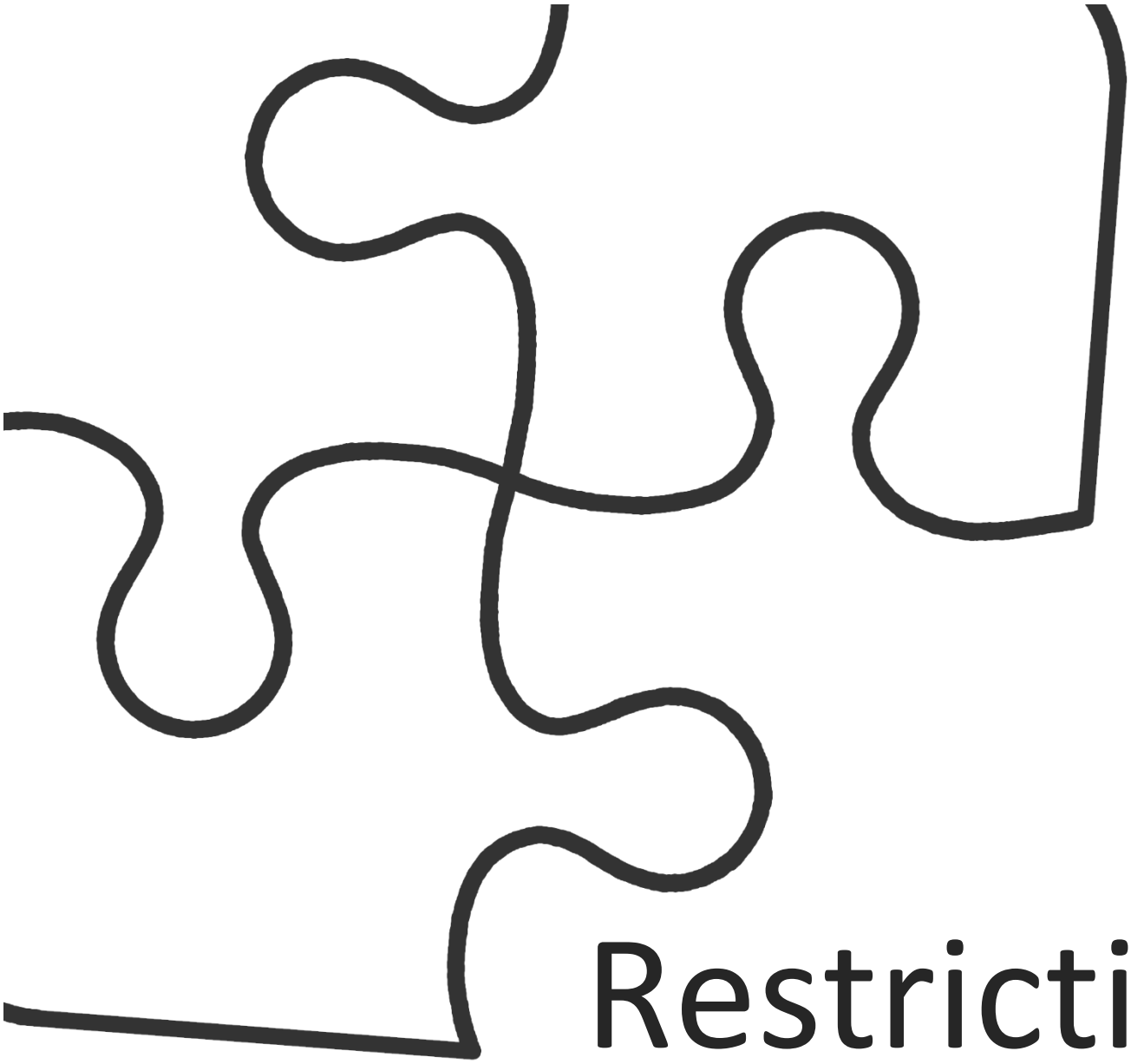
Restrictive Practice Guidelines

Guidance on strategies used during situations of risk to best support an individual

Full Resource Pack

June 2020

lancashire **safeguarding** adults board



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Restrictive Practice Guidelines (Full Resource Pack)

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1. Restrictive Intervention Guidelines

There are ongoing, potential risks, around restrictive practice, in ensuring that residents and staff within Services are supported within a positive culture and learn from experience. Health and Social Care often work together in Lancashire when undertaking safeguarding, quality assurance and contract monitoring within Care Homes. These guidelines are intended to provide support to health and social care settings when restrictive intervention is being used. This guidance should be read and used in conjunction with the LSAB Positive Behaviour Support guidelines document.

It is acknowledged that there may be occasions when more restrictive practices are required to protect the individual and those around them. These guidelines are intended to provide support to health and social care settings when restrictive interventions are being used and good practice guidance around such interventions.

Purpose of Restrictive Intervention

Restrictive interventions are strategies used in response to situations of risk and during situations to best support an individual to lead a fulfilled and meaningful life. They involve managing a challenging situation in order to minimise the immediate risk. These strategies are person centred and are used to manage an immediate risk and keep everyone safe. They do not aim to control the behaviour or deliver long term and lasting behavioural change.

Restrictive practice can include a range on interventions. These can range from environmental measures up to physical interventions. The following identifies the types of interventions used in care settings (Not an exhaustive list).

Environmental:

- 24 hour support/observations/1:1
- Key pad access
- Access to space
- Locked doors/drawers/medication cabinets
- Seclusion
- Segregation
- Assistive technology
- Non inclusive environments (access)

Mechanical:

- Bed rails
- Lap straps
- Arm cuffs/splints to reduce self-injury
- Grab belts
- Harnesses in vehicles
- Use of mittens

Pharmaceutical:

- Regular sedative medication
- PRN sedative medication
- Rapid tranquilisation (N.B this practice tends to be used in clinical settings and under very specific guidelines. NICE Guidance on the use of rapid tranquilisation can be found here)
- Covert medication (LSAB guidance can be found here)

Any form of pharmaceutical intervention must be agreed within a multi-disciplinary meeting with minimum membership of GP, provider and pharmacist

Physical:

- Proactive working practices i.e. Manual guidance/assistance and ensuring staff are prepared for potential situations.
- Keeping safe techniques i.e. breakaway techniques.
- Person specific interventions i.e. Hair pull release.
- Restrictive person specific i.e. anything that would restrict the individual's freedom of movement, such as 2 person escorts.
- Removal of mobility aids

Whilst it is recognised that de-escalation techniques and positive behavioural support is used throughout any intervention, when restrictive intervention is used, services must ensure that the techniques and methods used to restrict a service user:

- Are proportionate to the risk and potential seriousness of harm it is intended to prevent.
- Are the least restrictive option to meet the need. The level of force utilised matched the severity of the circumstances. (The more restrictive the intervention the more it will need to be justified that it was in the individual's best interest).
- Are a last resort. It will need to be evidenced that there was no other way, in the circumstances to meet the need regarding 'Duty of Care'.
- Are used for no longer than necessary and take account of the service user's preferences. It will need to be demonstrated that a less restrictive approach was utilised as soon as practicable.
- If known and it is possible to do so take account of the service user's physical health, degree of frailty and developmental age. This should be informed by the GP and multi-disciplinary team and be reflective of any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used.

NICE violence and aggression

NICE Learning Disabilities and behaviours that challenges services, design and delivery

It is important to remember that many of the people who come to be in a position where they are restrained may already have a history of trauma and this experience can be re-traumatising. Sensitivity to this is crucial as, if not recognised, the situation could quickly escalate.

It is vital that aftercare arrangements are developed and implemented to maximise recovery and minimise any potential traumatising effects of any restraint.

Following the use of any restrictive intervention staff members must continue to monitor the individual for signs of emotional or physical distress for a significant period of time following the application of restraint. After the application of a restrictive practice the staff team should monitor the individual for a 24 hour period and ensure this is documented. For any physical interventions that may restrict the breathing mechanism such as a Two Person Escort it is advised that this monitoring period is increased to 48 hours. This timeframe should be discussed with the individual's GP, who should be part of the multidisciplinary team.

This is due to the higher risk of Positional Asphyxia. Positional Asphyxia can occur when the position of the human body interferes with respiration (breathing), resulting in suffocation. Restraint Related Positional Asphyxia occurs when an individual is placed in a position that prevents or impedes their breathing and they cannot escape their position. Unconsciousness or death can occur rapidly. If an individual shows signs of discomfort or distress Staff members should immediately cease the intervention.

Case Study

Ethel is 82 years old and has a diagnosis of vascular dementia. She resides at Bluebird Lodge Care Home. Staff report she has been more confused in recent weeks, continually wanting to leave the care home, becoming physically and verbally abusive towards staff and residents. Recent blood tests returned normal and she has been screened for a UTI with no infection present. A referral has been made to mental health services for additional support given the changes to behaviour. A key pad is attached to all external doors to prevent Ethel from leaving the care home. She is observed during all waking hours by staff and by the use of assistive technology to track movements during the night. Ethel is prescribed regular sedative medication which is taken each evening to support a consistent sleep pattern. At times when Ethel is agitated, she is manually guided to her bedroom where staff attempt to engage her in specific activities whilst keeping other residents safe from harm. Ethel is therefore subject to environmental, pharmaceutical and physical interventions that would be described as restrictive practice.

Legal Requirements

The Mental Capacity Act (2005) and its Code of Practice set out the most important legal information on restraint. The Mental Capacity Act's Code of Practice (2015) states when it might be necessary to use restraint as:

'Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.' s6.44

On a practical level the legal requirements that need to be satisfied prior to any restrictive physical intervention are:

- Capacity tests (for a specific decision relating to restraint) need to be completed by a competent and experienced individual, along with any other relevant professionals or people who know the service user well. In these capacity tests you would need to consider the following:

- ✓ Assume capacity. You would need to assess this by seeing if the individual can understand the decision to be made, can retain that information, can weigh up the information to formulate a decision and finally communicate the decision either verbally, via symbols, signs, or other means.
- ✓ That the individual has been given every opportunity, including all practicable help to understand the decision. This means that using the preferred method of communication and others if possible at different times of the day, different days of the week, presented by different people.
- ✓ That individuals are aware of their right to make unwise decisions.
- ✓ Any decision made has to be in the persons' best interests.
- ✓ That the intervention is the least restrictive option and for the shortest time possible. This should form part of any Positive Behavioral Support Plan.

Once you have ascertained that the individual lacks capacity to consent to some or all of the restrictive practices, a best interest decision will need to be made in relation to each relevant restrictive practice. A best interests meeting may be convened to carry out this process (but is not essential so long as interested parties are consulted). A Best Interests meeting or consultation should include all relevant professionals (MDT) advocates, family and people who know the individual best. Wherever possible you should invite and support the individual to participate in the meeting/discussion. If they are unable to participate, try to obtain any wishes views or preferences of the person themselves.

At the meeting/discussion you should talk through the capacity assessments that you have completed so everyone is clear around these determinations. For each restrictive practice, options and alternatives should be gathered and explored so that the MDT can be satisfied that each is necessary and proportionate to the risk of harm to the person. This is done by discussing the benefits and burdens of all options. Each person involved should be able to contribute their view and no decision should be ratified without full agreement of all involved. The decision maker is responsible for the overall decisions, however, if there is a disagreement or objection (including from the person themselves) on a best interests determination that cannot be resolved, this will need to be referred to the Court of Protection. Finally the decision and supporting evidence should be documented and kept as evidence at site.

Where restrictive practices are in place or being proposed, you will need to consider whether these either collectively or individually, amount to a DOL. (**Reminder of Cheshire West)**. (A restriction in and of itself may not constitute a DOL).

A DoL will require appropriate authorisation through either DoLS, COPDOL or Welfare application dependent on the setting. It should also be noted that even where there is an LPA or Deputy (Personal welfare) they do not have scope of authority to authorise care arrangements which amount to a DoL, and these will still need appropriate legal authority.

