# Benchmark No. 11
# Management of Behaviour and Cognitive Impairment

## British Association of Neuroscience Nurses

# Neuroscience Safe Staffing Benchmark Statements

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## History

The Neuroscience Nursing Benchmarking Group (NNBG) was established in the 1990`s as a result of increasing concerns over inconsistencies in practices as part of a subsidiary of BANN. The group aims to improve on the quality of care by comparing and sharing practice with each other, and set explicit standards for comparison of current practice against the ideal standard. The group is committed to searching for the best evidence related to specific areas of neuroscience practice. Membership of the group consists of representatives from neuroscience units within the UK and Ireland, together with educational colleagues from both the NHS/HSC and Higher Educational Institutes. The group is further subdivided into regions and the first edition of this benchmark was developed by the North West regional group of the NNBG in 2006.

In 2016, the NNBG consolidated back into BANN and further information about NNBG can be found on the BANN website www.BANN.org.uk . This second edition of the benchmark has been developed by the restructured NNBG working group under BANN.

BANN would like to acknowledge the leadership and significant contribution made by the NNBG, and all its contributors, to neuroscience nursing over the years.

## Benchmark No.11 Management of Behaviour and Cognitive Impairment

# KEY POINTS

- Following a full risk assessment an individualised multi-disciplinary care plan must be implemented and evaluated specific to all aspects of care relating to the use of any restrictive interventions.

- If the use of restrictive interventions amounts to a deprivation of liberty, then the relevant referrals must be made under the Deprivation of Liberty Safeguards (MCA, 2005, Mental Capacity (Amendment) Act 2019).

- Accurate documentation includes the clinical need for the physical intervention, the type of intervention employed, the date and time that the intervention was implemented, reviewed and discontinued.

- The least restrictive therapy should be chosen for the shortest period of time.

- The patient must be reassessed at regular intervals or when their health needs change.

- Patients and relatives are included in the decision-making process and on-going management wherever possible. All verbal and written information must be current; evidence based and is documented in the patient's notes.

- Pharmacological interventions are only considered when all other factors have been considered in the management of behaviour and cognitive impairment.

- Documentation must include the drug, the dose the mode of delivery, time frame and potential contra-indications.

- Clinical staff are provided with a structured competency-based training and education programme for the care of the patient.

- The care plan is evidence based, dated and reviewed within the last two years and updated accordingly.

- Best interest meetings with family/carers are clearly documented.

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FACTOR 1 – Documentation

| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 1.0 A full risk assessment of the patient is performed and documented prior to the use of any restrictive interventions. This must include a comprehensive assessment addressing: | | | | |
| a. The cause and the triggers for the altered behaviour i.e. physiological (dementia, learning disabilities, possible drug interactions), psychiatric (including substance abuse and drug history) or neurological (brain injury, infection). | NPSA 2015 | | | |
| b. Complete history of pre-morbid drug history including non-prescribed drugs, alcohol and substance, benzodiazepine use. | DoH, 2005 | | | |
| c. Assessment of mental capacity and the ability to consent to treatment. | | | | |
| d. The use of a validated assessment scale to establish a baseline level of agitation or aggressive behaviour i.e. Mini-Mental State Examination (MMSE), Modified Overt Aggression Scale (MOAS). Richmond Agitation Sedation scale (RAS). | Braine, 2005 | | | |
| e. The diagnosis of possible delirium is made using a recognised assessment tool. | Mattes, 2010. | | | |
| f. There is evidence of the use of alternative approaches to the management of the behaviour i.e. environmental modifications, behavioural or exercise programmes. | Rasheed *et al* 2019 | | | |
| g. Pharmacological interventions and escalation guidelines are available. | | | | |
| h. There is an identified schedule for reassessment of the intervention. | | | | |

| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 1.1 Following a multi-disciplinary team assessment an individualised care plan is implemented and regularly re-evaluated in accordance with the patients changing healthcare needs. | | | | |
| 1.2 An inter-disciplinary care plan includes the following issues:<br>a) Consideration of pre-disposing or trigger factors that may be contributing to the behaviours. e.g. Environment, time of day, pain, hunger, etc.<br>b) Dialogue with the family/carers on the patient's need for restrictive interventions.<br>c) Daily multi-disciplinary re-evaluations of care delivered, including consultation with a pharmacist.<br>d) Recognition that the least restrictive intervention has been used for the shortest period of time.<br>e) The date and time that the intervention was implemented, reviewed and discontinued.<br>f) Mental Capacity assessment (if appropriate).<br>g) Deprivation of Liberty documentation (if appropriate). | RCN, 2017<br><br>Ridley & Leitch, 2019 | | | |
| 1.3 An escalation plan is in place for continuing management. | | | | |

