Appendix 5

Specific considerations and adaptations to the standards for services supporting people who have eating disorders

Type of service

Services managing Eating Disorders provide support to individuals with a range of different mental health disorders that involve disordered eating behaviour. These behaviours can include restriction of dietary intake, binging, purging (including vomiting and laxative misuse) and excessive exercise, or a combination of any of these.

Eating difficulties may relate to differing psychopathology and therefore accurate diagnosis and formulation is essential. The primary motivation for dietary restriction could relate to sensory sensitivities, such as to food textures in Avoidant/Restrictive Food Intake Disorder (ARFID), or a desire to self-punish in patients with emotional dysregulation and histories of trauma, rather than the fear of fatness and body image disturbance more typically seen in Anorexia Nervosa. Such patients may be particularly prone to escalations in risk (and subsequent restrictive interventions) if submitted to compulsory treatment programmes that do not understand and take account of the underlying causes of their eating difficulties.

Refeeding may include enteral feeding such as naso-gastric (NG) tube or Percutaneous Endoscopic Gastrostomy (PEG) feeding and may need to be completed with the use of physical interventions in the most complex cases.

Eating Disorders are often associated with low weight and can cause serious physical health issues including reduced bone density, low energy levels, and cessation of menstruation, all of which can impact on the functioning of internal organs such as the heart. Inpatient treatment is often needed for patients with significant weight loss, chronic or complex conditions and a large part of treatment focuses on controlled refeeding. This will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques.

Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working with eating disorders. This will help to link clinical practice with training.

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions / physical restraint techniques authorised in recognition of under-developed anatomy / physiology and the difficulties in managing physical position to refeed safely. Supportive measures such as using pillows, beanbags or specialist feeding chairs are common practice and are to be encouraged in making a patient as comfortable as possible in the circumstances. Restrictive measures such as neck braces, soft cuffs or leg restraints are not acceptable practice and should be avoided.
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with individuals in psychological and emotional distress, in particular around complex NG restraint feeds that may have involved several members of staff.

Appendix 22

Specific considerations for training temporary / flexible / agency staff

Type of service

All staff who are likely to use restrictive interventions must have training that is certified as complying with the RRN training standards − this includes temporary staff, staff employed through an external agency and floating or bank staff.

It is never desirable to employ temporary staff to provide support to vulnerable people whose distress may present as behaviour that challenges and which may require staff as a last resort to use restrictive interventions. The practice has been associated with increased risk.

Where this absolutely cannot be avoided it is the responsibility of the service provider to ensure all staff working in their services have appropriate and up to date training that is certified against the standards and is appropriate for the service they are asked to work in. There should be a procurement contract in place between the service provider and agency that ensures this is the case as well as a system for monitoring this (for example by inspecting training certificates). Particular care should be taken where staff are moved from service to service to meet need and where they may have undergone more than one training programme in physical interventions as confusion regarding practice may happen with implications for safety.

It is the responsibility of the agency to ensure any temporary staff sent to work in a service have had the appropriate certified training and experience for that population and setting.

It is the responsibility of the agency to request the information needed from their customers (service provider who commissions them) so they can select appropriate workers with the appropriate training and experience for each placement. This will include training that is certified as complying with the training standards where this is required within the service.

In some cases the agency will need to commission training from a certified training provider to meet these requirements. Alternatively, agencies may also be a training provider in which case they will need to have their training certified.

The training must be based on a training needs analysis and section one of the training standards should be referred to and followed for pre delivery arrangements with the training provider.

Agencies will need to have processes in place to:

- Check that each temporary staff member has had certified training, which meets all the standards and includes preventative working
- Check that the training for each temporary staff member is appropriate for the populations that they are being employed to work with (matched to the TNA provided) for each piece of work
- Check that the training is in date and refreshers have been completed satisfactorily for each temporary staff member
- Ensure an appropriate level of supervision and debrief is available for all their staff. Ideally this should be provided by the service provider that commissions the worker but if this has not been provided the agency must take steps to make sure it is available

Service providers that have developed their own certified training or are approved as an affiliate to deliver training in house may deliver training to temporary staff who they have contracted to use.

Where individual temporary staff do not belong to an agency and are commissioned directly by the service, the individual person effectively adopts the role of the agency.

