# Mental health crisis care: physical restraint in crisis

## A report on physical restraint in hospital settings in England

June 2013

mind.org.uk/crisiscare

mind
for better mental health

**It was horrific… I had some bad experiences of being restrained face down with my face pushed into a pillow. I can't begin to describe how scary it was, not being able to signal, communicate, breathe or speak.**

**Anything you do to try to communicate, they put more pressure on you. The more you try to signal, the worse it is.***

---

* All the quotes in this report are from people who have either experienced or witnessed physical restraint. Many are taken from interviews conducted between February and April 2013.

# Executive summary

This report sets out Mind's findings on the use and impact of physical restraint in mental healthcare settings in England. Our research found huge levels of variation across the country in the use of physical restraint, and highlighted the psychological and physical injuries caused as a direct result of being physically restrained.

Physical restraint is an extreme response to managing someone's behaviour when they are in a mental health crisis. It can be humiliating, cause severe distress and at worst it can lead to injury and even death.

In 1998, David 'Rocky' Bennett died at a medium secure mental health unit. An independent inquiry found that he died as a direct result of prolonged face down physical restraint and the amount of force used by members of staff during the incident. The inquiry made specific recommendations about the use of physical restraint, especially in regards to face down or prone position restraint.

Shockingly, since Rocky Bennett's death there have been at least 13 restraint-related deaths of people detained under the Mental Health Act 1983[1]. Eight of these occurred in a single year (2011). More than 15 years since Rocky Bennett's death, we are still no closer to implementing the lessons learned from his death and people are still dying as a result of physical restraint.

It is unacceptable that successive governments have neglected to take action, failed to establish national standards for the use of physical restraint in England and to introduce accredited training for healthcare staff.

Physical restraint can be frightening and hugely disempowering for anyone, let alone someone in a highly distressed state. It should only be used as a last resort.

Face down physical restraint is a life threatening form of physical restraint because of the severe impact it can have on breathing. It is a disproportionate and dangerous response to someone's behaviour when they are in a mental health crisis. Face down physical restraint has no place in healthcare settings and there must be an immediate end to its use.

## Our key findings are[2]:

- The huge variation in the use of physical restraint across England is unacceptable. In a single year, one trust reported 38 incidents while another reported over 3,000 incidents.
- Last year there were almost 1,000 incidents of physical injury following restraint.
- Face down restraint, which means pinning someone face down on the floor, is dangerous and can be life-threatening. It can feel like you're being suffocated and can cause even more distress. Last year alone it was used over 3,000 times. Yet some trusts have put an end to face down restraint altogether.

## Our key recommendations are:

- For Government to introduce an end to face down physical restraint in all healthcare settings urgently. Include the use of face down physical restraint in the list of 'never events'.
- For Government to establish national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint.

# Foreword

There is a fundamental contradiction at the heart of mental health, between care and control. While mental health services in general are driven by the commitment to help and support people who are distressed or in crisis, many aspects of our work involve containment and control of people who are considered a risk to themselves or others as a result of their mental health problems. This poses a significant challenge to clinical staff and those managing and regulating mental health care. We have a huge responsibility to ensure that the power invested in us as clinicians is not abused and there are checks and balances in place to prevent harm and ill treatment of people who are at the sharp end of coercive psychiatric care.

Sadly, it would seem many people using mental health services continue to experience not only harm but serious injury and even death as a direct result of psychiatric interventions. This is most obvious in relation to the use of physical restraint in mental health care. In most of medicine, any procedure or intervention that carries with it a significant risk of harm to the patient will be subject to strict controls, supervision and explicit guidelines on their use and careful surveillance of such practice. However, as this report by Mind shows, this is far from the case when it comes to the use of physical restraint. It would appear that there is a huge variation across England in the use of physical restraint, the procedure is too often associated with physical or psychological harm to the victims of restraint and, currently, there are no national standards or accredited training for healthcare staff in England on its use. Mind's report, rightly, calls attention to these deficiencies. It argues for the need to change the culture and environment of healthcare settings which can often trigger behaviours that may lead to restraint and for support and accredited training for staff in the use of restraint, underpinned by respect for service users and involving those who have been at the wrong end of restraint procedures.

What this report also highlights is the lack of any progress in regulating and minimising the use of physical restraints in psychiatric settings.

It is now 10 years since the publication of the Independent Inquiry into the death of David Bennett and 20 years since the inquiry into the death of Orville Blackwood, Michael Martin and Joseph Watts at Broadmoor Hospital. These inquiries drew similar conclusions about the use of physical restraint and made similar recommendations. The Bennett inquiry was unequivocal in its recommendations about "face down" or prone physical restraint, identifying this procedure as carrying a significant risk of death to the person being restrained. Yet this and other recommendations made by the Bennett Inquiry and previous reports have still not been implemented. This is a major failure on the part of successive governments and the NHS. As data from the Independent Advisory Panel on Deaths in Custody shows, people continue to die in our psychiatric units as a result of being subject to physical restraint. It is totally unacceptable that the lessons learnt as a result of the tragic deaths of Orville Blackwood, Michael Martin, Joseph Watts and David Bennett continue to be ignored and people using mental health services still remain at high risk of injury and even death as result of the use of physical restraint.

Given the grave psychological and physical risks associated with physical restraint, there is a compelling and urgent need for a common set of guidelines and national standards on the use of physical restraint in all settings, including mental health care.

**Dr S P Sashidharan**
**Consultant psychiatrist and panel member of the independent inquiry into the death of David "Rocky" Bennett**

# What we wanted to know about physical restraint

Following a year long independent inquiry in 2010/2011[3], we sent Freedom of Information (FOI) requests to all 54 mental health trusts in England asking how they use physical restraint in their trust, the impact of physical restraint and the procedures and training in place which govern the use of physical restraint.

We received responses from 51 trusts[4]. Three trusts failed to reply. Of those that replied, one declined our request citing cost and time and one said they could provide no data due to the way their data system captured information.

We did not approach independent providers. Further research is needed to identify the experience of people in these settings.

Our findings show a staggering variation in the use of physical restraint in mental health trusts in England. It is used far too often in some parts of the country.

Some mental health trusts have successfully managed to end the use of face down physical restraint completely and others reported low numbers of physical restraint. However, other trusts continue to have a shameful overreliance on physical restraint and use face down physical restraint too readily in their response to managing a crisis situation.

On a mental health ward the experience of being controlled and physically restrained can be traumatic and result in a loss of dignity and respect, or even death in some cases. When people's lives come crashing down and they are at their most vulnerable, they need help immediately not further harm. People in hospital for mental healthcare should feel confident that physical restraint should only be used competently, safely and only as a last resort with minimum force[5].

# Background

When someone is having a mental health crisis, they may become frustrated, frightened and extremely distressed. Even when they seem aggressive and threatening, or refuse treatment, they still desperately need help and compassion.

Healthcare staff do a challenging job and physical interventions are often used to manage a person's behaviour if they are deemed to be at risk to themselves or others. However, physical restraint should only be used as a last resort when there's no other way of stopping someone from doing themselves or others immediate harm.

According to both the Care Quality Commission's *Count me in* census[6] and the *Mental Health Minimum Dataset*[7], physical restraint is 'the physical restraint of a patient by one or more members of staff in response to aggressive behaviour or resistance to treatment'. The fifth and final *Count Me In* census, carried out in 2010, found that about 12 per cent of patients had experienced one or more episodes of physical restraint[6].

Currently in England, there is no national framework to govern the use of physical restraint and current training used by mental health trusts remains variable and unaccredited. This lack of standardised policy contrasts with Wales which has a nationwide All Wales NHS Violence and Aggression Training Passport and Information Scheme. In Wales, staff are taught to use face-to-face safe-holding when a hands-on intervention is required. Although some physical restraint training approaches in England emphasise the importance of safety, dignity and respect, our research has shown that use of such training is not standard practice for all mental health trusts.

Urgent action is needed to ensure that the care delivered by healthcare professionals is built on humane values and embodies the principles of dignity and respect where the person's choices are paramount.

## Mental Health Act and the use of physical restraint

If a person is detained under the Mental Health Act 1983 and is a hospitalised inpatient then staff are entitled to exercise a degree of control over that person, for example preventing that person from leaving the hospital or requiring them to leave a public area of the hospital. Force may be used to achieve this if it is necessary, but it must be reasonable and proportionate.

Physical restraint is not defined in the Mental Health Act but the key guidance on use of restraint and detained patients is in the Code of Practice to the Act. Chapter 15 of the Code of Practice, *Safe and Therapeutic Responses to Disturbed Behaviour,*[8] explains that restraint is a response of last resort and requires that:

- All hospitals should have a policy on the recognition and prevention of disturbed or violent behaviour as well as risk assessment and management including the use of de-escalation techniques, enhanced observation, physical intervention, rapid tranquilisation and seclusion. (15.6)
- Physical restraint, rapid tranquillisation, seclusion and observation should only be used where de-escalation has proved insufficient and never as punishment. (15.8)
- Professionals should not categorise behaviour as disturbed without taking account of the context. (15.13)
- Individual care plans are fundamental to management of disturbed behaviour. In addition, problems may be minimised by promoting the therapeutic culture of the ward, and identifying and managing problem areas. (15.16)
- Hospitals' policies on the management of disturbed behaviour should include clear written policies on the use of restraint and physical interventions, and all staff should be aware of the policies which should allow for post-incident review. (15.21)

# Recent developments in policy and practice

A number of recent initiatives have highlighted the issue of physical restraint.

## Mid Staffordshire

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[9] highlighted significant problems of inhuman and degrading treatment across the NHS that are particularly pertinent to mental health. Some services were found to be using force and coercion where people were not involved in deciding about the care and treatment they received. The report made it clear that the quality of care in the NHS must be delivered based on dignity and respect.

## Winterbourne View

The Department of Health's final report into the horrific abuse encountered by many at Winterbourne View[10], an independent provider of services for people with learning difficulties, highlighted the extremely high number of physical restraints regularly being used on inpatients. The numbers of recorded incidents was so high that the Care Quality Commission concluded it would be impossible to justify the necessity of physical intervention for every incident.

The report made strong recommendations for clear guidance around preventing and managing challenging behaviour. It emphasised that physical restraint must only be used as a last resort, where the safety of the person would otherwise be at risk, and never to punish or humiliate.

In our own call for evidence for this report, people told us they felt they were treated "worse than a criminal" and had been pinned to the floor by members of staff with very little or no communication.

Following the Winterbourne View investigation, the Care Quality Commission produced a briefing on restrictive practices in mental health and learning disability settings[11]. It explored a programme of unannounced inspections of services alongside evidence from visits to people detained under the Mental Health Act. Although the briefing identified the use of different types of restrictive practices which are still prevalent, such as seclusion/segregation techniques, there was also evidence of the use of physical restraint varying in frequency and intensity with some inspection reports highlighting how common the practice was in some areas.

## Independent Advisory Panel on Deaths in Custody

In 2008 the then government set up the Independent Advisory Panel on Deaths in Custody[12] to help shape government policy in this area through the provision of independent advice and expertise to the Ministerial Board on Deaths in Custody. The remit of the panel covers deaths occurring in various settings including of people detained under the Mental Health Act in hospital. The panel have been hearing from families who have been affected by the death of a relative within state custody and liaising with practitioners from both the health and legal profession. They are developing common principles on the use of physical restraint, to apply to all sectors, expected to be released later in 2013.

## Metropolitan Police Service

The Metropolitan Police Service set up an Independent Commission on Mental Health and Policing looking into how it responds to people with mental health problems[13]. The review carried out an examination of cases from the last five years where someone with a mental health condition had either died or been seriously injured following contact with the police. The Commission's report found the tactics and behaviour used by the Metropolitan Police Service to physically restrain people with mental health problems the most disturbing of their findings and it examined several cases which involved prolonged physical restraint by the police.

The Commission's report recommends that the Metropolitan Police Service develop policy and training for police officers on physical restraint which is developed in partnership with people with mental health problems[14].

## National Institute for Health and Care Excellence (NICE)

The 'Violence' guidelines produced by the National Institute for Health and Care Excellence (NICE) are set to be replaced in 2015 by an updated version entitled 'The short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments'. The new guidelines will include the views of people who have experienced the use of physical intervention and seclusion, as well as other aspects of restraint such as rapid tranquilisation.

## Royal College of Nursing

Earlier in 2013, the Royal College of Nursing held its annual congress where members overwhelming voted to lobby UK governments to review, accredit and then regulate national guidelines of approved models of physical restraint in healthcare[15]. Nurses spoke out about poor practice they had witnessed and the critical need for establishing appropriate guidelines.

## Implementing Recovery through Organisational Change (ImROC)

In the meantime, some health settings are making progress to reduce the use of physical restraint. The Implementing Recovery through Organisational Change (ImROC) programme is run by the Centre for Mental Health and the NHS Confederation[16]. The aim of ImROC is to encourage organisations to be recovery-oriented and to improve the quality of the service they provide to support people more effectively. Organisational culture and the quality of interactions is core to the approach and some mental health trusts participating in ImROC are successfully working towards zero use of physical restraint.

All these initiatives are welcome, but there urgently needs to be definitive national standards and accredited training to bring all these practices together and address the huge variations in physical restraint we found across England.

# Race equality

There has been slow progress to date on changing the stark inequalities in the acute sector of mental healthcare for people from some Black and minority ethnic (BME) communities, and they continue to be over-represented in hospital and as detained patients[17]. While the *Count Me In* census did not show ethnic differences in the use of physical restraint, this issue has a strong resonance in Black communities because people from these communities are disproportionately treated in inpatient and secure settings, and because of recent cases of deaths of young Black men in police custody[18]. INQUEST identified that 'in 2008, BME deaths accounted for 32 per cent of all deaths in police custody[19].'

The report produced by the Independent Commission on Mental Health and Policing found various 'failures in the system, misjudgements of errors in the system' and a degree of 'discrimination' towards people with mental health problems. It also found 'evidence of… a small number of alleged racist incidents[20].' The findings demonstrate that issues of racism continue to be prevalent within the Metropolitan Police Service, and that it is likely that these views will have an impact on how some officers, including frontline officers and custody officers, respond to people from BME communities.

There was also strong criticism in our own crisis care inquiry of how Black men are treated. They are disproportionately diagnosed with schizophrenia, treated with suspicion and assumed to be violent and dangerous by staff due to misplaced perceptions and cultural stereotypes[3].

## Case study: Maat Probe Group

During our 2010/2011 crisis care inquiry and call for evidence, we heard about aggressive treatment and physical injuries towards people with mental health problems in inpatient wards. We heard about physical restraint from the Sheffield based African Caribbean service user group Maat Probe, several individuals who responded to the call for evidence, the Centre for Mental Health and the Care Quality Commission.

When the Maat Probe Group carried out a monitoring exercise in 2009 to investigate Black people's experiences of mental health services, they found that 46 per cent of the people they interviewed had been restrained by mental health staff. Of these, 79 per cent felt it was aggressive and 34 per cent had been physically injured. People talked about being pinned to the floor, having a knee on the back of the neck and feeling violated.

Members of Maat Probe Group told us about the importance of communication between staff and people in crisis in preventing and dealing with difficult situations – for example, to listen and respond to people's fears about medication. The group also felt there needed to be better understanding and awareness among staff about people's cultural backgrounds and ethnicity.

As a result, the Maat Probe Group's top priority was for an alternative to conventional methods of control and physical restraint to be used in resolving difficult situations on the ward – methods taught in programmes such as RESPECT, SCIP or Studio III Training.
The group have successfully lobbied for the mental health trust in Sheffield to adopt RESPECT Training and are currently evaluating its impact to date (see page 23).

The death of Rocky Bennett prompted an inquiry in 2004 which found that Rocky died as a direct result of force used during physical restraint by five nurses, and that his death would not have occurred if there had been approved guidelines in place[21]. The inquiry also prompted the Delivering Race Equality programme[22] and encouraged the Department of Health to work on the management of violence that was intended to result in definitive guidance and accredited training.

Unfortunately definitive national standards for physical restraint and accredited training are still to be established and implemented, even though these recommendations were made almost ten years ago. This means each mental health trust in England and each independent hospital uses its own training scheme.

Physical restraint is linked with death, and people with mental health problems continue to experience excessive force, physical injury and psychological harm in psychiatric settings. Continuing to leave the practice of physical restraint unchecked and open to variation in England, and failing to put an end to the use of face down physical restraint is unacceptable.

# Face down physical restraint

> **Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when they are restrained for long periods. And that I think is a matter of fact.**[23]
>
> Dr Nat Cary, Consultant Home Office Forensic Pathologist, in evidence to the David Bennett inquiry (2004)

Face down physical restraint means pinning and holding someone face down for a period of time. It is particularly dangerous and life threatening because of the impact it can have on a person's breathing. Along with other forms of physical restraint, it can also be dehumanising and distressing and should have no place in a healthcare setting where people go to recover.

Face down physical restraint was identified as a contributing factor in the death of Rocky Bennett. The medical experts who gave evidence at the inquiry all agreed that the single most important cause of death was the prolonged period (20 to 30 minutes) of prone restraint carried out by nurses[24]. Despite specific recommendations made in the 2004 inquiry about the use of face down physical restraint, there is still an over-reliance on this practice when managing a mental health crisis in healthcare settings. The Care Quality Commission's latest Mental Health Act Monitoring Report 2010/11 refers to concerns about the recent deaths of three detained patients during restraint in the prone position, where lack of training was identified at inquest as a contributory factor[25].

We have found through our research that some trusts have put an end to face down physical restraint altogether. They use other forms of physical restraint, developed jointly with people with mental health problems, which promote respect-based principles. These alternatives show that it is entirely possible for staff to manage challenging behaviour effectively without the need for the life threatening and dangerous use of face down physical restraint.

# What mental health trusts told us about physical restraint

> Restraint is used too quickly and services need to understand why someone is behaving in that way. To come at someone who's already in a bad way makes it so much worse and causes even more distress.
>
> On-duty psychiatrist

We know healthcare staff do a challenging job and sometimes need to make difficult decisions very quickly. However, in situations where staff feel there is a threat to the safety of the patient in distress or the people around them, de-escalation alternatives to physical restraint should be considered first. If none of the de-escalation alternatives are effective, only then should physical restraint be carried out. It should only be used as the last resort, when there is no other way of stopping someone from doing themselves or others immediate harm.

Through our FOI requests we asked for a range of data for the year 2011–2012 from all 54 mental health trusts in England about:

- how they use physical restraint
- the impact of physical restraint
- the current procedures and training which underpinned the trust's physical restraint policy[26].

We asked for the information to be broken down by both gender and ethnicity.

We received very low responses for ethnicity. A large number of trusts did not provide data on gender and ethnicity citing that they did not capture this information or that it would be too costly to collect. This is highly worrying given the disproportionate numbers of people from BME communities using secondary mental health services and being detained in custody. The failure to record the ethnicity of people being physically restrained could be masking the true extent of inequalities faced by people from BME communities.

Overall, responses showed stark variations in how the practice of physical restraint is used throughout England, and recording of the impact caused due to physical restraint also varied from trust to trust.

# Use of physical restraint

## Incidents of restraint

| Total number of incidents of physical restraint by one or more members of staff | |
|---|---|
| Number of respondents | 47 (87 per cent of all trusts) |
| Total | 39,883 |
| Range | Highest 3,346; lowest 38 |
| Median | 455[27] |

> …[during physical restraint] the six of them then started talking about what they were going to do for their Christmas holidays… they were talking about these matters while pinning down a 20-year-old terrified woman.

These figures show the huge variation in how physical restraint is used in NHS mental health settings. The range displays the highest and lowest reported figures received from the trusts which replied to this question. The range varied enormously from 38 incidents of physical restraint in one trust to over 3,000 in another. This level of variation is appalling, even if each trust may use different definitions of restraint in their records. Nor is it clear from the data whether all physical restraints are effectively recorded.

What is clear from the information, even allowing for potential poor reporting, is that it is possible to deliver a mental health service with minimal use of physical restraint. It is unacceptable that some trusts are reporting hundreds or thousands of incidents a year.

## Number of patients restrained

| Total number of patients who experienced physical restraint by one or more members of staff | |
|---|---|
| Number of respondents | 39 (72 per cent of all trusts) |
| Total | 19,044 |
| Range | Highest 3,133; lowest 38 |
| Median | 247 |

> They hold them, release them after five minutes, take a 30 minute break and then hold them again. It's again and again… they're too quick to use restraint
>
> Ward Psychiatrist

Again we found a huge variation in the total number of people who experienced physical restraint by one or more members of staff. Worryingly this data suggests that some people may be being restrained repeatedly.

## Face down restraint

| Total number of incidents of face down physical restraint by one or more members of staff | |
|---|---|
| Number of respondents | 27 (50 per cent of all trusts) |
| Total | 3,439 |
| Range | Highest 923; lowest 0<br>(in 4 Mental Health Trusts) |
| Median | 65 |

> It was like a rugby scrum... They got on top of me and held my face down to the floor... with my arms behind my back. There was someone on every limb... it stayed with me.

Data from the numbers of incidents of face down physical restraint revealed that at least 3,439 incidents of face down physical restraint occurred in England during 2011-2012; over half of the face down physical restraints occurred in just two trusts. These extremely high figures suggest that face down physical restraint is occurring at least nine times a day on average – and this is just within the 50 per cent of trusts who sent us data.

One trust reported 923 incidents of face down physical restraint in one year which is highly concerning, especially as we also know from our findings that some trusts have worked hard to eliminate face down holds and consequently reported zero prone position restraints.

## Restraint and medication

| Total number of incidents where physical restraint was used to administer medication | |
|---|---|
| Number of respondents | 31 (57 per cent of all trusts) |
| Total | 4,300 |
| Range | Highest 592; lowest 1 |
| Median | 74 |

> Four of them held me down onto the bed and gave me an injection. I kept saying that I didn't want it and that I wanted a female nurse. No one listened to me... The younger staff members are the worst. They're new and excited by their training and get carried away with it.

Information received for numbers of incidents where physical restraint was used to administer medication, was another area where the figures were exceptionally high. Over 4,000 recorded incidents of physical restraint were reported for medication purposes with a mid-range of 74 incidents in 2011–2012. Some trusts explained their reasons for using physical restraint to administer medication, such as to calm an inpatient who had become highly distressed through the use of rapid tranquilisation. But we heard in our crisis care inquiry that some staff don't try to understand why someone is refusing medication and are using physical restraint too quickly.

## Police involvement

| Total number of incidents where police were involved in physically restraining a patient | |
|---|---|
| Number of respondents | 27 (50 per cent of all trusts) |
| Total | 361 |
| Range | Highest 100; lowest 0<br>(in 3 Mental Health Trusts) |
| Median | 8 |

> It made me feel like a criminal like I had done something wrong, not that I was just ill and needed to get better. That's all it is.

Of half the responses received for incidents where police were called to physically restrain someone in a healthcare setting, there was significant variation in the numbers of recorded incidents. One trust alone in 2011-2012 reported 100 incidents whereas three trusts reported not having to call the police at all. Given this variation in the need to call the police, it raises the question of how necessary or appropriate it is to call law enforcement into health settings.

One person responding to our crisis care inquiry, who witnessed physical restraint on a ward, described what happened when staff were unable to de-escalate a situation and police were called in, "storming the car-park, alarming visitors and patients". They heard staff making accusations to someone in crisis (which did nothing to defuse things) and police mocking the situation.

# Impact of physical restraint

## Physical injury

| Total number of incidents of physical injury following physical restraint | |
|---|---|
| Number of respondents | 34 (62 per cent of all trusts) |
| Total | 949 |
| Range | Highest 200; lowest 0<br>(in 5 Mental Health Trusts) |
| Median | 7 |

> **It hurt a lot of the time as well. Being 20 and quite petite resulted in me quite often being left with bruises after being restrained.**

We found that, while no deaths during the period of 2011–2012 were reported to us, in the 75 per cent of the trusts which answered questions about physical injury as a direct result of restraint, the recorded incidents of physical harm varied from zero to 200.

Interestingly, one trust commented that they were unable to determine if the injuries sustained were due to a prior incident or if they were caused by the physical restraint itself. One way to eliminate this uncertainty is to ensure that every person who has experienced physical restraint has the opportunity to write an account of the episode of physical restraint and this is filed in their notes, as required in the Mental Health Act Code of Practice. The Care Quality Commission's *Monitoring the Mental Health Act in 2010/2011* report stated that although many services find this requirement challenging, compliance with the Code's guidance would mark a positive cultural shift for many hospitals and they will continue to promote it through their visits[28].

Earlier this year Mind and the Sheffield based African Caribbean mental health Maat Probe Group – who also gave evidence to our *Listening to experience* inquiry – jointly hosted a workshop to explore people's experiences of physical restraint in mental healthcare settings. The Maat Probe Group had successfully influenced their mental health trust to focus on more therapeutic holds and de-escalation techniques which start from a position of respect for the person with mental health problems. We also heard from people who described the physical injuries they had received as a direct result of being physically restrained, such as a 'Chinese burn' (gripping and twisting one's skin in opposite directions so as to cause a burning sensation) or having their fingers bent backwards. These forms of physical injuries have no place in mental healthcare and cannot be justified as safe or respectful.

## Psychological harm

| Total number of incidents of psychological harm following physical restraint | |
|---|---|
| Number of respondents | 14 (25 per cent of all trusts) |
| Total | 96 |
| Range | Highest 74; lowest 0<br>(in 11 Mental Health Trusts) |
| Median | 0 |

> I've suffered physical abuse when I was younger and being held down where someone forces their weight on you is triggering for me… it's the last thing that's going to make me conform; I don't want them touching me.

The lowest response rate, just 25 percent, to our FOI requests was to the question on psychological harm caused as a result of being physically restrained. Many of the trusts were unable to provide this information because it was either captured in an individual's medical records and extracting this information would be costly, or because psychological trauma is not routinely recorded. Others suggested that psychological trauma was open to different interpretation and not easily identifiable. One trust went as far as to say that "it would not be possible to record this information as it would be difficult (impossible) to clarify that a patient's psychological presentation was linked solely to their restraint and not to their underlying mental health issues."

From our call for evidence, we also heard about staff belittling people when they were being physically restrained and continuing with their conversations and ignoring the person being physically restrained. Many respondents to our inquiry told us again and again how humiliating, distressing and disempowering physical restraint can be and this can only have a negative impact on recovery. Some told us of long term psychological impact from an episode of physical restraint.

While we understand that it would be difficult to fully attribute psychological harm to the incident of physical restraint, especially if the person is not given the opportunity to report their experience, some trusts do record psychological harm.

However, physical restraint doesn't have to be negative, and we did hear from one or two people about how physical restraint could be done well and positively. They told us about being listened to during physical restraint and being held in a safe way which didn't fully restrict their movement or cause pain.

# Complaints about physical restraint

| Total number of complaints received following physical restraint | |
|---|---|
| Number of respondents | 37 (68 per cent of all trusts) |
| Total | 111 |
| Range | Highest 21; lowest 0<br>(in 10 Mental Health Trusts) |
| Median | 2 |

> What's the point of complaining? They don't believe you and you know you'll see them [staff] again the next day. It's not worth it.

Given the many negative experiences of physical restraint we heard about through our crisis care inquiry and call for evidence, it might be expected that numbers of complaints would be relatively high. However the responses we received indicated very few recorded complaints were lodged about physical restraint in the year 2011–2012. Sadly these low numbers are unsurprising and fit with other research we have conducted.

Through our engagement of people with mental health problems, Mind knows that there is a huge issue of underreporting of safety incidents and poor treatment among people with mental health problems. The power imbalance between people in crisis and staff is a significant deterrent to raising a complaint. People may not have confidence to complain or think they will not be listened to, so believe it is not worth bothering. They may also lack the confidence or ability to complain because their mental health problem makes it difficult for them to engage in the complaints process. For these reasons, the low figures for physical restraint complaints are likely to reflect under-reporting of abuse or inappropriate treatment rather than an absence of a need to complain about the service people have experienced.

## Case study: Rosemary's story

Rosemary was 55 at the time of her inpatient experience in a mental health hospital. This is her account of what happened to her.

It was a bright day and the doors to the hospital garden were open so Rosemary went outside. Two women were out there smoking and asked Rosemary to go back inside. Because Rosemary had not had the opportunity to go outdoors for a while she went ahead and sat on the bench. The two women, who were in fact duty nurses, went inside coming back a little later with other staff.

All the members of staff approached Rosemary and began to try to remove her physically from the bench. They managed to pull Rosemary off and went on to pin her on the floor in full physical restraint, face down. She had one nurse on each arm plus one sitting on her legs. They then started to inflict pain, one giving her a Chinese burn and twisting her fingers.

Rosemary was told to get up but couldn't, as they were holding her arms and wouldn't let go. Eventually she got to her knees and then to her feet. She had been face down on a muddy path and her face was covered in mud and dirt. She asked for someone to wipe her face before she was taken back inside, but her request was ignored. Rosemary was then taken back on to the open ward in front of everyone. with one nurse walking backwards in front of her, one behind, and one holding each of her arms. People on the ward had also been able to witness the physical restraint through the window.

Soon after leaving hospital, Rosemary developed post traumatic stress disorder (PTSD) as a result of the incident and ten years later still has flashbacks. As a result of this experience, Rosemary has tried three times to take her own life and has been admitted into hospital.

Rosemary now receives treatment for her PTSD and is making progress in her recovery.

## Case study: Lucy's story

This is Lucy's account of what happened to her.

Between the ages of 16 and 17, Lucy was in an inpatient unit where staff were allowed to physically restrain people. From Lucy's experience, the times when she had witnessed and experienced physical restraint, it was only used as the last resort. Lucy felt that even though she had experienced a history of violence perpetrated by others, physical restraint used as a last resort made her feel safer and more secure in moments where she was unable to control her behaviour in a crisis. When physical restraint had been used on Lucy, it helped her feel grounded because it was carried out in a gentle and respectful way, she felt it was entirely appropriate. It made Lucy feel like somebody was there to help.

# Our analysis of physical restraint

> I went into this job to care for people and make them better and ideally you wouldn't restrain anybody. But it happens quite often. At what point do people intervene? When there's fear, people do drastic things and act less controlled.
>
> Staff nurse

Physical restraint is often a response by healthcare staff to behaviour which is perceived as challenging and potentially disruptive or violent. When people are highly distressed and in a mental health crisis, their behaviour may appear erratic and violent which can lead to staff initiating a form of intervention to either protect the inpatient, others or themselves.

The way someone behaves in a situation or in a crisis can be a response to various factors, and not just a manifestation of someone's diagnosed mental health problem. The culture and environment of wards can act as a trigger for challenging behaviour. If people are not listened to or given the opportunity to have a say in their care, have nothing to do or no-one to talk to, tensions can rise and people may become frustrated and distressed.

Problems with inpatient environments – often overcrowded, noisy, unsafe and with limited therapeutic input – have been identified over the last 10 years or more[29]. We heard of people being locked in their rooms without access to outdoor space or even something as simple as a request for a cup of tea being turned down. These limiting conditions and rules placed upon people's everyday movements, especially when they are at their most unwell and vulnerable, can have severe adverse effects on their mental health and can be a trigger for challenging behaviour.

The aim of inpatient wards should be to provide a therapeutic and safe environment which aids the person's recovery by providing care which encompasses the person's choices and their needs. Physical interventions and other restrictive practices such as seclusion, should be severely limited and used only when other techniques such as de-escalation have been exhausted.

# The importance of communication

I was manhandled. They didn't explain anything to me but just threw me on the floor and another person stood over to watch. There was no explanation or communication the whole time.

During our crisis care inquiry and call for evidence from people who had experienced being physically restrained, there was a recurring theme of little or no communication with them to find out how to remedy or de-escalate a situation. People told us about being disregarded and given no choice or information before, during or after physical restraint. We heard from someone who asked staff to take extra care if they were to be physically restrained because their existing self-harm abrasions were still very painful and should be carefully avoided. This request was ignored.

Often this lack of communication follows a more general failure to engage with people and to create relationships where the person is able to trust and work with staff on an ongoing basis and where staff in return understand each person's needs and behaviour.

Effectively creating a joint care plan between staff and the person, or identifying things that might increase or decrease distress, anxiety or trigger challenging behaviour in a person can help manage future crises.

In order to understand each person's actions, staff should be encouraged to actively listen and respond to someone's needs through continually referring to their care plan, not only their mental health diagnosis.

We heard at our workshop with the Maat Probe Group that people feel their race and ethnicity can define how they are treated by professionals. Staff can assume that someone's behaviour is threatening or challenging when in fact their cultural background can mean they are often more animated or speak in louder tones. This is not aggressive behaviour and staff may feel less intimidated if they are more culturally aware.

Treating people with dignity and respect, listening to them and trying to understand their frustrations or refusals, providing activities, therapies and access to outdoor space will help their recovery and prevent challenging situations.

Some of the psychiatric nurses are gems. They go the extra mile and try and look out for you.

# Evidence of training and good practice

Training in the prevention, de-escalation and management of challenging behaviour must be based on humane values and people should be treated according to the choices they have previously identified through joint care plans and advanced directives.

To truly understand and therefore positively support someone in immediate crisis, there should be an explicit acknowledgement that individuals know what they need for their own recovery. People should have more say over what happens at a time when they may not be able to exercise choice directly.

Current Royal College of Nursing guidance states that physical restraint should only be used as a last resort and not solely to reduce workload. In most circumstances, physical restraint can be avoided by positive changes to the provision of care and support and an individual's choice should be acknowledged and included in a care plan and risk assessment[30]. Cultural awareness training and in-depth learning techniques should be pursued so staff and providers understand the context of a person's actions.

## Case study: RESPECT Training Solutions

RESPECT Training Solutions is based in North Lincolnshire and aims to provide a holistic and ethical approach to physical interventions in mental health settings. Their training has been created with direct involvement from people who have experienced physical restraint and carer involvement, emphasises support rather than control and seeks cooperation where possible.

This person-centred training is based around prevention and designed to help staff empower people. The principles of RESPECT are based on:

- No use of facedown holds
- Avoidance of labelling people
- Care rather than simply control
- Developing healthy environments
- Awareness and avoidance of abuse
- Recognising differences between threat and violence/de-escalating
- Presenting a realistic view/reducing fear in staff

Sheffield Health and Social Care Foundation Trust have employed RESPECT Training Solutions techniques in their practice since the Maat Probe Group worked with the Trust to promote awareness and prevention methods to physical restraint.

Sheffield Health and Social Care Foundation Trust use prevention methods to minimise incidents of aggression and violence, such as creating an environment of dignity and allowing a collaborative approach with people with mental health problems.

They emphasise the need for use of physical restraint to be honestly and openly acknowledged, and that all incidents should be recorded. Where this is not the case, the use of physical restraint is deemed inappropriate and regarded as abuse. Underlying issues or circumstances that may lead to aggressive behaviour are taken into account to de-escalate situations. Staff are provided with an understanding of the cultural and diverse needs of people through training, and promoting awareness of physical and psychological harm to people and staff as a result of using physical restraint.

## Case study: West London Mental Health NHS Trust

As an ImROC pilot site (see page 9), the Trust has made improvements through embedding recovery principles into routine clinical practice including the provision of a Wellness Recovery Action Plan (WRAP) for everyone. There is now an expectation that the individual is able to discuss their WRAP in all care programme approach meetings. This Trust no longer uses face down physical restraint.

The Trust has appointed advisors to support resolution of high risk incidents using only the necessary amount of physical intervention. The main focus is on exhausting all routes of de-escalation before more restrictive but still proportionate approaches are considered.

By being aware of the emotional and physical environment, other underlying causes of aggression are also taken into account.

When physical restraint is deemed necessary, staff are required to be sensitive to the person and consider any physical, sensory or communication impairment, gender, race and ethnicity, religious and cultural beliefs. The focus is on the intervention being proportionate and on ceasing physical restraint as soon as it is safe to do so. The person is then encouraged to discuss the incident and their crisis care plan is updated accordingly.

## Case study: Hertfordshire Partnership NHS Foundation Trust

The Trust uses the RESPECT Training Solutions model and principles and is currently developing a conflict reduction strategy which it hopes will further reduce incidents where physical restraint is used. The Trust has also launched its own RESPECT campaign which focuses on managing appropriate behaviour and making improvements to the care environment, especially regarding the dignity of staff, service users and carers. This includes a new self assessment framework for dignity and equality that is being trialled across their learning disability services before being fully rolled out across the Trust. One of the key aims of their RESPECT campaign is to create services and workplaces where the potential for abuse is significantly minimised.

# Our recommendations

Crisis and acute mental health services are a crucial part of healthcare. They provide support and treatment for people when they are most unwell and vulnerable. How people are treated in these circumstances makes a huge impact on their recovery and willingness to seek help should they need it again.

Our findings have shown that physical restraint is used far too often in some parts of the country and the practice varies significantly. Some mental health trusts use respect based and de-escalation techniques, yet other trusts still use the dangerous and life threatening technique of face down physical restraint.

Over the years, unnecessary and avoidable deaths, such as Rocky Bennett's, have occurred because of excessive physical restraint but lessons have not been learned. Repeated calls for reappraising the use of physical restraint, introducing accredited training and bringing an end to face down physical restraint continue to be ignored by decision-makers.

We believe that the use of control and physical restraint needs urgent reappraisal and that the use of face down physical restraint should be ended. We are calling for established national standards on the use of physical restraint and accredited training for healthcare staff in England. The traditional practice of face down holds should be ended immediately as it is a dangerous and life-threatening response to managing someone's behaviour when they are in a mental health crisis.

The recommendations made below are long overdue and the need to urgently reform the practice of physical restraint is as crucial as it has ever been.

## Recommendations for Government and NHS England

- For Government to introduce an end to face down physical restraint in all healthcare settings urgently. Include the use of face down physical restraint in the list of 'never events'.
- For Government to establish national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint.
- For NHS England to introduce standardised data capture methods to ensure every mental health trust is collecting the same accessible data on physical restraint. This data should be published regularly and show:
  - the frequency of physical restraint for each person
  - the frequency of physical restraint to administer medication
  - incidents where physical restraint has been used resulting in physical and/or psychological harm
  - where a person makes a complaint directly relating to physically restraint.

  All the above must be captured according to gender and ethnicity breakdown.

## Recommendations for Clinical Commissioning Groups

- Set clear standards in your commissioning contracts which promote respect-based training in physical restraint and an end to face down restraint.
- Require providers to report on how staff will be trained and supported to use de-escalation and alternatives to physical restraint, that the methods used are safe and that physical restraint incidents are reported and feed into ongoing data collection.

- Monitor the use and impact of physical restraint in your area and include this data in regular performance reviews to monitor and interrogate provider practice.
- Ensure providers have sufficient policies in place to monitor and improve the environment and culture of wards to minimise the need for physical restraint.

## Recommendations for providers

- Urgently end the use of face down physical restraint
- Commit to working without coercion and train your staff in de-escalation techniques and respectful alternatives to physical restraint to help them manage challenging situations and support the recovery of people in crisis
- Provide ongoing cultural and ethnicity training for staff which is regularly reviewed and updated
- Ensure staff are using joint care plans to discuss and record possible responses to challenging behaviour
- Ensure that people who have been subjected to a physical intervention are given the opportunity to write their account of the episode as soon as possible and this is then recorded in their file
- Board members - ensure that your governance arrangements are sufficiently robust to satisfy you that staff are well trained and supported to use de-escalation and alternatives to physical restraint, that the methods used are safe and that physical restraint incidents are reported and feed into ongoing organisational learning
- Review the environment and culture of wards to ensure:
  - more therapeutic environments
  - people are treated with dignity and respect
  - people's needs are listened to
  - people's culture and ethnicity are respected
  - outdoor access and therapeutic activities are provided which help recovery and prevent challenging situations.

## Recommendations for staff

- Urgently end the use of face down physical restraint
- Commit to working without coercion and ensure that physical restraint is only ever used as a last resort and only when all other methods of de-escalation have been tried
- Where you do have to intervene, use alternatives like face-to-face safe-holding, talk to and reassure people throughout and give people an opportunity to record their experiences afterwards
- Listen to and understand people's needs and cultural background to help you prevent and respond to difficult situations. Your ability to be warm and compassionate can reduce distress and uncover the reasons behind their behaviour, preventing the need to intervene physically
- Use your communication skills to effectively understand people and build relationships where both staff and the person understand what care is needed
- Involve people in planning their care and respect their choices. Jointly agree how to respond to challenging behaviour through joint crisis plans which set out the triggering situations for the person and how they would like to be treated in a crisis.

# Methodology

Mind commissioned an independent panel to carry out an inquiry into acute and crisis mental healthcare in 2010/2011. We ran a call for evidence, held hearings and visited a range of services and used this information throughout this report. The research was published in our *Listening to experience* report[3], including people's experiences of being physically restrained in mental healthcare settings.

## Freedom of Information requests

In February 2013, we sent FOI requests to all 54 mental health trusts in England. We wanted to find out how they use physical restraint, the impact of physical restraint, and trusts' procedures and training which govern the use of physical restraint. We asked for all questions to be answered with a breakdown by gender and ethnicity.

As of 10 May 2013, we received a response, or partial response, to our requests from 51 trusts. Three trusts failed to reply at all. Of the rest, one declined our request citing cost and time and one said they could provide no data due to the way their data system captured information.

Our largest response rate to one question was 87 per cent per cent (47/54) and the lowest response was 24 per cent (13/54). The majority of trusts answered at least one question with data and/or polices and where trusts didn't give full replies they cited cost or data capturing issues. The largest single reason for not providing data for use or impact of physical restraint was because the data was captured in the individual's care records and could not be extracted. Many trusts also did not collect gender and/or ethnicity data in an accessible way but recorded only in individual care records. As a result, our data set is not complete and we cannot provide a full picture for every mental health trust in England.

We are reporting raw numbers and have not adjusted for general or patient population size. However we do not believe the high figures for some trusts and significant variation between trusts can be explained purely by differences in population. Even if differences are partly due to variable reporting practices, this in itself is unacceptable.

In relation to face down physical restraint, some trusts have completely ended face down physical restraint and use alternative methods to this practice, so high numbers of face down physical restraint in other trusts cannot be due solely to population size.

We have used the median number in these calculations as not all trusts answered all the questions and it is less subject to outliers.

## Mental health and physical restraint Freedom of Information request questions

### 1. Use of physical restraint

For the year 2011–12, please provide information on the following, providing a breakdown by ethnicity and gender for each item where possible:

a) the total number of incidents of physical restraint by one or more members of staff

b) the total number of patients who experienced physical restraint by one or more members of staff

c) the total number of incidents of face down physical restraint by one or more members of staff

d) the total number of incidents where physical restraint was used to administer medication

e) the total number of incidents where police were involved in physically restraining a patient.

### 2. Impact of physical restraint

For the year 2011–12, please provide information on:

a) the total number of incidents of physical restraint which resulted in the patients'
(i) physical injury, (ii) psychological harm,
(iii) death

b) the total number of complaints relating to physical restraint (from a person, or representative on behalf of a person who was subject to physical restraint).

### 3. Procedures and training

Please give details of:

your physical restraint policy, including details of training and risk assessment of training packages and techniques taught

a) any policies and practices you use to prevent the need for physical restraint

b) any examples of good practice in using alternatives to control and physical restraint

c) what process is used to report, review and reflect on incidents of physical restraint and allow the person who has been restrained to record their own account of the incident.

## Call for evidence

We revisited previous evidence given to our original inquiry panel and findings from the original *Listening to experience* report.

In addition, we used our online social media channels to seek responses from people with mental health problems who had experienced any form of physical restraint. We also asked the National Survivor User Network (NSUN) to publicise the call for evidence in their membership bulletin.

We interviewed people who had experienced or witnessed physical restraint, and staff members and other professionals who also witnessed physical restraint on wards.

In the interviews, we asked:

- What experiences have you had of being restrained or witnessing physical restraint?
- What was the reason for you being restrained?
- What happened and how did it make you feel at the time?
- Did staff talk to you before they restrained you to find out what was wrong?
- How did you feel afterwards?
- Were you given a chance to write an account of what happened as part of the reporting of the physical restraint?
- Were you offered any other support after being restrained?

# Endnotes

1. Independent Advisory Panel on Deaths in Custody (2012), *Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2011*

2. Freedom of Information Act request 2013

3. Mind (2011), *Listening to experience: An independent inquiry into acute and crisis mental healthcare*

4. Based on responses to Freedom of Information request received by 10 May 2013

5. National Institute of Clinical Excellence (2011), *Service user experience in adult mental health: Improving the experience of care for people using adult mental health services.* NICE Clinical Guidance 136, Quality standard 14

6. Care Quality Commission (2011), Count me in 2010: *Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*

7. The NHS Information Centre for Health and Social Care, Mental Health Minimum Dataset (MHMDS). The MHMDS reports information on people in contact with specialist secondary mental health services.

8. Department of Health (2008), *Code of Practice: Mental Health Act 1983, Chapter 15 Safe and therapeutic responses to disturbed behaviour*

9. The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC

10. Department of Health (2012), *Transforming care: A national response to Winterbourne View Hospital: Final Report*

11. Care Quality Commission (2012), *Briefing: Restrictive practices in mental health and learning disabilities settings*

12. Independent Advisory Panel on Deaths in Custody, set up in 2008 by the Ministerial Council on Deaths in Custody, chaired by Lord Toby Harris

13. Metropolitan Police Service (2012), Independent review into MPS and its contact with people with mental health problems including death or injury as a result of police contact. Chaired by Lord Victor Adebowale

14. Independent Commission on Mental Health and Policing Report (2013)

15. Royal College of Nursing Congress and Exhibition 21–25 April 2013, Agenda item 10 http://www.rcn.org.uk/newsevents/congress/2013/agenda/10-regulating-and-accrediting-physical-restraint [accessed 9 May 2013]

16. Implementing Recovery Through Organisational Change (2011), Joint initiative from Centre for Mental Health and the NHS http://www.imroc.org/

17. Bhui K. et al (2003), *'Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review*

18. Care Quality Commission (2011), Count me in 2010: *Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*

19. Inquest (2012) Inquest submission to the Home affairs Committee Inquiry on the Independent Police Complaints Commission

20. Independent Commission on Mental Health and Policing Report (2013)

21. INQUEST (2004), Briefing: The restraint related death of David 'Rocky' Bennett

22. Delivering Race Equality in Mental Health Care (2005), *An action plan for reform inside and outside services: The Government's response to the independent inquiry into the death of David Bennett*

23. Independent Inquiry into the Death of David Bennett (2003), An independent inquiry set up by HSG(94)27, Dr Cary Expert witnesses: Consultant Forensic Pathologist

24. INQUEST (2004), Briefing: The restraint related death of David 'Rocky' Bennett

25. Care Quality Commission (2011), *Monitoring the Mental Health Act in 2010/11: The Care Quality Commission's annual report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983*

26. See methodology for further details

27. We have used the median number in these calculations as not all trusts answered all the questions and using the mean average would not give a true reflection of the data. See methodology for further details

28. Care Quality Commission (2011), *Monitoring the Mental Health Act in 2010/11: The Care Quality Commission's annual report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983*

29. Department of Health (2002), *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*; Care Quality Commission (2011), *The state of healthcare and adult social care in England: An overview of key themes in care in 2009/10*

30. Royal College of Nursing (2008), *Let's talk about restraint: rights, risks and responsibilities*

For more information on our campaign and how we can work together for excellent crisis care, contact:

**Vicki Ensor**
t: 020 8215 2223
e: crisiscare@mind.org.uk

Mind, 15–19 Broadway, Stratford,
London E15 4BQ

**mind.org.uk/crisiscare**

Registered charity number 219830.
Registered company in England number 424348.

mind
for better mental health

www.nhsprotect.nhs.uk/reducingdistress

NHS

Protect

# Meeting needs and reducing distress

## Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

**We would like to thank all colleagues and organisations that have assisted in the development of this guidance, in particular thanks to NHS England and the Royal College of Nursing for ongoing help and support.**

# Endorsements

Alzheimer's Society
Leading the fight against dementia

bild
all about people

British Geriatrics Society

Challenging Behaviour foundation
making a difference to the lives of people with severe learning disabilities

The College of Emergency Medicine

College of Occupational Therapists

Mind
for better mental health

Royal College of Nursing

Royal College of Physicians

RC PSYCH
Royal College of Psychiatrists

[redacted]

# About the guidance

The purpose of this guidance is to provide practical strategies to help identify, assess, understand, prevent and manage clinically related challenging behaviour, by preventing or minimising a person's distress, meeting their needs, and ensuring that high quality care is delivered within a safe environment.

