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Positive and Proactive Care

Reducing the Need for Restrictive Interventions

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Acknowledgements

The Forum is grateful for the assistance from Partnerships in Care to help our first two roadshows off to an excellent start by providing logistical support as well as suitable venues.

Zeba Arif, Chair, RCN Forensic Nursing Forum; President AU Pakistan Nurses Association (APNA-UK), previously Team Leader Forensic Psychiatry, North London

Geoff Barry, Senior Lecturer, University of South Wales

Annette Duff, Forensic Nurse Consultant/ Cognitive Behaviour Psychotherapist, BABCP Accredited/ Approved Clinician, Norfolk and Suffolk NHS Foundation Trust

Angela Davies, Clinical Nurse Specialist, Child and Adolescent Mental Health Service CAMHS

Ian Hulatt, RCN Professional Lead for Mental Health

Shirley Foster, RCN Nursing Co-ordinator

Dave King, Clinical Nurse Specialist, Forensic Mental Health Security Lead, Humber Centre for Forensic Psychiatry

Michelle Parker, Recovery Lead/Care Pathways Co-ordinator, The Spinney, Partnerships in Care, North West

Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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Contents

The case for change

Certainly everyone who watched the programme on Winterbourne View residential care home on television in 2011 was appalled and repelled by secret footage of the abuse meted out to the vulnerable and defenceless residents by the staff. Concerns were then raised about restrictive practice.

Consequently, the steering committee members of the RCN Forensic Nursing Forum identified the absence of a regulatory body to oversee the nature and quality of physical intervention training: considering and describing practices such as observation and engagement, searching techniques, physical interventions, de-escalation techniques which affect most nurses everywhere.

Nurses deal with practical, ethical and moral dilemmas of restrictions and restraint. With the lack of guidance and regulation in 2011, there was increased risk to patient care. Within some services there was an over reliance on the use of restraint, rather than preventative approaches to challenging behaviour.

The forum committee proposed a resolution for RCN Congress 2013. This urged RCN Council to lobby UK governments to review, accredit and regulate national guidelines of approved models of physical restraint. This was debated and passed by 99.8% of the voting members.

The forum, with the full support of the College and their professional adviser, played a key leadership role resulting in the Department of Health (DH) policy document, *Positive and Proactive Care* (DH, 2014). The guidance presents a current and comprehensive strategy to reducing restrictive practice; it also uses a principle-based approach that is evident in the other health care policy drivers for all four UK countries.

In the foreword the Minister for Care and Support notes, "there is a clear and overwhelming case for change" (DH, 2014).

There is now recognition that staff have been carrying out their tasks as they were trained, but are struggling in difficult situations. These individuals need to be equipped with the skills to perform their duties differently.

The DH document has key actions on improving care, leadership, assurance and accountability, transparency, monitoring and oversight. A core principle for those who are employed in a nursing role is that their conduct ensures service users' safety, dignity and respect.

In 2014/15 the forum organised a series of roadshows underpinned by the DH document in Warrington, Wales, London and Northern Ireland. Speakers were invited to present on the subject of reducing the need for restrictive practice. The roadshows gave the RCN the chance to engage with nurses, whose practice involves the use of restriction and/or restraint, and to discuss with them about the implications for reviewing their practice so that it meets the principles and actions related to DH (or regional) policy.

Aims and objectives of the roadshows

The DH document presents a current and comprehensive strategy to reducing restrictive practice; it also uses a principle-based approach that is evident in the other health care policy drivers for all four UK countries. Since health care policy drivers impact on the practice of nurses in care settings, generating discussion about how to use principle-based approaches to reduce restrictive practice should not only be achievable, but welcomed. This issue continues to create a dilemma for nurses who ethically and morally use principles to inform their practice, but have to be practical about the use of restriction.

The DH policy has key actions on improving care, leadership, assurance and accountability, transparency, monitoring and oversight. There is also a well defined framework of 129 topics that include the different approaches that can be used to support service users, clear definitions of the range of restrictions that are used in practice, programmes and key methods that need to be developed to enable the reduction of restrictive practice. There is a useful summary of actions, which can be reproduced for nurses as a quick reminder of the action that they need to continue to take in order to have a more positive and proactive approach to restriction and restraint.

