

POLICY AND GUIDELINES ON THE MANAGEMENT OF AGGRESSION AND VIOLENCE

1. INTRODUCTION

- 1.1 This policy provides guidance to staff who may be required to respond to violent or potentially violent behaviour from service users.
- 1.2 This policy and guidelines apply to all DRH care facilities including care homes, independent hospitals and supported accommodation (with the exception of Appendix A which applies solely to Fairfield House)

1.3 Policy objectives:

- To inform staff of the policies and guidelines for safe, effective and appropriate working practices.
- To minimise the risk of violence to staff and service users.
- To contribute to the promotion of a safe environment for staff and service users.
- To ensure that all staff are aware of their responsibilities in the prevention and management of aggression and violence.
- To ensure effective mechanisms for reporting, recording and evaluation of aggressive and violent incidents.
- To ensure that the dignity of all service users remains a primary goal of support
- To ensure that staff or service users who may become victims of violence receive appropriate support

2.0 DEFINITIONS

- 2.2 **Aggression** is a normal human emotional response and defence mechanism. It may take the form of an act or gesture, verbal or physical, which is precipitated by feelings of pressure, threat or stress. People who suffer from a mental illness or learning disability may experience relatively high levels of stress and/or a low stress threshold. They may also be more susceptible to perceptions of threat and pressure. People with impaired psychological resources may experience increased frustration due to unmet needs.
- 2.3 **Violence** can be defined as the use of physical force that inflicts pain, injury, and psychological distress. It may or may not involve the use of a weapon. Violence, like aggression, is a strategy that some people use in certain situations to express feelings of anger, fear, despair or frustration.

3.0 STANDARDS

3.1 DRH will ensure compliance with the following standards which will help to meet the goals of this policy.

- i) Each service user will have a comprehensive personal profile which seeks to identify how that person seeks to meet their basic human needs.
- ii) Each service user will have a detailed support plan that identifies how that person will be helped to meet their basic human needs within the context of the personal profile
- iii) Each DRH Care Facility utilises an effective process for evaluating the risks of aggression and violence associated with specific service users.
- iv) A comprehensive risk assessment completed for each service user will include potential for aggression and violence. This will be reviewed at least annually.
- v) For those service users for whom a specific risk has been identified the support plan will include comprehensive guidance to prevent/minimise risk and this will be reviewed at least quarterly.
- vi) All direct care staff will participate in crisis prevention training which addresses the causes, prevention and management of violence and aggression. Training will be repeated annually. Staff will also complete annually the Health and Safety Workbook which will contain elements relating to violence and aggression.
- vii) In DRH facilities where risk assessment indicates that physical intervention is likely to play a part in the management of violence training will be provided in Applied Physical Training with annual refresher training.
- viii) When a service user has been identified as posing a significant risk of aggression and violence, all team members involved in the care of that service user shall be appropriately trained to carry out the agreed responses.
- ix) Every DRH Care Facility will provide general written guidance to staff on the action to take in response to emergency situations. This guidance will include reference to any emergency alarm systems.

- x) DRH, its staff and managers will take all reasonable steps to prevent or manage violent incidents.
- xi) In exceptional circumstances, the safety of staff and service users may require the assistance of the police. In such circumstances the Chief Executive/Deputy Chief Executive must be informed immediately.

4.0 GUIDELINES FOR THE PREVENTION OF AGGRESSION AND VIOLENCE

4.1 Recognition of causative factors:

Aggression arises from many different causative factors and frequently from a combination of these factors. Effective prevention requires a comprehensive assessment of all possible contributory factors.

- **Personal factors:** low stress threshold, pain, sensory impairment; epilepsy, emotional states; fatigue; boredom confusion, delusional states
- **Impact of staff/others** – excessive demands, high expressed emotion, low tolerance, criticism, poor communication, lack of interpersonal skill, fear/apprehension; excessive control; inappropriate values and beliefs.
- **Environmental factors:** space/crowding, light, noise, temperature; lack of structure or inflexible routines.