A unique feature of the guidance is that the principles and approaches outlined in it are exactly the same for any adult patient and service user in any NHS healthcare setting.

Although specific techniques and interventions may differ, the strategies for delivering high quality personalised care that meet the patient and service user's needs remain the same. The importance of positive engagement and communication cannot be over-emphasised.

## How should the guidance be used?

- Clinical staff should apply the approaches outlined here to their practice, in conjunction with their professional judgement in specific situations
- Support staff and carers should apply the approaches when assisting in the delivery of care
- Organisational managers should implement it when meeting their legal responsibilities to ensure the health, safety and wellbeing of staff, patients and service users.

The guidance can be read as a whole; however each section stands alone and will be of particular interest to specific audiences, depending on their role, setting and client group.

The following table identifies those accountable for preventing and managing challenging behaviour, and signposts the relevant section(s) in the guidance:

| Roles | Responsibilities | ✓ | Sections |
|---|---|---|---|
| **Chief executive, board members, directors of care, senior managers** | **Ratify and monitor the effectiveness of policies, systems and procedures to prevent challenging behaviour**<br>**Ensure the safety of staff, patients and service users in compliance with legal and regulatory requirements**<br>**Ensure the delivery of high quality, compassionate, personalised care**<br>**Demonstrate a commitment to the reduction of restrictive interventions**<br>**Take swift, decisive action if suboptimal care is being delivered**<br>**Make available resources, including training for a highly skilled workforce**<br>**Demonstrate strong organisational and clinical leadership**<br>**Develop a positive culture where high quality care can flourish, and encourages staff to report concerns about poor practice**<br>**Seek assurance that these priorities are being met through regular feedback, outcomes and incident analysis.** | | **Intro, 1, 2, 5, 6, 7** |

| Roles | Responsibilities | ✓ | Sections |
|---|---|---|---|
| Doctors, nurses, allied healthcare professionals with a supervisory role | ○ Provide leadership and foster a culture in which compassionate, personalised care is delivered and where physical interventions are only ever used as a last resort<br>○ Help formulate policies, systems and procedures to ensure an awareness and understanding of challenging behaviour to help prevent it<br>○ Support, instruct and advise on long term strategies to deliver personalised care consistently to prevent challenging behaviour<br>○ Provide good role modelling and clinical supervision for positive engagement and communication<br>○ Support, instruct and advise on escalating and emergency situations<br>○ Encourage reporting of all incidents of challenging behaviour through the incident reporting system<br>○ Manage post incident reviews, debriefs and the implementation of lessons learnt<br>○ Release staff for targeted training commensurate to the risks faced<br>○ Ensure information sharing with clinical colleagues, security staff, training staff, the police and appropriate external agencies. | | Intro, 1, 2, 3, 4, 5, 6, 7 |
| Doctors, nurses, allied healthcare professionals | ○ Follow all policies, systems, procedures, guidance and updates to keep safe<br>○ Understand challenging behaviour, how to recognise it, how it relates to clinical conditions, how to prevent and manage it<br>○ Apply effective personalised care strategies to prevent challenging behaviours<br>○ Maintain compassion, empathy and positive attitudes when delivering care<br>○ Apply effective strategies for the clinical assessment, diagnosis and management of challenging behaviour<br>○ Apply effective strategies to manage escalating and emergency situations<br>○ Report all incidents of challenging behaviour to the line manager and through the incident reporting system<br>○ Understand and reduce risks and implement preventative strategies as is reasonably practicable<br>○ Undertake all necessary training, education and updates to keep safe and to provide the highest quality care. | | Intro, 1, 2, 3, 4, 5, 6 |
| Security and emergency response teams | ○ Identify and understand challenging behaviour, common triggers and simple prevention strategies<br>○ Understand own role in preventing challenging behaviour in longer term care, including legal requirements around physical interventions<br>○ Undertake all necessary training, education and updates in relation to the safe and appropriate application of physical interventions. | | Intro, 1, 2, 3, 4, 5, 6 |

# Contents

**KEY**

| | |
|---|---|
| Applies to all | ALL |
| Senior managers | M |
| Supervisors | S |
| Doctors | D |
| Nursing Staff | N |
| Allied healthcare staff | A |
| Response teams | R |
| Carers | C |

# Foreword

The challenge of keeping patients safe at times when they may be especially vulnerable and are outwardly exhibiting challenging behaviour has been increasingly recognised over the last few years. This guidance, *Meeting needs and reducing distress*, is aimed at improving the safety and wellbeing of patients whose challenging behaviour arises from their clinical condition. It provides a welcome focus on an extremely important issue, particularly for the acute and primary care settings.

*Meeting needs and reducing distress* is part of a wide and far-reaching programme of work on the avoidance and safe management of restraint that is being developed by a range of agencies, both within and beyond healthcare settings.

There are three particular aspects of the publication I would like to highlight:

First and foremost, is the need for assessment to uncover any acute physical or neurological cause to the challenging behaviour. A recent review of the National Reporting and Learning System uncovered a small but significant number of incidents where challenging behaviour was not recognised as a sign that the patient had a life-threatening illness and needed emergency intervention.

Secondly, is the fact that any episode of challenging behaviour is a demonstration of distress from the patient and a source of worry and concern to their family, friends, and to healthcare staff as they strive to provide the very best safe and compassionate care. To reduce distress there is a strong requirement to maintain a safe, supportive and clinically led service with active patient participation, that is reliant on forward planning, training and teamwork to ensure both patients and staff feel fully supported and valued. It is recommended you read this publication alongside *Compassion in Practice*, so the required steps can be taken at a local level to create a positive and proactive environment where alternatives to restraint have been established.

Finally, is the need to recognise any physical intervention or restraint used in response to challenging behaviour as a patient safety incident that must be reported through local systems and shared with the National Reporting and Learning System. An open and transparent structure for learning from incidents and working in partnership with patients and the public will ensure 'the power of pervasive and constant learning', as recommended in Professor Don Berwick's report into NHS patient safety.

Our vision for patient safety in the NHS is to ensure that every time any person needs to access our services, they can be confident they will be treated in an environment where safety is paramount and every step will be taken to keep risk to a minimum. The ultimate aim is to make the NHS the safest healthcare system in the world, and now, more than ever, we are committed to establishing a culture that is rooted in continual improvement.

**Dr Mike Durkin**

**National Director of Patient Safety**
**NHS England**

# Introduction to challenging behaviour

## Meeting needs and reducing distress

### Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Introduction to challenging behaviour

Clinically related challenging behaviour is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs.[1] It may result from an individual feeling threatened, fearful or anxious, suffering delusions or hallucinations, or it may be in response to a difficult situation, or a misinterpretation of the actions of other people. It may simply be a result of an individual trying to express that they are hungry, thirsty or in pain.

Preventing challenging behaviour is concerned with understanding the reasons for a person's distress by recognising their vulnerability, anticipating needs and designing care accordingly.

It challenges perceptions, motivating professionals and organisations to ask:

***'What are we doing to make things worse?'***

and

***'How can we change what we are doing to make things better?'***

This is a collective endeavour which involves everyone and may require a review of existing care models, following an approach which relies on engaging, occupying and talking to the person through the delivery of high quality personalised care.

It may require time and sustained effort to change existing cultures. There may need to be a change in perceptions about certain conditions and types of patients and service users. For example, an older person showing challenging behaviour needs to be treated with the same concern and expedience as any other individual.

Negative staff attitudes can be a factor in causing or provoking challenging behaviour and an effective approach relies on compassion, empathy and respect for the person.

Previous government strategies have pursued a 'zero tolerance' approach to tackling violence and aggression in the NHS. While this has been a helpful starting point, it is problematic in the context of this work. This guidance adopts a person-centred approach that relies on greater tolerance and understanding.

## Background

Clinically related challenging behaviour, although underreported, is a significant problem in the NHS.[2] This includes behaviour arising from dementia, delirium, injury to the head and brain, cancer, substance and alcohol abuse and withdrawal, mental health conditions and learning disabilities. It may also result from other factors, such as bereavement, anxiety and fear, adverse reactions to medication and treatment, or a feeling that staff are not paying attention.

This type of behaviour has been well publicised particularly in connection with older people with dementia, however it could instead be found in a young person who is otherwise physically fit and is recovering from a head injury. Statistically, however, the former outweighs the latter.

Behaviours such as grabbing, biting, scratching, pinching, poking, hair pulling, punching, kicking and slapping, along with self-injurious behaviours can, if left unchecked, pose a significant safety risk to staff or result in the person bringing harm to themselves, as well as causing alarm and distress to other patients and visitors.

Challenging behaviour can take place in any health care environment; however the picture in terms of prevalence is complex. In the acute sector, most incidents necessitating restraint did not take place in A&E, as is often thought, but occurred on acute medical wards.[3]

Individuals who present with challenging behaviours and who may be vulnerable should not be labelled or stigmatised as being violent and aggressive. Often, challenging behaviour is a function of a patient's inability to communicate their needs. It does not form a necessary 'part of their condition.'

---

1 Stokes, G. (2000), Challenging behaviour in dementia: A person centred approach. Bicester: Winslow Press.

2 NHS Protect (2013), 79% of reported physical assaults against NHS staff in England in 2012-13 were due to medical factors (medical illness, mental ill health, severe learning disability or treatment administered).

3 National Patient Safety Agency (2012), National Reporting and Learning System (NRLS) data.

## Consequences of not addressing challenging behaviour

The consequences of challenging behaviour can be severe, especially over the long term. Some of these include:

- Ineffective delivery of healthcare
- An overreliance on anti-psychotic medication, seclusion and physical interventions
- An increase in physical injuries and psychological ill health among patients, service users and staff
- Reductions in staffing due to sickness and absence, low morale and confidence
- Higher staff turnover, reductions in permanent staff and a greater need for temporary staff
- Difficult management decisions around staffing, resources and training
- Inability of an organisation to meet its legal duties to protect staff and vulnerable individuals
- Inability to deliver important national agendas for improving patient care
- Diminished organisational reputation and negative publicity
- An increased number of complaints.

## When things go wrong

The poor care at Mid Staffordshire NHS Foundation Trust and the abuses at Winterbourne View Hospital illustrate only too clearly what can go wrong when there are poor standards of care and a culture which allows it to happen. These events had serious repercussions on the safety, wellbeing and dignity of patients and service users; staff failed in their duty of care to patients and service users and put themselves at risk; and organisations tolerated poor practice and failed to be accountable for delivering high quality care.[4,5]

A key lesson is that when the delivery of care is sub-standard, this often exacerbates and perpetuates a person's distress, leaving staff increasingly unable to cope, and abusive practices can soon become the norm.

## Purpose and scope of this guidance

The purpose of this guidance is to provide practical strategies to help identify, assess, understand, prevent and manage challenging behaviour, to improve the quality of care given to individuals by ***preventing or minimising distress and meeting needs***, and ensuring that care is delivered within a safe environment. This will complement the forthcoming Department of Health guidance on the minimisation of restrictive practices across health and adult social care.

The scope of the guidance includes strategies to improve the experience of:

- All individuals, many of whom may be vulnerable, who cause harm to themselves and/or to others
- Staff who deliver essential treatment and care, after care and rehabilitation
- Other individuals who may also be vulnerable and disturbed
- Relatives, carers and visitors involved in caring for someone who is in distress.

This will be achieved by:

- Improving the assessment, diagnosis and management of those individuals who are at risk of challenging behaviour, so that such behaviour might be prevented
- Improving the understanding of how challenging behaviour relates to specific clinical conditions and unmet needs
- Improving the approach, skills and attitudes that minimise distress and meet needs
- Providing practical strategies to risk assess and manage challenging behaviour
- Providing managers with guidance enabling them to give staff appropriate training, and make resources available to prevent and manage challenging behaviour.

---

[4] Robert Francis QC (2013), Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, *http://www.midstaffspublicinquiry.com/report*

[5] Department of Health Review: Final report (2012), Transforming care: A national response to Winterbourne View Hospital, *https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response*

## Guiding principles

The approach followed by this guidance is in accordance with the values in the NHS Constitution[6]:

- Working together for patients - we put the patient first in everything we do
- Respect and dignity – we value every person: patients, families, carers and staff
- Commitment to quality of care - we insist on quality of care: safety, effectiveness and patient experience every time
- Compassion – we respond with humanity and kindness to each person's pain, distress, anxiety or need
- Improving lives – we strive to improve health and wellbeing and peoples' experience of the NHS
- Everyone counts – we make sure nobody is excluded, discriminated against or left behind.

## Legal framework

The following laws apply when preventing and managing clinically related challenging behaviour:

### Common law

Health professionals have a duty of care to their patients and must take reasonable steps to avoid acts or omissions that are likely to cause foreseeable harm to the individual by employing a suitable standard of care.

### Equality Act 2010

NHS organisations have a responsibility for tackling health inequalities and promoting equality of access to healthcare for all people. This includes avoiding direct or indirect discrimination on the basis of age or disability, and making reasonable adjustments to ensure that services are appropriate and accessible for people with disabilities.

### Human Rights Act 1998 and the European Convention on Human Rights

All public authorities, including the NHS, have a statutory duty to act in accordance with the Human Rights Act 1998. The act translates the protections of the European Convention on Human Rights into UK law, including the following articles:

*Article 2 – Right to life*

*Article 3 – Prohibition of torture, inhuman or degrading treatment*

*Article 5 – Right to liberty and security of person*

*Article 8 – Right to respect for private and family life*

*Article10 – Freedom of expression*

*Article 14 – Prohibition of discrimination.*

### The Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 Code of Practice provides guidance to health professionals on how they should proceed when undertaking duties under the Act. The Code and guiding principles under the Code, published in 2008, are currently being reviewed by the Department of Health for publication in 2014. This will include a revision to the section on 'Safe and Therapeutic responses to disturbed behaviour'.

The current guiding principles which should be considered when making decisions about a course of action under the Act are set out in Chapter 1 of the Code. These are:

- Purpose - decisions must be taken with a view to maximising the safety and wellbeing of patients, promoting their recovery and protecting other people from harm
- Least restriction - keep to a minimum the restrictions imposed on the patient's liberty
- Respect - the person's past and present wishes and feelings, for diversity including religion, culture and sexual orientation
- Participation - involvement of the person in planning, developing and delivering care and treatment
- Effectiveness, efficiency and equity - in the use of resources.

---

[6] Department of Health (2013), The NHS Constitution - The NHS belongs to all of us *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf*

## The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves and where this is not possible, for decisions to be made in their best interests. This framework is underpinned by five principles:

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
5. The least restrictive option should be considered before any decision is made on behalf of the incapacitated individual.

## Deprivation of Liberty Safeguards (under the Mental Capacity Act 2005)

Deprivations of Liberty Safeguards (DoLS) exist for individuals who lack the mental capacity to consent to their treatment or care. The safeguards are designed to:

- Prevent arbitrary decisions to deprive a person of liberty
- Provide the person with a representative
- Allow a right of challenge against the unlawful deprivation of liberty
- Provide a right for deprivation of liberty to be reviewed and monitored regularly.

When making arrangements for the care of someone who lacks capacity, healthcare providers must apply for authorisation for deprivation of liberty, based on the answers to the following questions:

- Is deprivation of liberty in the person's best interests?
- Has the least restrictive option been considered?
- Is it needed to keep the person safe from harm?
- Is it a reasonable response to the likelihood of the person suffering harm?

## Health and Safety at Work Act 1974 etc, and Management of Health and Safety at Work Regulations 1999

NHS organisations have responsibilities under the Health and Safety at Work Act 1974 to ensure, as far as is reasonably practicable, the health, safety and welfare of employees, patients, service users, visitors and members of the general public. The associated regulations require employers to assess, manage, monitor and review the health and safety risks to employees.

## Other legal considerations

Challenging behaviour may be a result of clinical factors, or it may take place as a result of someone's intentional or reckless actions (e.g. drunkenness). The approach for de-escalating and pacifying a situation applies in both scenarios.

Where someone is being challenging as a result of clinical factors that seriously impair their mental capacity, whether temporary or permanently, at the time that the incident takes place, their behaviour would generally not constitute a malicious act that carries criminal culpability.

Each incident should be assessed on a case by case basis, as clinical factors and impaired capacity may be transitory in nature and have to be present at the time that the incident took place for there to be no criminal culpability.

Where an incident is caused by either intentional or reckless behaviour, this may constitute a criminal offence and should be managed in line with tackling violence guidance produced by NHS Protect.

Finally, it is important to ensure that for all incidents the victim is given the necessary care, support and assistance and that all incidents are reported through established incident reporting systems.[7]

---

[7] NHS Protect (2009), Tackling violence against staff, *www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Tackling_violence_against_staff_2009.pdf*

# Section 1
# Understanding clinically related challenging behaviour

**Meeting needs and reducing distress**

**Guidance on the prevention and management of clinically related challenging behaviour in NHS settings**

# Understanding clinically related challenging behaviour

## Introduction

Our definition of clinically related challenging behaviour is:

> **Any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely.**

Other definitions are widely available.[8]

## Common characteristics

Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

## Types of behaviour

Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypoactivity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

There is no continuum of behaviour and where someone is sufficiently distressed or alarmed, their behaviour may instantly result in a physical action.

## Patterns of challenging behaviour

Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the ‘shop floor’)
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- ‘Sundowning’ (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

---

[8] ‘Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion,’ Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, in Challenging Behaviour – A Unified Approach, (2007).

**Table 1 - Types of behaviour**

| Non Verbal | Verbal | Physical |
|---|---|---|
| Agitation<br>Wandering, pacing, following<br>Intimidating facial expressions, staring<br>Intimidating body posture<br>Cornering, invading personal space<br>Interference with equipment or property<br>Being withdrawn, extreme passivity, refusal to move | Shouting<br>Swearing<br>Crying<br>Screaming<br>Repetitive statements or questions<br>Personal comments or questions<br>Racist, sexist, offensive speech<br>Bizarre, psychotic content, not based on known reality | Scratching<br>Grabbing, hair pulling<br>Biting<br>Hitting, slapping, punching<br>Pinching<br>Spitting<br>Kicking<br>Pushing, shoving, knocking into someone<br>Striking or throwing furniture or objects<br>Inappropriate touching (self or others)<br>Urinating, smearing<br>Undressing<br>Self harm<br>Absconding<br>Removal of lines, masks, catheters, dressings, incontinence pads<br>Non-compliance, resistive behaviour (e.g. refusing medication, blood tests) |

## Triggers and antecedents

Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

## Precursors

Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor concentration

- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. ‘I want to go…’
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character: e.g. excessive crying or laughing hysterically.

## Reasons for challenging behaviour

There is ***always*** a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially ‘unforeseen’ events occurring. The main categories are:

1) Physical factors
2) Cognitive factors
3) Psychological and emotional factors
4) Environmental or social factors

Communication problems, which have been included as cognitive factors here, are extremely important and may warrant a separate category.

## Understanding the reasons for challenging behaviour

Staff need to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

### Physical factors

The physical causes which may lead to challenging behaviour include features of an individual’s condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confusional state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor.

Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable.  Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

### Cognitive factors

Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems. They often result in an inability to articulate needs, or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person’s ability to understand information and make choices.

### Psychological or emotional factors

Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

### Environmental or social factors

Factors relating to an individual’s surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual’s rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

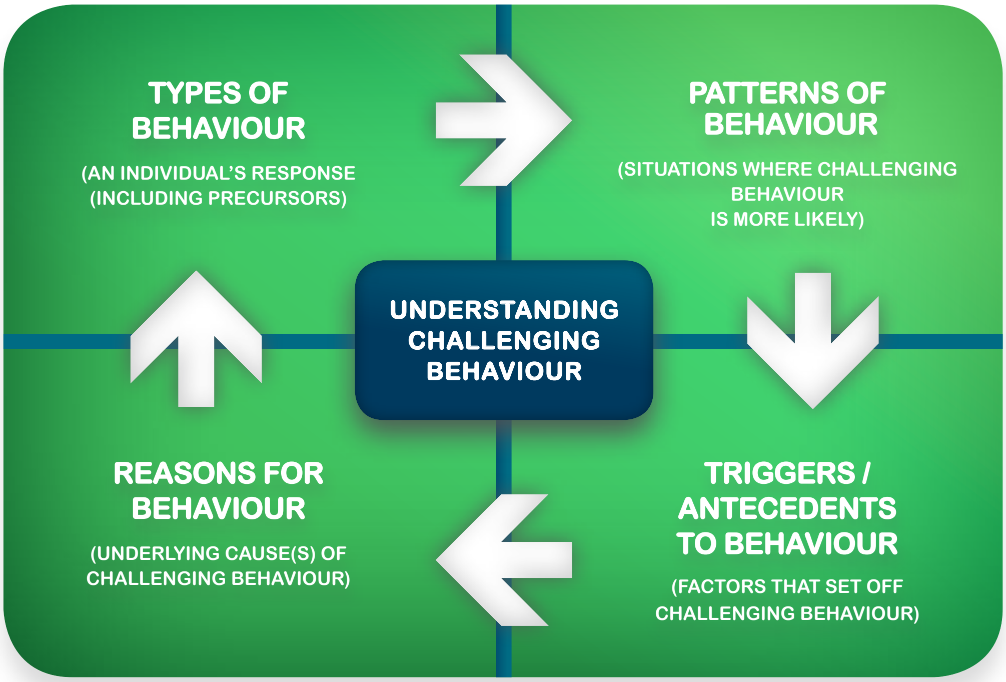
A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between Multi-Disciplinary Teams (MDTs).

Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation. People belonging to certain cultural backgrounds may become agitated, due to a lack of knowledge regarding how they behave in certain situations. This can lead to a lack of trust and misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

**Table 2 - Reasons for challenging behaviour**

| Physical | Cognitive | Psychological/ emotional | Environmental/social |
|---|---|---|---|
| Hypoxia<br>Hyperglycaemia<br>Hypoglycaemia<br>Electrolyte abnormality<br>Dehydration<br>Constipation<br>Infection<br>Pain<br>Visual or hearing impairment<br>Sleep deprivation<br>Medication (effects)<br>Illicit drugs or alcohol<br>Drug or alcohol withdrawal<br>Pre or post-operative<br>Hunger, thirst<br>Incontinence, urgent toilet needs<br>Earache<br>Epilepsy | Communication problems (expression and understanding)<br>Memory loss<br>Difficulty with language or dialect<br>Reduced spatial awareness<br>Learning disabilities<br>Disorientation<br>Poor executive function (reasoning, planning, foresight)<br>Loss of insight<br>Autism | Fear<br>Anxiety<br>Anger<br>Depression<br>Social isolation<br>Mania<br>Fixed beliefs or current thinking<br>Separation anxiety<br>Loss of self worth | Noise<br>Lights<br>Temperature<br>Overcrowding, or busy environment<br>Inappropriate signage<br>Lack of information<br>Long waiting times<br>Cultural factors<br>Lack of continuity of staffing, or care<br>Loss of routine<br>Unfamiliar surroundings<br>Pace of surroundings<br>Lack of meaningful activity<br>Over-stimulation<br>Under-stimulation<br>Imposed boundaries or routine<br>Stopping a habit/ behaviour (e.g. smoking) |

## Figure 1 – Understanding challenging behaviour



# Section 2
# Managing risk and assessing behaviours

## Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Managing risk and assessing behaviours

## PART ONE – Understanding risk

### Introduction

In high-risk, potentially dangerous situations, prevention, avoidance and de-escalation are always the preferred approaches. Physical interventions, rapid tranquilisation, seclusion and heightened levels of observation should only be used as a last resort in conjunction with continuous de-escalation, where these other approaches prove insufficient.

### Assessing risk

Risk assessment is concerned with assessing the likelihood and consequences of challenging behaviour and implementing appropriate measures to avoid, mitigate or control the risks. Protective factors, such as greater collaboration with other colleagues and services, and family involvement should also be emphasised.

A formal risk assessment for individual patients will not always be possible in fast paced emergency departments, admissions units and intensive care, as in these settings: there is little or no lead up to situations; there is limited or no observation time; the person does not necessarily have a history of challenging behaviour (or at least one that is readily accessible by staff); lengths of stays may be short; the individual may already be in crisis and require immediate stabilisation.

Similarly, acute medical wards are usually busy and detailed risk assessment for all patients would not be feasible. Nonetheless, risk assessment should be used selectively for those patients with a propensity for serious challenging behaviours and it is important for such areas to have policies and procedures in place to minimise the risks.

In emergency and acute clinical settings it is important that staff can quickly identify the triggers of challenging behaviour, recognise the precursors, dynamically assess the risks and implement timely de-escalation strategies to reduce the dangers. Staff should still try to ascertain as much background information as possible from the patient and carers and from notes, to enable positive engagement to take place. Assessments and adjustments to the patient's care plan should be shared with all who need to know.

### Risk factors

Risk factors increase the likelihood of challenging behaviour and require quick management decisions.  Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour (see Figure 2).

The following factors point to an increased risk of challenging behaviour:

#### Person

**Historical factors**

- History of aggressive/violent behaviour
- History of intent to harm others
- History of mental condition(s)/self harm/ suicide attempts
- Cognitive impairment
- Previously detained under a section of the Mental Health Act
- Forensic, criminal related history, e.g. prisoners in hospital etc
- History of abuse or trauma
- History of substance and alcohol abuse or withdrawal
- History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc.

**Current presentation**

- Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.

## Environment

- Environmental factors, e.g. new environments, busy, active, crowded treatment areas
- Other agitated or distressed patients or service users
- Other agitated or distressed patients or service users
- Lack of meaningful activities.

## Situational

- Activities being undertaken, e.g. washing, dressing, giving medications etc
- Services being provided and the client group
- Staff member, e.g. inconsistent staff attitudes, awareness and approach
- Staffing, e.g. staffing levels, skill levels and training
- Certain times of day
- Patient, e.g. mix/tensions, patient-on-patient incidents
- Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

## Preventing the risk of challenging behaviour

- Preventing the risk of challenging behaviour relies on meeting personalised care needs:

  ***'Care where the patient is an equal partner with the health care professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.'*** **(NHS Education for Scotland, 2010)**[9]

- This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care. Empathic understanding means seeing problems from the perspective of the patient or service user.
- It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.
- In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.
- Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person, as staff tend to feel empowered and supported by this approach.
- Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction can positively or negatively reinforce challenging behaviours and of the need to communicate with the patient in a sensitive way.
- A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforcers and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible (see Section 2, Part 3).

---

[9] See also Professor Peter McGill, Positive Behaviour Support (PBS), The Tizard Centre, University of Kent.

# Managing the risk of challenging behaviour

## Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

## De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

## 'Art of doing nothing'

The 'art of doing nothing' and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

## Leave and return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention, or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

## Better understanding and tolerance

Some challenging behaviours may be difficult to stop (e.g. wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

## Observation

Observation[10] that goes beyond normal therapeutic engagement assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, it should respect dignity and privacy and must be conducted safely. Organisations should have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

## Physical intervention and rapid tranquilisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquilisation are required. Clinical staff need to be confident about when these short term intervention strategies are required .e.g. immediate control of a dangerous situation (see Part 2 below) and when they are not required, i.e. where de-escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, 'advance directives'[11] (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This

---

[10] See definition in NICE clinical guideline 25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

[11] See the MHA Code of Practice, 2007.

includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues, relatives and carers should assist.

### Post-incident reviews

Post-incident reviews and/or reviews of near misses are invaluable in identifying lessons to be learnt. It is good practice to include staff involved in the incident or situation, witnesses, other colleagues, the patient or service user and carer to ascertain the reasons for their behaviour. The person's perspective can help identify triggers relating to staff communication, actions or behaviours. A post incident review will only be effective if it is documented and shared with everyone involved in delivering care for that individual (see Section 6).

## PART TWO

## Emergency situations: Principles around physical intervention

### The purpose of physical intervention

Physical intervention may be required to:

> ***Take immediate control of a dangerous situation; to end or reduce significantly the danger to the patient or others around them; and contain or limit the patient's freedom for no longer than is necessary*** **(Mental Health Act Code of Practice (1983) 2008).**

It requires some form of physical contact and application of force to guide, restrict or prevent movement such as touching, guiding, escorting, holding, chemical and mechanical restraint and seclusion.

### When applied inappropriately

There are inherent dangers to patients and staff in the inappropriate use or poor application of physical intervention in challenging situations. Between 2009-2012, 126 out of 823 physical intervention incidents caused moderate or severe harm and even led to death of two patients in the acute healthcare setting. Staff involved in incidents ranged from clinical (nursing and support staff) and a significant proportion involved security staff and police either in isolation or in combination.[12]

Even where physical intervention only involves what is perceived as minimum force (e.g. something as innocuous as holding a wrist), when used against the vulnerable, for example an older person, it has the potential to lead to injuries such as bruising, skin tears and fractures.

### When physical intervention must be considered

Physical interventions should be used to manage an emergency situation: ***one of immediately apparent risk to the health, safety and wellbeing of the patient or service user, staff or third parties.***

Based on a rapid risk assessment, an immediate judgment is needed as to whether the patient or service user showing challenging behaviour has an acute illness which could be potentially life threatening and must receive urgent attention. In this situation, emergency physical intervention and rapid tranquilisation may be essential in order for a clinical procedure to take place.

In these circumstances, staff may need to take immediate action to prevent harm. Not to act in these circumstances could constitute a breach of their duty of care under common law.[13]

Any form of physical interventions must always be in line with NICE clinical guideline CG25 and should be:

- Necessary, justifiable and proportionate
- Conducted by appropriately trained and competent staff
- Combined with strategies to continuously de-escalate
- Carried out using the least restrictive interventions
- Used for the minimum amount of time
- Enable staff to continually monitor the patient for signs of medical or physical distress

---

[12] National Patient Safety Agency, NRLS data, (2012).

[13] See RCN guidance (2008), "Lets talk about restraint" rights, risks and responsibilities, *www.rcn.org.uk/development/communities/rcn_forum_communities/mental_health/resources/a-z_of_resources/restraint*

- Formally recorded as soon as possible after the event.

## Rapid risk assessment

A rapid risk assessment must be carried out before any decision is made for physical intervention. The rationale for any action must be recorded and justified. However, in an emergency situation a formal risk assessment may not always be possible and the decision making must be documented retrospectively. There is a judgement here, in which the need to use reasonable force to protect someone, must be balanced against the risks of potentially behaving negligently by not acting.

## Assessing capacity

Staff must presume that the individual has capacity unless there is a good reason to suspect it is lacking. If someone is behaving 'oddly', or dangerously, there may be *prima facie* evidence to suspect capacity is lacking and a need to assess it under the Mental Capacity Act 2005 (MCA).

Under the MCA, physical intervention is acceptable if the person lacks capacity and the decision is the least restrictive option and is made in their best interests. There is judgment involved, but as long as it can be shown that there were grounds to doubt capacity, and the action taken was necessary to preserve health or life and proportionate to the gravity of the risk, then it is appropriate and legal.

However in a dangerous situation, a full mental capacity assessment may be impractical and practitioners should not delay immediate action necessary to preserve life or health. An assessment should be completed following the intervention to regain control of the situation.

## Use of reasonable force

All staff must understand the law concerning the use of reasonable force during a physical intervention and how such action can be justified in light of the desired outcome. The main principles are ***proportionality, necessity and reasonableness:*** Are there any viable alternatives to using force? Is it proportionate and necessary to the situation that presents itself? Does it use the least amount of force for the shortest time? Finally, can its use be justified in a court of law, if necessary?

## Roles and responsibilities

An organisation's physical intervention policy should identify a clear decision making process for the acceptable use of physical interventions. This should include a division of responsibilities, who is permitted and not permitted to do what and who should take the lead. It should outline a process for planning and undertaking physical interventions, highlight the continuing risks of harm (particularly positional asphyxia), and explain the need for constant physical monitoring, post incident support and debriefing. Safety considerations include the designation of appropriate areas or rooms to enable safe de-escalation, observation and physical interventions.

Organisations must hold up-to-date records and specify a minimum number of trained and competent staff that are available (e.g. a rapid response team) to manage an emergency situation safely.

Staff involved in physical interventions should be appropriately and specifically trained. However, there must always be a pragmatic approach to safely managing a situation, for example some escorting or guiding by staff who are not specifically trained may be permitted in some circumstances (e.g. where an older person with dementia is wandering away from a controlled area).

Finally, organisations need to centrally record and analyse restraint incidents, to avoid the inappropriate use of restraint, reduce levels of restraint and develop new safe techniques.

## When to call the police

This should be determined by local arrangements with the police, however they should generally be called:

- Where a crime has possibly been committed
- Where the victim requests it
- Where all possible avenues to safely de-escalate and manage a situation have been exhausted and have failed
- Where staff, patients and the public remain in imminent and grave danger.

## Figure 2 - A framework for explaining challenging behaviour

**PERSON**

**HISTORICAL FACTORS**

- Aggressive/violent behaviour
- Intent to harm others
- Mental health condition/self harm/ suicide attempts
- Abuse or trauma
- Cognitive factors
- Previously detained under the Mental Health Act
- Forensic/criminal history
- Substance and alcohol abuse or withdrawal
- Disruption to service delivery and resources

**CURRENT PRESENTATION**

- A specific diagnosis
- Cognitive factors, (e.g. communication problems)
- Physical factors, (e.g. pain, sensory impairment)
- Psychological/emotional factors (e.g. fear, anxiety, depression, fixed beliefs, current thinking)

**TRIGGERS / ANTECEDENTS**

Environmental factors

- New environments, busy, active, crowded treatment areas
- Other agitated or distressed persons
- Lack of meaningful activities.

Situational factors

- Activities – (e.g. washing, dressing and giving medications)
- Services being provided and client group
- Inconsistent staff attitude, awareness and approach
- Staffing levels, skill levels and training
- Time of day
- Patient mix/tensions, patient on patient incidents
- Restrictions, denial or confrontation (e.g. a person wanting to leave, cigarette requests)

**PRECURSORS**

Recognisable cues (e.g. tense/angry facial expressions, pacing, vocalising distress)

**CHALLENGING BEHAVIOUR**

Non verbal, verbal, physical actions

Staff exposed to challenging behaviour on a routine basis can over time become ‘conditioned’ to the behaviour. This is particularly true for low level behaviours, which are historically underreported. By this we mean staff are unable to acknowledge, recognise or describe these behaviours or perceive them as being a normal part of their duties, leading to the widely used expression ‘it’s part of the job’.

Staff need to be ‘reflective practitioners’ who can observe, analyse and understand the reasons for challenging behaviours and implement simple, immediate or longer term prevention strategies. This approach has a vital learning and education element.

Prevention through better understanding is about identifying how to avoid challenging behaviour in the first place by asking:

Culture and habit in dealing with individuals and their carers, for example by being more collaborative, less confrontational and tolerating behaviours may be more important than specific actions. For example, individuals who are ‘uncontrollable’ in one area often inexplicably settle down when on a specialist unit or a mental health ward.

## Functional assessment and formulations

The successful prevention of challenging behaviour is underpinned by a good formulation (explanation) of the behaviour and the identification of appropriate interventions, which can be used by all staff interacting with the patient.

The explanation is derived through functional assessment. Functional assessment is particularly suitable for assessing individuals who are unable to communicate their needs verbally in any setting. This approach relies upon identifying the typical context in which the individual’s challenging behaviour occurs and factors which may well perpetuate the behaviour. It also requires identifying relevant characteristics of the individual as well as less immediate environmental and situational influences.

Typically these observations are recorded and organised on Antecedent Behaviour Consequences (ABC) charts, or similar specialist screening tools, whereby staff record events that occurred immediately before, during and after the behaviour, along with any observations or ideas on why the incident occurred. An ABC chart is a post incident chart which can be used for as long as is needed to identify behaviour triggers and patterns, in order to identify appropriate and effective care strategies.

The chart should be completed by the member of staff who witnessed the behaviour as soon as possible after the incident happened, ideally during, or possibly at the end of their shift when the incident is still fresh in the mind.

### Antecedents and triggers of the behaviour

These may originate from a single factor or a combination of factors relating to the person, other persons, staff delivering the care or the environment immediately before the incident occurred.

### Behaviours at the time of the incident

How did the individual react during the incident, what was their appearance like and their actions? A detailed description is important to understanding the behaviour. Generalisations should be avoided, e.g. describing the individual as ‘verbally abusive’ or ‘physically aggressive’ will not provide the detail needed to understand behaviours.

### Consequences of the incident

Does the analysis indicate that staff behaviours, reactions, or interventions negatively or positively reinforces the individual’s behaviour? Does the individual want something that is not available (a person, object or activity)? Are they trying to remove something that is aversive to them, or are they simply engaging in a behaviour that is stimulating and feels good? Can any simple practical prevention strategies be identified? Often minor modifications to care can have dramatic effects: for example, modifying someone's bathing or washing routines may stop agitation or aggression.

Training should be provided to staff, where appropriate, on accurate assessment (using ABC charts) see Section 5.

## Delivering care

Understanding the reasons for challenging behaviour, including identifying what needs to be done to minimise an individual's distress, will help MDTs understand the appropriate role and limitations of drug treatments. A thorough understanding of non-pharmacological interventions is needed, for the following reasons:

- It is often an individual's distress and the context in which care is delivered that can lead to challenging behaviour
- It is not an inevitable consequence of conditions such as dementia or delirium
- Staff attitudes and skills may need to change, e.g. not blaming the individual
- It requires staff to honestly appraise their performance and clinical leaders (ward managers, consultants) to develop a culture which promotes personalised care
- It may require models of care and ways of working to be modified (e.g. making adjustments to care pathways to minimise distress).

Challenging behaviour also requires designing on-going and follow-up care on discharge for people with mental health or other needs. This includes:

- Community provision of counselling, rehabilitation and care services
- Up-skilling family carers
- Community mental health teams
- Care homes and dementia outreach services
- Community Learning Disability Teams (CLDTs)
- Primary care social care access services
- Debriefing (e.g. after recovery from an episode of delirium)
- Support for carers, in particular family support networks.

# Section 3
# Care strategies

## Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Care strategies

## Introduction

This section provides prevention care strategies to meet the immediate and longer term needs of patients and service users. While particularly applicable to nurses, it will be relevant to all health care professionals who interact with patients, service users and their families and contribute to decision making and care planning to minimise challenging behaviour, including doctors, allied health professionals, ancillary and non-clinical staff.

This section should be read in conjunction with Section 4 - Medical assessment.

## Escalating and emergency situations

- If in doubt, do what is safe. Staff should never put themselves, patients, service users or visitors in danger. Staff need to be able to respond to an escalating situation, seek assistance and know when to withdraw to a place of safety.
- On presentation, the patient should be rapidly assessed as to whether their behaviour may be as a result of acute illness (e.g. meningitis) or injury (e.g. head/brain injury) which requires immediate lifesaving treatment and care.
- In a dangerous or emergency situation, individuals displaying challenging behaviour require the same level of care and attention, irrespective of their clinical presentation and where the behaviour takes place.
- Good communication should be the overarching strategy to de-escalate, calm, reduce distress, stress or anxiety and will help move through the rest of the strategies.
- Be aware of non-verbal cues and body language which may be interpreted as aggressive or confrontational by someone in distress.
- Move away from speed, efficiency and being task focused, and attempt to initiate a conversation to gain the individual's cooperation.
- Avoid trying to 'control the situation', focus on finding out what the problem is that is causing the person's distress.
  - Be compassionate, empathise, reassure and understand distressing situations from an individual's perspective throughout:
  - What do they perceive is happening?
  - Does the individual understand what is going on, even if they have been told?
  - May they perceive something or someone as a threat?
  - Is their understanding limited by cognitive problems?

## A practical approach for managing escalating and emergency situations

### Planning

1. Orientate staff to the care environment (including safe places and exits), safety procedures, security arrangements and points of contact for help.
2. All staff (including agency staff) should be familiar with the local security provisions, have the relevant numbers to call, call points and procedures.
3. Make sure that staff are issued with all safety equipment and alarms (including lone worker devices) as appropriate. For example, in emergency departments there are usually emergency buzzers in every room and some staff carry personal alarms.

### Escalating situations

4. Use effective verbal and non-verbal communication skills as the first strategy for de-escalation (see communication techniques on p. 32-33).
5. Approach the individual in a calm and non-confrontational way. If necessary stand back to give them personal space. Ask: "You seem upset. Can I help you?"
6. Allow time to talk to the person, family and carers listen to their concerns and offer lots of reassurance. Can reasonable requests be incorporated within the delivery of care?
7. Give clear and consistent information. Repeat it, especially if the individual has a learning disability, head injury, short-term memory loss or is intoxicated.
8. Ensure that the person understands why you are doing certain things (e.g. carrying out examinations).
9. Explain what is going to happen and why and reach agreement, e.g. "Here is your medication, how would you like to take it?" Is a degree of compromise needed?

*Consider:*

10. Any immediate causes of distress and find solutions. Is the person deaf, do they understand English, or are they unable to express themselves? Do they require immediate pain relief?
11. Removing monitoring equipment, venous and arterial lines, or catheter if they are the source of discomfort or distress and it is safe to do so.
12. Using distraction techniques (e.g. chat about the weather, past life, hobbies and interests) to focus the person's attention away from the issue or situation causing agitation or distress.
13. Moving the individual to a quiet bay, separate waiting area or side ward or to a unit that is able to provide specialist care.
14. Removing yourself and change staff members if you are unable to defuse a situation.
15. 'Watch and wait' or 'leave and return' if safe and appropriate to do so, and if it is judged that the individual's behaviour may settle as a result.
16. Continually evaluating the situation and make a judgment about whether it is getting better or worse and needs escalation. If necessary, seek support or help from:
    - ○ A mental health or learning disability liaison team or contact point
    - ○ An emergency 'response team' (where applicable)
    - ○ A doctor, if the individual is acutely unwell or may need rapid tranquillisation

  - A security manager/supervisor, to enable them to have their teams on stand by
  - Other senior doctor or manager as appropriate.

17. Special observation to prevent further escalation. Make an assessment first, decide on level of observation required and ensure the safety of staff, patients and service users during the observation period.

## Emergency situations

18. The first priority is to ensure that staff, the patient or service user and others in the vicinity (including visitors) are cared for and safe.
19. A senior doctor or nurse should act as a single point of contact, coordinator and decision-maker during the incident, with an overall view of events.
20. Continue to make constant attempts to calm and de-escalate.
21. Consider physical intervention and/or pharmacological management within the overall context of the behavioural and medical management.
22. If the situation becomes dangerous:
    - Consider calling for help, activating an alarm, or leaving the area.
    - Request assistance from security staff
    - Call the police.
23. Managers should ensure that, where proportionate, the staff member(s) involved is able to take a break, move to a quiet area or undertake different duties. If this is not possible, clinical supervision may be an alternative.
24. The staff member, the patient or service user should be given access to immediate medical attention if required. Reassurance should be provided to all.
25. Document the incident via the incident reporting system, incident forms and/or individual notes. Allow for personal notes from staff involved in the incident.
26. The staff member, in consultation with the ward or unit manager, may want to report the incident to the police (if they have not already been called). Seek advice from the Local Security Management Specialist (LSMS) or union representative if required.
27. The ward or unit manager should evaluate the event and offer staff the option to debrief if necessary, when they feel the time is right.
28. Conduct an incident review where appropriate, reviewing risk assessments and communicating lessons learned to the rest of the team.
29. Facilitate an in-depth clinical assessment of the patient by a MDT to respond to any physical or organic needs or causes of discomfort (e.g. dementia, delirium, depression, other mental disorders, acute precipitants or predisposing factors).
30. Plan ongoing care for the individual and record this in the care plan. Decide who the care plan needs to be shared with (e.g. security staff).

## Sub-acute and longer term situations[14]

***Appendix 2: case studies 1-6 demonstrate how these approaches apply in practice.***

The following care strategies are designed to minimise and prevent challenging behaviours:

### 1 Involve family and carers

- Explain the service routine to the family.
- Ask for personal profile information on the individual for planning care.
- Encourage family contact as often as possible, in line with the patient's or service user's wishes and clinical need.
- Give family and visitors advice on how to interact with the individual and what to expect.
- The family should receive verbal and written information on the effects of the individual's condition and treatments, subject to patient confidentiality.
- Support the family in coming to terms with the events or illness.
- Be proactive and inclusive towards family, carers and other visitors. Can they help with activities, occupation, or other care tasks if available and willing to do so?

### 2 Gather information

- Learn about medical history, liaise with family, carers, clinical staff and the ambulance crew; check records.
- Develop a personal profile: include important chronology and events, personality traits, previous occupations, interests, hobbies, likes and dislikes, preferences, normal routines, needs and aspirations, spiritual, cultural and religious needs and practices. For individuals unable to communicate their needs, family and carers will be able to give detailed information.
- Use something equivalent to the 'This is me' tool[15], or the 'Hospital Passport'.
- Have they got any sensory impairments, physical health problems or any retained abilities? Physical health needs must be attended to.
- Learn about the individual's functional ability, what are they able to do for themselves, what provokes distress and what relieves and calms them; liaison with speech and language and occupational therapists[16] is important here.
- Observe and record any challenging behaviour, using an ABC analysis chart or similar where practical.

### 3 Group meeting to plan care

- Ensure that all relevant staff work collaboratively in planning care.
- Discuss all possible causes of behaviour (based on the indications under 2.) Make a written formulation (explanation). Involve the individual, family and carers (where possible).
- Discuss overall care aims and objectives, all possible care strategies and delivery aimed at minimising distress and meeting needs.
- Think about the effect of staff interactions (including where appropriate gender preferences and cultural sensitivity), routines and environmental factors.
- Look to promote familiarity and routine for the patient or service user.
- Look to minimise lengths of stay, ensure appropriate discharge planning and follow up care, including the use of community mental health and intermediate care teams.

---

[14] Amalgamated from Poole's Algorithm (2009), Nursing Management of Disturbed Behaviour in Aged Care Facilities NSW Health; includes elements of Brighton and Sussex Foundation Trust (2012), Guidelines for the management of behavioural disturbance and cognitive impairments following acute brain injury.

[15] The Alzheimer's Society, *http://alzheimers.org.uk/site/scripts/download_info.php?fileID=849*

[16] Occupational therapists specialising in working with people with learning disabilities may offer sensory integration therapy as a treatment approach for challenging behaviour.

## 4 Initiate care plan

- Make sure that all staff, the patient or service user, their family and carers are aware of the plan, its aims and objectives.
- Discuss the plan at all handover meetings.
- Monitor consistency of approach in applying the plan.
- Plan regular evaluations and modification of the care plan where necessary.