For DoL's, the provider must submit the correct documentation and evidence to csc.acscustomerservices@lancashire.gov.uk, which is the local DoLS team for individuals residing in Lancashire. A court of protection should be referred to the Responsible Body[1]

The authorisation process then involves a number of professionals visiting, assessing and interviewing the person who is being deprived of liberty. These will include a doctor to make sure

[1] The Responsible Body is the funding organisation responsible for the care package

that the person has a diagnosis which allows one of the processes to be used (this means that they have what is described as a mental disorder). Another professional is called a 'Best Interests Assessor' (BIA) and they establish whether a DoL is occurring. If so, they will assess if it is in their best interests and that care and/or treatment cannot be done in a less restrictive way that is proportionate to the likelihood and seriousness of harm. Further to this, they will assess the arrangements for their care prevents them from coming to any harm. A BIA, Mental Health assessor, nurse assessor or GP will complete the assessment of capacity regarding the decision of where care and treatment takes place. From there a decision will be made whether to grant the appropriate authorisation either by the Local Authority (DoLs) or the Court of Protection (CoPDoL or Welfare Order). This can be done for a maximum of 12 months but may be less depending on the decision being made. Conditions may also be set out in the authorisation that the provider needs to adhere to.

In July 2018 the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS and COPDoLS) with a scheme known as the Liberty Protection Safeguards (LPS). The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation. The new standards mean that one scheme will apply in all settings (e.g. care homes, hospitals, supported living, people's own homes etc.) and will be available to anyone over the age of 16. The role of "Supervisory Body", which authorizes deprivations of liberty, will be abolished. It will be replaced by the "Responsible Body". There will be different Responsible Bodies in different settings. For some cases the Responsible Body will be the NHS Trust; in other cases the role will be filled by the Clinical Commissioning Group (or Local Health Board in Wales); and in other cases still it will be the local authority. There will only be 3 assessments:

The "Capacity" assessment, the "Medical" assessment and the "Necessary and Proportionate" assessment.

Documentation / information that the provider will need to hold are:

- Audit of need detailing prescribed interventions bespoke to each individual.
- Adequate Restrictive Physical Intervention model training that complies with Restraint Reduction Network training standards.
- Evidence of Physical assessment of all attending staff members booked on the physical intervention training.
- Evidence of Theory assessment of all attending training to ensure attending staff members have a clear understanding of the purpose and responsibilities relating to physical intervention.
- Certificates of completion to be accessed by local authorities, CCG's and CQC.
- Training calendar or training matrix to ensure that all relevant staff are trained and have annual refreshers.
- Course feedback detailing the effectiveness of the training and understanding of the staff that have been trained.
- Evidence of that a high percentage of staff have completed first aid training.
- Evidence that all staff have completed relevant Safeguarding training.
- Copies of the Mental Capacity Assessments and Best Interest Decision for each restrictive practice being implemented (this must be reflected in the DoLS).

- Evidence of proactive and active working practices to best support the individual and reduce the need of restrictive practices being utilised.
- Evidence of incident analysis detailing slow triggers, fast triggers and outcomes, any potential common themes and these must be considered when updating or creating care and support plans and risk assessments. There must also be evidence that this is shared with the wider staff team.
- Evidence that all incidents are shared with all relevant parties i.e. MDT.
- Restrictive practice reduction plan for each individual to evidence that the provider is regularly reviewing restrictions with the aim to utilize less restrictive options.

When developing the laws and regulations regarding physical intervention there was a requirement to reference other legislation, including the Human Rights Act 1998, Care Act 2014 etc. It would be best practice to keep abreast of current law and changes in legislation to ensure that providers remain compliant in these areas.

Case Study

George is 24 years old and has a diagnosis of Autism, learning difficulties and communication difficulties. He resides at Deer's Leap Specialist Residential Home. George has a very limited ability to communicate verbally and uses PECS (Picture Exchange Communication Systems) to express his needs and wishes. George moved into his new home four months ago and has recently begun to present a variety of behaviours including self-injurious behaviours and behaviours towards others that some may consider "challenging". There have been several incidents where George and staff members have been injured as a result of this. The following steps were taken as a result of this:

1. *Full review and analysis of incidents to highlight any common themes and these findings shared with his MDT.*
2. *The service requested input from a PBS Practitioner to aid in the formulation of Proactive, Active and Reactive strategies.*
3. *Risk assessment and care plan updated and reviewed reflecting the current and potential risks.*
4. *MDT (Multi-Disciplinary Team) are contacted to discuss the change in presentation regarding George.*
5. *Mental capacity assessment completed by the service to ascertain if George has the ability to understand and retain the information given to him, retain that information long enough to be able to make the decision, weigh up the information available to make the decision, communicate his decision. The team at the service used staff that George appeared to like the most, at various times of the day and over a period of several days to ask George how he would like to be supported during times of increased anxiety. The staff team utilised a variety of communication methods such as spoken word supported by George's favored means of communication (PECS), Talking Matts and simple yes/no cards.*
6. *Unfortunately, after completing the assessment it was felt that George was unable to understand the information being conveyed. This was shared with the MDT and a meeting with them was scheduled to discuss what action should be taken in George's best interest to reduce the risk of harm to George and others.*
7. *During the Best interest meeting discussions were held and documented detailing what options were available, the benefits and burdens of each option and which option would be*

utilised that would be least restrictive in nature. The decision was made that keeping safe techniques/break away techniques should be utilised and a restrictive person specific intervention in the form of two-person arm support to reduce the possibility of George harming himself when engaging in self-injurious behaviors. This was then agreed by all present and documented within the best interest assessment form.

8. *An amendment to George's current DoLS authorization was requested and once the team had visited site and met with George this further authorisation was granted subject to review.*
9. *The staff team supporting George then completed appropriate training from a BILD accredited and approved training provided that complied with the Restraint Reduction Network Training Standards.*
10. *After 8 months it then became apparent that the Proactive and Active strategies that were implemented appear to have been successful. The service relayed this to the MDT and the decision was then made to contact the DoLS team and reduce some of the restriction that had been previously implemented.*

Training

Before any physical intervention techniques are used, staff must receive adequate training on positive behaviour support and approaches. Any training model that is utilised within services must comply with the Restrain Reduction Network Training Standards 2019. These Standards will be mandatory for all training with a restrictive intervention component that is being delivered. For each type of intervention being used, a tailored package of training needs to be provided: which is prescribed for each individual. Staff will need to be assessed as being competent in each intervention being used. The Restriction Reduction Standards state after initial training, staff must attend an annual refresher for the next three years. The following year would require a full course of training being completed. A copy of the restriction reduction standards can be downloaded here these will become mandatory in 2020

All staff need to be trained and competent in the application of mental capacity assessment and best interests.

Risk Assessments

Each person must have an individual risk assessment for the use of each restrictive practice being used and there should be evidence of Multi-agency involvement and sign off.

Case Study

Alex is 38 years old and has a diagnosis of Learning Disability and Autism. Alex lives in 24 hour supported accommodation and was admitted via the emergency department to the acute medical assessment unit at City Hospital, with a perished gastrostomy tube. Alex was accompanied with 2 support carers, who report that a previous change of PEG tube was poorly managed and caused Alex great distress.

Following a 2 stage capacity assessment it was determined that Alex lacked capacity to consent for the replacement of his PEG tube, it was therefore deemed in his best interest to proceed with a gastroscopy and tube change under general anaesthetic. A DoLS application was completed.

Co-ordination commenced with the Gastro consultant, safeguarding team, emergency theatres, anaesthetics, theatre staff, security and support carers. A meeting was held to discuss reasonable adjustments for Alex and to develop a care plan to support this procedure.

Alex was placed first on the list the next morning, carers were orientated around the hospital to ascertain best route to accompany Alex to theatre and the theatre room was also adjusted following risk assessments.

Alex required a Safe hold in order to insert a cannula as detailed within the care plan.

Post procedure Alex was able to remain in theatre recovery for a period of observation with his carers and was discharged later that day.

Review

Where PI is in place there is an expectation this is reviewed on a monthly basis and this review should contain the following:

- Number of incidents requiring PI and a breakdown of techniques used (e.g. breakaways, guided support, seated restraint).
- Number of incidents not requiring PI (possibly evidencing benefits of positive support plans in place).
- Brief thematic analysis of incidents requiring PI and those not requiring PI (what can be learnt from this to inform the person's PBS plan going forward).
- Incident analysis of the perceived functions of the behaviour- for known functions focus should be on how these situations/ triggers can be managed better if possible (or highlight the residual risk of factors that it is not possible to control); where the function is not known this should be a prompt to review the service users' functional assessment.

It would also be useful that other care plans for the service user are reviewed so that assurance can be given so that the foundations of good support are in place for the person. Documents that it would be beneficial to review would be as follows:

- Service user care and support plans.
- Risk assessments.
- Health action plans.
- Person centred plans.
- Communication passport/ care plans.

Debrief

Review of incidents etc.

All uses of restricted intervention should be recorded within a 24hour period and reviewed by the services management team. During this process it should provide the management team the opportunity to undertake the following:

- Ensure appropriate action was taken immediately after the event i.e. contacting GP, 111 service, police etc.
- Quality check the report, inform relevant individuals and key stakeholders etc.
- Make the relevant referrals and notifications if required i.e. safeguarding, CQC etc.
- Triage reports based on priority and risk.

- Facilitate debriefs with staff members and service users if required.
- Ascertain if any further action is required such as, review of risk assessments and support plans, if a strategy meeting is required etc.

As described above in the review section, review and analysis of incidents should take place on a monthly basis as well as after a significant event. This analysis should take into account a wide variety of aspects such as activities and scheduling, what went well and what didn't go well, functional assessment to try to understand what purpose the behaviour served for the individual, skill building (supporting the individual to have this purpose met without the need to present behaviours that some may deem as challenging) and analyse of near misses as well as possible areas of de-escalation and best practice that can be shared with the wider team.

Functional assessment should take the form of the examination of antecedents (slow triggers and fast triggers). Slow triggers are the events which sensitise an individual to his/her environment. Fast triggers are the events that immediately precede the presentation of behaviours. It should also analysis any consequences following the behaviour. Once this data is gathered staff teams will then be able to identify any common themes and implement strategies regarding how best to support the individual to have this need met without the need to present behaviours that may be perceived as challenging.

Whilst the use of any kind of restrictive intervention may occasionally be necessary to keep people safe in certain situations, it is also traumatic for those involved. As such a fully embedded debrief process is vital to ensure support is provided for all involved where possible:

- Debriefing should take place as soon as possible after an incident has occurred.
- Debriefing should not be forced upon the individual and/or staff member and should be led by the person to be debriefed.
- It should allow ventilation of feelings in a controlled, safe environment and should offer the opportunity for staff to express themselves without fear of reprisal or accusations of unprofessional behaviour.
- It is vital that where possible accessible debriefs are utilised to meet the individual communication needs for service users and if required staff members.

Debriefs should also provide an opportunity to reflect in the practices and interventions being used as well as the opportunity for further functional analysis and the identification of precursor behaviours signifying an escalation in presentation.

Appendix 1 - Mental Capacity Assessment Template

Name	
Date of Birth	
Person completing the assessment	
Role	
Date of completion	

What prompted this capacity assessment? (I.e. summary of relevant history)

What is the specific decision to be taken?

Is there a Lasting Power of Attorney (LPA) Health and Welfare / financial, Enduring Power of Attorney (EPA), Court Appointed Deputy (CPD), Advocate (IMCA, IMHA)?

Determination of Capacity

Is there an impairment of or disturbance in the functioning of the person's mind or brain (diagnostic test i.e. dementia, learning disability, stroke etc.)?

What reasonable steps were taken to maximise the person's capacity to make the decision?

Functional Assessment

Understanding

Retention

Balancing/weighing up

Communication

Can the decision be delayed because the person is likely to regain capacity in the near future?

Views of interested others *(e.g. family, friends, carers, LPA, IMCA, CPD etc. give names and roles. If no-one justify)*

Views of professionals involved

Outcome of assessment

Appendix 2 - Best Interests checklist & Balance Chart Template

Decision Maker: _____

The named decision maker should consider all relevant circumstances of which he/she is aware, and which it is reasonable to regard as relevant in making the decision on behalf of a person who lacks capacity. This should include medical, social, welfare, emotional and ethical matters. Under no circumstances must a best interest decision be made by the desire to bring about a person's death.

Decision to be made: _____

How the decision is phrased here becomes important in helping to maintain a focus on the decision to be made and the extent of the boundaries of the best interests' process (should be the same wording as decision on the capacity assessment).