4.2 Effective assessment utilises various structured tools. These include:

- **Physical health status:** DRH Health Checklist.
- **Mental health status:** Nurses Observations Scale for In-Patient Evaluation (NOSIE); Mini PASS-ADD Checklist.
- **Behavioural issues:** Motivation Assessment Scale; Functional Assessment Interview

However the most sensitive predictor of aggression and violence is a previous and recent history of aggressive or violent behaviour

4.3 **Human Givens Approach to Person Centred Planning:** A thorough understanding of each service user emotional/physical needs, and preferences is an integral element of any effective prevention strategy. Aggression can be seen simply as an inability to successfully

meet a basic need. Person Centred Planning utilising the Human Givens approach is essentially a mechanism for more successfully assisting a service user to meet their basic emotional and physical needs. Support Plans must identify known triggers for aggression as well as agreed responses for diffusion.

4.4 The following list is intended to provide suggestions for responding to common causative factors (see 4.1 above) :

- **Low stress threshold:** avoid over-criticism, excessive demands and emotional over-involvement. Ensure that new staff are made aware of potential triggers such as noise and crowding for individual service users. Managers should take prompt corrective action to address staff interventions that appear to exacerbate aggression.
- **Pain:** Many of our service users will have great difficulty communicating the presence of pain and discomfort. They may express their suffering through behaviours, which may be aggressive in nature. Support staff need to observe and understand the way pain is experienced and expressed by individual service users. Where this is appropriate, pain indicators and pain management plans will be identified.
- **Autism:** people with autism may be extremely sensitive and at times find their environment (noise; crowded rooms; bright lights) overwhelming and disturbing. Loss of emotional control may result.
- **Emotional reactions:** Service users may have a similar difficulty coping with and communicating feelings such as sadness, frustration, anxiety, and loss. An inability to communicate an unmet need may lead to increasing frustration and aggression.
- **Boredom:** Service users may have difficulty engaging with everyday activities and with those around them. Long periods of inactivity may result in frustration, irritation and aggression. Systematic support planning utilising the principles of person centred Active Support, will play an important part in reducing levels of boredom.
- **Sensory impairment:** Visual, hearing and tactile impairments may result in both frustration and confusion. Staff need to be fully aware of the both the presence of any impairment and the impact that impairment has on the individual service user.
- **Epilepsy:** Epilepsy has many hidden consequences over and above the visible seizure. These can include permanent headaches, sensory disturbances and emotional fluctuations. These may contribute to an aggressive episode.

- **Mental Health:** Confusion or misinterpretation of surroundings/events and the intentions of others are commonly associated with both aggression and violence. It is important that staff develop the skills and knowledge necessary to identify and respond to significant mental health problems. Staff need to know when to seek the support of the local specialist mental health team.
- **Communication:** Staff need to be aware of the impact they may have on the behaviour of the individual service user. Aggressive episodes often relate directly to an interaction between that service user and a member of staff. Communication should always be appropriate to the individual service user's capacity to understand and respond. Staff should be aware of their own body language, listening skills, voice tone, volume and the importance of personal space. All staff should be willing to learn from colleagues more appropriate styles of communication with particular service users.
- **Values and attitude:** Everyone in the care team should subscribe to explicit positive values based on a belief in the intrinsic worth of each service user in their care. These values should be communicated verbally and in writing to all new staff joining the team. These values should be clearly expressed within the Role, Purpose and Function document for each Home. They should be reviewed, at least, annually by each team.
- **Environmental factors:** These factors can often interact with personal factors such as stress thresholds. The team should be sensitive to those environmental factors which may contribute to aggression and violence. These factors may include variations in temperature, noise (from radios; television for example) numbers of people in a room, traffic etc.)
- **Staff responses:** Incidents of aggression and violence in care services can arise from interactions between staff and clients. All care staff have a responsibility to be aware of their own emotional reactions – both in general terms and in relation to specific service users. Detailed guidance should be available within individual care plans to team members so as to minimise conflict with service users from whom aggression or violence is a known risk. Every member of staff should have access to support from colleagues and managers to assist them to deal with potentially difficult interactions. Staff should make effective use of supervision processes.