The RCN roadshows supported nurse education around other frameworks that have developed in the regions, or through ongoing work that the RCN and the forum has been involved in. For example, the use of competency frameworks and training such as "New to Forensics", which is a clinically relevant programme designed to support the education of staff working in forensic settings who are involved in a variety of different situations, including restrictive practice.

Furthermore, the roadshows presented the opportunity to educate nurses about the impact of regularly being involved in restriction and restraint and the impact that this has on their psychological wellbeing. These events supported nurses by raising awareness and supporting the development of this guidance, establishing regional and country professional knowledge in relation to restrictive practice, looking at the approaches that can be developed that are in keeping with their code of conduct and their professional responsibilities.

Restrictions with reasons

There is a need for consistency in the assessment of restricted items, rather than have a blanket ban of prohibitive items in place. Far better to assess access to any item on basis of personal and interpersonal as well as environmental risk, taking into account common sense considerations of the item in question. Categorising items as green, amber and red also clarifies the risk.

(However, it should be noted that there is a National Banned List, pertaining to weapons and drugs).

In fact all interventions must be evidence based and outcome measures duly documented and monitored.

A service user's care plan would include an own items' risk assessment, which would be a dynamic, changeable list of allowed items. This would also mention their access to IT, and online resources.

Rights vs limits in freedom

Restrictions with a reason may be rationalised as a safety plan: to be assessed in terms of how risk applies to the service user and avoiding the default position of a blanket ban. In short it should be individualised and appropriate.

Restriction should always result in safety: educating service users about risk and safety so they learn how to keep themselves free from danger when they leave the hospital or unit, and can achieve protection from harm for themselves and their environment.

This individualised approach to risk assessment, forms the basis of the government's *See, Think, Act* initiative around relational security [1] (termed the Relational Security Explorer). It provides a framework for the systematic assessment and evaluation of a personalised risk management process.

One of the most fundamental rights of service users and staff, is the provision of a safe environment in which to live and work. Without a detailed understanding of individual risk markers, and the courage and conviction to act to ameliorate risk, we risk failing those in our care, and our colleagues.

Service user perspective

Restraint and seclusion: to be physically handled, and then placed somewhere devoid of anything movable.

> *'I was restrained face down with my face pushed into a pillow. I cannot begin to describe how scary it was, not being able to signal, communicate, breathe or speak. Anything you do to try and communicate, they put more pressure on you. The more you try to signal, the worse it is.'*
>
> A personal account

An over reliance on restraint is frequently a first, rather than the last resort and creates a vicious cycle of upset and increased force. A much more humane approach would be to create designated de-escalation areas, where people can go to calm down, and engage with staff in a non-threatening environment.

A recurring issue arising from our roadshows was that not enough information is shared, that often it is restriction for the sake of restriction. Examples given by delegates included: 'absolutely will not cross the threshold of the office door!', dining rooms being locked, even though cutlery has been locked away securely, whereas restricting access to bedrooms during daytime comes across as unnecessarily inflexible.

(1) Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. Safe and effective relationships between staff and patients must be professional, therapeutic and purposeful, with understood limits.

Emerging themes

Although each of the roadshows had different speakers, topics and perspectives, we found that the 'emerging themes' were similar.

This publication is styled on those themes and presents the opportunity to educate nurses about the impact of regularly being involved in restriction/restraint and the toll this takes on their psychological wellbeing.

Cultural change

Cultural change involves tackling the prevailing culture that supports restraint in some areas, and changing that to put the person first; to accept them and treat them as individuals and empower them to take control of their own recovery. Collaborative empowerment is central to care. Without cultural change there is a risk of substituting one form of restrictive practice for another.

Another aspect of this is to understand and prevent the reasons for violence and aggression, as well as understanding users' diverse cultural needs and religious beliefs. Many service users have not had positive role models in their lives and we, as caregivers, are possibly the first.

Safewards [(2)] is a model to help nursing staff understand the causes of violence and aggression and how we can respond to reduce conflict and resolve these situations. This in turn should lead towards 'Force Free Future' or zero restraint and incorporates training packages about risk management.