## 5 Plan communication strategies

- Use the communication techniques outlined in Table 4.
- Plan communication strategies to achieve treatment objectives and get agreement from the person if they have capacity, otherwise from their family, carer or advocate.
- Assess the person's communication abilities (both understanding and expression) and change the way you communicate accordingly. See a speech and language therapist report if available and consider referring to a therapist for advice and support.
- If the person has difficulties understanding spoken communication, agree and develop an approach for communicating with them, by discussing with others who have successful communication strategies in place and following recommendations from a speech and language therapist report if available.
- Use appropriate language and be aware of cultural practices; if the person does not understand English, seek an interpreter or family members who are bilingual.
- Make sure hearing aids and glasses are on and in working order where needed. Consider portable external hearing aids if necessary.
- Is the person in bed? Get low to the bed to aid effective eye-level communication.
- If there are barriers to communication, consider moving the individual to a quiet area, reducing background noise (TV, radio etc).
- Use visual methods to support speech such as pictures and photos (e.g. angry/sad faces), body language and gestures.
- Consider substituting a staff member where the individual may be having difficulties with them, if this forms a barrier to effective communication.
- Always keep calm, even if the individual starts to become agitated or distressed,e.g. trying to get out of bed or pulling at their lines. Do not shout, argue, or become upset in front of the individual.
- Always keep calm, even if the individual starts to become agitated or distressed, e.g. trying to get out of bed or pulling at their lines. Do not shout, argue, or become upset in front of the individual.

## 6 Adapt environment

- Adapt or modify the environment, e.g. make it 'home-like', calm and comfortable, less crowded, reduce noise, improve lighting and avoid temperature fluctuations.
- Allow personal objects, photographs and notes from family and friends and reminders of when visitors will return.
- Address any disorientation and way-finding problems (e.g. the way to the ward, bed and toilet); have reminders of the date, time, location, day and night, if appropriate.
- Reduce excessive noise; switch off radios and TVs if needed. Consider impact of electronic alarms (call buzzers, infusion pumps, mattress alarms, bed brake alarms and telephones) on distress levels.
- Consider moving the individual to an area of low stimulation. A single room is preferable (not appropriate if behaviour suggests a need for social contact, or if falls risk is unacceptably high). Avoid excessive bed moves.
- For individuals in need of stimulation, consider environmental adaptations and designated areas or spaces to engage them and reduce boredom.
- Nurse on low beds for individuals assessed at risk of falling or climbing out of bed.

- Encourage day and night routine. Keep the bed area well lit during the day and dark and quiet at night if safety of individuals allows.
- Allow the individual to move around the ward or unit corridors with supervision if safe to do so. Consider security measures for staff (e.g. personal alarm, mobile phone).

## 7 Activity programme

- Involve occupational therapists to assess, intervene in and evaluate activities to promote an individual's health and wellbeing and build their skills and motivation.
- Develop meaningful and enjoyable activities.
- Match activities to a person's interests and current abilities wSeek the assistance of volunteers, students, family members and other staff in the planning and delivery of the activity programmes.
- Plan appropriate activities on a daily, weekly (including weekends where practicable) and monthly basis as appropriate.
- Consider discussions, reminiscences, music, games, exercises, creative activities; (getting dressed and social eating also constitute valuable activities).

## 8 Independence and mobility

- Maintain dignity and promote self confidence.
- Encourage the person to do as much as possible for themselves.
- Ensure attempts to minimise falls do not have restrictive consequences.
- Encourage participation in an exercise programme.

## 9 Normalise sleep and rest periods

- Allow for a short rest period only in the afternoon.
- Provide exercise, stimulation and daylight during the day.
- Use the bed area for sleep only.
- Avoid caffeine in the evening.
- Provide help and reassurance with toileting and orientation at night.
- Accept that a person may be wakeful at night; provide reassurance and gentle activities.

## 10 Nutrition

- Make sure that the individual has an adequate diet and has sufficient fluid.
- Can the individual feed themselves or do they need assistance with eating and drinking? Do they eat slowly and need more time?
- Consider strategies for individuals who are at risk, e.g. use a 'red tray' system for those who require assistance during mealtimes from nurses, HCAs and volunteers.[17]

## 11. Document, monitor and evaluate

- Review care plan daily and modify when necessary.
- All changes to care strategy must be documented and communicated to all staff.

---

[17] Age Concern, (2010), Still hungry to be heard, *www.ageuk.org.uk/BrandPartnerGlobal/londonVPP/Documents/Still_Hungry_To_Be_Heard_Report.pdf*

## Communication techniques: an approach for talking AND listening to an individual when delivering care

### Engage

Establish a personal connection, e.g. introduce yourself, make eye-contact, smile, ask how the individual wants to be addressed.

### Conversation

Speak clearly and calmly and try to initiate a conversation. Do not be afraid to talk to the person. Talk to family members and carers.

### Empathise

'Step into their world.' How would you feel in their situation? Acknowledge their concerns, validate feelings and show compassion.

### Listen

Actively listen, accept and validate feelings and ideas expressed. Try to be open-minded and not judgemental.

### Reassure

Acknowledge any concerns, anxieties and worries and explain that they will be addressed, wherever possible.

### Understand

If there are difficulties with spoken communication, use the individual's first name to get attention, speak slowly, keep information simple, and allow time to process, understand and respond. Avoid sounding patronising.

### Clarify

Check your understanding, repeat what you heard back, check it is accurate, ask them to repeat it if necessary.

### Question

Consider alternatives to multiple questions, e.g. make statements ('you look unwell today'), use 'we' (we must do something about that), ask questions with yes/no answers, ask questions and offer a number of choices.

### Transparent

Be open, honest and transparent and get your message across when communicating about what needs to be done.

### Collaborate

Work out a compromise between what you need to do and what the individual wants or will accept; as a rule look to give choices. Tell the individual 'If you do x, we'll do y.' Tailor the approach if the person has limited reasoning skills.

### 'Talking through'

Provide a running commentary of what you are doing, e.g. 'now we are going to sit down here' etc. Explain procedures and interventions at each episode of care.

**Avoid confrontation**

Adopt a firm but gentle tone, if necessary. Avoid using a harsh or patronising tone of voice.

**Defuse**

Remove yourself from the situation: ‘I’ll just leave you for a short while’. Consider swapping staff if your communication fails.

**Promises**

Never make ‘false’ promises that you cannot keep, e.g. in a busy unit, ‘I’ll see you in a minute’.

**Inquire**

Ask about their behaviour: ‘When you shout, what does it mean?’ ‘When you’re angry, how would I know that you’re angry?’ ‘What would you like me to do when you’re angry?’

**Reinforce**

Encourage positive behaviours and avoid punitive behaviours such as embarrassment, humiliation and allow face saving in front of peers.

**Non-verbal communication (including voice tone)**

Always consider:

- Giving personal space
- Approaching and communicating in view
- Non threatening stance and posture (open posture)
- Body movement (avoiding sudden movements)
- Making eye contact
- Friendly and reassuring voice tone
- Facial expression (smile)
- Acknowledging (nodding)
- Appropriate use of touch (reassurance, affection).

## Debriefs

Debriefs are distinct from post incident reviews (see Section 2 Part 1). Post incident reviews analyse the incident, to identify weaknesses and prevent it from reoccurring. Debriefs are part of the essential support offered to staff following an incident of challenging behaviour and sufficient time should be allocated for them to take place.

Debriefs should be conducted as a conversation among peers, to:

- Allow staff a forum to reflect on the incident
- Share their reactions and feelings in a supportive environment
- Consider what might be learned from the experience.

A debrief can be arranged at the discretion of the team leader, but a good knowledge of staff members, their attitudes and normal workplace dynamics will assist in determining whether one is needed. A formal debrief is especially beneficial where the incident was serious enough to cause stress, trauma or distress to those who were involved.

Alternatively, for low-level, less serious incidents, staff may request the opportunity to have an open conversation about the incident, or arrange one informally among them. In some cases staff may not wish to debrief and may simply wish for the incident to be acknowledged. Staff should be offered other types of support, such as one-on-one meetings and formal psychological interventions (i.e. counselling or therapy) where needed.

Debriefs should have emotional or educational objectives. Trying to address both in one meeting runs the risk of blurring its focus and may even make what should be a supportive atmosphere feel punitive. These different types of objectives should therefore be dealt with in two separate meetings and the experience is always best for everyone when all meetings are purely supportive.

Consideration should also be given as to whether follow-up sessions are required to prevent or reduce the severity of post-traumatic stress disorder (PTSD), depression, anxiety or general psychological morbidity found in affected staff.

While the utmost sensitivity is required with regard to the possible emotional and psychological trauma experienced by staff members, challenging episodes offer lessons about effective care. Debriefs are invaluable for reflecting on an incident and refining practice. This process, known as ‘reflective practice’, is an important source of personal professional development, enabling individuals to learn from their own experiences.[18]

The timings for debriefs should be determined by the circumstances. For less serious incidents, debriefs may be held soon after the incident. However, for serious incidents, if the debrief is held too soon it may not allow enough time for the stress or trauma symptoms to fully manifest itself so that people are able to talk about them.

The patient or service user (and their family) should also be given the opportunity to debrief, so they can learn from the situation and be reassured.

Finally, it is also important to celebrate and learn from good practice – what did we do well?

---

[18] See as an example Christopher John’s (1995), Model of Structured Reflection.

# Section 4
# Medical assessment and management

## Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Medical assessment and management

## Introduction

Challenging behaviour can be caused by physical ill health and/or mental health problems and staff need to be skilled in diagnosing its underlying causes. This section provides strategies for both the immediate and longer term medical assessment and treatment of common physical causes of challenging behaviour.

Diagnosis and drug prescription is mostly specific to medical practitioners. Other clinical aspects and responsibilities, including information gathering, liaising with families and other carers, monitoring, review and decision making will be shared with multi-professional colleagues. These have been included to encourage a consistent approach.

All professionals need to be flexible and vary their approach according to the situation that presents itself. Good communication with the team and close working with others, especially in dangerous situations, are required. The advice set out in this section applies to all groups, including doctors.

## Emergency situations[19]

- First, make a rapid assessment of the situation and the safety considerations that apply:
    - If there is a threat to your personal physical safety, ensure that where possible you have the help of one or more other healthcare professionals who are trained in how to work in close proximity to the patient, position themselves safely and apply physical intervention techniques.
    - Is the physical environment safe? (e.g. risk of the individual falling from a trolley)
    - Can accompanying persons help? (e.g. family, security, police). Might they represent a threat as well?
    - It may be necessary to clear the area of other patients, visitors and staff. Crowds can be threatening or intimidating and reducing levels of arousal may help some patients to calm down.
    - Assess for resuscitation needs using the ABCDE approach (Airway, Breathing Circulation, Disability, Exposure), including hypoglycaemia and fitting.
    - If you need to get immediate control of an emergency situation in which an individual is uncooperative, agitated or physically aggressive, you may elect to deliver rapid tranquilisation and/or safe physical intervention to maintain safety and facilitate a medical assessment or immediate treatment. This must follow a treatment algorithm and be in accordance with national guidelines[20] (see also Section 2 Part 2).
    - Should rapid tranquillisation be required, it must be delivered by appropriately trained and competent staff.[21] Physical intervention, where necessary, must also be delivered safely where at all possible by appropriately trained staff. You must document your assessment of the situation, your (rapid) assessment of mental capacity (in line with the MCA) and justify the decision to use restraint or rapid tranquilisation.
- Make a clinical assessment:
    - Take a history if possible. At minimum ask about current symptoms, worries, problems and general health (people with dementia can often report accurately on the here and now, even if their recent recall is poor). Prompt about pain, headache, breathing, need for the toilet, hallucinations and delusions, recent falls or trauma.
    - Try to get further information from a collateral source if one is immediately available. Ask about the current problem, previous memory or mental health problems, previous general health and physical function, drug history, alcohol or illicit drug use.
    - Complete any examination not done under 'ABCDE', including level of consciousness, temperature[22], cognition (e.g. use AMT score), delirium assessment (e.g. CAM), neurological examination and other aspects of mental state. Seek evidence of delirium, hypoxia, infection, metabolic derangement,

---

[19] Harwood R et al (2012), Guidelines on the emergency control of the acutely disturbed adult patient, Nottingham University Hospitals NHS Trust.

[20] NICE CG25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

[21] NICE CG25 (2005), The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.

[22] NICE CG 50 (2007), Acutely ill patients in hospital - recognition of and response to acute illness in adults in hospital.

  poisoning or drug toxicity, causes of pain, full bladder and constipation.
    - Assess communication ability, both understanding and expression, including hearing and vision.
- Order investigations, including FBC, U&E, Ca, CRP, LFT, urine analysis and chest X-ray. If specifically indicated, CT head scan and other tests.
- Consider (later if needs be) tests for vitamin B12, folate, MRI, EEG, LP, blood or urine toxicology, CK (for NMS) and autoantibodies.
- If collateral information is not immediately available, seek it (e.g. by telephone) as soon as possible.

## Sub-acute or longer term situations

### Assessment

- Try to prevent (or minimise) distress behaviours arising using approaches that meet the person's needs (see Section 3).
- Identify the exact nature of the behaviour, circumstances and possible provoking factors and establish whether these have changed over time. Consider an ABC chart.
- Assess for delirium: <1 week history of increased confusion, fluctuation, inattention or drowsiness. Consider risk factors for delirium in all admissions (i.e. age over 65, cognitive impairment, dementia, #NOF, severe illness)[23] and specifically as a potential cause if there is distress or challenging behaviour.
- If delirium present seek a cause (drugs, drug withdrawal, infection, hypoxia, metabolic, neurological, some combination, something else) and follow a management guideline. Assess clinically as for emergency situations.
- Assess for evidence of other serious mental disorders, e.g. psychosis, depression, anxiety. Seek specialist advice if unsure or for help with managing unfamiliar conditions.
- Identify, document and address provoking or exacerbating factors:
    - Physical problems: pain, constipation, urinary symptoms, fatigue, earache, thirst or hunger.
    - Activity-related: boredom, misinterpretation of care tasks.
    - Treatment related: catheters, monitors, infusions, effects of medication.
    - Environment: noise, temperature, lighting, change of room, ward or bed space.
- Make a formulation (explanation) or diagnosis for the problem behaviour.

### Non-pharmacological approaches

- Use approaches based on the care needs of the individual. Review information already collected and seek any missing data, by re-contacting a collateral source if necessary. Work with nursing and other multi-professional colleagues to develop a care plan. Ensure you have information on biography, preferences, routines and previous exacerbating and relieving factors.
- A low stimulus environment (e.g. single room) may be needed.
- Try to involve family or other carers if available.
- Reassure (as often as required), or consider one-to-one nursing care (fear or anxiety is often driving difficult behaviours). Do not confront, punish, embarrass or humiliate.
- If possible try 'leave and return' for things that do not need doing immediately. If possible attempt to engage in activity or distraction. Consider taking the individual to a quiet space to calm down.
- Consider 'watchful waiting': the symptoms may settle over 2-3 days.

### Drug treatments

- If symptoms remain problematic, identify the dominant target symptom:
    - Psychosis: delusions or hallucinations (but care over 'delusions' due to forgetfulness)
    - Depression, anxiety
    - Emotional liability; distress (e.g. crying, anger) disproportionate to emotional stimulus
    - Apathy

---

[23] NICE CG 103 (2010), Delirium: diagnosis, prevention and management.

  - Aggression, agitation
  - Sleep disturbance
  - Wandering
  - Vocalisations, shouting, calling out.
- Consider drug treatment if there is distressing psychosis, or behaviour that is harmful or severely distressing to the individual or puts others at risk, or if drug or alcohol withdrawal is likely. Continue individualised care approaches.
- Consider if this could be Dementia with Lewy Bodies or Parkinson's Disease Dementia? Key features: Parkinsonism, visual hallucinations, delusions, fluctuating cognition. If unsure get specialist advice and avoid anti-psychotic drugs.
- Assess capacity to give or withhold consent to treatment. If absent, assess best interests (involve the individual, take account of current and past expressed wishes, values and beliefs, consult family or other carers, use least restrictive option). If unbefriended consult an Independent Mental Capacity Advocate (IMCA) (but do not let this delay treatment which is immediately necessary). Consider if the extent and duration of any intervention constitutes a Deprivation of Liberty and apply for authorisation if necessary.
- Follow a treatment guideline depending on symptoms. See guideline for managing psychological and behavioural distress in patients with diagnosed or suspected dementia.[24]
- Consider best location of care. If initial management is unsuccessful, or behaviours cannot be contained, take further senior advice. Refer to mental health services, urgently if necessary.

## Follow up

- Review for effects and side effects. Discontinue ineffective treatments. Review again after 6 weeks and three months.
- Consider need for referral to mental health services or community mental health or learning disability teams.
- Communicate treatment changes with GPs and other interested clinicians (e.g. mental health).

---

[24] Harwood R et al. (2012), Managing behaviour and psychological problems in patients with diagnosed or suspected dementia Nottingham Area Prescribing Committee.22 NICE CG 50 (2007), Acutely ill patients in hospital- recognition of and response to acute illness in adults in hospital.

# Section 5
# Training

## Meeting needs and reducing distress

### Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Training

***This section should be read in conjunction with Annex 1, Appendix 3 and case study 7.***

## Introduction

All staff in direct contact with patients or service users need to be made aware of the key messages contained within this guidance that are relevant to their roles and environment. This will range from basic awareness of challenging behaviour, its causes and how to prevent it, to role specific guidance and training, for example, using ABC analysis charts, care plans and behaviour management strategies.

This training section is intended to help organisations establish the level of knowledge and skills required within different roles and environments and how this can best be delivered. The main focus of this guidance is on preventing challenging behaviour: fundamental to which is understanding the reasons for someone's distress, attentive treatment that meets the person's needs and high quality clinical care delivered by medical, nursing and allied healthcare professionals.

Qualified and experienced staff may have much of the core knowledge and skills required but they will benefit from understanding more about challenging behaviour, and the specific tools and strategies that will aid its identification, prevention and management.

Additionally, those performing support roles including care, domiciliary and portering staff in regular contact with patients or service users need to have some understanding of challenging behaviour so that they can recognise triggers and reduce risks to themselves, other patients and service users.

In communicating this guidance, organisations have an opportunity to reinforce key policy messages, including that which is directly related areas such as safeguarding, consent and mental capacity.

It may help to consider training at three levels:

1. **Core learning needs:** An awareness of challenging behaviour for all staff that interact with patients, including non-clinical ward based staff, plus existing Conflict Resolution Training (CRT) requirements.[25] Core learning may also include additional training requirements such as dementia or learning disability awareness.[26]
2. **Role specific input:** Guidance and training relevant to specific job roles where there are defined responsibilities for the prevention and management of challenging behaviour, such as clinical assessments, care planning, special observations, ABC analysis and delivering individualised care.
3. **Targeted training and support:** Additional risk based training and support that can be planned, for example in an environment where challenging behaviour and injuries are generally more prevalent, or reactive, i.e. responding to quickly changing needs.

---

[25] Promoting Safer Therapeutic Services (PSTS) training in mental health settings.

[26] Alzheimer's Society, person-centred dementia care training, *www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200307*; and Mencap, learning disability awareness training *www.mencap.org.uk/training*

These three levels of training are described in more detail under the following headings:

## 1. Core learning needs

It is important that all staff, whether providing care directly or in a support role, have a basic awareness of challenging behaviour and a common language to describe and deal with it. For many this will be enough to recognise and reduce risks, whereas for others this will simply form a foundation.

This core learning can be delivered in various ways and should include:

### Challenging behaviour awareness

A central theme of challenging behaviour awareness should be effective communication: how done incorrectly it can reinforce negative behaviours and how it can be used properly in a positive, preventative way.

### Conflict resolution training (CRT)

Frontline NHS staff should also receive training in conflict resolution. This provides input on positive communication and calming skills, but not specifically with regard to challenging behaviour, where communication may be temporarily or permanently impaired. Organisations may choose to provide challenging behaviour awareness as part of a combined course with CRT or include it in other training initiatives such as those addressing staff training needs around dementia[27] or learning disabilities.

*It is important therefore that all staff interacting directly with patients receive both CRT and the Challenging Behaviour core learning needs outlined above.*

This guidance includes a set of corresponding core learning outcomes. These can be used to support the delivery of challenging behaviour awareness training as part of an enhanced CRT package, see **www.nhsprotect.nhs.uk/reducingdistress**

### Promoting Safer and Therapeutic Services

The Promoting Safer and Therapeutic Services (PSTS) training in mental health settings may already combine CRT with challenging behaviour awareness. The core learning outcomes that accompany this guidance can be mapped across to PSTS,
see Appendix 3.

## 2. Role specific input

This guidance provides a range of tools and strategies for preventing and managing challenging behaviour which include role-specific responsibilities. Certain roles will require additional focused input on top of the core learning outlined above.

Most people in these roles already have extensive knowledge and training and the focus is on building upon this in the context of challenging behaviour and the specific responsibilities each of them has in its prevention and management.

*(continues)*

---

[27] Department of Health (2012), Common core principles for supporting people with dementia: a guide to training the social care and health workforce, *https://www.gov.uk/government/publications/common-core-principles-for-supporting-people-with-dementia*

The following list, while not exhaustive, provides some examples:

- **Managers** need to be aware of their responsibilities for implementing this guidance and monitoring compliance with it and around risk assessment, encouraging reporting, reviewing incidents and identifying additional training and support needs.
- **Doctors** require training on medical assessment, diagnosis and treatment protocols and tools for challenging behaviour.
- **All clinical staff (doctors, nurses, HCAs, allied healthcare professionals)** require training on developing personalised care strategies and plans for preventing and managing challenging behaviour.
- **Security and/or Emergency Response Team members** need to have a full understanding of their powers, rights and responsibilities, including in relation to procedures such as clinical holding, detention, removal and special observation. They need training in how to prevent, calm and manage challenging behaviour and may need training in the medical risks associated with the use of physical intervention in individuals who may be acutely unwell.
- **Support staff (domestics, porters, catering staff, cleaners)** need to have an awareness of the common signs and triggers of challenging behaviour, related risks and simple prevention and calming strategies. They also need to understand their role in preventing and managing challenging behaviour.
- **Other agencies** such as ambulance and police services, also need to be made aware of relevant trust guidance and protocols if it is foreseeable that their personnel may also become involved in an emergency situation and/or in physical intervention on an individual, where these can involve substantial risk.

## 3. Targeted training and support (planned and reactive)

In addition to core and role-specific learning needs, there will be areas within each organisation where there is a higher prevalence of challenging behaviour and where staff will need additional training and support. This can be influenced by such factors as the care environment, patient groups and the nature of the procedures and treatments provided. For example, although an individual with dementia may be treated for a medical matter in various parts of an organisation, some wards may receive a higher number of such individuals for longer periods of time. Similarly, drug and alcohol complications can impact on a range of services yet may be most problematic in a medical admissions ward/unit. There will also be units which can foresee specific challenges relating to, for example, a procedure, a condition, response to treatment or post-operative care.

Organisations should review the risks and needs within each area and identify what, if any, additional targeted training is required. Incident data, supported by staff and stakeholder consultation, will help in identifying any priority areas. As with any risk based approach, the better the reporting and analysis of information on risks and trends, the easier it will be to identify needs and focus support.

Much of the risk can be predicted, allowing training to be planned and reviewed on an ongoing basis; however, there will be situations that occur with little warning and require a quick response. An example could be where an individual is admitted who has complex needs and presents a high degree of challenging behaviour. Organisations should still prepare for such scenarios, for example by having specific environments and appropriately skilled staff to support the individual and their needs safely. It is also important to be able to provide focused/individual-specific problem solving support to areas experiencing difficulty, plus focused guidance and training if needed (see Figure 3).

[redacted]

## Figure 3 ‘Targeted’ training needs assessment: A risk-based approach

## Delivering learning

**Core learning** is focused mainly on raising awareness of challenging behaviour and the simple steps everyone can take to help prevent it. This can be achieved through one, or a blend of learning methods, including e-learning and course based training. There is an important part to play for role modelling by skilled practitioners (such as mental health and learning disability liaison services) and clinical mentoring.

NHS Protect recommends that CRT must include face to face training.[28] Whichever methods are used, it is important that organisations can evidence that key messages are received and understood by staff. This is more likely to be achieved where a learner is actively engaged in activities, interactions and case studies which require them to apply knowledge.

**Role specific learning** can also vary in approach but it is important to ensure that those undertaking specific assessments and care plans as well as those engaged in behaviour management and response roles are competent to do so. Staff involved in observations must have their training needs identified.

Medical staff should assess their training needs and how these will be met during appraisal and personal development planning.

Consideration should be given to including key learning within induction and refresher training and threading it into existing pre and post registration training and postgraduate medical training.

**Targeted training** may need to include practically based training for staff who are particularly vulnerable and for those that respond to risk behaviours. Nursing, clinical support and medical staff in areas of heightened risk of challenging behaviour may need practical input on how to position themselves and work safely in close proximity to an individual who may be confused, unpredictable and vulnerable. This may include avoidance and disengagement skills and low level skills for containing, guiding and re-directing. For some this may extend to low level holding skills to allow essential treatment and care.

---

[28] NHS Protect (2013), Conflict resolution training: implementing the learning aims and outcomes *www.nhsbsa.nhs.uk/Documents/SecurityManagement/Conflict_resolution_training_guidance_July_2013.pdf*

Security and/or response teams and nurses in specialist settings such as mental health units may need additional skills to hold an individual who is extremely physically challenging and presents a serious risk to themselves and/or others.

The strategies and skills used to physically manage an individual whose challenging behaviour is non-deliberate in a clinical context can be very different to those taught during conventional breakaway and physical intervention training. It is important therefore that such management strategies are highly relevant to the task or activity performed and appropriate for the patient or service user.

All such training should place emphasis on prevention and CRT, include relevant law and reference NICE, CQC and Deprivation of Liberty Safeguards (DoLS) guidance.

## Reinforcing learning

Organisations should also take every opportunity to refresh and reinforce key messages on the prevention and management of challenging behaviour and embed them in core inductions and refresher training.

It is vital that organisations monitor compliance with the training and evaluate the transfer of knowledge and impact of training in a reduction of injuries and restrictive practices.

# Section 6
# Communication and information sharing

Meeting needs and reducing distress

Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Communication and information sharing

## Introduction

Sharing patient identifiable information within the NHS to safeguard patients and protect staff is not a breach of confidentiality.

Patient confidentiality is a core principle of the NHS. However, it is important that the duty to preserve a confidential health service, which is clearly in the public interest, does not impede the sharing of relevant patient information where it is also in the public interest to ensure the public's safety.

The Department of Health's NHS confidentiality code of practice and supplementary guidance should be read in conjunction with this section.[29] This will aid the decision making process for sharing patient confidential information where it is necessary to do so. The code of practice specifies that disclosure is permissible where it is made in the public interest to prevent serious harm to others:

> ***In some cases, it will be clear that a proportionate disclosure is required in order to: Prevent serious harm being caused to one or more other individual(s), such as…a serious assault...***

## Methods of communication

Communication and information sharing should be open and transparent and involve the person, family and carers from the outset. A number of methods can help to achieve this.

### Transfer

The maintenance of meticulous medical records and care plans which includes information on what causes a person's distress and what their specific needs are is vital when an individual is transferred from one care setting to another.

Staff have a legal obligation to relay information (verbally and in written form) on known risks of challenging behaviour and mitigation strategies to the professionals receiving the individual (e.g. behaviour which occurs at the care home, in the back of the ambulance, in A&E, from ward to ward, from ward back to the community).

Information exchange also needs to take place where an individual has been sent for diagnostic tests and returns to their original care setting.

### Care plans

Promoting emotional and psychological wellbeing should be a routine part of all care planning. Specific care planning is needed where there is significant distress or challenging behaviour. This should be discussed with the MDT, reviewed regularly and communicated at the transfer of care. Care planning should include the individual where possible or their family, carers or advocate if not. It should incorporate patient profiles, formulations (explanations) of the behaviour, risk assessments and information on the individual's health and social care needs.

Care plans will describe the specific care interventions that have been discussed with and agreed by everyone concerned; they should include all strategies to prevent situations that precipitate challenging behaviour.

In some instances, a copy of the care plan should be given to the individual to discuss treatment goals. If this is not appropriate, its content must be communicated to them by whatever means are necessary in order to aid their understanding. Where an individual is cognitively impaired, care plans should be discussed and agreed with their family, carer or advocate.

Regular review meetings should be held to ensure that the identifiable behaviours have been resolved, or to start the process again if new behaviours are identified.

### Shift handovers

Handovers are best practice for continuity of care and serve as important forums to provide feedback on challenging behaviour that occurred during previous shifts and to inform oncoming shifts. Although it is acknowledged that there may be time constraints, the nurse in charge should allocate sufficient time during handovers for communication on changes in the individual's behaviour and solutions for staff taking over care. These should be documented in the care plan. Handovers may be a particularly suitable forum to review low level incidents.

---

[29] Department of Health (2003), Confidentiality: NHS Code of practice; and (2010), Confidentiality: NHS Code of practice - supplementary guidance: public interest disclosures, *https://www.gov.uk/government/publications/*confidentiality-nhs-code-of-practice

### Profiles and passports

Individual profiles and passports are a way to transfer care information along with the individual, for example when they move from a care home to a hospital ward and back again. The profile or passport should ideally be completed prior to admission by those responsible for the individual's care, or by the primary nurse, family and carers on admission; it will become a valuable running document for staff to add more information to as the individual is moved between care settings.

### Post incident reviews

Thorough post incident reviews are vital for learning lessons from a staff and patient safety perspective, updating the care plan and sharing information with all those responsible for delivering care. At a wider department and organisational level, a review of incidents may help to identify shortfalls in the delivery of care (e.g. where a disproportionately high level of interventions have been used) and may require disseminating best practice to staff, updating policies and training programmes.

### Markers and alerts

Markers and alerts may be considered to communicate information regarding challenging behaviours. They may refer staff to the care plan or highlight behaviours and simple care interventions. Their use is widespread in mental health and ambulance settings (address flagging) as an integrated part of a risk assessment process.

All individuals deserve equal treatment and care and any decision to add a marker/alert to electronic or paper records should be based on current information (avoiding opinion or hearsay). Staff should avoid forming pre-conceived attitudes towards an individual based on the presence of a marker/alert, and markers should never be used punitively.

Organisations must have arrangements for sharing marker information with other organisations to which the individual is transferred, even where systems for sharing information are incompatible.

There must be clear criteria for notifying a person, their family and carers before adding a marker (if there is an immediate threat this should be done retrospectively), as well as proper review procedures to delete and remove a marker, i.e. when there is no longer a risk.

The following CRT descriptors may be adapted for a challenging behaviour marker:

- Compliance – individual does what is requested
- Verbal resistance – saying "no", swearing, threats (depending on severity can be part of aggressive resistance)
- Passive resistance – non-response to requests, sits or lies down, refuses to move, refuses to take medication etc
- Active resistance – avoids being held, pushes away, puts obstacles in way
- Aggressive resistance – verbal abuse and threats, physical action, e.g. pinching, scratching, biting, slapping, grabbing etc
- Serious or aggravated resistance – throwing objects, objects as weapons, attacking etc.

For further information, see the NHS Protect guidance '*Procedures for placing a risk of violence marker on electronic and paper records*' 2010:

**www.nhsbsa.nhs.uk/SecurityManagement/Documents/SecurityManagement/Procedures.pdf**

## External information sharing

### Information sharing protocols

Any organisation looking to share confidential information externally about a person's challenging behaviour, especially with colleagues working in the community who may be particularly vulnerable, should take advice from their Caldicott Guardian. This is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing between the NHS, local authorities, social services and partner organisations which satisfies the highest standards.

The Department of Health's NHS code on confidentiality provides the following guidance:

***'NHS organisations should have developed, or be in the process of developing, information sharing protocols that set out the standards and procedures that should apply when disclosing confidential individual information with other organisations and agencies. Staff must work within these protocols where they***

***exist and within the spirit of this code of practice where they are absent.'***

It is recommended that organisations develop information sharing protocols to prevent and manage challenging behaviour, in accordance with the legal framework described under the following headings:

## Common law

Confidential personal information can be disclosed with the consent of the person, or without their consent where it is in the public interest or it is required by law. It is in the public interest to share proportionate patient confidential information in relation to challenging behaviour where there is a risk of harm to patients or staff.

## Crime and Disorder Act 1998

Confidential patient information can be disclosed in the public interest where the information is needed to prevent, detect or prosecute a crime or disorder and for crime reduction purposes. These principles are in accordance with Section 29 of the Data Protection Act.

## European Convention on Human Rights

The sharing of personal data must be in accordance with Article 8 of the European Convention on Human Rights:

*'Article 8*

1. *Everyone has the right to respect for his private and family life, his home and his correspondence*
2. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.'*

Public authorities have a duty to share confidential information concerning challenging behaviours in the interests of public safety.

## Data Protection Act 1998

The processing and disclosure of personal data must adhere to eight "Data Protection Principles". These specify that personal data must be:

1. Processed fairly and lawfully
2. Obtained for specified and lawful purposes
3. Adequate, relevant and not excessive
4. Accurate and up to date
5. Not kept any longer than necessary
6. Processed in accordance with the "data subject's" (the individual's) rights.
7. Securely kept
8. Not transferred to any other country without adequate protection in situ

The Information Commissioner's Office (ICO) advises on and enforces the Data Protection Act 1998 in relation to the sharing of confidential information:

**http://www.ico.gov.uk/for_organisations/data_protection/notification/need_to_notify.aspx**

## Caldicott Principles

Information sharing protocols governing information sharing between organisations should adhere to the following principles:

### Principle 1

Justify the purpose(s)

### Principle 2

Do not use patient identifiable information unless it is absolutely necessary

### Principle 3

Use the minimum necessary patient identifiable information

### Principle 4

Access to patient identifiable information should be on a strict need-to-know basis

### Principle 5

Everyone with access to patient identifiable information should be aware of their responsibilities to maintain confidentiality

### Principle 6

Understand and comply with the law.

# Section 7
# Organisational responsibilities

## Meeting needs and reducing distress

### Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

# Organisational responsibilities

## Introduction

Healthcare providers must face up to the challenge of preventing challenging behaviour. The Winterbourne review[30] highlighted the failure of residential care managers to recognise the warning signs and address the poor delivery of care, which led to a culture where abuse could happen. The Francis Report[31] highlighted shortfalls in care, higher than normal mortality rates and numerous complaints by staff, patients and relatives that went unheeded by senior managers and the trust board.

Both reports recommend that providers should be accountable for having in place good systems of governance and processes to deliver the highest quality of care.

## PART ONE - Responsibilities

Chief executives, boards and senior managers should demonstrate strong leadership, to effect the delivery of high quality and safe individual care. This should be a central strand of clinical governance and effectiveness.

Providers of NHS care must liaise with commissioners to optimise the individual's positive experience of care and protect them from harm; see Domain 4 and 5 of the NHS Outcomes Framework domains for commissioning health services from 2012-13:

**www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700**

A board strategy to prevent challenging behaviour must require:

- The delivery of planned care of the highest quality, where the individual experience is of equal importance to any other organisational goal
- A commitment to  the safety needs of patients, service users and staff
- A commitment to a reduction in restrictive interventions
- An emphasis on compassionate, person centred care[32]
- Availability of sufficient resources, access to training, teaching and supervision by specialist staff and commitment to a highly skilled workforce
- Having a challenging behaviour group/lead, where appropriate, to roll out a prevention strategy across the organisation
- Strong leadership from senior clinicians, directors of nursing, general and clinical managers and ward managers, to oversee the care delivered by ward staff
- Approval and implementation of effective policies and procedures which are strongly weighted towards prevention
- Gaining assurance that these priorities are being met through regular feedback, evaluation of outcomes and incident analysis.

### Costs to the organisation

There is a lack of evidence on the true financial cost of challenging behaviour in the NHS, although it is generally agreed to be very high.[33] NHS Protect estimated that the total financial cost of physical violence to the NHS was £60.5 million during 2007-08[34]. Attributable costs include staffing (sickness, absence and replacement), litigation and damages, provision of Conflict Resolution Training (CRT), extra policing and staff turnover.

At an organisation level, the costs are significant. One 'typical' large mental health trust reported 759 physical assaults and 1,427 non-physical assaults in 2009-10. The number of staff days lost through absence immediately following an incident was 872 days. When replacement costs were added, the overall loss to the trust was £122,000.

In another 'typical' large acute trust in 2012, its security pay budget was around £1.4 million and the bulk of this cost was attributable to

---

[30] Department of health final report  (2012), Transforming care: A national response to Winterbourne View Hospital, *https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response*

[31] Robert Francis QC (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, *www.midstaffspublicinquiry.com/report*

[32] Department of health (2012), Compassion in Practice, nursing, midwifery and care staff, our vision and strategy, *www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf*

[33] Studies have found links between the increased costs of providing services for those with learning disabilities and challenging behaviour (Knapp et al 2005).

[34] NHS Protect (2010), Cost of violence against NHS staff – A report summarising the economic cost to the NHS of violence against staff.

[redacted]

managing challenging behaviour. The security team dealt with 142 physical assaults and 185 non physical assaults, 80% of which were linked to clinically related challenging behaviour. They also responded to 263 calls for assistance with confused patients, conducted 87 clinically related restraints and attended 209 calls to help deal with patients with mental health issues and patients leaving wards or A&E against medical advice. Attributable costs include £63,000 spent on security officer 'bed watches' and £50,000 on CRT and physical intervention training.

## Benefits to the organisation

Preventing challenging behaviour has numerous benefits including:

- Financial savings, with reductions in: lengths of stay, re-admission rates, staff absence, staff turnover, observations, stocks of items, safety equipment and medication
- More efficient, effective and productive delivery of healthcare, fewer physical interventions and better outcomes
- Delivery of important national priorities around better quality of care, compassion in healthcare, and dignity and respect
- Increased staff confidence, satisfaction and motivation, and improved staff retention
- Increased patient, service user and carer satisfaction and reduction in complaints and litigation
- Better systems for communication, reporting and for discussing solutions
- Enhanced organisational reputation.

## Legal responsibilities

### Care Quality Commission outcomes

Health care organisations must comply with the Care Quality Commission's (CQC) regulatory framework: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.

Preventing challenging behaviour is essential to demonstrate compliance with CQC outcomes around Involvement and information; Personalised care, treatment and support; Safeguarding and safety; Staffing; and Quality and management.

More information is available at:

**www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf**

### Health and safety legislation

Ensuring the health and safety of staff is coterminous with minimising challenging behaviour. The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety in the United Kingdom and is enforced by the Health and Safety Executive. A breach of an employer's duty under the act may be dealt with through criminal law.

Under the Act, organisations have a legal duty to ensure, as far as reasonably practicable, the health, safety and welfare of their employees and other people who might be affected by their business, i.e. patients, service users, visitors and the public.

The following regulations, made under the Act, must be considered when managing the risks from challenging behaviour:

- The Management of Health and Safety at Work Regulations 1999 require employers to: assess risks to employees; identify the precautions needed; make arrangements for the effective management of precautions; appoint competent people to advise them on health and safety; and provide information and training to employees.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) put duties on employers to report serious workplace accidents, occupational diseases and dangerous occurrences (near misses). This includes any act of physical violence to a person at work, which results in sickness of over 7 days.

  More information is available at:
  **www.hse.gov.uk**

## Other responsibilities

**Local Security Management Specialist**

Where applicable, organisations must employ or have access to a Local Security Management Specialist (LSMS) to ensure the safety and security of those who work within and use the NHS. The LSMS's responsibilities include:

- Ensuring that the organisation has robust and up-to-date policies and procedures for the prevention and management of challenging behaviour
- Advising on physical security measures, to improve the safety of staff (e.g. personal alarms, physical security, CCTV)
- Assistance in ensuring that technology is available to protect lone workers
- Playing an active part in incident reporting, risk assessment and advising on appropriate security and training provisions to protect staff
- When necessary, liaising with and assisting the police with their investigations
- Assisting clinical staff where necessary in a post-incident review to identify lessons learnt.

# PART TWO - Organisational strategy for preventing challenging behaviour

An organisational strategy to fulfil the requirements outlined in Part One should be underpinned by policies and procedures that incorporate the following:

## Changing culture

Putting patients and service users first in everything that is done is the starting point for delivering the highest quality care which minimises the risk of challenging behaviour[35].

Ensuring that organisations have a patient focused culture which prevents challenging behaviour takes time, resources, leadership, continuous effort and a commitment by all. It includes all staff having a shared vision and values based on the NHS Constitution[36].

Cultural change to prevent challenging behaviour requires the same level of commitment in any clinical setting, from emergency settings to older persons' care. This may require redesigning models of care where necessary, e.g. the delivery of direct care putting an emphasis on staff having time to engage and talk to patients whilst undertaking their duties.

Staff should be encouraged to provide regular feedback about the standards of care and should feel supported to raise issues without fear of recrimination. Regular 'clinical supervision' may assist staff in sharing concerns.

Staff should have a clearly established confidential route to make complaints or whistle-blow if they have serious concerns about safeguarding and/or staff safety in line with local policies and reporting procedures.

## Reporting

Data from the latest NHS Staff Survey suggests that just under two-thirds of incidents of physical violence and 44% of bullying, harassment and abuse cases were reported.[37]

Some of the reasons for underreporting include:

- Stoical acceptance and tolerance on the part of staff in the face of adversity

---

[35] Department of Health (2013), Patients First and Foremost, The initial government response to the report of the mid Staffordshire public enquiry *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf*

[36] Department of Health (2013), The NHS Constitution-The NHS Belongs to all of us, *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf*

[37] NHS Staff Survey, (2012), *http://www.nhsstaffsurveys.com/cms/*

- Staff empathising with the ill person and not blaming them
- Staff concern that reporting may reflect poorly on their ability to manage an incident
- Reporting being too complicated, time consuming or not suitable for lower level incidents
- Staff perception that no action will be taken to give them adequate support
- Lack of management feedback on actions taken to tackle or reduce incidents.

Key messages for managers to pass on to staff to encourage reporting include:

- A high level of reporting is an indication of good organisational governance, a commitment to ever improving care and recognition of the need to support victims.
- Reporting assists risk departments in identifying trends, patterns, 'hotspots' and lessons learnt. It helps identify whether incidents were down to the behaviours of one or two individuals, or indicative of wider phenomena requiring action across a service or organisation.
- Reporting has an inherent value to risk management and improved care by:
    - Enabling immediate changes to the care plan and the delivery of care
    - Enabling improvements to the delivery of care, e.g. modifications to the environment making care more needs focused
    - Providing a mechanism for staff to receive support and feedback
    - Providing a learning opportunity for staff to problem solve and develop solutions.
- Managers should provide feedback to clinical teams summarising what incidents occurred in the preceding month and changes made to respond to them.
- Reporting should be made as easy as possible, by looking to reduce duplication on incident forms, other risk and care planning documentation.
- Wards may find it impractical to complete a detailed incident form for low level incidents and may consider incorporating a less detailed form into existing systems.
- Wards may consider keeping an incident tally. This gives staff a sense of ownership in the implementation of local strategies to prevent future incidents, and gives them confidence and control over their working environment.[38]

## Risk management

If organisations do not have robust processes for assessing risk, decision making may well be based on anecdotal evidence and perceptions of risk. Risk assessments, underpinned by incident reporting, can take place at different levels:

- Individual risk assessments on admission or post incident to feed into the person's care plan
- Unit/ward risk assessments that require a MDT response to change the delivery of care
- Serious incidents which threaten service delivery, staffing and resources and require a risk management group or committee and board/senior management level response.

Where risks of challenging behaviour are identified, risk reduction measures should include:

- Training needs analysis and new programmes
- Staffing: review of numbers, skills mix, use of agency staff and HCAs, shift patterns
- Environmental audit and redesign
- Review of current working practices
- The better protection of vulnerable staff, e.g. lone workers.

## Protection of lone workers

Lone workers, especially those who are community based, are particularly at risk from challenging behaviour. Lone workers need to be identified, their duties risk assessed and prevention measures put in place. These may include access to personal safety training, specific technology, a buddy system, support from other colleagues, an escalation process and when to withdraw to places of safety. See NHS Protect lone worker guidance:
**www.nhsbsa.nhs.uk/2460.aspx**

---

[38] Design Council (2011), Reducing Violence and Aggression in A&E, *http://www.designcouncil.org.uk/our-work/challenges/health/ae/*

## Training

Training programmes for preventing challenging behaviour should be underpinned by training needs analysis and the delivery of bespoke training. A 'broad brush' approach does not meet the needs of staff, leads to low levels of compliance and satisfaction and is a poor use of resources. To be effective, clinical staff must be released to attend face-to-face and refresher training programmes.

A tailored programme should include:

- Core skills (challenging behaviour awareness and CRT/ PSTS, accompanied by additional training such as dementia or learning disability awareness)
- Role specific learning (delivering individualised care, clinical assessment and care planning)
- Targeted training (assault reduction and physical intervention).

Role specific learning should be part of continuous professional development. This must be available to all healthcare professionals both pre- and post-registration, and to health care assistants and assistant practitioners as appropriate to their role (see Section 5 Training).

## Staffing

Even if staffing levels are not considered low in relation to the normal nursing template for a particular patient group, it only takes one or two individuals showing challenging behaviour to skew the allocation of staff on a ward and create a situation where it is impossible to deliver good quality care.

Delivering compassionate care requires staffing levels to be sufficient.[39] The RCN links minimum staffing levels to better outcomes for patients, better quality of care, better experience, more efficient and effective working and fulfilling CQC's inspection requirements to safeguard the health, welfare and safety of patients and service users.

See:

**www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL.pdf**

When planning care, organisations need to consider:

- Optimum staffing levels to deliver compassionate care
- Mapping of staff skills levels and mix to the provision of care
- Recognition of the positive contribution that continuity of care makes to preventing distress and meeting needs
- Decisions on the best use of temporary staff and HCAs
- A central register of those with physical intervention training.

## Delivery of care

According to the NHS Institute for Innovation and Improvement, ward nurses in acute settings spend an average of just 40% of their time on direct individual care. The Productive Ward programme aims to help healthcare professionals to evaluate the processes of care within their ward/unit, to free up staff time to enable them to provide more direct care. This includes organising the ward space so that the delivery of care is more reliable, efficient and safe, thereby improving the experience of both staff and patients or service users.

One proviso, there is an inevitably a degree of paperwork involved in care planning, and although this is not classed as direct care, it is an important part of planning care.

See:

**www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html**

## Care environment

A well designed, maintained and managed care environment can minimise a person's agitation and distress, reduce staff stress levels and enable them to take ownership and help achieve an environment in which optimum standards of care can be delivered.

The King's Fund's Enhancing the Healing Environment (EHE) programme has shown that relatively straightforward and inexpensive changes to the design and fabric of the care environment can have a considerable impact

---

[39] Safe Staffing Alliance (2013) recommends an absolute minimum of one nurse to eight patients (1:8) otherwise patient care may be jeopardised.

See the overarching design principles and an environmental audit tool at:

**www.kingsfund.org.uk/projects/enhancing-healing-environment**

The Design Council programme ‘Reducing violence and aggression in A&E’ recognised that violent and aggressive behaviour can result from personality characteristics, pain or anxiety and environmental factors. The following escalatory factors can push some individuals over their ‘tolerance threshold’:

- Crowds or clash of people
- Lack of progression and/or long waiting times
- Inhospitable environments
- Dehumanising environments
- Intense emotions
- Unsafe environments
- Perceived inefficiency
- Inconsistent response to challenging behaviour
- Staff fatigue.

The project produced three solutions:

1) Better information and communication to reduce a patient’s anxiety levels
2) A staff centred programme to enable staff to engage directly with issues of violence and aggression
3) A design toolkit, including environmental layout and atmospheric recommendations.

See:

**www.designcouncil.org.uk/our-work/challenges/health/ae/**

## Personalised care

Finally, when developing this guidance, one of the best guides we came across illustrating how to deliver good care is: Dementia: Understanding the risks and preventing violence, published in Canada by WorkSafe British Columbia and is freely available.