5.0 OBSERVING WARNING SIGNS

Changes in the service users normal behaviour or appearance may serve to alert staff to the possibility that the service user may be escalating to physically violent behaviour, for example:

- Tense or angry facial expression
- General signs of over-arousal, including increased/laboured breathing, pacing, erratic movements or changes to normal patterns of behaviour.
- Increased speech volume
- Prolonged eye-contact
- Distress including a failure to communicate, withdrawal, fear.

Behaviour that preceded an earlier incident of aggressive/violent behaviour should be recorded in the service users risk-assessment and support plan.

The CPI Crisis Development Model		Table 1
Crisis Development Behaviour Levels	Staff Response/Attitudes	
The Anxiety Level – signs of restlessness and irritation e.g. pacing (def: “a noticeable increase or change in behaviour which is manifested by a non-directed expenditure of energy”)	This generally requires a supportive staff response involving empathy and active listening. Staff should avoid being judgemental or dismissing the person’s concerns	
The Defensive Level – the person Shows signs of a loss of rationality and control. The person may challenge staff with increasing verbal belligerence and hostility. They no longer comprehend the meaning of the language used by staff but are tuned into tone of voice and posture. Abuse may become increasingly personal and testing for staff	The best response at this stage is a directive approach which involves setting clear and simple behavioural limits. Limits setting should be objective, dispassionate, reasonable and enforceable. Limit setting should avoid appearing threatening.	
The Acting-out person –this level is defined as total loss of control. The person is incapable of controlling their behaviour and verbal aggression turns into physical assault – or self-harm. They now present a real danger to others – or themselves.	At this stage non-violent physical crisis intervention may well be indicated in order to prevent harm.	
Tension reduction – this is both a physical and emotional release after a tremendous build-up of energy. The individual will begin to regain some emotional control and rationality but may be at a very vulnerable emotional level.	The individual requires a response involving therapeutic rapport and communication. The person who has acted –out may well require considerable reassurance from staff. Enabling the person to regain a sense of safety and security is important.	

6.0 GUIDELINES FOR THE MANAGEMENT OF AGGRESSIVE OR VIOLENT INCIDENTS.

- Remain as calm as possible.
- Do not respond to hostility with hostility
- Avoid confrontation – you can be both firm and conciliatory.
- Use positive calming body language.
- Do not invade personal space if this is likely to inflame a difficult situation. Keep a reasonable distance – at least one arms length.
- Speak slowly with a soft calm voice.
- Avoid sudden movements or changes in tone of voice.
- Focus on achieving a positive outcome for everyone – little will be gained if you try to “win”.
- Give time to allow “verbal venting”
- Be prepared to listen to the other person and try to understand their perspective and feelings.
- Try to acknowledge the feelings that the other person experiences.
- Ignore personal insults and concentrate instead on resolving the problem.
- If you feel yourself becoming angry move away.
- Your first priority is to prevent injury – to yourself and others. Do not risk your own safety for the sake of property.
- If violence is threatened in a crowded area, encourage the person into a quieter area, alternatively, move others away.
- Identify and keep clear an escape route.
- Do not allow yourself to become isolated.
- If withdrawal from the situation appears sensible, maintain face to face contact do not turn your back.

If you call for help, state as clearly as possible, where you are and the nature of the problem.

Positive Behavioural Approach Service users whose behaviour frequently challenges staff and fellow service users as a result of their violence or aggression may benefit from a positive behavioural approach to support.

Positive behavioural approaches aim to change challenging behaviour by environmental management (to prevent the occurrence of the behaviour) Positive approaches also involve teaching alternative responses to the service user which serve the same function as the target behaviour for the service user.

For a positive behavioural approach to be effective a thorough **functional assessment or analysis** is critical. This involves a clear description of the target behaviour; the conditions in which it occurs (or doesn't occur); the events that maintain the target behaviour; and strong “theories” or hypotheses that link target behaviours with specific triggers and consequences and observational data to test these hypotheses.