Force Free Future should not be considered an impossible aspiration. Developing intelligent kindness and recognising challenging behaviour is an unconscious response to an unmet need. Care can be transformed by understanding that a person's behaviour may be based on functional analysis [(3)]. This would make persuasion and negotiation part of practice (psychosocial intervention). Avoiding assumptions, threats and provocation adds to positive outcomes.

Clinical supervision is critical – reflection, questioning practice, involvement of patients in all aspects of their care needs would undoubtedly improve interactions between staff and service users. 'Be yourself' is a useful tenet to keep in mind.

Other points that would enhance force-free practice is imparting relevant information to service users, as well as working with families and carers, which naturally leads to joint care planning and shared decision making.

A quote from a service user says it all: 'It is these individuals who go the extra mile without recognition and sometimes without support themselves who make the difference.'

Risk management

Caring in secure settings is characterised by challenging situations, chaotic backgrounds and complex issues, such as attempted suicides. People in custody, which includes a large percentage of women, may have undiagnosed and unmet needs: anxiety disorders, possibly learning disabilities, as well as psychotic disorders resulting from alcohol and drug misuse. Good practice is to ensure that health and social care needs are met from the start, and these are shaped around the individual.

Nursing staff need to balance competing information with a number of competing demands. In other words, offsetting risks and rights against limits to freedom, where inevitably rights are treated as risks in secure settings.

'Self confidence is the first requisite to great undertakings' *Samuel Johnson*.

When health professionals are empowered, then service users are empowered.

(2) Safewards is a model devised by a team led by Professor Len Bowers and offers a series of easy to implement interventions that wards can implement in order to reduce conflict and the need for containment. Simple strategies such as 'getting to know you' books where staff share information about themselves and thus facilitate conversation and find areas of common interest, or 'positive words' where information shared about patients includes acknowledgement of positive behaviours and attributes, not just focusing on the negative aspects.

(3) Functional analysis helps us to understand the causes and triggers of behaviours, and to identify what function those behaviours may serve for the individual in question.

Service users recommend staff training and development in positive and proactive care, and formulate practice accordingly. If staff can get this right, then compassionate care should follow naturally. Continued improvement is better than delayed perfection.

Staff should appreciate the impact of forensic settings upon users – they are usually 'struck by locks and airlocks' – and be aware of and understand service users' vulnerabilities, their anxieties and fears.

Relational security is key, care should be purposeful, respectful and safe. Staff have to be able to explain to service users as well as colleagues the rationale for the care and treatment being delivered.

Dignity and compassion

Winterbourne View was the catalyst that highlighted, amongst other issues, the failure of the Care Quality Commission to respond to concerns raised and assure appropriate care. Members of the public were appalled by the brutal behaviour and neglectful acts carried out by some staff. The initial and understandable reaction was to legislate and ban restraint. However, the incidents at Winterbourne View were not related purely to the use and abuse of restraint, they were more complex than that. Practice in the challenging area of restrictive interventions should be based on intelligence and kindness, underpinned by best practice guidance.

Compassion and restrictive practice is mutually exclusive. Practice should be based on intelligence and kindness.

Enforcing blanket bans such as denying access to the kitchen, bedroom and fresh air, limiting movement and restricting egress, and medicating without adequate explanation are all examples of restrictive practice.

'Coercion in care is a cultural attachment, not a clinical necessity' *Workshop presenter, Sophie Corlett.*

To maintain the dignity of the service users it is important to improve and optimise the physical environment of the secure areas, enhance the décor, simplify the ward layout, use unlocked doors whenever possible and ensure easy access to outdoor, albeit secure, spaces and privacy. In addition it is crucial to consider that safe and ethical use of restrictive processes is proportionate to the risk of harm.

Legal perspective

When we talk about restraint in nursing there are two issues, namely accountability and negligence.

Accountability: health care professionals are personally answerable to the law of the land for all their actions and omissions. That is why detailed and unambiguous documentation is vital.

Care plans have to be recovery focused, encompassing behaviour and attitude, dignity and respect, as well as happiness and hope of the service user. It is thought that restrictive practice can be prevented by positive relationships. It should also be noted that the service user may seek possible legal redress in relation to restraint.