Attendees/ Consulted parties:_____

What are the views of family, friends, anyone engaged in caring for the person, anyone interested in the person's welfare, anyone named by the person to be consulted? Please give details of each person consulted and their views. Identify and maintain a copy of any additional information given

Assessment

1. Has the person been permitted and encouraged to participate as fully as possible in the decision making process?
E.g. by simplifying information, using pictorial aids, having trusted family/friends involved to assist with communication. Please state what has been done to aid participation

2 Have you considered the person's past and present wishes, feelings, beliefs and values that would have been likely to influence his/her decision if he/she had capacity?
Include any relevant written statements made when competent or any religious, cultural, moral and political beliefs and values. Please state any that are relevant to the decision to be made:

3 Have you identified the relevant circumstances that he/she would take into account if they were making the decision themselves? List these below:

Options available are:

1.

2.

3.

Benefits of	**Burdens of**
Benefits of	**Burdens of**

Weighting Tool Key

Options agreed to be in best interests of NAME are**:**

Magnetic Significance ***
Highly Significant **
Significant *

Appendix 3 - Post Physical Intervention Monitoring Record

Post Physical Intervention Monitoring Record					
Service User Name		**Date of Birth**			
Are there any additional risk factors associated with this person? *e.g. brittle bones, diabetes, heart disease, alcohol abuse, drug abuse, asthma, etc. (seek additional medical advice)*					
Date of the Intervention		**Approximate duration of the intervention**		**Approximate duration of the intervention**	
What Physical Intervention was used?		**Was it a planned or unplanned response?**			
Guide to Monitoring Intervals: 0-12 hours following the intervention: Monitoring intervals will be 15 minutes between each observation 12-24 hours following the intervention: Monitoring intervals will be 30 minutes between each observation After 24 hours – Observations will be hourly After 36 -48 hours – Observations will be two-hourly NB: The times given may vary according to the individual's risk assessment and the answers you give in the first part of this form.		**KEY:** **BC** = Behaviour change (Describe in comments box) **A** = Alert **N** = Non-Responsive **BFS** = Breathing fast and shallow **NB** = Noisy Breathing **L** = Lethargy			

Time (24 hr)	**Observation (use key)**	**Activity/Comments What are they doing? What is the Schedule?**	**Initials**

Signature of Site/Service Manager on completion of period of observation	

Appendix 4 - PINCH ME (Checklist for delirium symptoms)

Pain

Infection

Nutrition

Constipation

Hydration (Dehydration)

Medication

Environment, e.g. changes to environment causing disorientation

Also watch out for sensory impairment, sleep disturbance and immobility.

Another common cause is withdrawal – (e.g. from alcohol, or from prescribed drugs if stopped too quickly)

2. Families and Members of the Public Guidance – Restrictive Intervention Information

Restrictive Practice, what is it and why is it used?

Restrictive practice means any practice or intervention that has the effect of **restricting** the rights or freedom of movement of a person with disability. It is used for a number of reasons including to manage behaviours that challenge, to keep people safe and also to help people live a more positive life.

What does restrictive practice look like?

Restrictive practice can include a range on interventions. These can range between environmental, mechanical, pharmaceutical and physical interventions. Examples of the different interventions are listed below (please note this is not an exhaustive list).

Environmental

- 24 hour support/observations/1:1
- Key pad access
- Access to space
- Locked doors/drawers/medication cabinets
- Seclusion
- Segregation
- Assistive technology
- Non inclusive environments (access)

Mechanical

- Bed rails
- Lap straps
- Arm cuffs/splints to reduce self-injury
- Grab belts
- Harnesses in vehicles
- Use of mittens

Pharmaceutical (medication)

- Regular sedative medication
- As required sedative medication

- Rapid tranquilisation (N.B this practice tends to be used in clinical settings and under very specific guidelines)
- Covert medication (medication given without the persons' knowledge)

(Any form of pharmaceutical intervention must be agreed within a multi-disciplinary meeting with minimum membership of GP, provider and pharmacist).

Physical

- Proactive working practices i.e. manual guidance/assistance and ensuring staff are prepared for potential situations.
- Keeping safe techniques i.e. breakaway techniques.
- Person specific interventions i.e. hair pull release.
- Restrictive person specific i.e. anything that would restrict the individual's freedom of movement, such as 2 person escorts.

Legalities

Some people have the capacity to make decisions about their care and treatment, including restrictive interventions. Where this is the case the person will be involved in the planning of their care involving any restrictive practices. This should be clearly documented within their care and support plans and reviewed on a regular basis with the individual.

Other people may lack the capacity to consent to restrictive interventions being used as part of their care. The Mental Capacity Act (2005) is the legal framework that is used in order to ensure any restrictive interventions used are done so legally. There are a number of legal processes that must be completed under the Mental Capacity Act (2005) before any restrictive interventions are used with a person who lacks capacity to consent to them. These include a capacity assessment and a best interest meeting. These processes ensure that the rights and safety of the person are upheld at all times and that any restrictive interventions are used in the best interest of the person.

Restrictive practice can be daunting to hear of or indeed witness, especially if this is new to you. The strict legal requirements and frameworks help to ensure that restrictive interventions are used appropriately, safely and with dignity and respect at all times.

The law says that:

'Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible'

(The Mental Capacity Act, 2005)

When restrictive intervention is used, services must ensure that the techniques and methods used to restrict a person are:

- Proportionate to the risk and potential seriousness of harm it is intended to prevent.
- The least restrictive option to meet the need.
- A last resort.

- Used for no longer than necessary and take account of the service user's preferences.

Safeguarding

It is important that anyone subject to any form of restrictive interventions is safeguarded at all times. If any restrictive interventions are carried out without the correct legal framework having been implemented, this could amount to a safeguarding matter and should be reported via the appropriate Local Authority safeguarding mechanisms.

Resources and Guidance

There are a number of guidance documents and information resources available for people to access for further information on restrictive practices/interventions.

https://pathways.nice.org.uk/pathways/violence-and-aggression#path=view%3A/pathways/violence-and-aggression/managing-violence-and-aggression-in-adults.xml&content=view-index

https://www.nice.org.uk/guidance/ng93/resources/learning-disabilities-and-behaviour-that-challenges-service-design-and-delivery-pdf-1837753480645

https://restraintreductionnetwork.org/know-the-standard-2/

http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults/resources/mca-dols/lsab-restrictive-practice-guidance.aspx

3. Positive Behaviour Support Guidelines

This guidance is to support Health and Social Care settings to understand the approach of Positive Behaviour Support and to develop effective support plans. This guidance should be read and used in conjunction with the **LSAB Restrictive Interventions Guidelines** document.

What is Positive Behaviour Support (PBS)?

PBS is a person centred framework for providing long-term support for people who have, or may be at risk of developing behaviours that challenge.

It involves understanding the reasons for behaviours, considering the person as a whole to develop and implement a range of evidence-based support to better meet their needs, improving the quality of life of the person and those around them, thus reduce the likelihood of behaviours that challenge occurring in the first place.

There are several core dimensions that differentiate PBS from other approaches. It is considered to consist of ten, overlapping elements to create a multi-component framework. The table below provides an overview of the 10 components of PBS, you can read more about each component in the research paper on the BILD website here.

Values	1. Increase the quality of life for the individual and everyone else around them; family, staff.
	2. Works by developing and building the skills of the individual and not punishing the individual or the behaviour.
	3. Practitioners work in partnership with the individual and the people who are important to them.
Theory and Evidence Base	4. An understanding that challenging behaviour happens for a reason and serves important functions for the individual.
	5. PBS primarily uses applied behaviour analysis to describe, predicate and change behaviour.
	6. The secondary use of other complementary, evidence-based approaches to support behaviour change; Occupational Therapy, Speech and Language and other Physiological Therapies.
Process	7. Uses decisions based on facts and research – not opinions or hearsay.
	8. A formal assessment (Functional Assessment) is made to create a clear structured plan of action. What practitioners do is directly informed by what they know about the individual.
	9. The PBS plan should tell people what to do to proactively prevent the challenging behaviour from happening and manage it well reactively if it does.
	10. Above all it should make sure people are actively supported over the long term to maintain their quality of life. To include monitoring and evaluation of interventions.

Gore et al., 2013

What are behaviours that challenge?

'Behaviours that challenge' also referred to as 'challenging behaviour' or 'behaviours of concern' are more likely to be prevalent in people with developmental and health problems that affect communication and the brain e.g. learning disabilities, dementia or acquired brain injuries.

A person's behaviour can be defined as "challenging" if it puts them or those around them at risk; it is usually taken to mean aggression (physical or verbal), self-injury, damage to property or socially inappropriate behaviour. However, there is also a need to recognise and respond to behaviour that has a negative impact on a person's wellbeing and/or stops or makes it difficult for the person to be involved in ordinary activities, relationships at home and in the community.

Many people we support experience levels of anxiety and stress and have difficulties coping with at least some aspects of their environment and the people in it. Behaviours that challenge develop as an understandable, though not intentional, response to these sorts of circumstances as a means of communication.

Consequently, the term 'behaviours that challenge' emphasises that such behaviours represent challenges to service and those that support them, rather than labelling the person as the problem.

What is a Behaviour (PBS) Support Plan?

A PBS plan is a document created to help understand and manage behaviours that challenge with the aim to reduce the likelihood of behaviours happening and teaching the service user new skills and ways of communicating their needs.

Whilst the emphasis is on preventing the need for behaviours that challenge; it also helps care staff by providing a step by step guide to identify when they need to intervene to prevent an episode of behaviour happening or escalating.

They provide consistency through everyone supporting the person using the same techniques and approaches, in turn helping development of more socially acceptable ways of communicating needs. The PBS plan should help inform other risk assessments and care plans for the service user.

The following sections will support you to create an effective PBS plan, the person (if possible) and those involved in their care e.g. care staff and the person's family and/or representative are fully involved in the assessment process and co-produce and implement any approaches agreed on the plan.

Initial assessment of the behaviour

A Functional Behavioural Assessment is a process for determining the function of (or reason behind) the person's behaviour that challenge. The complexity and duration of the assessment process should be proportionate to the behaviour. You should seek professional support and advice with writing Behaviour Support Plans when;

- You are unclear about the function of the person's behaviour
- Support plans / strategies are not effective
- Behaviours are considered high risk
- The person may be committing a criminal offence

A Functional Assessment involves the collection of data, observations and information to develop a clear understanding of the relationship of events and circumstances that trigger and maintain the behaviour. The assessment should consider;

- The person's life history
- Physical health
- Mental health
- Communication and social skills
- The broader social and physical environment
- What happens immediately before the behaviour starts (antecedents) and what happens as a result of it (consequences)

This typically involves direct and indirect methods in order to understand the reason for the behaviour from the person's perspective.

- **Indirect methods** include asking people and looking at existing information to assess the broader physical or social environment.
- **Direct methods** involve objectively observing and recording the person's behaviour and events in the environment while the behaviour is occurring

Identifying which behaviour(s) to focus on

Deciding which behaviour to focus on requires a balance between what is most challenging for the person and those around them and being realistic about what we can effectively change within current environments, structures and resources.

It is important to break things down into manageable components rather than trying to address everything at once e.g. choosing one behaviour that challenges as the target for intervention in the behaviour support plan.

Another factor to consider in choosing the behaviour to target is the likelihood of success over the short term. Once success has been seen in one area, the person and those around them can build on that success and systematically address other problem behaviours.

Defining the behaviour

When priority behaviours have been identified, one of the first and most important steps when planning to assess and intervene with behaviours that challenge is to objectively and specifically define the behaviour.

It is helpful to gather information to provide a description of the behaviours that are emerging or apparent.

The definition of the behaviour(s) should take into consideration and identify the following areas;

- **Appearance:** What the behaviour looks like
- **Place:** Setting(s) in which the behaviour occurs
- **Severity:** How severe the behaviour is
- **People:** With whom is the behaviour occurring, proximity of others and what are they doing when the behaviour starts e.g. staff/visitors/other service users
- **Time:** What time(s) of the day does the behaviour occur
- **Frequency:** How often the behaviour occurs
- **Duration:** How long the behaviour lasts
- **Impact:** What the impact is on the person and others around them

Having a clear and concise definition of the behaviour is an essential first step in developing a PBS plan. A good definition is measurable and observable and should describe in detail what someone would see and hear during an episode.

