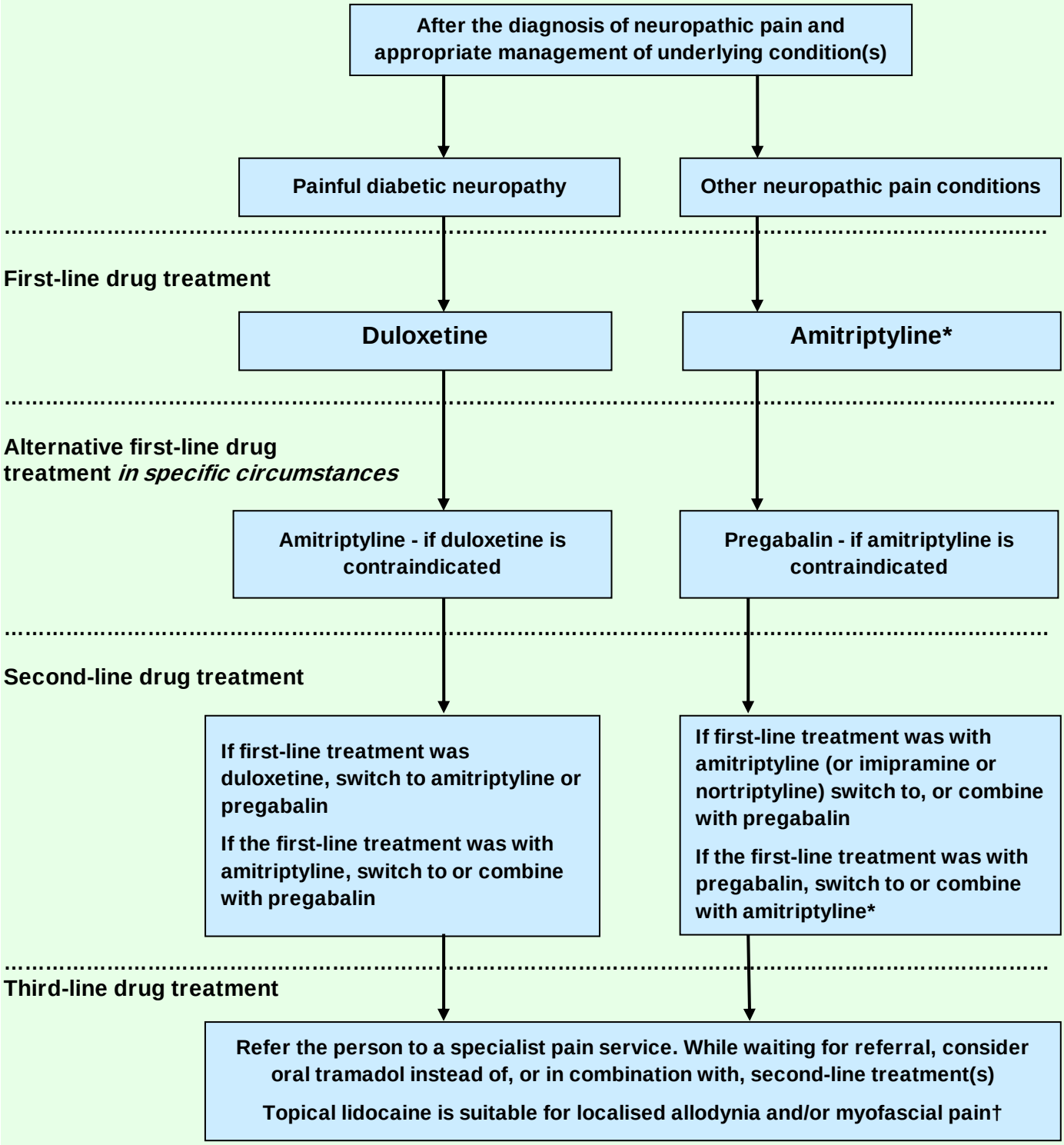
'Immunisation against infectious disease' Edited by Dr David Salisbury CB FRCP FRCPCH FFPHM, Director of Immunisation, Department of Health, Dr Mary Ramsay BSc MB BS MRCP MSc MFPHM FFPHM, Consultant Epidemiologist, Health Protection Agency and Dr Karen Noakes BSc PhD, Principal Scientist Immunisation, Department of Health 2006.

For further information please see:

https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Health and Social Care in Northern Ireland

Neuropathic pain – pharmacological care pathway for non-specialist settings



Notes:

***** If satisfactory pain reduction is obtained with amitriptyline but the person cannot tolerate the adverse effects, consider imipramine or nortriptyline as an alternative

† Topical lidocaine could be an earlier choice for post-herpetic neuralgia in elderly/very elderly patients who are prone to falls when taking TCAs and anticonvulsants

Issued April 2011 ● Review date: April 2013

Pharmacological Care Pathway Guidance Notes

Health and Social Care in Northern Ireland

Referral to a specialist pain service

Consider referring the person to a specialist pain service AT ANY STAGE, including at initial presentation and at the regular clinical reviews, if they have severe pain, or if pain significantly limits their daily activities, or if their underlying pain condition has deteriorated.

If possible, amitriptyline should be tried before pregabalin (non-diabetic neuropathic pain)

Current evidence suggests that tricyclic antidepressants and anticonvulsants are similarly effective at reducing pain, and have similar rates of adverse events. There is no direct evidence to distinguish between the clinical effectiveness and safety profiles of pregabalin and amitriptyline in neuropathic pain conditions. The following Numbers Needed to Treat (NNT) and Numbers Needed to Harm (NNH) for neuropathic pain have been reported:[1-4]

- Tricyclic antidepressants: NNT=3.6; NNH for major adverse effects leading to drug withdrawal =28; NNH for minor adverse effects = 6
- Gabapentin: NNT= 4.3; NNH for major adverse effects leading to drug withdrawal = not significant; NNH for minor adverse effects = 3.7
- Pregabalin: NNT= 4 to 11 (depending on dose and condition); NNH for major adverse effects leading to drug discontinuation = 6 to 17; NNH for minor adverse effects = 3 to 12
- Duloxetine: NNT=6; NNH for major adverse effects leading to drug discontinuation = 17; NNH for minor adverse effects = not reported.

In their clinical guideline,[5] NICE do not state a preference between amitriptyline and pregabalin, so prescribers may base their decision on clinical judgement of the patient's condition, co-morbidities and cost of treatment. One month's treatment with amitriptyline (75mg daily) costs £1.93 whereas pregabalin (2 x 300mg daily) costs £64.40.[6]

Starting drug treatment and titrating drug dosages

Address the person's concerns and expectations when agreeing which treatment(s) to use by discussing benefits and adverse effects, why a particular treatment is chosen, coping strategies, and non-pharmacological treatments. To avoid unrealistic expectations, realistic treatment goals should be set. Pain reduction of at least 30% is generally accepted to be a clinically meaningful result.[7] Explain that pain reduction and self-management may be achievable and worthwhile goals. Explain the importance of dosage titration and the titration process. When introducing a new treatment, consider overlap with the old treatments. With all agents, start at a low dose and titrate upwards to an effective dose or to the maximum tolerated dose (see Table ONE).

How long is an adequate trial of a drug?

A trial of up to 2-3 months at the maximum tolerated dose should be adequate to assess efficacy. If **no benefit** has been derived during this trial period the drug should be stopped and another agent considered. If response has been inadequate after this time, addition of, or switch to, another agent should be considered. (See Table ONE)

Clinical reviews

- After starting or changing treatment, perform **an early clinical review** of dose titration, tolerability and adverse effects.
- Throughout treatment, **perform regular clinical reviews** to assess and monitor effectiveness of treatment. Include assessment of pain reduction, adverse effects, daily activities and participation, mood, sleep quality, and overall improvement.

Duration, reducing and stopping drug treatment

If satisfactory improvement is achieved following introduction and upward titration of a drug, maintain the person on this drug and dosage for a period of at least **six months**. Thereafter, an attempt can be made to reduce dosage with a view to stopping treatment altogether or maintaining the person on the lowest efficacious dose. Dosage reduction should be carried out **very slowly**, with dose reductions at intervals of about two weeks (e.g. pregabalin 300mg twice daily could be reduced to 150mg in the morning and 300mg at night – for two weeks; then 150mg twice daily - for two weeks; then 75mg in the morning and 150mg at night - for two weeks, etc.) Importantly, even if a drug cannot be stopped completely, it is important to attempt to reduce it to the **lowest efficacious dose** if it is to be used in the long-term.

Other points

- **Opioids** - NICE advise that opioids other than tramadol should **not** be started without an assessment by a specialist pain service.[5] However, the patient may have to wait several months to be seen by a pain specialist so this may not be practical. An approach might be to consider referral to a specialist if pain cannot be controlled by moderate doses of strong opioids (i.e. 120-180mg morphine-equivalent per day).[8]
- **Gabapentin** is only appropriate if pregabalin is effective but not tolerated. If pregabalin has been ineffective it is not appropriate to try gabapentin. Similarly, pregabalin is **not** an appropriate alternative if gabapentin has been ineffective.

Reference List

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Table One: Dosages of some agents used in neuropathic pain[5,7,9]

Drug	Starting dose	Dose titration and duration of trial	Maximum dose
Amitriptyline¥	10mg daily	Increase dose by 10mg to 25mg every 3-7 days. Duration of adequate trial 6-12 weeks at maximum tolerated dosage.	75mg daily†
Duloxetine	60mg daily	Increase dose after one week if necessary. Discontinue if inadequate response after two months.	120mg daily in divided doses
Pregabalin	150mg daily* in **two divided doses**	Increase after 3-7 days to 150mg **twice daily**, increased further if necessary after additional 7 days to 300mg **twice daily**. Three month trial should be adequate to assess efficacy.	600mg daily in **two divided doses**
Tramadol	50-100mg not more often than every 4 hrs	A four week trial at the maximally tolerated dose should be adequate to assess efficacy.	400mg daily

¥ Amitriptyline is not licensed for neuropathic pain but the evidence for treatment efficacy and safety is deemed sufficient to make this recommendation.
† Higher doses could be considered in consultation with a specialist pain service.
* A lower starting dose may be appropriate for some people.

Pregabalin Review Checklist

Patient Details	1	2	3	4	5
Patient ID					
Pregabalin Prescribing					
Amitriptyline tried first line? **Any contraindication to amitriptyline?**	Y / N Y / N	Y / N Y / N	Y / N Y / N	Y / N Y / N	Y / N Y / N
Pregabalin initiated by (If hosp, state consultant / clinic e.g. pain clinic)	GP / Hosp	GP / Hosp	GP / Hosp	GP / Hosp	GP / Hosp
Length of time on pregabalin?	1 - 3 m ❑ 3 - 6 m ❑ 6 m - 1 yr ❑ >1yr ❑	1 – 3 m ❑ 3 - 6 m ❑ 6 m - 1 yr ❑ >1yr ❑	1 - 3 m ❑ 3 - 6 m ❑ 6 m - 1 yr ❑ >1yr ❑	1 – 3 m ❑ 3 - 6 m ❑ 6 m - 1 yr ❑ >1yr ❑	1 – 3 m ❑ 3 - 6 m ❑ 6 m - 1 yr ❑ >1yr ❑
Date of last review					
Has level of pain been recently assessed?	Y / N	Y / N	Y / N	Y / N	Y / N
Intended duration / treatment plan documented	Y / N	Y / N	Y / N	Y / N	Y / N
Current dose					
Quantity and interval of script					
Has dose been optimised i.e. ONE capsule twice daily	Y / N	Y / N	Y / N	Y / N	Y / N
Has concordance been assessed?	Y / N	Y / N	Y / N	Y / N	Y / N
Has dose reduction / withdrawal been attempted?	Y / N	Y / N	Y / N	Y / N	Y / N
Other analgesics					

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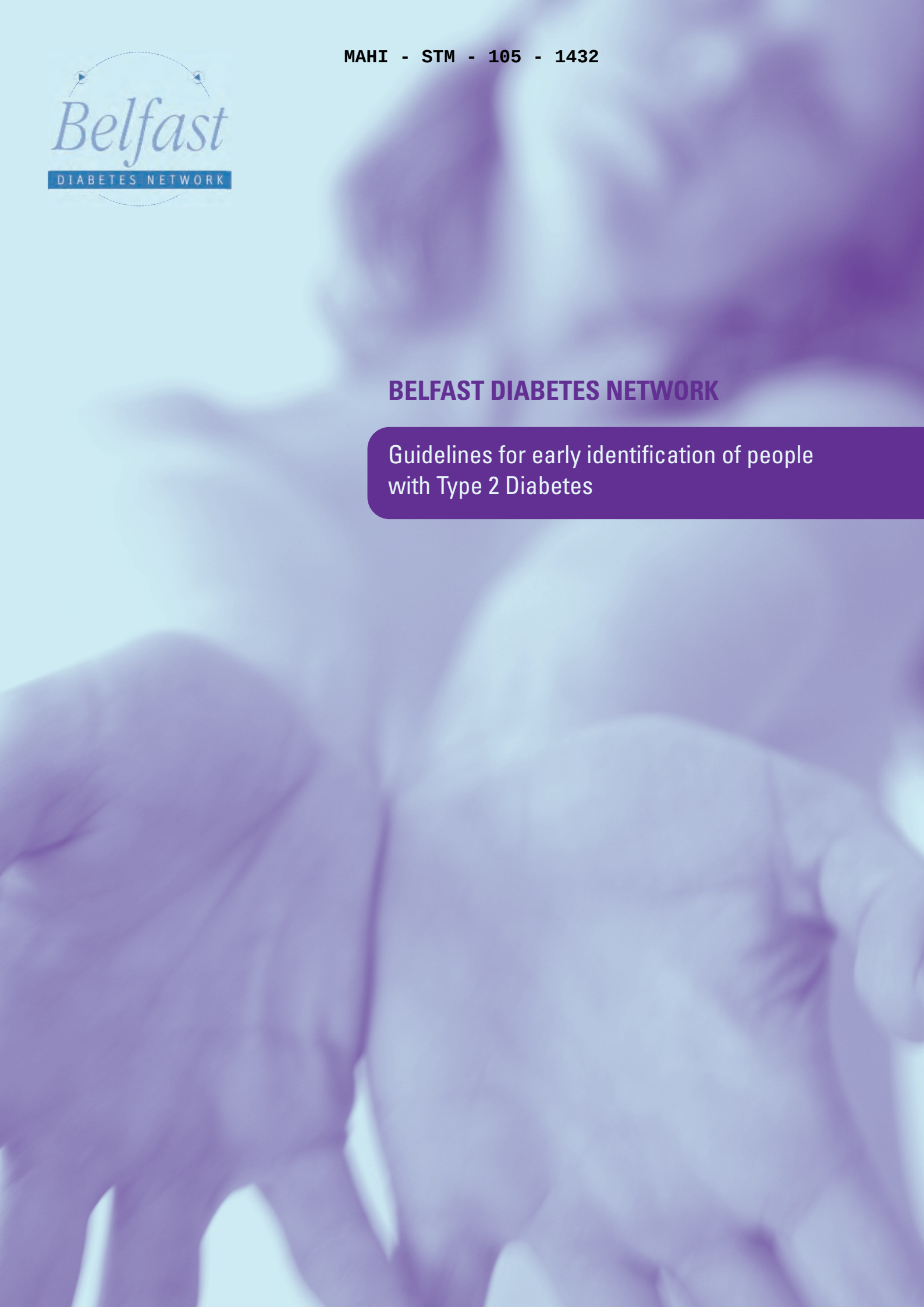
Guidelines for early identification of people with Type 2 Diabetes



INTRODUCTION

Identification of those at high risk of developing Type 2 diabetes can contribute to reducing the devastating complications of coronary heart disease, renal disease, blindness, stroke and foot disease (1). Up to 50 per cent of people with Type 2 diabetes have complications at diagnosis (2). There is a long and latent asymptomatic period in which the condition can be detected (3). However, it is estimated that approximately 0.75 million people with diabetes remain undiagnosed in the UK (3). With the expectation that the number of people with diabetes in the UK will reach 3 million by the end of the decade, action is needed to ensure that people with diabetes are identified early.

In 2002, the Department of Health (1) recognised that there was a case for a more systematic approach to screening for Type 2 diabetes. This led to a consensus for an integrated approach combining cardiovascular disease and diabetes, and in February 2006 the National Screening Committee recommended that diabetes be included in a Risk Assessment and Control [Management] Programme (to ensure all people with known vascular disease, high blood pressure or diabetes receive a comprehensive risk assessment.
It seems clear that a national screening programme for diabetes (as compared to breast cancer for example) will not be co-ordinated centrally. The work of screening will have to be organised at regional and local level. These guidelines are an attempt to use current knowledge to effect action here and now. They reflect current realities of practice already established in Belfast.

WHOM TO TEST

General population screening is not recommended. It is generally agreed that targeted case finding of high risk groups is the most efficient strategy. This may be done most economically and effectively as part of other health care examinations, such as screening for cardiovascular risk factors. The more risk factors a person has, the more likelihood there is of having diabetes and the higher the sensitivity and specificity of screening tests. Evidence is not currently strong enough to weight individual risk factors.

CRITERIA FOR SCREENING FOR DIABETES

a) Aged over 40 years (and over 25 in those from Black, Asian and minority ethnic groups with one or more risk factors below:

- First degree family history of diabetes
- BMI of 25-30kg/m^2 and above
- Waist measurement ≥ 94cm (≥ 37 inches) for men and ≥ 80cm (≥ 31.5 inches) for women (≥ 90cm inches (≥ 35 inches) for Asian men)

b) Ischaemic heart disease, cerebrovascular disease, peripheral vascular disease or treated hypertension
c) Gestational diabetes
d) Polycystic ovary syndrome with a BMI ≥ 30
e) Impaired glucose tolerance or impaired fasting glycaemia
f) Severe mental health problems
g) Hypertriglyceridemia not due to alcohol excess or renal disease

adapted from Diabetes UK (4)

TESTING METHODS

There is limited evidence available to identify the most effective and practical method of screening . The Belfast Diabetes Network recommends fasting venous plasma glucose measurement in an accredited laboratory as the standard screening method.

- Fasting tests are best done in the morning before breakfast.
- Active case finding of those at increased risk of developing diabetes should be performed every three years (5).
- Screening is probably most cost-effective when performed as part of a general health review, when other cardiovascular risk factors can be measured .
- Fasting tests will inevitably miss those people with carbohydrate intolerance whose hyperglycaemia is only manifest after a carbohydrate load (impaired glucose tolerance).

Alternative methods have shortcomings

- Postprandial urinalysis for glycosuria is insensitive and is not recommended.
- Random blood glucose values are difficult to interpret. Very high results are a good indicator of diabetes, but values in the range 6-10 mmol/l need to be rescreened using a fasting test.
- Fasting capillary blood testing may be convenient for use in general practice and pharmacies, but will miss 20-30 per cent of cases. Some blood glucose meters use capillary blood, which gives a lower reading than plasma. Others meters convert to give a plasma rather than a whole blood reading. Therefore when using a finger prick test the person doing the test should know what is being measured.

Pharmacists considering setting up an early case identification service for diabetes are advised to consult the professional requirements relating to diagnostic testing and health screening as set out in the Code of Ethics. For further information about screening services within pharmacies please refer to Diabetes UK: Care for community pharmacists 2003 (6) or the Royal Pharmaceutical Society for Great Britain practice guidance on the care of people with diabetes 2004 (including guidance on early identification) (7).

RESPONSE TO SCREENING RESULTS

It is important to consider the impact a positive screening result may have on an individual. Diabetes is a chronic condition with potentially disabling outcomes and a high mortality rate. As well as medical considerations, there may also be an impact on lifestyle, including employment and insurance issues. If the screening test is positive he/she should be told that the test has indicated a possible rise in blood glucose which needs further checking. The person should be asked not to make any changes in diet or drug therapy but should make a routine appointment with their GP in the two to four weeks for a further test (an earlier appointment may be suggested if the person is symptomatic).

RESPONSE TO SCREENING RESULTS

Fasting venous plasma glucose (mmol/l)

<6.1	Low probability of diabetes	Advice about healthy living and reduction of risk factors Rescreen as clinically indicated
6.1-6.9	Probability of impaired fasting glycaemia	Consider OGTT to confirm or rule out diabetes
7.0-11.1	Probability of diabetes	Repeat fasting sample to confirm diabetes
≥11.2	High probability of diabetes	Repeat fasting sample to confirm diabetes

The GP should then confirm the diagnosis either by a repeat fasting plasma glucose or oral glucose tolerance test (OGTT). An oral glucose load, in the form of a glucose-containing drink, with subsequent measurement of blood glucose is the basis of the oral glucose tolerance test (OGTT) the 'gold standard' for assessment of carbohydrate tolerance. . At its simplest a person consumes 75g of oral glucose in liquid form and has a single blood glucose assay 120 minutes later(as timed by the individual) gives a reasonable approximation to a formal OGTT and is potentially usable on a larger scale.Glucose assays should be performed in a reputable laboratory. (?develop a protocol for GP in NW) No therapy should be instigated until a final diagnosis in line with the World Health Organisation's (WHO) criteria (8) has been established.

DIAGNOSIS OF DIABETES

A diagnosis of diabetes can be confirmed by:

- A random venous plasma glucose concentration ≥ 11.1mmol/l
- A fasting venous plasma glucose (FPG) concentration ≥ 7.0 mmol/l or
- A two hour venous plasma glucose concentration ≥ 11.1mmol/l 2 hours after 75g anhydrous oral glucose tolerance test

In asymptomatic subjects, performing the test on one occasion is not enough to establish the diagnosis. It must be confirmed by carrying out at least one further test on a subsequent day.

Patients at risk with a negative screening result should have repeat testing in 3 years.

INTERMEDIATE RESULTS

Screening for diabetes will identify people with Impaired Fasting Glucose (fasting venous plasma glucose ≥6.1 - <7.0 mmol/l) or Impaired Glucose Tolerance (venous plasma glucose ≥7.8 - <11.1 mmol/l 2h after oral glucose).

Changes in fasting and 2 hour post glucose values are often inconsistent, e.g. those with IFG may have normal, slightly raised or frankly diabetic values 2 hour after oral glucose and should be tested with an OGTT to rule out diabetes.

Impaired glucose tolerance, and perhaps IFG, is associated with an increased risk of premature cardiovascular disease. Early management with diet and exercise can reduce progression to diabetes. Screening for other cardiovascular risk factors in mandatory. This population need to be given lifestyle advice, support and information about healthy eating and physical activity and should be screened for diabetes annually.

Cardiovascular risk should be assessed using standard tables in the British National Formulary and multiplied by 1.5 for those with IGT or IFG. If CVD risk is greater than 20% additional protective medications including statins and aspirin should be considered, and the need for antihypertensive medication assessed (9). No medications are currently licensed for possible prevention of diabetes in IGT or IFG.

LIFESTYLE ADVICE IN THE BELFAST TRUST AREA

Regular physical activity reduces the chance of at risk patients progressing to diabetes and makes established diabetes easier to control, Moderate physical exercise for 30 minutes most days is suitable for the majority of people. To find out about opportunities contact your local leisure centre or health Promotion Department (Detail please supply??)

Smoking cessation is key for patients at risk of diabetes. Help and advice is available through the smokers' helpline on 0800 858585

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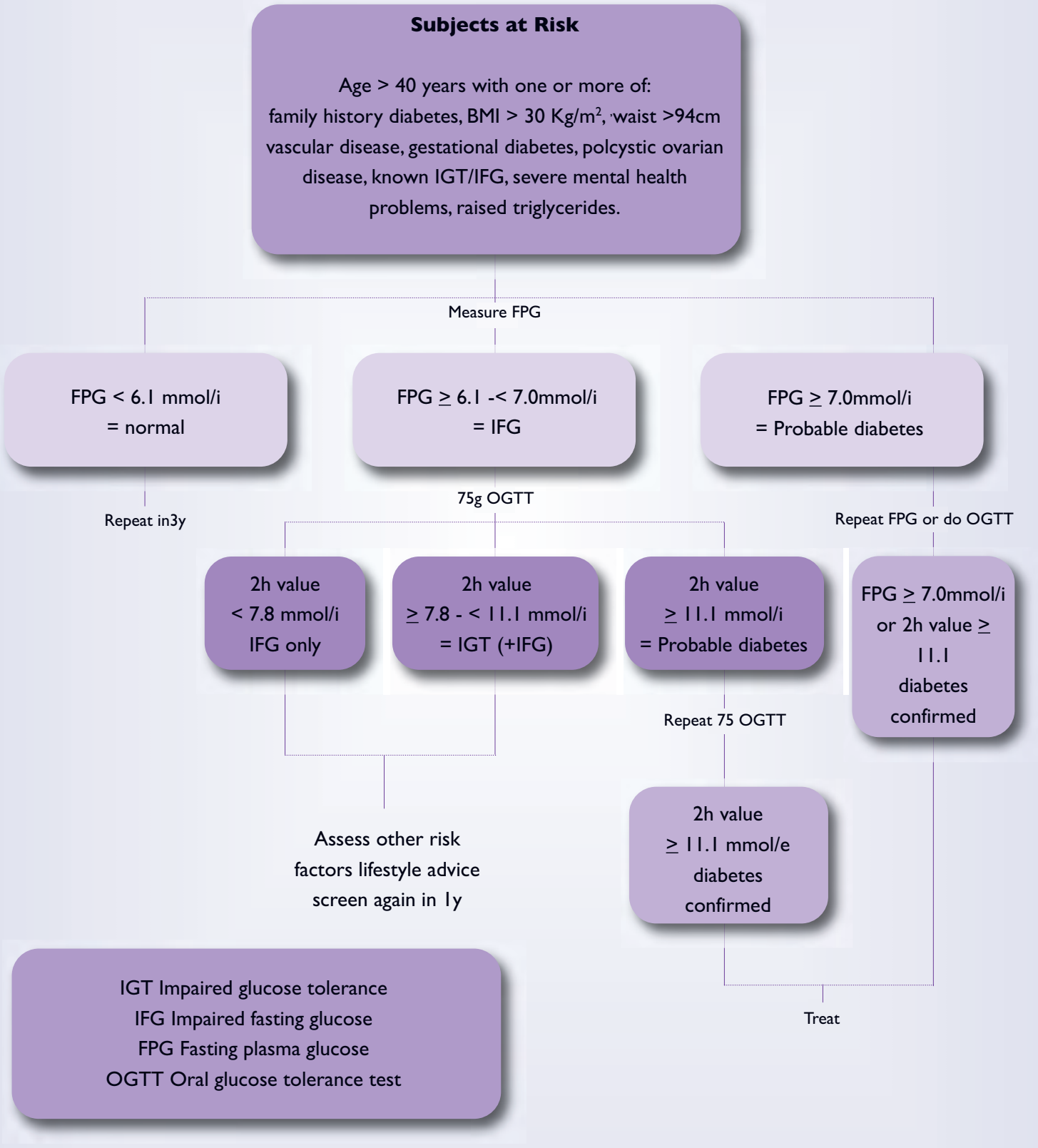
SUMMARY OF SCREENING RECOMMENDATIONS



Guidelines for early identification of people with Type 2 Diabetes

BELFAST DIABETES NETWORK

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Regional Standard Operating Procedures for the Podiatric Assessment of Vascular and Neurological Status and Wound Classification

JANUARY 2018

Contents

Introduction

Podiatry Managers in Northern Ireland (NI) recognised that there was a lack of data on and variation in the availability and quality of care in diabetic foot ulcer (DFU) management.