Negligence: this is rapidly becoming a growth area in litigation. People are becoming more aware of their rights. The best way of avoiding a case is by good practice and clear and concise record keeping. It is important to be absolutely clear about the duty of care and what constitutes a breach of duty, and whether that breach caused foreseeable harm.

Children and Adolescent Mental Health Services (CAMHS) perspective on restrictive interventions

Secure inpatient facilities for young people remain largely under developed in Wales. Most child and adolescent mental health services (CAMHS) staff are community based and would not routinely experience the need to apply restrictive practices. However, with a recent shift in young people accessing CAMHS inpatient services there is an increase in complex presentations with challenging behaviours necessitating restrictive practice from a workforce with little experience. Assaults on staff have increased and perhaps highlight the need for specialist CAMHS to join this discussion.

The roadshows in Wales and Northern Ireland raised a whole host of broader issues when considering vulnerable young people in custodial environments: prison, police cells, court cells and transfers to secure facilities. In the main this responsibility is entrusted to private sector organisations.

In 2015 the BBC's *Panorama* aired a very chilling and disturbing report on the mistreatment of young people at a

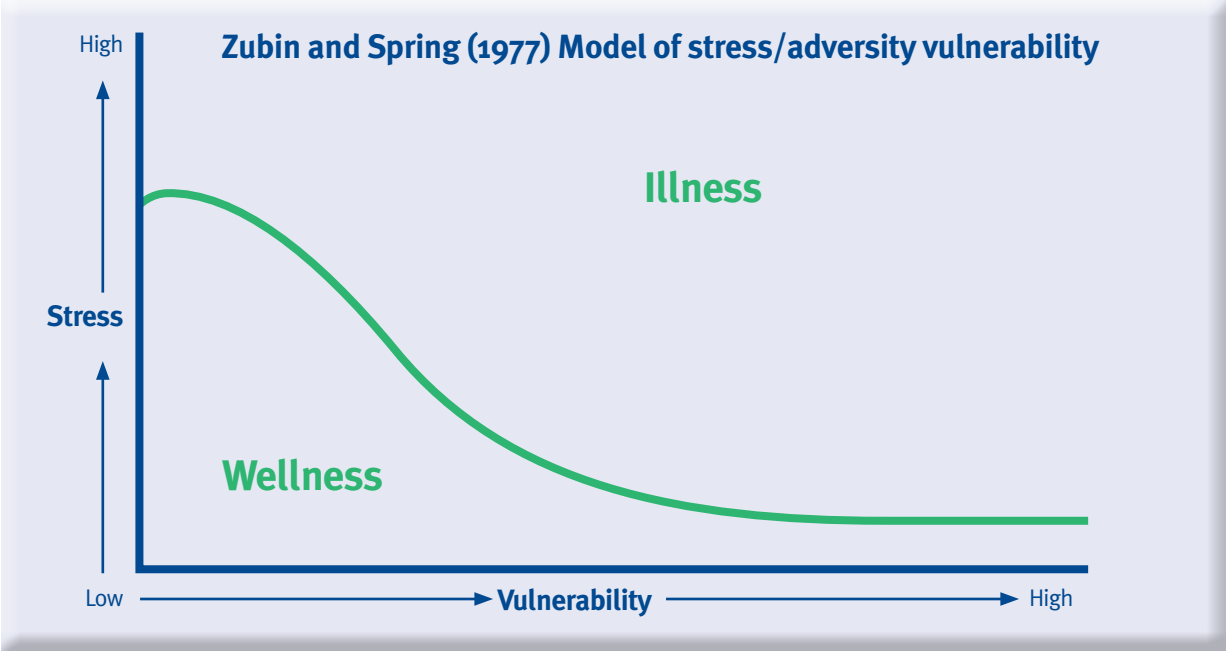


Figure 1: Zubin et al., Stress vulnerability model (1977)

young offender's centre run by G4S for people with learning disabilities and challenging behaviour. Incidents caught on film involve unnecessary force, foul language and baiting the young residents into arguments.

Legally, children remanded into custodial units are considered 'looked after' and have rights to appropriate care. The correlation between mental health and youth offending is widely acknowledged making this cohort extremely vulnerable.