Analysis of Function – identifying possible causes

The relationship between the behaviour and its function is not conscious and use of behaviour is rarely deliberate or intentional.

Behaviours that challenge always have a **function** for the service user and it is essential to understand what that purpose serves so we can respond in constructive ways.

There are two ways that a behaviour is reinforced;

Positive reinforcement refers to an increase in the rate of behaviour as a result of the presentation of a preferred event or stimulus.

Negative reinforcement refers to an increase in the rate of a behaviour as a result of the withdrawal (or prevention of occurrence) of a non-preferred stimulus or event.

A reinforcer is something which strengthens the behaviour to which it is applied: these may be internal or external to the person. Reinforcers are not always pleasant things e.g. being shouted at may not appear pleasant to most of us but if behaviour is ignored, behaviours may increase so the service user gets a response, even if they are being shouted at.

Although there are many reasons why a person may display behaviours that challenge, there are common purposes or function behind the behaviour that will generally come under one of the following categories;

- **Social Attention:** This may be due to limited communication skills, boredom, and inability to occupy themselves. Some people may learn that behaving in a particular way is a reliable way of attracting others' attention, even if this is negative.
- **Tangibles:** The desire for certain things e.g. food, drink, objects or activities
- **Escape or Avoidance:** This could be to avoid certain people, situations or activities that they don't like, or don't find rewarding
- **Sensory:** This may be behaviour that is internally rewarding or self-reinforcing to meet needs e.g. warmth, touch, pleasant sounds or avoid pain, discomfort, noise.

As part of your functional assessment or analysis, consider the use of a Functional Assessment Screening Tool (FAST) to identify a number of factors that may influence the occurrence of behaviours that challenge.

Finding out why/when the behaviour occurs – The ABC Approach

We need to know about the sequence of behaviours which lead up to an episode or period of behaviour(s) that challenge as they rarely occur 'out of the blue'. There are always links between the behaviour and what happens before and after it. The ABC model is a useful way to understand how these are related and helps us identify the function of the behaviour and has direct implications for how we respond to it. It involves looking at the:

- **A**ntecedents (what happened before the behaviour)
- **B**ehaviour (what is the actual behaviour?)
- **C**onsequences (what happens afterwards?)

Antecedents can be broken down into two types:

- **Setting Events:** longer term underlying factors e.g. health issues, changes in emotional states, particular activities or sensations, places, individuals, objects, changes to the routine earlier in the day. These could happen hours or days before the actual incident or could be from an annual event
- **Triggers:** things that happen immediately before the behaviour e.g. seeing a particular person, hearing a particular noise, experiencing a sharp pain.

If triggers occur when the person has already experienced one of more of the setting events, it is more likely that behaviours that challenge will occur.

Consequences are the things that happen after the behaviour. While these are always things that impact on the person, they are not always obvious as they include:

- Things that are added or taken away e.g. contact or conversation, items, activities or sounds.
- The way other people react or respond
- Things that happen immediately and later
- Changes in feelings or sensations

Behaviour (ABC) charts allow care staff and practitioners to objectively record incidents of behaviours that challenge including the antecedents, behaviour and consequences during an incident. These can be useful for low frequency behaviours or near misses as part of functional assessments and reviews/analysis exercises. It should be considered how these align with incident reporting and management processes.

These should then be reviewed and analysed to support identification of strategies to include on a Behaviour Support Plan. Thinking about what already is working well is also very useful.

An example ABC recording chart template and filled examples can be found in Appendix 1.

Identifying Strategies

A PBS plan should contain a range of strategies, referred to as **'Proactive', 'Active'** and **'Reactive'** strategies which not only focus on managing the behaviour(s) that challenge when they occur, but also develop and introduce approaches that promote changes over time and ensure the service user has access to things that are important to them.

Consult with the service user directly whenever possible and also talk to people that know the person well and involved in their care. The emphasis of the plan should be on preventing the need for behaviours that challenge, but it's important to be realistic about the changes you can make and some proactive strategies will take longer to have effects.

Active strategies detail how to support the service user should early warning signs of behaviours escalating are being displayed. Reactive strategies should be used as a last resort unless there is an agreement with the person that this is the best approach for them. They should be used together with proactive interventions as when used in isolation, such approaches do nothing to enable improvements over time. There should be a graded approach that considers the least restrictive options.

The strategies should support care staff to identify when a person may display behaviours that challenge, giving them chance to intervene before the behaviour escalates. This helps to ensure that the focus of the plan is not just on the behaviour that challenge but provides ways to support the person to have a good life, enabling the person to learn better, more effective ways of communicating what they need.

When everyone supporting the person uses the same approaches it helps the development of more socially acceptable ways of communicating their needs, the PBS plan is a useful tool to see what is and what isn't working for the service user, and enables care staff to adapt or change strategies as necessary.

Risk assessment & Care Planning

When assessing and managing the risk of behaviours that challenge, a multidisciplinary approach to risk assessment and risk management should be used. The risk assessment and care planning process should be carried out with the service user, and where appropriate their family member/representative and incorporate any advice or input from health professionals.

The regularity of the review should depend on the assessment of the level of risk. The PBS plan should be supported by an accurate and thorough risk assessment.

If the person is transferring to another care setting, the content of the risk assessment and care plan should be shared and incorporated into any additional document such as hospital passports.

Behaviour (PBS) Support Plan

A written PBS plan should be developed based on the shared understanding about the function of the behaviour and should;

- Identify reactive strategies to manage any behaviours that challenge that are not preventable, including how care staff should respond if a person's behaviour escalates and there is a significant risk of harm to themselves or others.
- Incorporate risk management and take into account the effect of the behaviour support plan on the level of risk.

- Be compatible with the abilities and resources of the service, including managing risk, which can be implemented within these resources.
- Be supported by data that measure the accurate implementation of the plan.
- Be monitored using the continuous collection of objective data
- Identify any training for care staff or family members to improve their understanding of behaviour that challenges.
- Identify those responsible for delivering the plan and the designated person responsible for coordinating this.
- The strategies you choose should be different depending on the function of the behaviour.

Below is some guidance to assist you to write a PBS plan. Strategies have been divided into 'stages' of increasing severity to encourage people to respond to the first signs of distress and resolve issues before they escalate. This will help to ensure that the least restrictive interventions are being used and that the strategies being used are proportionate to the level of risk.

'Traffic light' System

A format which has been found to be particularly useful in helping care staff to understand the different stages of behaviour is based on a traffic light system using colour coding on PBS support plan. This format enables care staff to more easily identify when they could intervene to prevent behaviours escalating into an episode of 'challenging behaviour'. An example of this in practice can be found on Appendix 2

Green (Primary/Proactive)	Calm and relaxed – this is 'typical behaviour' for the person. Proactive strategies to be used.
Amber (Secondary/Active)	Anxious, distressed or aroused – indication that problems are about to occur. 'Secondary' strategies such as distraction or diversion to prevent escalation.
Red (Tertiary/Reactive)	Incident – occurrence of the behaviour itself. Tertiary strategies to
Blue (Recovery)	Calming down/recovery phase – but still need to be careful and ensure that the person returns to the 'green' phase and re-establish relationships.

Proactive (Primary) "Green" Strategies

Proactive strategies are put in place before the behaviour occurs, rather than being responsive, with the aim to remove the trigger that prompts the behaviour for the service user. Some of these strategies should be developmental so the service user is supported to develop new skills and ways of communicating their needs.

These strategies look at a range of changes we can make in the service user's environment, the ways we communicate and in staff attitudes to reduce the need for the behaviour. The aim is to support the service user to stay in this phase as much as possible thinking about areas such as;

- Making the day more understandable for the person.
- Teaching the person alternative ways to communicate what they need and/or developing coping strategies

- Supporting a predictable routine and structure for the person
- Leisure activities that are personally meaningful and physical exercise
- Increasing the range of activities and interactions available to the person.
- Picking up signs of anxiety for that person.
- Changing the environment e.g. reducing noise, increasing predictability

Early Warning Signs (Secondary) "Amber" Strategies

Secondary prevention involves reducing the risk associated with imminent challenging behaviour and its potential escalation. This part of the plan will describe what to do in response to early warning signs, to help staff intervene as early as possible, before the person's behaviour escalates.

Signals may be subtle, but through assessment and observations, these should be clearly defined so staff can immediately take action and therefore avoid moving onto 'red'. The people who care and support for the service user on a day to day basis will more than likely understand and know these early warning signs and so their input is invaluable.

Many episodes of behaviours that challenge occur because the early warning signs are not recognised or because care staff fail to change their own behaviour once the signs become evident.

At this stage the service user may be starting to feel anxious or distressed. Care staff need to take quick action to support them to return to the 'green' phase as quickly as possible to prevent escalation of behaviour.

These strategies may include;

- Reducing the demands being placed on the service user and communication with them
- Distraction and diversion to activities they find rewarding and enjoyable
- Reassurance to the person
- Individual relaxation techniques

Reactive (Tertiary) 'Red' Strategies

Reactive strategies are designed to keep the person and those around them safe from harm and return to a calm situation as soon as possible. When behaviour escalates to ‘red' and an incident of behaviours that challenge is occurring, the signs will be more obvious than in the 'amber' phase.

This phase is where behaviours that challenge occur and there is a risk to the service user and others. The plan needs to detail actions staff need to take to quickly achieve safe and rapid control over the situation.

These strategies focus on minimising the physical and emotional harm caused by behaviours that challenge, during and after an event.

Restrictive Interventions

Reactive strategies may include the use of agreed **restrictive interventions** e.g. PRN medication, seclusion, physical interventions – these should be used as a last resort unless it is agreed and evidenced through the MDT assessment that they should be used sooner e.g.

paracetamol to manage pain proactively or the person may request their arms are held to support reduction in anxiety.

If restrictive interventions are used as part of the reactive strategies, please refer to **LSAB Restrictive Intervention Guidelines** document for further guidance. A thorough risk assessment should be carried out and any outcomes should be incorporated into the behaviour care plan to clearly direct staff.

Restrictive interventions are crisis management techniques, not a strategy for managing behaviour. Physical interventions are not designed to reduce the frequency or severity of negative behaviours but rather to ensure the service user's safety.

Consequently, these interventions are only used when the person is at risk of causing harm to themselves or others and if possible, all other strategies have been utilised. Only the restrictive practices agreed and approved as part of a multi-disciplinary process should be used by staff who have received training should undertake these. The goal should always be to increase and improve proactive interventions so the need for physical intervention or restrictive practices is minimised.

Post Incident Support 'Blue' Strategies

This section should specify the procedures to be followed after an incident for both the person and care staff.

When a person is calming down and recovering from an incident of behaviours that challenge, think about what the person looks like and what they do or sound like e.g. body language, facial expression, language/tone of voice/behaviours
For the person, this section should also specify any immediate behavioural actions that need to be implemented following incidents for example:

- Giving the service user more space
- Procedures for ensuring their physical and emotional safety e.g. via physical checks and supportive counselling/reassurance giving
- Procedures for care staff in terms of any immediate medical checks and emotional support. Longer term observations and checks may be needed, especially where restrictive intervention has been used.
- Engaging in an activity (ensuring the person is ready to do so)

This phase is where the incident is over and the person is starting to recover and become calm and relaxed again. We still need to be careful here as there is a risk of behaviour escalating again quickly.

Where appropriate, debrief may be required where possible the person and the staff members involved and you can find more about these in the LSAB Restrictive Interventions Guidelines document.

Monitoring Effectiveness and Review

NICE recommends that Behaviour (PBS) Care Plans should be reviewed frequently, fortnightly for the first 2 months and monthly thereafter. There may be a requirement for the plan to be reviewed sooner;

- Following a significant incident
- Any changes or increases in behaviour(s) that challenge
- Use of restrictive interventions increases
- Indications or evidence that the person's quality of life decreases

It is important to note, that changes you make to a service user's routine may result in an initial increase or change in behaviour, some strategies that supports a positive change in a service user's life may take time but it needs to be monitored closely to ensure strategies remain appropriate.