A GAIN regional audit of DFU management against national standards provided baseline information on the assessment, clinical management, healing times and amputation rates in 100 patients presenting with a new DFU.

A variation in podiatry practice across N.I was identified and the following recommendations were made.

- Diabetes foot assessments should be standardised within the region.
- A regional diabetic foot ulcer classification system should be adopted and embedded in clinical case notes.

A cross Trust regional task and finish group (appendix 1) was established with the remit of reviewing evidence, developing standard operating procedures for neurological and vascular assessments, outlining diagnostic criteria and implementing a wound classification system. The scope was extended to include all patients who attend the podiatry service.

Regional training was delivered to each Trust.

Safe Operating Procedures

A **Standard Operating Procedure** (SOP) is a step-by-step description of the processes involved to safety and efficiently complete a task

Implementation of SOPs will ensure standardisation of care across all Trusts within the region. It will facilitate robust inter trust communication and allow benchmarking of services across N.I.

Neurological Assessment

Overview

Most common among diabetic neuropathies is chronic distal symmetrical polyneuropathy (DSPN), accounting for about 75% of the diabetic neuropathies. It is common, occurring in at least 20% of people with type 1 diabetes after 20 years of disease duration. DSPN may be present in at least 10%–15% of newly diagnosed patients with type 2 diabetes with rates increasing to 50% after 10 years of disease duration. DSPN is the primary cause of foot ulceration, and it is also a prerequisite in the development of Charcot neuroarthropathy.

The following clinical tests may be used to assess small and large fiber function distal to proximal

- Small fiber function: pinprick
- Large fiber function: vibration perception, 10g monofilament

Standard Operating Procedure

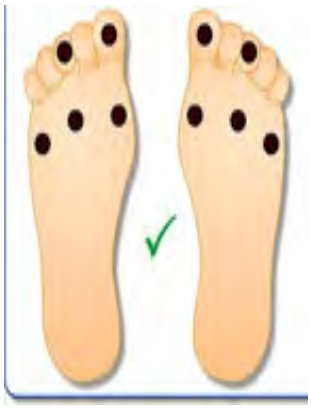
<u>10g monofilament</u>

1. Use only Bailey **or** Owen Mumford branded 10g monofilaments.

Bailey Owen Mumford

2. Depress the monofilament twice prior to use on a patient
3. Apply to patient's hand to familiarise them with the sensation and explain how the test is to be carried out.

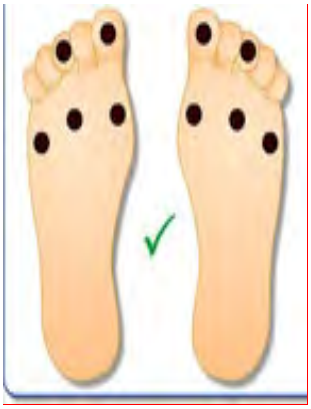
4. Ask the patient to close their eyes and tell you when they feel the monofilament touching the foot
5. Five sites are tested on each foot; apex of the 1st and 3rd toes and the 1st, 3rd and 5th metatarsal heads.



6. With the monofilament at a 90° angle to the foot, test the sites in a random order.
7. Depress the monofilament with enough force to cause a bend in the monofilament and remain in contact with the skin for between 1 and 2 seconds.
8. Do not allow the monofilament to slide across the surface of the skin.
9. Avoid areas of callus or ulceration.
10. Record the findings in the podiatry record.
11. Rest the monofilament for 24hours if used on 10 patients in the same day and replace after 100 uses.

Neurotip

1. Hold a Neurotip by the cap and press it firmly down into the neurotip holder of the Neuropen as far as it goes. Twist off the cap.
2. Apply to patients hand to familiarise them with the sharp sensation and explain how the test will be carried out. is to be carried out
3. Ask the patient to close their eyes.
4. Five sites are tested on each foot; apex of the 1st and 3rd toes and the 1st, 3rd and 5th metatarsal heads. Test the sites in a random order



5. Press the Neuropen at a 90° angle to the foot until the marker is within the 40g marker zone. Hold in position for 1-2 seconds.
6. Avoid areas of callus or ulceration.
7. Remove the Neurotip from the Neuropen and dispose of the Neurotip in a sharps box.
8. Record the findings in the podiatry record.

Neurothesiometer

1. Select “volts” and “normal” options for the range switches. Ensure the rotary knob is set at zero
2. Apply probe to patients hand to familiarise them with the sensation and explain how the test will be carried out.
3. Ask the patient to close their eyes during the assessment
4. Apply the probe to the apex of the hallux.
5. Turn the rotary knob up until patient is aware of vibration and then very slowly turn it down.
6. Note reading when patient can no longer feel vibration
7. Repeat twice and record average

Vascular Assessment

Overview

The incidence of peripheral arterial disease increases with age. In the general population 20% of people aged over 60 are affected. In most people with intermittent claudication (IC) the symptoms remain stable however 20% affected with IC will progress to critical limb ischaemia.

Peripheral arterial disease (PAD) affects 1 in 3 people with diabetes over the age of 50, and can also increase the risk of heart attack and stroke. Key definitions outlining the severity of the disease are listed below.

1. **PAD** is impaired peripheral circulation

2. **Critical limb ischaemia** is the presence of **ulceration** or **rest pain** for greater than **two weeks** in conjunction with an impaired peripheral circulation (**PAD**)

3. **Acute limb threatening ischaemia** is the **sudden onset** of vascular compromise and carries a high risk of **mortality** or **limb loss**.

Standard Operating Procedure

1. Complete physical examination of both limbs recording colour, temperature and condition of skin and nails.

2. Record signs and symptoms including the presence of pain or ulceration affecting the leg or foot

3. Complete The Edinburgh Claudication Questionnaire when intermittent claudication is suspected.(Appendix 2)
4. Palpate dorsalis pedis and posterior tibial pulses on both feet. Record absence or presence of pulses.

5. Listen to Doppler sounds for each pulse on both feet; Apply gel over the sensor of an 8- to 10-MHz Doppler probe. Placed the probe in the area of the pulse at a 45- to 60-degree angle to the skin surface moving the probe until a clear signal is heard. Record the Doppler sound as monophasic, biphasic or triphasic.

6. Carry out an ABPI assessment if pedal pulses are absent, Doppler sounds are monophasic or Doppler sounds are biphasic in the presence of signs and symptoms of peripheral arterial disease.

ABPI with the Doppler Method,

1. Put the patient in the supine position for five to ten minutes. The head and heels should be supported
2. The blood pressure cuff should contour at least 40% of the limb circumference. Do not place a cuff on a distal bypass or ulcer. Cover ulcers/wounds with an impermeable dressing. For those patients who have undergone a mastectomy an upper limb brachial pressure measurement is not carried out on the side where surgery has occurred.
3. Advise the patients to remain still during the measurement;
4. Position the cuff around the ankle with the straight wrapping method, as with brachial measurement. Check that the lower edge is 2 cm above the superior aspect of the medial malleolus.
5. Apply gel over the sensor of an 8- to 10-MHz Doppler probe. Place the probe in the area of the posterior tibial pulse at a 45- to 60-degree angle to the skin surface moving the probe until a clear signal is heard.
6. Inflate the cuff progressively to 20 mm Hg above the level of flow signal disappearance. Slowly deflate at about 2mmHg per second to detect signal reappearance. If flow is still detected at the maximum level of inflation (200 mm Hg), deflate the cuff immediately.
7. Repeat this process at the dorsalis pedis artery.
8. Move to the other leg and repeat the process for both posterior tibial and dorsalis pedis arteries.
9. Use Doppler to detect brachial blood flow during the arm pressure measurement. Apply the cuff with a 2cm gap between elbow crease and the bottom of the cuff. Follow the same sequence of limb pressure measurement as used in the leg (point 6 above)
10. Move to the other arm and repeat the process

11. Report the ABPI separately for each leg and each artery. Calculate by dividing the posterior tibial and dorsalis pedis blood pressure readings by the higher of the right or left arm systolic blood pressure.

12. Wipe Doppler probe and reusable cuff with alcohol wipes. Dispose of single use cuffs in clinical waste bag.

Wound Classification

Overview

Any wound classification system designed for general implementation must encompass all the variables that contribute to outcomes for patients. Adoption of a simple score based system which includes the following variables, **S**ite, **I**schemia, **N**europathy, **B**acterial Infection, **A**rea and **D**epth (SINBAD) will allow for both clinical description of the wound and audit.

The SINBAD classification system is a validated prognostic tool. It is the wound classification system used in The National Diabetic Foot Audit (NDFA).

Although designed for the classification of diabetic foot ulcers the task and finish group recommends its use for classification of all wounds. Post-surgical wounds will be classified six weeks following surgery.

Standard Operating Procedure

1. A full medical history must be recorded
2. A neurological and vascular exam must be completed
3. Site

   Record site of wound and apply a score of either 1 or 0 as indicated.

   Forefoot i.e. distal to the tarso-metatarsal junction Score 0

   Hind foot: proximal to the tarso-metatarsal junction Score 1
4. Ischaemia

   Score 1 if there is a diagnosis of PAD

   Score 0 if PAD is not present

5. Neuropathy

   Score 1 if there is a diagnosis of neuropathy

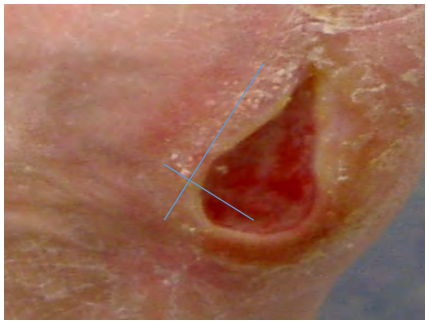
   Score 0 if neuropathy is not present

6. Bacterial infection

   If either soft tissue or bone infection is present, score 1. If absent score 0

7. Area

   Measure the two maximum dimensions of the wound at right angles and multiply.



3.2cm x 1.7cm=5.44cm²

   Score 1 if the area is greater than 1cm^2 .If less than 1cm2 score 0.

8. Depth

   If probing to tendon, joint capsule, periosteum or bone, score 1. If the wound is superficial, score 0.

9. Add all scores together and record in podiatry record.(Appendix 3)
10. Record the rational for scoring in the O (objective) of the SOAP format

Diagnostic Criteria

Neuropathy

Neuropathy is present when a patient fails any of the following tests

Failure to feel the monofilament on two or more sites on one or both feet

or

Failure to feel the neurotip on two or more sites on one or both feet

or

The patient has a neurothesiometer reading of 25v or greater.

Peripheral Arterial Disease (PAD)

PAD is diagnosed if any of the following are identified

1. Intermittent claudication, confirmed with The Edinburgh Claudication Questionnaire
2. If a patient has Diabetes mellitus **and** neuropathy with an ABPI value less than 0.9
3. If a patient does not have diabetes or has diabetes but not neuropathy with an ABPI values less than 0.9 or greater than 1.3
4. If Doppler sounds are Monophasic

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Appendix 1

Task and Finish Group Membership

Gail Thompson	SEHSCT (Chair)
Stephen McAlister	SEHSCT
Elaine Davidson	NHSCT
Jane Beggs	NHSCT
Jackie Campbell	SHSCT
Margaret McTurk	SHSCT
Aileen Gallagher	WHSCT
Catherine Buchanan	WHSCT
Helen Reid	WHSCT
Kim Martin	BHSCT
Bronagh Monaghan	BHSCT

Appendix 2

The Edinburgh Claudication Questionnaire

(1) Do you get a pain or discomfort in your leg(s) when you walk?
Yes
No
I am unable to walk

If you answered "Yes" to question (1)- please answer the following questions.
Otherwise you need not continue.

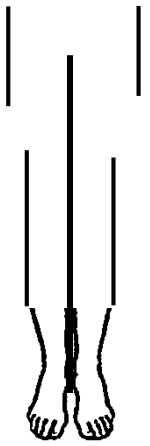
(2) Does this pain ever begin when you are standing still or sitting?
Yes
No

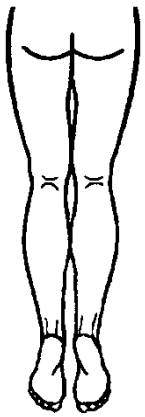
(3) Do you get it if you walk uphill or hurry? Yes
No

(4) Do you get it when you walk at an ordinary pace on the level?
Yes
No

(5) What happens to it if you stand still? Usually continues more than 10 minutes Usually disappears in lO minutes or less

(6) Where do you get this pain or discomfort? Mark the place(s) with "x" on the diagram below



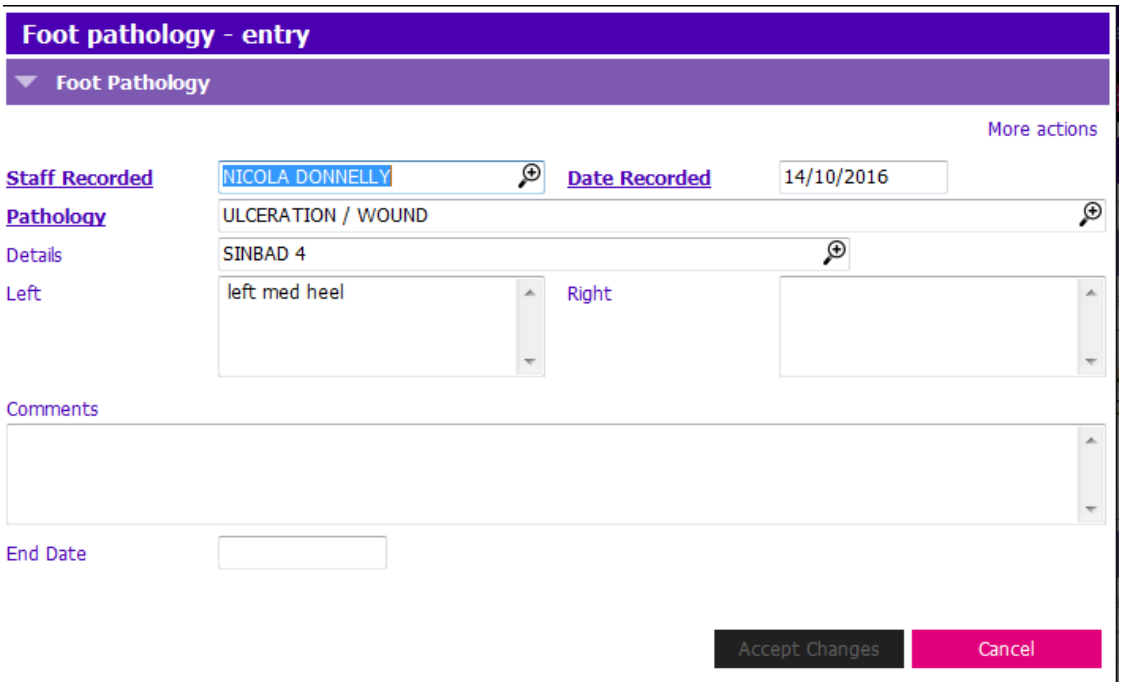


Definition of positive classification requires all of the following responses:
'Yes' to (I),
'No' to (2),
'Yes' to (3), and
'Usually disappears in 10 minutes or less' to (5);
grade I ='No' to (4) and grade 2 ='Yes' to (4).

If these criteria are fulfilled, a definite claudicant is one who indicates pain in the calf, regardless of whether pain is also marked in other sites; a diagnosis of atypical claudication is made if pain is indicated in the thigh or buttock, in the absence of any calf pain. Subjects should not be considered to have claudication if pain is indicated in the hamstrings, feet, shins, joints or appears to radiate, in the absence of any pain in the calf.

Appendix 3

Recording SINBAD scores



When the SINBAD score has been calculated, it must be recorded. The SINBAD score will record this in the 'A' section of SOAP as SINBAD=5 and also within PARIS as detailed below.

Click on Pathology section of PARIS click on insert a row

Select ulceration/wound from the drop down menu. Then click on details which will display the SINBAD scores and select the one that applies to the wound. If the patient has more than one wound then it is the wound with the higher SINBAD score which is recorded. This is the target wound.

Record the location of the wound/s and also in the comments box state which wound is the target wound if multiple wounds.

If the SINBAD score changes, this is recorded in SOAP and not in Pathology

When the target wound heals or if the outcome is amputation etc. the end date box must be populated ad the reason i.e. healed, amputation etc. within the original pathology section

NORTH WEST PODIATRY SERVICES
CLINICAL EFFECTIVENESS GROUP –
RHEUMATOLOGY

GUIDELINES FOR THE MANAGEMENT OF FOOT HEALTH FOR PEOPLE WITH RHEUMATOID ARTHRITIS

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1. INTRODUCTION TO THE GUIDELINES

1.1 The Aims of the North West Clinical Effectiveness Group

The North West Clinical Effectiveness Group (NWCEG) for the Foot in Rheumatic Diseases was initiated by the North West Region Podiatry Heads of Service in 2003. Members of the group include podiatrists who currently work with patients with rheumatic diseases, a representative from service managers and an academic link with the University of Salford.

The work of this group now continues with the aim of contributing to the global aim of improving the care of patients with musculoskeletal (MSK) and rheumatic diseases (Woolf 2012) by supporting service development and the professional development of those podiatrists involved in the management of patients with rheumatic diseases through the following objectives:

- To provide a support network for NHS podiatrists in the NW region working within the field of rheumatology and musculoskeletal services.
- To cascade learning and best practice
- To develop, review and promote protocols / guidelines that identify benchmarks and essential / desirable standards as a framework for podiatry service providers and clinical commissioning groups / within the NW region
- The development of audit and evaluation tools
- To promote podiatry within the wider rheumatology / MSK community and as part of the multidisciplinary team
- To update these guidelines and be aware and highlight other relevant guidelines in relation to the management of the foot in rheumatic disease as a framework for service provision and development
- To review new evidence from research and disseminate this into clinical practice.
- To encourage clinical development in this field through increasing awareness amongst service commissioners and providers.
- To identify the training and education needs of podiatrists to facilitate the development of specialist skills required to work at an advanced / extended scope level

1.2 The Purpose of the Current Revised Guidelines

The first guidelines were produced by the NWCEG in 2004 under a broad remit of The Management of the Foot and Ankle in Rheumatic Diseases.

In 2008 The PRCA Standards of Care for People with Musculoskeletal Foot Health Problems were launched. They are ‘patient facing’ in respect of the service that patients can expect and in this context superseded this aspect of the original NW guidelines

During 2010 the NWCEG identified a need for standards to be defined for the *specific foot health management* of patients, particularly those with rheumatoid arthritis. To this end, the original guidelines were revised and developed to be ‘practitioner facing’ with the objective of 'doing the right thing, to the right patient, in the right way, at the right time’ by rationalising and improving the quality of foot health management. They focused on the assessment and management of foot and ankle problems associated with rheumatoid arthritis. The Guidelines for the Management of Foot Health for People with Rheumatoid Arthritis were launched in October 2010.

Over the years the guidelines have been used across the Northwest region to both instigate service provision and support service review. Further to this they have been adopted by various podiatry services as best practice guidelines both across the UK and internationally.

The guidelines received national recognition as being the first in this area and received the support of the Podiatry Rheumatic Care Association (PRCA), and the NHS electronic library for Health (NeLH). The NW CEG has also been actively involved in the development of the PRCA Standards of Care for People with Musculoskeletal Foot Health Problems (PRCA 2008) and as registered stakeholders, in the development of NICE guidance for the Management of Rheumatoid Arthritis in Adults (NICE 2009).

The aim of these revised guidelines remains to provide all podiatrists who may be managing patients with RA with recommendations for the current evidence based and best practice management of RA related foot and ankle problems.

It is important to note that despite the new paradigm of early targeted therapy leading to an improvement in the impact of Rheumatoid Arthritis generally, the impact of foot problems on Quality of Life remains an issue for many patients and hence the podiatrists role in both identifying foot problems at an early stage and inputting appropriately into the wider multi-disciplinary management cannot be underestimated.

2. BACKGROUND TO RHEUMATOID ARTHRITIS

2.1 Epidemiology and Clinical Features of RA

Rheumatoid Arthritis (RA) is an auto-immune, systemic, inflammatory joint disease with a chronic, unpredictable and fluctuating course (Conaghan et al 1999). As a result of this inflammatory activity, the joints may become stiff, painful and swollen; ultimately causing irreversible damage. The sooner one starts treatment for rheumatoid arthritis, the more effective it's likely to be, so early diagnosis and intensive treatment is important (Arthritis Research UK, 2017). There are around 400,000 adults in England with RA (National Rheumatoid Arthritis Society (NRAS) 2010).

Rheumatoid arthritis affects adults of any age yet prevalence increases with age, with peak age of onset between 40–60 years and is highest at age 70 years and over (Symmons D et al, 2002). Around three quarters of people with rheumatoid arthritis are of working age when they are first diagnosed (National Audit Office, 2009).

Rheumatoid arthritis is two to three times more common among women than men (Riise T et al, 2001). The severity of RA may fluctuate both within and between individuals (Grondal et al 2008). Any joint may be affected but commonly the hands, feet and wrists are the most common sites. (Harris 2005). Barrett et al (2000) suggest 1 in 7 give up work within one year of diagnosis. RA is economically costly. In fact, the total UK costs, including indirect costs and work related disability, are estimated to be up to £41,735 / person which translates to approximately £3.8 - £4.8 billion per year (NRAS 2010). Around 1 in 6 people with rheumatoid arthritis have major depressive disorder (Matcham et al, 2013) compared to the UK average of 2.9% (Global Burden of Disease Study).

Although any synovial joint may be affected it is well documented that RA is a condition that can affect the feet (Otter et al 2010; Turner and Woodburn, 2008). The foot is often the first area of the body to be systematically afflicted by RA (Otter et al. 2004) and at diagnosis, 16% of patients may have foot joint involvement progressing to 90% as the disease duration progresses (Grondal et al 2008). 75% of patients with RA report foot pain within 4 years of diagnosis with the degree of disability progressing with the course of the disease. Shi et al (2000) states that virtually 100% of patients report foot problems within 10 years of disease onset. The degree of clinically important disability progresses with the course of the disease; it has been identified to be as early as of less than 2 years disease duration (Turner et al, 2006).

The presence of foot complaints, both in the early and in the chronic stage of RA, has been shown to be extremely detrimental to patients' daily lives and activities, especially ambulation (Wickman et al 2004). Approximately 68% of RA patients in the UK remain physically inactive. Low physical activity in patients with RA becomes a vicious cycle of disease progression and increased pain, thus affecting both physical and mental health (Sokka and Hakkinen , 2008)
The basic pathological changes in the rheumatoid foot result from synovitis and bursitis (Hooper et al, 2012) and tenosynovitis (Barn et al., 2013), coupled with mechanical stress (Turner and Woodburn 2008). These structural and functional changes often affect gait and mobility (Woodburn 2002, Turner et al 2006).

Effects on the foot are diverse and multidimensional including pain, changes in gait, deformity and restrictions in the choice of footwear (Bouysset et al 2006). Specifically, the most common foot deformities in RA patients are hallux valgus, metatarsus primus-varus and splaying of the forefoot (Goksel Karatepe et al 2010). These forefoot manifestations of RA are frequently found in the metatarso-phalangeal (MTP) joints (Van der Leeden et al 2008). Synovitis of the MTP joints can have a destructive impact on the quality and structure of the joints (Siddle et al., 2012b, Riente et al., 2006) and the surrounding soft tissues and bursitis affect the inter metatarsal bursae (Hooper et al., 2012) and contribute to forefoot deformity. Tenosynovitis and midfoot synovitis lead to the development of pes plano-valgus deformity (Barn et al., 2012) These foot problems result in disability in weight-bearing activities, abnormal gait patterns and altered plantar pressure measurements (Turner et al., 2008).

This foot deformity also predisposes to callus formation and as the foot shape alters, and there is a decrease in tissue viability it can leave the feet vulnerable to ulceration (Firth et al 2008). Further to this, bacterial and fungal skin infections and nail pathologies are more prevalent in this patient group adding to the serious risk of ulceration and systemic infection. The risk of opportunistic infections is increased if the patient's medical management is with immunosuppressive drugs (Strand et al 2007, Otter et al 2004).

The feet can remain symptomatic even when the disease is in remission, supported with the current early medical intervention paradigm of early diagnosis and early targeted therapy (Emery et al., 2002). Despite studies which report improvements in physical function related to biological therapy, Sanders et al (2017), discovered that foot problems clearly remain an unremitting feature of life for patients with rheumatoid disease, even when in receipt of biologics. That said, it is widely accepted that there is a 'window of opportunity for early targeted therapy of RA related foot problems (Woodburn et al, 2010).

2.2 Recommendations for the Management of RA Foot Problems

Foot problems in RA are common, but under-reported by both patients and the rheumatology team (Blake et al., 2013, Williams and Graham, 2012) and often neglected in clinical practice ((Williams and Graham, 2012). This not only affects the potential to aid early diagnosis of RA (Emery et al., 2002) but also the need for effective foot health interventions. Any delay in referral to Podiatry has consequences for the patient, which can vary from minor, living with discomfort, to major, where delays result in the development of foot deformity (Blake et al., 2013).

Goals for the management of the RA foot are aimed at reducing the pain in the feet, improving foot function, mobility and quality of life using safe and cost-effective treatments, such as: - palliative foot care, prescribed foot orthoses and specialist footwear aimed at preventing any deterioration in the tissues and in joint alignment (Grondal et al 2008, Woodburn and Helliwell 1997). Woodburn et al also suggest that there is “Window of Opportunity” in early rheumatoid arthritis for effective podiatry intervention. The foot health needs for the patient with RA are varied and range from simple foot care advice, palliative care for nails and skin and orthotic / specialist footwear provision through to management of ulceration and infection (Helliwell 2003, Korda and Balint 2004).

Specific tools for measuring the impact of foot pathology on foot pain function and disability in patients with rheumatic diseases have been validated (Walmsley et al., 2012, Budiman-Mak et al., 2006 Helliwell et al., 2005, Budiman-Mak et al., 1991). These are now being used in clinical practice as well as in research.

It is becoming increasingly recognised that management strategies for RA should be aggressive, comprising proactive management and prompt intervention (Luqmani et al, 2006). The Arthritis and Musculoskeletal Alliance (ARMA 2004) recommends that all patients with suspected RA should be seen by a specialist in rheumatology within 12 weeks to confirm diagnosis and enable prompt and effective treatment, and have access to a full multidisciplinary team (MDT) assessment and intervention early in the disease process, including foot health assessment. Further to this, Woolf et al (2007) suggest that management requires an integrated coordinated multidisciplinary, multi-professional approach, with care focussed upon the needs of the affected person, providing access to a combination of expertise and competencies.

Given that podiatrists are considered the experts in the management of foot and ankle problems and recognised by NICE (2009, updated 2015) as primary provider of foot health services for this patient group, they should be an integrated part of the MDT. This view is supported by ARMA (2004), the British Society for Rheumatology (BSR) (Luqmani et al 2006) who all strongly advocate the need for a dedicated and specialist podiatry service for the diagnosis, assessment and management of foot problems associated with RA along with periodic review.

Patient organisations (Arthritis Research UK, Arthritis Care, and the National Rheumatoid Arthritis Society) also recommend that patients have access to specialist foot care and increasingly rheumatologists are requesting specialist foot care services for their patients (Redmond et al 2006, Williams and Bowden, 2004).

In this respect, podiatry care should be made available to all patients with rheumatoid arthritis and patients should understand the role of the podiatrist in helping them to effectively manage their foot health and how to seek help should they experience problems. Good communication between health professional and their patients' is essential. People with RA should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals (NICE 2009). To achieve this treatment and care should take into account peoples' needs and preferences.