DRH employ a Clinical Nurse Advisor to support staff with positive behavioural approaches. Psychology support is also available from Dorset Healthcare NHS Foundation Trust.

6.1 **RESTRAINT:**

In certain circumstances it may be necessary to physically intervene to restrict or limit a service user's movement or mobility in order to prevent a risk of serious injury

There are four main categories of restraint :

1. **Physical intervention:** one or more members of staff holding or moving someone, or blocking their movement to stop them from leaving.
2. **Physical restraint:** stopping an individual's movements by the use of equipment (eg. bed rails, belts and tables).
3. **Environment restraint:** managing the environment to restrict free movement (eg. by locks or complicated key pads).
4. **Chemical restraint:** the use of medication to restrain; this could be regularly prescribed medication, medication prescribed to be used "as required"

6.2 Interventions must be in the best interests of the service user, with any restrictive methods used for the shortest time possible Any intervention by staff must be justified in both ethical and legal terms. Restraint must always be justified in proportion to the risk posed by the service user's behaviour.

6.3 However, any justification would have to be based on a sound appraisal of less intrusive and less restrictive alternatives. Interventions must be in the best interests of the Service user, with any restrictive methods used for the shortest time possible. Any physical intervention must be carried out in accordance with DRH Policy and the service users Support Plans.

6.4 Sections 5 and 6 of the **Mental Capacity Act 2005** state that restraint can only be used on an informal or voluntary service user when:

- 1) the person using it reasonably believes it is necessary to prevent harm to the service user and:
- 2) its use can be justified as proportionate to the likelihood and seriousness of the harm. The restraint must also be in the service user's best interests (Sec 1(5) MCA 2005).

6.5 Any restraint must be the "least restrictive option" (Sec 1(6), i.e. the minimum amount of restraint for the shortest duration. Restraint that does not meet these conditions is unlawful and is not permitted in any DRH facility..

6.6 Restraint to administer medication (Fairfield House)

Restraint may only be used to administer medication to an unwilling service user detained under the Mental Health Act at Fairfield House when there is legal authority to treat that patient without consent. Restraint should only be used in an emergency situation or when failure to administer the medication is likely to lead to an emergency situation. The use of restraint to administer medication should always be discussed with the responsible clinician and appropriately documented.

6.7 Use of mechanical restraints

6.7.1 The use of mechanical restraints is prohibited within any DRH facility.

A mechanical restraint means “the use for the primary purpose of controlling the adult’s behaviour, of a device to restrict the free movement of the adult, or prevent or reduce self-injurious behaviour”

6.7.2 The term mechanical restraint does not include:

- a device to enable the adult to be transported safely
- a device for postural support
- a device to prevent injury from involuntary bodily movements such as seizures
- a surgical or medical device to properly treat a physical condition
- bedrails or guards to prevent injury while the adult is sleeping.

7.0 PHYSICAL INTERVENTIONS AND RESTRAINT

7.1 Where the need for some form of physical intervention has been identified following a thorough assessment, appropriate interventions for the individual service user should be developed with the advice and guidance the DRH CPI Trainer and Advisor

7.2 Support plans will identify the circumstances when an individually tailored form of intervention may be used and will include detailed illustrated guidance.

Any physical intervention should meet the following criteria

Staff should:

- Always keep the service user’s airway clear.

- Never inflict pain or use pain (or the threat of it) as a punishment.
- Do not use the prone - face down - position (the only exception permitted will be at Fairfield House when it is necessary to administer medication by intramuscular route to a service user for whom there is legal authority to administer and in the absence of that service users consent).
- Consider the impact of their size, weight, and height relative to the service users.
- Always consider the service user's feelings, maintain respect and ensure that the service user receives adequate reassurance after the incident.
- Always be able to justify the intervention in terms of ethics and the law.
- After any Physical Interventions have been used when safe to do so staff must re-establish communication with the Service User and use Post intervention techniques identified during Crisis Prevention training

7.3 Reasons for using restraint can include the following:

- i) Significant level of violence
- ii) Significant threats or attempts at self-injury
- iii) Prolonged and serious verbal abuse, threats, disruption.
- iv) Prolonged over activity, risk of exhaustion.
- v) Attempts to abscond while detained under Mental Health Act
- vi) Restraint may also be used in order to administer medication to an unwilling service user where there is legal authority to treat without the service users consent (under the Mental Health Act or the Mental Capacity Act)

Certain kinds of physical interventions or restrictive practices would be contrary to law and could lead to criminal or civil action against staff.