Temporary staff should be made aware that if they do not feel skilled to manage behaviours that challenge, despite any training they have had, they will need to inform the service provider who has commissioned them as soon as possible.

Appendix 23

Specific considerations and adaptions to the training standards related to student nurses and midwives

Type of service or setting

It must be noted that the educational experiences of nursing students and midwives are directed by the educational standards and proficiencies which are produced by the Nursing and Midwifery Council (NMC, 2018). These cover any approved educational programme for nursing and midwifery within the four nations.

Nursing and midwifery students, as part of their educational journey, spend time working in a range of clinical areas where people may present with distress and behaviours of concern.

Regardless of the chosen field of practice, placements for student nurses can include a wide range of Adult, Child, Mental Health and Learning Disability and can require them to operate across health, social care and educational settings.

Placements may include services which operate across the lifespan, ie both children and young people and adults. Similarly, services may provide support in varied settings, including: people's own, or family, homes; registered care homes; acute hospitals (physical healthcare); and specialist mental health and/or learning disability inpatient services. As well as building-based services, placements may well include peripatetic teams such as health visiting teams, community children's teams, community mental health teams (CMHT), district nursing teams and community learning disability teams (CLDT).

With regard to student midwives, their placements are similarly likely to include a range of community, out-patient, acute care and specialist support services.

Students have supernumerary status within clinical placements, ie their role is not that of a paid staff member; it is therefore not expected that they will be involved in undertaking physical restraint. None the less, they witness or participate in other forms of restrictive practice, such as administering 'as required' medications, which may amount to chemical restraint; restricting a disturbed person's access or egress from a building by securing exits/entrances; the use of bed rails to prevent falls, which also restrict a person's wider freedom of movement; or, the application of restrictions, used as a service wide basis (such as restricted access to phones or internet) which could be regarded as 'blanket restrictions' that are coercive in nature and could be construed as amounting to psychological restraint.

In services where indents including violence or aggression, or other forms of disturbance such as self-injury or property destruction occur, students may well be involved in post-incident reporting processes, as well as in supporting post-incident reviews of debriefs.

Students, as part of their educational development, are also highly likely, under the supervision of a registered nurse and in conjunction with wider MDTs, people who use services and their families, to be involved in clinical assessment, and the development and evaluation of care plans which may include the use of reactive management of behaviours of concern. It is essential therefore, that they are supported as part of any induction to a new placement, to understand their roles and any expectations regarding the boundaries of their involvement.

Considerations for training providers when delivering instruction to student nurses/midwives (in addition to NMC requirements, as shown below):

1. Student nurses and midwives may also find themselves in situations where they may experience unwanted physical contact or aggression from which they need to break free. It is therefore appropriate for student nurses to receive instruction in breakaway/disengagement techniques (as defined in S2.7.5 of the *Restraint Reduction Network Training Standards*)
2. Where students may witness the use of restrictive practices/restraint techniques, be that as part of reactive responses to behaviours of concern; or as part of a plan for the routine provision of personal care; or to enable a specific clinical intervention of investigation to be undertaken, in addition to exploring processes for dynamic risk assessment, there should be an emphasis on approaches that can support personalised planning and support
3. Instruction in the use of primary preventative strategies should be prioritised. This should be based on evidence-based models such as Positive Behaviour Support (suitable for all settings) and setting specific programmes such as Safe-wards (mental health services)
4. There should be an exploration as to how support can be optimised by a correct understanding of a person's communication; as well as any routines, activities or objects that a person may find to be supportive. The importance of individualised strategies in reducing distress, restraint and restrictive practices should be emphasised as an essential component of any holistic person-centred support

5. Training must emphasise that person-centred approaches require the optimisation and maintenance of effective communication, including with:
    - Individuals
    - Families
    - Carers
    - Advocates
    - Members of the MDT
    - Other relevant parties who are important to the individual and can assist in communicating their needs and preferences
6. Training should include consideration of generic risk factors which can be encountered in health, social care and education services that a student may access for placement where aspects of conflict resolution may be required, such as managing distressed individuals, breaking bad news. Students should also be directed to seek information concerning service specific risk factors relating to particular placements during any induction to a new practice placement. Responsibility for this lies with the organisation offering the placement, as they have knowledge relating to local risks and likely impacts on student experience
7. Training should include the following wider approaches and mechanisms:
    - Safeguarding
    - Arrangements and processes for raising concerns
    - How to access emotional support/counselling
    - Accurate recording of information/incident reporting
    - Post incident de-briefing

