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 adults and children 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, laxative misuse, and misuse of Insulin in those with T1 diabetes) 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 adverse consequences of eating (such as fear of choking / vomiting) 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 (which is usually only used in the management of long-term enteral feeding and rarely in eating disorders). These interventions may need to be completed with the use of physical restraint in the most complex cases.

Trainers with specialised knowledge and experience in feeding under restraint need to deliver the training. Ward based trainers may be 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.

Royal College of Psychiatrists (2022) state:

"Occasionally patients may become so distressed that they resist weight gain by any means, and in such cases, NGT feeding under restraint may need to be considered as a life-saving intervention, although it should only be required very rarely…

…The use of NGT feeding under restraint should always be a risk-based decision for each occurrence, carried out as infrequently as possible to follow principles of least restrictive practice and prevent traumatisation of patients and those around them

Dietetic guidelines have been developed on the best practice for delivering enteral nutrition under restraint. The key principles of this guidance include:

- *delivery of feed via push syringe bolus (not gravity bolus or enteral pump)*

- *reducing the number of episodes of feeding to twice a day, and*

- *increasing the volume of the bolus delivered as tolerated up to 1000ml per bolus."*

Specific adaptations to the standards for this setting:

- The assessment of types of restrictive interventions must show how they take account of the possibility of under-developed anatomy/physiology.
- Supportive measures such as using pillows, beanbags or specialist feeding chairs are common practice and are to be encouraged in making a patient as safe and 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 at all times.
- 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. Support should also be offered to the patient and other patients when someone has been fed under restraint on the wards.

References

Royal College of Psychiatrists (2022) *Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (Replacing MARSIPAN and Junior MARSIPAN). College Report CR233.* Available here: https://bit.ly/3EPslEo

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

Restraint Reduction Network

Appendix 24

Specific considerations and adaptions to the training standards for staff who transport mental health patients who also may have learning disabilities and autism

Type of service or setting

Mental health patients in NHS commissioned services are likely to be transported in vehicles for four main reasons:

- transporting people who have absconded
- escorted leave
- transfer between hospitals
- admission

If a person is under the care of an NHS commissioned service, where it can reasonably be foreseen that restrictive interventions may be required, any staff who provide direct support to the person during a journey are required to have training that is certified against these training standards. This training must include preventive training and de-escalation as described in the *Restraint Reduction Network Training Standards* (2.1-2.15)

Who does it apply to?
Any staff involved in transport where a risk assessment indicates there is a likelihood of distress arising that could lead to the use of a restrictive intervention, and they will need to provide direct support.

Employees of private security firms, who are commissioned to transfer people between hospitals on behalf of a service regulated by the CQC must also have certified training.

It would not apply to taxi drivers, where their type of vehicle has been chosen as an appropriate mode of transport because a risk assessment has indicated the person is unlikely to become distressed and the need for escalation techniques and restrictive interventions would be highly unlikely.

Considerations for training providers when delivering training in this setting

Content of training curriculum

1. All staff involved, including the driver, must have preventative training and be competent in person centred de-escalation techniques
2. All staff involved must understand the importance of person centred approaches and what key information they need to know in advance about the person they are transporting
3. Training must ensure there is a focus on the needs of the patient and that speed of the transfer is not the aim (people with lived experience have said that sometimes they feel like a job or package to be delivered)
4. Training must explore what a high quality, safe and calm transfer feels like for a person; and how it can be achieved. Some people may be highly distressed and unwell, therefore the training must cover and explore additional elements that increase the likelihood of people becoming more distressed, for example:

   - If people are not allowed sufficient and reasonable time to be prepared, eg they are woken up during the night

   The training should also cover:

   - how staff can minimise anxiety and distress before people enter a vehicle
   - how, in response to signs of mounting anxiety and distress, escorting staff must / should interact with the person and use personalised de-escalation techniques

- circumstances where risk considerations are such that a vehicle should pull over, in order to support further attempts at de-escalation