7.4 Seclusion

Seclusion is absolutely prohibited in any DRH facility Seclusion has been defined as a practice which "involves separating an adult or child against their will, restricting their freedom of movement and forcing them to spend time alone".

(The Joint Guidance issued by the Department of Health and the Department for Education and Skills July 2002)

7.5 MAINTAINING SERVICE USERS DIGNITY & SELF-ESTEEM

- Try to ensure that the service user does not feel humiliated (for example, respecting their need for dignity and privacy commensurate with the needs of administering the intervention).
- Explain the reasons for using the interventions to the service user at the earliest opportunity using any communication methods appropriate to the patient and their condition.
- Reassess the service user's care plan and help them to reintegrate into the home milieu at the earliest safe opportunity following the intervention.
- Where practicable, give service users the opportunity to document their account of the intervention in their notes. (a member of staff can record the service users verbatim account, if necessary)

8.0 TEAM WORKING

- 8.1 Failure to work in a co-ordinated and consistent manner in accordance with a service users support plan is frequently a contributing factor to aggressive behaviour. Managers will make every reasonable effort to consider the views of all team members during the design of a service users support plan . However, once a support plan has been approved by the Manager all staff are expected to comply with this.
- 8.2 Support plans will be reviewed regularly. Non-compliance by staff with a service users support plan may well result in disciplinary action – including the possibility of dismissal.

9.0 TRAINING

- 9.1 DRH and its managers have a responsibility to ensure that staff are adequately prepared to comply with each individuals support plan. The training implications of each support plan must be clearly understood by individual staff and home managers. Normally, these training needs can be met within the resources of the Home but where necessary external resources can be accessed.
- 9.2 Training needs can be identified through discussion at shift

hand-over meetings, monthly staff meetings, supervision sessions and annual staff reviews. Training needs that cannot be met or resourced by the Home should be notified to the DRH Training Committee via the Homes representative on this committee.

- 9.3 All staff will receive regular Crisis Prevention and Intervention training which enable participants to:
- Identify and recognise early signs of aggression and violence.
 - Use techniques for physically breaking free from specific and identified forms of aggressive situations (based on the experiences and concerns of participants)
 - Display an awareness of, and the need for, good de-escalation skills.
 - Demonstrate how to adapt skills for use in different types of situations.

Updates will be at least annual. All Homes should arrange an informal refresher session mid-year. Support for these sessions will be available from DRH CPI Trainers. Where assessment has identified the need this can be increased to six monthly.

- 9.4 Applied Physical Training (physical interventions) is available to all staff who may be required to participate in agreed physical intervention and who have completed a full in-house course in crisis prevention.
- 9.5 When it has been identified that a specific service user may require an intervention that involves some degree of restraint, all team members must receive sufficient training and guidance to enable them to apply the restraint technique safely and appropriately.
- 9.6 Access to additional forms of training will be available on request.
- 9.7 All crisis prevention and intervention training is delivered in-house by approved CPI instructors

10.0 RECORDING AND REPORTING

- 10.1 Effective prevention and understanding of aggression is dependent on comprehensive documentation. Any violent incident as well as significant or unexpected aggression should be clearly recorded in the service users case notes. Incidents must also be reported to Connaught House using DRH Adverse Incident Reporting Forms. Effective reporting may help patterns to be identified by the team or the Health and Safety Advisor
- 10.2 If any member of staff is unclear as to the need to report a specific incident they should discuss this with their line manager.
- 10.3 A quarterly analysis of all incidents, as well as accidents, will

be presented to the Board together with any specific recommendations for action. To help them with practice audit & support planning managers can request incident reports for individual service users at any time.