At one of the roadshows, a very moving service user account on experiences of restraint was given, one can only wonder how a looked after child might process any restrictive practice.

The legislation clearly directs that children and adolescents should be seen as young people before offenders and yet in Cwm Taf, South Wales, for example, there are no specialist CAMHS criminal justice liaison nurses.

The roadshows helped to raise the issues associated with restrictive practice and shared good practice around the country, and should influence the practice of CAMHS nurses, particularly those caring for young people in custodial settings.

There is hope on the horizon with the changes in the Policing and Crime Bill amendments include Section 136 of the Mental Health Act, with police stations no longer being considered a place of safety for children and young people.

Wellbeing of staff

At the roadshows an important emphasis was placed on the need to support the wellbeing of the staff who are delivering on this element of care both within and outside of secure services.

This aspect held a cognitive behavioural therapy focus and utilised the stress vulnerability model (Zubin et al., 1977) to exemplify how understanding and managing personal vulnerabilities and related stress led to wellbeing "having as good a life as possible" within conditions or parameters that cannot be removed, only modified.

We held emotional wellbeing workshops which encouraged the regular benchmarking of mood, levels of anxiety and irritation, diet, the quality of interpersonal connections, use of substances (prescribed and other, for example, alcohol), sleep (quality and quantity) and fluid intake.

The workshops explored thought management and self-soothing strategies, encouraging delegates to utilise these techniques in order to increase their own wellbeing. It was also acknowledged that personal use would also potentially aid professional authenticity with service users.

The workshops also included the identification and exploration of specific benchmarking tools, for example *The Wheel of Life* (which supports self evaluation of areas of life that would benefit by being changed, see Appendix 3) and *The Stress Questionnaire* (which supports diagnosis

of stress levels, see Appendix 2), along with practical methods for improving both personal and professional qualities of life.

Principles of human rights guidance

This encompasses practical implications of compassion, dignity and kindness, hence blanket policies are not always the best practice and other relevant circumstances should always be taken into consideration. It is important to clearly articulate risks and potential responses in the care plan.

In this context, knowledge of Articles 3 and 5 of the Human Rights Act is particularly relevant to reducing restrictive practice.

Article 3[4] prohibits torture or 'inhumane or degrading treatment or punishment.' There are no exceptions or limitations to this right. This could then apply to poor conditions in detention. Since this is an absolute right the intention becomes irrelevant. What is key is the level of vulnerability, as even raised voices may be seen as a breach of this article.

Article 5[5] of the Human Rights Act is the right to liberty and security. It is a major decision to detain someone and then have processes in place to protect them. However, it can be argued that detention is for therapeutic purposes.

It is interesting to note that the Council of Europe does not distinguish between restraint and seclusion, but do stipulate that seclusion rooms should be of appropriate size and standard.

Within the limit of resources individualised care plans have to be sustainable. Post-incident reviews, when conducted, have to be independent and clearly demonstrate how justified the response was to the incident.

(4) Thousands of cases come into Council of Europe and are investigated for Article 2 or 3 compliance. These are independent, prompt and impartial investigations.

(5) Health care professionals are responsible for the safety of those detained and for their protection. They can be held accountable for the limits to freedom they impose.

Next steps

Nurses working with mentally disordered offenders, in whatever setting – be it A&E, elderly, even general medicine, are increasingly expected to review their practice in line with contemporary legislation and guidance. As this document is written, Positive and Proactive Care and the new MHA Code of Practice are prompting forensic services to examine their clinical and security practices, especially where they are felt to be too restrictive in nature or scope. CQC inspections repeatedly raise concerns about this sensitive aspect of forensic health care, and there may yet be work to be done with health departments and regulatory bodies in the four countries.

As part of the Positive and Proactive Care agenda, the Department of Health has been examining restrictive practices in data gathering exercises. A recent benchmarking publication has helped to better inform services about the degree and nature of restraint and seclusion in their services, in comparison to similar organisations. Furthermore, a questionnaire was circulated nationally to examine the type of physical intervention training that is being delivered to staff in health and social care. Though it is far from clear that this will result in the accreditation and regulation that was called for in the original resolution to RCN Congress in 2013, it is reassuring that the issue remains high on the agenda for the RCN and health departments across the United Kingdom.