5. The use of any restraint must not be standard practice
6. Any restraint techniques that are taught, including physical restraints and mechanical or chemical restraint, must be approved by the commissioning organisation
7. The content of training in restraint techniques for transport staff, must be based on a Training Needs Analysis (standard 1.1, 1.2) and fully meet the *Restraint Reduction Network Training Standards*
8. Any use of restraint must be based on a person centred risk assessment, which established its necessity and proportionality to a legitimate aim; as well as that it is the least intrusive method by which to achieve this aim
9. There should be a full risk and care plan for any journey. The risk and care plan must be established by the commissioning organisation in collaboration with the transport provider and should include provision for toilet / comfort stops and the ongoing wellbeing of the person being transferred. Where there is an identified absconsion risk, plans for any further restrictions should ensure a person's dignity is respected and protected
10. There should always be at least one identified staff member, whose role is to engage with the person, monitor their comfort and assist them at comfort stops
11. Escorting staff should be mindful of the tone and content of any conversations between themselves, which may be overheard by the patient, during the transportation

Specific adaptations to the standards for this setting

The risk assessment that informs the types of restrictive interventions / physical restraint techniques that are authorised for use must recognise the complexities and risks of using restrictive interventions in enclosed and moving vehicles. It is very easy for people to overheat in this environment and it carries an additional risk of all parties being injured by fixtures.

Linked Appendices (this is not an exhaustive list)

Appendix 17 – England
Appendix 18 – Northern Ireland
Appendix 19 – Scotland
Appendix 20 – Wales

Restraint Reduction Network

Appendix
25

Specific considerations for non-physical skills training online

Introduction

The Restraint Reduction Network Training Standards focus on preventing the need for restraint wherever possible. Therefore the standards require two days (12 hours) face to face training in preventative approaches as specified in standards 2.1-2.15 prior to being taught physical skills techniques. The majority of these two days must be face to face. (Standard 1.2.1).

Blended learning options may be offered as an alternative or to complement to the 'face to face' training in preventative approaches

Blended learning approaches cover a wide range of methods of delivery and usually offer a mixture of methods that could consist of:

- Self-directed (generally eLearning or studying other materials on your own at your own pace) − no interaction with a trainer. May include online knowledge assessments, a range of blended learning materials films, reading, etc. Self-directed learning can be paired with online tutorial time with a trainer who can check knowledge and skills and facilitate further exploitation of topic – usually called flipped learning
- Live online webinars / lectures – minimal interaction with the trainer
- Live online classroom session with a trainer – some interaction with a trainer, typically a replication of online training, PowerPoint and activities

- Live online small group discussions that enable the trainer to check all individuals' understanding and values – maximum interaction with a trainer

Training people to use restrictive intervention safely and adopt preventative and least restrictive approaches involves a number of skills and competence requirements as well as evidence that the learner has the appropriate attitude and values. It is the latter that is more challenging to check without being in a room with someone.

This guidance offers best practice principle based on current understanding about the cognitive differences involved in learning online and the impact of being on screen for a good percentage of a working day. It is recognised that further evidence will emerge of the impact of online learning over the next few years and this guidance will be reviewed at regular intervals.

It is important that trainers take this into account and consider the most helpful delivery method for each component of learning. Physical skills will always need to be taught in the classroom.

Principles for practice

It is recognised it may take some time for providers to work towards these principles. These principles for practice should be fully adopted by 2022.