- How and when to access support from:
  - Practice Education Facilitator/Practice Placement Liaison (Titles may vary across areas and countries), including how to access
  - Practice Assessor/Supervisor
  - Academic Assessor

The following considerations regarding training and its associated governance relate to the training of all registered nurses (NMC, 2018):

Nursing Proficiencies:

3.5 Demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals

3.6 Effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

3.7 Understand and apply the principles and processes for making reasonable adjustments

3.8 Understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity

Annexe A:

4.2.3 A calm presence when dealing with conflict

4.2.4 Appropriate and effective confrontation strategies

4.2.5 De-escalation strategies and techniques when dealing with conflict

Annexe B:

1.1 Mental health and wellbeing status
1.1.1 Signs of mental and emotional distress or vulnerability
1.1.2 Cognitive health status and wellbeing
1.1.3 Signs of cognitive distress and impairment
1.1.4 Behavioural distress-based needs
1.1.5 Signs of mental and emotional distress including agitation, aggression and challenging behaviour
1.1.6 Signs of self-harm and/or suicidal ideation

1.2 Physical health
1.2.1 Symptoms and signs of physical ill health
1.2.2 Symptoms and signs of physical distress
1.2.3 Symptoms and signs of deterioration and sepsis

2.12 Undertake, respond to and interpret neurological observations and assessments
2.13 Identify and respond to signs of deterioration and sepsis
2.14 Administer basic mental health first aid
2.15 Administer basic physical first aid
2.16 Recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support
2.17 Recognise and respond to challenging behaviour, providing appropriate safe holding and restraint

https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/nurses/future-nurse-proficiencies.pdf

Midwifery Proficiencies:

6.69 Recognise, assess, plan, and respond to pre-existing and emerging complications and additional care needs for women and new-born infants, collaborating with, consulting and referring to the interdisciplinary and multiagency team as appropriate; this must include:

6.69.1 Pre-existing and emerging physical conditions, and complications of pregnancy, labour, birth, postpartum for the woman and foetus, and complications for the new-born infant, infant feeding challenges, perinatal loss, and maternal illness or death

6.69.2 Physical disability

6.69.3 Learning disability

6.69.4 Psychological circumstances and mental illness including alcohol, drug and substance misuse/withdrawal, previous perinatal loss, stress, depression, anxiety, postpartum psychosis

6.71 Implement first-line emergency management of complications and/or additional care needs for the woman, foetus, and new-born infant when signs of compromise and deterioration or emergencies occur until other help is available; this must include:

6.71.11 Organise safe environment, immediate referral, and appropriate support if acute mental illness, violence or abuse is identified

6.71.5 Communicate concerns to interdisciplinary and/o multiagency colleagues using recognised tools

6.86 Demonstrate effective team management skills when:

6.86.4 De-escalating conflict

https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf

The nursing student and midwifery experience will cover the total lifespan approach; therefore they may come into contact with any population group identified within these standards and need to be aware of any related or associated appendices.

Specific guidance or legislation relating to delivering training in this setting/service:

- Standards Framework for Nursing and Midwifery Education (2019)
- Standards of Proficiency for Registered Nurses (2018)
- Mental Health Legislation and associated “Code of Practice”
- Mental Capacity Legislation and associated “Code of Practice”
- Children and Families Act 2014
- “Three Steps to Positive Practice”, (RCN, 2017)
- Restrictive physical interventions and the clinical holding of children and young people, (RCN, 2019)

Linked Appendices (this is not an exhaustive list)

Consideration must be given to the training needs analysis which must be completed with consideration of the expected students practice placement experiences where population specific appendices may also have clear relevance:

Appendix 14 – Specific considerations and adaptations to the training standards for lone working
Appendix 17 – England
Appendix 18 – Northern Ireland
Appendix 19 – Scotland
Appendix 20 – Wales