See:

**www2.worksafebc.com/Topics/Violence/Resources-HealthCare.asp**

## Annex 1 – Clinically related challenging behaviour - prevention and management training

| Level | Core | | Role specific | Targeted: Risk based | |
|---|---|---|---|---|---|
| Module | Clinically related challenging behaviour awareness | Conflict resolution training (CRT) | | Clinical assault reduction training | Physical intervention skills |
| Content | Awareness<br>Recognition<br>Risks<br>Prevention<br>Responsibilities<br>Support<br>Responsibilities<br>Support | Risk awareness<br>Dynamic risk assessment<br>Responsibilities<br>Communication<br>Calming<br>Reporting<br>Support | Assessment and diagnosis<br>Care planning<br>Delivering Individualised care<br>Preventive strategies<br>Special observations<br>Behaviour management<br>Problem solving<br>Recording and support | Risk awareness<br>Proxemics and positioning<br>Safer practices<br>Avoiding blows<br>Relevant releases<br>Guiding and re-directing | Policy, law and ethics<br>Relevant and appropriate restrictive skills<br>Medical risks<br>Duty of care<br>Teamwork<br>Leadership<br>Emergency response |
| Audience | *All staff with direct individual contact (Can be a combined course)* | | *As appropriate for doctor, nurses and managers* | *As appropriate for doctors and nurses working in heightened risk environments* | *Security and response functions* |
| Links | Integrate with: Violence reduction policy, NICE, CQC, DOLS | | | | |

[redacted]

# Appendices

## Meeting needs and reducing distress

### Guidance on the prevention and management of clinically related challenging behaviour in NHS settings

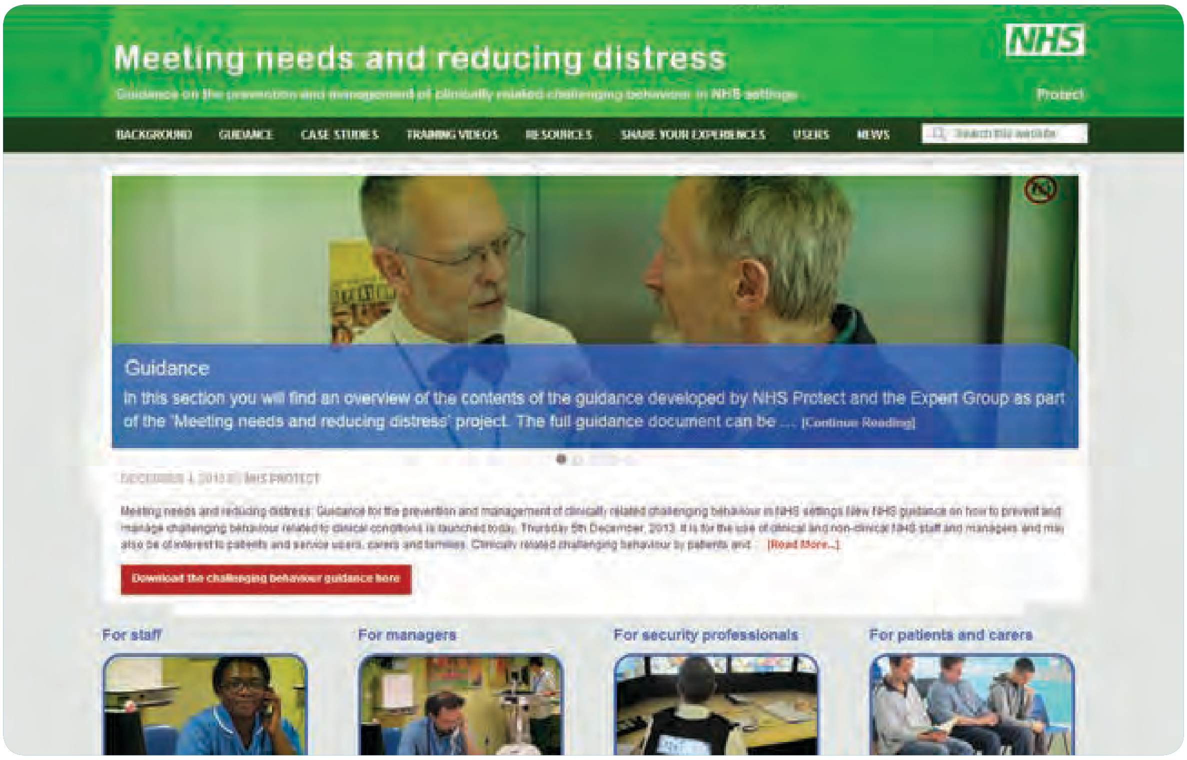
# Appendix 1
# Challenging behaviour website

NHS Protect has developed this website as a point of reference and best practice for anyone who would like to learn more about the prevention and management of challenging behaviour:

**www.nhsprotect.nhs.uk/reducingdistress**

The website includes the following key content:

- A downloadable copy of this guidance, summaries of each section, case studies and useful tools for clinical staff
- A set of core learning outcomes to assist trainers in delivering challenging behaviour awareness training in clinical areas
- Scenario-based videos which can be incorporated into staff inductions, challenging behaviour awareness training or used as a separate learning resource for staff
- A valuable resource for staff to share their experiences in preventing and managing challenging behaviour.



Guidance

In this section you will find an overview of the contents of the guidance developed by NHS Protect and the Expert Group as part of the 'Meeting needs and reducing distress' project. The full guidance document can be … [Continue Reading]

DECEMBER 4, 2013 BY NHS PROTECT

Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings New NHS guidance on how to prevent and manage challenging behaviour related to clinical conditions is launched today, Thursday 5th December, 2013. It is for the use of clinical and non-clinical NHS staff and managers and may also be of interest to patients and service users, carers and families. Clinically related challenging behaviour by patients and … [Read More...]

# Appendix 2
# Case studies

**1. Imperial College Healthcare NHS Foundation Trust**

**Learning disabilities**

**2. Sussex Partnership NHS Foundation Trust**

**Learning disabilities**

**3. King’s College Hospital NHS Foundation Trust**

**Dementia**

**4. South London and Maudsley NHS Foundation Trust**

**Dementia**

**5. Cambridge University Hospitals NHS Foundation Trust**

**Dementia**

**6. South London and Maudsley NHS Foundation Trust**

**Mental ill health**

**7. Brighton and Sussex University Hospitals NHS Trust**

**Training**

# 1 Imperial College Healthcare NHS Foundation Trust

## Background

A 40 year old woman was brought into a London emergency department by ambulance following an episode of prolonged fitting. Her arrival caused disruption, as she was very combative, both with the ambulance personnel and with the emergency staff. She presented as incoherent, uncoordinated and very unstable on her feet. Despite this physical vulnerability, she refused to sit on a trolley or on a chair and backed herself into a corner of the resuscitation room.

On presentation, the clinical team's judgement was that she had no serious injury or illness that put her in immediate physical danger.

## Personalised interventions

Very little was known about this woman, which is often the case in the emergency department. The staff observed that initially she appeared to be mute but then became increasingly agitated on overhearing staff discussing her condition. All well-intentioned efforts to calm and reassure her were met with great resistance on her part. The woman appeared very frightened and anxious and the initial impression was that she had a severe neurological or psychiatric condition. Mindful of her safety and their own, the majority of emergency staff withdrew to an observable distance, leaving one senior member of nursing staff with her. This appeared to alleviate some of her anxiety and the nurse tried various different methods to communicate with her. The nurse had experience of caring for patients with learning disabilities and discovered the woman responded to sign language. It appeared that all she wanted to do was to walk. The nurse spent the next hour walking around the department with the woman, supporting her and calmly reassuring her but at the same time managing to assess her and find out more about her.

## Outcome

The more the woman walked, the more her mobility improved and she then began to talk. It transpired that she had a learning disability and suffered from epilepsy. What had happened that day was not unusual for her. After having a fit she would normally experience transient loss of speech and have difficulty mobilizing. Once the woman had gained her equilibrium she was quite happy to sit down and be formally assessed.

## Key messages

The emergency department is a fast moving environment; it is a bright, loud and at times intimidating place in which to treat patients. It is therefore essential that emergency staff recognise what effect this environment may have on their patients and are creative and adaptive in order to meet their needs effectively, rather than expecting them to conform to conventional hospital practices. The approach has to be centred on the individual involved and above all must be kind and compassionate. The woman in this case needed time, understanding and a period of one-to-one attention in order to be able to communicate effectively and recover. Among the competing demands of a busy emergency department, it is essential that staff recognise the importance of such interventions and give them the priority that they deserve.

Source; Julia Gamston - Senior Nurse, Emergency Department, Imperial College Hospital Trust.

# 2 Sussex Partnership NHS Foundation Trust

## Background

Gary is a thirty seven year old man with learning disabilities who also has a diagnosis of autism. These factors impact on him to the extent that he has no spoken language, major skills deficits and some challenging needs – he has behavioural outbursts which put himself and others at risk and cause serious damage to the environment. Like many people on the autistic spectrum, predictability and familiarity are very important to him, and he can become very distressed when faced with sudden and unexpected changes to his routine and when the world becomes a confusing place.

Gary moved out of the family home when he was nineteen and entered residential care. Sadly, this did not go smoothly; for the next five years he was moved from one placement to another as each failed to provide appropriate care and support for him. There were a range of factors to account for this including inadequate planning, poor management, low levels of unskilled and inexperienced staffing, co-resident incompatibility and so on. By the end of a third unhappy placement, Gary was extremely distressed and his behaviour had deteriorated alarmingly.

## Personalised interventions

It was at this point that a single person service was commissioned for Gary, predicated on the Positive Behaviour Support (PBS) model. PBS promotes a highly person-centred approach to service design so that the service is tailored to individual need. Accordingly, interventions are based on a proper functional analysis so that the causes of challenging behaviour, rather than the symptoms, can be effectively addressed. However, PBS is not simply concerned with reducing challenging behaviour; it is, equally importantly, designed to address the wider questions regarding lifestyle and personal development. In Gary's case a service has evolved which, increasingly over time, has provided him with:

- A timetable of activities that reflects his preferences and needs
- Opportunities to develop new skills relating to, for example, choice-making, communication and daily living
- Predictability and consistency of routine
- A stable staff team who know him well and who are effectively managed; and
- A robust organisational framework of service delivery whose component parts work together in a logical and coherent way.

## Outcome

Gary has now lived alone, with staff support, for twelve years. He has a rich and varied community based schedule which allows him to carry out the ordinary activities of daily life as anyone else might do, attend health appointments when necessary, have holidays and follow other leisure pursuits, eat out in pubs and restaurants and so on. Importantly, he now sleeps well at night – which had previously long been a problem – and this represents just one significant barometer of positive change.

He has come a long way from the forlorn figure he had become twelve years previously – angry, depressed, confused and disengaged from life. Since that time much productive effort has been invested in providing a truly person-centred service which has demonstrated the potential for change to occur even in the most unpromisingly extreme circumstances.

Source:

Shephard (2012) In celebration: living a life through Positive Behaviour Support. Tizard Learning Disability Review Volume 17 Issue 2 2012.

Baker & Shephard (2005) The rebranding of behavioural approaches for people with learning disabilities and challenging behaviour. Learning Disability Review, 10,2. 12-15.

# 3 King's College Hospital NHS Foundation Trust

## Background

Marjory Warren Ward is a 30-bed ward on the Health and Ageing Unit. The ward treats and cares for older people, many of whom will have dementia, delirium or a combination of the two conditions. The ward was not originally designed to specifically accommodate the needs of patients with dementia.

Hospital admission can be a distressing and overwhelming experience for patients with dementia. Environmental factors can trigger behavioural changes in this patient group, whereby patients often wander due to under-stimulation or because signage is inadequate and they are looking for something. It is recognised that a lack of stimulation and boredom can cause agitation.

With generous funding provided by The King's Fund 'Enhancing the Healing Environment' (Environments of Care for People with Dementia) programme, together with donations from the Friends of King's College Hospital and the trust itself, Marjory Warren Ward was transformed into a dementia-friendly environment in 2012. The main aim of the project was to improve the general ward environment for people with dementia by enhancing the décor to ensure it complies with current best design practices. The project team identified four main areas for improvement:

- Entrance to the ward
- Day room
- Nurses' station

General orientation and clinical 'feel' to ward.

## Transformation of the ward

The entrance was transformed to make it more welcoming for visitors to the ward:

The ward corridors were transformed into pleasant walkways by the use of appropriate artwork, colour and provision of lighting and interactive tactile surfaces. The 'clinical feel' of the ward was dramatically reduced. Hand-rails and non-slip flooring were installed throughout to promote independence and safety when mobilising. Patterned, shiny floors which might confuse people with dementia were replaced throughout. Lighting and signage were improved and day and night clocks were put up to help aid orientation.

The overall ward environment was 'de-cluttered' through innovative use of storage. Seating and artwork were installed around the nurses' station to encourage patient interaction.

Seating was installed outside the ward entrance to provide a 'quiet haven' for patients, staff and visitors and enable them to admire the views of London from the windows there.

The existing dayroom was transformed into a multi-sensory space. The room needed to be flexible enough to be used both for agitated patients who might require a low stimulus environment and as a space where structured and unstructured activity could also take place. Lighting, imagery and sounds can also be adjusted to suit mood in addition to the provision of reminiscence materials and atomisers. Portable sensory equipment is also provided to stimulate activity in patients who are bed-bound or who are confined to a side room for infection control reasons.

Artwork was installed in every bay to make each area distinct. Bed numbers are clearly shown to help aid orientation.

Artwork was installed throughout the ward including a tactile quilt created by patients, staff and carers with support from the Dulwich Picture Gallery. Images of the London skyline and local landmarks are seen throughout the ward to trigger conversations and memories and provide a more homely, less threatening environment of care for people with dementia.

## Conclusions

Marjory Warren Ward is now one of the highest scoring wards in the trust's patient satisfaction survey, which includes the environment. Patients feel more confident when mobilising. Anecdotally, when patients are transferred to Marjory Warren Ward from the Medical Assessment Unit with one-to-one nursing, this is not required 24 hours after admission to the ward. The overall impression from patients, staff and visitors is that the environmental improvements have had a significant positive impact on patient well-being and also on staff motivation levels.

### Feedback

*Makes you forget about your problems for a while – Patient*

*Apart from the amazing environment, smells and views, I was struck by how contented the staff looked. It's brilliant. I want to work here – Visitor*

*The ward is very patient-centred, calm and homely – Visitor*

*The ward appears very friendly and relaxing. The flooring especially has reduced the falls. Patients can walk or mobilise without the fear of falling. Sensory Room - Very relaxing and calming environment for patients and families to sit. I am very happy to work in this environment. Much cleaner, tidier and relaxing - Junior Sister, Marjory Warren Ward*

*Not only has the new ward enhanced the environment for patients, the staff have clearly benefited. There is a renewed enthusiasm for work which is resulting in improved quality of care and improved perceptions of care from the patients. - Consultant Physician, Marjory Warren Ward.*

Source: Emma Ouldred - Dementia Nurse Specialist, King's College Hospital Foundation Trust.

# 4 South London and Maudsley NHS Foundation Trust

## Background

Mr J has been admitted to an acute older persons' mental health unit for assessment of non cognitive symptoms of dementia. He is finding it difficult to get used to the unit and cannot remember why he is here. At busy times of the day, Mr J will attempt to leave the unit, which will affect his well being and safety. At times he can become verbally aggressive and there have been a few occasions when he has pushed staff out of the way in order to leave the ward. Mr J verbalises repeatedly "why are you keeping me prisoner, who are you?"

## Personalised interventions

Mr J's primary nurse spent time with him and the family to obtain a life story at the time of admission. The primary nurse used the "This is me" tool to obtain Mr J's likes and dislikes, activities he enjoys, his role in society and the values he finds most important. This tool enabled staff to be clear about Mr J's preferred names, what he likes to eat, his favourite clothes and what is helpful at times of distress. Mr J. really enjoys a clean shave and his wife demonstrated how he likes this done. All this information was used to inform his care plan.

Based on the information received and what has been observed since he has been on the ward, at the times when Mr J is distressed the following has been helpful:

- Speaking clearly, slowly, using his preferred name and ensuring he has time to respond in every interaction
- Answering any of Mr J's question honestly and as succinctly as possible
- In any interaction, ensuring that Mr J is orientated to the environment
- Increasing staff one-to-one time at these times
- Showing Mr J familiar objects that he likes
- Providing an activity that he enjoys at the times he is likely to be distressed. This could include listening to music, reading a newspaper to him, walking in the garden, looking through his family photo album with him, talking about past positive memories, use of therapeutic touch and offering drinks that he likes
- It has been observed that Mr J is less distressed at busy times when his wife visits – flexible visiting for his wife and family to attend have been implemented
- Helping Mr J to speak with his wife on the phone
- Involving Mr J in helping staff with tasks so that he feels useful and significant.

## Outcomes

- Overall reduction in Mr J's distress; as a result of a team approach that delivers responsive care, incidents are resolved quickly
- Staff feel supported and enabled to provide responsive care
- The family state that they feel involved in Mr J's care and feel that he is safe in hospital
- Mr J is spending less time at the door and has made no attempts to leave
- Mr J appears to recognise staff and positively interacts with them.

## Key messages

- The critical dimension of **ALL** care is to be kind, compassionate, respectful and to treat the person how you would like to be treated
- Always look behind the behaviour that the person is presenting with and try to understand it
- Challenging behaviour in dementia is the person communicating something and it is our role to know the person so we have a better understanding of what they are trying to say
- Staff must always see the **PERSON** with dementia rather than the person with **DEMENTIA**[40]
- Family and informal carers are crucial to understand the needs of the person and their full involvement in care will lead to better outcomes.

Source: Vanessa Smith Assistant Director of Nursing and Quality: Mental Health of Older Adults and Dementia Clinical Academic Group, South London and Maudsley NHS Foundation Trust.

---

[40] Kitwood, T.M. (1997) Dementia Reconsidered: The Person Comes First. Buckingham: Open University Press.

# 5 Cambridge University Hospitals NHS Foundation Trust

## Background

The individual is a 38 year old female. She has a personality disorder of the antisocial and impulsive type and a heavy substance misuse problem. She has some forensic history, having being detained in a secure forensic unit, and has also been in prison for burglary. She has been treated under the Mental Health Act three times in the last eight years and has one admission to a Psychiatric Intensive Care Unit (PICU).

Her mother died of a drug overdose when she was 8 years old. Her father, an alcoholic, died 3 years ago; they had lost touch but were briefly reunited before he died. She has one sibling, a professional, although she has no contact with them. She was born in London and had a very difficult childhood. She was sent to special school for behavioural disturbance, was bullied by other local children and called “stupid” and worse. Her poor reading and writing abilities indicate that she is dyslexic. Her father physically abused her and she hid in a cupboard frequently to avoid him. She left home at 14 years of age to live with travellers; her mother had also been a traveller. She has a heavy drug habit (less so now as has come off crack cocaine by herself and heroin) and misuses alcohol.

For her current admission, she went to the emergency department saying she was suicidal, however she was deemed at low risk and discharged. Following discharge, she jumped 20 feet and fractured both ankles.

Her challenging behaviour followed admission to a busy orthopaedic ward and she was placed in a single room to try and manage the disruption. She shouted abuse at nurses from the room saying she needed painkillers. The nurses found it difficult to care for her as she was very intimidating. They also found it difficult to develop a rapport with her. She would lower herself from the bed and shuffle into the corridor on her bottom and shout verbal abuse at the nurses, ignoring all other patients. Security was frequently called to get her back into her room. She was closely observed by a nurse outside her room providing one- to-one care.

A nurse specialist was called in after a weekend when security had been with her six times just on the Sunday. The patient had an intimidating manner when the nurse arrived.

## Personalised interventions

### 1. Engagement

The nurse worked by treating the patient as politely as possible at all times with a calm voice and low expressed emotion, introducing herself and sitting down to demonstrate that she was willing to spend time with the patient. The patient was asked what she would like and the nurse tried to fulfil her wishes if at all possible, or else gave a clear explanation as to why not.

The patient wanted to go out for a break from the ward, which they did. This was an opportunity to begin engaging the patient by asking her what had happened (getting the patient’s narrative of recent events rather than reading medical and nursing notes). This is when she spoke about her abusive past history (corroborated by medical notes). She talked about her challenging behaviour and she said she was in pain and no one would give her painkillers.

## 2. Aims of care

The aim is to enable staff to see her as a person with individual needs; and to reduce her verbal aggression and the need for security.

## 3. Nursing care plan

Staff negotiated with her so she understood what the nurses were trying to do and she could see how she could benefit from it. The aim of the plan was to ensure her needs were met so she did not have to exhibit challenging behaviour to be noticed.

Staff instigated a Positive Behaviour Programme (positive behaviour for the nurses not the patient) where they were to go into her room every hour, ask if she wanted anything and have a chat. When drawing up the plan it was made quite clear what kinds of requests were appropriate e.g. requests for painkillers, drinks, breaks from the ward etc.

A record of these visits was kept on the patient’s wall where she could see it and also outside (thinking about confidentiality and minimal information) on her door to remind the nurses to do them.

The nurses discussed her difficult past history so they could see that she had no pattern of her needs being met. The only way she knew how to function in an institution was to be aggressive, as in that way some needs would be met. They were very sympathetic as they had no knowledge of her past history and so had been frightened of her. She was regretful about some of her behaviour and said that she was aware that she had frightened an old lady when she was swearing in the corridor, which demonstrated that she had some control over her behaviour.

## 4. Daily evaluation

On the first night after the start of the intervention the patient had one verbally aggressive outburst at 3.00am but there was no need for security. Since then, she has had no verbal aggression, no shuffling into the corridor and there has been no need for security or for close observations. Initially nurses spent up to 3 hours a day with her at various times but that went down to 1 hour within 4 days.

The programme has been in place for a week and she is currently awaiting surgery.

Source: Dr Joy Bray - Mental Health Specialist Nurse, Cambridge University Hospitals NHS Foundation Trust.

**Addenbrooke's Hospital**
Office of Chief Nurse
**Assessment & Rota for Specialling**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | ■ | | | | ■ | | | | |

**NHS No**

**For staff use only:**
**Surname:**
**First names:**
**Date of birth:**
**Hospital no:**
**(Use hospital identification label)**

## Adult Mental Health Nursing Care Plan

**Ward:** ______________________
(To be completed by mental health nurse for nursing care to be carried out by the nursing team).

### Issue(s) to be worked with:-

**X finds it very difficult being confined in hospital in a single room, also if staff are confrontational as it reminds her of very difficult incidents of abuse in her childhood.**

### Agreed way of caring:-

1. X is on a Positive Behavioural Programme this means that:
   - Please can her allocated nurse go into her room every hour to see if she wants anything, also to ask her how she is and have a chat.
   - Record in her room-on the chart on the wall, when you have been in so she knows when the next visit is.
   - Tick on the chart on her door to remind you when the next interaction is.
2. X can go down for a ward break 4 times a day about 8,12,5 and 10 but we are not rigid about this. She knows that staff may be too busy and is OK with this as long as she is told rather than left.
3. If you think X is becoming agitated ask her what the problem is and try and help, remind her that we are doing our best and that things have been going really well recently.

### Review:-

**Daily review.**

**Patient's Signature:**
**Date:** DD / MM / YYYY
**Nurse's Signature:**
**Designation:**

**Time (24 hour clock):** _ _ : _ _
**Print Name:**
**Contact No:**

# 6 South London and Maudsley NHS Foundation Trust

## Background

This person has had a number of experiences within mental health services. Having had a few admissions to the acute service, he has eventually found himself in the forensic service. He has had varied experiences in the community before admission to the forensic service, and during this time he had also had re-admissions to the acute service.

He was treated for a two week period, given medication and when he went on leave and did not return on time he was discharged. For a second time he again tried to seek help and was given medication which he took during the admission and for a while after, but he got forlorn and stopped taking it because it did not appear to be doing anything and there was very little follow-up care.

He is a young man with a number of issues which he feels need to be addressed. The main one is his mood and this has been the main area which needed to be addressed on each of the preceding admissions. During his initial admissions, he explained he was asking for help but again as soon as he appeared well enough or it was possible to send him on leave he was discharged.

His latest admission to the forensic service has been under the Mental Health Act 1983 which initially he was upset about and still felt that if he was given the care and attention he had asked for in the past, it would have avoided a criminal history appearing on his file. This he felt would restrict his plans for the future.

In terms of his experiences, he spoke of the variations in communication in different wards. He has also found that even in the forensic service, there are variations in staff approaches, from those staff members who focus on obeying rules to those who are encouraging and have a positive influence on him. He explained that there were differing styles of interaction with him and he experienced various responses and attitudes by both staff members and other patients.

## Personalised interventions

He found that the acute service was very busy, he was very much ‘in the shadows’, staff had done plans for him and the doctors told him what they thought he needed. He did not feel listened to by many members of staff. However, there were a few who spoke to him and made him feel comfortable on the ward, although he thought that they were nursing assistants, as the qualified nurses seemed to be very busy. He felt that the people who helped him most were those who treated him as a human being, not as a patient and were not necessarily being nice to him all of the time but who treated him with respect.

One approach he found particularly useful in the forensic service was the Primary Patient Pathway Meeting where all staff and the patient are responsible for setting and achieving targets and all are accountable for things not being done, including the primary and associate nurse. This meeting also had the benefit of giving him direction and some idea of what he had to achieve and what this would mean for him.

This meeting included him doing daily illness awareness work, which helped his communication with the team and reduced the number and level of incidents. It gave him more confidence in the system and his own ability which aided his progress to lower levels of security and eventual discharge.

## SAMPLE PPP: PRIMARY PATIENT PATHWAY MEETING

**Date:**

**Present:** X (service user), Y, Z (staff)

**Discussed:**

- One-to-one work: X has drawn up a list of 5 reminders or guidelines for himself as reference to pursue his goals. These are:
    1. Never let people or what people say ever get you down.
    2. Save some money so you will have some money when you need it.
    3. Always keep clean because when you are clean your self-esteem is higher and it also makes you wear clean clothes.
    4. Always make sure you plan your day and keep to your schedule.
    5. Make sure you eat well and drink plenty of fluid because good eating and drinking makes you feel healthy.
- X is also practising deep breathing and focusing on a point which helps to clear the mind, it was evident from the feedback he had written that he had put a lot of thought and effort into these tasks.
- X is doing work with the psychologists, they have been completing questionnaires and are doing something with objects, he says the sessions are OK.
- Group work – X has managed to attend all groups, his participation is very good especially at sports and he is becoming more involved in discussion groups.
- X has managed to use leave almost daily and the feedback from staff is that he is very engaging when out on one-to-one off the ward.

**Plans:**

- X may try to be the organisational group chair in two weeks' time. He will set this as a goal during a review of that week.
- Computer use - X to have half an hour each week, looking at how to enter and exit the computer and also practice using the mouse.
- X to have a one-to-one with Primary Nurse J at the end of the week.
- At reviews, to ask for hospital grounds leave.
- X to think about whether he is interested in attending KGV assessment sessions[1] with the Associate Nurse P; the session would be taped to discuss in the future.
- X to undertake illness awareness work to identify early warning signs and trigger factors for behaviour and anxiety and develop action plans.

---

[1] Lancashire, S. (2004) KGVM Symptom Scale, King's College London.

## Helpful

- Spending time with me
- Smiling when they meet me
- Listening when I need to talk to someone
- Showing they are trying to help
- Getting information for me
- Telling me the truth
- Helping me get accommodation
- Talking in the day area
- Coming to see me when they see I am quiet
- Working with me to do illness work to help get leave
- Telling me what pathway I would benefit from
- Helping me through problems
- Giving me ideas on what to do
- Motivating me to help myself
- Helping me to understand things
- Treating me like a person
- Getting leave and moving on.

## Unhelpful

- Not having time
- Listening to what I am saying but not hearing what I say
- Strict with rules but no explanation
- Being too busy
- Not explaining things
- Being rude
- Being abrupt
- Saying you are here because you are not well
- Diverting me to the doctor for answers
- When I think they are judging me
- When I feel alone and no one cares
- When I pass each day without knowing when I will get released or get some help or my mood will improve
- Stopping medication because they think it is in my best interests
- Being treated differently when rules are bent for others and I am picked on
- Not getting help but feeling I was in the way, just a number and the bed needed.

These are some of the statements made by X, which often show poor reflection on the part of the nurses. In some cases a move away from controlling the patient towards exploring and accepting decisions made by him appears essential in facilitating greater engagement. It is noticeable that the Primary Patient Pathway is of great benefit because without meaningful engagement we have nothing.

Source: Jim Tighe, Team Leader, Cane Hill, South London and Maudsley Hospital NHS Foundation Trust.

# 7 Brighton and Sussex University Hospitals NHS Trust

## Summary

Over an 18-month period in 2012-13, Brighton and Sussex University Hospitals NHS Trust (BSUH) has seen a reduction in assaults, restraints and safeguarding incidents on wards following the introduction of a new training programme. The programme has been delivered within existing budgets and with minimal additional costs through integration of Conflict Resolution Training (CRT) and clinically related challenging behaviour awareness and assault reduction skills training.

Key success factors:

- Thorough research of risks, causes and training needs
- High relevance to staff by using real scenarios taught on a training ward
- Buy in of the chief nurse and matrons aided staff release from wards
- Security team support to wards post training has further improved communications, relationships and encouraged transfer of learning into working practices.

## Background

The trust identified that a substantial number of reported assaults on staff were related to the clinical condition of the patient. This ranged from physical conditions to mental health issues, such as dementia and sometimes a combination of these. This situation is not unique, as NHS Protect has identified that 79% of assaults occurring nationwide are clinically related in 2012-13.

The existing CRT and conventional ‘breakaway’ training, although effective in de-escalating conflict, is not appropriate for complex causes of clinically related challenging behaviours. The trust security function set out to address this gap by gaining trust wide support and the full backing of the Chief Nurse.

It engaged conflict specialists[42] to help research and design a bespoke programme that met CRT requirements and built an understanding of how to recognise, prevent and respond to clinically related challenging behaviour.

For staff in services experiencing higher levels of challenging behaviour, practical skills were included to help reduce risks when undertaking tasks in close proximity to patients. This included positioning awareness and simple skills to re-direct and guide individuals, and guidance on how to reduce risks of harm to confused and vulnerable patients.

The initiative set out to achieve two complementary goals:

- To design and deliver a bespoke training programme to help security and clinical staff teams work together to reduce clinically related challenging behaviours
- To reduce the use of restraint and ensure patient safety and dignity is maintained when intervention is necessary.

## Method

The first step was to analyse incident data to understand the nature and causes of challenging behaviours and identify priority

---

[42] Maybo, *www.maybo.co.uk*.

would form part of the training.

*"The training design was based on a comprehensive Training Needs Analysis informed by a bespoke staff survey and review of incidents. It has been an incredibly thorough and risk/evidence based approach"*

*Security Operational Manager*

Staff attended a one day course which covered CRT outcomes and included additional knowledge and skills to:

- Recognise, prevent and defuse conflict and challenging behaviours
- Avoid clinically related assaults through safer positioning and working practices
- Safely guide and re-direct confused patients.

Security staff had two further days of training including safer holding skills, ejection and incident response.

The training was mapped to the NHS CRT syllabus and to the National Occupational Standards for Work Related Violence, and it was City & Guilds accredited.

Bespoke eLearning also provided a foundation knowledge of conflict management which was assessed and recorded through a sophisticated learning management system. The face to face training is delivered on a training ward with wheelchairs, patient trolleys and beds to provide extra realism and opportunities for manual handling; dementia trainers have been closely involved to ensure full integration.

A further key success factor has been ward based 'coaching' and the support internal trainers and security team have provided to clinical staff. This has helped to ensure transfer of knowledge gained in training into working practices and safer behaviours i.e. Level 3 Kirkpatrick evaluation.

*"Everyone is now talking a common language about communication strategies, personalised care, de-escalation strategies and, where it becomes necessary, safer physical intervention".*

*Chief Nurse.*

## Roll-out

The programme has been rolled out to 32 Security officers and 761 clinical staff on a priority basis, i.e. to those wards experiencing the highest levels of clinical assaults and challenging behaviour. Members of the security team also attended the clinical courses to promote communications and teamwork between functions.

## Resourcing and sustainability

When it started, the training programme faced a twofold challenge: covering costs of training delivery and securing the release of operational staff, who would need to be covered. To achieve support from local clinical managers to release and cover staff, the team presented their research on risks and needs at a stakeholder workshop with a taste of the proposed training.

The success of this initiative over the past 18 months has helped secure additional investment and in-house trainers are now in place to further ensure its sustainability and reduce direct delivery costs to as little as £12 per head.

*"We have delivered a greatly enhanced training package within the same training time and at similar cost to the trust".*

*Security Operational Manager*

The thorough review of risks and training needs was key to getting senior managers' buy in to the training and the stakeholder workshop and pilot courses helped win the support of local matrons and managers who had to release staff.

The feedback from the initial courses was excellent, which spread good news and led to staff asking to go onto the training. A matron for older people who came on one such course, said "Why didn't someone show me this 20 years ago?" and immediately instructed her ward managers to come on the training and get their staff trained.

The commitment of the Health and Safety, HR, Clinical Divisions and Safeguarding and Security teams was excellent and the biggest turning point for the programme was obtaining the active backing of the Chief Nurse.

## Results

There is strong evidence to show this training has resulted in a drop in assaults and restraints and has informed the development of good practice guidance in this area. Targeting of highest risk areas has been effective and the fully trained neurology unit has seen a reduction from 15 to 6 assaults in 12 months, which it attributes to the training.

*"Evaluation of this training by security and clinical staff has been very positive and we have seen a11% reduction in the number of reported physical assaults across the trust so far and a reduction of up to 60% in targeted wards".*

*Security Operational Manager*

Staff training evaluations post training consistently rate the training as 'excellent' and comment on its practicality and relevance to their work.

*"All staff trained felt very positive and more confident in dealing with confused and aggressive patients and I see them putting the training into practice. Through teams training together, working relationships have improved and nurses are quicker to call security. This is the first course I have seen of its kind after 30 years of working with "challenging" patients. Thank you".*

*Matron Neurosciences*

Following implementation, restraints for a clinical reason are down from 87 to 69 and the security team are now using low arousal methods instead of the traditional 'pain compliant' techniques.

*"Since the training the adult safeguarding team have seen a reduction in the number of safeguarding alerts raised in relation to allegations of physical abuse due to intervention by staff to manage violent or aggressive behaviour".*

*Associate Director, Quality/Safeguarding Adults*

## Conclusions

This training programme is successfully addressing one of the most complex areas of behavioural safety, which was also proving costly due to staff injuries and presented safeguarding concerns. The programme is an excellent example of partnership in developing and implementing training.

Learning has been successfully transferred to working practices by securing full management buy-in and on-going support to wards from the trainers and security team. Relationships and respect between clinical and support staff have improved. The training has delivered a win-win outcome by improving staff safety and contributing positively to patient-centred care and safety.

*"The programme we have piloted and implemented has strengthened relationships and had a positive effect on staff confidence and patients' perception of safety."*

*Chief Nurse.*

Source: Simon Whitehorn Security Operations Manager, Brighton and Sussex University Hospital NHS Trust and Bill Fox, Executive Chairman, Maybo.

This BSUH programme won the 'Training initiative of the year' category at the 2013 Security Excellence Awards

# Appendix 3
# Clinically related challenging behaviour - awareness level learning outcomes

All staff interacting with patients need to be aware of clinically related challenging behaviour and the common causes and indicators of this. They need to recognise simple steps they can take to help prevent such behaviour and to ensure their safety and that of the patient when it occurs.

Some roles will have additional responsibilities and development needs in this area, for example relating to diagnosis, treatment, care planning and emergency incident response.

The following learning outcomes may form part of a stand alone learning programme or be integrated with existing core training such as Conflict Resolution Training (CRT), forming an enhanced 'CRT and Challenging Behaviour Awareness' course.

As far as practicable learning will:

- Be delivered in the context of the staff group, patients and environment to ensure its highest relevance.
- Include organisational information, policy and guidance relevant to the prevention and management of clinically related challenging behaviour.
- Make staff aware of their important role in helping to recognise and prevent challenging behaviour and of the support available to them in this.

Understand what is meant by clinically related challenging behaviour and recognise its common causes and signs:

- State the definition of clinically related challenging behaviour.
- Give examples of how it can present in the behaviour of a patient and its early signs (precursors).
- Describe how challenging behaviour can result from unmet needs and communication difficulties.
- Give examples of common causes and triggers including physical, cognitive, psychological/emotional and environmental/social factors.

Be able to identify, reduce and manage risks associated with clinically related challenging behaviour:

- Describe how a patient presenting clinically related challenging behaviour may be vulnerable.
- Give examples of steps staff can take to reduce patient vulnerability.
- Describe risks for staff in contact with a patient presenting challenging behaviour.
- Give examples of how staff can reduce risks when in close proximity to the patient.
- Describe key principles in managing the risk of challenging behaviour.
- State action to be taken in an emergency situation and how assistance can be obtained.

Identify positive steps all staff can take to help prevent clinically related challenging behaviour and provide best support and care for patients:

- Explain the individual's rights, including the right to make choices and to be treated with dignity and respect.
- Explain why it is important to positively engage and learn from patients and their families in understanding their needs and concerns.
- Explain how positive staff attitudes, communication skills and good individualised care are critical in helping prevent and manage challenging behaviours.
- Describe how to record and report information and observations to support care planning.
- Explain why it is important to share information with colleagues and hand over professionally.
- Describe action to be taken when there are concerns over the treatment, care or safety of a patient.
- State where advice and support can be found.

# Appendix 4
# Glossary

## ABCDE

An approach used for resuscitation in an emergency situation: A=Airways; B=Breathing; C=Circulation; D=Disability; E=Exposure.

## Challenging behaviour

Any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely.

## Delirium

A short term state of confusion, or a worsening of pre-existing confusion, due to a physical cause.

## Delusions

A falsely held belief that is firmly maintained in spite of unquestionable and obvious proof or evidence to the contrary.

## Dementia

A set of symptoms which includes loss of memory, communication and reasoning functions. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer's Disease. Dementia is progressive, which means the symptoms will gradually get worse.

## Emergency

A situation of immediately apparent risk to the health, safety and wellbeing of the person, staff or third parties.

## Hypoxia

A condition in which the whole body or a region of the body is deprived of an adequate oxygen supply. Severe or the rapid onset of hypoxia can lead to changes in levels of consciousness, seizures, coma and death.

## Information sharing protocol

An agreement for the necessary, appropriate and lawful secure sharing of personal confidential information across organisations, to meet the public interest while protecting the individual rights of the person(s) the information relates to.

## Personalised care

An approach that places the individual an equal partner in planning, assessing and designing care to make sure it is appropriate for their needs.

## Personality disorder

A type of mental health condition in which the person has difficulty perceiving, feeling and relating to situations and to people and foreseeing the consequences of their actions.

## Physical intervention

Any physical contact between persons involving the use of reasonable force to restrict movement or mobility and is intended to prevent serious harm to the patient, service user or staff member.

## Positive behaviour support

A framework for developing an understanding of an individual's challenging behaviour and using this understanding to develop effective support.

## Psychosis

A mental health condition that stops the person from thinking clearly, telling the difference between reality and their imagination and acting in a 'normal' way.

# Appendix 5
# Expert group responsible for developing this guidance

**Dr Peter Baker**
Consultant Clinical Psychologist, Sussex Partnership NHS Foundation Trust (representing the British Institute of Learning Disabilities)

**Dr Tony Bleetman**
Lead Consultant Emergency Medicine, The North West London Hospitals NHS Trust (representing the College of Emergency Medicine)

**Dr Joy Bray**
Mental Health Specialist Nurse, Cambridge University Hospitals NHS Foundation Trust

**Nicole Casey**
Senior Policy Officer, NHS Protect

**Adrian Clarkson**
Area Security Management Specialist, South West, NHS Protect

**Rebecca Cooper**
Policy and Prevention Development Manager, NHS Protect

**Mary Dawood**
Nurse Consultant Emergency Medicine, Imperial College Healthcare NHS Trust

**Dr Duncan Forsyth**
Consultant Geriatrician, Cambridge University Hospitals NHS Foundation Trust

**Bill Fox**
Executive Chairman, Maybo

**Julia Gamston**
Senior Nurse, Emergency Department, Imperial College Healthcare NHS Trust

**Professor Rowan Harwood**
Consultant Geriatrician, Nottingham University Hospitals NHS Trust (representing the Royal College of Physicians)

**Stephen Hines**
Paramedic, London Ambulance Service

**Peter Lester**
Trust Security Advisor, Cambridge University Hospitals NHS Foundation Trust

**Louise Maris**
Divisional Lead Nurse Neurosciences, Cambridge University Hospitals NHS Foundation Trust

**Andrew Masterman (Chair)**
Policy Lead - Violence Strategy, NHS Protect

**Emma Ouldred**
Dementia Nurse Specialist, King's College Hospital NHS Foundation Trust (representing the Royal College of Nursing)

**Dr Brodie Paterson**
Senior Lecturer, University of Stirling, School of Nursing, Midwifery and Health

**Dr Anand Ramakrishnan**
Consultant Old Age Psychiatrist, Nottinghamshire Healthcare NHS Trust (representing the Royal College of Psychiatrists)

**Vanessa Smith**
Assistant Director of Nursing and Quality: Mental Health of Older Adults and Dementia Clinical Academic Group, South London and Maudsley NHS Foundation Trust

**Professor Graham Stokes**
Director of Dementia Care, BUPA Care Services UK

**Davina Teeluck**
Policy Officer, NHS Protect

**Dr Ben Thomas**
Director of Mental Health and Learning Disability Nursing, Department of Health

**Jim Tighe**
Team Leader, Surrey and Borders Partnership NHS Foundation Trust

**Simon Whitehorn**
Security Operations Manager, Brighton & Sussex University Hospitals NHS Trust

# Appendices

Department
of Health

# Closing the Gap: Priorities for essential change in mental health

**Title:** Closing the gap: priorities for essential change in mental health

**Author:** Social Care, Local Government and Care Partnership Directorate

**Document Purpose:** Policy

**Publication date:** January 2014

**Target audience:** Local Authority CEs, CCG CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Health and Wellbeing Boards, Directors of Public Health, Medical Directors, Directors of Nursing, Directors of Adults SSs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Youth offending services, Police, NOMS and wider criminal justice system, Coroners, Royal Colleges, Transport bodies

**Contact details:**

Social Care, Local Government and Care Partnership Directorate,
Room 313 Richmond House,
London SW1P 2NS

Published to gov.uk, in PDF format only.

www.gov.uk/dh

# Closing the gap: priorities for essential change in mental health

**Prepared by the Department of Health**

# Foreword

In our mental health strategy, *No Health Without Mental Health*, we set ourselves – and society as a whole – some big challenges. We stated that mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time. We made it clear that tackling premature mortality of people with mental health problems is a priority. And we recognised that more must be done to prevent mental ill health and promote mental wellbeing.

We stand firmly behind that strategy, and the principles which underpin it – and two years on, the foundations have been laid. In many local areas, there have been real changes to the quality and availability of mental health services. Through the Time to Change campaign, led by Mind and Rethink Mental Illness, discrimination against people with mental health problems has decreased.

Mental health is moving up the policy agenda across government.  Working together to improve outcomes for people with mental health problems is therefore a major policy priority for many government departments; from unemployment to policy on tackling gang culture.

All too often, for example, poor mental health precipitates premature job loss. This is a waste for individuals and for the economy. In addition, we know that not having a job is too often associated with the onset or recurrence of mental health problems and being out of or away from work can sustain the symptoms of mental ill health. Effective support requires a joined-up approach between health and employment services and supportive action by employers.

Mental health was at the heart of the first Mandates to NHS England and Health Education England which set out the Government's objectives for these organisations. It is also at the heart of the new public health system: mental health is firmly included within local government responsibilities for improving public health.  Work led by Public Health England to promote good mental health, prevent mental ill health and improve wellbeing will help make a reality of these ambitions.

These are all hugely positive changes. But many people would, we are sure, agree with our view that things are not changing fast enough.  We are not yet making enough of a difference to enough people.

People who use mental health services, and those that care for them, continue to report gaps in provision and long waits for services. There is still insufficient support within communities for people with mental health problems. In some areas there have been stories of people of all ages being transferred sometimes hundreds of miles to access a bed. We are not yet making an impact on the enormous gap in physical health outcomes for those with mental health problems. And so much more could be done to promote good mental health and prevent mental ill health.

We know that in tough financial times, funding for mental health at a local level can get squeezed. We are determined that it does not. We need to see funding channelled in the right direction to bring benefits across a number of areas, from education and employment to criminal justice and beyond.

That's why we are challenging the health and social care community to go further and faster to transform the support and care available to people with mental health problems – both children and adults. And we are challenging the public health community, with local government in the lead, to help give mental health and wellbeing promotion and prevention the long overdue attention it needs and deserves.

This document sets out that challenge. It identifies 25 aspects of mental health care and support where government – along with health and social care leaders, academics and a range of representative organisations – expect to see tangible changes *in the next couple of years*: changes that will directly affect millions of lives for the better.

The 25 areas we have highlighted here are in no way the full extent of our ambition for change; that can be found in the strategy. They are, however, all priorities for action and progress in the next couple of years.

Achieving that progress is something we cannot do alone. It requires not only the commitment of those working within the system, but also support and engagement across all of society. From the way that mental health is covered in the media, to how it is addressed in schools, to the response of families and friends, we can all do more to improve the lives of people with mental health problems and to promote wider mental wellbeing.

We know there is a real hunger for change – not only amongst those who suffer from mental health problems, but also amongst those who work to support them.

Together, we can accelerate the pace of change in both services and attitudes – transforming the lives of people with mental health conditions, and our communities, for the better.

Nick Clegg

The Rt Hon Nick Clegg MP

**Deputy Prime Minister**

Norman Lamb MP

**Minister of State for Care and Support**

# Contents

# Introduction

In 2011, the government published its mental health strategy, *No health without mental health*. This set out our long-term ambitions for the transformation of mental health care – and more importantly, for a broad change in the way people with mental health problems are supported in society as a whole. The strategy was built around six unambiguous objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

This document supports all of those objectives – just as it supports the mental health strategy implementation framework and suicide prevention strategy, published in 2012. But the principles and many of the programmes described in those documents are about long-term change, at the population level.

The actions in the implementation framework, many of which are underway, focus on how local partners can work to achieve the long-term objectives, and how national organisations can support and enable them. They are about organisational change, working together, using the resources available. They remain central to our direction and ambition.

## How this document fits in

This document aims to bridge the gap between our long-term ambition and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.

It therefore sets out 25 areas where people can expect to see, and experience, the fastest changes. These are our priorities for action: issues that current programmes are beginning to address and where our strategy is coming to life.

Many are about mental health care and treatment, but others reflect the work done across the entire health and care sector, and indeed across government as a whole, to reduce the damaging impact of mental illness and improve mental wellbeing. In addressing these priorities, we will also continue to rely on the involvement of many partners across the voluntary sector – from national charities to local community groups.

## More information

There is much more detailed information and evidence-based policy available about each of the 25 areas highlighted here, just as there is about our broader direction and long-term ambition.

# Increasing access to mental health services

## 1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need

We want to ensure that the right services are being commissioned in each local area, to reflect local need. That means not only making sure that there is a hospital bed available locally for every adult who needs one, but also offering high-quality, safe care in the community, that reflects what patients want and need and focuses on recovery.

So we are making sure commissioners – many of whom have less knowledge of mental health services than they do of physical health services – get the right information about what services are most effective at helping people recover, and what best looks like. The National Institute for Health and Care Excellence (NICE) has already published a wide range of quality standards around mental health, and is currently developing and reviewing several more. These will provide the core of the information available to commissioners. To give them further support, NHS England:

- has recently launched its mental health leadership programme for Clinical Commissioning Groups (CCGs);
- is working with relevant expert bodies to develop best practice specifications for commissioning specialist mental health services, for example for schizophrenia and bipolar disorder;
- is developing a range of clinical commissioning tools to support commissioners, including tools that will support integration of physical and mental health care.