Where possible the person should be involved in the review process and where appropriate, family and/or representative to gain their views. This should be used alongside information and data relevant to the behaviour, through direct and indirect methods (as detailed above) to monitor the effectiveness of the intervention. You may need to seek further advice and support from healthcare professionals.

The review process should be flexible and continuing (rather than a fixed) process, because factors that trigger and maintain behaviours may change over time. This should include the following;

- Number of incidents where Physical Intervention (PI) was not required – this could provide evidence of benefits/effectiveness of PBS plans in place.
- Number of incidents where PI's were required and a breakdown of techniques used (e.g. breakaways, guided support, seated restraint)
- Brief thematic analysis of all incidents above looking what could be learnt from this to inform the person's PBS plan and approaches from staff going forward.
- Review of information on debriefs.
- Incident analysis to review the perceived functions of the behaviour along with how these situations/triggers can be possibly better managed

Any information should be compared to any initial functional assessment. If following a review it indicates that there has been a reduction in incidents, shows progress on acquiring new skills or increased quality of life then the approaches can continue or be developed further to meet the new circumstances if required. If this is not the case, then returning back to the start of the assessment process and re-evaluating the behaviour and interventions used will be needed.

It is vital that you develop and review Restraint Reduction Plans for service users to ensure that services are utilising least restrictive options when supporting people with behaviours that challenge, further information on these can be found in the **LSAB Restrictive Intervention Guidelines** document.

Staff Training in PBS Approaches

Staff must receive adequate training to understand and implement PBS, any staff members undertaking assessments, observations or developing plans must be adequately trained. Care staff must be trained in methods of avoiding behaviours that challenge, including anticipation, prevention, de-escalation and breakaway techniques.

In relation to de-escalation, NICE recommends that Health and Social care provider organisations should train staff to enable them to:

- recognise the early signs of agitation, irritation, anger and aggression
- understand the likely causes of aggression or violence, both generally and for each service user
- use techniques for distraction and calming, and ways to encourage relaxation
- recognise the importance of personal space
- respond to anger in an appropriate, measured and reasonable way and avoid provocation.

The Restraint Reduction Network Standards 2019 have been written for training services delivered within health and social care settings to ensure training promotes human rights, supports cultural change to a more person-centred and values based approach which is necessary to reduce reliance on restrictive practices.

Staff must have face to face training in preventative / primary strategies and secondary strategies before they are taught to use restrictive interventions with an annual refresher. Any training with a restrictive intervention component will need to be certificated against the standards, these standards will be a requirement in CQC regulated services from April 2020.

References / Further information

BILD
Introduction to PBS animation:
Resources

PBS Academy
PBS Observational Checklist
Providing Positive Behavioural Support: A Checklist for Service Providers

National Institute for Health and Care Excellence (NICE)

- Guideline NG11 – Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- Guideline NG97 – Dementia: assessment, management and support for people living with dementia and their carers
- Pathway - Anticipating, reducing the risk of and preventing violence and aggression in adults
- Pathway – Restrictive interventions for managing violence and aggression in adults
- Guide
- Quality Standard QS154 Violent and aggressive behaviours in people with mental health problems
- Quality Standard QS101 Learning Disability: behaviour that challenges

Skills for Care

- Behaviours which challenge - training design & commissioning

The Challenging Behaviour Foundation

- Information sheets

Appendices

- **Appendix 1 - Example Behaviour (ABC) Recording Chart**
- **Appendix 2 – Example of completed Behaviour (ABC) Recording Chart**
- **Appendix 3 – Example Behaviour Care Plan**

Review Date

May 2021 – (or at a time when Liberty Protection Safeguards are in-situ if this comes before)

Appendix 1 - Example Behaviour (ABC) Recording Chart

Service User	.....	Service	.....

Date & Time	Staff	Setting	Trigger	Action (Behaviour)	Result (Consequence)	Individuals reaction	Duration & Comments

Appendix 2 - Example of completed Behaviour (ABC) Recording Chart

Service User	.....	**Service**	.....

Date & Time	**Staff**	**Setting**	**Trigger**	**Action (Behaviour)**	**Result (Consequence)**	**Individuals reaction**	**Duration & Comments**
	Initials	What was the individual doing leading up to the behavioural presentation and anything else you think may have contributed.	What happened directly before the behaviour - What people, things, or events might have triggered the behaviour? Did a member of staff disrupt an activity, was a demand placed? Was a requested item unavailable? Etc.	Describe the behaviour that you saw.	What happened as a result of the behaviour? How did the people, things, events around the person change as a result of the Incident? Did it result in the termination of an activity, removal of demand etc?	What was the person's response? What did they do as a result of the consequence? Did the behaviour stop, did the behaviour escalate? Etc.	Note the duration of the incident and any further comments.
Example							
12/10/12	*PS, TM & BO*	*George had just eaten his dinner and was repeatedly asking for crisps*	*As George had just had his dinner we said no and informed him he would have to wait.*	*George began to shout, spit and rock back and forth.*	*We tried supporting George to calm then asked him to access a quieter room*	*George went into the lounge*	*10 mins*
12/10/12 *Follow on from above*	*Above*	*Previous incident*	*I (PS) went into check on George and he was starting to strike his leg with a closed fist*	*This increased and George began to strike the side of his face.*	*I used a firm prompt asking him to stop. I then told him we would make a plan. I got the activity strip and put on pictures for shower, garden and then crisps.*	*George stopped striking himself, read the activity strip with me and went through the sequence.*	*Incident 5 mins* *40 mins to go through the activity sequence and for George to calm.*

Appendix 3 - Example Behaviour (Traffic Light) Care Plan

Service user Name: George Smith

Identified triggers for the behaviour
Physical Environment • Unfamiliar places without reassurance and explanation from staff • Others raising their voice or being around loud individuals • Being around individuals that George perceives as being unpredictable or having a lack of control e.g. inebriated individuals at the pub or other service users displaying behaviours that challenge **Interaction with others** • George feeling that he is not being involved or is being ignored • Staff not justifying why he is unable to have something e.g. item, activity • Being around people who he perceives as being abrupt or rude • Being given too much information and not providing George with time to process this. • If George is left alone for long periods of time or not engaged with **Activities** • Being rushed when completing a task or activity • Being asked to complete a task or activities that he doesn't enjoy – e.g. cinema, putting washing away • Unplanned changes to routine if not explained and given time to process this as well as an alternative and reassurance • Absence of daily walks • Discussing significant events with George too far in advance such as medical appointments or transitions to other services. **Other:** • Discussing specific topics such as his brother and unsuccessful placements • Injuring himself – this can cause George to pick at this and exacerbate a wound.

How George presents when calm	What actions staff need to take	How George presents when his anxiety is escalating	What actions staff need to take	How George presents in an anxious state	What actions staff need to take (in addition to Amber)
• George will smile • Tell jokes • Rub his hands together when being mischievous • He will talk about favoured topics such as music or drumming • Take part in a wide range of activities • He will be responsive when you communicate with him • He will eat a well and enjoy a balanced diet	• Staff should read and be familiar with George's support plans, Behaviour Plan and Risk Management Plans. • Maintain a calm, friendly tone of voice which is not too loud • Provide frequent and consistent encouragement and reassurance before and throughout tasks and activities. • Provide George a details plan of his day • Maintain clear and familiar routines as detailed in George's care plans • Do not provide George with too much information • Ensure activities are pre-planned and set up to avoid lengthy wait periods. • Prepare George 20 minutes prior to commencement of the activity. • Provide frequent choice making	• Repetitive questioning increases • George will ask a variety of questions to gain reassurance from others • Repeatedly asking "do you like me?" or "I like you, do you still like me?" or "everyone in the house likes me don't they?" • Saying "There's nothing to worry about is there?" • George may frown and generally look worried • He may use closed body language e.g. folding his arms • Bite his lip and pick at it • Picking the backs of his hands or fingers • Talk about being ill and asking "I'm not going to die am I?" • George may show concern regarding	• If appropriate and safe to do so, continue to attempt strategies identified at **Green** stage • Provide reassurance regarding areas or topics of concern • If George is unable to tell you what is upsetting him, ask questions to ascertain this • Offer activities that he finds motivating that you can provide there and then as detailed in his Activities Care Plan. • Discuss topics that George has good memories of i.e. recent activities he enjoyed or Preston festival. • Change the environment – ensure it is low stimulus so you can listen to George. • Offer George to walk with you in the garden. • Remind him that we cannot help if he does not talk to us.	• Engages in more intense repetitive questioning • He may shout and swear at staff members and his parents • Threatening to hit others • Using derogatory sexualised language • Threatening to "bite his finger off" • Stating that he wants to die • Attempting to throw furniture or damaging walls/items • Refuse to go for his daily walk or engage in any activities • Pressing call points and fire points • Refusing to eat or drink • Refusing to engage in personal care • Engaging in impulsive actions such as although edible, they may not be deemed as appropriate e.g. drinking curry source from the jar • Self-injurious behaviours e.g. picking his skin, biting his own	• If appropriate and safe to do so, continue to attempt strategies identified at **Amber** stage • Ensure you are closest to the room's exit • Reassure George by saying "it's ok" and offering your hand out to him • Do not put any unnecessary demands or requests on George • If asked, reassure George that he (and/or others) are well and fine • Use assertive commands to redirect George away from areas of concern or high risk • Request George to go with you to a more suitable environment • If George is targeting a specific staff member, they need to be encouraged to leave the immediate environment • If George will not move to a more suitable environment, ensure other vulnerable adults in the environment are taken to a safe place.

	opportunities throughout the day • Ensured that preferred items are available. • If George cannot have an item or do a task, provide an explanation why. • Plan any changes to routine carefully and introduce them with a detailed explanation of the change as well as alternatives. • Give time for him to process information	family or staff member's health • Going to the toilet frequently or staying there for a long period of time • George may withdraw and lie in bed for prolonged periods of time • He may refuse food and/or drink or binge eat • Showing no interest in doing activities • George may walk away from staff when they are talking to him	• When George wants time alone, respect his decision that he wants some space, be in the vicinity for when he wants to engage with you. Regularly monitor George and provide reassurance. • Ask George to undertake breathing exercises and his countdown routine, complete this with him. • Follow PRN protocols where appropriate.	hand, striking his own head.	
				If you cannot remove yourself; maintain a safe space, adopt a safe stance and ensure you have your back to the exits. • If the above strategies have been attempted and are unsuccessful and there is a continued risk of harm to the individual and/or others then staff should use approved techniques in a gradient approach as a last resort. - Stance - Assertive command - Protective Stance - Touch support - Front arm catch - PRN medication as per protocols If you have had to withdraw from George's room, ensure you are still able to observe the noises he is making and keep checking at regular intervals if George is ready to re-engage with you.	

How you know George is calming	What actions staff need to take
• George may spend some time on his own in his bedroom. • He may make humming noises • He may try to apologise to you • He may try to begin re-engaging with staff • He may ask to have a drink, something to eat or go for a walk • George may wish to discuss the event or incident • George may become easily or upset more than once in the same day • On occasions George may cry	• Where feasible, comply with George's requests • Provide George with space and allow him to spend some time in his room if he requests to do so • Provide regular re-assurance • Remind George that we are here to keep him safe and that he can talk to us if he wishes • Support George to re-engage • Present George with a drink and snack • Change of staff if necessary • Continue with scheduled activities ensuring to continually risk assess • Adapt activities after consulting team or management if the risk of continuing scheduled activities are too high. • Engage George in highly preferred, calming activities which include: drumming, time alone in his room, listening to music, going for a walk or out in the garden • Discuss incident or event with George in a reassuring manner and remind him that we are here to help

- **In the event that PRN medication is administered, this must be recorded at the time of administration and accurately documented. This then must be documented on the back of the MAR sheet along with the reasons for administration and the result the medication had.**
- **Staff must document all use of physical intervention and PRN medication or if George or staff are injured on an incident report prior to leaving shift that day and uploaded onto the system.**
- **If you are concerned of illness or injury to George or others, seek medical advice and assistance.**
- **Inform the Senior Staff member on shift of the incident and seek support via a debrief following a serious incident occurring.**

Name and role of staff member		**Service user signature (where appropriate)**	
Date completed			
Planned review date			

4. Physical Intervention, Restrictive Practice & Positive Behavioural Support Focussed Audit Tool for Provider Services

N.B please read and use in conjunction with the LSAB 'Restrictive Practice' and 'Positive Behavioural Support Best Practice' Guidance

Questionnaire to be completed by most senior person or delegated auditor within the service (6 monthly as a minimum or more frequently as required). Whilst Care Plans are covered in section 4.1 of the audit, this tool is intended as a service review which may lead to an individual's review of support.