This Forum believes positive and proactive care is on the agenda of every care provider and every care evaluator in every care sector. Acknowledgment of what positive and proactive care is has gained interest and then momentum in all areas of care with user, carer and professional groups all advocating and calling for this as standard practice. Whilst in some areas of care there will always be a need for restrictive practices and interventions the guidance will direct the users, carers and professionals to consider, ideally together, which is the least restrictive option.

The guidance provides a platform for reflection and ultimately change, whether that be attitude, protocol or practice. This publication aims to support those reflections and changes and the projected success of this is based upon the input from nursing and health care users and professionals from each of the four countries.

Above all it is crucial to maintain focus on staff wellbeing using all supports available, for example, clinical supervision, staff support groups but also compassionate mind skills training and structured self-monitoring.

This would entail putting into place individually developed self-care strategies that include reflection, supervision, even a self-soothing toolkit. All this could also be part of an individual's a revalidation portfolio.

However…

A "Force Free Future" may only be attainable if we are able to balance the laudable aims of "Positive and Proactive Care", with the harsh realities of clinical practice. NHS Protect noted that in the 2014/15 period there were nearly 68,000 assaults on NHS staff. The emotional impact of violence, coercion and objectification cannot be underestimated – yet this impact is clear to see on both patients and staff. Victims abound on both sides of this dyad.

Until we begin to replace emotive language and rhetoric with evidence-based practice, and practice-based evidence, we are in danger of arriving at the wrong solution to the problem. The specific themes that emerged during the RCN roadshows last year, may be seen to have overlooked a key issue – that is "What is the evidence base for Positive and Proactive Care"?

Specific concerns exist around key directives within the DH document, such as the wholesale implementation of Positive Behavioural Support (PBS) in mental health services, the "banning" of face down (prone) restraint, and the post-incident review process. A number of these issues have an evidence base around them, but that evidence may be seen to be at odds with the agenda behind *Positive and Proactive Care*. More worryingly, the lack of existing evidence around how one may successfully implement PBS within mental health settings, may be seen as the "elephant in the room" for the initiative. In addition, what constitutes a "good" PBS plan, may be the subject of debate and variance across services. At best this may entail a clinical area grasping that a thorough functional analysis of behaviour is key to the development of valid PBS approaches, at worst clinical services may simply "re-hash" existing risk management plans.

The difficulty faced by service providers is that although Positive and Proactive Care is not deemed to be statutory guidance, its implementation is being monitored by the Care Quality Commission (CQC), and any service deemed to be non-compliant will attract criticism and sanctions.

This robust and energetic response by the CQC , can be seen to be at odds with their lack of response to the concerns raised to them by a "whistleblower", when they were alerted to the issues in Winterbourne View (*The Guardian*, 2011).

References

Department of Health (2014) *Positive and Proactive Care*, London: DH.

Royal College of Psychiatrists Quality Network for Forensic Mental Health Services (2015) *See Think Act. Your Guide to Relational Security*, London: RCP.

Zubin, J and Spring, B (1977) Vulnerability: A New View on Schizophrenia, *Journal of Abnormal Psychology*, 86, pp.103-126.

Further resources

Non-violent Resistance in the care of children
www.partnershipprojectsuk.com

Equality and Human Rights Commission

England
www.equalityhumanrights.com/en/human-rights

Scotland
www.equalityhumanrights.com/en/commission-scotland

Wales
www.equalityhumanrights.com/en/commission-wales

Appendix 1: List of roadshow speakers

Arbury Court Warrington (In Association with Partnerships in Care) 9 October, 2014

Emma Lenehan, RCN Employment Relations Advisor

Ian Hulatt, RCN Mental Health Advisor

Ian Callaghan, National Service User Lead, Recovery and Outcomes

Dr. Yasir Kasmi, Consultant Forensic Psychiatrist, The Spinney

Donna Mead, Ward Manager, The Spinney

Collette Duffy, Clinical Nurse Manager, The Spinney

Cynthia Marimo, Ward Manager, The Spinney

Dr. Frank McGuire, Consultant Clinical Psychologist, Mersey Care Secure Division

Danny Angus, Team Manager, Mersey Care

Claire Lamza, Chair, RCN Forensic Forum

Annette Duff, Forensic Nurse Consultant, Cognitive Behavioural Psychotherapist, (BABCP Accredited) Approved Clinician, Norfolk and Suffolk NHS Foundation Trust