Further guidance is provided by the Joint Commissioning Panel for Mental Health, a collaboration between seventeen leading organisations, co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners. It is focused on encouraging commissioners to use a values-based commissioning model, and is producing a wealth of practical guidance on what good services for mental illness, dementia and learning disabilities should look like.

To further build our understanding of psychosis and what best practice care is, in March 2014 we will hold a national summit on psychosis in partnership with Rethink Mental Illness. This will bring together a range of stakeholders to determine the best ways to support local commissioning of best practice care for psychosis and severe mental illness.

Integrated approaches to local commissioning also have an important role to play in promoting mental wellbeing and preventing mental illness, as part of the local Health and Wellbeing Strategy. Public Health England (PHE) is working to build up the evidence base around what kind of services and programmes are most effective.

Nationally PHE, NHS England and the Local Government Association will work together to develop resources that will support local authorities and CCGs in commissioning services to meet the needs of those in mental health crisis.

For example, PHE alcohol and drug teams will work with NHS England area teams, Local Authorities and CCGs to promote and support the commissioning of joined up mental health and substance misuse provision.

## 2. We will lead an information revolution around mental health and wellbeing

We need a truer, more up-to-date and more detailed picture of mental health and wellbeing nationally and in each area. This is essential to delivering measurable improvements in community and population mental health, service improvements, evidence-based commissioning and to changing attitudes to mental wellbeing. Until now, the quality and amount of information about mental health has lagged behind that about physical health.

We are therefore setting up a new national Mental Health Intelligence Network (MHIN), using a similar approach to the successful National Cancer Intelligence Network and Child and Maternal Health Intelligence Network. It will draw together comprehensive information about mental health and wellbeing to provide a greater insight into mental health problems, how they vary with age and in different parts of the country, and what the most pressing needs are in each area. It will also gather information about the services being provided – and how effective they are.

The information will be available to all, so that local people can see for themselves how their area is doing. But its main purpose will be to help local Health and Wellbeing Boards, CCGs and other partners to decide what types of health and social care services are needed in their area, and how they can improve the mix of services and support available.

We will also gather more information about mental health to let us know how we are doing on our promises in the NHS, Social Care and Public Health Outcomes Frameworks. These include a number of outcomes and measures around mental health and wellbeing. The information used to assess whether those outcomes have been achieved can be used in other ways too. And we will also measure our progress against the priority activities described in this document – reporting back next year.

Reviewing our outcomes frameworks is not just about checking on progress. It also gives us a good opportunity to check whether we are focusing on the right outcomes. The extra information we will gather will help us answer this question: where necessary we can add further outcomes. For example, we are currently investigating the development of an outcome indicator around recovery – working out what we can measure, and how.

The Department of Health has developed a Mental Health Dashboard which tracks the key measures that already exist and highlights the priority outcomes from the outcome frameworks. This will be used to support overall strategy and policy development, as well as to make sure everyone can see what is happening.

All of these national level actions need to be backed by improvements in information sharing locally, between services. We know there is a lot of effort in many areas to address this: it is the essential foundation of a more personalised, joined-up response from public services to people with mental health problems.

With this new emphasis on information about mental health, we will have a clearer picture of how things are, how they can improve, and what services are available – which will, in turn – drive improvements in care.

### Building information about mental wellbeing

Arguably the most ambitious part of our strategy is our determination to promote and sustain good mental health for all, and to prevent mental health problems developing. Alongside the MHIN, we are also launching a new programme of work, led by PHE, that will gather information around mental health and wellbeing and what affects them. This will help build our understanding of what can be done to promote and retain good mental health, prevent mental health problems and improve the health and wellbeing of those living with and recovering from mental illnesses.

In early 2014, PHE will publish a framework for action and a series of information briefings based on the existing evidence that set out what the new public health system can do to help improve the public's mental health as part of wider work on improving health and wellbeing.

## 3. We will, for the first time, establish clear waiting time limits for mental health services

Far too many people of all ages wait too long to get the mental health services they need. The longer they wait for support, the more likely it is their condition gets worse. This has to change. The Mandate to NHS England sets out our commitment to put mental health on a par with physical health, where there are already well-established standards for access to services. A commitment to access and/or waiting times standards for mental health services is critical to achieving parity of esteem for mental health services.

NHS England is currently gathering information about access to and waiting times for adult mental health services around the country, and whether any particular groups of people experience longer waits or poorer access than others.

Based on this information, we will then set new national standards that focus on improving access to adult mental health services. These will be introduced starting in 2015, and cover access to or waiting times for services. We will also work with a range of partners to identify the most effective ways to ensure those standards are met.

But we expect waiting times to be reduced long before the standards come into effect – and for children and young people's mental health services, as well as for adult services. For example, in recent years we have invested in a dedicated transformation programme for children and young people's services – enhancing access to evidence-based therapies. The 2013 Mandate to NHS England sets a new expectation that this should extend across the whole country, delivering a nationwide service transformation of children and young people's mental health services. We expect this to further improve children and young people's access to evidence-based, outcome-monitored therapies to a level comparable with the standards set for adult services.

We will publish data gathered by NHS England so that everyone can see clearly the waiting times for different services and in different areas. This in itself should act as a catalyst for change.

## 4. We will tackle inequalities around access to mental health services

Simply making services available is not enough. We are also looking at ways to overcome inequalities around service usage – and around the outcomes those services achieve.

For example, evidence shows that people from black and minority ethnic (BME) communities have to date been less likely to use psychological therapies. We are working with the Race Equality Foundation and other stakeholders to try and understand why this is the case and to understand inequalities around access to other services. NHS England are also working with BME community leaders to encourage more people to use psychological therapies.

We also know that older people typically access mental health services less frequently than their working age counterparts. Again, we are seeking to understand why, so we can address this. For instance, only 6% of people who used psychological therapies were over 65: in response, we supported an advertising campaign delivered through Age UK and Carers UK that aimed to raise awareness amongst older people that they could use psychological therapies. We have also developed a new curriculum for psychological therapists that train them to work better with older people.

Work is already underway to address the stigma of mental health problems in different communities – particularly those who experience disproportionately high levels of mental illness, or those where the stigma of mental illness remains most significant. For example, the Time to Change campaign is launching a pilot project to support young African and Caribbean men, with the aim of reducing the stigma and discrimination experienced in statutory services. We will monitor the impact of this and apply the lessons learned in other areas.

In addition, we know that offenders and ex-offenders are disproportionally affected by mental health problems. Whilst liaison and diversion schemes will go some way to ensuring that offenders access mental health services, we need to ensure that services are in place for any section of the population that are affected by mental health issues, including ex-offenders.

### Ensuring veterans have access to the services and support they need

The Armed Forces Covenant requires, "… that those injured in service, whether mentally or physically, should be cared for in a way which reflects the Nation's moral obligations to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving service, they should be able to access services with health professionals who have an understanding of armed forces culture."

The Government's mandate to NHS England requires the NHS and its public sector partners to help one another to achieve their objectives. This includes, in particular, demonstrating progress against the Armed Forces Covenant.

Dr Andrew Murrison's report on access to mental health services to the Armed Forces and Veterans *'Fighting Fit'* made a number of recommendations to meet the needs of the Armed Forces community. The Department of Health, MoD, NHS England, together with service charities such as Combat Stress, Royal British Legion, Help for Heroes and others have worked in partnership to deliver services against the recommendations made by Dr Murrison. The priority over the coming 18 months is to ensure that the services put in place are evaluated, so further services can be commissioned beyond the end of the current spending review. Subject to the evaluation, these will include:

- commissioning of veterans' mental health teams across the country;
- provision of an online mental health counselling service;
- provision of a National Veteran's Mental Health Network, Veteran's Information;
- a service and e-learning package for GPs.

The Department of Health will work with NHS England and others to help achieve this.

## 5. Over 900,000 people will benefit from psychological therapies every year

Psychological therapies work. In the last three years alone, they have helped more than 45,000 people to recover from and cope with mental health problems so that they can come off benefits and return to work. They help many people manage long-term mental health problems day-to-day; they are also a key means of early intervention. Many GPs want to be able to direct patients – including children and young people – to relevant psychological therapies at an early stage, as a way of preventing the deterioration of mental health.

We have already committed over £450 million to improve access to NICE-approved psychological therapies. We have asked Health Education England (HEE) to make sure that enough therapists are trained. We have shared best practice for delivering these therapies to children and young people. We are also exploring how psychological therapies can be used to help with severe mental illness and personality disorders – as part of a wider programme of care – and looking at how they can be integrated into care for people who have depression or anxiety that is related to a long-term physical condition.

Now we are actively incentivising CCGs to increase access to psychological therapies through the Quality Premium scheme, which provides additional funding to those that meet key goals.

Already, some 600,000 adults are benefiting from psychological therapies every year. We want this number to increase so more people get the help they need, when they need it, to support and accelerate recovery and manage long-term conditions. Our investment will mean 300,000 more adults will be able to access psychological therapies.

### What are psychological therapies?

Often known as "talking therapies", psychological therapies involve a person talking to a trained therapist, either one-to-one, in a group or with their wife, husband or partner. Types of psychological therapy that are approved for use within the NHS – based on extensive reviews of evidence about what works – include:

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple Therapy for Depression
- Counselling for Depression
- Behavioural Family Therapy & Cognitive Behavioural Family Interventions
- Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

## 6. There will be improved access to psychological therapies for children and young people across the whole of England

We want to do more to promote mental wellbeing amongst children and young people, and prevent them from developing mental health problems. Half of those with lifetime mental health problems first experience symptoms by the age of 14; early identification and where necessary intervention can make a massive difference. Good mental health can help achievement in school and avoid poor health outcomes in the future: in short, it is vital to helping children to fulfil their potential.

We know that psychological therapies work for many people. But we also know that they need to be delivered in different ways to children and young people, compared to adults. Younger children in particular may not be able to talk about their feelings or problems in the way adults can. So we have invested in providing psychological therapies in a way that we know works for children and young people too.

Already, over half the country is involved in our transformational programme. NHS England is planning for a country-wide extension of the programme, and the Government's aim is that all of England is involved by 2018.

## 7. The most effective services will get the most funding

In 2012 we started to introduce a new payment system for adult mental health services. Many adults receiving care are allocated to a mental health ‘cluster’ based on their need; services are then tailored according to the needs of the people they treat. In some local health economies, these ‘clusters’ are also used as the basis of payment replacing a system of block payment arrangements, generally based on what the service historically received rather than how many patients it is currently supporting.

We are working alongside Monitor and NHS England to develop the payment system further, in a way which enables commissioners to use payment systems increasingly to reflect quality and outcomes as well as volumes of activity. From April 2014, the Health and Social Care Information Centre will produce monthly reports for commissioners and providers which show how providers are doing against a number of quality and outcome measures. This will make it easier for commissioners of mental health services to hold providers to account. In the future this could mean that the best services – i.e. those that deliver the most successful outcomes, such as highest recovery rates – get more funding.

## 8. Adults will be given the right to make choices about the mental health care they receive

Just like people with long-term physical conditions, we want adults with mental health problems to be able to exercise choice about the care they receive and how they receive it. This is a general principle that should apply to all aspects of care. But we are establishing new legal rights around mental health care.

The NHS Constitution Handbook sets out legal rights for physical health patients in England to choose the organisation that provides their NHS care when they are referred for their first outpatient appointment with a service led by a consultant. From April 2014, the scope of the legal right will be extended to adults with mental health problems. They will be given the opportunity to choose which provider and consultant or mental health professional will be in charge of their care when they attend their first outpatient appointment. Some exemptions will apply, including when people need urgent or emergency treatment, or are detained under the Mental Health Act 1983. Patients should speak to their GP first about their choices.

Anyone eligible to receive social care services will be able to choose to receive a personal budget, and the NHS is working with local areas on applying personal health budgets to mental health – giving people even more control over their care. Through the way choice and personal budgets are used, the best care and services will be recognised and rewarded – empowering individuals and improving the quality of services.

## 9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor

The Serious Case Review into the events at Winterbourne View made it clear that restraint and restrictive practices – such as medication and seclusion – have been over-used in the care of people with challenging behaviour in health settings, and not always as a last resort. This is not acceptable.

We also recognise that dealing with patients who are aggressive or threatening, or who refuse treatment, is difficult. To help care providers adopt a positive alternative, we have asked the Royal College of Nursing, working with other relevant organisations and authorities, to develop new guidance on different models for reducing the use of restraint. This will include the use of positive behaviour support to minimise the use of restrictive interventions. It will also provide clear guidance on the use of restrictive practices as a demonstrable last resort. By following this guidance, providers will be able to ensure that they are using restraint in a transparent and ethical manner, and that they are acting within the law. We will expect all commissioners and providers to adopt this guidance. Subject to consultation on the guidance, we will make clear that the practices of deliberately holding people on the floor or restraining people in a way that impacts on their airway, breathing or circulation are high risk approaches and we want to see an end to their use as an accepted part of normal health and care. We will be looking at other levers alongside this guidance to effect change and to make sure that all the actions that will reduce the use of restrictive practices are being considered - including training, information and regulation.

Clearly, new training will be necessary to support this, and we will also look at other ways to help embed the change we want to see into everyday practice.

To ensure that there is the right legal framework around mental health services, we are also reviewing how the Mental Health Act and Mental Capacity Act have been implemented and how their provisions and requirements are being followed in practice.

## 10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services

The most important measure of quality is what people who use mental health services think. The Francis Report highlighted the Friends and Family Test as a means of identifying poor quality services early. The Friends and Family Test asks patients and staff how likely they are to recommend a health or care provider's services to their friends and family if they needed similar care or treatment.

We have already piloted using the Friends and Family Test in some mental health care settings. From the end of December 2014, it will be routinely used in all mental health care settings. We would encourage providers to start using it sooner.

We will publish the results so that providers are open to scrutiny – helping us increase transparency around mental health services. By ensuring that the voices and views of patients, families and carers are heard, we can also learn about potential service improvements of all kinds.

## 11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients

We want people to have confidence that mental health services meet the standards we expect. So the Care Quality Commission (CQC) is currently developing a new model for monitoring, inspecting and regulating mental health providers that will ensure poor quality services or gaps in provision are identified sooner. This will mean we can respond faster and so improve quality of care overall.

For example, in response to concerns about access to places of safety, where people can be taken for an assessment of their mental health needs rather than being taken into police custody, the CQC has launched a thematic review of emergency mental health care.

By October 2014, there will be a new set of measures about care quality, new rating systems for mental health services and a new inspection process for mental health NHS trusts, which puts patient opinions and experiences at its heart. The CQC will carry out more visits to service providers, and talk to people who use those services, as well as their families and carers. It will also ensure it speaks to people detained under the Mental Health Act.

This will be backed up by greater use of experts during inspections, as well as use of external sources of information, including:

- providers’ own reviews,
- advocacy services,
- national surveys,
- Healthwatch information,
- information held by local community groups, and
- social media

to gather a fuller picture of what people’s experience of care is really like. The CQC will also directly take into account the priorities in this document, where they apply to the provider.

Where problems are identified, the CQC will use its powers to ensure action is taken to improve care. If services are putting patients at risk in any way, it can use enforcement powers to stop further admissions, suspend services or even prosecute service providers.

The new regulatory model will apply to all mental health service providers registered with CQC. This includes inpatient and community services for children and young people, adults of all ages and inpatient assessment/treatment services for people with a learning disability. The CQC has appointed a Deputy Chief Inspector for mental health services to oversee the process.

## 12. Carers will be better supported and more closely involved in decisions about mental health service provision

We know that caring for someone with a mental health problem can be hugely draining, both emotionally and financially, and we are determined to improve the support available to carers. The changes to carers' assessments, which will be introduced when the Care Bill becomes law, will ensure many more carers can get support – whether caring for those with mental or physical health problems, or both. The Children and Families Bill will ensure that young carers' assessments are simplified – for the first time, all young carers will have the right to an assessment of their needs for support as part of a whole family approach to assessment.

Local commissioners will also be expected to consider specific support for carers – such as respite care – in the services that are available locally.

The Standing Commission on Carers, which advises government, is focussing its fact-finding visits during 2013/14 on how carers of those with mental health problems are supported.

As we said in our strategy, we also want to ensure that carers are involved more closely in decisions about service provision. This is something that the Carers Trust is focusing on with its Triangle of Care project, funded by the Department of Health. The project has produced best practice guidance on how carers can be better involved in both the planning and delivery of mental health services. A self-assessment tool for providers has also been developed, which aims to ensure that providers are following best practice.

### Addressing the mental health needs of carers

The mental health needs of carers themselves are often overlooked. A carer looking after someone with a severe mental health condition can often feel isolated and frustrated, which in turn can lead to carers themselves becoming depressed.

One way we are looking to address this is through working with the Alzheimer's Society to develop an online tool for carers of people with dementia. The tool will provide cognitive behaviour therapy for carers, aiming to help them understand their feelings of depression, frustration and anxiety and develop coping mechanisms. It reflects the fact that their caring responsibilities make it more difficult for this group to visit services. The tool will be clinically trialled in 2014.

# Integrating physical and mental health care

## 13. Mental health care and physical health care will be better integrated at every level

As much as 80% of all mental health care takes place in GP surgeries and hospitals. So it is essential that staff working in these settings understand the symptoms of mental illness and the physical health needs of people with mental health problems. This will help guide treatment decisions, as well as lead to better day-to-day care. Physical illnesses can be diagnosed sooner; treatment plans adapted to reflect mental health needs; recovery accelerated.

We are working across the whole system to improve integration between physical and mental health care.

- As set out in our Mandate, NHS England is expected to make rapid progress, working with CCGs and other commissioners, to help deliver our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. This includes ensuring there are adequate liaison psychiatry services.
- We have tasked HEE to develop training programmes that will enable all healthcare employers to ensure that their staff have a greater awareness of mental health problems and how they may affect their patients. This should include understanding the links between patients' mental and physical health, so that staff know what actions they can take to ensure that patients receive appropriate support for both their mental and physical health care needs.
- NHS England is launching a new programme dedicated to ensuring that, across the entire health system, mental health has equal priority with physical health.
- We are making sure that best practice approaches to caring for patients with many common conditions include potential psychological care needs.
- PHE has embarked on work to improve the understanding of mental health issues within the public health workforce.
- The Royal College of GPs (RCGP) will work to support, develop and improve GPs' knowledge and experience of the management of severe mental illness, including physical health and crisis care. It is adapting its Curriculum Statement for Mental Health and will appoint a Mental Health Clinical Lead. It is also developing proposals to enhance and extend GP training so that all future GPs will receive specialist-led training in the care of young people and adults with mental health problems.
- We are also looking at improving the standards of physical health care within mental health in-patient facilities to support earlier diagnosis and treatment of common illnesses. This is vital to our on-going goal of reducing premature mortality.

To support the integration of physical and mental health care, and social care, we have allocated £3.8 billion to help every Health and Wellbeing Board in the country to develop its own plan for joined up health and care locally. On 1 November 2013, we announced that 14 Integrated Care pioneer sites will be leading the way in joining up care services. Most of these sites include a focus on mental health, and plan to offer joined up care across the whole spectrum of services.

## 14. We will change the way frontline health services respond to self-harm

Self-harming can be one of the first outward signs of mental illness. It can be, though is not always, the sign of a mental health crisis – particularly when it is severe enough that the person ends up in an Emergency Department. And it is a habit that, once started, is hard to break: it is estimated that 1 in 6 people who require treatment in Emergency Departments due to self-harm will be back again within a year.

NICE guidelines already make it clear that anyone who attends an Emergency Department for self-harm should be offered a comprehensive assessment of their physical, psychological and social needs. However, we know that too often this does not happen: in fact, people who self-harm are often treated as low priority in Emergency Departments. Many report too that GPs can be dismissive of self-harm.

We now know more about self-harm than ever before. We understand better why people self-harm, and – thanks to the research undertaken as part of our suicide prevention strategy – have a greater insight into the links between self-harm and suicide. We want to put that knowledge to work, to improve the care and support offered to those who self-harm, recognising that the mental health needs might be far greater than the physical ones. By understanding those needs earlier, we can do more to prevent long-term mental health conditions developing. We can also reduce repeat admissions to Emergency Departments, and in some cases, help prevent suicide. Emergency Departments should aim to refer all those who present with self-harm for a psychosocial assessment, as set out in the NICE guidelines. We expect GPs to refer people who disclose self-harm to psychological therapies as appropriate.

In the revised Public Health Outcomes Framework, we have therefore introduced a new indicator that is specifically about self-harm. Under this indicator, we will measure:

- attendances at Emergency Departments for self-harm per 100,000 population
- percentage of attendances at Emergency Departments for self-harm that received a psychosocial assessment.

This two-part indicator helps us not only understand the prevalence of self-harm but also how Emergency Departments are responding. This information can then inform future commissioning.

We are also looking at how other frontline services respond to incidents of self-harm – including across the criminal justice system, whether in prison or where the police attend an incident involving self-harm. For example, self-harm is closely monitored within prisons. There is a well-established process for supporting prisoners at risk of, or who have, self-harmed, called Assessment, Care in Custody and Teamwork (ACCT). The process includes a requirement to consider mental health, and where appropriate refer prisoners on to mental health services. We will examine what other services can learn from this.

In addition, the survey recommended by the Chief Medical Officer into the prevalence of mental health problems amongst children and young people includes specifically investigating the prevalence of self-harm. It is widely acknowledged that teenagers – in particularly teenage girls – are amongst the most likely to self-harm, but we would like to gather more detailed data around this.

## 15. No-one experiencing a mental health crisis should ever be turned away from services

There are far too many examples of public services failing to respond effectively to people experiencing a mental health crisis. Children and adults alike have been turned away because health services are full, or made to wait until Monday morning because services are not available at the weekend. In some cases, they do not receive adequate treatment and support early enough, because information about their problem is not effectively shared between services. This is simply unacceptable and *must* change.

To tackle this, we will soon publish a new national Crisis Care Concordat. This will set out clearly what kind of support people in mental health crisis should receive, no matter where they are in the country or which public service they turn to – or which service those who care for them turn to. In particular, it focuses on better co-ordination between emergency services and mental health services, so that mental health support is available as soon as possible. This not only serves the individual concerned better, but also helps those emergency services perform their roles better.

So for example, when police take an individual to a “place of safety” under the Mental Health Act, the Concordat sets clear expectations as to how mental health services should respond. It also makes it clear that police custody should not be used as a place of safety and that emergency departments should be able to quickly get hold of a psychiatrist when a patient is or appears to be suffering from a mental health crisis. Wherever possible, the goal is through early intervention to avoid hospital admission for the mental health problem – and instead provide alternative care and support.

The Concordat emphasises the pivotal role of Approved Mental Health Professionals not only in arranging Mental Health Act assessments quickly, but also in ensuring that the least restrictive option is put in place and that the person’s rights are safeguarded.

The Concordat has been jointly developed by a range of services, as well as other stakeholders. It will mean that whether individuals themselves request help because they are in crisis, or any public service recognises that someone they are dealing with is experiencing a crisis, the response will be consistent, compassionate and comprehensive. Most importantly, no-one who needs urgent support during a mental health crisis should be turned away.

## Street triage – a new approach to effective and co-ordinated crisis response

We are also piloting street triage as a way of helping people experiencing a mental health crisis get the help they need faster. This involves trained mental health professionals working with police officers, as a first-line response – either directly on the street or through a dedicated phone line. If the police are called to an incident where a person is suicidal or self-harming, creating a disturbance or upsetting others, but has not committed a crime, they can ask the mental health professional to conduct a rapid needs assessment and direct the individual to the most appropriate source of help. Street triage is being tested with nine police forces around England, and is a good example of how the principles of the Concordat can be turned into action.

# Starting early to promote mental wellbeing and prevent mental health problems

## 16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression

Arguably the most ambitious part of our strategy is our determination to promote and sustain good mental health for all, and to prevent mental health problems developing.

We now know much more about the causes of some of the most common mental disorders such as depression and anxiety – and what can be done, in many cases, to prevent them. We will therefore focus on raising awareness of the interventions that we know work – like taking steps to reduce isolation in older people, working proactively with troubled families, and early interventions to prevent people struggling to find work from developing depression.

We are focusing in particular on maternal mental health during pregnancy and after birth including postnatal depression. This is important not only for mothers, but also their children. Mental health issues affect around 10% of women either when pregnant or after their baby is born, better support for parents can improve the mental health outcomes for them and their children. We are therefore determined to help children start well. Experiences in the early years can be hugely influential on lifetime wellbeing.

Whilst the majority of new mothers with mental health problems can be effectively managed within the extended primary care team, a minority with more serious problems will require specialist care. This should be provided by specialist community perinatal mental health teams and if necessary, admission to specialist mother and baby units. The NHS England Clinical Reference Group for perinatal mental health is working to improve the quality of care, promote equity of access to specialist care and reduce unwarranted variation in the quality of care that individuals receive.

Under new plans HEE, the national training body, will make sure there is enough training in perinatal mental health so there are specialist staff available for every birthing unit by 2017.

The Institute for Health Visitors is also updating the training given to all health visitors around mental health, so that they are better able to identify mothers who are at risk, and able to support them in a more targeted and effective way.

Improved training and support for health visitors and midwives will enable them to spot the early signs of maternal mental health problems and work together in pregnancy and the first postnatal year to meet the physical health, mental health and wellbeing needs of parents, babies and families. Where mothers are identified as needing support, services should not only support recovery from depression, but also look to help mothers to care for their babies.

This is in line with the Government’s wider strategy to ensure families and children have the best start in life: we are expanding the health visitor workforce by 4,200 (over 50%), by 2015. More than 5000 new midwives are now in training and we are ensuring more vulnerable women and families benefit from the support of family nurses. Having more health visitors and midwives will help to ensure that women have personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period.

## 17. Schools will be supported to identify mental health problems sooner

We know that many schools want to do more to help children who are, or may be, experiencing mental health problems. Many now have their own programmes and mental health support – such as a school-based counsellor, whilst others have whole school approaches to mental and emotional health. We want to ensure that such programmes offer the best support possible, but also that schools are better able to identify mental health problems in their pupils sooner.

This requires health and education professionals to work collaboratively so that the right decisions can be made to support each child - referring those who need extra support to the right places sooner.

The new Special Educational Needs (SEN) Code of Practice, which is expected to be introduced in September 2014, will provide statutory guidance for education and health services on identifying and supporting children and young people with mental health problems who have a special educational need. It will ensure a child’s mental health needs are captured within any assessment of their educational, health and social care needs. It sets the expectation that there should be clear arrangements in place between local health partners, schools, colleges, early years providers and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS).

To help them do this, the Department of Health is funding the development of an interactive e-Portal that will bring together the latest evidence and guidance around mental health problems in children and young people. This will be launched in early 2014, and provide e-learning materials as well as signposting further support. It is designed to be used by all those working with children and young people – including in health and social care and the police, as well as schools. It will also be a useful reference for Clinical Commissioning Groups who are required, under the new SEN duty, to ensure that schools have access to SEN services.

Clearly, schools can contribute to mental wellbeing and our bigger ambitions in many other ways – like in the way they tackle bullying, or how they address discrimination. The mental health strategy implementation framework includes a number of actions schools and colleges can take. Many already are, and we urge those that have not yet considered the actions to do so as a priority. PHE will provide national leadership in this area with its focus on supporting families to give children and young people the best start in life.

## 18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18

It has long been recognised that far too many young people who rely on mental health services are ‘lost’ to the system when they reach adulthood. From a point where they receive regular, focused support for their mental health needs, they find themselves on their own, unprepared for the abrupt cultural shift from a child-centred developmental approach to an adult care model. They may disengage, in many cases dropping through the care gap between the two services and losing much needed continuity of care. Those affected are often the most vulnerable and disadvantaged; getting lost in transition only adds to this – and makes them more likely to end up out of work and not in education or training. It can also mean their physical health deteriorates. For a significant number therefore, transition is poorly planned, poorly executed and poorly experienced.

For so many reasons, this “cliff-edge” situation must end.

We support the NHS England work to develop a service specification for transition from CAMHS. Monitoring the outcomes of transitions from CAMHS to adult mental health services or to other services such as the voluntary sector or primary care is neither universal nor robust. CCGs and Local Authorities will be able to use the specification to build on best practice and the evidence from a range of service models to commission high quality, measurable person-centred services that take into account the developmental needs of the young person as well as the need for age appropriate services. The service specification will include a range of quality indicators such as personalised transition plans that include, for those young people who do need to transfer to adult services, joint meetings with CAMHS and adult mental health services. For those who do not, it will include information on how to access services if they become unwell. We will need to take a cross-service approach, involving housing, employment services and social workers – and not least, the young person themselves – so that we can ensure they get the support they want.

At all times our focus will be on what works best from the perspective of young people, their own experiences and the perspective of families and carers. We will undertake a high-level scoping study to examine evidence for both physical and mental health services focused on the 15-24 year age group and the implications this might have for care pathways, social workers and health professionals in the UK.

We will also continue to examine how we can best ensure information about mental health problems in childhood – and what support has worked – is included within individual medical records for future reference.

# Improving the quality of life of people with mental health problems

## 19. People with mental health problems will live healthier lives and longer lives

We want people with mental health problems to live as long, and full a life as the rest of the population. As set out in our strategy, having a mental health problem also increases the risk of physical ill health. Currently, men with a severe mental illness die on average 20 years earlier than other people; women 15 years earlier. They have higher rates of cancer, heart disease, respiratory disease and diabetes.

We have made it clear that we expect the NHS to narrow this gap and reduce the number of premature deaths in people with mental health problems. Building on the principles in the strategy and in the NHS and Public Health Outcomes Frameworks, we will shortly be publishing a five-year action plan on how to reduce avoidable deaths. This will include specific actions aimed at people with common mental health problems, and for those with more serious mental health problems. NHS England and PHE will lead this work.

People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems. These difficulties are frequently exacerbated for people with mental health problems who often live in poverty, have poorer social networks, and more difficulties accessing housing, employment, education and other opportunities. These issues are, of course, heightened by the stigma and discrimination still experienced by people living with mental health problems.

PHE and its partners are exploring a range of ways to highlight these issues and address these inequalities. By raising awareness, the first steps can be taken to improve outcomes.

For example, GPs, health care professionals and social workers can alert people to the importance of their physical health needs. Mental health support workers and carers can encourage people to cut down and stop smoking and become more active. Services themselves, such as stop smoking support, then may need to be adapted to ensure they are relevant and effective for people living with and recovering from mental health problems.

We also need to do more to support people with mental health problems to take care of their physical health, encouraging them to access existing health and dental checks, and to understand the effects of medication and the need for screening and immunisation. We have to ensure people living with mental health problems have the same levels of access to and outcomes from these as the general population.

These changes will not deliver results overnight, but they can make a difference. The more we can do to help people with mental health problems live healthier lives, the more progress we can make in preventing these shockingly early deaths.

### Changing the way we help missing people

It is estimated that four out of every five adults who go missing are experiencing a mental health problem at the time they disappear. This ranges from those who deliberately run away to escape a crisis, or those who go missing from mental health hospitals and care homes, to those who simply get lost out of confusion brought on by dementia.

The consequences can be tragic. Someone who is unwell and who has no support can rapidly come to harm through suicide, neglect or self-harm. They may be fearful, confused and disorientated. Their health may deteriorate rapidly. The sooner they are identified and supported, the better the chances of safeguarding their wellbeing.

We want to ensure that they get the best possible response. That is why we are contributing to the National Crime Agency's Missing Person's Bureau national framework for police, NHS and health care providers which sets out agency responsibilities in protecting adults who go missing and also how to carry out the most effective and successful enquiries. The framework also sets out preventative measures to reduce missing incidents.

We will distribute this framework to care providers and health staff when it has been published early next year.

## 20. More people with mental health problems will live in homes that support recovery

We know that having settled accommodation can be invaluable for people living with a long-term mental health problem. When people live in a place that helps them feel safe and secure, it can support recovery and reduce the likelihood of further episodes of mental illness. It can also help safeguard their physical health. However, there are currently no clearly defined models for what such accommodation should look like.

To help define models, we would like to allocate up to £43 million from the Care and Support Specialised Housing (CASSH) Fund to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities.

Our ambition is to receive bids from potential developers by 2015 and we would hope to see some homes available by 2017. By using some of the Care and Support Specialised Housing Fund to encourage developers to think specifically about homes that can support people who have a mental illness or learning disability to live safely and more independently for longer we can help showcase some good practice for future developments.

In 2014, the Department of Health will host a national forum on mental health and housing. This will be an opportunity to bring together government departments, system partners and stakeholders to explore the barriers and issues in relation to access to suitable housing for people with mental health problems and share good practice. It will also help understand how national policy can best be used to support.

## 21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided

People of all ages with mental health problems come into contact with the criminal justice system in a range of different ways – as victims, witnesses, suspects or offenders – and a bad experience can make them feel unsafe and increasingly vulnerable. This can lead to their condition deteriorating.

Clearly a sensitive and appropriate response is vital – both in terms of managing the immediate situation and enabling the right justice outcome, for the individual and for society.

To help achieve that, we want to ensure that as soon as someone comes into contact with the criminal or youth justice system, their needs are assessed. For some, particularly young men from black and minority ethnic communities, or those involved in gangs, this may be the very first time their mental health problems are identified and assessed. If a mental health issue is identified, appropriate support should be offered from the outset, as well as further down the line – in court, in the aftermath of an incident or during sentencing.

One way we are doing this is to introduce ‘Liaison and Diversion’ services at police interview and custody suites, and at courts. Liaison and Diversion services will also link up to other parts of the justice process, such as prison and probation.

These services mean that as soon as someone is suspected of committing an offence, their needs are assessed quickly by professionals and relevant support is provided – whether in custody, or in a place of safety. Accurate, timely information on the person will be shared with police and the courts so that decisions about charging, sentencing or disposal are based on an authoritative assessment of their mental health, any learning disability and whether they have a substance misuse issue.

This model is being trialled in 20 areas over the next two years, and will be evaluated in depth to see what impact it has. We aim to roll it out quickly across England after that – reaching 50% coverage by 2015/16 and full national coverage thereafter, subject to the full business case.

We are also looking to change the way that people with mental health problems are supported post-sentencing. For example, it may be that where courts have wanted to impose a community sentence with a Mental Health Treatment Requirement, lack of suitable mental health services means that has not been possible, and a different sentence has to be imposed. This is something that needs to be considered within local commissioning, with the aim of ensuring that any Mental Health Treatment Requirement can be met locally. It also requires greater integration between justice services and local commissioners.

## 22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support

People with mental health problems are far more likely to be victims of crime than perpetrators. We want to ensure that when they are victims, they get all possible support to cope in the aftermath – and where necessary to ensure justice is done.

The new Victims' Code, which came into force on 10 December 2013, makes it clear that anyone with a mental health problem should be offered enhanced support at every stage of the criminal justice system. That includes having the right to ask for special measures – such as being able to give testimony by video link rather than in person – to be used in court.

To ensure that people who need this enhanced support get it, the police and the Crown Prosecution Service have a duty under the Victims' Code to assess victims at an early stage, and to refer any victim eligible for enhanced services for pre-trial therapy, if it is deemed necessary.

In addition, to help protect victims of crime from developing mental health problems, every victim is entitled to have their details passed on to services who offer emotional and practical support to help victims to cope with and, as far as is possible, recover from the impacts of the crime. These services can also be accessed by victims who do not report the crime to the police.

From 1 October 2014 the majority of emotional and practical support services for victims of crime will be locally commissioned by Police and Crime Commissioners (PCCs), rather than Central Government. They will be able to join with commissioners for health and social care locally to ensure a shared approach to support provision for victims and witnesses with mental health problems.

## 23. We will support employers to help more people with mental health problems to remain in or move into work

Too often, mental ill health can contribute to people falling out of work. We know that appropriate work is generally good for health and wellbeing, including for people who have mental health problems. Furthermore, returning to suitable work can improve mental health.

Helping more people who have mental health problems to work is a big challenge for health, social care and employment services and for employers themselves and it is therefore vital that services work together to find a solution.

The positive impact that work can have on health and wellbeing is one of the reasons why increasing employment of people with mental health problems is included within the NHS, Social Care and Public Health Outcomes Frameworks. There are two related objectives here: helping those out of work gain employment and, as importantly, helping employed people with mental health problems remain in work.

We want to support employers to promote workplace wellbeing. By helping staff to cope, employers can increase productivity and prevent the build-up of unmanageable stress at work. Supporting employers to promote mentally healthy workplaces has the potential to prevent or reduce sickness absence: mental health problems are now the single largest cause of sickness absence in England. Given the benefits for both the employer and the employee, promoting wellbeing at work is a vital element of our overall prevention strategy.

Many employers are increasingly sensitive to these issues and want to support their staff at challenging times and build the managers' capacity to organise work to enable all staff to contribute and be recognised. We want to support them, so NHS England is working with the Department for Work and Pensions (DWP) to identify best practice for employers – from recruitment and retention to reducing stigma, as well as in areas such as providing effective workplace support.

We also want to improve the information available to employers and individual line managers so that they can better recognise the signs of stress and mental health problems, and encourage them to talk about issues with their staff. This includes with staff who have had mental health problems in the past, as an understanding employer can make a substantial difference to how quickly people can recover. PHE is taking forward a major programme of work supporting employment and mental health for employers and the wider public health system, including work on PHE staff mental health and wellbeing.

From late 2014, the Government is bringing in a new Health and Work service to provide employers with the advice they need to help more people stay in work when health problems arise. The service will provide advice to employers, employees and GPs and offer return to work assessment and support for employees who have been on sickness absence for four weeks back into work.

Websites such as Time to Change and the Public Health Responsibility Deal provide useful information and links to resources for employers and line managers – see www.time-to-change.org.uk/your-organisation/support-employers - and https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl+24.

## 24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work

For those out of work, we are looking at how we can better coordinate mental health and employment support services. The Department of Health and the DWP jointly commissioned researchers at RAND Europe to look into the available evidence about what works and we have recently published *Psychological Wellbeing and Work: Improving Service Provision and Outcomes* which sets out their findings.

The report puts forward a number of recommendations about what effective support requires including:

- Evidence-based models of service delivery that combine addressing employment needs and mental health support;
- More integration between existing treatment and employment services to improve outcomes in both areas;
- New applications of evidence-based models (or a combination of approaches); and
- Timely access to coordinated treatment and employment support for a greater number of people with common mental health problems.

The report also put forward proposals which the Government is now considering developing into pilots. These will focus on improving support for people with common mental health problems and better integration between employment and health services. Potential initiatives could include developing the link between psychological therapies and employment support, enhancing support for those out of work to build resilience, and access to a range of work and wellbeing assessments delivered online, by telephone and face to face. Further work will begin in 2014.

### Psychological Wellbeing and Work: Improving Service Provision and Outcomes - Main Findings

a. The interaction between mental health and employment is complex and unlikely to lend itself to a “one size fits all” solution.

b. Health and employment services are often not joined-up and do not tackle either the mental health problem or the employment need discretely.

c. Service provision is often delayed and problems can worsen as a result.

d. The assessment of employment and health needs is poor and there are low rates of diagnosis or referral to specialist health and employment support.

e. Timely access to psychological therapy varies significantly between areas.

f. Work Programme employment outcomes are disappointing compared with those for other client groups.

g. There is no systematic evidence that better health treatment alone will deliver employment outcomes.

h. Although there is some good evidence for what works to help employees retain work when mental health problems arise, evidence of what works for people in the benefit system is limited.

This work will complement existing programmes designed to help people with severe mental illness gain or maintain employment. These include the Access to Work mental health service which provides additional support to individuals with a mental health condition who are absent from work or finding work difficult, and the Work Choice programme which provides support for people with more intensive needs.

## 25. We will stamp out discrimination around mental health

The stigma associated with mental health problems and the discrimination people experience needs to be continually challenged – and ultimately, removed. This will help millions of people affected by mental health problems to fulfil their potential as active and equal citizens.

This is one of the principles underpinning the Time to Change campaign. Led by mental health charities Mind and Rethink Mental Illness, Time to Change aims to change public attitudes and behaviour towards mental health and people with mental health problems. It is England’s most ambitious programme to end mental health stigma and discrimination and has already reached in excess of 29 million people.

Discrimination on the grounds of mental health is already unlawful, under the Equality Act 2010. Research has shown a 5.5% reduction in average levels of discrimination since 2008. People with mental health problems already experience less discrimination from friends (14%

less than in 2008), family (9% less) and in social life (11% less). There has been a 3.6% positive increase in public attitudes towards people with mental health problems since 2008.

We’ve already made a financial commitment of up to £16 million to the Time to Change campaign, and our funding is being used to support activities such as the Time to Talk Day in February 2014. Now we have set an aspiration of leading by example. We want all Government departments and NHS organisations to sign the Time to Change pledge: many already have.

We are also challenging the media to support our efforts, both through news reporting – broadcast and print – and through the depiction of people with mental health problems in dramas and other programmes. There have already been examples of programmes with a hugely positive impact, but these have often had mental health as a focus. The Time to Change website offers a range of resources and information to journalists and scriptwriters: we want these to be more widely used.

Some of the most important audiences for Time to Change are children and young people - whether they have mental health problems, and are looking for guidance, or are being challenged to change their attitudes and eliminate discrimination. The campaign website has a dedicated section for young people and makes extensive use of social media, blogs and videos to get its messages across to this audience in a relevant way. Events are run in schools and a number of celebrities have supported the campaign.

By changing the attitudes of these generations, we will be better placed to achieve our long-term goal, of the stigma of mental illness being removed and discrimination no longer tolerated. That is why Time to Change is at the heart of so much of our public health work, both in terms of supporting people who have a mental health problem, and in terms of prevention. It is the driver of true long-term change.

# Mental health is everybody's business

Improvements to mental health services are urgently required – and as we have shown, we are committed to delivering those. But to make the most difference to the most people, we need to look beyond mental health services into wider public services; then beyond public services into our society as a whole.

The 25 priority actions set out in this document demonstrate this. Just like the rest of our mental health strategy, many demand joint working within government, to focus services on the individual. But others require the input of partners, charities and representative organisations – as well as employers, families and carers.

We know that these organisations and individuals – including those working in frontline services – share our hunger for change. So we reiterate our call to action:

As we accelerate our work to improve service delivery, across not only mental health services but the entire public sector, and to deliver our overall ambitions, we ask again for the support and involvement of our societies in achieving those goals.

# Further information

No health without mental health: a cross-government mental health outcomes strategy for people of all ages
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

No health without mental health: implementation framework
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Integrated care and support: our shared commitment
https://www.gov.uk/government/publications/integrated-care

Independent commission on mental health and policing report
http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/

At risk, yet dismissed: The criminal victimisation of people with mental health problems
http://www.victimsupport.org.uk/about-us/news/2013/10/risk-crime-people-mental-health

A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs
http://www.hmic.gov.uk/publication/a-criminal-use-of-police-cells/

The Victims' Code
https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

New CQC mental health inspection guidance
(http://www.cqc.org.uk/sites/default/files/media/documents/cqc_afreshstart_mental_health_2013_final.pdf)

Mental health sub-group report of the children's outcomes forum
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf)

Disability and health employment strategy
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

Starting today, the future of mental health services – by the Mental Health Foundation
http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today.pdf?view=Standard

Alone with my thoughts, MindFull
http://www.mindfull.org/static/mf/pdfs/alone_with_my_thoughts.pdf?245411050713

Building resilient communities, Mind and the Mental Health Foundation
http://mentalhealth.org.uk/content/assets/PDF/publications/building-resilient-communities.pdf

Overlooked and forgotten: a review of how well children and young people's mental health is prioritised in the current commissioning landscape
http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

Care Bill fact sheet
https://www.gov.uk/government/publications/the-care-bill-factsheets

Faculty of Public Health - better mental health for all resource
http://www.fph.org.uk/better_mental_health_for_all

Foresight report on mental capital and wellbeing
http://www.bis.gov.uk/assets/BISCore/corporate/MigratedD/ec_group/116-08-FO_b.pdf

Mental health promotion and mental illness prevention: The economic case (LSE)
http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

Mental wellbeing impact assessment checklist
http://www.nmhdu.org.uk/silo/files/mental-wellbeing-checklist-a4.pdf

How healthy behaviour supports children’s wellbeing
https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing

Mental wellbeing impact assessment
http://www.apho.org.uk/resource/item.aspx?RID=95836

ONS measuring wellbeing
http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html

JCPMH guidance for commissioning public mental health services
http://www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/

Wellbeing outcomes star
http://www.outcomesstar.org.uk/well-being-star/

Warwick Edinburgh Mental Wellbeing Scale
http://www.healthscotland.com/documents/1467.aspx

Public Health responsibility deal
https://responsibilitydeal.dh.gov.uk/

Lethal discrimination, Rethink Mental Illness
http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf

Suicide prevention strategy
https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

Faculty of Public Health
http://www.fph.org.uk/further_resources

Crisis care reports
http://www.mind.org.uk/news-campaigns/campaigns/crisis-care/about-the-campaign/?ctaId=/news-campaigns/campaigns/crisis-care/crisis-care-slices/we-need-excellent-crisis-care/

Talking therapies
http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

Public mental health
http://www.mind.org.uk/news-campaigns/campaigns/public-health/

User guides for the mental health strategy implementation framework
http://www.mind.org.uk/about-us/policies-issues/mental-health-strategy/

The mental health challenge for local authorities
www.mentalhealthchallenge.org.uk

Mental health promotion and mental illness prevention: The economic case
http://www.centreformentalhealth.org.uk/publications/mental_health_promotion_economic_case.aspx?ID=630

Doing what works: individual placement and support into employment
http://www.centreformentalhealth.org.uk/publications/doing_what_works.aspx?ID=592

Bridging the gap: The financial case for a reasonable rebalancing of health and care resources
http://www.centreformentalhealth.org.uk/publications/bridging_the_gap.aspx?ID=679

Implementing Recovery through Organisational Change
http://www.centreformentalhealth.org.uk/recovery/publications.aspx

Fulfilling potential: Office for Disability Issues
http://odi.dwp.gov.uk/fulfilling-potential/index.php

Crossing boundaries: improving integrated care for people with mental health problems:
http://www.mentalhealth.org.uk/publications/crossing-boundaries/

Getting on with life: baby boomers, mental health and ageing well:
http://www.mentalhealth.org.uk/publications/getting-on-full-report/

Resilience and results: how to improve the emotional and mental wellbeing of children and young people in your school:
http://www.cypmhc.org.uk/media/common/uploads/Final_pdf.pdf

National Involvement Standards (developed by service users and carers)
http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf

Service users' experiences of recovery under the 2008 care programme approach
http://www.nsun.org.uk/assets/downloadableFiles/service-users-experiences-of--recovery-under-the-2008-care-programme-approach--a-research-study--dorothy-gould-2012.-full-report2.pdf

Dancing to our own tunes
http://www.nsun.org.uk/assets/downloadableFiles/dtoots-report---for-website2.pdf

Values-based commissioning
http://www.nsun.org.uk/assets/downloadableFiles/values-based-commissioning-report--20132.pdf

HM Government

# Mental Health Crisis Care Concordat

## Improving outcomes for people experiencing mental health crisis

18 February 2014

**Title:** **Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis**

**Author:** **Department of Health and Concordat signatories**

**Document Purpose:** **Guidance**

**Publication date:** **February 2014**

**Target audience:** Local Authority CEs, CCG CEs, NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Health and Wellbeing Boards, Directors of Public Health, Medical Directors, Directors of Nursing, Directors of Adults SSs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Youth offending services, Police, NOMS and wider criminal justice system, Royal Colleges

**Contact details:**

Mental Health and Disability
Social Care, Local Government and Care Partnership Directorate,
Room 313 Richmond House, London SW1P 2NS

Published to gov.uk, in PDF format only.

www.gov.uk/dh

## Mental Health Crisis Care Concordat: the joint statement

*"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.*

*We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery.*

*Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England."*

## Signatories to the Concordat

Association of Ambulance Chief Executives
Association of Chief Police Officers
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Police and Crime Commissioners
British Transport Police
Care Quality Commission
College of Emergency Medicine
College of Policing
The College of Social Work
Department of Health
Health Education England
Home Office
Local Government Association
Mind
NHS Confederation
NHS England
Public Health England
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists

The national organisations that are signatories to this Concordat have made a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England.