## FACTOR 2 – Protocol

| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 2.0 Evidence based guidelines/policies are available for the management of behaviour and cognitive impairment. For patients who lack capacity this will include:<br>a) The most appropriate intervention for managing the patient's behaviour.<br>b) Clinical holding policy.<br>c) Guidelines for debriefing of staff post-incident.<br>d) Family/carers have the opportunity to be included in the decision-making process and on-going management wherever possible | NPSA 2015 | | | |
| 2.1 **Pharmacological Interventions**<br>Protocol and guidelines Staff providing direct patient care have knowledge of the following:<br>a) Administration of covert medications policy.<br>b) Rapid Tranquilisation<br>c) The patient is prescribed and administered the appropriate medication to meet their needs.<br>d) The effectiveness and response to the pharmacological intervention is monitored.<br>e) Contraindication with other medications is documented.<br>f) The potential risks, complications and side effects of prescribed medications is identified e.g., extra pyramidal symptoms, dystonia, anti-cholinergic effects. | Bourne, 2008<br>Chew, 2009<br>Ridley & Leitch, 2019 | | | |

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| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 2.2 **Physical Interventions**<br><br>Staff providing direct patient care have knowledge of the following:<br><br>a) Conflict resolution.<br>b) De-escalation skills.<br>c) Personal risks associated with clinical holding.<br>d) Identification of potential risks to the patient of clinical holding.<br>e) Level of clinical holding is proportionate to the patient's behaviour.<br>f) Documentation of tissue integrity and patient hygiene.<br>g) Falls Risk Assessment | MCA, 2005.<br><br>MCA, Liberty Protection safeguards 2020<br><br>DOL's, 2015<br><br>Cleary, 2015<br><br>NPSA. (2015). | | | |

**FACTOR 3 – Education**

| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 3.0 All healthcare professionals applying restrictive interventions are provided with local training.<br><br>Training includes:<br><br>a) Assessment and recognition of behaviours<br>b) Conflict Resolution training.<br>c) Breakaway techniques.<br>d) Importance of de-escalation, distraction, interaction, verbal and non-verbal communication.<br>e) Completion of a comprehensive risk assessment.<br>f) Defining what is classified as 'Physical Restraint'<br>g) Defining what is classified as 'Clinical holding'.<br>h) Awareness of personal professional responsibilities and legal accountability when employing restrictive interventions.<br>i) Recognition of the potential risks, personal safety and complications associated with restrictive interventions<br>j) Consideration of the legal and ethical issues underpinning enhanced care.<br>k) Importance of limiting sensory under-load or over-load.<br>l) Identification of techniques and equipment to maintain patient safety, for example:<br>• Mechanical restraints – mittens, splints, bedrails, tilt back chairs, seat belts, lap straps intended to provide postural support.<br>• Electronic Surveillance – tagging, pressure pads, door alarms. | DoH, 2005, 2012. 2014 2015<br><br>NPSA. 2015.<br><br>Cleary, 2015<br><br>NMC, 2015<br><br>Restraint reduction network, 2019<br><br>Vindola-Padros *et al* 2018 | | | |

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| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| • Psychological restraint – repeated verbal commands.<br>• One to One enhanced care.<br>• Seclusion – confinement and isolation of a patient away from the other patients.<br>m) Nursing care relevant to the restrictive intervention e.g., tissue viability.<br>n) Nonpharmacological sleep promotion strategies. | | | | |
| 3.1 Staff have knowledge of delirium assessment using a recognised tool i.e. Confusion Assessment Method (CAM), confusion assessment method for the intensive care unit (CAM-ICU), Intensive care delirium screening checklist (ICDSC). | Bourne, 2008 | | | |
| 3.2 Staff can demonstrate awareness of the legal and ethical implications of using restrictive interventions associated with mental health and mental capacity:<br>a) Mental Health Act (1987, 2007) Great Britain, Mental Health Act (2001) Ireland<br>b) Adults with Incapacity Scotland (2000) Mental Capacity Act England, Wales, Ireland & Northern Ireland (DH, 2005)<br>c) Human Rights Act (1998)<br>d) DoL's (2015) & Vulnerable Adult Order<br>e) 'Best interest' decision making | | | | |

**FACTOR 4 – Patient Information**

| STATEMENT OF BEST PRACTICE | EVIDENCE & REFERENCES | ACHIEVED | NOT ACHIEVED | VARIABLES |
|---|---|---|---|---|
| 4.0 Patient information is available and reviewed in accordance with local policy. | | | | |
| 4.1 Patients/carers must be given current evidence based verbal and written information including:<br><br>a. Rationale for the intervention (physical, pharmacological).<br>b. How often the patient will be reviewed<br>c. Possible complications<br>d. Risks and benefits | DH, 2005, 2012, 2014. | | | |
| 4.2 Any information verbal /written that is given to the patient/carers is documented in the patients notes | | | | |

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