Essential standard

'Podiatrists are experts on foot disorders; both patients and rheumatologists can profit from the involvement of a podiatrist' (Korda and Balint 2004)

3. PODIATRY SERVICE PROVISION

3.1 Philosophy of Podiatry Services for People with RA

The broad philosophy of podiatry management of people with RA is to relieve pain, maintain function and mobility, prevent or minimise deformity and reduce the risk of ulceration thereby maintaining or improving the individuals' independence and overall quality of life.

Podiatry services should provide a specific and dedicated service for the diagnosis, assessment and management of foot problems associated with RA that can be provided in a variety of settings, such as local clinics, hospital out-patient departments, and rheumatology departments (both outpatient and inpatient). However, it is acknowledged that some patients choose to access private podiatry care from HCPC registered practitioners.

3.2 Clinical Specialist Role

A podiatry team led by a dedicated podiatry clinical specialist in rheumatology is desirable. This specialist should provide specialist care directly to patients, provide advice for other members of the podiatry and multidisciplinary team (MDT) and facilitate the development of appropriate clinical skills in other members of the podiatry team This clinical specialist should work within the rheumatology department (outpatients and inpatients) for at least part of their work schedule.

The advantages of this are that the specialist podiatrist can:

- Improve the profile of podiatry services within rheumatology
- Provide timely interventions for acute problems using extended practices that historically have required referral to secondary care.
- Provide timely referrals to appropriate members of the MDT.
- Develop inter professional working practices.
- Develop their role as advisor to the MDT
- Manage foot problems with a greater understanding of implication of medical therapy and disease management

3.3 Essential Requirements for a Podiatry Service

Based on the national recommendations (NICE 2009 and ARMA 2004) the following are considered the essential requirements that a podiatry service is expected to provide for patients with RA:

- A team of podiatrists able to meet the needs of the local population diagnosed with RA

- A team of podiatrists with knowledge of the foot health management of patients with RA and knowledge of the medical and rehabilitation management of the disease.

- A system for prioritising referrals so that foot pathologies are managed in a timely way

- The facilities for rapid assessment for patients should urgencies occur so that patients in acute pain or at risk of infection receive timely interventions. Patients who are being managed with biologic therapies should have immediate access to a specialist podiatrist if they present with foot ulceration or other infections affecting the foot.

- Provision of the appropriate facilities / skills for baseline vascular and sensory assessment i.e. hand held Doppler ultrasound and 10g monofilament. It is known that patients with rheumatoid arthritis are more at risk than the general population for coronary heart disease (resulting in circulatory insufficiency to the lower limb), vasculitis and neuropathy. Baseline and annual assessments of the vascular and neurological status of patients will both identify and monitor any problems or changes (Kitas 2003).

- Annual review and assessment of foot health in RA patients with identified foot problems (NICE 2009)

- The skills to provide biomechanical assessment of foot structure and function

- Provision of the appropriate facilities for biomechanical assessment of foot structure and function with either manufacturing or supplying foot orthoses. It is know that foot orthoses are a vital and effective intervention in rheumatoid arthritis (Hennessey et al 2012, Woodburn et al 2002a).

- Provision of specialist footwear or referral to an orthotist depending on local arrangements. It is known that many foot problems cannot be accommodated in normal

retail footwear and the benefits of specialist prescription footwear are recognised (Williams et al 2006,)

- Individual patient education and care plans. Patients need information to enable them to make informed choices about their treatment. The information should be provided with professional support and guidance with the emphasis on behavioural change rather than just information giving (Graham et al., 2011).

- A system of providing prompt and appropriate information to the referrers and other appropriate members of the multidisciplinary team. This is to facilitate good communication and collaboration between the podiatrist and the other members of the team so that care is timely and appropriate.

- Clinical documentation for recording of assessments, management plans, treatments and other interventions. In addition to the legal requirements for documentation of clinical treatments they can be used for purposes of audit

- An effective system of Continuing Professional Development, which includes
    - Annual Update Courses in Rheumatology
    - Multidisciplinary training

3.4 'Gold Standard' Requirements for a Podiatry Service

- This would include all the essential criteria plus the following desirable criteria

- A team of podiatrists, led by the clinical specialist in the management of patients with RA. A designated clinical lead with advanced / extended scope skills e.g. joint injections, experience and competencies would co-ordinate the service at a clinical level and be responsible for cascading new evidence based practice to other members of the podiatry team. They would act as clinical advisor for the team and be responsible for ensuring appropriate CPD in this area.

- The facilities for providing telephone advice and rapid assessment for patients

- Access to/provision of the appropriate facilities/skills for advanced vascular and neurological assessment such as Doppler assessment for ABPI's, vascular and MSK diagnostic ultrasound.

- Provision of the appropriate facilities and skills for lower limb mechanics and foot pressure assessment. Many rheumatic disorders affect both the architecture and function of the foot and lower limb resulting in abnormal gait and increased foot pressures. Quantifiable assessment of these will enable monitoring and timely intervention. Where available, In-shoe foot pressure assessment will identify the effects of orthotic and footwear interventions (McCormick C et al 2013, Redmond A et al 2009, Van der Leeden et al 2006, Otter S et al 2004)

- The facility for an annual review and assessment of all RA patients. This is so that patients who do not have current problems are monitored at least annually in order to detect problems early.

- An effective system of Continuing Professional Development, which includes
  - The development of advanced clinical skills such as soft tissue and intra-articular injection techniques, imaging modalities such as MSK ultrasound
  - The training in skills such as lipid and blood pressure monitoring
  - Attendance at regional, national and international rheumatology meetings and conferences (for example, the British Society of Rheumatology Conferences)
  - Support for research (either uni-professional or multi-professional) in collaboration with outside agencies (for example, universities, medical schools, and medical charities).
  - Attendance at local podiatry groups / meetings with the opportunity for networking with colleagues and peers

4. REFERRAL GUIDELINES

It is recommended that all patients with rheumatic diseases, which manifest themselves in the foot and ankle should have access to a dedicated and specialist podiatry service (NICE 2009, Williams and Bowden 2004). The Standards of Care for people with Musculoskeletal Foot Health Problems (2008) document states that **all patients** should be referred **within 3 months of diagnosis**, not just those with a problem.

> **Essential standard**
> All patients should be referred for foot health assessment within 3 months of diagnosis of RA (PRCA 2008)

4.1 Referral Pathway

A pathway of referral should be in place to facilitate patient referrals to the specialist podiatrist service by any member of the podiatry team, the multidisciplinary rheumatology team, primary care team or private practitioners.

A question about foot problems and foot pain should be included in any assessment by consultants and their teams or primary care specialists to facilitate an appropriate and timely referral of the patient to the podiatry service.

4.2 Foot Screening Pathway

The aim of the Foot Screening Pathway (Appendix 1) and the Primary Assessment/ Annual Screening Tool (Appendix 2) is to enable any member of the podiatry team or other designated personnel assessing a patient to identify those patients who are at risk from ulceration or the development of deformity and to initiate appropriate and timely interventions care. It is recommended that private practitioners who manage patients with RA for general foot care on a regular basis make links with the specialist podiatry services in order to facilitate timely referral of those patients who foot health deteriorates.

Thorough assessment and review are essential in managing patients' foot health with the aim of reducing pain, improving mobility and independence. Further to this, podiatrists aim to provide holistic care enabling patients with RA to maximise their potential to fulfil their social and occupational roles.

It has been shown that health and illness is mainly determined by lifestyle psychological factors and socio-cultural environment rather than on biological status and conventional health care (Micheal 2004). According to Waddell and Burton (2006) work is the most effective way to improve well being of individuals therefore ignoring socio cultural factors such as a patient's ability to work could potentially lead to poorer health outcomes.

Individual podiatry services will have different clinical arrangements for new and existing patients with RA in both primary and secondary services (and private practice) However, an initial structured foot assessment and screening must be carried out for all patients with RA at the first point of contact with any podiatrist and then referral on to the specialist podiatrist if the management needs require specialist intervention or the input from the multidisciplinary team. The assessment should include appropriate outcome measures and should be repeated periodically to detect any changes in foot health status. The suggestion is that those patients identified with foot problems should be reviewed on an annual basis as a baseline minimum.

Essential Standards

All people with RA and foot problems should have access to a podiatrist for assessment and periodic review of their foot health needs. (NICE 2009)

All podiatry patients with RA should receive an initial structured foot assessment complete with appropriate outcome measures with onward referral to more specialised colleagues as required

Referral to a Podiatrist is an integral part of the **early** management of RA patients.
(ARMA 2004)

5. PATIENT AND FOOT HEALTH ASSESSMENT

Clinical assessment should be systematic and thorough. The following components of a patient assessment / screening process should be carried out as a minimum standard of care for all new or existing patients presenting with new foot pathologies (see Appendix 1 and 2) . This enables an individual tailored care plan to be produced. It is recommended that all existing patient records are updated in line with these standards.

5.1 Essential Requirements for Assessment

Podiatry referral should be offered to all patients with RA and a Baseline Assessment should include:-

- Full Medical and surgical history (including disease duration).
- Medication and pain management.
- General health and systemic factors, examination for signs of extra-articular features of disease- nodules, bursa, vasculitis, tendonitis, tenosynovitis.
- Detailed assessment of foot and lower limb function and structure (both non weight-bearing and weight-bearing).
- Feel, look and move the foot assessing the foot position, deformities, range of movement and location of painful, tender, swollen sites.
- Assessment of foot pain using a scale of 0 (no pain) -10 (worst pain imaginable)
- Assessment of patients' main presenting problem, the pattern of distribution and chronological development of symptoms. The impact of the problem, patients' perceptions/knowledge and expectations also needs to be addressed.
- Vascular assessment based on clinical signs and patients' symptoms. Foot pulses should be assessed using Doppler ultrasound which provides an objective measurement of vascular status.
- Sensation assessment with 10g monofilament as a minimum.
- Assessment of nails, skin lesions and tissue viability also noting history of previous ulceration.
- Examination of the patients' footwear and its suitability for both home and outdoor use (Footwear Suitability Scale – Appendix 3).
- Assess the need for pressure relief and foot orthoses.
- Assess the need for referral for patients' requiring a surgical opinion or to other members of the MDT such as physiotherapy, occupational therapy or orthotist.
- Lifestyle and social factors- ability to self care, neglect, smoking, alcohol, occupation and activity/mobility.

- An annual review of foot health should be offered to those with identified foot problems. Patients should be monitored and reassessed for changes in foot health and general health status, allowing further outcomes to be predicted and patients' treatment and management plans to be changed accordingly

5.2 'Gold Standard' Requirements for Assessment

In addition to the essential standards it is desirable that the following are also carried out:

- Baseline measurements of foot pain, function and health status using measurement tools such as the Foot Function Index (Budiman Mak et al 2006), Leeds Foot Impact Scale (Helliwell et al 2005) or the Salford Rheumatoid Arthritis Foot Evaluation Index (Walmsley et al 2012).
- Assessment of the impact of foot problems on activities of daily living including a patient's ability to continue in or find employment
- The use of tools such as DAS28 to evaluate disease activity
- ABPI if further investigation of vascular status is required.
- Assessment of tendon reflexes where indicated
- All existing patient records are updated in line with these standards.
- Direct referral for x-rays / ultrasound / MRI scans for detailed assessment and diagnosis
- Annual review for patients with RA

5.3 Musculoskeletal Ultrasound for Foot and Ankle Pathology

The use of musculoskeletal ultrasound (US) by non-radiologists has become a valuable adjunct to clinical practice, particularly within rheumatology as technology has improved and equipment has become smaller, more portable and user-friendly (Brown, 2009, Taggart et al., 2011, Micu et al., 2012, Siddle et al., 2016). US is painless, harmless (no ionising radiation) and is readily accessible for use within the clinical environment. Advances in Grey Scale (GS) and Power Doppler (PD) US imaging have enabled better and timelier assessment of changes in joints and soft tissues due to inflammation associated with rheumatoid arthritis (Schmidt, 2007, Balint et al., 2008).

For rheumatoid arthritis, the precise detection of synovitis has become fundamental to the management of inflammatory disease (Brown, 2009,Kang et al., 2012) as well as defining the threshold for minimal disease activity (Terslev et al., 2016). As such, there has been an increase in focus on the use of US techniques in the assessment of rheumatoid foot pathology (Bowen et al., 2013). Several authors have described the use of US to identify soft tissue

pathology within the foot (Riente et al., 2006, Joshua et al., 2007, McNally, 2008, Micu et al., 2012) especially pathology within the foot that is otherwise unseen by clinicians (Wakefield et al., 2008, Bowen et al., 2010, Bowen et al., 2011, Hooper et al., 2012). Additional advantages over other imaging techniques are that any area of the foot can be scanned rapidly at one time-point and treatments such as guided steroid injections can be implemented immediately (Bowen et al., 2013, Taljanovic et al 2015).

Summary of US detectable foot pathologies associated with rheumatoid arthritis

- Effusions and impingements of the ankle joints.
- Visualisation of synovial hypertrophy, especially within the metatarso-phalangeal joints
- Tenosynovitis of extensor digitorum longus, extensor digitorum brevis, flexor digitorum longus, flexor digitorum brevis, tibialis anterior, tibialis posterior, peroneus longus and peroneus brevis tendons.
- Visualisation of Achilles tendon in its full length - calcification, ruptures and retro-calcaneal bursitis can be differentiated.
- Diagnosis of synovitis, especially within the metatarso-phalangeal joints.
- Diagnosis of Morton's neuroma.
- Diagnosis of adventitial (within plantar fat pad) and anatomical (intermetatarsal) bursitis.
- Diagnosis of persistent post-operative pain.
- Screening of diabetic and rheumatoid patients for high metatarsal pressures.
- Guidance of needle placement for steroid injections

Podiatrists' scope

As clinical expertise in performing musculoskeletal US has advanced, there is a consequent requirement for adequate training by non-radiologists to learn the techniques. Clinicians such as podiatrists arguably have a discrete detailed anatomical knowledge of the foot and one study has demonstrated good reliability of a podiatrist tested against a radiologist (kappa 0.702, $p < 0.01$) in the use of US for the evaluation of foot disease in RA (Bowen et al, 2008). US is compounded in that it is highly operator dependent and there is a lengthy period required to develop the necessary skills (Taggart et al., 2011,Marhadour et al., 2010). Some useful resources are available that aid interpretation of US images. Riente et al. (2006) and Scire et al (2011) provide detailed documentation of a proposed scanning protocol for the foot. Additionally, the US imaging characteristics of the normal anatomical structures of the foot are well described (Micu et al., 2012) as well as techniques for imaging the small joints of the forefoot (McNally, 2008) and the ankle and foot (Micu et al., 2012).

See Appendix 6.

6. MANAGEMENT OF FOOT PROBLEMS

6.1 Focus of Management

Treatment and care should take into account peoples' needs and preferences. People with RA should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals.

Good communication between healthcare professionals and patients is essential. It should be supported by evidenced-based (where possible) information / care plan tailored to the individual person's needs. Treatment, care and information given should be appropriate to the individual and take into account cultural, religious, language needs and be accessible to people with physical, sensory or learning disabilities (NICE 2009).

Following a detailed assessment a management plan will be formulated between the podiatrist and the patient. This may involve referring the patient to other members of the rheumatology team for advice on interventions such as foot surgery, physiotherapy, specialist footwear or steroid injections. It could also involve encouraging patients to seek help from other organisations such as their employers and the job centre to ensure that the complications of their disease are recognised and individual issues are addressed

Dependent on the presenting problems the podiatrist may offer the following interventions (each is then covered in detail)

- Patient education relating to all issues surrounding foot health – pages 19-20
- Foot orthoses and Footwear (Advice / therapeutic) – pages 21-26
- Management of plantar callus - pages 27-28
- Conservative and surgical management of pathological nail conditions - pages 29-31
- Management of Foot Ulceration – pages 32-33
- Joint injections or referral to the member of the multidisciplinary team responsible for this – pages 34-35
- Referral for a surgical opinion - pages 36-37
- Referral to other members of the rheumatology team i.e. physiotherapy, occupational therapy, specialist nurses, orthotists and consultants
- Providing supporting letters for employers to help patients access adaptations in their work place to help with foot problems e.g. shorter hours on feet, chairs to sit as needed

- Regardless of the intervention/s, regular review appointments and open access to the podiatry service for any developing acute problems

6.2 Patient Education Related to Foot Health

Providing an accepted working definition of the concepts of *patient education* and *patient information* is useful in defining what constitutes the provision of simple foot health information and the provision of foot health education. Jotterand et al, (2016) provides the following as a working definition for Health Information:

"Health information or providing health information to a patient is the act by which a provider communicates all relevant clinical facts to a patient about his or her health condition. This information includes data about the nature of the condition, symptoms, diagnosis, treatments options, etc."

and Health Education:

"...health education is a more complex process since it requires the provider to create a learning environment that promotes learning, communication with learners (patients), establishing the right context for learning, and addressing potential challenges to the learning process… health education demands knowledge in how to treat a medical condition but also a robust understanding of the principles of teaching and learning geared toward the specific needs of patients and their decisional needs."

Whilst the overall goals of both health information and health education remain similar in that they assist patients to make informed health choices, health education aims to foster empowerment, promote positive health behaviour and increase patient participation in their individual health care decisions. The achievement of these aims is through educational strategies to enhance patient autonomy and improve quality of life (WHO, 1998; Jotterand et al, 2016).

Therapeutic patient education is recognized and recommended as an integral component in the management of people with inflammatory arthropathy, including RA (Zangi et al, 2015). The Standards of Care for People with Musculoskeletal Foot-health Problems (PRCA, 2008) recommend specifically that patient-centred education should be provided to enable patients to make informed choices about their foot care, and the role of the podiatrist as a vital member of the Multidisciplinary team for the management of R.A. has been reinforced (NICE 2009). The development and publication of a number of international and national guidelines and recommendations that support the use of PE for people with RA, (Zangi et al, 2015; NICE, 2009; PRCA, 2008), demonstrates recognition of the significant impact that PE can have upon the ability of people to manage their illness, adjust to their condition and maintain their quality of life (Newman et al, 2004; deRidder et al, 2008). Further to this research has shown that individuals who are actively involved their own disease management have better outcomes,

improved self-efficacy, less pain and reduced incidence of depression (Lorig et al, 2005; Kjeken et al, 2006).

There is a large body of evidence that supports the effectiveness of P.E. for patients with R.A. that is delivered via a staged approach over the lifetime of the patient, with the content and timing of education provision being driven by the needs of the individual (Barlow et al 2002; Hammond 2003; Waxman et al 2003; Hennell et al 2004; Fautrel et al 2005; Koehn and Esdaile 2008). Podiatry-based research shows that identifying health education needs, and provision of supportive verbal and written information can foster an effective therapeutic relationship, supporting effective foot health education for people with RA (Graham et al 2012a; Graham et al 2012b; Graham and Williams, 2016, Graham, Stevenson and Williams, 2017). Further to this podiatrists should be mindful of the health literacy level of their patients. According to Adams (2010), adults with limited literacy are less likely to ask questions of clinicians during the medical consultation and those with a less than university level of education are unlikely to classify themselves as 'education seekers'. Communication needs to be tailored to take into account the patient preferences for the type of patient education media, the frequency of its' delivery and the skills competencies of the individual patient (Adams, 2010). Addressing the health literacy needs, together with learning preferences (use of visual and kinaesthetic learning strategies that support and compliment traditional verbal and written information and skills competencies) may encourage a deeper, rather than surface learning approach and result in improved clinical outcomes for the patients that we manage (Bullen et al, 2017).

Using the recommendations and findings from the literature above as a guide, together with the PRCA (2008) Foot Health standards, Podiatrists should embed the following key points into the development of their Foot Health P.E. provision for individuals with R.A.

- Education should be encouraged throughout the patients' medical care with each consultation becoming an opportunity for P.E and be based on an educational-behavioural approach and an identification of the patients learning preferences.
- The content of P.E. should be individualized and engaged, taking the individual experiences as the point of departure according to the patients' needs / wishes at the point of contact and should reflect the fluctuating nature of the disease. Patients in remission may sometimes prefer to focus on being well and avoid thinking about possible side effects and chronic disease (Kristiansen et al 2012)

Patient Education should aim to include:

- Disease specific information regarding; the causes & course of the disease and disease management both verbal and written.

- Direction on appropriate use of the internet for sourcing educational material.
- Details regarding access to patient support groups
- Advice regarding lifestyle choices (weight management, smoking cessation).
- Advice regarding retail/therapeutic footwear/foot orthoses.
- Maintenance of foot hygiene.
- Aspects of self-care (including safe & unsafe practices.
- Information regarding changes in foot health that should prompt further investigation.
- Access to service / providers of podiatry care

Simple information giving only has short-term, limited effects upon health behaviour, but should be used within a staged approach throughout the course of the disease. An opportune time for general information giving is early in the diagnosis, based upon the patients' own knowledge requirements. To maintain the potential effects of P.E over the lifetime of the patient, educational 'booster' sessions may be required.

Essential Standard
Patient education should include foot health self management advice and if necessary demonstration, explanation of foot problems and their impact on the individual, information on general disease management and sign posting for future foot health needs. It should seek take into account the learning preferences and health literacy level of the individual.

6.3 Foot Orthoses and Footwear

The benefits of foot orthoses (insoles) and footwear have been recognised and recommended “Functional insoles and therapeutic footwear should be available for all people with RA if indicated” NICE (2009). For the purposes of clarity foot orthoses and footwear options will be discussed separately. However, the practitioner should always consider them together in relation to footwear suitability, choice of foot orthoses and the potential mechanical effect of the footwear on not just the foot but the orthoses as well.

Foot orthoses

Foot orthoses are provided to two main groups of patients with RA; those with foot problems associated with early disease and those with more established foot problems. The use of appropriate footwear (Williams et al 2007) in conjunction with foot orthoses has been recognised as minimising the pain and disability associated with RA (Hodge 1999) when there is established foot deformity. The choice of foot orthoses in relation to design and function is dependent on the amount of motion in the joint of the foot. This factor is not dependent on disease duration as some patients with early disease have limited motion and some with longer disease duration have good range of motion within the joints of the foot.

It is demonstrated that foot orthoses not only achieve pain reduction in the early RA foot but have a sustained effect on the foot structure and hence achieve stability of the joints of the foot and improve the patient’s mobility (Woodburn at al 2002(a)).
Therefore, there is the potential to prevent major functional and structural foot problems by providing foot orthoses early on in the disease process if joint mobility is still good. However, as foot changes have the potential to occur within 2 yrs of disease onset (Turner and Woodburn, 2008) it is essential that patients are referred for assessment of foot function as early as possible following diagnosis.

Essential Standards
Patients with a diagnosis of RA should be assessed as soon as possible following diagnosis for structural problems with the lower limb and foot.
All patients with RA and foot pain should be considered for foot orthoses and /or footwear advice, irrespective of disease duration.

Once the structural problems are established and joint mobility is reduced, management consists of reducing symptoms of pain and resultant mobility problems. Further to this, redistributing foot pressures may contribute to the prevention of tissue breakdown and ulceration over high pressure areas of the foot. RA subjects with metatarsal pain have 20 – 40 % lower pain pressure threshold (Hodge et al, 1999), these patients require more planter pressure reduction to diminish their pain sensation.

Essential Standard Patients with established foot deformity should be assessed for accommodative foot orthoses and footwear advice/ specialist footwear

There is a broad range of devices that employ a variety of different approaches to modify foot and lower limb structure and function with general consensus within services providing them that foot orthoses include these main groups:

- Simple cushioning insoles
- Insoles to which additional padding/additions can be applied
- Contoured insoles intended to change the function of leg and foot joints, either:
    - Custom made to a cast of the patient's foot
    - Supplied off the shelf +/- adaptations

However, the boundaries between the modes of action of the types are not always exact and an individual device may include elements of more than one type or mode of action. However, Clark et al., (2006), and Jackson et al., (2004) concluded that foot orthoses;

- reduce pain and improve functional ability
- Both hard and soft foot orthoses have the potential to reduce forefoot pain
- Hard foot orthoses have the potential to reduce rearfoot pain in patients with early RA
- Hard foot orthoses have the potential to reduce hallux abducto valgus

There is only anecdotal evidence for the use of simple cushioning insoles. Two small studies indicate that prefabricated metatarsal padding (dome and bar shapes metatarsal pads) reduces mean peak plantar foot pressure by up to 21% with bars and 12% with domes (Jackson et al 2004) and both equally (Hodge et al 1999).

A systematic review conducted by Hennessey et al (2012) concluded that custom orthoses may be beneficial in reducing pain and elevated forefoot plantar pressures in the rheumatoid foot and ankle. However, more definitive research is needed in this area.

Hard Contoured foot orthoses are provided in order to improve the function of the foot and/or lower limb. This assumes that there is some mobility in the joints of the foot in order to improve function and realign the bony architecture. They are particularly useful for use in patients with early diagnosis of RA. In this case there is an attempt to not only reduce pain but to maintain good foot function and hence structure whilst the foot is vulnerable to deformity due to the combination of the inflammatory process and abnormal mechanics.

Customised accommodative orthoses (total contact orthoses) are designed so that the material follows closely the contours of the underside of the foot. The purpose is to redistribute the pressures applied to the foot by standing and walking more evenly. This is particularly useful where there are areas of increased pressure, for example, under the metatarsal heads. In this instance the pressure is shifted to areas of the foot that do not normally bear weight such as the arch area (Li et al 2000). They are particularly used where there is limited or no joint mobility such as in the established RA foot and where tissue viability is poor. These orthoses are often made from materials that also provide a cushioning effect, such as softer EVA or with additional foam linings.

Dynamic impression insoles made by sequential foam padding & moulded under successive walking compression have been demonstrated to reduce peak pressures & the VAS pain score when compared to the moulded custom insole (Chang et al, 2012).

Essential Standards
Functional foot orthoses should be provided where the tarsal joints are unaffected. Accommodative / cushioning orthoses should be provided for those patients with structural foot deformity, painful symptoms and activity restriction

Footwear

The choice of orthoses is governed by the suitability of the patient's footwear, which may not accommodate the ideal foot orthoses for their particular problem. All footwear is in itself capable of modifying the structure and function of the body and therefore falls clearly within the definition of orthoses and may the only thing that needs changing to solve functional problems. Inappropriate footwear can be both a major contributing factor to foot impairment.

However, when it is right it has the potential to alleviate pain and increase mobility and independence (with or without foot orthoses).

In order for health professionals & researchers to accurately & efficiently critique an individual's footwear, a valid & reliable footwear assessment tool is required (Barton et al 2009, Nancarrow 1999)

Footwear can be sub divided into three main groups:

- Standard retail footwear
- Niche retail including comfort footwear as well as extra depth, extra width and odd-size suppliers.
- Specialist therapeutic footwear

Standard Retail footwear

There are now many manufacturers of retail footwear that are both appropriate for the foot health of our patients The features of retail footwear that makes them ideal for the RA foot would be -

- Stable heel – broad enough for stability or elongated / flared to increase this effect further
- Extended heel counter
- Padded topline – to reduce irritation to the retro-calcaneal area and the infra-malleolar areas
- No prominent internal seams
- Winged toe puff
- Increased toe spring or rocker sole – to reduce forefoot plantar pressures
- Low laced – for ease of access

(Williams A and C 2010)

The suitability of retail footwear can be assessed using the Footwear suitability tool (Nancarrow 1999) see Appendix 3

Essential Standard Footwear assessment and advice should be given to all patients.