In addition, a number of third sector and voluntary organisations have agreed to be identified formally as **supporters** of the Concordat.

The list of supporter organisations is available at www.gov.uk

# Contents

# 1. Concordat statement: The vision

This Concordat is about how we, as signatories, can work together to deliver a high quality response when people – of all ages – with mental health problems urgently need help. Mental illness is a challenge for all of us. When a person's mental state leads to a crisis episode, this can be very difficult to manage, for the person in crisis, for family and friends, and for the services that respond. All may have to deal with suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control, or irrational and likely to endanger the person or others.

Every day, people in mental health crisis situations find that our public services are there when they need them – the police officers who respond quickly to protect people and keep them safe; the paramedics who provide initial assessment and care; the mental health nurses and doctors who assess them and arrange for appropriate care; and the Approved Mental Health Professionals, such as social workers, who coordinate assessments and make contact with families.

These services save lives. There is much to be proud of. But we must also recognise that in too many cases people find that the same services do not respond so well. There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises.

Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

This is a very serious issue – in the worst cases people with mental health problems who have reached a crisis point have been injured or have died when responses have been wrong. In other cases, patients have had to travel long distances when acute beds have been unavailable.

There are also particular barriers to achieving better outcomes for people in black and minority ethnic (BME) communities, such as the higher levels of detention under the Mental Health Act 1983 and the higher rates of admission to hospital that people from some BME groups experience. Where a particular group or section of society is reaching crisis point at a disproportionate rate, or accessing mental health services through involvement with the criminal justice system at a high rate, this needs to be identified and addressed by commissioners.

This Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

This Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

We believe this Concordat serves as an important joint statement of intent and common purpose, and of agreement and understanding about the roles and responsibilities of each service. This will help to make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well.

# 2. “When I need urgent help… ”

## What people who use services should expect

**What should I expect if I, or the people who depend on me, need help in a mental health crisis?**

**The following statements were developed by Mind, the mental health charity, with service users, families and carers in a consultation carried out for the Concordat.**

- **Access to support before crisis point**

When I need urgent help to avert a crisis I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.

- **Urgent and emergency access to crisis care**

If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

- **Quality of treatment and care when in crisis**

I am treated with respect and care at all times.

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate or support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

- **Recovery and staying well / preventing future crises**

I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if I experience a crisis in the future and there is an agreed strategy for how this will be carried out.

I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.

# 3. Aim, purpose and scope

## Aim and purpose

This Concordat is a joint statement, written and agreed by its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs.

It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. All the bodies and organisations that have signed up to the Concordat agree that improvements need to be made and sustained.

The Concordat has also been informed by engagement with people who have needed these services in the past and who were willing to share their experiences. This engagement has been led by voluntary organisations, principally Mind and Black Mental Health UK. With these contributions, the Concordat outlines an approach to improving services that reflects what people say they need - whether they are existing service users, carers, or other people seeking access to help, care or treatment.

The Concordat also contains an action plan. This brings together the initial commitments made by the signatories to undertake work that supports the Concordat and helps to bring about its success. Much of this work is already underway. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

## Making it happen – local Mental Health Crisis Declarations.

The Concordat has been agreed by a partnership of national organisations and representative bodies. But real change can only be delivered locally. The most important ambition of the Concordat is that localities all over England adopt its principles.

The signatories of the Concordat therefore expect that local partnerships between the NHS, local authorities, and criminal justice system work to embed these principles into service planning and delivery.

Just as the Concordat establishes a national agreement of principles, the ambition is for every local area to commit to agreeing and delivering their own Mental Health Crisis Declaration. This should include:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat – establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality
- Development of a shared action plan and a commitment to review, monitor and track improvements
- A commitment to reduce the use of police stations as places of safety, by setting

an ambition for a fast-track assessment process for individuals whenever a police cell is used; and

- Evidence of sound local governance arrangements

The Department of Health and the Home Office, with the Concordat signatories and other partners, are planning practical ways to support and promote the development of these local agreements.

## Scope and context

This Concordat focuses on people who experience acute mental health crisis. It spans the health, social care and criminal justice systems, but is also relevant to other partners such as housing providers.

It defines the service responses expected for people of all ages suffering mental health crises. It takes into account the factors that can lead to a crisis, such as physical, psychological, spiritual, educational or social problems.

Although the Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention.

Where the Concordat uses the term ‘criminal justice system’, this includes the youth justice system.

The Concordat builds on and does not replace existing guidance. Current service provision should continue while the improvements envisaged in this document are put in place.

## The role of the NHS – parity of esteem

The Government has put mental health at the centre of its programme of health reform. It has therefore included a specific objective for the NHS, in the Mandate from the Government to NHS England[1], to “put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole”.

The Mandate for 2014-15 also establishes specific objectives for the NHS to improve mental health crisis. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services.
- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.
- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat

NHS England is responsible for deciding the best way to achieve these ambitions, and the others contained in the Mandate. This Concordat supports this work by setting out ways that local health commissioners, working with their partners, can make sure that people experiencing a mental health crisis get as responsive an emergency service as people needing urgent and emergency care for physical health conditions.

---

[1] Department of Health. The Mandate; a mandate from the Government to NHS England: April 2014 to March 2015. Department of Health, November 2013.
https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

We recognise that there is relatively limited information available to assess current service provision. NHS England will work with partners to carry out a robust gap analysis of current demand for these services against available service provision. The availability of psychiatric beds will form part of this analysis. This information will be used to support clinical commissioning groups to understand their baseline position, as they develop plans based on local needs and circumstances to move toward the Concordat's vision, and deliver this part of the Government's mandate to the commissioning system. NHS area teams will assure these plans, and are expected to pay particular attention to parity of esteem between mental and physical heath, including that sufficient crisis services are being planned by CCGs.

The immediate commitments made by NHS England are contained in the Action Plan of this Concordat.

NHS England is also currently carrying out a full review of urgent and emergency care services. The review recognises that the NHS urgent and emergency care system must be responsive to the needs of the most vulnerable people in society who rely on it, and this includes people suffering mental health crises.

## Public Health England

In 2012, the Government published the mental health strategy *No health without mental health*[2]. The strategy's implementation framework[3] includes a commitment for Public Health England to work to reduce mental health problems by promoting improvements in mental health and wellbeing. The work led by Public Health England will seek to develop the resilience of the population throughout people's lives by addressing the individual, community and societal factors that can lead to a crisis, such as environmental, psychological, emotional or social problems. This is because what will help to reduce mental health crises in the future will be making sure people have good housing, decent income and good health. Local government now has a statutory responsibility for improving the health of their populations, and Public Health England will support them in this endeavour.

## The case for change

There is growing evidence[4] [5] that it makes sense, both for the health of the population and in terms of economics, to intervene early when people may have an issue with their mental health, in order to reduce the chances of them going on to develop more serious and enduring mental health problems which are worse for the individual and harder and more expensive for the NHS to treat.

---

[2] Department of Health. No health without mental health; a cross-government mental health outcomes strategy for people of all ages. Department of Health, February 2011. https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[3] Department of Health. No health without mental health; implementation framework. Department of Health, July 2012. https://www.gov.uk/government/publications/mental-health-implementation-framework

[4] NHS Confederation, Mental Health Network. Early intervention in psychosis services. Briefing 219. NHS Confederation, May 2011 http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf

[5] Knapp, Martin, McDaid, David and Parsonage, Michael. Mental health promotion and mental illness prevention: the economic case. Department of Health, 2011 http://eprints.lse.ac.uk/32311/

An independent inquiry by Mind[6] found that access to crisis care services varies widely across the country – in the types of crisis care available, in staffing levels, and in the range of options available for those who need a safe place to go that is not a hospital. It found that in some areas the lack of community-based options, including those that support the discharge of people who have finished their hospital treatment, meant that beds were not always available for those who needed them urgently. This had meant that some patients in need of urgent care were sent to hospitals many miles from their family and community. In particular, the inquiry found there was insufficient 24 hour mental health care provision in some areas, and criticised what it identified as a decreasing number of inpatient psychiatric beds.

Primary care teams and Emergency Departments experience wide variations across England in access to specialist mental health services.

A Criminal Use of Police Cells, the joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons and the Care Quality Commission[7], highlighted the issue of people in crisis being detained by police officers and taken to police stations, sometimes because mental health crisis services are unable to respond, often because of a lack of capacity in the system. Although the numbers reduced in 2012/13[8], it still happens far too often.

The Independent Commission on Mental Health and Policing[9] made recommendations to the Metropolitan Police and forces nationally on how to prevent serious injury and deaths when officers respond to incidents involving people with mental health conditions. It concluded that mental health was part of the core business for the police, who should be trained to be aware of the vulnerabilities people may have, because mental health issues are common in the population. The report was clear that the support of other agencies is essential because the police "cannot and indeed are not expected to deal with vulnerable groups on their own".

Other identified issues include a lack of clarity about which service should do what and when, and the continued high levels of detention of people from BME communities, and their over-representation on inpatient wards[10].

This Concordat addresses these issues, by bringing together the national leadership of those services that need to work together effectively to respond to people in mental health crisis in a coordinated and timely way.

---

[6] Mind. Listening to experience: an independent inquiry into acute and crisis mental healthcare. Mind. 2011. http://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

[7] Her Majesty's Inspectorate of Constabulary, Care Quality Commission, Her Majesty's Inspectorate of Prisons, and Healthcare Inspectorate Wales. A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs. HMIC, CQC, HMIP, HIW June,2013 http://www.hmic.gov.uk/media/a-criminal-use-of-police-cells-20130620.pdf

[8] Information Centre for Health and Social Care. Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment, Annual figures, England, 2012/13. October 2013 http://www.hscic.gov.uk/catalogue/PUB12503

[9] Independent Commission on Mental Health and Policing report. May 2013. http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/

[10] Information Centre for Health and Social Care. Mental Health Bulletin: Annual report from MHMDS returns – England, 2011-12, further analysis and organisation-level data. February 2013 http://www.hscic.gov.uk/catalogue/PUB10347

# 4. Effective commissioning

Developing an effective local system that anticipates, and where possible prevents, crisis, and which ensures timely and supportive crisis care, is first and foremost a commissioning responsibility. It is at heart a leadership challenge for commissioners. Commissioners should have as their standard that they commission crisis care services that they would be content for their family or friends to use if they needed it. Local commissioners have a clear responsibility to put sufficient services in place to make sure there is 24/7 provision sufficient to meet local need.

Excellence in commissioning requires a mature multi-agency approach. Health and wellbeing boards will support this by bringing together health and social care commissioners, the local community and wider partners. Through the board, these partners will work together to develop a joint understanding of the local population's health and wellbeing needs and a shared strategy for meeting them. Central to this is the Joint Strategic Needs Assessment (JSNA) process, and the development of a Joint Health and Wellbeing Strategy (JHWS) to set out a shared set of priorities to address the identified need.

JSNAs and JHWSs together therefore provide a framework for developing the shared local understanding that each locality needs to have of the current and future health and care needs, and the partnership working to deliver it. This should include people experiencing mental health crisis.

Depending on local circumstances and the evidence in JSNAs, health and wellbeing boards might choose to review:

- Whether there are effective care pathways from police custody suites and courts to make sure individuals with co-existing mental health and drug and alcohol issues can effectively access appropriate substance misuse services.

- Whether sufficient resources are available within the crisis care pathway to ensure patient safety, enable service user and patient choice and to make sure individuals can be treated as close to home wherever possible. This could also consider the transient population that may create an otherwise hidden demand in particular areas. This might include homeless people and those vulnerable people who come to notice on the rail transport network.

- The needs of children and young people with mental health conditions, such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses.

Local health and social care commissioners will also be expected to develop their own commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans which are not consistent with these.

Clinical commissioning groups are required, under the Crime and Disorder Act 1998[11], to work in partnership with the police and other local responsible authorities in Community Safety Partnerships. These partnerships make strategic assessments of crime and disorder, anti-social behaviour, and drug and alcohol misuse and develop local strategies to deal with these issues.

Excellence in commissioning also requires a clear understanding of effective service responses as described and evidenced by the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE), with a focus on recovery which is demonstrated by measuring outcomes and clearly shown in service specifications. This will ensure that service providers collect, analyse and act on a range of agreed outcomes, including patient and carer experience and satisfaction data. Commissioners will want to ensure that they have effective local safeguarding arrangements in place to prevent or reduce the risk of significant harm to people whose circumstances make them vulnerable.

Addressing these questions will enable local commissioners to realise the ambitions set out in this Concordat.

Effective commissioning ensures that the support and services reflect:

- The needs of people of all ages and all ethnic backgrounds, reflecting the diversity of local communities
- An equal relationship between physical and mental health
- The contribution of primary, community and hospital care, as well as other partners
- The inclusion of seldom-heard groups, or those that need improved early intervention and prevention.

This can be achieved through service user and carer involvement in all elements of the commissioning cycle, strategic direction, and monitoring of crisis care standards.

The next section sets out the elements of an effective system which will support local areas to plan the changes needed to strengthen and improve responses in order to best address local circumstances. It is not the role of the Concordat to set out exactly how this will be translated at the local level. There can be no single national blueprint, as local circumstances will differ.

What we can do at national level is support, inform and equip the commissioning arrangements locally. We have set out a number of interventions for strengthening the commissioning system for mental health services, including crisis care. This includes:

– The establishment of the Mental Health Information Network in 2014 to ensure that commissioners have the best possible information about the state of mental health and wellbeing in every area. This will help them make good decisions about what works in making real improvements in local services, including advice about the level and types of services needed

– Working with the Association of Directors of Adult Social Services (ADASS), the Association of Directors of Children's Services (ADCS), and the Chief Social Worker to strengthen the social care contribution to commissioning

– Support from NHS England to improve specialist leadership skills among CCGs

---

[11] Crime and Disorder Act 1998. The Stationery Office.
http://www.legislation.gov.uk/ukpga/1998/37/contents

- Working with those areas which have been selected to be pioneers in the integration of health care services for mental health to demonstrate best practice and evaluate models of care.

In the NHS, mental health crisis care spans local commissioning led by CCGs, and primary care and specialised commissioning – led by NHS England.

NHS England, as part of its Parity of Esteem programme, will be producing a range of tools and resources to support effective commissioning of mental health services, including crisis services.

There are important roles, both for local Healthwatch organisations and local Overview and Scrutiny Committees, to hold local commissioners to account for performance in respect of crisis care services.

It is clearly important that commissioners have the opportunity to exchange experiences and practice. NHS England will facilitate this through their Commissioning Assembly and other groups.

The National Quality Board's recent guide to nursing, midwifery and care staffing capacity and capability[12] states that appropriate levels of staffing need to be sustained 24 hours a day, 7 days a week, to maintain patient care and protect patient safety. The guide is for providers and commissioners of mental health services, NHS acute services, maternity, learning disabilities and community services.

In addition, NICE announced in November 2013[13] that it will produce definitive guidance on safe and efficient staffing levels in a range of NHS settings, including mental health inpatient and community units.

Agencies, such as police and local government also have a key role. Close partnership between all the local commissioners and the NHS England area teams is needed to translate the models of urgent and emergency care developed by NHS England into local solutions that work for the demographic needs of their areas. In doing this, they will need to draw in contributions from other disciplines, such as housing and wider criminal justice.

Local commissioners also need to make sure primary care practitioners are fully involved in developing local plans, working in partnership with NHS England's area teams to secure this involvement. Partnership working is best supported by services working within catchment areas which are as co-terminus as possible, for example within the same area covered by local Emergency Departments and ambulance services.

---

[12] National Quality Board. How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013. http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[13] National Institute for Health and Care Excellence. NICE to produce guidance on safe NHS staffing levels. NICE. November 2013. Press release. http://www.nice.org.uk/newsroom/news/NICEToProduceGuidanceSafeNHSStaffingLevels.jsp

## Case Study

### A new vision for Urgent Mental Health Care in North West London

*Shaping Healthier Lives* is North West London's mental health transformation strategy, 2012-15. It involves collaborative work between eight clinical commissioning croups and two mental health trusts.

The aim is to improve the experience of, and outcomes from, mental health urgent assessment and care. It provides the framework for improving mental health services across North West London, including increasing the management of the health and wellbeing of people with mental health problems in primary care. There is a need for rapid access to assessment and care for those in crisis, to be provided when and where the service user most needs it.

Initial approaches to improve crisis assessment and care include:

- Roll out and embedding of a common access and care standards policy
- A review of the local skills mix, competency and training needs of staff
- Progress to align mental health services to those in primary care- covering the period 8am – 8pm as a minimum. Extension of home visiting for crisis resolution work, providing 24/7 cover every day of the year
- Simplification of the 'way in', with a single telephone number, available 24/7 every day of the year.

**Glen Monks**
**NWL Mental Health Programme Lead**

# 5. Core principles and outcomes

This section sets out the principles and statutory requirements that all services involved in responding to mental health crises should follow.

It also describes improvements in services that can benefit people who depend on this support.

People seeking urgent help with mental health conditions, and friends and family close to them, will approach a range of different services – including their GP, helplines or voluntary sector groups, Emergency Departments, social services, schools, colleges, mental health trusts, and the police.

The complexity of crises may mean that individuals need support for several aspects of their crisis. This means having their mental health issues understood within the context of their family, cultural or community setting and other urgent needs, such as self-harm, alcohol or drug misuse, or pregnancy.

For there to be an effective emergency mental health response system, there should be detailed coordination arrangements in place between all the agencies regularly contacted by people in mental distress. People should be able to expect a whole system response.

People needing help should be treated with respect, compassion and dignity by the professionals they turn to.

## A. Access to support before crisis point

### A1 Early intervention – protecting people whose circumstances make them vulnerable

Mental health services need to intervene early to prevent distress from escalating into crisis. People with mental health problems, or their families or carers, are often aware that they are approaching crisis and may know what they need to do to avert it. They need to know who to contact in these circumstances. Services, in turn, need to trust the judgement of these 'experts by experience' and respond swiftly.

Early interventions can include:

- The development of a single point of access to a multi-disciplinary mental health team. These teams include staff from different professions, such as social workers and psychiatrists, and have been shown[14] to simplify and improve access. This access point should be available to agencies across the statutory and voluntary sectors

---

[14] West M, Alimo-Metcalfe B, Dawson J, El Ansari W, Glasby J, Hardy G et al. Effectiveness of multi professional team working in mental health care. Final report. NIRH Service Delivery and Organisation Programme. 2012. http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-215_V01.pdf

- A joined-up response from services, for people of all ages who find themselves in crisis, with strong links between agencies, for example social care teams and substance misuse services
- Help at home services, including early intervention or crisis resolution/home treatment services
- Respite away from home or a short stay in hospital as a voluntary patient
- Peer support, including access to crisis houses or other safe places where people can receive attention and help
- Access to liaison and diversion services for people with mental health problems who have been arrested for a criminal offence, and are in police custody or going through court proceedings.

Each local area will need to decide the combination of services that best serves the particular needs of their population.

Care planning, including joint crisis care planning, for people with mental health problems is a crucial element of the preventative approach to crisis management.

Primary care, working in effective multidisciplinary teams and in partnership with a range of organisations, has an important role in supporting people experiencing mental distress or crisis.

Early intervention should be appropriate for people from vulnerable groups, including BME communities, people with learning difficulties, people with physical health conditions, people with dementia and children and young people, so they can find and stay engaged with services which keep them safe, improve their mental health and prevent further crises. People from these vulnerable groups are also at a high risk of going missing, with an estimated four out of five adults who go missing experiencing a mental health problem at the time they disappear.[15]

Early intervention work can include suicide prevention. The Mandate from the Government to the NHS states that, "It is… important for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population, such as people in the care of mental health services and criminal justice services".

## B. Urgent and emergency access to crisis care

### B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

The NHS Mandate for 2014-15 contains an objective for the NHS to make sure that every community develops plans, based on the principles set out in this Concordat, that mean no one in crisis will be turned away.

People in mental distress should be kept safe. They should be able to find the support they need – whatever the circumstances in which they first need help, and from whoever they turn to first. As part of this, local mental health services need to be available 24 hours a day, 7 days a week.

The Concordat signatories believe responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.

---

[15] Missing children and adults: A cross government strategy. Home Office, 2001. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117793/missing-persons-strategy.pdf

## B2. Equal access

Commissioners and providers should be aware that the Equality Act 2010[16] applies to mental health services, and requires that people should have equal, appropriate access. The Health and Social Care Act 2012 also introduced new legal duties regarding health inequalities for NHS England, stating that inequality of access to services and inequality of outcomes from them must both be reduced.

Equality is a key policy objective within England's cross government strategy for mental health, *No health without mental health*.

For some people from BME communities in particular, there is evidence that poor previous experience of services leads to a reluctance to have further engagement. There is also evidence that a lack of access contributes to situations where a crisis has to be reached, often involving contact with the police or child protection services, before a person seeks or receives support.

This Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities[17]. It recommends that commissioners:

- Consult and engage with BME groups early on when commissioning services – this may include the voluntary agencies that represent and support service users from BME communities
- Make sure staff are delivering person-centred care that takes cultural differences and needs into account
- Commission a range of care options that meet a diverse range of needs
- Empower people from BME groups by providing appropriate information, access to advocacy services, and ensure that they are engaged in and have control over their care and treatment.

## B3 Access and new models of working for children and young people

Children and young people with mental health problems, including children in care, care leavers, and those leaving custody in the youth justice system, should feel supported and protected at all times as they are especially vulnerable. In particular, this group should have access to mental health crisis care.

For those cases where children and young people need to be admitted to hospital for mental health treatment, the Mental Health Act 2007[18] introduced new provisions, that took effect in April 2010, to help ensure that patients under the age of 18 are accommodated in an environment that is suitable for their age – that is, not on an adult ward, unless their particular needs made it absolutely necessary.

For young people in the 16 to 18 years age group, who are making transitions between services and need continuity of care, there is a risk of additional distress when they first come into contact with adult services. Adult systems and processes may not offer the level of support and care that adolescents are used to. It is important that all staff who

---

[16] Equality Act 2010. The Stationery Office. http://www.legislation.gov.uk/ukpga/2010/15/contents

[17] Mind. Mental health crisis care: commissioning excellence for Black and minority ethnic groups: a briefing for Clinical Commissioning Groups. Mind. 2013 http://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf

[18] Mental Health Act 2007. The Stationery Office http://www.legislation.gov.uk/ukpga/2007/12/contents

work to support these young people should have the appropriate skills, experience and resources to support them effectively.

Parents who have been very closely involved in the care and support of their child can also face difficulties once their child is considered to be an adult. Parents can find themselves excluded from information relating to the young person's care unless there is consent. The need for early intervention and clarity about the role of parents in the young person's care plan is critical. Staff should be willing to take the views of parents into account, as well as those of other people who are close to the young person.

To help facilitate access, there needs to be robust partnership working and communication between organisations that offer primary care to children and young people and specialist secondary care services. The focus on the interface between specialist children and adolescent mental health services (CAMHS) and primary care therefore needs to remain a central policy issue in CAMHS planning.

Other partners, such as schools and youth services, should also be fully involved in developing crisis strategies for children and young people as they may well be the first to identify the problems that a young person is facing. The best interests of the child or young person should always be a significant consideration when services respond to their needs. Children and young people should be kept informed about their care and treatment, in the same ways that adults are.

### B4 All staff should have the right skills and training to respond to mental health crises appropriately

Staff whose role requires increased mental health awareness should improve their response to people in mental health distress through training and clear line management advice and support.

Because individuals experiencing a mental health crisis often present with co-existing drug and alcohol problems, it is important that all staff are sufficiently aware of local mental health and substance misuse services and know how to engage these services appropriately.

Local shared training policies and approaches should describe and identify who needs to do what and how local systems fit together. Local agencies should all understand each other's roles in responding to mental health crises.

Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities.

### B5 People in crisis should expect an appropriate response and support when they need it

People in mental health crisis who need help, need to receive it promptly.

NICE quality standards are designed to help service providers quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide. They also help commissioners assess whether the services they are purchasing are high quality and cost effective and focussed on driving up quality.

Service commissioners and providers should work towards NICE quality standard QS14, Quality standard for service user experience in adult mental health, Quality Statement 6, Access to services[19].

This quality standard recommends people in crisis referred to mental health secondary care services are assessed face to face within 4 hours in a community location that best suits them; service users and GPs have access to a local 24-hour helpline staffed by mental health and social care professionals; and crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.

In addition:

- Hospital, step-down and community services should be commissioned at a level that allows for beds to be readily and locally available in response to a person in urgent need, as required by statute[20].
- Accommodation and facilities, including community based solutions, designed to be suitable for patients younger than 18 years must be commissioned at a level that ensures local provision in response to a young person in urgent need.
- If people are already known to mental health services, their crisis plan and any advance statements should be available and followed where possible. Considerations regarding data sharing are covered in **section B8**.

### B6 People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the police must be supported by health services, including mental health services, ambulance services, and Emergency Departments.

The police have a power, under section 136 of the Mental Health Act,[21] to remove from a public place any person an officer believes is suffering from mental disorder and who may cause harm to themselves or another and take them to a designated place of safety for assessment under the Act.

NHS commissioners are required by the Mental Health Act to commission health based places of safety for this purpose. These should be provided at a level that allows for around the clock availability, and that meets the needs of the local population. Arrangements should be in place to handle multiple cases.

Police officers should not have to consider using police custody as an alternative just because there is a lack of local mental health provision, or unavailability at certain times of the day or night. To support this aim, it is essential that NHS places of safety are available and equipped to meet the demand in their area. The signatories of the Concordat will work together to achieve a significant reduction in the inappropriate use of police custody suites as places of safety.

Police officers responding to people in mental health crisis should expect a response from health and social care services within locally agreed timescales, so that individuals receive the care they need at the earliest opportunity.

---

[19] National Institute for Health and Care Excellence. Quality standard for service user experience in adult mental health: Quality statement 6, access to services. NICE. December 2011. http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-health-qs14/quality-statement-6-access-to-services

[20] Mental Health Act 1983, s. 140. The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

[21] Mental Health Act 1983, s. 136. The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

## Street triage pilots

The Department of Health is funding pilot schemes, managed by nine police forces, in partnership with local NHS organisations. Some other forces already have schemes in operation, including Leicestershire Police, as described in the case study below. In these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health problems. This advice can include an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim is, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of section 136. An evaluation is planned for 2014.

## Case Study

### British Transport Police and NHS London – Operation Partner

In February 2013 British Transport Police (BTP) and NHS London launched a pilot scheme bringing together Psychiatric Nurses to work alongside Public Protection officers and staff. Their remit was to apply a multi-agency approach to the vulnerable people who come to the BTP's notice on the railway network, often in suicidal circumstances. The overall aim is to provide a managed, risk based approach that effectively moves people from crisis to care.

This is achieved through a joint assessment of all cases over the preceding 24 hours and the formulation of a joint plan to reducing the risk of harm and to engage relevant care pathways. The NHS staff have access to health information systems and provide a telephone service to officers on the ground, giving information and advice so that more informed decisions can be made in the best interests of the individual concerned. At the time of writing, 689 cases have been jointly reviewed.

**Mark Smith**
**British Transport Police**

Police officers may find it helpful to follow the guidance on responding to people with mental ill health or learning disabilities[22]. Police officers should undertake appropriate training, to enable them to recognise risk and vulnerability and identify the need for health care. This training will support the police to decide whether individuals should be detained under section 136, or whether they can be helped in some other way. Training should also cover the roles and responsibilities of partner agencies.

As part of local Mental Health Crisis Declarations, local areas will each be expected to make a commitment to improve performance in this area – by reducing the number of such uses, and by setting

---

[22] Guidance on responding to people with mental ill health or learning disabilities. Association of Chief Police Officers, National Policing Improvement Agency, 2010.

an ambition for a fast-track process that either provides an assessment or arranges transfer to a health based place of safety for individuals whenever a police cell is used.

Commissioners and providers should make sure there is accurate and detailed data showing why and how often police cells are used as places of safety. Local partners should also review each individual case where a police cell has been used, to make sure the use was appropriate and to see whether there are lessons to be learned for the future.

The Department of Health will monitor the national figures on the use of section 136 and expects to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15.

### Local protocols

Every area should have a local protocol[23] in place, agreed by NHS commissioners, the police force, the ambulance service, and social services. This should describe the approach to be taken when a police officer uses powers under the Mental Health Act.

These local protocols should ensure that:

- When the police make contact with health services because they have identified a person in need of emergency mental health assessment, mental health professionals take responsibility for arranging that assessment.
- Individuals in mental health crisis are taken to a health based place of safety rather than a police station. The Mental Health Act Code of Practice states that “a police station should be used as a place of safety only on an exceptional basis”. Local protocols should set out an agreement about what constitutes a truly exceptional basis, for example seriously disturbed or aggressive behaviour. Local Mental Health Crisis Declarations should include local ambitions to reduce the use of police cells as places of safety.
- Particular reference is made to the needs of children and young people. Unless there are specific arrangements in place with Children and Adolescent Mental Health Services, a local place of safety should be used, and the fact of any such unit being attached to an adult ward should not preclude its use for this purpose, Protocols should help to ensure that police custody is never used as a place of safety for this group, except in very exceptional circumstances where a police officer makes the decision that the immediate safety of a child or young person requires it. Even in cases where police stations are used, the use of cells should be avoided, and alternatives considered wherever possible
- NHS staff, including ambulance staff, should take responsibility for the person as soon as possible, thereby allowing the officer to leave, so long as the situation is agreed to be safe for the patient and healthcare staff. There should not be an expectation that the police will remain until the assessment is completed
- Assessments under the Act are made in good time (see section B7).
- Partner organisations are clear about respective roles and responsibilities in order that responses to people in crisis are

---

[23] Department of Health. Code of Practice: Mental Health Act 1983. Chapter 10. The Stationery Office. 2008 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf

risk based, personalised, proportionate and safe, and that a guiding principle is to choose the least restrictive option, for example not choosing to detain someone when there is a viable alternative option.

- Arrangements are in place for escalation to more senior staff in case of disagreement.

### B7 When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised, and carried out with respect

Commissioners and providers should ensure that people who are in distress owing to their mental health condition, and who are in need of formal assessment under the Mental Health Act, receive a prompt response from section 12 approved doctors and Approved

## Case Study

### THE STREET TRIAGE CAR IN LEICESTERSHIRE

“Our street triage car has reduced the section 136 detention rate by 33% on the level prior to the introduction of the car” – Leicestershire Constabulary.

Since January 2013, Leicestershire Police and Leicestershire Partnership Trust (LPT) have jointly operated a mental health triage car, which is driven by a police officer and contains a mental health nurse from the crisis service operated by LPT.

It aims to improve the service provided to the people who police encounter who may be experiencing difficulties with their mental health or learning disability; responding at the earliest opportunity and then directing people to the most appropriate service available. The car provides an initial point of contact for police officers on the beat who encounter incidents which have a mental health element, before exercising their police powers.

The mental health nurse provides the training, experience and legal powers of a registered nurse, can conduct a mental health assessment, has mobile access to mental health services and information systems, and has experience of working practices and procedures in the NHS and in particular mental health services.

The police officer provides the training, experience and legal powers of a constable. These include powers under criminal law, the Mental Health Act and the Mental Capacity Act, has mobile access to criminal justice information systems, experience of working practices and procedures within the criminal justice system. The officer has been trained in public order and methods for gaining entry to locked or barricaded premises, and is qualified to higher driving standards, enabling emergency response if required.

The approach in Leicestershire appears to have led to a reduction in section 136 detentions of 33% of the level prior to the introduction of the car. The average time to help people when they are detained is now five hours and the car deals with 120 cases per month.

**Peter Jackson**
**Leicestershire Police**

Mental Health Professionals (AMHPs) so that arrangements for their care, support and treatment are put in place in a timely way.

Timescales should reflect the best practice set out in the Royal College of Psychiatrists guidance on commissioning services for section 136[24], which states that the Approved Mental Health Professional and doctor approved under section 12(2) of the Mental Health Act[25] should attend within three hours in all cases where there are no clinical grounds to delay assessment.

In the case of children and young people, the assessment should be made by a child and adolescent mental health services (CAMHS) consultant, or an AMHP with knowledge of the needs of this age group.

There should be no circumstances under which mental health professionals will not carry out assessments because beds are unavailable. Section 140 of the Mental Health Act states: Local health commissioners must keep those local authorities whose areas overlap informed of the hospital or hospitals where arrangements are in force to allow the reception of patients in cases of special urgency, so that AMHPs know where beds are available. Similarly, provision of dedicated AMHPs should be sufficient to meet needs, especially in out of hours periods.

When deciding upon any course of action, all professional staff should act in accordance with the Mental Health Act's principle of least restriction and to ensure that the services impose the least restriction on the person's liberty. This includes avoiding the stigmatising appearance that a mental health crisis is a crime, for example, police forces should consider using unmarked cars to travel to a property to enforce a warrant under section135 of the Act.

### B8 People in crisis should expect that statutory services share essential 'need to know' information about their needs

All agencies, including police or ambulance staff, have a duty to share essential 'need to know' information for the good of the patient, so the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks to the distressed person or to others[26]. This may include:

- The name, address/contact details of the person (or a description if these cannot be ascertained)
- Details of any relative(s)/friend(s) or carer who can be contacted and, for children, family and school details
- Gender/age
- Language spoken (if not English) and any communication needs e.g. sign language
- Description of current behaviour/ presentation
- Whether likely to be affected by drink or drugs
- Physical impairments and any prescribed medicines or dietary requirements
- Whether the person is already engaged with his/her GP and/or mental health

---

[24] Royal College of Psychiatrists. Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983, Position Statement PS2/2013. April 2013 http://www.rcpsych.ac.uk/pdf/PS02_2013.pdf

[25] Mental Health Act 1983, s. 12(2). The Stationery Office http://www.legislation.gov.uk/ukpga/1983/20/contents

[26] Department of Health. Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, Department of Health. 2009

## Case Study

### THE DEDICATED 136 NUMBER IN LINCOLNSHIRE

"Our central number for police has helped reduce the waiting time for people in crisis who need urgent health interventions"
– Lincolnshire Partnership Foundation Trust.

In March 2012 the section 136 working group for Lincolnshire , made up of police, Lincolnshire Partnership Foundation Trust (LPFT), the ambulance service, Approved Mental Health Professionals (AMHPs) and the Local Authority, created a joint mental health process which fully outlined operational protocols and responsibilities. Essential to this protocol was the use of a central 136 number for the police to use to enable them to access information and support from mental health professionals.

The 136 number connects officers to the mental health duty nurse at the Lincolnshire place of safety. The police expect an immediate response and advice on incidents involving an individual having a mental health crisis. The nurse is able to offer a rapid referral to healthcare services. This supports the police and ambulance services to engage with the individual in crisis with greater understanding and confidence. Section 136 is only used when necessary, because appropriate alternatives are fully considered.

The point of contact becomes the section 136 suite duty nurse once this number has been dialled and a clear data sharing process comes into play. The information is shared allowing for quicker decisions about what happens next.

**Mary Quint**
**The Lincolnshire Partnership Foundation Trust**

services and the name of the team and any involved professional

- Whether they have a mental health crisis plan or other advance statements
- Any clinical information e.g. prescribed medication, psychological therapy
- Any presenting risk factors (for example, self-harm, suicide, physical aggression, confusion, impaired judgement, self-neglect, missing from home)
- Any relevant health information – such as the person being diabetic
- Children, dependents, pets or other factors to take into account when planning the most appropriate response

Information on patients should, through appropriate sharing protocols, follow them through the system and make sure that people known to services get the treatment they need quickly, and where applicable, the services are aware of their crisis plan and any advanced statements – no matter at what point they re-enter the mental health system.

Within the requirements of the data protection legislation, a common sense and joint working approach should guide individual professional judgements. If the same person presents to police, ambulance or Emergency Departments repeatedly, all agencies should have an interest in seeking to understand why this is happening, and how to support that person appropriately to secure the best outcome. This may include identifying whether the individual is already in treatment

## Case Study

### INFORMATION SHARING AND POLICE TRAINING ON VULNERABLE PEOPLE IN LONDON

"Since the Metropolitan Police Service (MPS) introduced the recording of vulnerable adult information in April 2013, there have been in excess of 20,000 reports, which show that there has been an unmet demand for a mechanism to record information on vulnerable adults" – Metropolitan Police Detective Inspector, Mental Health Team.

The MPS has been working with a range of partners to adopt a fresh approach to the way in which information is collected and shared with partners to support better outcomes for all vulnerable adults, including individuals with mental ill health. The MPS wants to reduce the incidents of crisis interventions by police and mental health services, which arise in a complex city that tends to draw vulnerable people in from across the country.

Through delivering training and guidance to all newly trained police recruits, and all front line officers and staff, the MPS is working to change the way in which vulnerable people are identified and how that information is then shared. Concerns raised as a result can then be shared with partners, through processes such as the multi-agency safeguarding hub process, with public protection units and the community multi agency risk assessment conferences (which share information to increase the safety, health and wellbeing of all, for possible further assessment or support to be offered).

All front line officers will be trained by April 2014.

Find out more about the approach being developed by the MPS from
[redacted]

Find out more about the psychiatric public emergency assessment tool originally developed in the University of Central Lancashire by **Ivan McGlen,**
[redacted]

and/or is known to services, their GP or other community-based mental health services.

### B9 People in crisis who need to be supported in a health based place of safety will not be excluded

Irrespective of other factors, such as intoxication, or a previous history of offending or violence, individuals suffering a mental health crisis and urgently needing to be detained while waiting for a mental health assessment should expect to be supported in a health based place of safety.

When a decision is made by a police officer to use their power under section 136, it is essential that the person in crisis is screened by a healthcare professional as soon as possible. In the majority of cases it will be the ambulance service that will screen the person to exclude medical causes or complicating factors and advise on the local healthcare setting to which the person should be taken.

Intoxicated people, of whatever degree, where their mental state is in question, must have an adequate mental and physical clinical assessment to determine and manage the cause of their problem. People presenting with behaviour leading to use of section 136 but complicated by alcohol ingestion are best managed in a healthcare setting – either the locally designated place of safety or, if the level of intoxication appears to pose a medical risk, the Emergency Department. Either facility requires staff skilled to make mental health and physical health assessments, diagnosis and continued clinical monitoring, with access to investigation including scans.

When dealing with a person who is intoxicated, the paramount consideration should be to ensure their safety and the safety of others. No presumption should be made in regard to the cause of apparent intoxication until the person is in a safe environment for an adequate clinical assessment to be completed. Intoxication should not be used as a basis for exclusion from places of safety, except in locally defined and agreed circumstances, where there may be too high a risk to the safety of the individual or staff.

Similarly, a previous history of violence should not in itself lead to exclusion. Only in exceptional circumstances, in accordance with locally agreed risk management protocols, should a police custody suite be used to manage seriously disturbed and aggressive behaviour.

Currently, exclusion may also occur because local services cannot respond to the needs of people with personality disorder because of their diagnosis, gender or because they have self-harmed. Local commissioners should work towards the commissioning of local provision in line with current NICE guidance[27] with the aim of preventing the escalation of risk and reducing the need for crisis management by primary care, Emergency Departments or the police.

### B10 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

People in mental distress often seek help from Emergency Departments – sometimes directly, if they have harmed themselves, or are experiencing a physical or mental health crisis. They may also be brought in by others because they have attempted suicide or taken a substance which has altered their mental state. They may be brought in by the police if the person requires urgent medical attention – this may be voluntarily, under arrest for an offence, or through a detention under section 136.

Whatever the circumstances of their arrival, people in mental health crisis should expect Emergency Departments to provide a place for their immediate care and adequate liaison psychiatry services to ensure that they obtain the necessary and on-going support required in a timely way.

Clear responsibilities and protocols should be in place between Emergency Departments and other agencies and parts of the acute and mental health and substance misuse service to ensure that people receive treatment on a par with standards for physical health.

The 2014-15 Mandate to the NHS contains a requirement for NHS England to ensure there are adequate liaison psychiatry services. Clinical commissioning groups should therefore ensure that there are effective liaison psychiatry services in place, to make the links between Emergency Departments and mental health services.

---

[27] NICE Pathways. Personality disorder overview. http://pathways.nice.org.uk/pathways/personality-disorders

## Case Study

**Liaison psychiatry at Department of Psychological Medicine, Hull Royal Infirmary**

The A&E mental health liaison team operates seven days a week from 8am until 10pm.

It is a multidisciplinary team which includes a range of professionals who focus on people who deliberately self-harm and/or who have mental health problems within the acute care pathway.

This team therefore sees patients who have self-harmed in A&E and on the Hull Royal Infirmary and Castle Hill sites. The team will also arrange to see patients who are initially seen within the minor injuries units which are spread throughout Hull and East Yorkshire. The latter patients are usually seen within 24 hours.

The team provide an AGELESS service to patients who have self-harmed. They offer specialist psycho-social assessment, follow up where appropriate and limited outpatient work of a more psychotherapeutic nature where there is an identified need.

From: Liaison psychiatry in the modern NHS, Centre for Mental Health and NHS Confederation Mental Health Network, 2012 http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

There should be a local forum, such as a Local Mental Health Partnership Board, for agreement of protocols and escalation of issues, ensuring that:

- People experiencing mental health crisis, who are exhibiting suicidal behaviour, or who are self-harming, are treated safely, appropriately and with respect by Emergency Department staff
- Clinical staff identify mental health problems in people presenting with a physical health problem and refer them to a GP or specialist help where necessary
- Clinical staff are equipped to identify and intervene with people who are at risk of suicide, through on-going training in accordance with the relevant NICE guidelines, statutory and legal requirements under the mental health legislation and communicate with other services so that people who are at risk are always actively followed up
- Emergency Department staff should treat people who have self-harmed in line with the NICE guidance and work towards the NICE quality standard[28]. Screening should determine a person's mental capacity, their willingness to remain for further psychosocial assessment, their level of distress and the possible presence of mental illness and their need for referral for appropriate psychological therapies and follow up
- Commissioners work with hospital providers to ensure that Emergency Departments, police and ambulance services agree appropriate protocols and arrangements about the security responsibilities of the hospital and the safe operation of restraint procedures on NHS premises. Emergency Departments

---

[28] National Institute for Health and Care Excellence. Quality Standard for self harm. QS 34. June 2013. http://publications.nice.org.uk/quality-standard-for-selfharm-qs34

should have facilities to allow for rapid tranquilisation of people in mental health crisis, if necessary, and clear protocols to safeguard the patient. This should be in accordance with NICE Guidelines[29]. (http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf)"

### B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

The experience of people in mental health crisis accessing the NHS via the 999 system could be further improved by commissioning:

- The provision of 24/7 advice from mental health professionals, either to or within the clinical support infrastructure in each 999 ambulance control room. This would assist with the initial assessment of mental health patients and help ensure a timely and appropriate response.
- Enhanced levels of training for ambulance staff on the management of mental health patients. This could include the ability to provide more multi-agency training with other professionals to ensure a truly joined up approach
- Ambulance trusts to work flexibly across boundaries by exercising judgements in individual cases to ensure that an individual's safety and treatment is not compromised.

### B12 People in crisis who need routine transport between NHS facilities, or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way

In the case of routine transfers of mental health patients, not all contracts are operated by NHS ambulance services - there are many private sector providers of routine patient transport services.

Commissioners will need to make sure that the transfer arrangements put in place by mental health trusts and acute trusts provide appropriate timely transport for these patients. For example, police vehicles should not be used to transfer patients between units within a hospital. Caged vehicles should not be routinely used.

### B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way

Where a police officer or an Approved Mental Health Professional (AMHP) requests NHS transport for a person in mental health crisis under their section 135 and 136 powers for conveyance to a health based place of safety or an Emergency Department, the vehicle should arrive within the agreed response time.

The NHS ambulance services in England are planning to introduce a single national protocol for the transportation of section 136 patients, which will provide agreed response times and a standard specification for use by clinical commissioning groups.

Police vehicles should not be used unless in exceptional circumstances, such as in cases of extreme urgency, or where there is a risk of violence. As mentioned above, caged vehicles should not be used.

---

[29] NICE Clinical Guideline 25. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments
http://www.nice.org.uk/nicemedia/live/10964/29718/29718.pdf

## Case Study

### AN AMBULANCE SERVICE and POLICE CONVEYANCING POLICY IN THE NORTH WEST

"The policy has brought clarity to a very complex area of service. It has dispelled a few myths and unrealistic expectations held between agencies and placed the vulnerable person at the centre of day to day responses to mental ill health" – Greater Manchester Police

The North West Ambulance Service NHS Trust (NWAS) and North West Regional Police Forces, under the authority of the North West Regional Mental Health Forum, have agreed a policy which provides guidance for ambulance service personnel, medical and/or other healthcare practitioners, Approved Mental Health Professionals (AMHPs) and police officers to ensure that patients with mental ill health are conveyed in a manner "which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people", in accordance with the Mental Health Act.

The conveyance policy sets out the roles and responsibilities of each agency including the NHS trusts, the ambulance service, the police and local authorities both in and out of working hours. All parties involved in the creation of the policy use their multi-agency experience to agree effective processes and clear care pathways.

A person-centred approach is taken with the aim of ensuring that vulnerable people receive appropriate and timely care, minimising the role of the police and the use of police vehicles in the conveyance of people experiencing mental ill health. In practical terms, the policy explains that police assistance should only be sought if there is evidence of risk of either resistance (active), aggression, violence (to self or others) or escape. The policy determines that patients are conveyed to hospital in the most humane and least threatening way, consistent with ensuring that no harm comes to the patient or to others. In order to facilitate better multi-agency working, it provides relevant telephone numbers to enable faster referrals to take place, as well as specifying the response times NWAS aim to meet when requested to assist with a mental health related incident.

The policy has brought clarity to a very complex area of service. Professionals involved now 'Think Ambulance First'. It has also enabled senior police officers to challenge requests for police involvement in conveyance when the circumstances are not appropriate and emphasised to all agencies that each has responsibilities, inside and outside of working hours, for vulnerable people.

**Adele Owen**
**Greater Manchester Police**

## C. Quality of treatment and care when in crisis

### C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Responses to mental health crises should be on a par with responses to physical health crises. This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, every day of the year.

The dignity of any person in mental health crisis should be respected and taken into to account.

### C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

The Care Quality Commission (CQC) monitors and inspects many of the care services that provide a response to people experiencing a mental health crisis including acute and mental health hospitals, community based mental health services, GPs and primary medical services, NHS and independent ambulance providers and prison healthcare services. How these services respond to people experiencing a mental health crisis will form part of the regulatory judgement that leads to a rating.

The CQC is introducing changes to the way it monitors, inspects and regulates different care services, including developing a new approach which focuses on whether services are safe, effective, caring, responsive and well-led. For specialist mental health services, the CQC will put a greater emphasis on inspecting and monitoring the care that people with mental health problems receive in the community, including during a crisis. It will develop tools and methods to ensure that consideration is given to the key issues for people experiencing a mental health crisis in the future as part of the new regulatory approach. This development work will be informed by emerging concerns relating to the quality of mental health crisis care such as:

- The accessibility and responsiveness of services to support people through crisis and prevent admission to hospital, and
- The number of people who are admitted to hospital far away from their home area because of pressures on their local acute or admission wards.