Location name:			
Provider name:			
Auditor Name:		**Audit date:**	
Auditor location:		**Name and position of person supporting audit:**	
Location address:		**Location telephone number:**	
Type of service:	☐ Care home with nursing ☐ Care home without nursing ☐ Supported living	**Residents include:**	☐ People with a learning disability ☐ People with autism ☐ People with dementia

1	Section 1: Restraint - Physical Intervention		Actions Arising / Timescale
1.1	Do you sometimes physically intervene a person to restrict their movement?	☐ Yes ☐ No – If no please move to section 2	
1.2	**If yes,** how many people using this service have been subject to physical intervention on one or more occasions?	*Add number of people in last six month period*	
1.3	**What types of physical intervention are used**? Please note 'breakaway' is a 'keeping safe' technique and not a form of restrictive practice so should not be included here. (please refer to the LSAB Restritive Practice Guidelines for further clarity)	*Please tick all that apply* ☐ Guiding a person by linking arms ☐ Arm Supports ☐ Seated holds ☐ One person guide ☐ Two person guide ☐ Holding a person on the bed or floor (supine – on their back) ☐ Holding a person on the bed or floor (prone – face down) ☐ Other physical restraint	
4	**If other physical intervention** is used please describe.		
5	Is there always enough staff on duty that are appropriately trained to carry out a physical intervention safely? Check: - Staff induction. - Rotas. - Training for rota's staff - BILD accredited training (as appropriate). - Training needs analysis for each resident requiring physical intervention. - Competency assessment assurance of staff using physical intervention.	☐ Yes ☐ No	

2	**Section 2: Restraint - Mechanical Restraint** the use of a device (e.g. bed rails, safe suit, arm splints, harness, helmet or strap)		
2.1	Do you sometimes use mechanical restraints to prevent, restrict or subdue movement of person's body, or part of their body, for the purpose of maintaining the safety of the person or others?	☐ Yes ☐ No – if no please move to section 3	
2.2	**If yes,** how many people using this service have you used mechanical restraint with?		
2.3	How often do you use mechanical restraint?	☐ Daily ☐ More than three times a week ☐ Weekly ☐ More than three times a month ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months ☐ About once a year ☐ Less often ☐ Never	
2.4	What types of mechanical restraint are used?	*Please tick all that apply* ☐ Wheelchair belt (for reason of unsafe behaviour, not just to prevent the person falling from the wheelchair) ☐ Harness in the car (if different from normal seatbelt) ☐ Arm splints ☐ Safe suit ☐ Safe chair (that the person cannot get out of unaided) ☐ Bed Rails ☐ Recliner chairs ☐ Lap straps ☐ Other	

2.5	**If other,** please describe?		
3	**Section 3: Pharmaceutical restraint**		
3.1	Do you sometimes use pharmaceutical restraint, including the use of PRN (as and when needed) medicines to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce extreme agitation and anxiety?	☐ Yes ☐ No – If no please move to section 4	
3.2	If yes – how many people?		
3.3	If yes – how often	☐ Daily ☐ More than three times a week ☐ Weekly ☐ More than three times a month ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months ☐ About once a year ☐ Less often ☐ Never	
4	**Section 4: Recording of physical intervention, mechanical & pharmaceutical restraints**		
4.1	Is use of physical intervention, mechanical & pharmaceutical restraints in **every** person's care plan for whom it is sometimes used? Check: - Volume of individuals have a PI plan - Each intervention is detailed in the care plan. - Is adequate de-escalation and PBS recorded for each person? - Person centred? - Evidence of traffic light systems?	☐ Yes ☐ No	

	- Are PRN protocols in place for pharmaceutical restraint? (and how instructive are these?). - Health Action Plan in place? (where people with learning disability are being supported?). - Communication plans and passports? - Proactive strategies? (routines, timetables, activities, environmental strategies, staff matching person centred approaches, consistency).		
4.2	Is there a risk assessment for use of physical intervention, mechanical & pharmaceutical restraints for **every** person it is used with? Check: - Has a MDT approach has been applied? - Does it follow the Restraint Reduction Standards?	☐ Yes ☐ No	
4.3	Is there (for every person who may be subject to restrictive practice) a mental capacity assessment and where a person lacks mental capacity to consent to the use of physical intervention, mechanical & pharmaceutical restraints arrangements for their care or treatment, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005? * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.** Check: - Has an MDT approach been applied? - Where the person lacks capacity, has a Best Interests Decision been evidenced? (with MDT?). - Is there consideration of less restrictive options?	☐ Yes ☐ No	

	- Has there been appropriate review by appropriate professionals? (e.g. GP where pharmaceutical interventions are being used) - DoLs application/consideration?		
4.4	Describe how physical intervention, mechanical & pharmaceutical restraints are recorded? Consider: ☐ Daily care records ☐ Debrief/Incident reports ☐ Serious Incident/STEIS reports ☐ Behavioural recording charts ☐ Reflective Practice records ☐ Supervision discussion ☐ Team meetings ☐ Review and Analysis ☐ Near Misses ☐ Not recorded ☐ Other		
4.5	Describe how physical intervention, mechanical & pharmaceutical restraints are monitored? Consider: ☐ Reviewing relevant written records of use of restraint. ☐ Monitoring CCTV footage. ☐ Functional Analysis of all incident reports, monitoring review analysis. ☐ Not formally monitored ☐ Other		

5	**Section 5: Seclusion** Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Mental Health Act Code of Practice, DoH, defined at paragraph 26.103). **Where seclusion has been necessary and immediate but has not been included in the persons Multi Agency care plan, check safeguarding referrals have been made and consideration of the Mental Health Act for assessment as appropriate.**		
5.1	Are there any people that you sometimes ask to go to their bedrooms or a specific area in the house or garden due to their behaviour?	☐ Yes ☐ No – if no please move to section 6	
5.2	Please state: Is there a designated seclusion facility in place? ☐ Yes ☐ No Is there a non-designated area used for the purpose of seclusion? Consider: Person's bedroom, lounge areas etc. ☐ Yes ☐ No	If yes: does the facility meet the requirements of the MHA Code of Practice 2015, and follow the following key requirements: ☐ Can staff clearly observe and communicate with the Individual? ☐ Can staff clearly observe and communicate with the individual and/or 'time out'? ☐ Is the environment well insulated and ventilated, with temperature controls outside the room? ☐ Have access to toilet and washing facilities? ☐ Has furniture, windows and doors that can withstand damage? ☐ Anti ligature points?	
5.3	**If yes,** does the service have a robust seclusion policy that complies with the following standards (NICE):	☐ Appropriate documentation / recording of seclusion? ☐ Regular reviews (2 hourly) ☐ Appropriate staff observation (within eyesight)? ☐ Appropriately trained staff?	

		☐ Appropriate debrief / post incident review?	
5.4	What are the circumstances in which seclusion occurs i.e. reason why?	☐ Safety of staff. ☐ Safety of other people using the service. ☐ Safety of the individual. ☐The person wanted to be away from other people. ☐ Unsuitable physical environment e.g. lack of space. ☐ Unsafe fixtures and fittings which could cause harm to the person. ☐ Staffing levels (not enough staff to provide level of support needed). ☐ Staff lack expertise to support the person. ☐ You think this is not a suitable place for this person's needs to be met.	
5.5	How often is this intervention used in this service?	☐ More than once day. ☐ Daily. ☐ One or more times a week. ☐ More than once a month. ☐ Occasionally – less than once every three months. ☐ Rarely – less than once a year. ☐ Never.	
5.6	Evidence how you record the use of this intervention?	*Please tick all that apply* Does the care planning for residents requiring behavioural management strategies include: ☐ Service user history and relevant diagnosis. ☐ Advanced care planning – where residents can describe how they wish to be	

		cared for in certain situations (i.e. favouring holds, seclusion/LSE or medication). ☐ Preventative and proactive interventions used. ☐ Triggers to behaviour, examples of past incidences/situations that have led to escalation in behaviour. ☐ Antecedents to triggers and measures to best prevent – including environmental, staff approaches, communication, distraction methods. ☐ Step by step approach to best manage behaviours at various points in the escalation phase. ☐ Detail around how to manage worst case scenarios, including staff intervention, documentation and medical review as required. ☐ Detail relating to how best support the service user post incident (recovery stage) and how to prevent further escalation. ☐ Care plans must include debrief for both service user and those involved (staff) ☐ Detail of care review – MDT / Medical review	
5.7	How do you monitor use of this intervention?	*Please tick all that apply* ☐ Reviewing relevant written records of use of restraint. ☐ Monitoring CCTV footage. ☐ Functional analysis of all incident reports, monitoring review analysis. ☐ Not formally monitored. ☐ Other.	

5.8	Do the people that you use this intervention for have a DoLs in place? (If applied for please answer yes)	☐ Yes, for all people that it applies. ☐ No. ☐ In some cases.	
5.9	Has there been a mental capacity assessment completed for this intervention? (asking somebody to go and spend time alone) and where a person lacks mental capacity to consent, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005 * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.**	☐ Yes ☐ No	
6	**Segregation** (Caring for people separately to other people using the service) **& Long Term Segregation**		
6.1	Do you have anyone that you care for that is isolated from others? This could be in their bedroom or self-contained flat. It should still be considered as segregation even if the person is allowed periods of interaction with staff and peers? It is always considered segregation when it isn't the persons choice.	☐ Yes ☐ No – if no please move to section 6	
6.2	How many people are living in isolation from others? (If multiple, review 6.3 – 6.11 for a cross sector of people).		
6.3	Where does the segregation occur?	☐ It is in a self-contained flat in supported living setting ☐ It is within the care home	
6.4	How would you describe the segregation arrangement?	☐ It is a long-term living arrangement ☐ It is just used temporarily (i.e. the person has to stay in a room/place where they don't normally) ☐ It is a response to an infection prevention concern. ☐ It is the person's choice.	

6.5	What is the main reason for people being supported separately to others using this service?	☐ The service is designed to be supported living with self-contained flats. ☐ The person does not want to live with others and this is documented in their care plan. ☐ The person is unable to live with others for their own safety. ☐ The person is not able to live with others for the safety of others. ☐ Decision made by commissioners. ☐ Other adaptations in place based on persons diagnosis and medical history (please state).	
If you answered 'it is just temporary' to question 6.4, please answer 6.6 - 6.9, otherwise please skip to 6.10			
6.6	If the segregation is temporary how do you record its use? *Consider:* ☐ Daily care records ☐ Debrief/Incident reports ☐ Serious Incident/STEIS reports ☐ Behavioural recording charts ☐ Reflective Practice records ☐ Supervision discussion ☐ Team meetings ☐ Review and Analysis ☐ Near Misses ☐ Not recorded ☐ Other		
6.7	**If other method of recording used**, please describe		

6.8	Evidence how you monitor the appropriateness of providing this care? *Consider:* ☐ Care plan reviews. ☐ Internal review of relevant records. ☐ Statutory review. ☐ Reports to, and reviews by the commissioning authority. ☐ Audits in place to review segregation arrangements. ☐ Other.		
6.9	**If other method of monitoring used**, please describe.		
6.10	Do the people that you use this arrangement for have a DoLs in place?	☐ Yes ☐ No	
6.11	Has there been a mental capacity assessment completed for this and where a person lacks mental capacity to consent to being cared for separately to others using the service is there a record in their file of a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards? * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.**	☐ Yes ☐ No	

7	**Section 7 - Oversight Questions**		
7.1	Where you are monitoring the use of restraint, seclusion or segregation and the frequency or type has increased, have you referred this back to the specialists and local authority for advice?	☐ Yes ☐ No ☐ We would but this hasn't happened yet	
7.2	Do you monitor the staff involved in restraints to see if there is any pattern, e.g. if some staff restrain more than others? - What audits do you have in place? - What trends are identified?	☐ Yes ☐ No	
8	**Section 8: Minimising Restrictive Practice**		
8.1	Is there a written plan to work actively to reduce/minimise the use of restrictive practice for every person where physical intervention, mechanical or pharmaceutical restraint is currently used?	☐ Yes ☐ No	
8.2	Where staff use a form of restraint with a person, how do you ensure the person is safeguarded from abuse? Training – All training must comply with the Restraint Reduction Network Training Standards 2019. Services must provide evidence of all trained staff including: - Audit of need (training needs analysis). - Copy of completion certificates. - Training matrix detailing annual refreshers. - Physical intervention evaluation sheets. - Completed theory assessments. - Reflective practice document (incident analysis.) - Competency in relevant training (safeguarding, whistleblowing etc.). - Evidence of whistle blowing policy and staff notices up on site. - Clear statement of purpose or similar detailing providers stance on abuse. - Evidence of post incident debriefs.		