In early disease many patients experience forefoot pain and changes to the shape of their foot. Many patients recall that they had to increase their shoe size to accommodate a wider forefoot. Specialist footwear manufacturers can be very helpful in offering advice and providing wider-fitting shoes. The British Footwear Association provides detailed information about companies that make up the British footwear industry and consumer information about hard-to-find footwear suitable for all foot sizes and shapes - see Appendix 4.

Specialist therapeutic footwear

Stock footwear is specialist footwear which is available in a variety of styles and fittings, for example extra deep, and/ or extra wide and is generally suitable for mild to moderate deformity. Bespoke footwear is an option when there is major deformity such as advanced rheumatoid arthritis deformity or if there is a huge difference in symmetry, or if the foot dimensions are outside the measurements for stock footwear.

Two systematic reviews (Egan et al 2003 and Farrow et al 2005) indicate that specialist footwear is likely to be beneficial in patients with RA. Two RCT's (Fransen and Edmonds 1997 and Williams et al 2007b) indicate that this footwear contributes to the reduction in pain and increased mobility in patients with RA although the effect is improved when combined with orthoses.

It is generally considered that the following patients could be considered for referral for specialist footwear for the following reasons:

- Failing to obtain retail footwear to fit the dimensions of the foot (including asymmetry)
- Pressure symptoms such as skin lesions/sore areas on the feet
- Increasing foot pain due to pressure from existing footwear
- Excessive footwear 'wear' indicating that patients need more stability from increased surface area of the plantar aspect of the footwear and increased rearfoot control from the heel counter.
- History of foot ulceration where footwear has been a contributory factor.

The Society of Chiropodists & Podiatrists (CPD update, May 2006, pS6) – 'Who Should Be Referred for Specialist Footwear?' advises referring patients who have:

- Problems associated with systemic disease (e.g. RA).
- Functional/structural problems that impact on the foot.

- Width, depth, length outside range of retail footwear (and asymmetry).
- Provision of substantial foot orthoses that cannot be accommodated in retail footwear.

It has been found that patients considered that it was important to receive information at the point of referral so that they can make considered choices as to whether to be referred or not (Williams et al 2007a). Without some knowledge of what is available the opportunity to engage the patient in the decision making at this stage is lost and may be one of the reasons patient expectations are not met. The option of referral for a surgical opinion should be offered as an alternative to referral for footwear.

Stock footwear is specialist footwear which is available in a variety of styles and fittings, for example extra deep, and/ or extra wide and is generally suitable for mild to moderate deformity. This footwear is generally supplied with 3x3mm removable liners that provide the option for being replaced with orthotic devices. Stock footwear with specific modifications is termed 'modular'. Bespoke footwear is an option when there is major deformity such as advanced rheumatoid arthritis deformity or if there is a huge difference in symmetry, or if the foot dimensions are outside the measurements for stock footwear.
Arthritis Research UK (2012) commissioned a report looking at 'providing better footwear and foot orthoses for people with rheumatoid arthritis' and summarised with a series of recommendations, including: patients should be referred for prompt consideration for all types of insoles / footwear (retail to bespoke) as well as other options such as surgery; evidence should inform availability of options; and service users with feet very damaged by rheumatoid arthritis should receive a genuine bespoke service.

Essential standards –
Patients who are assessed as requiring therapeutic footwear should be informed of the potential benefits and limitations of this footwear (in respect of cosmesis) and allowed to decide on whether to be referred /provided with therapeutic footwear or not

Referral for surgical opinion should be offered as an alternative to referral for therapeutic footwear

6.4 Management of Plantar Callus

Persistent synovitis of the forefoot is associated with peri articular erosion, subluxation and dislocation of the MTP joints which in term exposes the metatarsal heads to increased pressure during gait. (Van der Leeden M, 2010). In response to increased focal stresses, the strateum corneum thickens initially in a normal physiology response to chronic excessive pressure or friction of the skin eventually however, pathological lesions (callosities) develop, which cause pain and contribute to impairment of gait and related functional and health status in people with RA.

Three studies have investigated callus reduction in RA.
Woodburn et al, (2000) concluded that a reduction in plantar callus with sharp debridement reduced forefoot pain for approximately 7 days, but increased forefoot pressures in 10 out of 14 feet. This was not statistically significant but indicates that reduction of callus over **prominent** metatarsal heads may lead to tissue damage. This would be of particular concern in patients with the following factors

- **Foot deformity**
- **Reduced tissue viability** (long term steroid therapy, vasculitis, concurrent peripheral vascular disease) and/or neuropathy.

Davys et al (2005) demonstrated a reduction in pain in 38 participants but concluded the effect was no greater than sham treatment. Localised pressure or gait function did not significantly improve following treatment, but they indicate what to include when managing plantar callus in RA patients:

- Pts need to be informed about causes and management of callus.
- It is recommended that thick **callus is debrided cautiously and frequently**.
- **If infection is present, then overlying callus should be debrided to expose the underlying infection**. If ulceration is present, surrounding callus and necrotic tissue should be appropriately debrided.
- **Removal of superficial callus over plantar bursae should be avoided altogether.**
- Advice about the use of emollients for dry plantar callus should be given. Patients should be encouraged to self manage by applying emollient daily and to use a foot file on these areas at least three times a week.
- Adhesive plantar padding **should not** be used as a pressure relief mechanism especially if there are tissue viability concerns. Instead a dry dressing secured with a bandage can be used for localised protection.

- Pressure relieving and functional orthoses have been demonstrated in studies to reduce forefoot pressures should be provided (McCormick et al 2013, Redmond et al 2009, Van der Leeden et al 2006, Otter S et al 2004 and Woodburn et al 2002 (a))
- Footwear advice should be provided with consideration given to footwear with the necessary depth and width to accommodate the patients' feet. (See Footwear and Orthoses – pages 24-29).
- Therapeutic footwear should be considered and when appropriate referred to an Orthotist.
- If the patient has severe pain in the forefoot and /or severely affected mobility, it may be appropriate to consider a surgical referral and opinion.
- Regardless of the interventions, regular review appointments and open access to the Podiatry service for any developing acute problems.

A more recent study by (Siddle et al., 2013) further adds to the concern about routine sharp debridement of callosities in people with RA. The study concluded that the long term effects of sharp debridement of painful forefoot plantar callosities in people with RA when used in conjunction with a combined therapeutic approach produced no additional benefit over a combined therapeutic approach alone.

The authors suggest that the use of sharp debridement should be confined to the short term alleviation of severe pain and address only high risk presentations such as extravasated blood and suspected ulceration.

Essential Standard
Callus should be assessed in relation to symptoms and causative factors before debridement is considered. The focus of callus management should always be the reduction of foot pressures with foot orthoses and suitable footwear first, before debridement is considered as a safe or unsafe intervention

6.5 Conservative and Surgical Management of Pathological Nail Conditions

Onychomychoses

Onychomycosis (OM) is an infection of the nail unit that can be caused by various species of dermatophytes, yeasts, molds and even some bacteria. OM infects between 2% and 18% of the population with increasing frequency as patient age increases to 20% and 30% for those older than 60 years and 70 years respectively, (Derby et al 2011, Ameen 2010) and there is an increased association with immune-compromised hosts (Bodman 2003). Bodman (2003 also identified that if OM is left untreated, it can lead to subungual and skin ulceration, in patients with RA.

The most sensitive diagnostic test is histopathological analysis of a nail clip biopsy. A Periodic Acid-Schiff stain (PAS) test is commonly used as a quicker and more sensitive diagnostic workup than traditional fungal cultures (Arca et al 2004). There are five types of OM:

- Distal Subungual Onychomycosis (DSO)
- Superficial White Onychomycosis (SWO)
- Proximal Subungual Onychomycosis (PSO)
- Total Dystrophic Onychomycosis(Primary) (TDO)
- Total Dystrophic Onychomycosis (Secondary) (TDO)

Treatment of Onychomychoses

- Regular Podiatry treatment. Thorough debridement of all dystrophic and hypertrophic nail plates to relieve painful pressure and facilitate topical agent penetration to the nail bed. This also allows the podiatrist to check for subungual ulceration.
- Clearanail is a new device which allows fine drilling of the nail plate; this allows penetration of the antifungal agent. There appears to be no contraindication in the use of this product in the Rheumatoid pt
- Topical Therapy. Topical Lacquers such as Trocyl (Tioconazole), Loceryl (Amorofine) and Lamisil (Terbinafine). These treatments can be effective in the treatment of early infections with limited involvement, such as DSO and SWO. Occasional local irritation and hypersensitivity reactions can occur, such as mild burning, erythema and itching.
  Bristow et al (2017) recommend micology of nail sample is best practice to determine causative organism prior to treatment(2017)
- BNF (2012) states systemic antifungal therapy is necessary if there is nail involvement although antifungal treatment may not be necessary with asymptomatic Tinea infection of the nails. Topical antifungals such as Amorolifine or Tioconazole may be useful for

treating early OM when there is mild DSO in up to 2 nails, SWO or where oral therapy is contra-indicated. Oral antifungal therapies e.g. Sporanox (Itraconazole) and Lamisil (Terbinifine hydrochloride) are frequently used as they have a broad spectrum of activity and require a short duration of treatment. These treatments would be recommended for PSO and TDO. There are many possible contra indications which require caution when prescribing.

- Hepatic and Renal Impairment
- Risk of exacerbation of Psoriasis
- Risk of Lupus-erythematosus like effect. (Autoimmune Disease)
- Pregnant and nursing mothers.
- Drug interactions

Patients with known or suspected immunodeficiency need to complete blood counts and monitoring as the drug may induce a transient decrease in absolute lymphocyte counts which may cause severe neutropenia. If clinical signs and symptoms are suggestive of a secondary infection and full blood count shows a neutrophil count <1000 cells/mm treatment should be discontinued.

Essential Standards
Fungal infections (of the nail and skin) must be investigated and treated. If left untreated they can lead to ulceration and secondary bacterial infection.
Discussion with the patients GP or consultant is advised before systemic treatment is instigated

Onychocryptosis

Onychocryptosis (O/C) is a common problem for which patients seek Podiatry treatment. The nail may puncture the soft tissue and allow bacterial invasion resulting in paronychia and infection, often accompanied by hypergranulation tissue.

Treatment of Onychocryptosis

In the first instance for mild O/C regular conservative podiatry treatment should be carried out in an attempt to resolve the situation. If indicated an appropriate dressing regime and antibiotic therapy should be arranged to assist management of localised infection. If the condition fails to resolve or presents as gross O/C with pain, infection and / or hypergranulation tissue, partial or total nail avulsion should be considered as first line treatment.

Essential Standard
Consultant advice should be taken on ingrown nails (O/C) if the patient is being managed with a biologic therapy and where there are signs of clinical infection and or the need for nail surgery

Before undertaking nail surgery, a thorough assessment should be carried out (as per local requirements) and informed consent obtained.

It is advised that **all** patients with RA undergoing nail surgery (regardless of their medical management) should have a written agreement by their consultant or GP obtained by the podiatrist planning to carry out the procedure.

The final decision to carry out nail surgery should take place on the day it is planned and cancelled if there are any changes in general or foot health or medication that may have implications to the procedure or post operative healing.

Prior to any decision regarding nail surgery it may be useful to consider the following:

- ESR and CRP should be checked prior to surgery to check current disease activity
- The trauma of a local anaesthetic and nail surgery on a patient with active disease can increase the risk of vasculitis progressing to gangrene.
- Raynauds phenomenon is characterised by an abnormal vasospastic response of the digital arterioles to emotional or temperature changes. Nail surgery should never be attempted during a vasospasm as the local anaesthetic stays in place longer acting as a partial tourniquet. It may be advisable to carry out the surgery in the warmer summer months
- Prostocycline infusion may be necessary to maximise the circulation to the area
- Patients taking immuno-suppressive drugs may require prophylactic antibiotics and possibly suspension of their therapy. Consultant advice should be sort as necessary.
- The patient's medication may need to be increased in preparation of the trauma to the body during the surgical procedure.
- The optimum time for surgery may be after the patient has had a disease flare up whereby close monitoring and altered medication has resulted in disease stability.
- The use of a tourniquet may not be advised for the whole time during surgery. Some consultants prefer that tourniquets are only used during phenolisation of the nail matrix.

This guidance is not intended to replace any local trust nail surgery policy or protocol which should be followed accordingly.

6.6 Management of Foot Ulceration

It is likely that ulcers in Rheumatoid Arthritis (RA) are multifactorial in origin and these factors may contribute to the poor rates of healing. Foot ulcers occur frequently on the dorsal aspect of hammer toes and plantar aspect of the MTP joints (Firth 2008) Foot ulceration can be recurrent, multiple sites are common with slow time to achieve healing which can pose risk of infection (Siddle 2011)

Arterial disease as a factor contributing to foot ulceration has a higher incidence and prevalence in RA (McEntegart et al 2001). Traumatic ulceration, secondary to foot or ankle deformities may be made worse by poorly fitting shoes and/or sensory neuropathy which is associated with RA. Immunosuppressive therapy (especially corticosteroids), poor nutrition (common in long standing RA) and active RA (Siddle 2012a) may also contribute.

The role of cutaneous vasculitis in the aetiology of ulceration can be difficult to determine in the feet. It is important to look for other clinical evidence of systemic vasculitis such as nail-bed infarcts, splinter haemorrhages, mononeuritis multiplex. Systemic rheumatoid vasculitis is a rare but serious extra – articular consequence usually occurring in longstanding RA patients or patients with refractory RA (Murosaki 2012)

The aim of ulcer management is to create the best environment for healing to occur and to minimise adverse factors that delay the healing process and patient comfort.
The factors are:-

- Existing disease/medication
- Poor nutrition
- Poor patient compliance with treatments and advice
- Inappropriate management of the ulcer.

Essential Standard
Optimum ulcer management can only be achieved by a holistic and integrated multi-disciplinary team approach

The foot assessment should be structured and detailed including vascular, neurological and foot structure/function assessments. Identification of risk factors such as poor nutrition, smoking and contributory factors such as ill-fitting footwear is vital as these are potentially

modifiable. Ideally ESR, platelet counts, blood glucose and FBC should be checked and X-rays may also prove valuable in the management of foot ulceration.

Aims of Treatment:

- Keep free from infection / relieve pain
- Prevent deterioration / improve foot function
- Promote healing / establish wound closure
- Prevent reoccurrence / maintain tissue viability

Treatment

- Assessment of the ulcer i.e. type, location, duration, size.
- Debridement of the ulcer if necessary
- Investigations as appropriate e.g. x-ray, wound swab if clinical infection is suspected.
- Management of any infection according to local policies
- Antibiotics via GP/consultant if required
- Suitable dressings according to type of ulcer – see local Trust Protocols.
- Pressure relief and/or provision of orthoses if indicated
- Footwear assessment with appropriate action including advice, adaptation and referral to orthotist if required.
- Referral to consultant/GP/multi-disciplinary team member.
- Patient education / involvement in the management of their condition.
- Advise consultant / rheumatology team of ulcer / infection, particularly if the patient is managed with a biologic therapy
- Analgesic needs may need to be altered by the onset of ulceration and during the course of healing
- Surgery is very rarely needed to manage the wound itself. However if the wound occurs over a prominent bony site or abnormal weight bearing area, it may be advisable to consider surgical intervention to aid healing or prevent reoccurrence (Firth J and Siddle H 2014)

Essential Standard

Contact the patient's consultant / rheumatology nurse **IMMEDIATELY** if the patient is being managed with Biologic therapy and develops an ulcer and/or infection.

6.7 Steroid Injection Therapy

The structures of the foot and ankle in RA are particularly susceptible to inflammation and are amenable to both diagnostic and therapeutic injection of steroid. This therapy allows for specific targeting of localised joints which may be symptomatic even though the general disease process is controlled by oral medications. Therefore, the main indication for use of therapeutic injection therapy is for active joint inflammation and pain relief but only in the absence of sepsis.

Essential standard Consider steroid injection therapy for targeting localised, inflamed joints and soft tissue structures when the general disease is controlled (but only in the absence of sepsis).

Hay et al (1999) found that the close proximity of joints in the foot can make accurate *clinical* localisation difficult and guided injections using ultrasound are recommended where possible. The use of injections can also be diagnostic if local anaesthetic is used allowing for identification of problematic structures (Helliwell et al 2007).

Administering steroids via the intra articular or localised soft tissue approaches has advantages over oral use of steroids. Typical systemic side effects seen with steroids are reduced and improvement can be rapid. Ward et al (2008) found improvement following corticosteroid injection up to and including 6 months post injection.

Common sites for injection include the ankle joint, subtalar joint, first metatarso-phalangeal joint, interphalangeal joints, the plantar fascia, interdigital spaces, the tarsal tunnel, retro-calcaneal bursae and tendon sheaths of the peroneal and posterior tibial tendons.

The choice of type of steroid used (long or short acting), +/- local anaesthetic is lacking and depends on individual consultant choices, local policies and availability. Commonly used steroid preparations include Methylprednisolone 10-60mg, Triamcinolone 10-40mg and Hydrocortisone 25-50mg depending on site of injection. Local anaesthetics used include Lidocane 1%, 2% or Bupivacaine 0.25%, 0.5%.

The benefit gained from injection therapy depends on a number of factors:

- Correct diagnosis of the presenting complaint

- Appropriateness of injection therapy as treatment option
- Degree of inflammation
- Accurate placement of the injection
- Type of steroid used
- The amount of rest following the injection
- Correction of any structural deformity using orthoses

All these factors contribute to both the benefit and duration of benefit from injection therapy. Jones et al (1993) found that clinical response was closely associated with accuracy of injection placement. In the foot, accurate placement is sometimes difficult and often injections are guided using x-ray screening or ultrasound (U/S). Without guidance, accuracy of placement depends purely on the skill of the practitioner. Using x-ray guidance often leads to delay in performing the injection and exposes the patient to radiation. U/S guidance is seen as the way forward and is likely to become more common as clinicians are trained in the modality and the technology becomes cheaper and more readily available (Brown et al 2004).

Essential standard Injection therapy should be seen as an adjunct to conventional podiatric management in combination with attempts to correct any structural deformity using orthoses (Helliwell et al 2007)

As with any invasive procedure there are potential risks, which the referring practitioner needs to be aware of and the administering practitioner needs to consider before injection is carried out and discussed with the patient before informed consent is obtained.

There is believed to be a higher risk of post injection infection associated with injections in the foot and ankle. However, anecdotally, this risk is reported to be low if good aseptic techniques are adopted for any joint or soft tissue injection procedure. Soft tissue rupture, especially related to injections of the plantar fascia is also more likely following steroid injection (Beales et al 1999).

6.8 Foot Surgery

Whilst it is recognised that advances in the medical management of RA with biologic therapies has seen a reduction in the requirement for orthopaedic surgery, many patients with the disease will go on to develop problems with their feet and ankles that may require a surgical opinion. People with RA should be referred for an early specialist surgical opinion if any of the following do not respond to optimal non-surgical management

- Persistent pain due to joint damage or other identifiable soft tissue cause
- Worsening joint function
- Progressive deformity
- Persistent localised synovitis

(NICE guidelines 2009).

Reasons for surgical referral may include:

- Persistent pain, stiffness, synovitis in the foot or ankle joints, tenosynovitis or tendon ruptures, loss of function (Loveday et al 2012)
- Foot deformities causing restriction in mobility due to pain, or recurrent ulceration.
- Osteomyelitis / septic arthritis.
- It is generally accepted that referrals for surgical opinion should be considered for patients with RA when optimum conservative management has failed to bring their symptoms to an acceptable level. A potential exceptions is early synovectomy in severe disease, to prevent rapid joint destruction (Canseco K et al., 2011)

However, the patients reason for seeking surgery may be different with (Wilkinson and Maher, 2011) concluding that for the most part patients expect pain relief, improved mobility and improved shoe fitting, but a small number of patients also expect a cosmetic improvement. The potential outcomes of foot surgery need to be discussed prior to referral to orthopaedic services to ensure that expectations are realistic and patients can make an informed decision.

Essential Standard

Red Flags requiring urgent referral include

- Tendon rupture e.g. Tibialis posterior, Achilles Tendon
- Septic arthritis
- Suspicion of cancer affecting skin or bone

A study by M Backhouse et al 2016 found major themes were strongly associated with patients views of the outcome of their surgery, these included functional ability, participation, appearance of feet and footwear, surgeons opinion and pain.
It is important to provide effective care for foot and ankle problems that persist in spite of improvements in disease management. Failure in non surgical care such as provision of orthoses and specialist footwear is often followed by surgical intervention with orthopaedic foot surgery accounting for one third of lower limb surgery in RA (Siddle et al 2011)

Conservative management (prior to surgical referral) should consider accommodative footwear, orthoses, steroid injections and a comprehensive individualised package of podiatry care. Backhouse et al (2011) in his study found that only 29% of the cohort had ever seen a podiatrist and suggested a lack of integration between foot care providers and raises questions about the timing of both conservative and surgical interventions. It is essential therefore that podiatrists link with orthopaedic services as well as integrating into Rheumatology/MSK services

In relation to surgical outcome Loveday et al (2012) describes the aims of surgery to be control pain, maintain foot and ankle function and prevent deformity, whilst Conaghan et al (1999) also adds the restoration of function with the overall aim being to maintain independent mobility thus improving quality of life. However, the aims of surgery need to be counterbalanced against the potential risks of:

- Infection (hence the need for monitoring and immediate access for management of the infection)
- Recurrence of deformity (hence patients need **re-assessment of foot orthoses following surgery)**
- Non – union Hence patients should be reassessed for further surgical intervention or continue to be managed conservatively)
- Neuro – vascular damage (hence patients need monitoring after surgery)

Essential standard
Patients will need reassessing for their footwear needs and the need for footwear following foot surgery

6.9 Outcome Measures / Screening Tools

Although there have been minor changes made to this section since the 2014 version of these guidelines, unfortunately no more recent PROMS specific to the general RA foot were found in our literature search. There are a few newer publications citing PROMS used for surgery of the RA foot; but these are not relevant to general clinical practice.

An outcome measure is an evaluation tool; the intention is to use the tool to obtain a baseline measurement, before treatment and again after treatment, to ascertain how effective the treatment has been. Outcome measures are used in conjunction with standard clinical assessments and any more detailed investigations deemed necessary.

Traditional outcome measures/ evaluation tools, used in the management of the RA patient, such as DAS28, HAQ, HAD and OSRA, whilst indicating the status and effects of RA in the patient, do not include foot and ankle even though the foot is often the primary site of RA symptoms.

Commonly used foot specific tools such as the Foot Function Index (FFI) (Budiman-Mak et al., 2006), the Manchester Foot Pain and Disability Questionnaire (MFPDQ) (Garrow et al., 2000) and the Bristol Foot Score(BFS) (Barnett et al., 2005) are not RA specific.

As there is a high prevalence of significant foot and ankle problems in RA patients (Grondal et al., 2008); outcome measures which are both foot and ankle specific, as well as RA specific, are required to aid the management of the RA foot.

The Government released a White Paper in July 2010 – Equity and Excellence: Liberating the NHS. States that patient reported outcome measures or PROMS should be used across the health service, where practicable, as an objective way of assessing whether an intervention has been effective or not.

Darzi (2008) recommends the use of patient-reported outcome measures (PROMs), as a means of ensuring that the patients' view of their illness and treatments are central to our interventions. This recommendation has been re-enforced by the expectation that PROMS will become increasingly more important in decision making about NHS provision and funding (Health., 2010) and the Kings Fund report (Devlin and Appleby, 2010)

The most commonly used PROM in clinical practice is the 10cm visual analogue scale (VAS). This is a scale between 0= no pain, to 10= worst pain imaginable and is used to gauge a patient's perception of their pain at a given time. This can be applied to global pain and then specifically to foot pain as a simple way of indentifying the impact of foot pain as part of the overall picture.

However, it has been shown that the RA patient does not necessarily rate foot pain as the main defining issue with their feet; they are more likely to identify quality of life, the ability to walk and footwear choices as their biggest concerns, (Williams et al., 2007a, Williams et al., 2010, Otter et al., 2012). Therefore more relevant PROMS are needed, in addition to VAS, to capture this information.

A systematic review by (Walmsley et al., 2010) found only one RA disease specific PROM for the foot and ankle; the Leeds Foot Impact Scale (LFIS) (Helliwell et al., 2005). LFIS is only available via application to the author and a copy is therefore not included in these guidelines.

(Walmsley et al., 2012) developed a new RA foot specific, validated PROM; the Salford Rheumatoid Arthritis Foot Evaluation (SAFE) Instrument. This contains 61 Questions in two sections; with the aim of accurately reflecting the RA patients' experiences to give a clinically meaningful measurement.

The Swindon Foot and Ankle Questionnaire' (SFAQ) (Waller et al., 2012) (Appendix 5) is a patient reported foot symptom tool. It is a simple but rapid way of screening for foot pathology rather than a tool to identify the physical and psychosocial impact of feet on the person consisting of 10 questions plus foot diagrams. Though not as comprehensive as the SAFE PROM, it is designed to be user friendly and the diagrams are a useful addition for the patient to identify their areas of concern.

Both the SAFE and SFAQ have been designed for the patient to complete prior to their appointment and the clinician to evaluate the score generated.

6.10 Audit

Clinical audit is a process which helps to ensure patients and service users receive the right treatment from the right person in the right way. It does this by measuring the care and services provided against evidence based standards and then narrowing the gap between existing practice and what is known to be best practice. Clinical audit should reflect national and/or local areas of concern and lead to improvements in the care provided. In the current climate audit can also show clinical commissioning groups that standards are been met as well as help drive business cases for development and investment in services.