The CQC also has specific responsibilities to monitor the use of the Mental Health Act and to protect the interests of people whose rights are restricted under the Act. This will include making sure the powers of the Mental Health Act are properly used by the range of professionals involved in its operation, including AMHPs and the police. The CQC will take account of this Concordat when inspecting and monitoring the support people receive from these agencies in response to their crisis, including inter-agency working at key points in the care pathway. They will also ensure that there is evidence that the least restrictive care has been provided and that mental health legislation and codes of practice have been complied with.

In addition, service providers have the responsibility for monitoring the quality of their responses to people in crisis.

Where specific concerns are raised that relate to the criminal justice system the criminal justice inspectorates will have regard to these in developing their joint inspection programme.

### C3. When restraint has to be used in health and care services it is appropriate.

Once a person is in a mental health setting, the Code of Practice requires the organisation to make sure staff are properly trained in the restraint of patients. The Code also requires adequate staffing levels.

There should be a clear local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological well-being.

The Department of Health and other partners are working on a programme to ensure the use of appropriate and effective restraint in health and care services.

### C4. Quality and treatment and care for children and young people in crisis

There should be clearly stated standards relating to how each service involves and informs children and young people about their care, including medication and diagnosis, to make sure it is age appropriate.

Each service should explain how they seek and respond to the views of children and young people, and how they are supported if they wish to make a complaint. It can be beneficial for children and young people who have experienced mental health services to take part in shaping services to meet their needs.

Children and young people should have access to an advocate. Mental health professionals should advise them if their circumstances give them this right, for example if they are sectioned, and make the necessary arrangements. Young people should also be supported in maintaining contact with their families where appropriate.

If a child or young person needs treatment, the first principle should be to treat at home or in the community if possible. If treatment is needed in an inpatient bed, local accessibility is important, so that the young person is close to home, friends and school, so long as none of these is contributing to the crisis. Young people need easily accessible and age appropriate information about the facilities available on the inpatient unit, geared towards their specific needs. This includes information on their rights and how to complain. They require extra support to settle in from a single key worker who remains the same throughout their stay where possible. They should be able to phone their families and friends. The units need to be safe, warm and decorated at an appropriate age level, and not appear to be an institution. Families should have regular meetings with the ward staff.

## D. Recovery and staying well / preventing future crises

As stated in **A1 Early intervention**, care planning is a key element of prevention and recovery. Following a crisis, NICE recommends[30] that people using mental health services who may be at risk are offered a crisis plan. This should contain:

- Possible early warning signs of a crisis and coping strategies
- Support available to help prevent hospitalisation

---

[30] National Institute for Health and Care Excellence. Quality Standard on crisis planning. http://www.nice.org.uk/guidance/qualitystandards/service-user-experience-in-adult-mental-health/CrisisPlanning.jsp

- Where the person would like to be admitted in the event of hospitalisation
- The practical needs of the service user if they are admitted to hospital, for example, childcare or the care of other dependants, including pets
- Details of advance statements and advance decisions made by the person to say how they would like to be treated in the event of a mental health crisis, or to explain the arrangements that are in place for them
- Whether and the degree to which families or carers are involved
- Information about 24-hour access to services
- Named contacts.

A person's transitions between primary and secondary care must be appropriately addressed. Commissioners should expect clear criteria for entry and discharge from acute care. This should include fast track access back to specialist care for people who may need this in the future, and clear protocols for how people not eligible for the Care Programme Approach (CPA) can access preventative specialist health and social care when they need it. The CPA is a particular way of assessing, planning and reviewing someone's mental health care needs.

The principles of integration of care are valuable in this respect, in making sure the pathway of services is comprehensive and is organised around the patient, particularly during transition from acute to community teams.

Meeting the needs of individuals with co-existing mental health and substance misuse problems requires an integrated and coordinated approach across the range of health, social care and criminal justice agencies.

In terms of local leadership, directors of public health, clinical commissioning groups, NHS England and police and crime commissioners all have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways to meet the needs of people with co-existing mental health and substance misuse problems. Health and wellbeing boards offer a forum for joining up local services and could coordinate the commissioning of services for people with multiple needs.

Clinical commissioning groups and local authority commissioners should ensure that service specifications include a clear requirement for alcohol and drug services to respond flexibly and speedily where an individual in crisis presents in a state of intoxication or in need of urgent clinical intervention. Workforce development has an important role to play in ensuring that staff receive the necessary training and support to work effectively and confidently. This should be reflected in the commissioning intentions of both substance misuse and mental health services.

Joined-up support is particularly important in criminal justice settings and it is critical that the development of liaison and diversion schemes is closely tied in with existing custody based interventions, such as those for drug misusing offenders to maximise their impact on this client group.

# 6. Next steps – enabling improvements in crisis care to happen

## Actions to enable delivery of shared goals

This Concordat sets out the principles under which statutory agencies should work together to refine and improve the services that support people with mental health problems when they need urgent help.

As a first step towards making sure that these principles are translated into improvements across the health and justice systems, the Concordat signatories have all made specific commitments, which are contained in the following annex.

These commitments cover all of the areas that this Concordat seeks to address - effective commissioning, access to support before crisis point, urgent and emergency access to crisis care, the quality of treatment and care when in crisis, and preventing future crises.

These actions represent a vital part of this Concordat. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

## Mental Health Crisis Declarations

The local dimension is critical to success, and central to this ambition is the expectation that local areas commit to delivering their own Mental Health Crisis Declaration.

The drive to achieve this will be supported by the national Concordat signatory organisations from spring 2014, through the use of existing networks and partnerships. In particular, the Department of Health will promote a number of road show events across England that will provide health and police partners in local areas with an opportunity to come together to review local practice and agree their Declaration.

A programme to support implementation is being developed, including:

- The opportunity to register local declarations online
- An independent evaluation of the support programme. This will include convening a national steering group to oversee and assess the implementation of the Concordat and its effectiveness
- Regional events across the England and an annual summit to assess progress, the first to be hosted by the Royal College of Psychiatrists.

# Annex 1
# Mental Health Crisis Care Concordat – Actions to enable delivery of shared goals

## 1. Commissioning to allow earlier intervention and responsive crisis services

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Matching local need with a suitable range of services | | | | |
| 1.1 | Share good practice on the development of JSNAs, local health plans and local commissioning plans, with a focus on establishing the local need for mental health and substance misuse services, working with local partners, and signposting to safe, effective and evidence-based local alternatives to hospital admission. | Within annual commissioning cycle (review and update). | LGA. | Least restrictive, most local and effective response to crises.<br>Reduction in out of area placements because of urgent need. |
| 1.2 | A toolkit will be developed with police forces to capture and articulate data which quantifies the demand for responses for people in mental health crisis, including local monitoring arrangements for MHA S135/136 to ensure needs related to mental disorder and intoxication. | Scoping work beginning April 2014. | Home Office, with policing partners and PHE. | Clearer evidence on which to base local commissioning. |
| 1.3 | Support, develop and improve Mental Health Clinical leads' knowledge and experience of commissioning for crisis care and physical health of people with severe mental illness. | By April 2016. | Royal College of General Practitioners. | Improved commissioning of mental health services. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improving mental health crisis services | | | | |
| 1.4 | Review of the availability, quality and gaps in the information needed to assess the level of local need for crisis care, develop baseline assessment of current provision and the gap analysis and monitor the effectiveness of responses to people who experience a mental health crisis including those who are assessed and detained under the Mental Health Act. | NHS England is developing its mental health intelligence programme and, from April 2014, when the data is routinely available, commissioners and providers will be able to review capacity in line with local need and agreed model. | NHS England Information Strategy and Mental Health Intelligence Network (NHS England, PHE HSCIC, CQC, NHS Benchmarking club, NHS clinical informatics network and AHSNs). | Improved national data to inform commissioning decisions. |
| 1.5 | Analysis of gap between current provision and concordat vision to inform actions. | From April 2014. | NHS England/ DH/PHE. | Focus commissioning support programmes on areas needing improvement. |
| 1.6 | Programme of support to CCGs to improve mental health crisis care commissioning. | From April 2014. | NHS England. | Commissioning Development Assembly working group to consider issues around commissioning mental health services. |
| 1.7 | Consider forming an improvement collaborative to share learning and transform services. | During 2014. | NHS England to lead with partners, including PHE. | Transformation of local services. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 1.8 | To develop bespoke guidance and model service specifications to support commissioners in delivering an integrated and responsive approach to meeting the needs of individuals experiencing mental health crisis where there are also co-existing substance misuse issues. | By September 2014. | PHE/NHS England/RC Psych/RCGP. | To provide clear, updated guidance to promote commissioning practice in line with concordat expectations. |
| Ensuring the right numbers of high quality staff | | | | |
| 1.9 | HEE will set up a Mental Health Advisory Group to advise on policies, strategy and planning of the future workforce for mental health. This will enable HEE to:<br>Ensure sufficient numbers of psychiatrists, other clinicians and care staff are trained to meet service needs.<br>Review and set out future requirements for workforce training as outlined in HEE Mandate, in particular, by rolling out the Improving Access to Psychological Therapies and dementia programmes.<br>Ensure agreement on the policy, funding and implementation plan for improvements to GP training including compulsory work-based training modules in child health, and mental health, including dementia and also include understanding of working in multi- disciplinary teams to deliver good integrated care. | From April 2014. | Health Education England and partners. | Staff are equipped to treat mental and physical conditions with equal priority. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improved partnership working at a local level | | | | |
| 1.10 | Development of a web portal to enable exchange of effective practice for police/health service/local authority partnerships. | Early 2014. | Home Office/ national police leads. | Spread of good practice. |
| 1.11 | NHS England mental health partnerships website, launched to support its strategic clinical networks (SCNs) to establish with partners examples of what good looks like, including in crisis services. | Mid 2014. | NHS England. | Spread of evidence based good practice. |
| 1.12 | Develop a programme of support, including online tools, to support local areas to develop their own 'Local Crisis Declarations' driven by local circumstances. | Spring 2014. | Department of Health/NHS England/Home Office. | Spread of good practice and evaluation of impact of the Concordat. |

## 2. Access to support before crisis point

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improve access to support via primary care | | | | |
| 2.1 | Develop a programme of work to support primary care to work collaboratively with other services, facilitating and co-ordinating access to specialist expertise and to a range of secondary care services including crisis care mental health and substance misuse services as required. | Ongoing. | Royal College of General Practitioners (with CCG Mental Health Network). | Prevention of avoidable crises. |
| 2.2 | Support, develop and improve GPs knowledge and experience of management of severe mental illness including physical health and crisis care through the RCGP Curriculum statement for mental health and the appointment of an RCGP Mental Health Clinical Lead. | April 2015. | Royal College of General Practitioners. | Prevention of avoidable crises. |
| Improve access to and experience of mental health services | | | | |
| 2.3 | DH to work with voluntary sector organisations to understand and respond to inequalities in access to mental health services, particularly for black and minority ethnic communities. | Development work before March 2014 | DH. | Improved outcomes and experiences of black and minority ethnic communities involved with mental health services. |
| 2.4 | Work with voluntary sector providers to assess any additional gaps in provision which are specific to the needs of LGBT people and those from 'seldom heard' groups experiencing mental health crises. | Development work before March 2014. | DH/NHS England/PHE/ HO. | Ensure services take account of the needs of diverse local populations when improvements are made. |

## 3. Urgent and emergency access to crisis care

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improve NHS emergency response to mental health crisis | | | | |
| 3.1 | Complete a Review of Urgent and Emergency Care, including specific reference to models of care that work for people in mental health crisis. | By October 2014. | NHS England. | Description of models and commissioning guidance by Oct 2014. |
| 3.2 | Planning process to deliver mental health crisis care objectives in 2014-15 Mandate. | Started November 2013. | NHS England. | |
| 3.3 | Audit and Review Emergency Department access to specialist mental health services across England and report back findings to NHS England and CCG networks. | September 2014 | Royal College of Psychiatrists, College of Emergency Medicine | Establish baseline for parity of urgent access standards for people experiencing mental health crises |
| 3.4 | Following NHS England Urgent and Emergency Care review, develop best clinical practice around mental health crisis. | September 2014 | Royal College of Psychiatrists (with partner agencies) | Improved commissioning of good clinical practice/quality services |
| 3.5 | Audit of mental health assessment rooms in Emergency Departments. | During 2014. | College of Emergency Medicine, through the PLAN accreditation network. | Service users experience a safe and improved environment and staff safety is improved. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Social services' contribution to mental health crisis services | | | | |
| 3.6 | Support local social services to review their arrangements for out of hours AMHP provision:<br>• consider the implementation of a scheme that employs sessional AMHPs in addition to existing resources to ensure they are able to respond in a timely manner<br>• explore potential for better integration of AMHP and EDT services with out of hours crisis provision of health and other partners<br>• authorities who have combined the services with children's safeguarding should satisfy themselves, in consultation with the police and mental health providers, that AMHPs can be available within locally agreed response times. | By April 2014. | ADASS (with LGA and College of Social Work). | Reduction in delays experienced by service users awaiting an AMHP assessment. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 3.7 | Support local social services to review and plan contribution to local mental health crisis services including:<br>• representation in local senior operational and strategic forums overseeing and developing crisis services<br>• in collaboration with local partners to have a system of ongoing review to ensure AMHP workforce is sufficient and capable to address local needs. | By April 2014. | ADASS (and LGA with College of Social Work). | Reduction in delays experienced by service users. |
| 3.8 | CQC and DH to review effectiveness of current approach to monitoring AMHP provision and whether the Care Quality Commission requires additional powers to regulate AMHP services. | April 2014. | DH and CQC. | Service users experience improved timeliness and quality of service. |
| Improved quality of response when people are detained under section 135 and 136 of the Mental Health Act 1983 | | | | |
| 3.9 | Update guidance, first published in Jan 2013, on the use of section 136 for commissioners and providers. | September 2014. | Royal College of Psychiatrists (with partner agencies). | Improved data collection and monitoring to inform commissioning standards. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 3.10 | CQC to carry out a review of health based places of safety including coverage, capacity, inclusion and exclusion criteria, staffing, arrangements for governance and multi-agency working including police support.<br>Develop this approach to monitoring the quality of health based places of safety as part of future inspections. | Survey completed by April 2014; monitoring approach developed by September 2014. | CQC. | Improved information made public on the availability and quality of health based places of safety. |
| 3.11 | The NHS ambulance services in England will introduce a single national protocol for the transportation of S136 patients, which provides agreed response times and a standard specification for use by clinical commissioning groups. | April 2014. | Association of Ambulance Chief Executives (AACE). | Consistent responses to S136 conveyance experienced by service users. |
| 3.12 | Model for more effective joint agency arrangements to address the safeguarding and needs of vulnerable people with complex need, including personality disorders, addictions or dependencies, who turn to emergency services for help at times of crises and are at risk of exclusion from mental health services. | By September 2014. | Royal College of Psychiatry and College of Emergency Medicine. | Reduction in repeated crises experienced by people with complex needs. |
| 3.13 | The Department of Health will monitor the national figures on the use of section 136. | By November 2015. | DH. | An expectation to see the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 3.14 | Review and update local Mental Health Act protocols on mental disorder and intoxication from alcohol or drugs to include guidance for emergency services, so that:<br>• People who appear to be mentally disordered and so intoxicated as to represent an immediate physical health risk to themselves will be medically assessed in an Emergency Department<br>• People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety<br>• People intoxicated as a result of alcohol or drug misuse who do not appear to be mentally disordered or who are not known a mental health service will be dealt with by the police through criminal justice processes. | From January 2014. | DH through updating Mental Health Act Code of Practice Chapter 10, and Royal College of Psychiatry Interagency group. | People are dealt with by the service most able to respond to their immediate needs. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improve information and advice available to front line staff to enable better response to individuals | | | | |
| 3.15 | Support agencies sharing key information about a person, in line with current guidance – Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services Ref 11929, DH 2009. | Summer 2014. | DH through local partnership board arrangements and through Caldicott and data protection officers. | Improved management experienced by the person in crisis. |
| 3.16 | Support local mental health service providers to develop arrangements which provide real time advice and support to the police when assessing the mental health needs of a vulnerable person. | April 2014. | National Policing Lead for Mental Health /NHS Confederation Mental Health Network to provide a joint Briefing paper including examples of current best practice. | Improved quality of assessments and experience by vulnerable people with mental health needs. |
| 3.17 | Street triage pilots in nine police forces will be conducted. The Department of Health and Home Office will share the evaluation and lessons learned from the pilots widely as they progress to benefit all other triage approaches being used. | 1 year pilot programme: Autumn 2013 to Autumn 2014. | Department of Health/Home Office. | New initiatives to improve the efficiency of responses and collaboration between health partners and the police are evaluated for the benefit of other areas. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Improved training and guidance for police officers | | | | |
| 3.18 | Review of curriculum available to police forces to enable officers to undertake sufficient training on mental health. The review will also survey the 'take-up' of, and adherence to, the available training, leading to recommendations for improvements to the police curriculum. | Summer 2014. | College of Policing (supported by the Home Office). | All police forces in England can realistically be able to ensure that all frontline officers (and others) who may deal with people with mental health problems, can receive sufficient training with minimal disruption to normal business. |
| 3.19 | Review of 2010 *Guidance on Responding to People With Mental Ill Health or Learning Disabilities*. | Commence in 2014. | College of Policing. | Police guidance is updated and easier to use, transferred into Authorised Professional Practice – and available to the public. |
| Improved services for those with co-existing mental health and substance misuse issues | | | | |
| 3.20 | Nationally: Public Health England, NHS England and the LGA will work together to develop resources that will support LAs and CCGs in the development of an effective framework for the commissioning of services that will meet the needs of those in mental health crisis. | April 2014. | PHE / LGA. | To drive improved service provision and encourage a consistent approach to commissioning services to individuals in crisis who present with co-existing mental health and substance misuse issues. |

## 4. Quality of treatment and care when in crisis

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Review police powers and use of places of safety under the Mental Health Act 1983 and CQC monitoring of operation | | | | |
| 4.1 | Review of Mental Health Act 1983 Code of Practice. | Updated Code of Practice published October 2014. | DH. | Response to recommendations of HMIC/CQC report on use of police cells for s136. |
| 4.2 | Review of legislative framework for sections 135 and 136. | Spring 2014. | DH and HO. | Recommendation for any change to primary legislation to support principles of Concordat. |
| 4.3 | Carry out a thematic review of the quality, safety and responsiveness of care provided to people experiencing a mental health crisis by regulated providers and providers/agencies with responsibility for operating the Mental Health Act 1983. | October 2013 – September 2014. | CQC. | Focused assessment of regulated providers and localities in relation to mental health crisis response; inspection of multi-agency responses within a sample of localities, particularly where concerns are identified; local and national reporting to inform improvement. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 4.4 | Based on the learning from CQC's thematic review, develop the approach to monitoring and inspecting providers that respond to people experiencing a mental health crisis and who are regulated by CQC so that key issues are routinely considered within the new model for regulation. | September 2013 – April 2015. | CQC. | Strengthened regulation of providers that respond to mental health crises to promote improvement in the experience and outcomes for people who use these services. |
| Patient safety and safeguarding | | | | |
| 4.5 | Positive and safe campaign on restraint practices. | Guidance published for consultation, December 2013. | RCN for DH. | Part of a wider programme to reduce the use of physical restraint in mental health services. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 4.6 | Develop resources to support safeguarding boards, specific to the circumstances and needs of, and responses to, people experiencing mental health crisis. | During 2014. | LGA/ADASS. | Ensure effective planning, monitoring and review of local safeguarding arrangements.<br>Support safeguarding boards to take oversight of the safeguarding implications of current arrangements between local organisations and how these might be strengthened.<br>Support safeguarding boards approach to monitoring the effectiveness of safeguarding arrangements for people experiencing mental health crisis.<br>Support the development of strategic plans (in advance of statutory requirement) that include the very specific needs of people experiencing mental health crisis. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Primary care response | | | | |
| 4.7 | Improve GP Trainees' understanding of the management of severe mental illness including physical health and crisis care in the community (through the extended training proposals). | April 2015. | Royal College of General Practitioners, Health Education England. | Improve primary care response to mental health crisis. |

## 5. Recovery and staying well / preventing future crises

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| Joint planning for prevention of crises | | | | |
| 5.1 | Information and good practice guidance about prevention and early intervention produced and disseminated. | From April 2014. | PHE. | Service users experience more appropriate and consistent responses, disseminating latest best practice evidence and disseminating emerging case studies. |
| 5.2 | Set standards for the use of Crisis Care plans, in line with Care Programme approach guidance (DH publication 2010) and NICE Clinical Guidance CG 136 (Service User Experience of adult Mental Health Services NICE 2013). | Date to be agreed. | NHS England. | Service users jointly produce contingency plans in case of relapse or crisis. |
| 5.3 | Bring to attention of Health and Social Care services vulnerable people identified in the course of day to day policing in order to contribute to management plans and develop role of Neighbourhood Policing in helping to protect vulnerable people. | Ongoing. | Police national leads. | Prevention of crises due to relapse in poor mental health experienced by a vulnerable person. |

| No | Action | Timescale | Led By | Outcomes |
|---|---|---|---|---|
| 5.4 | Commission services so that Liaison and Diversion Services and Street Triage refer individuals with co-existing mental health and substance misuse problems to services which can address their needs. | April 2014. | PHE/NHS England. | The needs of service users with co-existing mental health and substance misuse needs are better addressed in the development of services. |

Department of Health

# Positive and Proactive Care: reducing the need for restrictive interventions

Prepared by the Department of Health

| |
|---|
| **Title:** Positive and Proactive Care: reducing the need for restrictive interventions |
| **Author:** Social Care, Local Government and Care Partnership Directorate |
| **Document Purpose:** Policy |
| **Publication date:** April 2014 |
| **Target audience:** Executive directors of health and social care provider organisations; service managers, governance leads and executive quality leads in health and social care services; staff working in health and social care services; enforcement and inspection staff; chairs (and members) of local safeguarding adults boards; lecturers and those who deliver professional training and training in PBS and the use restrictive interventions; academic and research staff; people who use services, family members, carers and parents of people receiving services; independent advocates and organisations; police and people working in criminal justice settings; professional regulatory bodies; local authorities; legal representatives; security staff working in health and social care settings; commissioners of health and social care services. |
| **Contact details:**<br>Social Care, Local Government and Care Partnership Directorate,<br>Room 313, Richmond House, London SW1A 2NS<br>Email: Positive&Safe@dh.gsi.gov.uk |

Any enquiries regarding this publication should be sent to us at Social Care, Local Government and Care Partnership Directorate, Room 313, Richmond House, London SW1A 2NS. Email: Positive&Safe@dh.gsi.gov.uk

Department of Health

# Positive and Proactive Care: reducing the need for restrictive interventions

Prepared by the Department of Health

# Foreword

Investigations into abuses at Winterbourne View Hospital and Mind's *Mental Health Crisis in Care: physical restraint in crisis* (2013) showed that restrictive interventions have not always been used only as a last resort in health and care. They have even been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this.

There is overwhelming support for the need to act. Over 95% of respondents were supportive in consultation. The Royal College of Nursing Congress voted by 99% in favour of new guidelines. Whilst I appreciate there may be times when restrictive interventions may be required to protect staff or other people who use services, or the individuals themselves, there is a clear and overwhelming case for change.

This is about ensuring service user *and* staff safety, dignity and respect. This is absolutely not about blaming staff. Whilst at Winterbourne there was clearly abuse and this must not be allowed to happen, we know that many staff have just been doing what they have been trained to do and have been struggling in difficult situations and often with very little support. We need to equip these individuals with the skills to do things differently. The guidance makes clear that restrictive interventions may be required in life threatening situations to protect both people who use services and staff or as part of an agreed care plan.

Together *Positive and Proactive Care* and *A Positive and Proactive workforce* provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery. I want to thank the Royal College of Nursing for leading the multi-professional consortium who led on developing the Department's guidance and Skills for Care and Skills for Health in developing the complementary guidance to support the commissioning of learning and development. This was a great example of organisations working together to deliver high quality products that affect all of us.

This guidance is only one part of the story. From April 2014, DH will launch a new, wider two-year initiative *Positive and Safe* to deliver this transformation across all health and adult social care. We will identify levers to bring these changes about including improving reporting, training and governance. DH will also develop accompanying guidance in relation to children, young people and those in transition in healthcare settings.

I look forward to working with you to co-produce this programme. Through *Positive and Safe* we have the potential to make whole scale system-wide changes, ensuring we have a modern, compassionate and therapeutic health and care service fit for the 21st century.

**Norman Lamb**

**Minister for Care and Support**

# Contents

# Introduction

## The need for a guidance framework

1. In recent years a number of reports have focused on the use, or abuse, of restrictive interventions in health and care services. In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital*[1] which outlined the actions to be taken to avoid any repeat of the abuse and illegal practices witnessed at Winterbourne View Hospital. A subsequent Care Quality Commission (CQC) inspection of nearly 150 learning disability in-patient services found providers were often uncertain about the use of restrictive interventions, with some services having an over-reliance on the use of 'restraint' rather than on preventative approaches to 'challenging behaviour'.

2. Further impetus to drive forward the use of positive and proactive approaches arose from the publication of *Mental Health Crisis Care: physical restraint in crisis* in June 2013 by Mind.[2] The report found evidence of significant variations in the use of restraint across the country. They raised concerns about the use of face down or 'prone' restraint and the numbers of restraint related injuries that were sustained.

3. In response to these and other concerns about the inappropriate use of restrictive interventions across a wide range of health and care settings the Coalition Government committed the Department of Health to publish guidance on the use of positive and proactive approaches with the aim of developing a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time.

4. This guidance forms a key part of the Coalition Government's commitment set out in *Closing the Gap: essential priorities for change in mental health*[3] to end the use of restrictive interventions across all health and adult social care. 'Positive and Safe' is a new initiative to drive this forward. 'Positive and Safe' recognises that therapeutic environments are most effective for promoting both physical and emotional wellness and that restrictive interventions should only be used in modern compassionate health and social care services where there is a real possibility of harm to the person or to staff, the public or others.

5. The purpose of this guidance is to provide a framework to support the development of service cultures and ways of delivering care and support which better meet people's needs and which enhance their quality of life. It provides guidance on the delivery of services together with key actions that will ensure that people's quality of life is enhanced and that their needs are better met, which will reduce the need for restrictive interventions and promote recovery.

# Key actions

## Improving care

- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor. [Para 70]
- If restrictive intervention is used it must not include the deliberate application of pain. [Paras 58, 69, 75]
- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need. [Paras 64, 96]
- Staff must not use seclusion other than for people detained under the Mental Health Act 1983. [Paras 80, 89]
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support. [Paras 25, 36, 42, 53, 58, 62, 108, 116, 118]
- Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions. [Paras 35, 61, 65, 106, 108, 115]

## Leadership, assurance and accountability

- A board level, or equivalent, lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions. [Paras 29-31, 109]
- Boards must maintain and be accountable for overarching restrictive intervention reduction programmes. [Para 109]
- Executive boards (or equivalent) must approve the increased behavioural support planning and restrictive intervention reduction to be taught to their staff. [Paras 108, 119, 124, 125]
- Governance structures and transparent polices around the use of restrictive interventions must be established by provider organisations. [Paras 105-109]
- Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers. [Paras 114-118]

- Providers must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns. [Paras 109, 128]
- Boards must receive and develop actions plans in response to an annual audit of behaviour support plans. [Paras 58, 109]
- Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used. [Paras 46-53]

## Transparency

- Providers must ensure that internal audit programmes include reviews of the quality, design and application of behaviour support plans, or their equivalents. [Paras 58, 109]
- Accurate internal data must be gathered, aggregated and published by providers including progress against restrictive intervention reduction programmes and details of training and development in annual quality accounts or equivalent. [Paras 111, 118]
- Service commissioners must be informed by providers about restrictive interventions used for those for whom they have responsibility. [Paras 109-128]
- Accurate internal data must be gathered, aggregated and reported by providers through mandatory reporting mechanisms where these apply, e.g. National Reporting and Learning Service (NRLS) and National Mental Health Minimum Data Set (NMHMDS). [Paras 110-112]

## Monitoring and oversight

- Care Quality Commission's (CQC) monitoring and inspection against compliance with the regulation on use of restraint and its ratings of providers will be informed by this guidance. [Paras 8-10, 105, 106, 112]
- CQC will review organisational progress against restrictive intervention reduction programmes. [Para 108]
- CQC will scrutinise the quality of behaviour support plans which include the use of restrictive interventions. [Para 106]

## The status of the guidance

6. For adult users of health and social care services (18 or over), this new guidance replaces the 2002 non-statutory guidance [4] *The use of restrictive physical interventions for staff working with children and adults who display extreme behaviour in association with learning disability and /or autistic spectrum disorders* and *The use of restrictive physical interventions for pupils with severe behavioural difficulties.* However these may continue to be useful reference documents for those working with children and young people. Additional guidance is in preparation that will take account of the different legal framework and implications of the UN Convention on the Rights of the Child[5] for children, young people and individuals transitioning to adult services

7. The guidance provides information and good practice guidance to all health and social care for adults delivered or commissioned by the NHS or local authorities in England, including care delivered in an individual's own home or non-care settings such as police cells, immigration removal centres and prisons.

8. The Care Quality Commission (CQC) is responsible for registering and monitoring registered providers, and the quality and safety of the care they provide, under the Health and Social Care Act 2008. This guidance will inform CQC's programme of regular monitoring and inspection against CQC standards, particularly in relation to regulation 11 (safeguarding service users against abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010[6]. The Department is currently consulting on new regulations which will introduce new fundamental standards of care, and will replace the regulations referenced above by October 2014 (subject to parliamentary approval). One of these fundamental standards requires that care and treatment must be appropriate and safe, and includes reference to appropriate use of restraint.

9. Subject to parliamentary approval, this new regulation will give CQC the power to take action against providers who use control or restraint that is not provided in accordance with guidance and standards issued by appropriate professional and expert bodies, is unlawful, or is not necessary to prevent, or proportional to the risk posed were restraint not used.

10. This guidance will be one of the sources CQC use when assessing whether a provider is delivering safe and appropriate care, once the fundamental standards come into force. The guidance will also be used by CQC in determining what good looks like in care and treatment in CQC's new ratings system (inadequate/requires improvement/good/outstanding) for its integrated model of inspection. Where the guidance is not implemented the CQC will consider using its regulatory powers to facilitate change and improvement in local services.

## Who is this guidance for?

11. This guidance is of particular significance for health and social care services where individuals who are known to be at risk of being exposed to restrictive interventions are cared for. Such settings may provide services to people with mental health conditions, autistic spectrum conditions, learning disability, dementia and/or personality disorder, older people and detained patients. It is more broadly applicable across general health and social care settings where people using services may on occasion present with behaviour that challenges but which cannot reasonably be predicted and planned for on an individual basis. This may include homes where individuals employ their own support staff, and community-based primary and secondary care settings.

12. The guidance requires that actions are taken by those with responsibility at all levels in health and social care including commissioners of services, executive directors, frontline staff and all those who care for and support people in a variety of settings. This guidance must be considered and acted on by:

- commissioners of health and social care services
- executive directors of health and social care provider organisations
- service managers, governance leads and executive quality leads in health and social care services
- staff of all disciplines and degrees of seniority working in health and social care services
- enforcement and inspection staff
- chairs (and members) of local safeguarding adults boards
- lecturers and others who deliver professional training to health and social care staff
- academic and research staff
- those who provide training in PBS, and
- those who provide training on the use restrictive interventions.

13. The guidance will also be relevant to:

- people who use services
- family members, carers and parents of people receiving services
- independent advocates and organisations
- the police and people working in criminal justice settings
- professional regulatory bodies
- local authorities
- legal representatives, and
- security staff working in health and social care settings.

14. This guidance applies equally to health and social care staff working in non-health settings such as police cells, immigration removal centres and prisons. It does not apply to staff from other professions including the police and people working within criminal justice settings (for whom own professional guidance will apply).

15. It is important to note that healthcare centres in prisons come under their own rules and regulations. The control and order of people in healthcare centres, as well as prisoners in transit to an outside hospital and while they are undergoing medical treatment, which could include overnight in-patient treatment for an extended period, is the responsibility of the governor/director, or person in charge of the establishment.

## Aims of this guidance

16. This guidance aims to:

- encourage a culture across health and social care organisations that is committed to developing therapeutic environments where physical interventions are only used as a last resort
- provide guidance on the use of effective governance arrangements and models of restrictive intervention reduction so that lasting reductions in the use of restrictive interventions of all forms can be achieved
- help promote best practice principles across a range of health and social care settings
- ensure that restrictive interventions are used in a transparent, legal and ethical manner.

## Restrictive interventions defined

17. 'Restrictive interventions' are defined in this guidance as:

*'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:*

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the person's freedom for no longer than is necessary'.*

18. Judgements as to the acceptability and legitimacy of restrictive interventions will always be based on all presenting circumstances. Without a clear ethical basis and appropriate safeguards such acts may be unlawful.

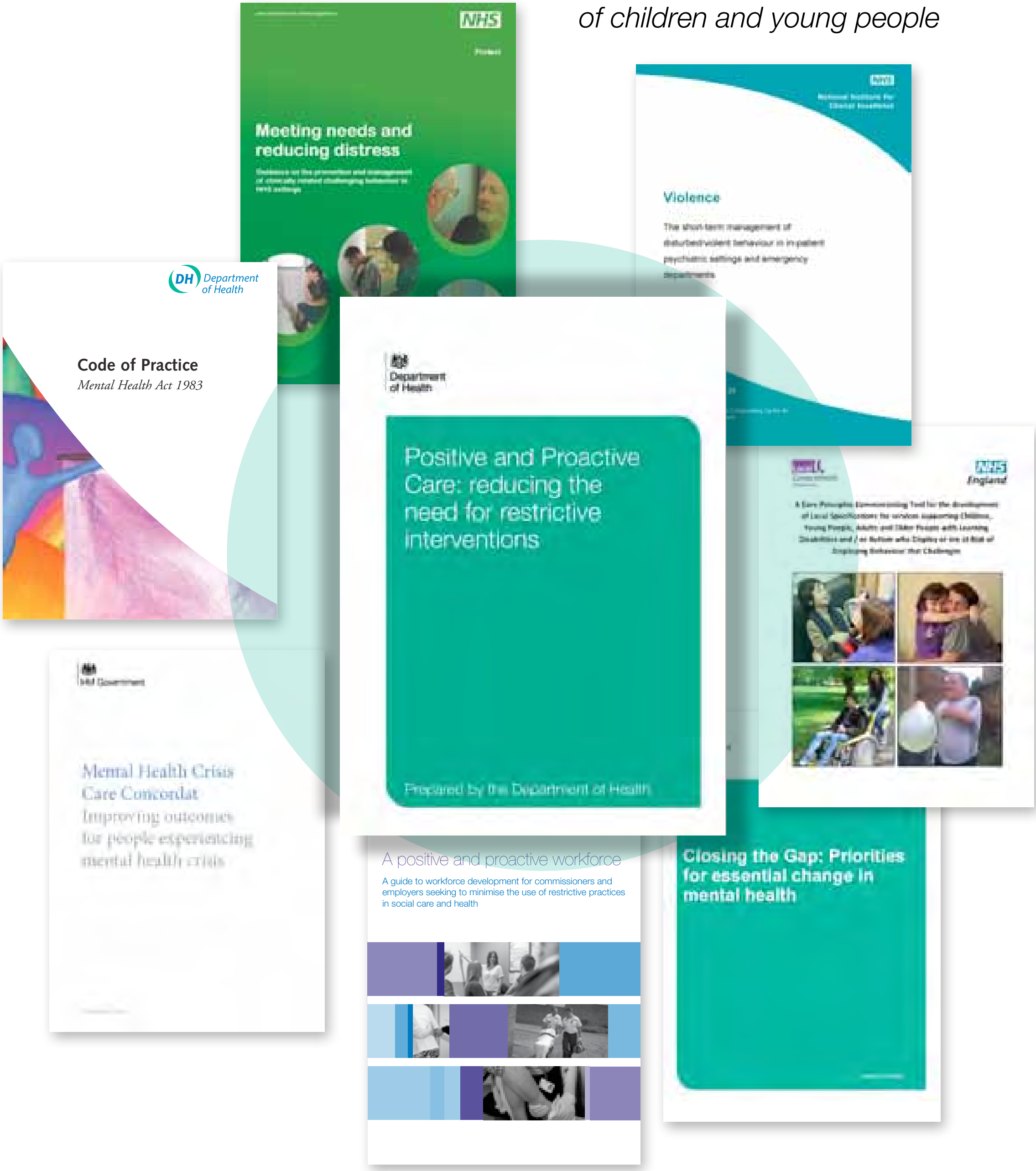
19. If carried out for any other purpose than those listed above concerns about the misuse of restrictive interventions should always be escalated through local safeguarding procedures and protocols.

## Related guidance

20. A range of useful guidance documents have recently been published which focus on the care and support of people who present with behaviours that challenge. This document cross references to those sources rather than repeating their content. Together they provide useful additional guidance concerning positive and proactive ways of reducing the need for restrictive interventions as well as providing a template for their safe, ethical and lawful application when used as a last resort. Whilst some documents focus on specific settings, user groups or interventions, they are unified by a set of common principles and by the central aim of providing safe, supportive and compassionate care.

21. A synopsis of the following key documents is provided in Appendix 1.

- *NHS Protect: Meeting needs and educing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings*[7]
- *HM Government: The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis*[8]
- *NHS England & LGA: A Core Principles Commissioning Tool*[9]
- *NICE: Clinical Guideline 25. Violence: the short-term management of disturbed / violent behaviour in in-patient psychiatric and emergency departments*[10]
- *DH: Mental Health Act Code of Practice*[11]
- *Skills for Health and Skills for Care (2014) A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*[12]
- *DH (In preparation) Positive and Proactive: guidance on support and care of children and young people*



# Key principles underpinning the guidance

## Six key principles

22. This guidance is based on six key principles which underpin the need to deliver positive and proactive care; these are applicable across all service settings. Rigorous governance is needed to ensure that positive and proactive care is the main approach within services to reduce excessive reliance on restrictive interventions and to ensure that if they are used, it is only ever as a last resort, and they are undertaken in a proportionate and least restrictive way.

23. For people who lack the capacity to consent to the use of a restrictive intervention, services must balance people's right to autonomy with the right to be protected from harm. Any decision to use restrictive interventions for a person who lacks capacity, must be made in the best interests of the person within the framework of the Mental Capacity Act[14] (MCA) (sections 4, 5 and 6). However, the Mental Health Act 1983 applies to any mental health treatment given to a person being treated under that Act.

## Key principles underpinning the guidance

- Compliance with the relevant rights in the **European Convention on Human Rights**[13] at all times
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their **quality of life** to be enhanced
- **Involvement and participation** of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations
- People must be treated with **compassion,** dignity and kindness
- Health and social care services must support people to balance safety from harm and freedom of **choice**
- Positive **relationships** between the people who deliver services and the people they support must be protected and preserved

## A human rights based approach

**24.** The Human Rights Act (HRA)[15] imposes a duty on public authorities, (including NHS Trusts, Local Authorities, and police forces) and services exercising functions of a public nature not to act in a manner that is incompatible with the European Convention on Human Rights[13] (ECHR) rights that have been made part of UK law by the HRA.

**25.** A human rights based approach can be achieved by applying what has been described as the 'PANEL' principles[16,17]. Table 1 shows the five 'PANEL' principles and how these might be applied when thinking about the care and support of people who present with behaviour that challenges services.

### TABLE 1

| Key principle | What it means | What it looks like in practice |
|---|---|---|
| **Participation** | Enabling participation of all key people and stakeholders. | Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights. |
| **Accountability** | Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach | Clearly outlining responsibilities under the Mental Health Act[18] and the Mental Capacity Act[14] (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards. |
| **Non-discriminatory** | Avoiding discrimination, paying attention to groups who are vulnerable to rights violations | Using person-centred planning approaches that do not discriminate on the basis of religion or belief, race or culture, gender, sexual preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights. |
| **Empowerment** | Empowering staff and people who use services with the knowledge and skills to realise rights | Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions; empowering people through appropriate interventions. |
| **Legality** | Complying with relevant legislation including human rights obligations, particularly the Human Rights Act | Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy[19]. |


Jenga
Jenga
Jenga
Jenga

# The guidance framework

**26.** People might be exposed to restrictive interventions as a response to some form of behaviour that challenges in a wide variety of different settings and situations. They include settings where people are well known and where individualised support can be planned with the aim of reducing the incidence of such behaviours. They also include other settings where it is not possible because the individual may not be known to the service. In both settings robust governance is essential to ensure appropriate practice.

## Individualised approaches

**27.** Some services support people whose needs and histories mean that individuals can reasonably be predicted to present with behaviours that challenge. Examples of such services might include acute psychiatric settings (including secure services), and residential units specialising in working with people with learning disabilities who present with 'challenging behaviour' or services for people who are elderly and confused who may become agitated.

**28.** Within such services the use of recovery-based approaches and delivery of care in accordance with the principles of positive behavioural support is essential.

## Recovery-based approaches

**29.** Recovery means working in partnership with people to improve their clinical and social outcomes. Originating in mental health services, recovery models are consistent with contemporary service philosophies across wider health and social care settings[20] and include the promotion of human rights based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion.

**30.** These models are founded on the principle that recovery is possible for everyone. Each person can achieve a satisfying and fulfilling life, in keeping with their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement within wider communities and society more generally.

**31.** International literature on seclusion and restraint reduction demonstrates that a recovery-focused model is essential for achieving a reduction in the use of restrictive interventions carried out against a person's wishes.[21, 22]

## Positive behavioural support

**32.** Positive behavioural support (PBS) provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life. Evidence has shown that PBS-based approaches can enhance quality of life and also reduce behaviours that challenge[23,24] which in turn can lead to a reduction in the use of restrictive interventions. It is founded on principles that have applicability for a much broader range of people and may use different terminology. PBS provides a conceptual framework[25] which recognises that people may engage in behaviours that are challenging because:

- they have challenging or complex needs that are not being met – these could be associated with unusual needs and personal preferences, sensory impairments, or mental or physical health conditions
- they are exposed to challenging environments in which behaviours of concern are likely to develop – examples might include environments which are barren and lack stimulation, where there are high levels of demand placed on people, where there may be institutional blanket rules, restricted or unpredictable access to preferred activities and those things the person values and where there is insufficient availability of positive social interactions, or where personal choices are not offered and/or honoured
- they typically have a generally impoverished quality of life.

**33.** Within PBS-based approaches these underlying difficulties are seen as the target for therapeutic intervention. The introduction of PBS or similar principles in a systematic, organisation wide context is an important mechanism by which to deliver many of the key elements associated with restrictive intervention reduction programmes[26] (see paragraphs 40-42).

**34.** PBS approaches comprise a number elements:

- Using **person-centred, values-based approaches** to ensure people are living the best life they possibly can. This involves assisting a person to develop personal relationships, improve their health be more active in their community and to develop personally. When done properly, person centred planning processes make sure that those who support people get to know them as individuals.
- Skilled assessment in order to **understand probable reasons why a person presents behaviours of concern**; what predicts their occurrence and what factors maintain and sustain them (this area of assessment is often referred to as a functional assessment). This requires consideration of a range of contextual factors including personal constitutional factors, mental and physical health, communication skills and the person's ability to influence the world around them. Patterns of behaviour provide important data, skilled analysis of which enables key areas of unmet need to be understood.
- The use of **behaviour support plans** which have been informed by an assessment of these factors in order to ensure that aspects of the person's environment that they find challenging are identified and addressed, that quality of life is enhanced and that wherever possible people are supported to develop alternative strategies by which they can better meet their own needs. These are referred to as **primary preventative strategies**.
- The behaviour support plan must detail the responses such as **de-escalation**

**techniques**, distraction, diversion and sometimes disengagement to be used by carers/staff when a person starts to become anxious, aroused or distressed. These are referred to as **secondary preventative strategies** and aim to promote relaxation and avert any further escalation to a crisis.

- Behaviour support plans include guidance as to how people should react when a person's agitation further escalates to a crisis where they place either themselves or others at significant risk of harm. This may include the use of restrictive interventions. Within behaviour support plans these are as identified as **tertiary strategies.**

35. Any person who can reasonably be predicted to be at risk of being exposed to restrictive interventions must have an individualised behaviour support plan.

36. **Care programme approach care plans, personal recovery plans or other personalised approach planning structures** may also incorporate behaviour support plans. They must always include clear evidence of health and social needs assessment, and be created with input from the person, their carers, relatives or advocates. This should identify:

- the context within which behaviours of concern occur
- clear primary preventative strategies which focus on improvement of quality of life and ensuring that needs are met
- secondary preventative strategies which aim to ensure that early signs of anxiety and agitation are recognised and responded to
- tertiary strategies which may include detail of planned restrictive interventions to be used in the safest possible manner and which should only be used as an absolute last resort.

## Whole service approaches

37. In some services, people's histories and health and social care needs may not be known or well understood and therefore individual planning is not possible. Examples include mental health services that admit patients without much knowledge of their background history; an accident and emergency department where a disagreement develops; a primary healthcare setting where a patient aggressively resists an intervention; or where the police service have contact with someone who may have a mental health problem, learning disability or autism.

38. In such services a range of whole service approaches can promote therapeutic engagement, avoidance of conflict situations and the safe support of people at times of behavioural crisis. These approaches must also be considered across all services of the nature identified in paragraph 27.

39. Oppressive environments and the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments can have a negative impact on how people behave, their care and recovery. They are inconsistent with a human rights-based approach. Providers should ensure that they abide by the Human Rights Act[15] and where possible do not have blanket restrictions in place. Where these are considered necessary, providers should have a clear policy in place and ensure that the reasons are communicated and justified to people who use services, family members and carers. Providers may be challenged to justify the use of such restrictions under the Human Rights Act[15].

## Restrictive intervention reduction programmes

**40.** A number of recent studies have shown that it is possible to achieve significant reductions in the use of restrictive interventions through a determined organisational commitment to changing approaches to aggression/ violence management[22,27,28]. A thorough knowledge review conducted by the Irish Mental Health Commission in 2012[29] explored a range of models for restrictive intervention reduction and found nine consistent components to be necessary:

- government level support
- careful attention to policy and regulation
- involvement of people who use services, their family and advocates
- effective leadership
- training and education
- staffing changes
- using data to monitor the use of restrictive intervention
- effective review procedures and debriefing and
- judicious use of medication.

**41.** All services where restrictive interventions may be used must have in place **restrictive intervention reduction programmes** which can reduce the incidence of violence and aggression and ensure that less detrimental alternatives to restrictive interventions are used. Such programmes should be planned in the context of robust governance arrangements, a clear understanding of the legal context for applying restrictions and effective training and development for staff.

**42.** Services' restrictive intervention reduction programmes must be based on the principles of:

- providing effective leadership
- involving and empowering of people who use services, their families and advocates
- developing programmes of activities and care pathways for people using services
- using clear crisis management strategies and restrictive intervention reduction tools
- effective models of post-incident review including learning from critical incidents
- data-driven quality assurance.

## Reducing and managing conflict

**43.** The Safewards[30] model has demonstrated significant effectiveness in achieving reductions in incidents of conflict and the use of physical restraint, seclusion and rapid tranquillisation in acute UK mental health settings. A range of practical approaches can be used which have wide ranging influences on people's behaviour and staff responses so that flashpoints are avoided, de-escalation is more effectively achieved and alternatives to restrictive interventions are consolidated into practice. Many of these highly practical approaches could be replicated across broader service settings and all providers should consider the implications of the Safewards model to their context.