Llanarth Court Wales (In Association with Partnerships in Care) 22 April, 2015

Ian Hulatt, RCN Mental Health Advisor

Geoff Barry, Senior Lecturer, University of South Wales

Ian Callaghan, National Service User Lead, Recovery and Outcomes

Keith Barry, Group Nursing Development Lead, PiC

Dr. Bronwen Davies, Clinical Psychologist, Caswell Clinic

John Griffith's, Ward Manager, Caswell Clinic

Dr.Damian Gamble, Consultant Forensic Psychiatrist, Llanarth Court

Christian Stewart, Ward Manager, Ashworth Hospital

Dr. Polly Turner, Forensic Psychologist, Ashworth Hospital

Elizabeth Bowring-Lossock, Lecturer, Cardiff University

Zeba Arif, Chair, RCN Forensic Nursing Forum

Royal College of Nursing HQ London (In Association with RCN London Region) 3 July, 2015

Zeba Arif, Chair, RCN Forensic Forum

Bernell Bussue, Director RCN London Region

Ian Hulatt, RCN Mental Health Advisor

Ian Callaghan, National Service User Lead, Recovery and Outcomes

Sophie Corlett, Director External Relations, Mind

Daniel Thorpe, Chief Inspector, TP Mental Health Team

Annette Duff, Forensic Nurse Consultant, Cognitive Behavioural Psychotherapist, (BABCP Accredited), Approved Clinician, Norfolk and Suffolk NHS Foundation Trust.

Royal College of Nursing, Northern Ireland 18 September, 2015

Noel McDonald, Operations Manager, Shannon Clinic

David Ford, Minister for Justice, Northern Ireland – Keynote Speaker

Zeba Arif, Chair, RCN Forensic Forum

Virginia McVea, Director of Northern Ireland Human Rights Commission

Rosemary Wilson, Nurse Lecturer, Barrister

Davy Martin, Lead Nurse, Shannon Clinic

Dr. Adrian East, Consultant Forensic Psychiatrist, Shannon Clinic

Dr. Boris Pinto, Consultant Forensic Psychiatrist, Shannon Clinic

Patrick Convert, Head of Programme, Regulation and Quality Improvement Authority

Rosalind Beattie, Security Nurse Lead

Martina Cole, Management of Aggression Trainer

Alphy Maginness, Director of Legal Services, Belfast Health and Social Care Trust

Appendix 2: The Stress Questionnaire

Stress Questionnaire - do you ever suffer from any of the following?

	Rarely	Sometimes	Often
Irritability			
Feeling depressed			
Feeling restless			
Tension			
Anxiety			
Lack of concentration			
Frustration			
Feeling panicked/attacks			
Frequent crying			
Increased smoking			
Increased alcohol consumption			
Finger or foot tapping			
Scratching scalp or hair twiddling			
Lethargy/fatigue			
Accident prone			
Insomnia			
Headaches			
Nausea			
Constipation/Diarrhoea			
Skin problems			
High blood pressure			
Excessive sweating or cold sweats			
Rapid or irregular breathing			
Allergies occurring more often			
Frequent colds			
Pre-menstrual tension			
Absent from work			
Working long hours			
Dreading going to work			
Boredom			
Lack of communication			
Taking work home			
Over concern with silly details			
Nail biting			
Never having time for yourself			

Add up your score as follows:

Rarely = 1 point

Sometimes = 2 points

Often = 3 points

Then find which category you fall into:

If you scored 35 – 50

You seem to have things under control, we all register some signs of stress at some point, just keep an eye on it. You might like to seek some form of relaxation, massage, reflexology or exercise to outlet any stress that might boil up inside you from time to time. You could be having a bad day, but make sure that it's only a one-off occasion.

If you scored 51 – 79

Stress does take affect on you. It is better you seek some help to alleviate it now. Do something that appeals to you, exercise, massage, swimming, that sort of thing, just some time to let yourself go.