The NWCEG – Rheumatology developed an audit tool in 2011 which can be used to audit current rheumatology service provision in relation to the foot health management of people with Rheumatoid Arthritis against available guidance and evidence standards at the time. The tool covers 4 areas:

- Service Provision
- Assessment
- Management
- Professional Development

If you would like a copy of the audit tool, please contact:

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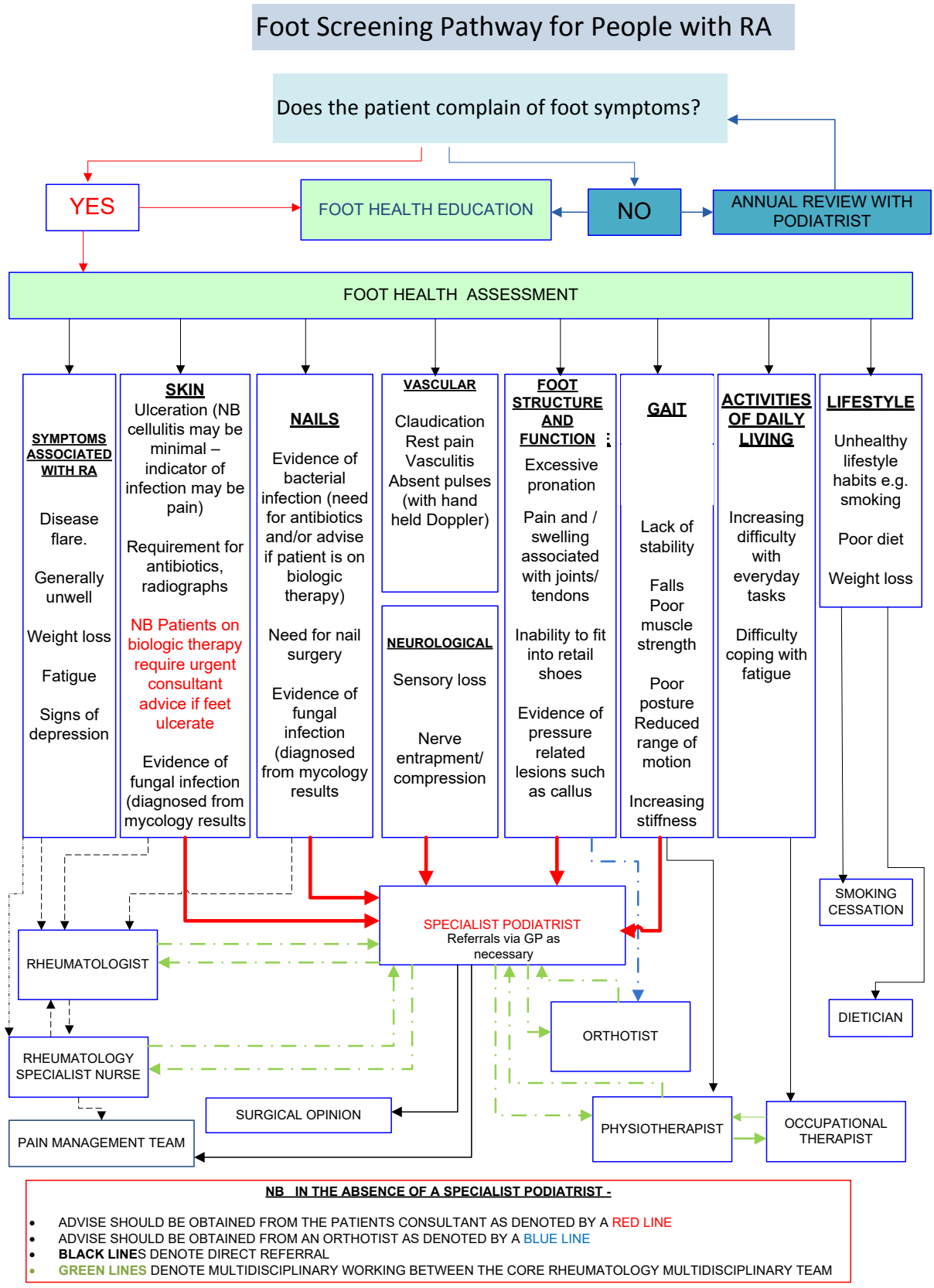
Appendix 1



Appendix 2

Example of Primary Assessment / Annual Screening Tool

Name: _____ NHS No: _____
Address: _____ Unit No: _____
D.O.B. _____
GP: _____ Consultant: _____
Diagnosis: _____ Duration: _____

Relevant Medical History: _____
Allergies: _____

1. Medication:
   NSAIDS: _____
   DMARDS: _____
   STEROIDS: _____
   BIOLOGIC: _____
   OTHER: _____

2. Vascular Assessment:

		Right	Left
Palpation	DP	palpable / non palpable	palpable / non palpable
	PT	palpable / non palpable	palpable / non palpable

Doppler Assessment:
DP _____
PT _____

Intermittent Claudication:	yes ☐	no ☐	yes ☐	no ☐
Rest Pain:	yes ☐	no ☐	yes ☐	no ☐

Other relevant information _____

3. Neurological Assessment:

	Right	Left
10g Monofilament:	normal / abnormal	normal / abnormal

Symptoms: sharp pain ☐ burning ☐ dull ache ☐ numb ☐ tingling ☐ other ☐

4. Foot Structure Assessment:
Previous foot surgery / injury: _____

Extra articular features:
N/A
Bursae sites _____
Nodule sites _____
Subluxed met heads _____
Foot position: _____
_____

Range of joint movement - NWB:	Right	Left
Ankle – knee extended	flexible / reduced / rigid	flexible / reduced / rigid
Ankle – knee flexed	flexible / reduced / rigid	flexible / reduced / rigid
Subtalar	flexible / reduced / rigid	flexible / reduced / rigid
Midtarsal	flexible / reduced / rigid	flexible / reduced / rigid
1st Ray	flexible / reduced / rigid	flexible / reduced / rigid
HAV stage	1 / 2 / 3 / 4 / 5	1 / 2 / 3 / 4 / 5
Lesser toe involvement	2 / 3 / 4 / 5	2 / 3 / 4 / 5

5. Nail / skin problems
   Nail pathology _____
   Skin pathology _____
   Callus sites _____
   History of ulceration yes ☐ no ☐ site _____
   Current ulcer yes ☐ no ☐ site _____

   Cause arterial / vasculitis / small vessel disease / pressure
   Treatment details _____
   _____

6. Current pressure relief / orthotic management
   Type: simple insole ☐ pre-mould ☐ functional ☐ TCI ☐ NA ☐

   Footwear: retail ☐ stock ☐ modular ☐ bespoke ☐
   Appropriate yes / no
   Uses footwear sufficiently to benefit foot health yes / no
   If no why? Uncomfortable ☐ appearance ☐ weight ☐ other ☐

7. Mobility: _____

8. Social factors: _____

9. Presenting complaint: _____

10. Any other relevant information (inc any treatment given):

_____

11. Plan / Action / Collaboration:

Routine podiatry treatment	☐	X-ray / MRI / US	☐
Annual recall / self referral	☐	Bloods	☐
Wound care management	☐	Injection clinic	☐
Orthotic intervention	☐	Education	☐
Consultant Rheumatologist	☐	Orthopaedic opinion	☐
Rheumatology Nurse	☐	Vascular investigation	☐
MDT. Specify.....	☐	Orthotist / Footwear	☐

Other _____

Clinician's Signature: _____ Date: _____

Appendix 3

Footwear Suitability Scale (Nancarrow 1999)

1. Is the heel of your shoe less than 2.5cm (1")?	As the height of your heel increases the pressure under the ball of your foot becomes greater. Increased pressure can lead to callus and ulceration	
2. Does the shoe have laces, buckles or elastic to hold it onto your foot?	If you wear slip on shoes with no restraining mechanism, your toes must curl up to hold the shoes on. This can cause the tops of your toes to rub on your shoes leading to corns and calluses. Secondly, the muscles in your feet do not function as they should to help you walk, instead they are being used less efficiently to hold your shoes on	
3. Do you have 1cm (approx thumb nail length of space between your longest toe and the end of your shoe when standing?	This is the best guide for the length of the shoe, as different manufacturers create shoes which are different sizes. Your toes should not touch the end of the shoe as this is likely to cause injury to the toes and place pressure on the toe nails	
4. Do your shoes have a well padded sole?	Shoes should have supportive, but cushioned sole to absorb any shock and reduce pressure under the feet	
. Are your shoes made from material which breathes?	A warm, moist environment can harbour organisms such as those which cause fungal infections	
6. Do your shoes protect your feet from injury?	The main function of footwear is protection from the environment. Ensure your shoes are able to prevent entry of foreign objects which can injure the foot. If you have diabetes a closed toe is essential to prevent injury to the foot.	
7. Are your shoes the same shape as your feet?	Many shoes have pointed toes and cause friction over the tops of the toes which can lead to corns, callus and ulceration. If you can see the outline of your toes imprinted on your shoes, then the shoe is probably the wrong shape for your foot	
8. Is the heel counter of your shoe firm?	Hold the sides of the heel of your shoe between the thumb and forefinger and try to push them together. If the heel compresses, it is too soft to give your foot support. The heel counter provides much of the support of the shoe and must be firm to press	
If you have not put a tick in every box, your footwear is probably not protecting and supporting your foot as it should be		

Appendix 4

List of Essential Standards

Page 8

- Podiatrists are experts on foot disorders; both patients and rheumatologists can profit from the involvement of a podiatrist

Page 13

- All patients should be referred for foot health assessment within 3 months of diagnosis of RA

Page 14

- All people with RA and foot problems should have access to a podiatrist for assessment and periodic review of their foot health needs.
- All podiatry patients with RA should receive an initial structured foot assessment complete with appropriate outcome measures with onward referral to more specialised colleagues as required
- Referral to a Podiatrist is an integral part of the **early** management of RA patients.

Page 20

- Patient education should include foot health self management advice and if necessary demonstration, explanation of foot problems and their impact on the individual, information on general disease management and sign posting for future foot health needs

Page 21

- Patients with a diagnosis of RA should be assessed as soon as possible following diagnosis for structural problems with the lower limb and foot.
- All patients with RA and foot pain should be considered for foot orthoses and /or footwear advice, irrespective of disease duration.

Page 22

- Patients with established foot deformity should be assessed for accommodative foot orthoses and footwear advice/ specialist footwear

Page 23

- Functional foot orthoses should be provided where the tarsal joints are unaffected.
- Accommodative / cushioning orthoses should be provided for those patients with structural foot deformity, painful symptoms and activity restriction

Page 24

- Footwear assessment and advice should be given to all patients

Page 26

- Patients who are assessed as requiring therapeutic footwear should be informed of the potential benefits and limitations of this footwear (in respect of cosmesis) and allowed to decide on whether to be referred /provided with therapeutic footwear or not
- Referral for surgical opinion should be offered as an alternative to referral for therapeutic footwear

Page 28

- Callus should be assessed in relation to symptoms and causative factors before debridement is considered.
- The focus of callus management should always be the reduction of foot pressures with foot orthoses and suitable footwear first, before debridement is considered as a safe or unsafe intervention

Page 30

- Fungal infections (of the nail and skin) must be investigated and treated. If left untreated they can lead to ulceration and secondary bacterial infection.
- Discussion with the patients GP or consultant is advised before systemic treatment is instigated
- Consultant advice should be taken on ingrown nails (O/C) if the patient is being managed with a biologic therapy and where there are signs of clinical infection and or the need for nail surgery

Page 32

- Optimum ulcer management can only be achieved by a holistic and integrated multi-disciplinary team approach

Page 33

- Contact the patient's consultant / rheumatology nurse **IMMEDIATELY** if the patient is being managed with Biologic therapy and develops an ulcer and/or infection.

Page 34

- Consider steroid injection therapy for targeting localised, inflamed joints and soft tissue structures when the general disease is controlled (but only in the absence of sepsis).

Page 35

- Injection therapy should be seen as an adjunct to conventional podiatric management in combination with attempts to correct any structural deformity using orthoses

Page 36

- Red Flags requiring urgent referral include
    - Tendon rupture e.g. Tibialis posterior, Achilles Tendon
    - Septic arthritis
    - Suspicion of cancer affecting skin or bone

Page 37

- Patients will need reassessing for their footwear needs and the need for footwear following foot surgery

Appendix 5

Useful Website resources

- Arthritis Research UK http://www.arthritisresearchuk.org
- Arthritis Research UK information resources regarding arthritis medication http://www.arthritisresearchuk.org/arthritis-information/drugs
- Arthritis Research UK video resources: Musculoskeletal ultrasound: a beginner's guide to normal peripheral joint anatomy. Issue 05-3. http://www.arthritisresearchuk.org/health-professionals-and-students/video-resources/msus/foot-scans.aspx
- British National Formulary (BNF) http://www.bnf.org/bnf/org
- British Society for Rheumatology http://www.rheumatology.org.uk/
- British Society for Rheumatology / British Health Professionals in Rheumatology (BHPR) http://www.rheumatology.org.uk/BHPR/
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- Healthy Footwear Group http://www.healthy-footwear-guide.com/
- National Rheumatoid Arthritis Society http://www.nras.org.uk/
- The British Footwear Association http://britfoot.com
- The American Institute of Ultrasound in Medicine (AIUM) Practice Guidance for the Performance of Musculoskeletal Ultrasound Examination. http://www.aium.org/resources/guidelines/musculoskeletal.pdf

Appendix 6

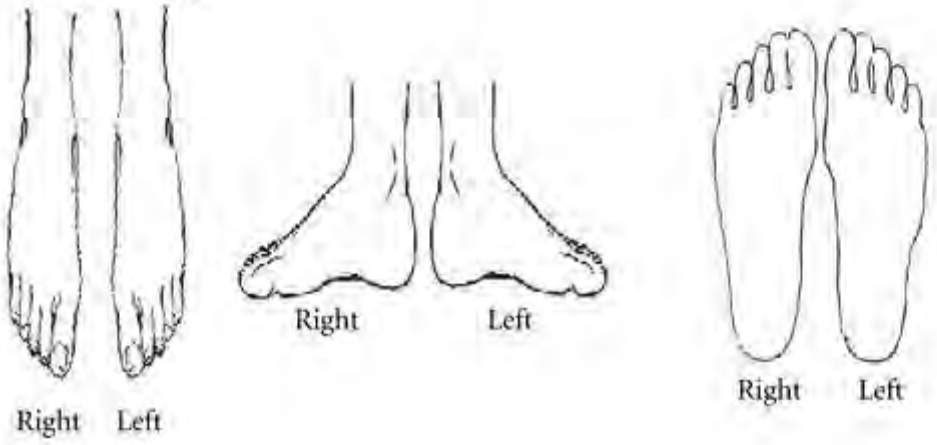
Swindon Foot and Ankle Questionnaire

Swindon foot and ankle questionnaire

During the past week, have your feet or ankles	Yes	No
(1) been painful?	☐	☐
(2) been swollen?	☐	☐
(3) made walking difficult?	☐	☐
(4) made standing up difficult?	☐	☐
(5) stopped you going to work?	☐	☐
(6) made other daily activities difficult?	☐	☐

	Yes	No
(7) Do your shoes rub the skin on your feet or ankles?	☐	☐
(8) Have you had callouses or hard dry skin?	☐	☐
(9) Have you had your footwear adapted or insoles made?	☐	☐
(10) Have you had surgery or are you due to have surgery for your feet or ankles?	☐	☐

If you have suffered or are suffering from foot or ankle pain, please indicate its location on the drawing



Appendix 7

US training for non-radiologists

The European League Against Rheumatism (EULAR) task force for musculoskeletal US in rheumatology have recently produced an updated consensus-based comprehensive and practical framework on standardised procedures for musculoskeletal US imaging in rheumatology (Moller et al, 2017). Guidelines to support training for rheumatologists have also been formulated [24] but currently there are no recommendations to support the education and training needs of non-medical health professionals using musculoskeletal US (Siddle et al 2016).

The main concerns for the use of US by podiatrists revolve around the need for agreement of standards of competency for the technique, accreditation by appropriate bodies and recognised mentorship schemes. Various methods of training for the techniques exist and this may often make selecting an appropriate course confusing. Many short introductory courses to using US exist and can be a useful stimulus to further learning and web based packages have been developed that form a useful adjunct to face-to-face teaching (eg the EULAR online course https://www.eular.org/edu_online_course_msus.cfm and the musculoskeletal US in rheumatology educational resource devised by Glasgow Caledonian University UK https://www.gcu.ac.uk/arthritisresearchukultrasound/). Neither are substitutes for continuous learning with an experienced mentor. Concerted national and international efforts are attempting to address standardization of training. Models to support the learning needs of non-radiologists, e.g. Rheumatologists, in the use of US have been devised in Europe and America (Siddle et al 2016; Kang et al, 2012; McAlindon et al 2012; Naredo et al 2008) and advice can be sought from the UK College of Podiatry US users group.

Recommended training programmes

- BSR (*British Society for Rheumatologists*) US short courses (beginners, intermediate, advanced)
- BMUS (*British Medical Ultrasound Society*), EULAR (*European League Against Rheumatism*), and EFSUMB (*European Federation of Societies for Ultrasound in Medicine and Biology*) have established training guidelines and begun to work towards certification of competency in ultrasound for non-radiologists
- CASE: Consortium for the Accreditation of Sonographic Education UK
    - University of Bournemouth/AECC accredited focused Podiatry Musculoskeletal Ultrasound Course.
    - Kent and Canterbury Hospital, East Kent Hospitals University Foundation Trust (US screening for hands and feet).

Title:	**Guidelines for empirical antibiotic prescribing in hospitalised adults**		
Policy Author(s)	Dr Grace Ong, Consultant, Tissue Pathology & Molecular Labs Tel: [redacted] Dr Ronan McMullan, Consultant, Tissue Pathology & Molecular Labs Tel: [redacted] BHSCT Antimicrobial Stewardship Committee members		
Responsible Director:	Caroline Leonard, Surgery and Specialist Services		
Policy Type: (tick as appropriate)	*Directorate Specific ☒	Clinical Trust Wide ☐	Non Clinical Trust Wide ☐
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			

Approval process:	Drugs and Therapeutics Committee Standards and Guidelines Committee Executive Team Meeting	**Approval date:**	01/10/2021 07/12/2021 12/01/2022
Operational Date:	January 2022	**Review Date:**	January 2027
Version No.	9	**Supercedes**	V8 – January 2021 – January 2026
Key Words:	Empirical, antibiotic, prescribing		
Links to other policies			

Summary

Title:
Guidelines for empirical antibiotic prescribing in hospitalised adults

Purpose:
The purpose of this guideline is to provide consistent Trust-wide guidance for the empirical antibiotic management of hospitalised patients with the commonly encountered bacterial infections.

Objectives:
To improve the quality of antibiotic prescribing and standardise the use of antibiotics across the Trust.

Policy Statement(s):

1 A regularly updated antibiotic guideline will be available to provide direction for prescribers in the first-line empirical management of a variety of important and commonly encountered infections in all clinical areas throughout the Trust.

2 Antimicrobial prudence is an essential component of the Trust's infection prevention strategy.

3 It is expected that the majority of prescribing decisions will reflect these recommendations. Where alternative drugs are prescribed, the prescriber should record the reason for this in the patient record.

4 Changing from intravenous to oral routes of administration, where appropriate, is an aspect of good practice supported by this guideline.

5 Prescribing practice, adopting this guideline as the reference standard, will be the subject of regular clinical and pharmacy-based audit.

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

The existing and emerging threat from antimicrobial resistance and the increasing incidence of multi-drug resistant infections, mandates for the existence of Trust guidelines for empirical antibiotic prescribing. The intended outcome from these guidelines is to maintain the appropriateness of antibiotic prescribing decisions, taking account of both efficacy and minimising unintended consequences of antibiotic use including rising prevalence of resistance and healthcare-associated pathogens.

1.2 Purpose:

The purpose of this guideline is to provide consistent Trust-wide guidance for the empirical antibiotic management of hospitalised patients with the commonly encountered bacterial infections.

1.3 Objectives

To improve the quality of antibiotic prescribing and standardise the use of antibiotics across the Trust.

2.0 SCOPE OF THE POLICY

This guideline is intended to apply to all hospitalised adults throughout the Belfast Trust. All dosing regimens within assume normal renal and hepatic function.

It does not apply to children. Please refer to the trust guidelines or empirical antibiotic prescribing in hospitalised children 0-14 years for management of children.

3.0 ROLES AND RESPONSIBILITIES

It is the responsibility of all staff who prescribe antibiotics to do so broadly in accordance with this policy.

It is recognised that circumstances will arise necessitating use of antibiotics other than those suggested; it is expected that the reasons for prescribing alternative agents are recorded in the patient record.

The dissemination, education, audit and performance management measures which arise from this policy will be supported by the Drug & Therapeutics Antimicrobial Subcommittee, microbiologists, infectious disease physicians, pharmacy, the Medical Director and Trust Directors.

It is expected that clinical service groups and individual clinical teams will participate in the systematic audit of antibiotic prescribing practice within their respective areas.

4.0 CONSULTATION

These guidelines have been reviewed by the Trust Drug and Therapeutics committee and have undergone review by the Standards and Guidelines committee. The drafting process included contributions from a range of stakeholders relevant to the various components of the guideline and included members of the Belfast Trust Antibiotic Stewardship Committee.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Key Policy Statement

The importance of antibiotic stewardship has become increasingly clear in respect of both infection prevention and limiting the rise of antibiotic resistant organisms.

This guideline aims to address the need for quality improvement and standardisation in antibiotic use. It is an essential component of the Trust's infection prevention strategy.

Failure to adopt antibiotic prudence may threaten this strategy and expose the Trust and its clients to risk from increasing prevalence of healthcare-associated infection and antibiotic-resistant pathogens.

5.2 Policy Principles

To improve the quality of antibiotic prescribing and standardise the use of antibiotics across the Trust

The guideline provides direction for prescribers in the first-line empirical management of a variety of important and commonly encountered infections. These include: respiratory, neurological, intra-abdominal, skin/soft tissue, and urinary tract infection as well as septic shock.

It also includes guidance for prescribers on monitoring serum levels of certain antibiotics, intravenous to oral switch practice, and other areas of antimicrobial therapeutic practice.

A regularly updated antibiotic guideline will be available to provide direction for prescribers in the first-line empirical management of a variety of important and commonly encountered infections in all clinical areas throughout the Trust.

Antimicrobial prudence is an essential component of the Trust's infection prevention strategy.

It is expected that the majority of prescribing decisions will reflect these recommendations. Where alternative drugs are prescribed, the prescriber should record the reason for this in the patient record.

Changing from intravenous to oral routes of administration, where appropriate, is an aspect of good practice supported by this guideline.

Prescribing practice, adopting this guideline as the reference standard, will be the subject of regular clinical and pharmacy-based audit.

5.3 Dissemination

Following ratification by the Standards and Guidelines Committee and approval by the Policy Committee this guideline will be published on the Belfast Trust Intranet Site and staff will be informed.

The policy and guidelines section is regularly accessed by staff.

The policy will be available on a Trust approved App available for smart phones and an internet site.

5.4 Resources

All staff will be made aware when this guideline is published on the BHSCT intranet site.

5.5 Exceptions

The policy does not apply to non-hospitalised adults

6.0 MONITORING AND REVIEW

There is on-going prospective audit coordinated through HCAI improvement plan and Antimicrobial Steering Committee.

7. EVIDENCE BASE / REFERENCES

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21. American College of Chest Physicians/Society of Critical Care Medicine Consensus Conference: "Definitions of the systemic inflammatory response syndrome and allied disorders in relation to critically injured patients." *Crit Care Med* 1997;25:1789-95.

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26. European Federation of Neurological Societies (EFNS): EFNS guideline on the management of community-acquired bacterial meningitis: report of an EFNS Task Force on acute bacterial meningitis in older children and adults

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8.0 APPENDICES

Appendix 1: First line empirical antibiotic therapy in hospitalised patients
Appendix 2: Management of infection in intensive care units
Appendix 3: Management of a febrile episode in Neutropenic Patients
(Please refer to Guidelines for the management of oncology/haematology adult patients (>18) with neutropenic sepsis)
Appendix 4: Management of (a) delayed/chronic and
(b) early/acute prosthetic joint infection
Appendix 5: Guidelines for Diagnosis and Treatment of Central Venous Catheter related infections in Adults
Appendix 6: Antibiotic dosing in patients on Haemodialysis
Appendix 7: Management of foot ulcer infection in patients with Diabetes
Appendix 8: Management of patients with a compound fracture
Appendix 9: Gentamicin Aide
Appendix 10: Management of *C. difficile* Infection (CDI) in adults
Appendix 11: Guidelines for empirical antibiotic treatment of post-neurosurgical infections in hospitalised adults
Appendix 12: Ear, Nose, Throat & Eye Antimicrobial Guidelines

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Guidelines for empirical antibiotic prescribing in hospitalised adults** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy haspotential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

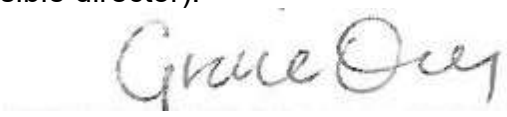
Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

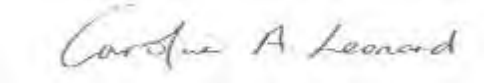
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



19/01/2022

_____ **Date:** _____

Policy Author



19/01/2022

_____ **Date:** _____

Director

Guidelines for Empirical Antibiotic Prescribing in Hospitalised Adults in Belfast Health and Social Care Trust

Contents

Appendix 1: BHSCT FIRST-LINE EMPIRICAL ANTIBIOTIC THERAPY IN HOSPITALISED ADULTS 2020-2023

These empirical guidelines are a generic indicator of good practice, based on a Northern Ireland Regional Framework. They have been modified by Trusts to meet local conditions.

Treatment should be reviewed daily to ensure that antibiotic therapy is still indicated. If bacterium is cultured, antimicrobial therapy should be reviewed once sensitivities are known. If no bacterium is cultured the antibacterial can be continued or stopped on clinical grounds.

All senior clinicians are advised to note the contents of this guidance. Whilst the guidelines are not intended to restrict the clinical judgement of senior medical staff, it is requested that they specify the reasons for making a choice outside the guidelines in patients' notes.

IMPORTANT NOTES ABOUT THIS GUIDELINE:

1. **All regimens assume normal hepatic and renal function**
2. **Not all regimens are suitable in pregnancy/breast feeding**

"**Microguide**"**App** is available for free download search on Google play & iTunes
http://microguide.horizonsp.co.uk/viewer/bhsct/adult

PRUDENT ANTIBIOTIC PRESCRIBING

To reduce emergence of resistant organisms and *Clostridium difficile* associated diarrhoea:

- De-escalate to narrow spectrum from broad-spectrum empirical regimens based on cultures where possible.
- Avoid clindamycin, cephalosporins and fluoroquinolones outside guideline limitations. Minimise carbapenems and long courses of antimicrobials.

WHEN PRESCRIBING

1. Always document in the medical notes **and on the kardex** the indication, drug prescribed, dose, frequency, route and planned duration or review date.
2. Document baseline investigations requested.
3. Obtain samples for microbiological culture before administration of antibiotics (where possible)
4. Review microbiology results and de-escalate therapy as appropriate (contact micro if advice required)

ANTIBIOTIC ASSAYS:

In order to interpret assays, the following data is required:

- Agent to be assayed
- Last dose (mg)
- When last dose given (hour, date)
- If sample is a pre or post dose level
- Time of assay (hour, date)

Information required on Lab request form:

- Agent to be assayed
- If sample is a pre or post dose level

Failure to provide this information may result in the assay not being performed.

PENICILLIN ALLERGY (antibiotics in red contain penicillin)

Obtain a reliable history & document exact nature in case notes and on kardex

High risk:
History of: anaphylaxis, urticaria, early onset rash, angioedema, bronchospasm, hypotension, laryngeal oedema, Stevens-Johnston or toxic epidermal necrolysis:

- Avoid penicillins, cephalosporins and other beta- lactam antibiotics.
- Aztreonam may be less likely to cause hypersensitivity in penicillin sensitive patients and can be used with caution (avoid aztreonam if allergic to ceftazidime)

Low risk:
Minor non-confluent, non-pruritic rash restricted to a small area of the body, rashes >72 hours after administration, nausea, diarrhoea:

- Life threatening allergy very unlikely, therefore a trial of beta-lactam therapy under observation may be considered as appropriate.
- Consideration should be given to immunological proof of allergy (RAST test) once patient has recovered from their infection.

IV to ORAL SWITCH

Review the need for IV antibiotics **daily**. Document progress and the IV-PO switch plan within 72 hours.

Haemodynamically Stable: temperature <38°C for >48 hours, pulse <100 beats/min or return to baseline, resolution of tachypnoea and hypotension or return to baseline, no hypoxia or return to baseline.