	- Transparency with regard to incident reporting and that it is shared with MDT's. - Daily logs / body maps being reflective of incidents. - Any uses of unprescribed restraint are reported and investigated thoroughly to ensure it was reasonable, proportionate and necessary. - Regular review of care plans and risk assessments to show evidence of lessons learnt. - Competence assessment for staff by the manager. - Episodes of restraint reported to CQC, commissioning authority and safeguarding (as appropriate), person's family/advocate.		
9	**Section 9: Actively seeking feedback**		
9.1	Do you actively seek feedback? This could be from the individual, internal staff, visiting professionals and relatives.	☐ Yes ☐ No	
9.2	Evidence how you ensure that feedback is captured from all parties? Consider: ☐ Whistleblowing policy is on display. ☐ Safeguarding poster is on display. ☐ Complaints policy is on display. ☐ Regular relative meeting. ☐ Regular staff meetings. ☐ Anonymous suggestions box. ☐ Relatives 1-1 review sessions. ☐ Regular staff supervision in line with company policy.		

5. Physical Intervention, Restrictive Practice & Positive Behavioural Support Focussed Audit Tool for Commissioners

Questionnaire to be completed by Commissioner/Contracts Officer with registered manager/provider or most senior person available

Location name:			
Provider name:			
Auditor Name		**Audit date**	
Auditor Location		**Name and position of person supporting audit**	
Location address		**Location telephone number**	
Type of service	☐ Care home with nursing ☐ Care home without nursing ☐ Supported living	**Residents include**	☐ People with a learning disability ☐ People with autism ☐ People with dementia

1	**Section 1: Restraint - Physical Intervention**	
1.1	Do you sometimes physically intervene a person to restrict their movement?	☐ Yes ☐ No – If no please move to section 2
1.2	**If yes,** how many people using this service have been subject to physical intervention on one or more occasions?	*Add number of people in last six month period*
1.3	**What types of physical Intervention are used**? Please note 'breakaway' is a 'keeping safe' technique and not a form of restrictive practice so should not be included here. (please refer to the LSAB Restrictive Practice Guidelines for further clarity)	*Please tick all that apply* ☐ Guiding walk / simple arm hold ☐ One / two person arm holds (standing) ☐ One / two person holds (Seated) Although no longer recommended, are there instances where the following are used; ☐ Holding a person on the bed or floor (supine – on their back) ☐ Holding a person on the bed or floor (prone – face down) ☐ Other physical restraint Safeguarding triggers:
1.4	**If other physical intervention** is used please describe.	
1.5	Is there always enough staff on duty that are appropriately trained to carry out a physical intervention safely? Check: - Staff induction - Rotas - Training for rota's staff - BILD approved training (as appropriate) - Training needs analysis for each resident requiring physical intervention. - Competency assessment assurance of staff using physical intervention	☐ Yes ☐ No

2	**Section 2: Restraint - Mechanical Restraint** the use of a device (e.g. bed rails, safe suit, arm splints, harness, helmet or strap)	
2.1	Do you sometimes use mechanical restraints to prevent, restrict or subdue movement of person's body, or part of their body, for the purpose of maintaining the safety of the person or others?	☐ Yes ☐ No – if no please move to section 3
2.2	**If yes,** how many people using this service have you used mechanical restraint with?	
2.3	How often do you use mechanical restraint?	☐ Daily ☐ More than three times a week ☐ Weekly ☐ More than three times a month ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months ☐ About once a year ☐ Less often ☐ Never
2.4	What types of mechanical restraint are used?	*Please tick all that apply* ☐ Wheelchair belt (for reason of unsafe behaviour, not just to prevent the person falling from the wheelchair) ☐ Harness in the car (if different from normal seatbelt) ☐ Arm splints ☐ Safe suit ☐ Safe chair (that the person cannot get out of unaided) ☐ Bed Rails ☐ Recliner chairs ☐ Lap straps ☐ Other

2.5	**If other,** please describe?	
3	**Section 3: Pharmaceutical restraint**	
3.1	Do you sometimes use pharmaceutical restraint, including the use of PRN (as and when needed) medicines to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce extreme agitation and anxiety?	☐ Yes ☐ No – If no please move to section 4
3.2	If yes – how many people?	
3.3	If yes – how often?	☐ Daily ☐ More than three times a week ☐ Weekly ☐ More than three times a month ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months ☐ About once a year ☐ Less often ☐ Never
4	**Section 4: Recording of physical intervention, mechanical & pharmaceutical Restraints**	
4.1	Is use of physical intervention, mechanical & pharmaceutical restraints in **every** person's care plan for whom it is sometimes used? Check: - Volume of individuals have a PI plan - Each intervention is detailed in the care plan - Is adequate de-escalation and PBS recorded for each person? - Person Centred? - Evidence of traffic light systems? - Are PRN protocols in place for pharmaceutical restraint? (and how instructive are these?)	☐ Yes ☐ No

	- Health Action Plan in place? (where people with learning disability are being supported) - Communication plans and passports? - Proactive strategies? (routines, timetables, activities, environmental strategies, staff matching person centred approaches, consistency)	
4.2	Is there a risk assessment for use of physical intervention, mechanical & pharmaceutical restraints for **every** person it is used with? Check: - Has an MDT approach has been applied? - Does it follow the Restraint Reduction Standards?	☐ Yes ☐ No
4.3	Is there (for every person who may be subject to restrictive practice) a mental capacity assessment and where a person lacks mental capacity to consent to the use of physical intervention, mechanical & pharmaceutical restraints arrangements for their care or treatment, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005? * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.** Check: - Has an MDT approach been applied? - Where the person lacks capacity, has a Best Interests Decision been evidenced? (with MDT) - Is there consideration of less restrictive options? - Has there been appropriate review by appropriate professionals? (e.g. GP where pharmaceutical interventions are being used) - DoLs application/consideration? - Any safeguarding concerns?	☐ Yes ☐ No
4.4	How is physical intervention, mechanical & pharmaceutical restraints recorded?	*Please tick all that apply* ☐ Daily care records ☐ Debrief/Incident reports ☐ Serious incident/STEIS reports ☐ Behavioural recording charts ☐ Reflective practice records ☐ Supervision discussion

		☐ Team meetings ☐ Review and analysis ☐ Near misses ☐ Not recorded ☐ Other
4.5	How is physical intervention, mechanical & pharmaceutical restraints monitored?	*Please tick all that apply* ☐ Reviewing relevant written records of use of restraint ☐ Monitoring CCTV footage ☐ Functional Analysis of all incident reports, monitoring review analysis ☐ Not formally monitored ☐ Other
5	**Section 5: Seclusion** Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Mental Health Act Code of Practice, DoH, defined at paragraph 26.103). **Where seclusion has been necessary and immediate but has not been included in the persons Multi Agency care plan, check safeguarding referrals have been made and consideration of the Mental Health Act for assessment as appropriate.**	
5.1	Are there any people that you sometimes ask to go to their bedrooms or a specific area in the house or garden due to their behaviour?	☐ Yes ☐ No – if no please move to section 6
5.2	Does the service have a designated seclusion facility?	☐ Yes If yes: does the facility meet the requirements of the MHA Code of Practice 2015, and follow the following key requirements: ☐ Can staff clearly observe and communicate with the Individual? ☐ Can staff clearly observe and communicate with the Individual and/or 'time out'? ☐ Is the environment well insulated and ventilated, with temperature controls outside the room? ☐ Have access to toilet and washing facilities? ☐ Has furniture, windows and doors that can withstand damage? ☐ Anti-Ligature Points? ☐ No

5.3	**If yes,** does the service have a robust seclusion policy that complies with the following standards? (NICE):	☐ Appropriate documentation/recording of seclusion? ☐ Regular reviews (2 hourly)? ☐ Appropriate staff observation (within eyesight)? ☐ Appropriately trained staff? ☐ Appropriate debrief/post incident review?
5.4	What are the circumstances in which seclusion occurs i.e. reason why?	☐ Safety of staff ☐ Safety of other people using the service ☐ Safety of the individual ☐ The person wanted to be away from other people ☐ Unsuitable physical environment e.g. lack of space ☐ Unsafe fixtures and fittings which could cause harm to the person **Safeguarding indicators**: ☐ Staffing levels (not enough staff to provide level of support needed) ☐ Staff lack expertise to support the person ☐ You think this is not a suitable place for this person's needs to be met
5.5	How often is this intervention used in this service?	☐ More than once a day ☐ Daily ☐ One or more times a week ☐ More than once a month ☐ Occasionally – less than once every three months ☐ Rarely – less than once a year ☐ Never
5.6	How does the provider record the use of this intervention?	*Please tick all that apply* Care planning for residents requiring behavioural management strategies must include: ☐ Service user history and relevant diagnosis ☐ Advanced care planning – where residents can describe how they wish to be cared for in certain situations (i.e. favouring holds, seclusion/LSE or medication) ☐ Preventative and proactive interventions used. ☐ Triggers to behaviour, examples of past incidences/ situations that have led to escalation in behaviour

		☐ Antecedents to triggers and measures to best prevent – including environmental, staff approaches, communication, distraction methods ☐ Step by step approach to best manage behaviours at various points in the escalation phase ☐ Detail around how to manage worst case scenarios, including staff intervention, documentation and medical review as required ☐ Detail relating to how best support the service user post incident (recovery stage) and how to prevent further escalation ☐ Care plans must include debrief for both service user and those involved (staff) ☐ Detail of care review – MDT / Medical review
5.7	How do you monitor use of this intervention?	*Please tick all that apply* ☐ Reviewing relevant written records of use of restraint ☐ Monitoring CCTV footage ☐ Functional Analysis of all incident reports, monitoring review analysis ☐ Not formally monitored ☐ Other
5.8	Do the people that you use this intervention for have a DoLs, Court of Protection DoL or Welfare Order in place? (If applied for please answer yes)	☐ Yes, for all people that it applies ☐ No ☐ In some cases
5.9	Has there been a mental capacity assessment completed for this intervention (asking somebody to go and spend time alone) and where a person lacks mental capacity to consent, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005? * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.**	☐ Yes ☐ No
6	**Segregation** (Caring for people separately to other people using the service) **& Long Term Segregation**	
6.1	Do you have anyone that you care for that is isolated from others? This could be in their bedroom or self-contained flat. It should still be considered as segregation even if the person is allowed periods of interaction with staff and peers? It is always considered segregation when it isn't the person's choice.	☐ Yes ☐ No – if no please move to section 6

6.2	How many people are living in isolation from others? (If multiple, review 6.3 – 6.11 for a cross sector of people)	
6.3	Where does the segregation occur?	☐ It is in a self-contained flat in supported living setting ☐ It is within the care home
6.4	How would you describe the segregation arrangement?	☐ It is a long-term living arrangement ☐ It is just used temporarily (i.e. the person has to stay in a room/place where they don't normally) ☐ It is a response to an infection prevention concern ☐ It is the person's choice
6.5	What is the main reason for people being supported separately to others using this service?	☐ The service is designed to be supported living with self-contained flats ☐ The person does not want to live with others and this is documented in their care plan ☐ The person is unable to live with others for their own safety ☐ The person is not able to live with others for the safety of others ☐ Decision made by commissioners ☐ Other adaptations in place based on persons diagnosis and medical history (please state)
If you answered 'it is just temporary' to question 6.4, please answer 6.6 - 6.9, otherwise please skip to 6.10		
6.6	If the segregation is temporary how do you record its use?	*Please tick all that apply* ☐ Daily care records ☐ Debrief/Incident reports ☐ Serious Incident/STEIS reports ☐ Behavioural recording charts ☐ Reflective Practice records ☐ Supervision discussion ☐ Team meetings ☐ Review and Analysis ☐ Near Misses ☐ Not recorded ☐ Other
6.7	**If other method of recording used**, please describe.	
6.8	How do you monitor the appropriateness of this way of providing care?	*Please tick all that apply* ☐ Care plan reviews