If you scored 80 – 105

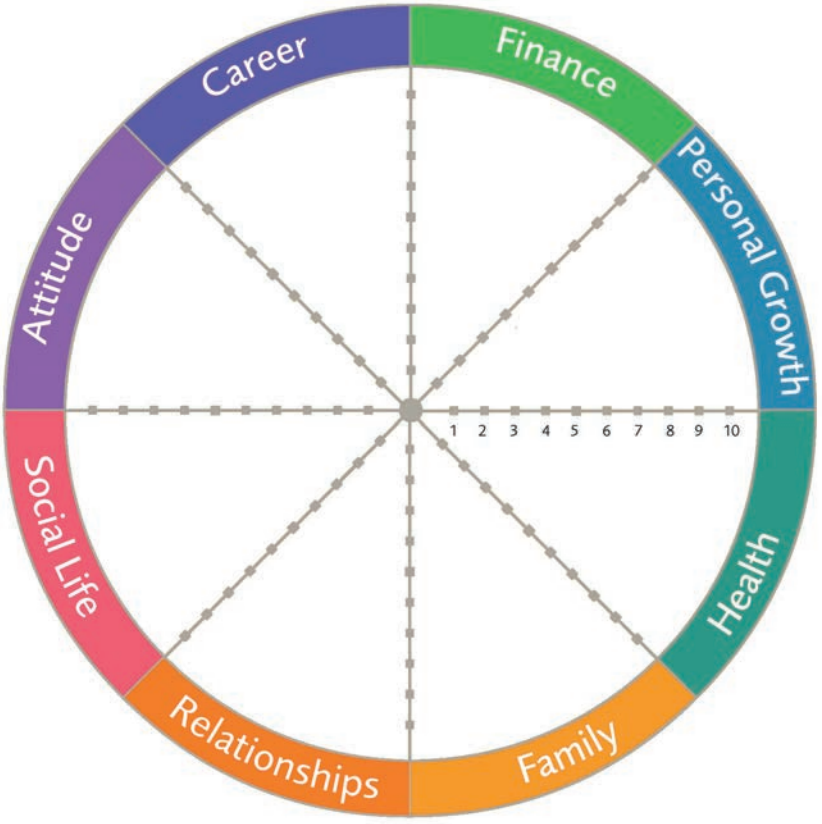
You need to do something about your stress levels, stress can have a physical affect and emotional affects on the body. Find something you feel would help, massage, reflexology, talking to someone or regular exercise, maybe one or two of these things.

Some physical symptoms may not be due to stress, or you could be worried if you've realised that you're under a lot of stress, in which case see your doctor.

Just remember that we all feel stressed from time to time and registering some of these symptoms is no cause for alarm.

- Contact the Counselling Service on 235750 or email counselling@bradford.ac.uk.
- Visit the website at **www.bradford.ac.uk/counselling** for more information.
- Make an appointment to see you doctor if your symptoms are very severe.

Appendix 3:
The Wheel of Life Assessment Tool



Take a snapshot of your life

The Wheel of Life represents eight dimensions of your life, including: Career, Finance, Personal/ Professional Growth, Health, Family, Relationships, Social life and Attitude.

You can change the categories you want to measure.

Instructions:

- Use the wheel of life to assess your level of satisfaction or creative fulfillment in each area.
- How satisfied are you with your life right now? What does success feel like in each dimension of the wheel? Mark the level of satisfaction you feel in each dimension on a scale of 0 (low) – to 10 (high).
- Join up the marks around the wheel and colour in the space between the spokes, until you have filled in your wheel. The new perimeter represents the wheel of your life.
- Does your wheel of life look and feel balanced? Or are you experiencing a bumpy ride?
- Consider your ideal level in each area of your life. A balanced life does not mean getting 10s in each life area: It's about a smoother ride.
- What are the gaps that need attention? What actions do you need to take?
- Explore creative ways you can use this tool.

What area would you like coaching on?

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

June 2016

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0345 772 6100

Published by the Royal College of Nursing
20 **Cavendish Square**
London
W1G 0RN

Publication code: 005 459