Oral (PO) route available: hydrated and drinking, adequate GI absorption, oral formulation or suitable alternative is available

Markers of infection resolving: WCC / CRP

Exclude deep-seated infection: no standing instruction for prolonged IV therapy e.g. osteomyelitis, endocarditis, meningitis, bacteraemia

Antibiotic	Standard dosage in NORMAL renal function	Timing of first level in NORMAL renal function	Expected level (mg /L)	Re-assay interval in NORMAL renal function (Days)
Gentamicin (Once daily regimen)	5 mg/kg (Endocarditis dose as per microbiology)	Trough before 2nd dose i.e. 19-24 hours after first infusion	Trough <1 **N.B.** Levels prior to 18 hrs after last dose are not suitable	2-3
Gentamicin (Divided dosing)	Dose as per microbiology	Peak level to be taken after 2nd or 3rd dose	General: Trough < 2, Peak 5 -10 Endocarditis: Trough < 1, Peak 3-5	2-3
Amikacin (Once daily)	15 mg/kg	Trough before 2nd dose i.e. 19-24 hours after first infusion	Trough < 5 **N.B.** Levels prior to 18 hrs after last dose are not suitable	2-3
Vancomycin See Intranet for BHSCT Vancomycin Policy	Initial **loading dose** based on actual body weight. **Maintenance dose** based on Creatinine Clearance.	Take a trough sample within 48hrs of starting therapy	Trough 10-20 **N.B.** Trough 15-20 for severe infections e.g. MRSA, bacteraemia, endocarditis, pneumonia	2-3
Teicoplanin See Intranet for BHSCT Teicoplanin Policy	**Loading dose:**10mg / kg 12 hourly for 5 doses (round dose to nearest 200mg) **Maintenance dose:** 10mg/kg/day	Teicoplanin trough level should be monitored at steady-state after administration of **5 loading doses** and **before** the 1st maintenance dose to ensure that a therapeutic trough serum concentration has been reached. Re-check level every 7 days.	Expected range: 20 - 50mg/L. Give dose while awaiting results of levels in patients with normal renal function	7

INFECTION SYNDROME / INDICATION		PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
Sepsis Sepsis is life threatening organ dysfunction secondary to the body's response to infection. Sepsis should be considered when the NEWS score is >4 or when any parameter has a score of 3 (RED). The SEPSIS 6 protocol should be instigated with the appropriate parenteral antimicrobial. Such patients should be reviewed by a senior clinician promptly and escalation considered. Blood cultures indicated as part of SEPSIS 6 protocol Refer to relevant section of treatment guideline for source of sepsis diagnosed e.g. if severe community acquired pneumonia refer to treatment for (CURB 65 3-5) or Sepsis from urinary tract refer to Urosepsis		Refer to the relevant body system section Consider addition of Gentamicin 5mg/kg 24 hourly IV if Hypotension	Refer to the relevant body system section Consider addition of Gentamicin 5mg/kg 24 hourly IV if Hypotension	Review treatment with blood culture or relevant culture results at 48 hrs to decide on duration	NEWS 2 can be accessed at: https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2 NICE NG 51 pathways and guidance can be accessed at: https://pathways.nice.org.uk/pathways/sepsis/sepsis-overview#content=view-node:nodes-when-to-suspect-sepsis
Neutropenic sepsis Neutrophil count of < 1.0 x 10^9/l + Temp > 38°C. or other signs or symptoms consistent with clinically significant sepsis		Piperacillin-tazobactam 4.5g 6 hourly IV In severe sepsis add Gentamicin 5mg /kg 24 hourly slow IV OD after line flush	Ciprofloxacin 600mg 12 hourly IV** PLUS Teicoplanin 10mg / kg 12 hourly IV x 5 doses then 10mg / kg 24 hourly IV PLUS Gentamicin 5mg / kg 24 hourly IV		Alternative regimen when receiving prophylaxic Ciprofloxacin: Aztreonam 2G IV 8 hourly + Gentamicin 5mg / kg 24 hourly IV + Teicoplanin 10mg / kg 12 hourly IV x 5 doses then 10mg / kg 24 hourly IV Neutropenic sepsis pathways can be accessed at: https://nican.hscni.net/wpfd_file/neutropenic-sepsis-2017-guidelines-for-the-management-of-oncology-haematology-adult-patients/
Community Acquired Pneumonia Pneumonia is typically an acute febrile illness with cough, breathlessness, often productive of sputum and pleurisy in a patient with or without existing chest disease and *new shadowing on CXR.* Assess severity using CURB 65 score: new Confusion, Urea >7mmol, Respiratory rate >30 / min, BP <90 systolic or ≤ 60 diastolic, Age **≥65** (Each criterion scores 0 or 1, max score = 5).	CURB 65 0-1	Amoxicillin 500mg – 1g 8 hourly PO	Doxycycline 100mg 12 hourly PO	5 days*	
	CURB 65 2	Amoxicillin 1g 8 hourly IV / PO + Clarithromycin 500mg 12 hourly PO	Doxycycline 100mg 12 hourly PO	5 days*	Send blood cultures, Pneumococcal urinary antigen tests and sputum culture. Consider Legionella urinary antigen if clinical suspicion
	CURB 65 3-5	Co-amoxiclav 1.2g 8 hourly IV + Clarithromycin 500mg 12 hourly IV. *Consider referral to ICU: If paO_2 < 8kPa despite high FiO_2; Progressive Hypercapnia; pH < 7.26; hypotension; GCS falling*	Levofloxacin† 500 mg 12 hourly IV *Consider referral to ICU: If paO_2 < 8kPa despite high FiO_2; Progressive Hypercapnia; pH < 7.26; hypotension; GCS falling* *Consider* careful addition of Clarithromycin †500mg 12 hourly IV if proven Pneumococcal pneumonia in ICU with monitoring for prolonged QT.	5 days*	Send blood cultures, Legionella and Pneumococcal urinary antigen tests and sputum culture. If suspicion of atypical/viral pathogen send respiratory sample for PCR Clarithromycin in proven Pneumococcal pneumonia shown to improve mortality in ICU patients †Caution-risk of QT prolongation with macrolide-quinolone combination

INFECTION SYNDROME / INDICATION		PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
Community Acquired Aspiration Pneumonia When patients aspirate gastric contents, they develop aspiration pneumonitis for which antimicrobial chemotherapy is NOT required. Pneumonitis does not require treatment in first 48 hours unless there is a change in sputum quality to purulent / mucopurulent, fever and new CXR changes which usually occur after 48hrs.		Amoxicillin 1g 8 hourly IV + metronidazole 500mg 8 hourly IV	Clarithromycin 500mg 12 hourly IV + Metronidazole 500mg 8 hourly IV	5 days*	Only treat if clinical / CXR evidence of pneumonia.
Bronchitis (Chronic) OR Infective Exacerbation of COPD No pneumonic changes on CXR. For infective exacerbations of COPD, only prescribe for patients with two of the following: increased SOB, increased sputum volume or increased sputum purulence.		Patient with no recent exposure to amoxicillin or risk factors for antibiotic resistant organisms including co-morbid disease, severe COPD, frequent exacerbations, antibiotics in last 3 months: *NB - This should be guided by previous sputum / endotracheal culture results* Amoxicillin 1g 8 hourly PO	Patients with serious penicillin allergy OR Previous recent amoxicillin: *NB - This should be guided by previous sputum / endotracheal culture results* Doxycycline 100mg 12 hourly PO (Doxycycline preferred in treatment failure) Or Clarithromycin 500mg 12 hourly PO / IV	5 days*	A cough of less than 2 weeks duration in healthy adults with no co-morbidities or systemic illness does not require antibiotics. Consider antibiotic use in >60 years or if underlying chest disease.
Hospital Acquired Pneumonia including Hospital Acquired Aspiration Pneumonia HAP is over diagnosed clinically. HAP diagnosis requires radiological evidence of new pulmonary infiltrates. Alternative diagnoses should be actively excluded.	< 4 days post admission	Refer to CAP CURB score	Refer to CAP CURB score	5 days*	In HAP ≥ 4 days post admission pseudomonas or staphylococcal pneumonia may require a longer duration of therapy. Discuss with micro/ID
	or ≥ 4 days and non-severe	Co-amoxiclav 625mg 8 hourly PO or 1.2 g 8 hourly IV	Co-Trimoxazole 960mg 12 hourly PO In case of aspiration add in Metronidazole 500mg 8 hourly IV to the above	5 days*	
	≥ 4 days post admission if severe	Piperacillin-tazobactam 4.5g 8 hourly IV ± Gentamicin 5mg / kg 24 hourly IV (if severe sepsis) If suspect MRSA add Teicoplanin 10mg/kg 12 hrly x 5 doses then 10mg/kg 24hrly IV	Vancomycin IV (see TDM section for dosing) + Ciprofloxacin 400mg 12 hourly IV** In case of aspiration add in Metronidazole 500mg 8 hourly IV to the above NB - This should be guided by previous sputum / endotracheal culture results	5 days*	
Uncomplicated (Lower) UTI ASYMPTOMATIC BACTERIURIA: do not treat unless pregnant or urology procedures planned, *even if catheter present*. Do not use dipsticks in over 65s or in the presence of a catheter Only change treatment in accordance with MSU susceptibility result if symptoms not improving		Nitrofurantoin 100mg 6 hourly PO with food If resistant to nitrofurantoin or trimethoprim then use : Pivmecillinam 400mg load then 200mg 8hrly PO	Trimethoprim 200mg 12 hourly PO (only if not used in the past 3 months)	Female: 3 days Male: 7 days	Nitrofurantoin: avoid if eGFR less than 45 mL/minute as drug will not concentrate in urine. Elderly women with uncomplicated UTI up to 5 days of Nitrofurantoin may be used if required
Complicated (Upper) UTI Risks for complicated UTI include: structural abnormality of the renal tract, male sex, recent urinary tract instrumentation, symptoms> 7days at presentation, diabetes, immunosuppression.		*Antibiotic therapy should be guided by previous urine culture results* Gentamicin 5mg / kg 24 hourly IV OR Piperacillin-tazobactam 4.5g 8 hourly IV if gentamicin inappropriate	*Antibiotic therapy should be guided by previous urine culture results* Gentamicin 5mg / kg 24 hourly IV OR Ciprofloxacin 400mg 12 hourly IV ***only if gentamicin inappropriate*	7 - 10 days	Review gentamicin requirement at Day 3 – 4. Consider oral step down therapy to a susceptible agent to complete course. Pyelonephritis up to 14 days depending on antibiotic agent used

INFECTION SYNDROME / INDICATION	PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
Catheter associated UTI Patients with urinary catheter invariably develop bacteriuria after a few days. Do not use dipsticks in the presence of a catheter Cloudy urine is not an indication for sending a catheter specimen of urine Treatment with an antibiotic is only required if there are signs & symptoms of systemic infection.	*Antibiotic therapy should be guided by previous urine culture results* Gentamicin 5mg / kg 24 hourly IV	*If Gentamicin therapy is inappropriate:* Ciprofloxacin 400mg 12 hourly IV ** or Ciprofloxacin 500mg 12 hourly PO**	Depending on severity of infection	Re-assess need for catheter; if it is required change/remove under antibiotic cover. Review gentamicin requirement at day 3 followed by oral step down therapy to a susceptible oral agent.
Urosepsis Symptomatic UTI + Risk Factors for Sepsis (refer to NICE NG 51 pathways and guidance can be accessed at: https://pathways.nice.org.uk/pathways/sepsis/sepsis-overview#content=view-node:nodes-when-to-suspect-sepsis.) Take blood cultures before antibiotics	Piperacillin-tazobactam 4.5g 8 hourly IV + Gentamicin 5mg / kg 24 hourly IV	Aztreonam 2G IV 8 hourly + Vancomycin IV (see Vancomycin in TDM guidelines) + Gentamicin 5mg / kg 24 hourly IV	Review treatment with blood culture or relevant culture results at 48 hrs to decide on duration.	Alternative regimen if Aztreonam unavailable: Ciprofloxacin 400-600mg 12 hourly IV + Vancomycin IV (see therapeutic drug monitoring) + Gentamicin 5mg / kg 24 hourly IV
Intra-abdominal infection (Including biliary tract infections)	*Community acquired non-severe:* Co-amoxiclav 1.2g 8 hourly IV	*Community acquired non-severe:* Teicoplanin 10mg /kg 12 hourly IV x 5 doses then 10mg/kg 24 hourly IV (see Teicoplanin in TDM guidelines) + Metronidazole 500mg 8 hourly IV + Aztreonam 2g 8 hourly IV	4-7 days if adequate source control	
	Hospital acquired / Severe: Piperacillin-tazobactam 4.5g 8 hourly IV ± Gentamicin 5mg/kg 24 hourly IV	*Hospital acquired / Severe:* Vancomycin IV (see Vancomycin in TDM guidelines) + Metronidazole 500mg 8 hourly IV + Ciprofloxacin 400mg 12 hourly IV**	4-7 days if adequate source control	
Cellulitis / soft tissue infections: No MRSA *Note: If symptoms bilateral, cellulitis unlikely* Mild: no signs of systemic toxicity, have no uncontrolled co- morbidity. Moderate: either systemically well, but with a co-morbidity e.g. peripheral vascular disease, chronic venous insufficiency or morbid obesity, which may complicate or delay resolution of their infection. OR may have a significant systemic upset such as acute confusion, tachycardia, tachypnoea, hypotension or may have unstable co-morbidities that may interfere with a response to therapy or have a limb threatening infection due to vascular compromise. Severe: have sepsis syndrome or severe life threatening infection e.g. necrotising fasciitis.	*Mild:* Flucloxacillin 750 mg-1g 6 hourly PO *Moderate- Severe:* Flucloxacillin 2g 6 hourly IV *Severe e.g. necrotising fasciitis- Urgent Micro / ID and Surgery advice*	*Mild:* Doxycycline 100mg 12 hourly PO *Moderate- Severe:* Clindamycin 900mg 8-hourly IV *Severe e.g. necrotising fasciitis- Urgent Micro / ID and Surgery advice*	5-7 days Depending on severity	Clinical features of NF are: Constant pain, bullous lesions, gas in the soft tissues, systemic toxicity & rapid spread along the facial planes. Necrotising Fasciitis is life-threatening, (take blood cultures and send wound swab/debrided pus or tissue for culture).
Cellulitis / soft tissue infections: Known MRSA	*Mild:* Doxycycline 100mg 12 hourly PO *Moderate- Severe :* Teicoplanin 10mg / kg 12 hourly IV x 5 doses then 10mg/kg 24 hourly IV OR Vancomycin IV (refer to vancomycin policy for doses)		5-7 days	

INFECTION SYNDROME / INDICATION	PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
Bacterial meningitis	Ceftriaxone 2g 12 hourly IV If >60 years, immunocompromised or pregnant add Amoxicillin 2g 4 hourly IV	Chloramphenicol 25mg/kg 6 hourly IV to a maximum dose of 4 grams per day If > 60yrs OR immunocompromised add co-trimoxazole 60-120 mg/kg/day in 4 divided doses IV	Depends on pathogen isolated Consult Micro/ID	Give dexamethasone 0.15 mg/kg to a maximum dose of 10 mg IV four times daily. Continue for 4 days only if confirmed/probable pneumococcal meningitis. Stop if other cause confirmed /probable. See notes[1] for further advice
Clostridium difficile-Associated Diarrhoea (CDI) Discontinue concomitant antibiotics as soon as possible Stop PPI treatment if it is not necessary Non-severe Disease: Temp <38°C WCC < 15x 10^9/L, creatinine< 130umol/L .	Non-severe disease: Oral Vancomycin 125mg 6 hourly (IV formulation can be used orally)	If patient is on antibiotic treatment for other systemic infection and cannot be stopped: Fidaxomicin 200mg PO/NG 12 hourly If the patient is NIL orally: Metronidazole 500mg 8 hourly IV	10 days (10-14 days if using IV metronidazole)	Fulminant CDI (hypotension, shock, ileus, toxic megacolon, colonic perforation) requires Urgent Surgical review. Refer to appendix 10. Discontinue concomitant antibiotics as soon as possible - stop PPI treatment if it is not necessary
Severe disease: Temp ≥38°C , WCC ≥ 15x 10^9/L, creatinine ≥ 130umol/L, Abnormal Abdominal XR, Distended Abdomen.	Severe Disease: Refer to appendix 10	Severe- Disease: Refer to appendix 10		

All dosing regimens assume normal renal and hepatic function. Check suitability of proposed regimen in pregnancy and breast-feeding

*Stop antibiotic unless microbiological results suggest a longer course is needed or the person is not clinically stable

** See MHRA advice for restrictions and precautions for using fluoroquinolone antibiotics due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019).

Notes from Guidelines

[1]Steroids improve the outcome in pneumococcal meningitis. It can be difficult to differentiate pneumococcal meningitis from other types of meningitis, but steroids should be given when pneumococcal meningitis is suspected e.g., if a patient reports recent ear infection, in people older than 65, and in people with underlying health problems. The dose of dexamethasone is 0.15 mg/kg to a maximum dose of 10 mg, four times daily for 4 days. Steroids should be continued if there is frankly purulent CSF with Gram-positive cocci on gram stain or if pneumococcal infection is confirmed.
Steroids may be discontinued if the CSF is not consistent with bacterial meningitis, i.e. CSF is not purulent, the white cell count is <1000 white cells, CSF protein is < 1gm/L. Steroids should also be stopped if another pathogen other than pneumococcus is found.
Steroids are contra-indicated if the patient is immunosuppressed. Steroids should not be given if there has been recent neurosurgery.

Use of Guidelines

Empirical guidelines are a generic indicator of good practice, which are based on a Northern Ireland Regional Framework, and have been modified by Trusts to meet local conditions.
Treatment should be reviewed once sensitivities are known. If no bacterium is cultured the antibacterial can be continued or stopped on clinical grounds.
All senior clinicians are advised to note the contents of antimicrobial guidance. Whilst the guidelines are not intended to restrict the clinical judgement of senior medical staff, it is requested that they specify the reasons for making a choice outside the guidelines in patients' notes.
All antibiotic guidelines and policies are available on the Trust intranet and the BHSCT MicroGuide® App and web viewer.

A <u>Start Smart-Then Focus</u> approach is recommended for all antibiotic prescriptions.

Start Smart means:
• do not start antimicrobial therapy unless there is clear evidence of infection
• take a thorough drug allergy history
• initiate prompt effective antibiotic treatment within one hour of diagnosis (or as soon as possible) in patients with severe sepsis or life-threatening infections Avoid inappropriate use of broad-spectrum antibiotics
• comply with local antimicrobial prescribing guidance
• document clinical indication (and disease severity if appropriate), drug name, dose and route on drug chart and in clinical notes
• include review/stop date or duration
• obtain cultures prior to commencing therapy where possible (but do not delay therapy)
• prescribe single dose antibiotics for surgical prophylaxis where antibiotics have been shown to be effective
• document the exact indication on the drug chart (rather than stating long term prophylaxis) for clinical prophylaxis

Then Focus means:
• reviewing the clinical diagnosis and the continuing need for antibiotics at 48*-72 hours and documenting a clear plan of action - the 'antimicrobial prescribing decision'
• the five 'antimicrobial prescribing decision' options are:
1. Stop antibiotics if there is no evidence of infection
2. Switch antibiotics from intravenous to oral
3. Change antibiotics – ideally to a narrower spectrum – or broader if required
4. Continue and document next review date or stop date
5. Outpatient Parenteral Antibiotic Therapy (OPAT)

It is essential that the review and subsequent decision is clearly documented in the clinical notes and on the drug chart where possible e.g. stop antibiotic
Due to advances in rapid diagnostics it may be possible to review prior to 48 hours after first dose.

Appendix 2: Management of infection in intensive care units

Refer to Appendix 1: 1st Line empirical antibiotic therapy in Hospitalised Adults for the following infection syndromes:

- **Community-acquired PNEUMONIA, Hospital-acquired PNEUMONIA, Sepsis, Urosepsis, Meningitis, Intra-abdominal sepsis, Skin & Soft Tissue INFECTION**
- Piperacillin-Tazobactam 4.5g could be increased to 6-hourly IV and Ciprofloxacin dose to 600mg 12 hourly IV when clinically indicated
- **Gentamicin 5mg/kg 24 hourly IV can be added if severe sepsis**
- **If high likelihood of MRSA infection** add Vancomycin IV (please refer to vancomycin policy for doses) or Teicoplanin (refer to Teicoplanin in BHSCT TDM guidelines) to the antibiotic regimen

INFECTION SYNDROME		PREFERRED EMPIRICAL REGIMEN	ALTERNATIVE REGIMEN Suitable in serious penicillin allergy	SUGGESTED DURATION	Comments
Ventilator-associated PNEUMONIA		**Piperacillin-Tazobactam 4.5g 6-8 hourly IV ± Gentamicin 5mg/kg 24 hourly IV (if severe sepsis)** **If suspect MRSA** add **Vancomycin** IV (please refer to vancomycin policy for doses)	**Vancomycin** IV (Please refer to vancomycin policy for doses) + **Ciprofloxacin** 400mg-600mg 12 hourly IV *** In case of aspiration add in **Metronidazole** 500mg 8 hourly IV to the above	5 days May be extended to 7 day if clinically appropriate (may require 10-14 days for *Pseudomonas pneumonia*)	Antibiotic regimen should be guided by previous sputum / endotracheal culture results
Anti-Fungal prophylaxis	**Recent abdominal surgery and recurrent GI perforations OR Anastomotic Leaks**	**Fluconazole 400mg IV daily**		Until resolution of underlying surgical condition	
Fungaemia (including those secondary from line infections)	**Positive Blood cultures with *Candida* Sp**	**1st line: Commence IV infusion of an **echinocandin** (Note : Echinocandin not recommended in UTI or CNS fungal infections) **OR** **2nd line: Ambisome 3mg/kg IV daily after test dose of 1mg.** Review therapy when sensitivities available. Step-down to PO **fluconazole** 400mg daily after 10 days of IV if species is susceptible, patient tolerates PO and patient is stable.		14 days following first negative blood culture Duration is longer if deep seated infection	Requires line removal – send tip for culture Repeat blood cultures daily to confirm clearance of candidaemia. Consider full ophthalmic assessment and echocardiography. If deep seated infection (e.g. Endocarditis, CNS involvement, Osteomyelitis, complicated UTI) identified consult Microbiology/ID for further advice

Echinocandin options: **Anidulafungin 200mg loading dose day 1, then 100mg OD via IV infusion or **Caspofungin** 70mg loading dose day 1, then 50mg OD via IV infusion (adjust dose if patient>80kg or hepatic impairment-see BNF for further details) or **Micafungin** 100mg OD (can be increased to 200mg daily if inadequate response) Adjust dose if patient < 40 kg – see BNF

*** See MHRA advice for restrictions and precautions for using fluoroquinolone antibiotics due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019).

NOTE: All dosing regimens assume normal renal and hepatic function

Notes from Guidelines

* Steroids improve the outcome in pneumococcal meningitis. It can be difficult to differentiate pneumococcal meningitis from other types of meningitis, but steroids should be given when pneumococcal meningitis is suspected, for example if a patient reports recent ear infection, in people older than 65, and in people with underlying health problems. The dose of dexamethasone is 0.15 mg/kg to a maximum dose of 10 mg, four times daily for 4 days. Steroids should be continued if there is frankly purulent CSF with Gram-positive cocci on Gram stain or if pneumococcal infection is confirmed.

Steroids may be discontinued if the CSF is not consistent with bacterial meningitis i.e. CSF is not purulent, the white cell count is < 1000 white cells, CSF protein is <1gm/L. Steroids should also be stopped if another pathogen other than pneumococcus is found.
Steroids are contra-indicated if the patient is immunosuppressed. Steroids should not be given if there has been recent neurosurgery.

Use of Guidelines

Empirical guidelines are a generic indicator of good practice which are based on a Northern Ireland Regional Framework and have been modified by Trusts to meet local conditions.

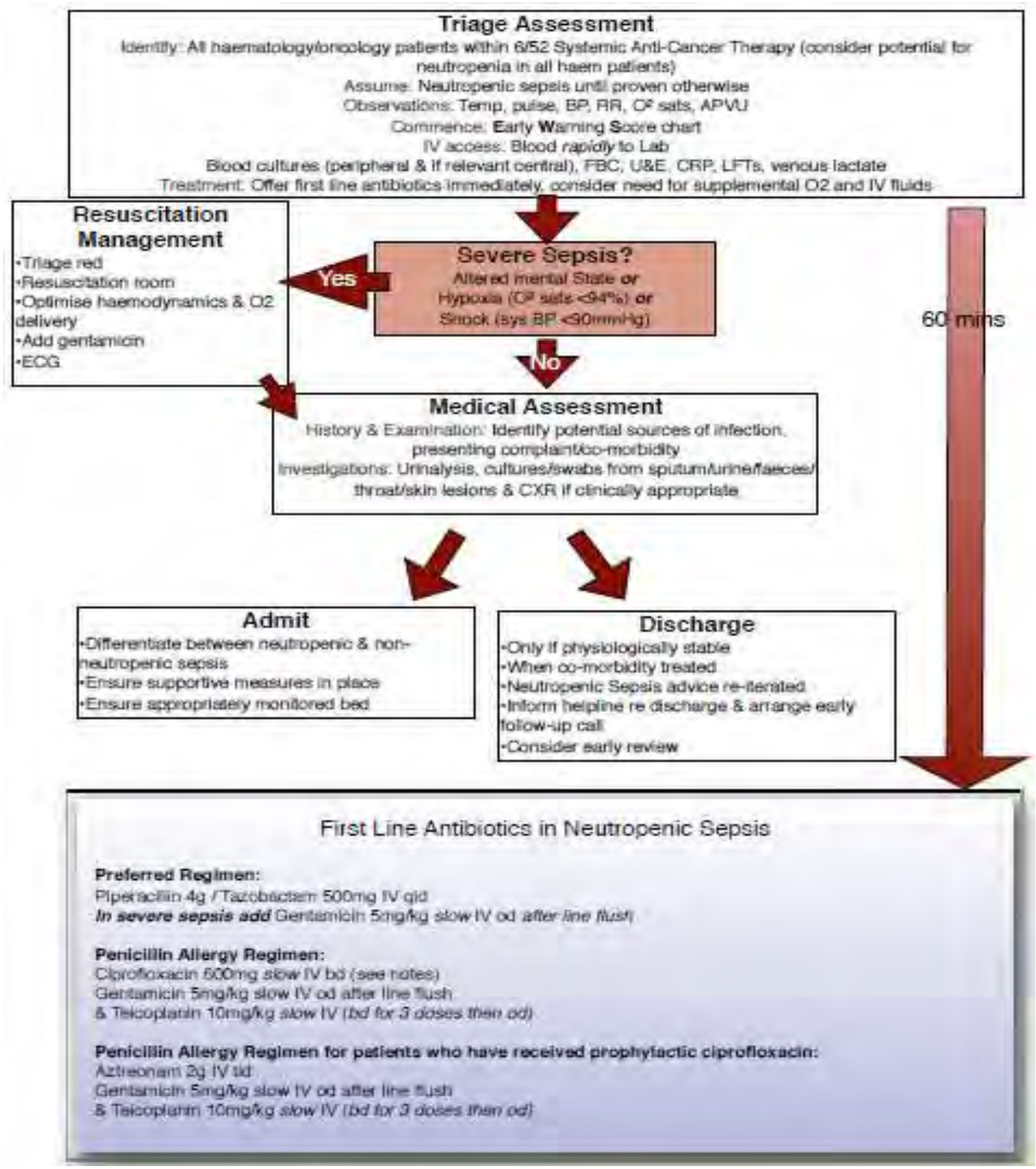
Treatment should be reviewed once sensitivities are known. If no bacterium is cultured the antibacterial can be continued or stopped on clinical grounds.

All senior clinicians are advised to note the contents of antimicrobial guidance. Whilst the guidelines are not intended to restrict the clinical judgement of senior medical staff, it is requested that they specify the reasons for making a choice outside the guidelines in patients' notes.

All antibiotic guidelines and policies are available on the Trust intranet and the BHSCT MicroGuide® App and web viewer.