		☐ Internal review of relevant records ☐ Statutory review ☐ Reports to, and reviews by the commissioning authority ☐ Audits in place to review segregation arrangements ☐ Other
6.9	**If other method of monitoring used**, please describe.	
6.10	Do the people that you use this arrangement for have a DoLs, Court of Protection DoL or Welfare Order in place?	☐ Yes ☐ No
6.11	Has there been a mental capacity assessment completed for this and where a person lacks mental capacity to consent to being cared for separately to others using the service is there a record in their file of a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards? * **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.**	☐ Yes ☐ No
7	**Section 7 - Oversight Questions**	
7.1	Where you are monitoring of the use of restraint, seclusion or segregation shows the frequency or type has increased, have you referred this back to the specialists and Local Authority for advice?	☐ Yes ☐ No ☐ We would but this hasn't happened yet
7.2	Do you monitor the staff involved in restraints to see if there is any pattern, e.g. if some staff restrain more than others? - What audits does the provider have in place?	☐ Yes ☐ No
8	**Section 8: Minimising Restrictive Practice**	
8.1	Is there a written plan to work actively to reduce/minimise the use of restrictive practice for every person where physical intervention, mechanical or pharmaceutical restraint is currently used?	☐ Yes ☐ No

8.2	Where staff use a form of restraint with a person, how do you ensure the person is safeguarded from abuse?	Training – All training must comply with the Restraint Reduction Network Training Standards 2019. Services must provide evidence of all trained staff including: ☐ Audit of need (training needs analysis). ☐ Copy of completion certificates. ☐ Training matrix detailing annual refreshers. ☐ Physical intervention evaluation sheets. ☐ Completed theory assessment. ☐ Reflective practice document (incident analysis). ☐ Competency in relevant training (safeguarding, whistleblowing etc.) ☐ Evidence of whistle blowing policy and staff notices up on site. ☐ Clear statement of purpose or similar detailing providers stance on abuse. ☐ Evidence of post incident debriefs. ☐ Transparency with regard to incident reporting and that it is shared with MDT's. ☐ Daily logs/body maps being reflective of incidents. ☐ Any uses of unprescribed restraint are reported and investigated thoroughly to ensure it was reasonable, proportionate and necessary. ☐ Regular review of care plans and risk assessments to show evidence of lessons learnt. ☐ Competence assessment for staff by the manager. ☐ Episodes of restraint reported to CQC, commissioning authority and safeguarding (as appropriate), person's family/advocate.
9	**Section 9: Actively seeking feedback**	
9.1	Is the service actively seeking feedback? This could be from the individual, internal staff, visiting professionals and relatives.	☐ Yes ☐ No
9.2	How do you ensure that feedback is captured from all parties?	☐ Whistleblowing policy is on display ☐ Safeguarding poster is on display ☐ Complaints policy is on display ☐ Regular relative meeting ☐ Regular staff meetings ☐ Anonymous suggestions box

		☐ Relatives 1-1 review sessions ☐ Regular staff supervision in line with company policy ☐ Staff 1:1 ☐ Visiting professionals ☐ Patients/service users ☐ others
9.3	Is feedback regularly reviewed?	☐ Audits of suggestions box ☐ Complaints response folder ☐ Supervision audit
10	**Section 10: Question for the Contract Monitoring Officer**	
10.1	At the end of this focussed audit, did you have any concerns about the use of restrictive interventions at this location?	☐ Yes ☐ No
10.2	If yes what action will you take?	☐ Safeguarding alert for one person ☐ Safeguarding alert for more than one person ☐ Contacted local authority to raise concern about provider/location ☐ Management review to discuss enforcement action - type of enforcement not yet decided ☐ MDT referral ☐ Share information with out of area commissioners ☐ Report to the police ☐ Contract default notice ☐ Suspension notice ☐ Share intelligence to RADAR

6. Restrictive Practice Audit - Glossary

Appropriate area for Seclusion
An area that respects the person's right to privacy and dignity; adequate furnishing (i.e. comfortable bed and bedding); access to toilets; adequate clothing; and patients not being disturbed by staff playing a radio or talking loudly in the observation area. Other considerations include rooms being a comfortable temperature (which may be a particular problem if the room has padding on walls); and are clean (being cleaned properly between uses).

Behaviour charts
An effective resource to monitor a behaviour which can challenge a service, identifying triggers and consequences (positive and negative) with a view to plan positive behavioural support. It focusses on how to adapt the residents care plan and improve care delivery as well as health outcomes

BILD
British Institute of Learning Disabilities is an independent charity. The BILD association of certified training offers a certification scheme ensuring training services comply with the Restraint Reduction Network Standards 2019

Breakaway
Safe and practical techniques taught by a professional which do not cause any distress to the person.

Care Plans
Strategies designed to guide health and social care professionals involved with individuals care. Such plans are **patient specific** and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

Debriefs
Debriefing is a facilitated reflection in the cycle of experiential learning which helps identify and close gaps in knowledge and skills. The personal reflective debriefing also would be appropriate to hold at the end of a stressful shift so staff can debrief immediately and not carry home the emotional burden of the day.

Functional analysis
Detailed analysis of behaviour to identify contingencies that sustain the behaviour**.**

Liberty Protection Safeguards
The (LPS) are the legislative framework for authorising a deprivation of liberty (within the meaning of Article 5 of the European Convention of Human Rights). They will replace the current process which is called the Deprivation of Liberty.

Long Term Segregation
Long-term segregation refers to a situation where the sustained risk of harm posed to others is a constant feature of a patient's presentation, as a result of which the patient is unable to mix freely with other patients on the ward or unit on a long-term basis.

Near Misses
An event not causing harm but has the potential to cause injury, ill health or damage to property.

Person Centred Plan
Person centred planning (PCP) provides a way of helping a person plan all aspects of their life, thus ensuring that the individual remains central to the creation of any plan which will affect them. Person centred planning is not an assessment.

Physical Intervention
A physical intervention refers to **any method of physical response whereby physical force of some kind is used** and which is designed to prevent, halt or restrict the movement or actions of the person(s) concerned.

Positive Behaviour Support
(PBS) is a person centred framework for providing long-term support for people who have, or may be at risk of developing, behaviours that challenge. Please see the Positive behaviour Support guidelines for further information

PRN medication
Medication that is given as required treating an acute and/or escalating symptom. When required (PRN) medication is given to a resident, sometimes with varying dosages, to treat a defined intermittent or short term condition. It is not required by the resident on a regular basis or at specific times (e.g. during medication rounds) but given at the request of the resident and/or in accordance with their prescriber's instructions.

PRN Protocol
A protocol should contain enough information to support staff to administer when required medicines as intended by the prescriber. This should include: 1. details about what the medicine is for 2. Symptoms to look out for and when to offer the medicine 3. Whether the person can ask for the medicine or if they need prompting or observing for signs of need.

Recovery Star
Co-developed by resident and staff members, looking at ten areas of their life providing an outcome measure, enabling people to measure their own progress and agree what they wish to work on next. As a key-working tool it enables staff to support individuals they work with to understand their recovery and plot their progress. As an outcomes tool it enables organisations to measure and assess the effectiveness of the services they deliver. Whilst Recovery Star is most common, other recovery models are also available.

Restraint Reduction Standards Network
An independent network which brings together organisations to reduce reliance on restrictive practice. They have developed the Restraint Reduction Network Training Standards 2019 providing a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. Certificate of training services will be a

requirement for NHS commissioned services and the Care Quality Commission from April 2020. The aim to facilitate culture change, not just technical competence. The Standards focus on the human rights, restraint reduction, prevention, de-escalation, safe use and recovery.

Restrictive Practice
Restrictive practices are any kind of support or practice that limits the rights or freedom of movement of a person in order to stop them hurting themselves, other people or breaking property.

Seclusion
A strategy for managing the physical and emotional safety of service users whose behaviour challenge services. It consists of supervised confinement of the patient to a separate room (i.e. involuntary isolation) to protect him or herself and others from harm. The strategy must be clearly documented in the persons care plan and agreed as part of a multi-disciplinary meeting detailing why this is the most appropriate form of intervention and regular review of the care plan must be in place to ensure it remains effective and for the shortest period necessary.

Segregation

Refers to a situation where to reduce the sustained risk of harm posed by a resident to self or others which is a prolonged feature of their presentation. A Multi-Disciplinary Team and Responsible Commissioner are involved in the planning and agreement of any segregation arrangement and regular review of the arrangements should be in place to ensure the plans remain effective and for the shortest period necessary.

Serious Incident
(SI) are incidents governed by the NHS Serious Incident Framework (2015) or superceding framework.

Serious Incident Framework
This governs the way in which NHS commissioned organisations respond to Serious Incidents and investigate them thoroughly in order to ensure learning is shared and similar incidents are prevented.

Strategic Executive Information System
(STEIS) is the national electronic system on which NHS organisations can report and manage Serious Incidents.

7 Minute Briefing
Restrictive Practice 2020

1 Background

Restrictive practice means any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability. Under the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 certain restrictive practices are subject to regulation.

Historically, most people living in institutions had little choice or control in their lives. Most services have developed in that they have become more person centred and tailored to people's needs. We need to keep people safe whilst supporting them to make choices and **restrictive practice** is an area this applies to.

2 Why it matters

There are ongoing risks around restrictive practice, in ensuring that residents and staff within Care Homes, Acute and Community settings are supported within a positive culture and learn from experience.

Health and Social Care often work together in Lancashire when undertaking safeguarding, quality assurance and contract monitoring within Care Homes.

3 Information

Restrictive interventions are strategies used in response to situations of risk and during situations where it is deemed to be in the individual's best interest to support them to lead a fulfilled and meaningful life. They involve managing a challenging situation in order to minimise the immediate risk. These strategies are person centred and are used to manage an immediate risk and keep everyone safe. They do not aim to control the behaviour or deliver long term and lasting behavioural change.

4

Restrictive practice can include a range of interventions. These can range between environmental, mechanical, pharmaceutical measures up to physical interventions.

It is recognised that de-escalation techniques and positive behavioural support is used throughout any intervention, when restrictive intervention is used.

5

The Mental Capacity Act (2005) and its Code of Practice set out the legal information on restraint. Capacity tests (for a specific decision relating to restraint) need to be completed by a competent and experienced individual, along with any other relevant professionals or people who know the person well. If a person lacks capacity to consent, a best interest meeting needs to be scheduled. This needs to include all relevant professionals (MDT), advocates, family and if possible you should always consider the person to participate in the meeting.

6 What to do

The MCA sub group has developed a suite of tools to support providers in the application and audit of Restrictive Practice and Positive Behavioural Support: LSAB RP/PBS

Familiarise yourself with the legal requirements

Read the NICE guidelines available
> NICE violence and aggression
> NICE Learning Disabilities and behaviours that challenges services, design and delivery

7 Questions to consider

Do current support plans accurately represent the person's needs?

Is there a Positive Behavioural Support plan with clear proactive strategies?

Is Physical Intervention clearly detailed, e.g. how often or how long? Specific techniques, within the person's plans?

Is additional support required to update plans?

If yes, refer to appropriate team.

Is the person at significant risk of harm and a safeguarding alert needs to be raised?

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership and Adult Safeguarding Boards

References

Department of Health and Social Care (2005), Code of practice: Mental Capacity Act 2005

Department of Health and Social Care (2015), Code of practice: Mental Health Act 1983

National Institute for Health and Care Excellence (2015), Violence and aggression: short term management in mental health, health and community settings

Restraint Reduction Network (2019), Training Standards 2019

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