- 10.4 Violent incidents should always be reported to the Care Quality Commission by faxing a copy of the Adverse Incident Report

11.0 AFTER CARE AND SUPPORT

- 11.1 In the event of a violent incident immediate support should be available –including first aid and medical attention, if required. The person in charge should determine whether an injured member of staff should attend A&E/Minor Injuries Unit and, if necessary, make the necessary arrangements.
- 11.2 The victim of a violent assault should also be offered additional help including the emotional support of their manager and colleagues, and the assistance of the occupational health department/ counselling services
- 11.3 When safe to do so , staff must check the physical and emotional well being of all service users involved

(see Table 1 The CPI Crisis Development Model above)

12.0 POST INCIDENT REVIEW

12.1 A review of any significant incident involving violence and aggression should be held as soon as possible. The review should seek to identify any lessons, which would help to prevent any similar incident reoccurring. A review should consider the following questions:

- **What was happening immediately before the incident?**
 - e.g. what was the service users doing?
 - what demands were made of the service user?
 - how were other people interacting with the service user?
- **What factors might have contributed to this incident ?**
 - e.g. noise, crowding, room temperature?
 - unmet need or expectations?
 - misunderstanding or misinterpretation?
- **How was this incident dealt with?**
 - e.g. did the member of staff remain calm?
 - did staff feel supported?
 - were staff happy with the way the incident was handled?

- **What lessons can be learnt for the future?**
 - e.g. are there issues for training or supervision?
 - are there issues about the physical environment?
 - are there any resource issues?
 - Is there a need for more detailed guidance in the care plan?

An action plan incorporating the lessons of each review should be recorded together with agreed completion dates. Any violent incident should be immediately reported to the appropriate inspection body by the shift leader.

11.2 POST INCIDENT STAFF REVIEW

Following any significant aggressive incident the staff involved should meet to discuss the events.

It may be helpful to separate the technical from the emotional aspects of debriefing. Emotional debriefing aims to identify potential stress reactions and to provide a supportive and structured setting to allow people to cope more effectively.

If a member of staff is unable to work as a result of a violent incident, the Manager should ensure that contact is maintained and that the person is adequately supported.

Where appropriate the victim of a violent incident may be referred to the Occupational Health Department for counselling.

Supporting Service Users:

Managers should ensure that any service user involved in a violent incident (whether assailant or victim) receives appropriate support and reassurance. The service users own interpretation of events should be sought separately as part of the "rebuilding" of rapport as soon after the event as possible..

12.0 RESPONSIBILITIES OF MANAGERS IN ALL DRH CARE FACILITIES

Managers have a duty to:

- Establish safe systems of work including appropriate assessment of risk.
- Ensure that detailed strategies are available and understood for any service user where a risk of violence has been identified.
- To ensure that risk management strategies and guidelines are implemented
- To ensure that all staff comply with mandatory training requirements
- Ensure that training needs are identified and that appropriate steps are taken to meet these needs.

- Ensure that incidents of aggression and/or violence are satisfactorily documented and reported
- Ensure that staff who are victims of an aggressive and/or violent incident are properly supported.

REFERENCES:

- Violence: The short-term management of disturbed/violent behaviour in psychiatric settings and emergency departments (NHS NICE 2005)
- Violence at Work – A guide to risk prevention (Unison)
- The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care (Institute of Psychiatry/UKCC 2001)
- Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings (NIMHE 2004)
- The Management of Violence and Aggression in Places of Care. An RCN Position Statement (RCN 1997)
- Code of Practice : Mental Health Act 1983 DoH 2008
- Participant Workbook for the NonViolent Crisis Intervention Training Programme CPI 2005
- The BILD Code of Practice for Trainers in the use of Physical Interventions. 2001. Kidderminster
- BILD Code of Practice for the Use of Physical Interventions. 2006.Kidderminster

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APPENDIX One

DEPRIVATION OF LIBERTY SAFEGUARDS

Introduction: The Deprivation of Liberty Safeguards (DoLS) were introduced via the Mental Capacity Act into English Law in order to comply with the European Convention on Human Rights and decisions made by the courts. The Safeguards were implemented with effect from 1st April 2009. The Safeguards provide a procedure by which mentally incapacitated people living in hospitals or registered care homes can, if necessary, be deprived of their liberty.