Appendix 3a (from management of neutropenic sepsis policy)

Please refer to Guidelines for the management of oncology/haematology adult patients (>18) with neutropenic sepsis
Please click here for full guideline



Appendix 3b (from management of neutropenic sepsis policy)

Please refer to Guidelines for the management of oncology/haematology adult patients (>18) with neutropenic sepsis
Please click here for full guideline

First 24 hours	24-48 hours
Monitoring	
EWSC every 30 minutes until stable; thereafter 4 hourly	EWSC x 4 daily Fever partial response: consider mucositis
Systemic anti-cancer therapy	
Stop systemic anti-cancer therapy & contact the working day for a decision on continuing	treating haematologist/oncologist within one treatment
Antimicrobials	
Clear evidence of a specific focus of infection? Consider liaising with microbiology before altering regimen Consider addition of *Teicoplanin* where: Clinically evident serious soft tissue infection, indwelling catheter infection, or MRSA +ve Ensure therapeutic monitoring & dose adjustment of antimicrobials if relevant	If improving consider switching to oral antibiotics after 48 hours treatment If clinical deterioration consider liaising with microbiology and switching to second line antimicrobials as well as viral and fungal infections Ensure therapeutic monitoring & dose adjustment of antimicrobials if relevant
Fluid & Electrolyte Balance	
Aggressive fluid replacement in dehydration Hourly urine output measurement Replace electrolytes judiciously Early critical care management if deterioration	Maintenance fluids as required Continue to monitor electrolytes daily
Neutropenia	
GCSF should **NOT** be used for the treatment of uncomplicated febrile neutropenia Consider GCSF in patients with a high risk of complications **only** on instruction from a haematology/ oncology consultant/registrar/associate specialist or staff grade High risk features include; *profound neutropenia (<0.1x10⁹/l) expected to be prolonged (>10 days)* *persistent fever despite appropriate antimicrobials* *evidence of invasive fungal infection* *pneumonia* *sepsis syndrome (hypotension & multi-organ dysfunction)* *uncontrolled primary disease* *haemodynamic compromise*	

Second Line Antibiotics in Neutropenic Sepsis
Consider discussion with microbiology
If not allergic to penicillin
Meropenem 1g slow IV tds
& Amikacin 15mg/kg slow IV od
+/- Teicoplanin 10mg/kg slow IV (bd for 3 doses then od) - indications above

Appendix 4a: Management of delayed/chronic prosthetic joint infection (PJI)

Notes - **Guidance below is based on a two-stage operative management**
- **This guideline also applies to management of early/acute PJI in patients requiring a 2-stage surgical approach**

PRE-OPERATIVE STAGE

- Pre-operative investigations should include measurement of inflammatory markers and microbiological sampling (e.g. joint fluid for cell count and culture). Isotope bone scans have limited value and should not be routinely requested.

FIRST STAGE PROCEDURE

- At least **five** intra-operative specimens (using different instruments) for microbiological examination are recommended. (Stop antibiotics ≥2 weeks beforehand).
- Antibiotic-loaded spacer or beads are recommended when a second stage procedure is intended.
- Surgical antibiotic prophylaxis should be withheld until sampling is complete.

FIRST-LINE EMPIRICAL ANTIBIOTIC THERAPY

- **Vancomycin** IV adjusting dose to maintain trough level 10-20mg/L (Please click here for vancomycin policy) **+ Rifampicin** 300-450mg PO 12-hourly (monitor LFTs)
- Typical 6 weeks duration if clinical response appropriate
- Regimen may be modified in light of culture results and/or adverse drug reactions – discuss with Microbiology

ONGOING MANAGEMENT

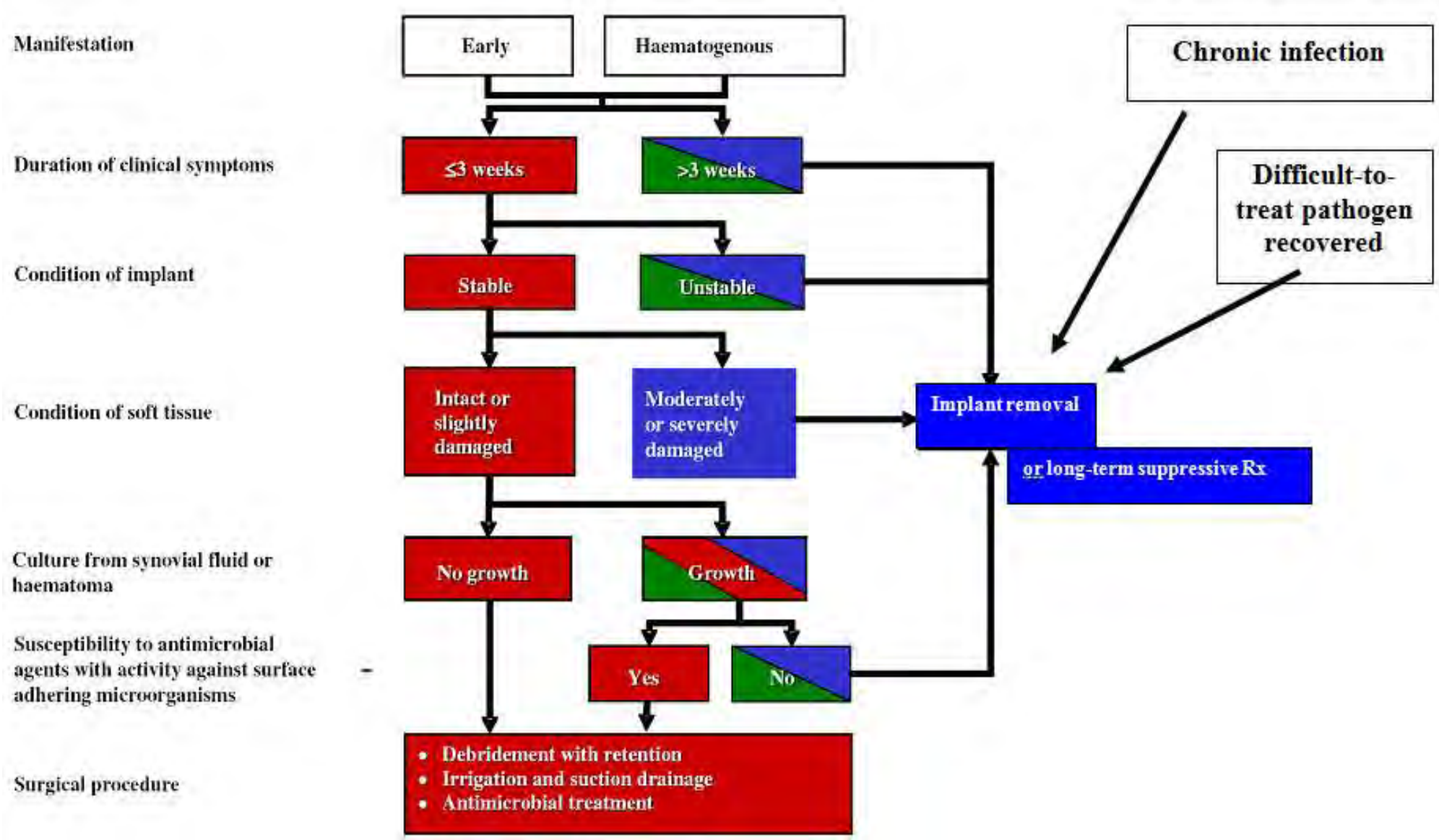
- Strongly consider placing PICC line, at the time of the initial procedure, for intravenous antibiotics.
- Consider outpatient home intravenous antibiotic management if available.
- Monitor twice per week: ESR, CRP, LFT, U&E, Vancomycin trough level[¥]

[¥]May require more frequent monitoring if abnormal or until stable

SECOND STAGE PROCEDURE

- At least 2 weeks following discontinuation of antibiotics
- A further **five** intra-operative specimens (using different instruments) for microbiological examination are suggested. Sample bone/tissue/fragments – avoid swabs
- Restart initial treatment regimen (after sampling complete) for prophylaxis and continue until specimens reported as no microbial growth (currently 5 days)

Appendix 4b: Management of acute prosthetic joint infection with retention of implant



Antimicrobial regimen - acute prosthetic joint infection with retention of implant

The precise regimen is guided by the organism recovered from deep tissue specimens. For the most part, these are likely to be infection with *Staphylococcus aureus* occurring within a few weeks of surgery. In general, the antibiotic regimen is guided by culture results and sensitivity data.
Success of implant retention approach depends on the availability of an antibiotic with good activity against surface-adhering pathogens, therefore this strategy may be contraindicated in the case of some difficult-to-treat organisms.

Preferred regimen for *Staphylococcus aureus* infection* (not MRSA):

- **Flucloxacillin** 2g QDS IV + **Rifampicin**** 300-450mg BD PO **for first 2 weeks**
- **then**: **Levofloxacin** 500mg BD PO + **Rifampicin**** 300-450mg BD PO for remaining duration

* **PLEASE DISCUSS TREATMENT OF OTHER ORGANISMS WITH THE MICROBIOLOGY TEAM**

**Monitor LFTs while receiving rifampicin

Total duration of therapy:

Hip implants: 3 months
Knee implants: 6 months

Appendix 5
Management of central venous catheter (CVC) related infections

A. GENERAL PRINCIPLES

- Discuss all complex cases with Microbiology/Infectious Diseases
- Fever/rigors related to CVC access should be treated as catheter-related bloodstream infection (CRBSI) until proven otherwise
- Send **paired blood cultures** from peripheral vein and CVC
- Diagnosis of CRBSI is supported when central cultures become positive ≥ 2 hours before peripheral cultures
- Send line tip for culture when suspecting CRBSI, not routinely
- Following diagnosis of CRBSI **short and long term** lines should be removed in the setting of:
    - Severe sepsis
    - Haemodynamic instability
    - Any deep/metastatic infection, such as, endocarditis, intravascular hardware infection, suppurative thrombophlebitis, osteomyelitis, tunnel infection, port abscess
    - Persistent positive blood cultures after 72 hours appropriate treatment (this should also prompt investigation of a deep/metastatic source)
    - The causative organisms are any of: *Staphylococcus aureus*, *Pseudomonas aeruginosa*, *Candida* spp.
- Also remove short term lines (<14 days) when infection is due to other difficult to treat organisms (Gram-negative bacilli, enterococci, bacillus, micrococcus, propionibacterium)
- Line salvage using a combination of systemic treatment and line lock therapy may be attempted in some cases, typically when the infection is due to coagulase-negative staphylococci
- Salvaged lines should be cultured 72 hours into appropriate therapy and one week after treatment completion. If positive the line should be removed
- **Note: For patients undergoing haemodialysis refer to 'Dose adjustment in Haemodialysis'**

B. EXIT SITE INFECTION

- Defined as erythema, induration and exudate of line exit site
- Send blood cultures and swab exudate
- If blood cultures positive treat as CRBSI
- Treat with Flucloxacillin 500mg PO 6 hourly or Doxycyline 100mg PO 12 hourly if penicillin allergy or history of MRSA
- Duration 7-10 days

C. TUNNEL INFECTION

(Note: for patients undergoing haemodialysis refer to 'Dose adjustment in Haemodialysis')

- Defined as erythema that extends along the line tunnel
- Send blood cultures
- If blood cultures positive treat as CRBSI
- Treat with **Flucloxacillin** 2 g IV 6 hourly or **Vancomycin** IV if penicillin allergy or history of MRSA (Please click here for vancomycin policy)
- Duration 7-10 days with oral switch when appropriate

D. EMPIRIC THERAPY FOR CRBSI

(Note: for patients undergoing haemodialysis refer to 'Dose adjustment in Haemodialysis')

- **Vancomycin** IV (Please click **here** for vancomycin policy)
- PLUS **Gentamicin** 5mg/kg IV stat then repeat as per levels (see therapeutic drug monitoring)
- PLUS in renal patients with no penicillin allergy **Flucloxacillin** 1g IV 6 hourly

E. ORGANISM DIRECTED THERAPY FOR CRBSI

(Note: for patients undergoing haemodialysis refer to 'Dose adjustment in Haemodialysis')

i. *Staphylococcus aureus* (MSSA)

- Remove line
- Send tip for culture
- Investigate for deep/metastatic infection including echocardiography
- Daily blood cultures until negative
- Minimum treatment 2 weeks from first negative blood culture
- Discuss complex infections with Microbiology/Infectious Diseases
- Treat with **Flucloxacillin** 2g IV 6 hourly or **Vancomycin** IV if penicillin allergy (Please click here for vancomycin policy)

ii. *Staphylococcus aureus* (MRSA)

- Remove line
- Send tip for culture
- Investigate for deep/metastatic infection including echocardiography
- Daily blood cultures until negative
- Minimum treatment 2 weeks from first negative blood culture
- Discuss complex infections with Microbiology/Infectious Diseases
- Treat with **Vancomycin** IV (Please click here for vancomycin policy)
- Commence topical decolonisation therapy and MRSA care pathway

iii. Coagulase negative staphylococci

- *Staphylococcus lugdunensis* should be managed as for *S. aureus*
- Remove short term lines and give 5-7 days **Vancomycin** IV (Please click here for vancomycin policy)
- Send tip for culture
- Line salvage may be attempted in infections related to long term tunnelled lines if there are no other contraindications

- Line salvage requires 14 days **Vancomycin** IV (Please click here for vancomycin policy) in combination with line lock therapy
- To lock a line, instil **Vancomycin** or **Gentamicin** at 10mg/ml to fill the volume of each lumen and retain for 24 hours or until next dialysis
- Salvaged lines should be cultured 72 hours into appropriate therapy and one week after treatment completion. If positive the line should be removed

iv. Gram negative bacilli

- Remove short term lines
- Remove long term lines if no longer required OR severe sepsis, haemodynamic instability, associated deep/metastatic infection, persistently positive blood cultures 72 hours into appropriate therapy or if *Pseudomonas aeruginosa* isolated
- Send tip for culture
- Treat with **Piperacillin-tazobactam** 4.5g IV 8 hourly or **Ciprofloxacin** 400mg IV 12 hourly if penicillin allergy
- Review antibiotic choice when final ID and sensitivities available
- Duration 10-14 days

v. *Candida* spp.

- Remove line
- Send tip for culture
- Investigate for deep/metastatic infection including echocardiography
- Full ophthalmic assessment within 1 week to exclude endophthalmitis (for neutropenic patients await neutrophil recovery)
- Daily blood cultures until negative
- Minimum treatment 2 weeks from first negative blood culture
- Discuss complex infections with Microbiology/Infectious Diseases
- Treat with **Anidulafungin** 200mg IV on the first day then 100mg 24 hourly or **Micafungin** 100mg IV 24 hourly (if >40kg; caution in hepatic impairment)
- If Anidulafungin/Micafungin intolerant use **AmBisome®** (3mg/kg/day)
- If sensitive, switch to **Fluconazole** 400mg/day after 5-7 days in stable patients with negative blood cultures

Appendix 6: DOSE ADJUSTMENT IN HAEMODIALYSIS

Drug	Dose	Comments	Is drug removed by dialysis?
Vancomycin	1g IV 48-96 hourly	Re-dose when trough <15 (aim trough 15-20)	No
Teicoplanin	10mg/kg IV loading dose then 200-400mg 48-72 hourly	Aim trough 25-60	No
Gentamicin	2mg/kg IV 48-72 hourly post dialysis	Aim tough <2 and one hour peak <10	Yes
Flucloxacillin	1g IV 6 hourly	Reference BNF	No
Anidulafungin	200mg IV on the first day then 100mg 24 hourly	No dose adjustment	No
Micafungin	100mg IV 24 hourly (if >40kg; caution in hepatic impairment)	No dose adjustment	No
AmBisome®	3mg/kg/day	No dose adjustment	No
Fluconazole	200mg PO 24 hourly	Post-dialysis on dialysis days	Yes
Piperacillin-tazobactam	4.5g IV 12 hourly	Reference BNF	Yes
Ciprofloxacin	400mg IV 24 hourly or 500mg PO 12 hourly	Reference BNF	No
Doxycycline	100mg PO 12 hourly	No dose adjustment	No

Appendix 7: Antibiotic guidelines for diabetic foot infection

- Antibiotic therapy is to treat infection, **NOT** to heal ulcers.
- Mild infections should be swabbed only if pus is present or initial treatment failure.
- Samples for microbiology should be obtained from all ulcers **PRIOR** to initiation of antibiotic therapy.
- Empiric therapy directed at *Pseudomonas aeruginosa* is usually unnecessary except for patients with risk factors for true infection with this organism.

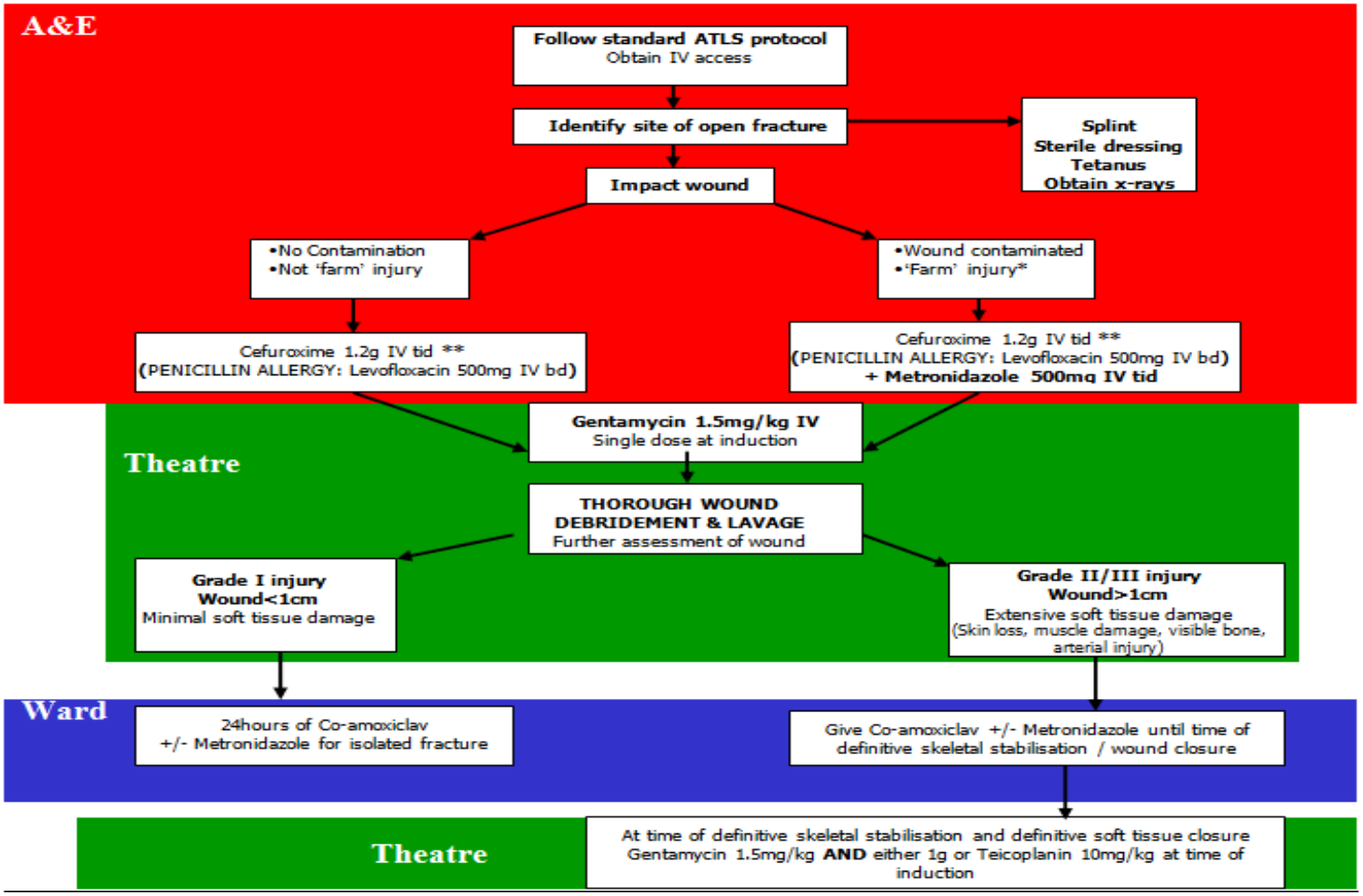
Infection Severity	PREFERRED REGIMEN Review antibiotic once culture results known	ALTERNATIVE REGIMEN Including patients with serious penicillin allergy	MRSA KNOWN CARRIER OR suspected to be pathogen	Duration of therapy & notes
Mild: Inflammation (pain, pus, erythema, warmth, induration); cellulitis <2cm from ulcer; infection limited to skin or superficial tissues	**Flucloxacillin** 500mg - 1g[1] PO four times daily Mild infection may require co-amoxiclav if treated recently (within past 4 weeks) with antibiotics	**Doxycycline** 100mg PO twice daily	**Doxycycline** 100mg PO twice daily	A longer course may be required based on clinical assessment, however skin does take some time to return to normal and full resolution of symptoms at 7 days is not expected. Review the need for continued antibiotics regularly.[2] **Suggested duration: 7 days**
Moderate: as above with no signs of systemic toxicity but infection spreading to deeper tissue (e.g. abscess, osteomyelitis, septic arthritis, fasciitis)and with cellulitis >2cm from the ulcer	**Co-amoxiclav** 625mg PO OR **Co-amoxiclav** 1.2g IV three times daily	**Ciprofloxacin** 500 -750mg PO twice daily[3] **PLUS** **Clindamycin** 450mg PO four times daily **OR** **Co-trimoxazole** 960mg PO twice daily **PLUS** **Metronidazole** 400mg PO three times a day **<u>If IV antibiotics are indicated:</u>** **Ciprofloxacin** 400mg IV twice daily **PLUS** **Clindamycin** IV 900mg IV three times daily	**Teicoplanin** 10mg/kg 12 hrly for 5 doses and then 10 mg/kg daily (monitor levels as per BHSCT TDM guidelines) **PLUS** **Co-amoxiclav** 625mg PO or 1.2g IV three times daily **<u>Alternative if penicillin allergic:</u>** **Teicoplanin** 10mg/kg 12 hourly for 5 doses and then 10 mg/kg daily (monitor levels as per BHSCT TDM guidelines) **PLUS** **Ciprofloxacin** 500-750mg PO twice daily[3] **PLUS** **Metronidazole** 400mg three times daily PO	Review at 48hrs with microbiology results and target antibiotic therapy appropriately. **Vancomycin** can be used instead of **Teicoplanin** when access to or prompt levels are required. **Suggested duration: 2-4 weeks** depending on response. Longer if bone involvement

Infection Severity	PREFERRED REGIMEN Review antibiotic once culture results known	ALTERNATIVE REGIMEN Including patients with serious penicillin allergy	MRSA KNOWN CARRIER OR suspected to be pathogen	Duration of therapy & notes
Severe infection as above with signs of SIRS, as manifested by the presence of ≥2 of the following: • Temperature >38°C or <36°C • Heart rate >90bpm • Respiratory rate >20breaths/min or PaCO2 <32mmHg • White blood cell count >12000 or <4000 cells/µL or ≥10% immature band forms **Or** ***Pseudomonas aeruginosa* confirmed**	**Piperacillin/Tazobactam** 4.5g IV 6 – 8 hourly	**Ciprofloxacin** 600 mg IV twice daily [3] ***plus*** **Clindamycin** 900mg IV three times daily.	**Vancomycin** IV (Please click here for vancomycin policy) Monitor as per BHSCT TDM guidelines. Aim for a trough level of 10-20mg/kg) **PLUS** **Piperacillin/Tazobactam** 4.5g IV 6 – 8 hourly. **Alternative if penicillin allergic:** **Vancomycin** IV (Please click here for vancomycin policy) Monitor as per BHSCT TDM guidelines. Aim for a trough level of 15-20mg/L) **PLUS** **Ciprofloxacin** 600mg IV twice daily[3] **PLUS** **Metronidazole** 500mg IV three times daily	Review at 48hrs with microbiology results and target antibiotic therapy appropriately. **2-4 weeks** depending on response, longer if bone involvement
Suspected Osteomyelitis Bone biopsy recommended for histology and culture, to establish diagnosis, define the pathogens and target antimicrobials	Refer to diabetes foot team and consider discussion with Microbiology /Infectious Diseases on a case by case basis			**4-6weeks minimum** for acute osteomyelitis. Total duration depends on organisms cultured and response to treatment.

1. The dose of 1 g four times a day would be off-license. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented.
2. www.nice.org.uk/guidance/ng19
3. See MHRA advice for restrictions and precautions for using fluoroquinolone antibiotics due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019).

Appendix 8

Management of Patients with Compound Fracture



*'Farm Injury' – Careful history to assess location of injury, contamination risk and subsequent risk of anaerobe infection
High risk examples: Farmyard/field, sewage works.
Contaminants include soil, dirt, faeces etc

**Signs of significant penicillin hypersensitivity include: urticaria, angioedema, brochospasm or anaphylaxis occurring immediately following penicillin administration

Appendix 9

Aminoglycoside antibiotics are typically used in the treatment of Gram-negative infections. They demonstrate concentration-dependent killing and produce prolonged post-antibiotic effects. Therefore, gentamicin requires peaks and troughs for efficacy. The aim of Once Daily Dosing is to achieve a high peak level and a negligible trough level. The drug distribution is primarily in the extracellular fluid, and therefore peak serum levels are lower in sepsis, severe burns, fever, congestive heart failure and peritonitis.