It is recommended that the following ten principles are taken into consideration when developing and delivering online preventative training:

1. Live screen time with a trainer is used thoughtfully and sparingly to minimise screen fatigue
2. Online sessions should not be more than two hours in length including break
3. Learners should not be expected to spend the majority of the day online
4. Materials should adjusted to support a slower learning pace online

5. Group's size and trainer ratio should reflect the activity and topic. Typically contact that needs:

- High interactivity with a trainer / facilitator. This should be a small group of learners (may include self-disclosure and challenging values), one trainer with six learners. This should be should be no less than 33% of the whole programme
- Medium interactivity with trainer. One trainer with maximum of 12 learners – mostly trainer led, some questions / activities to the group. This should be no less than 33% of the whole programme
- Minimum interactivity with trainer, eg Webinar for up to 25 learners with one presenter. This should be no more than 33% of the programme

6. Self-directed learning should be no more than 33% of the programme and could be paired with live tutorials to check understanding (flipped learning) and maximise learning

7. Online eLearning that is fixed, pre-recorded, and linear or computer managed should have a means of basic assessment such as a quiz with a specified pass mark of a recommended 80%

8. Any blended learning preventive content must be taught prior to physical skills and techniques and must be completed not more than two weeks in advance of the physical restraint training and referenced in the training

9. Training providers must be able to evidence that trainers delivering online sessions are competent in online delivery as well as face to face delivery (as different skills sets are needed to deliver online)

10 Training providers must have in place a policy that sets out behaviour and attendance expectations for online learners. Training providers will need to ensure learners and commissioning organisations are aware of the policy and the process for managing non compliance

Appendix
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Specific considerations to support a prevention curriculum (Standard 2.5)

If restrictive interventions are being taught, participants must have completed a minimum of two days' training (12 hours) in the underpinning theory, including training in preventative and secondary strategies, as specified in Standards 2.1–2.15, prior to participating in a practical, physical skills training session.

In some cases, training that covers primary preventative strategies (see Standard 2.5) have been covered on separate training courses, for example, Safewards or Positive Behaviour Support.

A. Training content

With reference to Standard 2.5, primary prevention curriculums should as a minimum cover the following topics.

1. Identification of the biological and psychosocial factors that increase the risk of people becoming distressed are related directly to people's quality of life. These factors are cumulative and include the following:

   - Societal inequalities, socioeconomic disadvantage and recognition of cultural distress due to dominant social norms and culture (examples include dominant neuronormative or white cultures).

- Underlying or undiagnosed, unrecognised and untreated, physical or mental health issues.
- Organic mental health conditions (examples include head injury or dementia, or acute confusional states, due to things like infections, dehydration).
- Sensory differences.
- Medication side effects.
- Poor communication environment.
- Poor physical environments, including inappropriate sensory environments.
- Lack of meaningful activity.
- Lack of control and choice, and involvement in daily life, service design or care planning.
- Lack of social networks.
- Poor rapport / good relationships with carers.
- Institutionalised living environments that include blanket rules and restrictions.
- Use of restrictive practices.
- Poorly organised and / or under skilled support.
- History of trauma and exposure to trauma triggers.
- Family stress.
- Anxiety, fear and other emotional states.

2. How these risks can be identified and people's quality of life and wellbeing can be improved to prevent distress and crisis from occurring.
3. How to understand what someone's distress is communicating about their situation and what areas of need remain unmet.

4. How to identify personal setting conditions and triggers for distress. (Conditions when triggers are more likely to have an impact).
5. How personalised support can be given to people who are likely to become upset or distressed.
6. How power imbalances and staff values, attributions and attitudes can impact on their response to distressed behaviours and use of restrictive interventions.
7. How some behaviours are soothing and prevent people from becoming distressed.
8. The organisational systems that need to be in place in services to support prevention, including explicit commitment to reduce inequalities and restrictive practices.

B. Impact of training

Training must evidence impact on practice and reducing reliance on restrictive practices (for example through the Kirkpatrick model or independent evaluative, or data-based case studies).

Evaluation of training must reflect:

- The experience of the participants' post training. Were learning outcomes met? Was the training enjoyable and of good quality?
- Whether skills, knowledge, and attitudes have changed as a result of the training (pre and post knowledge and skill checks, attitudes survey).
- Whether participants have changed their practice following the training (follow up).
- Whether the organisation has changed its practice (reduction in the use of restrictive practices, incidents etc).