It is envisaged that these Safeguards will be necessary only in the most unusual and rare circumstances. Care homes are expected to take all reasonable measures to ensure that care and support is provided without depriving a service user of their liberty.

What is Deprivation of Liberty? : Legislation does not provide a clear definition of what this term actually means. However, case law suggests that the following factors would be considered relevant in determining whether deprivation of liberty is occurring:

- Restraint is used to admit a person to an institution when that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period of time.
- The person loses autonomy because they are under continuous supervision or control.
- Whether constraints on the individuals freedom go beyond necessary restraints and restrictions to the extent that they constitute a deprivation of liberty.

The fact that restrictions may be justified on the grounds of risk does not mean that there is no deprivation of liberty.

Managing Authority: The care provider (DRH) is responsible for ensuring that care and support is provided without the need to deprive a service user of their liberty. Should the need ever arise to consider deprivation of liberty as essential for

the delivery of safe support the DRH would need to carefully assess that need and apply to the **Supervisory Body** for the appropriate authority. It is unlawful to detain someone without the appropriate authority. Normally applications should be made in advance of any deprivation of liberty.

Dorset County Council will normally act as the Supervisory Body for Care Home service users.

No application for authority to detain shall be made without a thorough assessment which considers:

- The nature of the restrictions on the person that lead to the conclusion that they might be deprived of their liberty;
- Why the necessary care and/or treatment cannot be provided in a way that is less restrictive of the person's rights and freedom of action;
- And
- Whether it is likely that the person will meet the requirements of all six of the DoLS assessments.

No application will be made to the Supervisory Body for authority to detain without the express agreement of the Chief Executive or Deputy Chief Executive on behalf of the Registered Provider (DRH)

Six Assessments: Once a Managing Authority has made an application for a standard authorisation the Supervisory Body must make arrangements for the necessary assessments which will inform its decision to grant or refuse the authorisation. The six assessments which must be completed prior to an application for a standard authorisation are:

- Age assessment – is the person 18 years or older
- Mental Health Assessment – does the person have a mental disorder
- Mental Capacity Assessment – does the person lack the capacity to consent to their care and/or treatment
- Eligibility Assessment – would a DoLS authorisation conflict with conditions already in place under the Mental Health Act, or would the person's care/treatment authorised under the Mental Health Act.
- No Refusals Assessment – would a DoLS authorisation conflict with either a relevant decision by a depute or donee, or with a valid Advance Decision
- Best Interests Assessment – is the person being deprived of their liberty and, if so, is this in their best interests

The assessments will be undertaken by suitably trained staff commissioned by the Supervisory Body.

In exceptional circumstances the Managing Authority can give an **urgent authorisation** before the standard authorisation process can be completed.

In the event that any DRH Manager believes that it may be necessary to deprive a service user of their liberty they should discuss this with the Chief Executive or Deputy Chief Executive who will determine whether a deprivation of liberty is appropriate and/or is likely to meet the requirements of all six assessments. If it is decided that a deprivation of liberty is appropriate and consistent with the

requirements of the six assessments an application for a Deprivation of Liberty Authorisation will be made.

Mental Health Act 1983 If a service user at Fairfield or Elsadene meets the criteria in Section 2 or Section 3 of the Mental Health Act and is objecting to remaining in hospital for mental health treatment it would not be appropriate to use DoLS authorisation. Service users in DRH care homes cannot be detained under the Mental Health Act.

References:

Deprivation of Liberty Safeguards – Guidance for Managing Authorities.2009. Dorset County Council; Bournemouth Borough Council; NHS Dorset; NHS. Bournemouth and Poole

Mental Health Act 1983 Code of Practice. 2008. TSO. London.

Mental Capacity Act Code of Practice. 2007. TSO.London

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