*Once daily infusions give over **30-60 minutes** in 100mL Sodium Chloride 0.9% or Glucose 5%*

THIS PRESCRIBING AIDE NOT APPLY TO	
Endocarditis	Dialysis
Cystic fibrosis	Myasthenia gravis (Gentamicin is contraindicated)
Pregnancy	Serum creatinine >300mmol/L
Ascites	Serum creatinine rise >35mmol/L in last three days
Major burns (> 20%)	

CrCl (mL/min)†	**GENTAMICIN**			**Expected levels-**
>70	5mg/kg	Once daily	Monitor levels	**19-24 hours** after dose **< 1mg/L**
30-70†	3-5 mg/kg	Once daily	Monitor levels	**19-24 hours** after dose **< 1mg/L**††
<30			***Seek specialist advice***	

†Use Cockcroft & Gault CrCl as an estimate of renal function NOT eGFR. http://belweb04.belfasttrust.local/bnf/bnf/current/index.htm

Aim to take the level as close **to 23 hours after the dose was given and during office hours if possible**

***For example** prescribe at (6pm)1800- Sample should be taken next day between 3pm-5pm*

††**Expected levels- 19-24 hours** after dose **< 1mg/L**

- †If the patient has reduced renal function this level may take longer to fall to <1mg/mL-
- If level is higher than expected; hold next dose & re-check level after a further 12-24 hours. Contact pharmacy or microbiology if further advice is required.
- Gentamicin distributes poorly into adipose tissue therefore **modify dose** in people who are **significantly under or over weight**- use adjusted body weight
- Dose requirements will change **if renal function alters – monitor serum creatinine daily**
- **Review daily**. Seek advice from microbiology if gentamicin is required empirically **for >48-72 hours**.
- **Stop after a maximum of 5 – 7 days** unless there is a clear need for prolonged therapy

If the actual body weight is greater than 120% of the calculated IBW, calculate the adjusted body weight (ABW)

- **Ideal Body Weight (IBW):** Males: IBW = 50 kg + 2.3 kg for each inch over 5 feet. Females: IBW = 45.5 kg + 2.3 kg for each inch over 5 feet
- **Adjusted Body Weight (ABW):** ABW = IBW + 0.4 (actual weight - IBW)

Cockcroft and Gault calculation for CrCl:

$$\text{Creatinine Clearance (mL/min)} = \frac{(140 - \text{Age}) \times \text{Body Weight (kg)}}{\text{Serum Creatinine (micromoles/L)}} \times F \qquad F = \begin{matrix} 1.04 \text{ females} \\ 1.23 \text{ males} \end{matrix}$$

Appendix 10

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Management of Adult *Clostridium difficile* Infection (CDI)

Discontinue concomitant antibiotics as soon as possible.
Stop proton pump inhibitor (PPI) treatment if it is not necessary

NON severe CDI
Temperature <38°; WBC <15x10^9/L and
Creatinine <130µmol/L

1. PO/NG **Vancomycin** 125mg four times a day for 10 days (IV formulation of Vancomycin can be used orally)
2. **If the patient is on antibiotic therapy for other systemic infection and cannot be stopped;**
   PO/NG **Fidaxomicin** 200mg twice daily for 10 days
3. **If the patient is NIL BY MOUTH:**
   Intravenous **metronidazole** 500mg every eight hours for 10 – 14 days

Severe CDI
Fever ≥38°; WBC ≥15 x 10^9/L and
Creatinine ≥130µmol/L

CDI treatment should be started empirically on suspicion

5. PO/NG **Vancomycin** 125mg four times a day for 10 days (IV formulation of Vancomycin can be used orally)
6. **If the patient is on antibiotic therapy for other systemic infection and cannot be stopped;**
   PO/NG **Fidaxomicin** 200mg twice daily for 10 days
7. **If the patient is NIL BY MOUTH**:
   Intra-colonic **Vancomycin** 500mg in 100ml NaCl 0.9% four times daily as retention enema for 10 days
   PLUS
   IV **metronidazole** 500mg three times daily for 10 days

Fulminant CDI
Presence of Hypotension; shock; ileus;
toxic mega-colon; colonic perforation

CDI treatment should be started empirically on suspicion

1. Surgical review is indicated
2. PO/NG **Vancomycin** 500mg four times daily **PLUS** IV **metronidazole** 500mg three times daily for 10 to 14 days
3. **In the presence of ILEUS or the patient is NIL BY MOUTH**:
   intra-colonic **Vancomycin** 500mg in 100ml NaCl 0.9% four times daily as retention enema
   PLUS
   IV **metronidazole** 500mg three times daily for 10 to 14 days
4. In case of no response to the above:
   Call Microbiology and consider Intravenous Immunoglobulins (150 – 400mg/Kg)

Appendix 11: Guidelines for empirical antibiotic treatment of post-neurosurgical infections in hospitalised adults

- This guideline should not replace clinical judgement in individual cases
- Contact microbiology doctor to discuss patients with severe sepsis
- Review antimicrobial treatment with culture results
- All doses assume ideal weight, renal and liver function
- Refer to the BNF for full information on contra-indications, cautions, interactions and side effects
- Check suitability of proposed regimen in pregnancy and breast-feeding
- Always take a detailed allergy history
- Treatment durations will be dependent on clinical, biochemical and radiological response
- Ensure patients on antibiotics are discussed at weekly multidisciplinary microbiology ward round

- **DO NOT** use Ceftriaxone or Ceftazidime for patients who have had a serious life-threatening reaction to a penicillin. (anaphylaxis, angioedema, urticaria or rash occurring immediately after administration of penicillin).

INFECTION SYNDROME / INDICATION	PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENTS
Superficial incisional skin/soft tissue infection: **NO MRSA** Mild: no signs of systemic toxicity, have no uncontrolled co- morbidity. Moderate: either systemically well but with a co-morbidity e.g. morbid obesity, which may complicate or delay resolution of their infection. OR may have a significant systemic upset such as acute confusion, tachycardia, tachypnoea, hypotension or may have unstable co-morbidities that may interfere with a response to therapy. Severe: have sepsis syndrome or severe life threatening infection e.g. necrotising fasciitis.	*Mild:* **Flucloxacillin** 750 mg-1g 6 hourly PO *Moderate- Severe:* **Flucloxacillin** 2g 6 hourly IV *Severe e.g. necrotising fasciitis-* Urgent Micro / ID and Surgery advice	*Mild:* **Doxycycline** 100mg 12 hourly PO *Moderate- Severe:* **Clindamycin** 900mg 8-hourly IV *Severe e.g. necrotising fasciitis-* *Urgent Micro / ID and Surgery advice*	5-7 days depending on severity	Consider drainage/ debridement Send wound swab, pus, tissue, blood for culture
Superficial incisional skin/soft tissue infection: KNOWN MRSA	*Mild:* **Doxycycline** 100mg 12 hourly PO *Moderate- Severe :* **Teicoplanin** IV (refer to teicoplanin policy for doses) OR **Vancomycin** IV (refer to vancomycin policy for doses)		5-7 days depending on severity	Consider drainage/ debridement Send wound swab, pus, tissue, blood for culture
Deep incisional skin/soft tissue infection i.e. involving bone	**Flucloxacillin** 2g 6 hourly IV OR If history of MRSA – **Vancomycin** IV (refer to vancomycin policy for doses)	**Vancomycin** IV (refer to vancomycin policy for doses)	Review with culture results Duration depending on diagnosis	If stable, do not commence antibiotics until samples obtained Debridement essential Send deep tissue, bone biopsy, blood for culture

INFECTION SYNDROME/INDICATION	PREFERRED REGIMEN Review antibiotic therapy once culture results known	ALTERNATIVE REGIMEN Including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
CSF shunt or EVD related infection i.e. ventriculitis	**Vancomycin** IV (refer to vancomycin policy for doses) **AND** **Ceftazidime** 2g 8 hourly IV Consideration should be given to the addition of intrathecal vancomycin	**Vancomycin** IV (refer to vancomycin policy for doses) **AND** **Aztreonam** 2g 6 hourly IV Consideration should be given to the addition of intrathecal vancomycin	Review with culture results	Remove infected hardware Send hardware, blood, CSF for culture If history of multidrug resistant organism e.g. ESBL, or recent cephalosporin treatment, call microbiology to discuss
Post-operative meningitis	**Vancomycin** IV (refer to vancomycin policy for doses) AND **Ceftazidime** 2g 8 hourly IV	**Vancomycin** IV (refer to vancomycin policy for doses) AND **Aztreonam** 2g 6 hourly IV	Review with culture results	Send blood and CSF for culture If history of multidrug resistant organism e.g. ESBL, or recent cephalosporin treatment, discuss with microbiology
Brain abscess/ subdural empyema – no previous neurosurgery	**Ceftriaxone** 2g 12 hourly IV AND **Metronidazole** 500mg 8 hourly IV or 400mg 8 hourly PO If known MRSA, **ADD** **Vancomycin** IV (refer to vancomycin policy for doses)	Discuss with microbiology	Review with culture results Duration depending on source control	Drainage were possible Send pus, blood, CSF for culture If history of multidrug resistant organism e.g. ESBL, or recent cephalosporin treatment, discuss with microbiology

INDECTION SYNDROME/INDICATION	PREFERRED REGIMEN **Review antibiotic therapy once culture results known**	ALTERNATIVE REGIMEN Including patients with serious penicillin allergy	SUGGESTED DURATION	COMMENT
Brain abscess/ subdural empyema – with previous neurosurgery	**Ceftazidime** 2g 8 hourly IV AND **Metronidazole** 500mg 8 hourly IV or 400mg 8 hourly PO AND **Vancomycin** IV (refer to vancomycin policy for doses)	Discuss with microbiology	Review with culture results Duration depending on source control	Drainage were possible Send pus, blood, CSF for culture If history of multidrug resistant organism e.g. ESBL, or recent cephalosporin treatment, discuss with microbiology
Deep brain stimulator infection	**Vancomycin** IV (refer to vancomycin policy for doses) AND **Ceftazidime** 2g 8 hourly IV	Discuss with microbiology	Review with culture results	If stable, NO antibiotics until samples obtained Remove infected hardware Send hardware, blood, CSF (if CNS involvement) for culture

Appendix 12: BHSCT Ear, Nose, Throat & Eye Antimicrobial Guidelines

Condition	Preferred Regimen	Alternative Regimen (e.g. Penicillin Allergy)	Comments
Throat infection, Pharyngitis, Tonsillitis	**Phenoxymethylpenicillin** 500mg 6-hourly PO for 5 days **OR** if severe or impaired swallow: **Benzylpenicillin** 1.2g 6-hourly IV (can be increased to 4-hourly if slow response) **Suggested duration: 5 days**	**Clarithromycin** 500mg 12-hourly PO/IV Route dependent on severity/ability to swallow. (**In pregnancy, Erythromycin** 500mg 6 hourly PO/IV) **Suggested duration: 5 days**	Uncomplicated tonsillitis: avoid antibiotic where possible – 90% of cases will resolve in 7 days without treatment. **Refer to FeverPAIN score to aid in predicting likelihood of Strep throat**
Peritonsillar abscess (Quinsy)	**Benzylpenicillin** 1.2g 6-hourly IV (can be increased to 4 hourly if slow response) **PLUS** **Metronidazole** 500mg 8-hourly IV Oral stepdown: **Phenoxymethylpenicillin** 500mg 6-hourly PO **Suggested duration: 10 days**	**Clarithromycin** 500mg 12-hourly IV **PLUS** **Metronidazole** 500mg 8-hourly IV Oral stepdown: **Clarithromycin** 500mg 12-hourly PO (**In pregnancy, Erythromycin** 250mg-500mg 6 hourly PO) **Suggestion duration: 10 days**	If following drainage and no improvement after 36-48 hours, switch to **Co-amoxiclav** 1.2g 8-hourly IV +/- **metronidazole** Needle aspiration or incisional drainage should be attempted at presentation. In immunocompromised patients or recurrent infections, send pus for gram stain and culture
Deep Neck Space Infection	**Ceftriaxone** 2g OD IV **PLUS** **Metronidazole** 500mg 8-hourly IV	**Teicoplanin** 10mg/kg 12-hourly IV x **5 loading doses**, then 10mg/kg 24-hourly IV (See Teicoplanin TDM guidance)	Send sample of pus/tissue from drainage for Gram stain and culture.

	If known MRSA, add **Teicoplanin** 10mg/kg 12-hourly IV x **5 loading doses**, then 10mg/kg 24-hourly IV (See Teicoplanin TDM guidance) **Suggested duration:** 10 days – 6 weeks depending on success of drainage. Discuss with microbiologist.	**PLUS Ciprofloxacin** 400mg 12-hourly IV **PLUS Metronidazole** 500mg 8-hourly IV **Suggested duration:** 10 days – 6 weeks depending on success of drainage. Discuss with microbiologist.	
Supraglottitis	**Ceftriaxone** 2g 12-hourly IV for 48 hours then re-assess. **If suitable for IV to PO switch:** **Co-amoxiclav** 625mg PO TDS **Suggested <u>total</u> duration (IV + PO):** 5 days	**Teicoplanin** 10mg/kg 12-hourly IV x **5 loading doses**, then 10mg/kg 24-hourly IV (See Teicoplanin TDM guidance) **PLUS Ciprofloxacin** 400mg 12-hourly IV **If suitable for IV to PO switch:** **Clarithromycin** 500mg PO BD (**In pregnancy, Erythromycin** 250mg-500mg 6 hourly PO) **Suggested <u>total</u> duration (IV + PO):** 5 days	Once airway secure, take and send blood cultures. Protocol should include: • 0_2 by facemask • 5mls of nebulised 1:1,000 adrenaline • IV dexamethasone 6.6mg • IV ceftriaxone 2g (after obtaining blood cultures
Otitis Externa	**1st line** **Gentamicin 0.3% and Hydrocortisone acetate 1% ear drops:** 2-4 drops 3-4 times daily **OR non-ototoxic regimen: Ciprofloxacin** ear drops +/-steroid ear drops twice daily **2nd line:**	**For mild infections where antibiotics may not be required:** **Hydrocortisone acetate 1% ear drops** 2-4 drops 3-4 times daily **Suggested duration:** 7 days	**Refer to an emergency ENT clinic if:** - persistent discharge or pain - diagnostic doubt - immunocompromised patient - poorly controlled diabetic patient - risk of malignant otitis externa - patient does not respond to 2nd line treatment option.

	Otomize® Ear Spray (Neomycin sulfate 0.5%/Dexamethasone 0.1%/Glacial Acetic Acid 2.0%): 1 spray 8-hourly **OR** **Betnesol-N®** (Neomycin 0.5% and Betamethasone 0.1%) 2-3 drops 3-4 times daily **Suggested duration:** 7 days **N.B.** All of these drops are potentially ototoxic and should not be used >10 days. Care should be taken if patient has had recent dose of any aminoglycoside drops in the preceding month, as dose is cumulative in the inner ear.		**N.B.** Patient's ear should be swabbed **before** treatment in severe or recurrent/chronic infections and is essential prior to initiating a 2nd line treatment. **For SEVERE and/or SPREADING infections , consider:** **Flucloxacillin** 1g PO QDS **OR** if penicillin allergic **Clarithromycin** 500mg PO BD
(Necrotising) Otitis Externa	**Ceftazidime** 2g 8-hourly IV **AND** **Ciprofloxacin** 600mg 12-hourly IV **Suggested duration:** 6 weeks Option for **Ciprofloxacin** 750mg 12-hourly PO stepdown at 3 weeks if no radiological evidence of NOE	**Ciprofloxacin** 600mg 12-hourly IV **Suggested duration:** 6 weeks Option for **Ciprofloxacin** 750mg 12-hourly oral stepdown at 3 weeks if no radiological evidence of NOE	This is a regionally agreed protocol developed with ID and Micro based on European guidelines. If shared care agreed between ENT and ID, patient may be discharged to complete course of 13.5g/day infusion of **Piperacillin-tazobactam at home.** **(Please discuss availability with specialist OPAT pharmacist).** **PLUS**

			Ciprofloxacin 600mg IV 12-hourly **OR** **ciprofloxacin** 750mg 12 hourly PO **Suggested duration:** 6 weeks
Otitis Media	**If symptoms are:** **a) <u>MILD</u>: consider analgesia only** **b) <u>MODERATE</u> with an intact ear drum:** **Co-amoxiclav** 625mg 8-hourly PO **Suggested duration:** 5-7 days **c) <u>MODERATE AND</u> a perforation evident or copious discharge suggesting unseen perforation:** **Gentamicin 0.3% and Hydrocortisone acetate 1% ear drops:** 2-4 drops 3-4 times daily **OR** **Otomize® Ear Spray (Neomycin sulfate 0.5%/Dexamethasone 0.1%/Glacial Acetic Acid 2.0%):** 1 spray 8-hourly **OR** **Betnesol-N® (Neomycin 0.5% and Betamethasone 0.1%):** 2-3 drops 3-4 times daily **Please note: Topical agents are interchangeable with respect to efficacy.**	**Clarithromycin** 500mg 12-hourly PO **Suggested duration:** 5-7 days (**In pregnancy, Erythromycin** 250mg-500mg 6 hourly PO)	Acute otitis media (AOM) resolves in 60% cases in 24 hours without antibiotics, which only reduce pain at 2 days and do not prevent deafness. Consider antibiotics if bulging membrane and marked multiple symptoms or otorrhoea. Recurrent: Considered as ≥3 episodes in 6 months or ≥5 episodes in 12 months.

	N.B. All of these drops are potentially ototoxic and should not be used >10 days. Care should be taken if patient has had recent dose of any aminoglycoside drops in the preceding month, as dose is cumulative in the inner ear. **d) SEVERE: ADD Co-amoxiclav 625mg 8-hourly PO to MILD regimen** **Suggested duration:** 5-7 days **2nd LINE OR non-ototoxic regimen:** **Ciprofloxacin ear drops +/-steroid ear drops**		
Acute mastoiditis (First episode)	**Ceftriaxone** 2g 12-hourly IV Send pus/tissue for Gram stain and culture **Once culture results known, review and consider (if appropriate):** **Co-Amoxiclav** 1.2g 8-hourly IV Consider step down to oral antibiotics 48-72 hours **Suggested duration:** 10-14 days	**Teicoplanin** 10mg/kg 12-hourly IV x **5 loading doses**, then 10mg/kg 24-hourly IV (See Teicoplanin TDM guidance) **PLUS** **Ciprofloxacin** 400mg 12-hourly IV Consider step down to oral antibiotics 48-72 hours **Suggested duration:** 10-14 days	Assess for cranial involvement. If suspicion, discuss with microbiology.

Acute mastoiditis (history of recurrent otitis media)	**Ceftriaxone** 2g 12-hourly IV Send pus/tissue for Gram stain and culture **Once culture results known, review and consider (if appropriate):** **Piperacillin-tazobactam** 4.5g 8-hourly IV Consider step down to oral antibiotics 48-72 hours **Suggested duration:** 10-14 days	**Teicoplanin** 10mg/kg 12-hourly IV x **5 loading doses**, then 10mg/kg 24-hourly IV (See Teicoplanin TDM guidance) **PLUS** **Ciprofloxacin** 600mg 12-hourly IV **PLUS** **Metronidazole** 500mg 8-hourly IV Consider step down to oral antibiotics 48-72 hours **Suggested duration:** 10-14 days	For patients with a history of recurrent otitis media (last episode within 6 months) or recent broad-spectrum antibiotics. Review recent bacteriology. Assess for cranial involvement, if suspicion, discuss with microbiology
Acute Sinusitis	**Amoxicillin** 1g 8-hourly PO **In patients more systemically unwell:** e.g., signs of a more serious illness, high risk of complications and/or worsening symptoms despite treatment with 1st choice for 2-3 days: **Co-amoxiclav** 1000mg/125mg 8-hourly PO **N.B.** the above dose is achieved by prescribing **amoxicillin** 500mg **in conjunction** with 625mg **co-amoxiclav**. **Suggested duration:** 5 days	**Doxycycline** 200mg loading dose on first day. Then, 100mg BD PO **OR** **Clarithromycin** 500mg 12-hourly PO (**In pregnancy, Erythromycin** 250mg-500mg 6 hourly PO) **Suggested duration:** 5 days	Only prescribe an antibiotic immediately if patient is systemically very unwell or has signs and symptoms of a more serious illness or condition, or has high risk of complications.
Acute Parotitis	**Flucloxacillin** 1g 6-hourly PO	**Doxycycline** 100mg 12-hourly PO	

	PLUS **Metronidazole** 400mg 8-hourly PO **If known MRSA:** **Doxycycline** 100mg 12-hourly PO **PLUS** **Metronidazole** 400mg 8-hourly PO **Suggested duration:** 10-14 days	**PLUS** **Metronidazole** 400mg 8-hourly PO **Suggested duration:** 10-14 days	
Pre-orbital Cellulitis	**Outpatient Pathway** If mild lid oedema only +/-mild temperature. **Co-amoxiclav** 625mg 8-hourly PO **Suggested total duration:** 7 days	**Clindamycin** 450mg 6-hourly PO **Suggested total duration:** 7 days	If proptosis and impairment of ocular mobility present treat as orbital cellulitis.
Orbital Cellulitis	**Ceftriaxone** 2g 12-hourly IV **PLUS** **Metronidazole** 500mg 8-hourly IV **+/-** **Vancomycin** (see dosing regimen on BHSCT Microguide® or via BHSCT Intranet) if suspicion of MRSA and/or severely unwell ADULT protocol devised in conjunction with ophthalmology and microbiology.	**Vancomycin** (see dosing regimen on BHSCT Microguide® or via BHSCT Intranet) **PLUS** **Ciprofloxacin** 400mg 12-hourly IV **PLUS** **Metronidazole** 500mg 8-hourly IV ADULT protocol devised in conjunction with ophthalmology and microbiology. **Suggested duration:** IV for minimum of 48-72 hours	**Emergency:** **Patient to remain fasting until CT & ENT review as surgery may be required. Also:** • Obtain IV access • FBP, U&E, CRP, blood cultures • Immediate 1st dose IV antibiotics

	Suggested duration: IV for minimum of 48-72 hours Change to oral for 5-7 days	Change to oral for 5-7 days	• Urgent CT scan with contrast (orbit and sinuses) • Urgent Ophthalmology review • ENT review • If intracranial involvement Neurosurgery review

Individual advice

MAHI - STM - 105 - 1566

Contact numbers

BT18-1923

Belfast Health and Social Care Trust
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General foot care advice

Podiatry Service

Skin care

- Wash your feet daily with mild soap and warm water
- Gently dry your feet especially between the toes
- If your skin is dry, apply a moisturising cream. Do not put cream in between your toes
- A pumice stone or foot file may be helpful for gentle filing of areas of hard skin
- ‘Over the counter’ corn and callous preparations commonly contain an acid and are not recommended.

Nail care

To prevent nail problems arising, toenails should be kept trimmed and neat at least once a week.

- Cut /file your toenails after a bath, as the nails are softer and easier to manage
- Cut /file your nails straight across or with the shape of the end of the toe
- Do not cut down the sides of your nails or cut them too short
- A relative, friend or carer my be willing to help you manage your nail care.

Footwear

A common cause of foot problems is inappropriate or poorly fitting footwear.

When choosing footwear consider:

- Shoes should fit correctly, providing adequate support, be held securely by laces, velcro or a buckle
- Ideally shoes should have a rounded and deep toe-box with a low wide heel, and well fitting heel cup
- Avoid pressure from seams.

First Aid advice

- Cuts or breaks in the skin should be gently cleansed with warm salted water and covered with a sterile plaster
- If minor foot injuries do not respond to home treatment within a few days or if you have developed signs of an infection in your foot such as:

  - pain/ throbbing

  - increased redness

  - inflammation

  - swelling

  - pus

Then please seek a referral from your GP or self referral via Belfast call management.

North and West Belfast Area

028 9063 5300

South and East Belfast Area

028 9056 5565

Belfast Health and Social Care Trust
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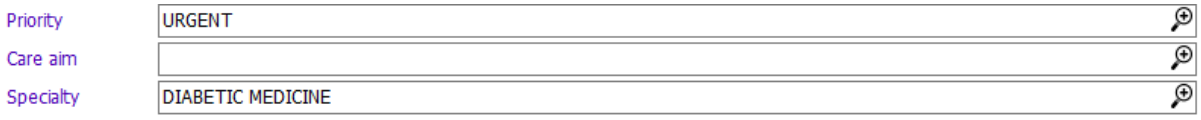
Document Title	**Standard Operating Procedure (SOP) for a Podiatrist - completing a nail surgery assessment**	Document number	
Version Number	**1**	Effective Date	
Version Date	**30/10/2022**	Page	**1**

This document is to provide guidance for Podiatrist when they are completing a nail surgery Assessment at clinic

If patient DNA's 1st clinic apt – discharge from service and advise Admin in appointment note section of scheduler to send 1st patient DNA discharge letter

If patient has diabetes and this has not been detailed on referral – go back into referral and insert Diabetic medicine into the speciality drop down box (Shown below)



CLINIC/DOM:

Nail surgery assessment apt:

- Ensure all patient information is correct (Name, address and telephone number)
- Accept and allocate patient to appropriate clinic (Remember 1st apt at clinic may be at any location – allocate patient to clinic they can attend).
- Complete all assessment as outlined in "Brilliant at the basics" click on link below https://bhsct.sharepoint.com/:f:/r/sites/GRP-communitypodiatry-ClinicalGovernanceChannel2/Shared%20Documents/Clinical%20Governance%20Channel/Clinical%20Risk%20Management/Brilliant%20at%20the%20Basics?csf=1&web=1&e=lyDTOm
- Complete Nail surgery tab on PARIS assessment
- Review all patient medical history/medications/allergies on NIECR.
- Allocate risk based on assessment outcomes.
- Remember all patients who are Low risk or above must be huddled in the wound clinic to discuss suitability for nail surgery.
- Issue with nail surgery leaflet
- If Diabetic issue with appropriate risk leaflet.

RISK and nail surgery procedure:

No risk: Book for nail surgery directly

No risk with infection: clinical decision making required regarding antibiotics and if review appointment is required prior to nail surgery procedure.

Low risk, low risk with pathology, Moderate or high risk:

Book provisional appointment for nail surgery

All patients must be discussed in a huddle prior to nail surgery procedure. Book into wound clinic for patient to be huddled.

Patient must be made aware that a discussion will be undertaken with other colleagues/GP or consultant to discuss their suitability

If referred by GP – complete all GP letters at end of assessment appointment

If patient has diabetes – complete and send GP annual review

Podiatry Mandatory Training Requirements

Name _____

Subject	How Often	Who	How	Contact	Date of completion
Adverse Incident reporting	One off	All staff	Trust Hub E Learning	Trust E Learning	
Anaphylaxis	Annual	All Staff	HSC E Learning	www.hsclearning.com	
ANTT	Every 2 years	All Staff	Podiatry Trained assessor	Trained Podiatry ANTT Assessors	
Attendance Management	Once	Specific staff	HRTPS Learning portal	HRTPS Ciaran McDonald	
Adult Basic Life Support	Annual	All Staff	HSC E Learning on successful completion please book face to face via HRPTS	www.hsclearning.com	
Child Safeguarding	Every 2 years	All staff	Virtual training	https://cec.hscni.net	
Complaints management	One off	All staff	Online training Click link to complete	http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Pages/Complaints/Complaints-Training.aspx	
Corporate Welcome	One off	All Staff	1ST day of new appointment	HR & Line Manager	
COSHH awareness	Every 3 years	All staff	E Learning Trust Hub	Trust E Learning	
Data Protection 2019 (GDPR) Awareness	Every 3 years	All Staff	E Learning Trust Hub	Trust E Learning	
Display Screen Equipment Awareness	Once	All staff	HSC E Learning	www.hsclearning.com	
Equality, good relations and human rights	5 yearly	All staff	HSC E learning	www.hsclearning.com	
Fire Safety	Annual	All Staff	HRPTS MS team training event	HRPTS Fire Safety Awareness via MS Teams	

Health and safety Awareness	Once	All staff	E Learning Trust Hub	Trust E Learning	
Health Surveillance	Annual	All staff	Trust MS Teams form	Form will be sent individually to each staff member to complete	
HIV awareness	One off	All staff	HRTPS Learning portal	HRTPS Learning portal	
Infection control for clinical staff	Every 2 years	All Staff	E Learning Trust Hub	Trust E Learning	
IRMER Training	Every 3 years	Specific staff	Trust Hub E Learning	Trust E Learning	
Local Induction	One off	All staff	Provided on appointment	Line Manager	
Management of Aggression	Every 2 years	All Staff	HRTPS Learning portal	Contact Eileen Tiffney	
Manual Handling Awareness	Every 2 years	All Staff	E Learning Trust Hub Poster_Moving&Handling_InstructionalVid	This will take you automatically to HSC learning site	
Mental Capacity Training Deprivation of Liberty	Every 2 years	All staff Podiatrist level 3	HSC Learning	http://mca-learning.health-ni.gov.uk/level3/	
Medical Devices	Every 3 years	All Staff	E Learning Trust Hub	Trust E Learning	
Prevention of Pressure Ulceration Adults	Every 2 years	All staff	E Learning Trust Hub	Trust E Learning	
Recruitment and Selection	Every 3 years	Specific staff	HSC E Learning	www.hsclearning.com	
Vulnerable Adults safeguarding	Every 2 years	All Staff	Virtual training	https://cec.hscni.net/	
Supervision	One off	All staff	HSC E Learning	www.hsclearning.com	