**44.** The Design Council[31] has recently reported on the use of design solutions and modified signage within A&E departments. They put forward a cost effective model which led to significant reductions in levels of frustration and potential triggers to violence.

**45.** All health and social care providers need to consider the contribution that environmental design may make to preventing conflict by better meeting people's needs at times of heightened anxiety, the negative impact of oppressive environments and blanket restrictions, and the practical implications of the Safewards model. These approaches can contribute to reducing undue reliance on restrictive interventions.

## Post-incident reviews

46. Service providers must ensure that where appropriate lessons are learned when incidents occur where restrictive interventions have had to be used.

47. The aims of post-incident reviews are to:

- evaluate the physical and emotional impact on all individuals involved (including any witnesses)
- identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted
- help people who use services and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were considered
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- where appropriate recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training
- where appropriate avoid a similar incident happening on another occasion.

48. Whenever a restrictive intervention has been used, staff and people should have separate opportunities to reflect on what happened. People with cognitive and/or communication impairments may need to be helped to engage in this process, for example, by the use of simplified language or visual imagery. Other people may not be able to be involved due to the nature of their impairment.

49. People who use services should not be compelled to take part in post-incident reviews. They should be told of their right to talk about the incident with an independent advocate (which may include an independent mental health advocate or independent mental capacity advocate), family member or another representative.

50. Discussions should only take place when those involved have recovered their composure. Immediate or post-incident reviews should:

- acknowledge the emotional responses to the event
- promote relaxation and feelings of safety
- facilitate a return to normal patterns of activity
- ensure that all appropriate parties have been informed of the event
- ensure that necessary documentation has been completed
- begin to consider whether there is a specific need for emotional support in response to any trauma that has been suffered.

51. Many restrictive intervention reduction models also include the use of a more in-depth review process, typically the next day, in response either to more serious incidents or a person's request. This may take the form of a facilitated staff team discussion to establish the warning signs of an impending crisis, what de-escalation strategies were used, how effective they were, and what could be done differently in future.

52. Someone who was not involved in the incident should be involved in both post-incident and in-depth reviews with people who use services. Reviews should be in a blame free context. The aim should be to understand from the person's point of view how the service failed to understand what they needed, what upset them the

most, whether staff did anything that was helpful, what staff did wrong, and how things could be better the next time. It is also important to establish whether anything could be done differently to make a restrictive intervention less traumatic.

**53.** The care team together with the person, their families and advocates should consider whether behaviour support plans or other aspects of individual care plans need to be revised/updated in response to the post-incident review. Any organisational factors such as the need for policy reviews, environmental modifications, staffing reviews or training needs must to be formally reported to service managers using robust governance arrangements.

## Managing unforeseen behaviour that challenges

**54.** The key principles within this guidance must be applied to the management of unforeseen behaviours that challenge, even in contexts where they cannot be anticipated or responses pre-planned such as accident and emergency departments or the ambulance service.

**55.** NHS Protect provides[7] useful guidance on understanding and responding to behaviour that challenges, whether or not it was anticipated. The Crisis Care Concordat[8] states key principles that will be relevant to many service settings (in particular A&E settings, acute mental health services and the ambulance service). In services where hospital security staff may be needed to respond to emergency situations to assist in the management of violent or aggressive incidents, they should also adhere to the provisions of the Mental Capacity Act 2005 (MCA)[14], as well as to Skills for Security good practice guidance[32].

**56.** The Crisis Care Concordat also states that once a person is in a mental health setting, the MHA Code of Practice[11] requires the organisation to make sure staff are properly trained in the restraint of patients. There should be a clear local protocol about the circumstances when, very exceptionally, police may be called to manage patient behaviour within a health or care setting. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing. Further guidance for the police is available in the Association of Chief Police Officers and National Policing Improvement Agency's *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*[33]. The National Police College is working on improving this guidance and the training that police officers receive as their response to the national Crisis Care Concordat.

**57.** The provisions of the Mental Health Act 1983 (MHA)[18] will only very rarely authorise the application of restrictive interventions in community-based health and social care services and non-mental health hospital settings. The MCA[14] will, if certain conditions are met, provide legal protection for acts performed in the care or treatment of people who lack the capacity to consent to the care or treatment (see paras 93-97). The MCA will be particularly relevant when staff in general hospitals are considering the use of restrictive interventions to protect the person. If the MHA and/or MCA do not apply, the use of force is only justified legally for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property and the same statutory and common law provisions apply within health and care services as elsewhere.

## The safe and ethical use of all forms of restrictive interventions

**58.** The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles.

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions should only ever be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.

**59.** If organisations and staff impose restrictive interventions on those in their care they must have a lawful basis for doing so. The law in respect of issues relevant to restrictive interventions, and the degree of restriction that might amount to an unlawful deprivation of liberty, continues to evolve and services should review and update their local policies on an on-going basis in light of legal developments.

**60.** There is considerable concern and controversy surrounding potential harm to individuals caused by restrictive interventions. In some instances they have caused serious physical and psychological trauma, and even death[34].

**61.** All restrictive interventions can pose risks. Transparent policies and appropriate governance structures must be established against a context of positive and proactive working and within care pathways which provide behaviour support plans. The risks vary from intervention to intervention; it is important that those who use restrictive interventions understand the risks associated with each intervention. In many instances a rigorous practice of identifying and assessing risks can be an effective safeguard to minimise risks.

**62.** Effective governance strategies must ensure that there is transparency around the use of restrictive interventions. Wherever possible people should be engaged in all aspects of planning their care including how crisis situations should be responded to. People should be involved in post-incident debriefings, and there should be rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.

**63.** Restrictive interventions are being used which may amount to assault or battery (if the person has mental capacity to refuse what is proposed), wilful neglect or ill treatment of people lacking mental capacity (an offence under section 44 of the MCA[14]) or unlawful deprivations of liberty.

64. When confronted with acute behavioural disturbance, the choice of restrictive intervention must always represent the least restrictive option to meet the immediate need. It should always be informed by the person's preference (if known), any particular risks associated with their general health and an appraisal of the immediate environment. Individual risk factors which suggest a person is at increased risk of physical and/or emotional trauma must be taken into account when applying restrictive interventions. For example, this would include recognising that for a person with a history of traumatic sexual/physical abuse, any physical contact may carry an additional risk of causing added emotional trauma. Or for a person known to have muscular-skeletal problems such as a curvature of the spine, some positions may carry a risk of injury.

65. Where there is a known likelihood that restrictive interventions might need to be used, they should, so far as possible be planned in advance and recorded in a behaviour support plan (or equivalent), which includes primary and secondary preventative strategies.

66. Restrictive interventions, as defined in this guidance, can take a number of forms. These are detailed below.

### *Physical restraint*

67. Physical restraint refers to:

> *'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.*

68. A member of staff should take responsibility for communicating with the person throughout any period of restraint in order to continually attempt to de-escalate the situation.

69. Staff must not cause deliberate pain to a person in an attempt to force compliance with their instructions. Where there is an immediate risk to life, in accordance with NICE guidelines[10], recognised techniques that cause pain as a stimulus may be used as an intervention to mitigate that risk. These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate that immediate risk to life. These techniques should only be used by trained staff having due regard for the safety and dignity of patients. The use of these techniques must be embedded in local policies.

70. People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.

71. This will best be achieved through the adoption and sustained implementation of restrictive practice reduction programmes and the delivery of care pathways that incorporate PBS.

72. If exceptionally a person is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible.

73. Where unplanned or unintentional incidents of any restrictive practice occur there should always be recording and debrief to ensure learning and continuous safety improvements.

74. Staff must not deliberately use techniques where a person is allowed to fall, unsupported, other than where there is a need to escape from a life-threatening situation.

**75.** Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation.

**76.** In all circumstances where restraint is used one of the support staff must monitor the person's airway and physical condition throughout the restraint to minimise the potential of harm or injury. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention to pallor or discolouration) must be carried out and recorded, and staff should be trained so that they are competent to interpret these vital signs. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint must stop immediately.

**77.** Support staff must continue to monitor the individual for signs of emotional or physical distress for a significant period of time following the application of restraint.

### *Mechanical restraint*

**78.** Mechanical restraint refers to:

> *'the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'.*

**79.** Mechanical restraints should never be a first line means of managing disturbed behaviour. The use of mechanical restraint to manage extreme violence directed towards others should be exceptional, and seldom used in this or other contexts outside of high secure settings.

**80.** It is recognised that following rigorous assessment there may be exceptional circumstances where mechanical restraints need to be used to limit self-injurious behaviour of extremely high frequency and intensity[35]. This contingency is most notably encountered with small numbers of people who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard a person from the hazardous consequences of their behaviour. Wherever mechanical restraint is used as a planned contingency it must be identified within a broad ranging, robust behaviour support plan which aims to bring about the circumstances where continued use of mechanical restraint will no longer be required.

**81.** There may be occasions when the use of restraint (including handcuffs) is needed for security purposes, for example when transferring prisoners into a healthcare setting. Guidance for prison and NHS staff to develop local procedures was agreed in a concordat[36] between the National Offender Management Service (NOMS) and the NHS Counter Fraud and Security Service (now NHS Protect), which forms part of the National Security Framework. Further guidance of transferring prisoners into a secure mental health setting is provided in the Mental Health Act 1983 Code of Practice[11].

**82.** There may be occasions where restraint (including handcuffs) is used for security purposes for transferring restricted patients in secure settings to non-secure settings. The use of restraint in these circumstances should form part of individual risk assessments to take account of dignity and respect and the physical and mental condition of the individual.

**83.** Medical staff have the right to request the removal of restraints while treatment is carried out. On occasion, in high risk cases, the Secretary of State for Justice will make permission for a restricted patient to leave the hospital conditional on the use of restraint. Hospital staff should discuss any concerns about this with mental health casework section.

### *Chemical restraint*

84. Chemical restraint refers to:

> *'The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness'.*

85. Chemical restraint should be used only for a person who is highly aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour. Chemical restraint should only ever be delivered in accordance with acknowledged, evidence-based best practice guidelines[10,37,38]. Prescribers should provide information to those who provide care and support regarding of any physical monitoring that may be required as well as the medication to be used and the route of medication.

86. The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term 'rapid tranquillisation' refers to intramuscular injections and oral medication. Oral medication should always be considered first. Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.

### *Seclusion*

87. Seclusion refers to:

> *'The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.'*
>
> *'Its sole aim is the containment of severely disturbed behavior which is likely to cause harm to others.'*

88. Only people detained under the MHA[18] should be considered for seclusion. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the MHA should be undertaken immediately. The MHA Code of Practice[11] lays down clear procedures for the use of seclusion including its initiation, ongoing implementation and review and termination.

89. The seclusion of a person under the MHA in a community setting (for whom neither a Deprivation of Liberty authorisation nor a Court of Protection order under the MCA to authorise the deprivation of their liberty is in place) is also likely to amount to an unlawful deprivation of liberty. If the circumstances of a person's care resemble seclusion, it is seclusion whatever it is called locally. An assessment should be undertaken promptly to determine whether the person should be detained under the MHA immediately.

### *Long-term segregation*

**90.** Long-term segregation refers to a situation where a person is prevented from mixing freely with other people who use a service. This form of restrictive intervention should rarely be used and only ever for hospital patients who present an almost continuous risk of serious harm to others and for whom it is agreed that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other users of the service.

**91.** Long-term segregation must never take place outside of hospital settings and should never be used with people who are not detained under the MHA. As such it must only ever be undertaken in conjunction with the safeguards for its use in the MHA Code of Practice[11]. The does not apply to the segregation of prisoners within prison establishments.

## Where restrictive interventions are not enough

**92.** NHS Protect guidance[7] indicates trigger points for the need to seek further assistance from the police service. If the police are called upon to help manage a dangerous situation they will use techniques and act in accordance with their professional training. Care and support staff have a continuing responsibility to alert police officers to any specific risks or health problems that the person may have as well as to monitor the person's physical and emotional wellbeing and alert police officers to any specific concerns.

## The lawful use of restrictive interventions in respect of people who lack capacity

**93.** The MCA[14] presumes that all persons 16 and over have the ability to make their own decisions and protects their right to make and act on their own free and informed decisions. It also provides important safeguards where people lack the capacity to make their own decision. The five principles of the MCA are shown below.

### Five statutory principles of the Mental Capacity Act

1. A person must be assumed to have capacity unless it is proved otherwise.
2. A person must not be treated as unable to make a decision unless all practicable steps to help have been taken without success.
3. A person is not to be treated as unable to make a decision merely because an unwise decision is made.
4. An act done, or decision made under the Act for, or on behalf of a person who lacks capacity, must be done in their best interests.
5. Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved in a less restrictive way.

**94.** Staff should seek a person's consent if they are proposing to act in connection with the care or treatment of that person. This means that staff must explain any proposed procedure in an accessible and easily understandable way to enable a person to make their own decisions. They should support the person to ask questions and to weigh up information relevant to the decision to be made.

**95.** If the person is unable to make the decision within the meaning of section 3 of the MCA, staff should carry out a formal assessment of the person's capacity in relation to the proposed specific intervention. Chapter 5 of the MCA Code of Practice[39] provides guidance on how to assess capacity. If the person is found to lack capacity within the meaning of section 2 of the MCA[14], then a decision about their care and treatment may need to be made on their behalf, in their best interests.

**96.** The person who does the act should follow section 4 of the MCA and the guidance outlined in chapter 5 of the MCA Code of Practice[39] in determining what is in the person's best interests. The person making the decision will need to:

- consider all relevant circumstances
- consider whether the decision can be delayed until the person regains capacity
- involve the person as fully as possible in making the decision and any act done for them
- consider the person's past and present wishes and feelings
- consider any advance decisions to refuse treatment or statements made about how they should be cared for and supported (including identifying whether the person has a donee of Lasting Power of Attorney or a deputy with the legal authority to make decisions)
- consider the person's beliefs and values that would be likely to influence their decision if they had capacity
- consult the person's family and informal carers
- take account of the views of an independent mental capacity advocate or other key people (such as family members and those who usually provide care and support)
- consider whether it is the least restrictive option, in terms of the person's rights and freedoms, by which to meet the person's need.

**97.** Section 5 of the MCA[14] (subject to the limits in section 6) will provide legal protection from liability (except for negligence) for acts that involve restrictive interventions if:

- the person applying the intervention has taken reasonable steps to establish that the person lacks capacity to consent to the intervention, and reasonably believes the person lacks capacity at the time it is applied and that it is in the person's best interests
- the person applying the restrictive intervention reasonably believes that it is necessary in order to prevent harm to the person, not others. Interventions for the protection of others would need to be justified by reference to other statutory or common law powers or defences; and
- any use, or threat of force, to implement a restrictive intervention which the person is resisting, or which restricts the person's liberty of movement, whether or not the person resists, is a proportionate response to:
  - the likelihood of the person suffering harm, and
  - the seriousness of that harm.

**98.** Sections 5 and 6 permit restrictions on liberty in the circumstances outlined above, but do not authorise acts that deprive a person of their liberty. Whether or not an act amounts to a deprivation, rather than a restriction, of liberty depends on the circumstances of the individual case. Factors which may amount to a deprivation of liberty in the circumstances of individual cases include:

- staff having complete control over a person's care or movements for a long period of time
- staff making all decisions about a person, including choices about assessments, treatment and visitors and controlling where they can go and when
- staff refusing to allow a patient to leave, for example, to live with a carer or family member
- staff restricting a person's access to their friends or family.

**99.** There will be a deprivation of liberty if a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. If a deprivation of liberty is necessary, it can only be authorised by a procedure set out in law, which enables the lawfulness of that deprivation of liberty to be reviewed. Legal authority to deprive the person of their liberty may be obtained under the Deprivation of Liberty Safeguards (DoLS)[40] in the MCA[14] or the MHA[18]. Each regime provides a procedure to authorise deprivation of liberty.

**100.** The DoLS were incorporated in the MCA[14] to ensure that there is a procedure for authorising deprivation of liberty in hospitals and care homes for adults who lack capacity to consent to admission or treatment for mental disorder. The Court of Protection can authorise deprivation of liberty in other settings. Detailed guidance on DoLS procedures can be found within the Deprivation of Liberty Safeguards Code of Practice[40].

**101.** Where the person is unable to consent and it is not clear restrictive interventions are in the person's best interest, consideration should be given to approaching the Court of Protection for a best interests decision as to the appropriateness of the proposed intervention.

**102.** The key safeguards afforded to people deprived of their liberty under the MCA are:

- the right to a representative and/or a independent mental capacity advocate
- the right to challenge a deprivation of liberty
- mechanisms for the deprivation of liberty to be reviewed.

**103.** The MHA[18] authorises deprivation of liberty if the person meets the criteria for being detained for the purpose of assessment and/or treatment for mental disorder, even in the absence of their consent. Guidance is given on the delivery of safe and therapeutic care and safeguards around the use of restrictive interventions in chapter 15 of the MHA Code of Practice[11].

**104.** Statutory or common law defences may apply, in the rare circumstances where, neither the MCA[14] nor MHA[18] apply. Reasonable force may be used for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property. In order to be 'reasonable', the force involved should be necessary and proportionate in the specific circumstances. Force should only be used as a last resort. These justifications and defences should not be relied on for the recurrent, long-term, and/or planned use of restrictive physical interventions in respect of an individual.

## Good governance

### *Corporate accountability*

**105.** In response to *Transforming Care: a national response to Winterbourne View Hospital*[1] and the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*[41] the CQC has developed a robust system of registration, regulation and inspection which allows corporate and NHS boards to be held to account for failings in care. In extreme circumstances, the CQC will prosecute providers without issuing prior warning notices.

**106.** During service visits and routine reviews (including regulatory inspections of service quality), the CQC will seek to assure themselves that people who are exposed to restrictive interventions have access to high quality behaviour support plans, designed, implemented and reviewed by staff with the necessary skills and that restrictive interventions are undertaken lawfully.

### *Protecting employees and others in the working environment*

**107.** The use of physical interventions is hazardous and places both staff and people who use services at risk of physical or emotional harm. The Health and Safety at Work Act 1974[42] (HSWA) places a duty on employers to ensure, so far as is reasonably practicable, that the health, safety and welfare at work of their employees and the health and safety of others who may be affected by the employer's undertaking is safeguarded. Within this Act, and other more specific health and safety legislation, there are requirements that employers need to comply with to protect employees and others. Employers need to:

- Assess the risks to employees and others (including reasonably foreseeable violence), decide on the significance of these risks, how the risks can be prevented or controlled and implement these arrangements to reduce the risks[43].
- Provide adequate information, instruction, training and supervision to ensure the health and safety of the employees. This would include the risks that arise from both violence and aggression, as well as those linked to the use of restrictive interventions and restraint[43].
- Monitor and review the arrangements implemented to reduce the risks to ensure they are effective[43].
- Establish transparent processes to ensure that both the hazardous nature of any foreseeable violence and aggression in the workplace, and of any restrictive interventions that are permitted are acknowledged.

## Key approaches to reducing harm

**108.** Key approaches include the following.

- Services must have restrictive intervention reduction programmes based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, service user empowerment and a commitment to effective models of post incident review.
- Restrictive intervention reduction programmes must be reviewed on an ongoing basis. As a minimum there must be evidence of at least an annual, full, evidence-based review of control measures leading to revision and update of corporate action plans.
  - All restrictive intervention reduction programmes and evidence of associated reviews must be made available for inspection by the regulators: CQC and Monitor.

- Where services are delivered to people who are known to present behaviours that challenge, care must be delivered in accordance with the principles of PBS.
- Any service user with a behaviour support plan advocating the use of restrictive interventions should have clear proactive strategies including details of primary and secondary preventative strategies.
- There must be assurance mechanisms which routinely examine the quality of training provided to staff about positive behavioural support, de-escalation and the use of restrictive interventions.
- There must be arrangements for staff with differing degrees of specialism and seniority to maintain the competence associated with their role (i.e. the competencies required to deliver an effective behaviour support plan are qualitatively and quantitatively different than those required by a specialist practitioner who undertakes complex assessments and devises behaviour support plans).
- Service providers must acknowledge and seek to minimise the risks associated with any restrictive interventions taught to staff. Training providers should issue care providers with specific risk profiles for each technique taught.
- There must be details of how board level (or equivalent) authorisation and approval of any restrictive interventions taught to their staff and used in practice.
- Services must maintain accurate information that allows them to readily identify which service users have behaviour support plans that include the use of restrictive interventions as tertiary strategies.

**109.** Effective governance frameworks are founded on transparency and accountability. Accordingly, all services where restrictive interventions are used must:

- Have an identified executive director or equivalent who takes a lead responsibility for restrictive intervention reduction programmes. People who use services and families should be informed who this is.
- Demonstrate a process of board level (or equivalent) reviews of restrictive intervention reduction programmes.
- Report on progress with restrictive intervention reduction programmes to commissioners of services.
- Reviews of the quality of design and application of all positive behaviour support plans should be included within a service provider’s internal audit and should inform organisational increased behaviour support planning and restrictive intervention reduction strategies.

## Recording and reporting

**110.** Services must comply with all expected data requirements, including recording and reporting on restraint in the National Reporting Learning Set (NRLS) and for mental health and learning disability providers the requirements in the National Mental Health Minimum Data Set (NMHMDS). NHS England will provide further guidance on NRLS reporting for all NHS-funded care.

**111.** Services must also publish a public, annually updated, accessible report on their increased behaviour support planning and restrictive intervention reduction, which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions. These should be included within annual quality accounts (or equivalent publications).

**112.** Clear and accurate recording of the use of restrictive interventions is needed to evaluate services' progress against their increase positive behaviour support planning and restrictive intervention reduction programmes. If restrictive interventions are to be used as a last resort, then senior managers must understand the extent of their application and this needs to be founded on accurate and transparent data:

- Services must monitor the incidence of the restrictive interventions defined in this guidance.
- If CQC inspectors find restraint used and not recorded or reported this will be construed as indicative of poor quality of practice.
- Any person with a behaviour support plan advocating the use of restrictive interventions should have clear proactive strategies including details of primary and secondary preventative strategies.
- Following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident). The record should allow aggregated data to be reviewed and should indicate:
  - the names of the staff and people involved
  - the reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
  - the type of intervention employed
  - the date and the duration of the intervention
  - whether the person or anyone else experienced injury or distress
  - what action was taken.

**113.** To help protect the interests of people with whom restrictive interventions are used, it is good practice to involve the person and, wherever possible, family carers, advocates and other relevant representatives (e.g. the attorney or deputy for a person who lacks capacity) in planning, monitoring and reviewing how and when they are used. This includes ensuring all reasonable adjustments and that documentation is a format the individual understands. If a person is not involved this should be fully documented and justified.

## Local policy frameworks

**114.** Organisations that provide care and support to people who are at risk of being exposed to restrictive interventions must have clear organisational policies which reflect professional or clinical guidance, current legislation, case law and evidence of best practice.

**115.** Policies should outline the organisational approach to restrictive intervention reduction, including training strategies. Arrangements for the provision of high quality behaviour support plans for people who are likely to present behaviours that may require the use of restrictive interventions must be included. Employers and managers are responsible for ensuring that staff receive training, including updates and refresher courses, appropriate to their role and responsibilities within the service.

**116.** All policies must be co-produced with people who use services and carers. They must include guidance to employees on the safe use of restrictive interventions as a demonstrable last resort, either as part of a behaviour support plan or as an emergency measure where behaviours cannot be predicted. There must be guidance on how the hazards associated with restrictive interventions will be minimised, for example, first aid procedures in the event of an injury or distress arising as a result of physical restraint.

**117.** Clear recording and reporting arrangements should be explicit along with the mechanism by which this data will inform the on-going review of a restrictive intervention reduction programme.

**118.** The policy should explain how people who use services, their carers, families and advocates participate in planning, monitoring and reviewing the use of restrictive interventions and in determining the effectiveness of restrictive intervention reduction programmes. This will include providing accessible updates and publishing key data within quality accounts (or equivalent report).

## Staff training and development

**119.** Education and training are central to promoting and supporting change. Staff who may be required to use restrictive interventions must have specialised training. Detailed guidance on staff development and training has been published jointly by Skills for Health and Skills for Care.[12] Corporate training strategies need to be explicit regarding learning outcomes relating to:

- the experience of people who use services
- trauma informed care
- core skills in building therapeutic relationships
- the principles of positive behavioural support
- legal and ethical issues
- risks associated with restrictive interventions
- staff thoughts and feelings on being exposed to disturbed behaviour
- the use of safety planning tools and advance decisions
- alternatives to restrictive interventions
- effective use of de-escalation techniques
- the risks associated with restrictive interventions and how these risks can be minimised
- the use of breakaway techniques by which to disengage from grabs and holds
- safe implementation of restrictive physical interventions; and
- post-incident debriefing and support for staff and people who use services.

**120.** In accordance with the recommendations of Skills for Care and Skills for Health[12]:

- anyone who may carry out a restrictive intervention or provide training in this area should have completed training in the MCA; and
- learning about a human rights-based, positive and proactive, non-aversive approach must precede any training on application of restrictive interventions.

**121.** Workforce development must include people who use services and experts by experience to increase awareness of what it feels like to be subject to restrictive interventions.

**122.** It is highly unlikely that a single training option will fit all health and care settings. NICE guidelines[10] identify potential core components of training in the use of physical interventions, although this guidance is aimed only at psychiatric in-patient services and emergency departments. The forthcoming NICE guidance will explore the evidence base relating to a far broader range of settings.

**123.** The precise nature and extent of restrictive intervention techniques, as well as the frequency of refresher training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present, the settings in which they are cared for, and the responsibilities of individual members of staff. As a minimum, staff should receive annual refresher training or professional development in accordance with Skills for Care and Skills for Health recommendations.[12]

**124.** Frontline staff who are often in the position to decide whether or not to use restrictive interventions, should be the focus of training initiatives[35]. Executive board members who authorise the use of restrictive interventions in their organisations should also undertake appropriate training in the use of PBS and physical interventions to ensure they are fully aware of the techniques their staff are being trained in.

**125.** Boards need to ensure that training and workforce development reflects the therapeutic nature and purpose of health and care settings and ensure that it has been appropriately developed for use in health and social care settings by health and social care staff rather than for other purposes (e.g. security). For specialist services it should be tailored to meet the needs of particular people (e.g. for those with a learning disability, autism or dementia).

**126.** Staff should only use methods of restrictive intervention for which they have received and passed professional development and/or training. Training records must record precisely the techniques that a member of staff has been trained to use.

**127.** There are no universally accepted standards for the use of physical restraint although both the British Institute of Learning Disabilities (BILD)[44] and the Institute of Conflict Management (ICM)[45] offer voluntary quality accreditation schemes. Over the last decade BILD have produced a range of publications and materials in relation to positive behavioural support and physical interventions.

## Responsible commissioning

128. All NHS and local authority commissioners, especially those who fund placements for people who are known to present with behaviours that challenge or regularly experience crisis situations where the risk of using restrictive interventions is increased, must assure themselves that the service has the necessary competencies to provide effective support and is pursuing a policy of reducing restrictive interventions. This must include ensuring that people have access to the specialist skills needed to develop effective behaviour support plans, including specialist skills to support individuals with particular needs. In the case of learning disability services, the Challenging Behaviour National Strategy Group has produced a range of publications to help commissioners know what is required[46].

129. Health and social care service commissioners must:
    - Not place people in services which use restrictive interventions unless these services have robust, regularly reviewed, organisational restrictive intervention reduction programmes.
    - Ensure that placements are only made and sustained on the basis of a full understanding of a person's needs and any associated risks.
    - Ensure through their review processes that commissioned services continue to meet the needs of individuals, their families and carers. This must include a review of all data regarding the application of restrictive interventions.
    - Where it is known that people present with behaviours that challenge, special attention should be paid to services' ability to deliver PBS.
    - Assure themselves that there are satisfactory arrangements within any commissioned services to maintain appropriate knowledge and skills across the workforce.
    - Assure themselves that commissioned services have mechanisms in place to ensure that physical interventions are delivered in as safe a manner as possible.
    - Take concerted and timely action as part of contract compliance where this is not the case.

# Summary of actions

130. Across the full range of health and social care services delivered or commissioned by the NHS or local authorities in England, people who present with behaviour that challenges are at higher risk of being subjected to restrictive interventions. Many restrictive interventions place people who use services, and to a lesser degree, staff and those who provide support, at risk of physical and/or emotional harm.

131. The following actions will ensure that people's quality of life is enhanced and that their needs are better met which will reduce the need for restrictive interventions, and that staff and those who provide support are protected.

- All services where restrictive interventions are used must have an identified **board level**, or equivalent, **lead** for increasing positive behaviour support planning and reducing restrictive interventions.
- All services where restrictive interventions may be used should have **restrictive intervention reduction programmes** in place. Such programmes must be based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, service user empowerment and a commitment to effective models of post incident review.
- In those services where people can reasonably be predicted to be at risk of being exposed to restrictive interventions, individualised support plans must incorporate the key elements of **behaviour support plans**. This will include how needs will be met and environments structured to reduce the incidents of behaviours of concern. They must also detail how early warning signs of behaviour escalation can be recognised and responded to together with plans for the safe application of restrictive interventions if a crisis develops.
- Plans for the use of restrictive interventions **must not include the physical restraint of people in a way that impacts on their airways, breathing or circulation**, such as face down restraint.
- Plans for the use of physical or mechanical restraint **must not include the deliberate application of pain** in an attempt to force compliance with instructions. Painful holds or stimuli cannot be justified unless there is an immediate threat to life.
- Where behaviour support plans, or equivalents which incorporate the key components, are used, reviews of their quality of design and application should be included within a service provider's **internal audit** programmes.
- Appropriate governance structures and **transparent policies** around the use of restrictive interventions must be established within a context of positive and proactive working.

- The choice of any restrictive intervention that has to be used must always represent the **least restrictive option** to meet the immediate need.
- Wherever possible, people who use services, family carers, advocates and other relevant representatives should be **engaged in all aspects** of planning their care including how to respond to crisis situations, post-incident debriefings, rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.
- Provider organisations must use a process whereby there is **board level (or equivalent) authorisation** and approval of the restrictive interventions taught to their staff and used in practice.
- Organisations that provide care and support to people who are at risk of being exposed to restrictive interventions **must have clear organisational policies** which reflect current legislation, case law and evidence of best practice. Accessible versions of the policies should be available to those who use the services.
- Services must publish a **public, annually updated, accessible report on the use of restrictive interventions** which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.
- Service **commissioners** must be informed about restrictive interventions used for those for whom they have responsibility.
- There must be **clear and accurate recording** of the use of restrictive interventions to evaluate services' progress against their restrictive intervention reduction programmes.
- Service providers must ensure that **post-incident reviews and debriefs** are planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.
- All staff who may be required to use restrictive interventions must have **high quality, specialised training**.
- Service commissioners must assure themselves that the **service has the necessary competencies** to provide effective support for the people they are funding.

# References

1 Department of Health (2012) *Transforming care: A National response to Winterbourne View hospital* London: DH

2 Mind (2012) *Mental health crisis care: physical restraint in crisis* London: Mind

3 HM Government (2014) *Closing the Gap: essential priorities for change in mental health:* London: TSO

4 Department of Health (2002) *Guidance for restrictive physical interventions: How to provide safe services for people with learning disabilities and autistic spectrum conditions* London: DH

5 United Nations (1989) *Convention on the Rights of the Child.*

6 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 London: HMSO

7 NHS Protect (2013) *Meeting Needs and Reducing Distress – Guidance on the prevention and management of clinically related challenging behaviour in NHS Settings* London: DH

8 HM Government (2014) *The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis.* London: TSO

9 NHS England & Local Government Association (2014) *Ensuring quality services. Core Principles Commissioning Tool for the development of Local Specifications for services supporting Children, Young People, Adults and Older People with Learning Disabilities and / or Autism who Display or are at Risk of Displaying Behaviour that Challenges* London: NHS England & LGA

10 NICE (2005) *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* London: NICE

11 DH (2008) *Code of Practice, Mental Health Act 1983* London: TSO

12 Skills for Care & Skills for Health (2014) *A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health* London: SfH/SfC

13 Council of Europe (1950) *The European Convention of Human Rights*

14 *Mental Capacity Act 2005* London: HMSO

15 *Human Rights Act 1998* HMSO

16 Scottish Human Rights Commission (2009) *Human Rights in a Health Care Setting: Making it Work - An Evaluation of a human rights-based approach at The State Hospital.* Glasgow: SHRC.

17 British Institute of Human Rights. (2013). *The Difference it Makes: Putting Human Rights at the Heart of Health and Social Care.* www.bihr.org.uk. [Accessed 25 January 2014].

18 *Mental Health Act 1984* London: HMSO

19 Curtice, M.J. and Exworthy, T. (2010) FREDA: a human rights-based approach to healthcare. *The Psychiatrist* **34**(4): 150-156.

20 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) *Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists.* London: SLAM/SWLSTG

21 Smith, G.M., Davis, R.H., Bixler, E.O., Lin, H.M., Altenor, A., Altenor, R.J., Hardenstine, B.D. and Kopchick, G.A. (2005) Pennsylvania State Hospital system's seclusion and restraint reduction program *Psychiatric Services* **56:** 1115 - 1122

22 Huckshorn, K.A. (2004) *Reducing the use of seclusion and restraint@ A national initiative for culture change and transformation* Lincoln, Nebraska: Roman Hruska Law Centre

23 Carr, E.G., Horner, R.H., Turnball, A.P., McLaughlin, D.M., McAtee, M.L., Smith, C.E., Ryan, K., Ruef, M., Doolabh, A. and Braddoch, D. (1999). *Positive behaviour support for people with developmental disabilities: A research synthesis.* American Association of Mental Retardation: Washington, DC.

24 Allen, D., Kaye, N., Horwood, S., Gray, D., Mines, S. (2012) The impact of a whole-organisation approach to positive behavioural support on the use of physical interventions *International Journal of Positive Behavioural Support* **2**(1): 26-30

25 McGill, P. (1993) Challenging behaviour, challenging environments and challenging needs. *Clinical Psychology Forum*, **56**, 14-18

26 Allen, D. (2011) *Reducing the use of restrictive practices with people who have intellectual disabilities* Kidderminster: British Institute of Learning Disabilities

27 Smith, G.M., Davis, R.H., Bixler, E.O., Lin, H.M., Altenor, A., Altenor, R.J., Hardenstine, B.D. and Kopchick, G.A. (2005) Pennsylvania State Hospital system's seclusion and restraint reduction program *Psychiatric Services* **56:** 1115-1122

28 Ashcroft, L., Bloss, M., Anthony, W.A. (2012) Best practices: The development and implementation of "no force first" as a best practice. *Psychiatric Services* **63**(5) 415-417

29 Mental Health Commission (2012) *Seclusion and Physical Restraint Reduction* Dublin: MHC

30 Bowers, L. (2014) *Safewards: a new model of conflict and containment on psychiatric wards* London: Institute of Psychiatry

31 Design Council and Department of Health (2011) *Reducing violence and aggression in A&E London:* Design Council

32 Skills for Security (2010) *Physical Intervention: reducing risk. A guide to good practice for employers of security personnel operating in healthcare settings.* Worcester: Skills for Security

33 Association of Chief Police Officers and National Policing Improvement Agency (2010) *Guidance on Responding to People with Mental Ill Health or Learning Disabilities London*: ACPO/NPIA

34 McVilly (2008) *Physical restraint in disability services: current practices; contemporary concerns and future directions* Victoria, Australia: Department of Human Services

35 Schreiner, G. M., Crafton, C. G. and Sevin, J. A. (2004) Decreasing the use of mechanical restraints and locked seclusion *Administration and Policy in Mental Health* **31:** 449– 463

36 Ministry of Justice National Offender Management Service (2010) *Concordat between the National Offender management Service & NHS Counter Fraud and Security Management Service. Prisoner Escort and Bedwatch Function* London: MoJ

37 Taylor, D., Paton, C., Kapur, S. (2012) *The Maudsley Prescribing Guidelines in Psychiatry* London: Wiley-Blackwell

38 Bhaumik, S. and Branford, D. (2005) *The Frith Prescribing Guidelines for Adults with Learning Disability* London: Taylor Francis

39 Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice* London: TSO

40 Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice*: London: TSO

41 Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary.* London: Stationery Office

42 *Health and Safety at Work Act 1974* London: The Stationery Office

43 *Management of Health and Safety at Work Regulations* 1999 SI 1999 No 2051 London: HMSO

44 BILD (2010) *Code of Practice for the use of restrictive physical interventions* Kidderminster: BILD Publications

45 Institute of Conflict Management (2008) *Quality award for training in managing work related violence* Leicester: ICM

46 McGill, P., Cooper, V. and Honeyman, G. (2010) *Developing better commissioning for individuals with behaviour that challenges services – a scoping exercise* Kent: Tizard Centre & The Challenging Behaviour Foundation

# Appendix 1: Useful documents that complement this guidance

- *NHS Protect (2013): Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings*[7]

  This guidance was developed by an expert group comprising doctors, security specialists and nurses. It provides important practical strategies, which should be applied across clinical settings, in order to help identify, assess, understand, prevent and manage clinically related 'challenging behaviour', by preventing or minimising a person's distress, meeting their needs, and ensuring that high quality care is delivered within a safe environment.

  The principles and approaches outlined apply to any adult patient in an NHS healthcare setting. Although specific techniques and interventions may differ, strategies for delivering high quality personalised care that meets a person's needs remain the same. The importance of positive engagement, communication between staff and de-escalation approaches are strongly emphasised.

- *HM Government (2014): The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis*[8]

  This Concordat is a multi-agency agreement between signed by more than 20 organisations including the police, mental health trusts and paramedics that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs.

  It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. In particular it examines how local authorities, health providers (including A&E departments) and the police service should work effectively.

- *NHS England & Local Government Association (2014): A Core Principles Commissioning Tool for the development of Local Specifications for services supporting Children, Young People, Adults and Older People with Learning Disabilities and/or Autism who Display or are at Risk of Displaying Behaviour that Challenges*[9]

  With the aim of informing decisions concerning the commissioning of services, the document was produced as a direct response to the scandalous events revealed to have occurred at Winterbourne View. It describes the core principles that should be present across all services for people with learning disabilities and / or autism who either display or are at risk of displaying behaviour which challenges.

  The document highlights the importance of a relentless person centred focus on outcomes, with all decisions being based on the best interests of the individual and a full recognition that family carers are most often those who know what the 'best interests' are. Rigorous adherence to the core principles will improve individuals' quality of life and reduce the prevalence and incidence of behaviour that challenges as well as inappropriate placements and the use of restrictive interventions

- *NICE (2005): Clinical Guideline 25. Violence: the short-term management of disturbed / violent behaviour in in-patient psychiatric and emergency departments*[10]

  This guidance examined and reported on the evidence base for the emergency management of acute behavioural disturbance across a selection of healthcare settings. Interventions and topics that are examined include: the care environment, prediction of violence and aggression, training, service user perspectives, emergency departments and the use of intensive supportive observations and a range of restrictive interventions.

  It is currently being updated in light of new and emerging clinical evidence and the new guidance is expected to be published in April 2015. When published, the expanded guidance will have broader applicability across the full range of adult health and social care services.

- *Department of Health (2008): Mental Health Act 1983 Code of Practice*[11]

  The Code provides guidance to staff who are involved in the treatment, care and support of people under the Mental Health Act 1983. Chapter 15 of the Code is of particular interest; it provides guidance on a range of interventions which may be considered for the safe and therapeutic management of hospital in-patients (whether or not they are detained under the Mental Health Act 1983) whose behaviour presents a particular risk to themselves or to others.

  The Code is currently being revised and is likely to be published late 2014. This will compliment this guidance, including having a stronger focus on positive and proactive care as well as additional safeguards around the application of restrictive interventions.

- *Skills for Care/Skills for Health (2014) A Positive and Proactive Workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*[12]

  This important guide is for commissioners and employers who are responsible for the development of a skilled, knowledgeable and competent health and social care. The document provides advice on the development of staff with the aim of ensuring that the use of restrictive interventions is minimised.

  The document addresses issues or developing person-centred organisational cultures, staff recruitment and retention, support, supervision, development of skills and knowledge and how to commission high quality training.

- *Department of Health (forthcoming 2014) Positive and Proactive care: reducing the new for restrictive interventions in the support and care of children, young people and individuals transitioning to adulthood*

  Children and young people face particular difficulties in relation to positive and proactive care and support. This requires careful consideration of their physical and emotional characteristics as maturing, still developing people with varying needs and capacity to understand their circumstances and who exhibit a very diverse range of behaviours. The care and support of children and young people is provided within different legal and service context and in accordance with the UN Convention on the Rights of the Child.

  Additional and separate guidance on reducing reliance on restrctive interventions when delivering services to children, young people and individuals in transistion is being developed.

Any enquiries regarding this publication should be sent to us at Social Care, Local Government and Care Partnership Directorate, Room 313, Richmond House, London SW1A 2NS. Email: Positive&Safe@dh.gsi.gov.uk

Department of Health

Skills for Health

skillsforcare

# A positive and proactive workforce

## A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health

# Ministerial foreword

Investigations into abuses at Winterbourne View Hospital and Mind's Mental Health Crisis in Care: physical restraint in crisis (2013) showed that restrictive interventions have not always been used only as a last resort in health and care. They have even been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this.

There is overwhelming support for the need to act. Over 95% of respondents were supportive in consultation. The Royal College of Nursing Congress voted by 99% in favour of new guidelines. Whilst I appreciate there may be times when restrictive interventions may be required to protect staff or other people who use services, or the individuals themselves, there is a clear and overwhelming case for change.

This is about ensuring service user and staff safety, dignity and respect. This is absolutely not about blaming staff. Whilst at Winterbourne there was clearly abuse and this must not be allowed to happen, we know that many staff have just been doing what they have been trained to do and have been struggling in difficult situations and often with very little support.

We need to equip these individuals with the skills to do things differently. The guidance makes clear that restrictive interventions may be required in life threatening situations to protect both people who use services and staff or as part of an agreed care plan.

Together Positive and Proactive Care and A Positive and Proactive workforce provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery. I want to thank the Royal College of Nursing for leading the multi-professional consortium who led on developing the Department's guidance and Skills for Care and Skills for Health in developing the complementary guidance to support the commissioning of learning and development. This was a great example of organisations working together to deliver high quality products that affect all of us.

This guidance is only one part of the story. From April 2014, DH will launch a new, wider two-year initiative Positive and Safe to deliver this transformation across all health and adult social care. We will identify levers to bring these changes about including improving reporting, training and governance. DH will also develop accompanying guidance in relation to children, young people and those in transition in healthcare settings.

I look forward to working with you to co-produce this programme. Through Positive and Safe we have the potential to make whole scale system-wide changes, ensuring we have a modern, compassionate and therapeutic health and care service fit for the 21st century.

**Norman Lamb**
Minister for Care and Support

# Contents

## 4. Implementation: information for specific situations

*A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.*

Published by:
Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP www.skillsforcare.org.uk
Skills for Health, 1st Floor, Goldsmiths House, Broad Plain, Bristol BS2 0JP www.skillsforhealth.org.uk

Skills for Care is the employer-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development. Skills for Health is the sector skills council for all health employers; NHS, independent and third sector.

Bibliographic reference data for Harvard-style author/date referencing system:
Short reference: Skills for Care & Skills for Health [or SfC&SfH] 2014
Long reference: Skills for Care & Skills for Health, *A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health,* (Leeds, 2014) www.skillsforcare.org.uk www.skillsforhealth.org.uk

# 1. Executive summary

Within the last few years, a number of reports have focused attention on the use, or abuse of restrictive interventions in health and care services. In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital* which outlined the actions to be taken to avoid any repeat of the abuse and illegal practices witnessed at Winterbourne View Hospital.

In June 2013 Mind published its report *Mental Health Crisis Care: physical restraint in crisis* which provided evidence of significant variations in the use of restraint across the country and raised concerns about the use of face down or 'prone' restraint and the numbers of restraint related injuries that were sustained.

*"A positive and proactive workforce; A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health"* has been co produced by Skills for Care and Skills for Health. It is one of a suite of guidance that has been written to support the introduction of 'Positive and Safe'.

Skills for Care and Skills for Health have worked extensively with focus groups and test sites representing experts in Positive Behaviour Support, people with learning disabilities, mental health problems, autism, older people, family carers, commissioners, social care employers and learning providers to inform and agree the content of the guide.

The guide will help commissioners and employers to develop a workforce that is skilled, knowledgeable, competent and well supported to work in a positive and proactive way to.

It will inform decision making when planning, purchasing or providing learning and development activites to support workers and individuals to work in a positive and proactive way.

In addition it outlines some key points for organisations to ensure that any restrictive practice or intervention is legally and ethically justifiable and underpinned by following key principles which are shared with the DH guidance:

- **Compliance** with the relevant rights in the European Convention on Human Rights at all times.
- **Understanding people's behaviour** allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- **Involvement and participation** of people with care and support needs and their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations;
- People must be treated with **compassion, dignity** and kindness.
- Social care and health services must support people to **balance** safety from harm with freedom of **choice**.
- **Positive relationships** between the people who deliver services and the people they support must be protected and preserved.

## 1.1. Key points

- This guide is concerned with developing workers so that they can work in a positive and pro-active way to minimise the use of all forms of **restrictive practices**. In everyday language we consider this to be: **"Making someone do something they don't want to do or stopping someone doing something they want to do"**.
- Anyone who may carry out a restrictive practice or provide learning in this area should have completed training in the Mental Capacity Act which covers the learning outcomes of the QCF unit MCA01, 'Awareness of the Mental Capacity Act 2005' (level 3) and other legislation relevant to their situation (see Appendix D).
- Learning about human rights based, positive and pro-active, non-aversive approaches must precede any training on or use of restrictive interventions.
- Significantly more time should be spent learning about positive and pro-active approaches and non-restrictive alternatives. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm and are part of an ongoing learning pathway.
- Bank / agency / casual / self-employed workers should receive training and support in line with all other workers in the team.
- Learning must be offered to individuals for whom restrictive practices are planned. Their family carers or support network should be included in learning proportionate to their level of their involvement in supporting the individual.
- Information must be offered to anyone experiencing planned or unplanned restrictive practices, and to their carers[1].
- Anyone delivering learning or assessing competence in restrictive practices should be occupationally competent and hold or be working towards achieving a recognised teaching /training qualification.
- All learning should be co-produced; including the voices of the people being supported and their carers in appropriate formats in design, production, delivery and evaluation.
- Workers in all social care and health services must have an appropriate level of awareness of the specific needs of people with whom they may come into contact. This may include people with dementia, psychosis, autism, borderline personality disorder, head injury, trauma, anxiety, learning disability, etc., and the ways in which these conditions may lead to behaviour that challenges or a resistance to essential care.
- Workers should have an understanding of how to access specialist advice and support for people, which includes advice on the impact of culture and the environment.
- Executive board members (and their equivalents in non-regulated services) who authorise

---

[1] 'Carer' is used throughout to indicate family or friends who provide social care or health support, as distinct from social care or health workers.

the use of restrictive interventions in their organisations must fully understand positive behaviour support and any physical interventions they authorise.

- Services offering positive behaviour support (PBS) must meet the specifications for a well trained workforce described in Ensuring Quality Services (EQS).

## 1.2. Acknowledgements

We wish to acknowledge the huge contribution made to this work by people who have shared their personal lived experiences, and friends and family members of people who have been subject to restrictive practices or restrictive interventions.

We also want to thank everyone who contributed to the development of the guide by being part of the steering group, the focus groups and guide test sites. In particular we wish to acknowledge the advice and support received from the following organisations:

- 2gether NHS Trust
- Amanda Hall Associates Limited
- Affinity Trust
- Alzheimers Society
- Ashmere
- Avon and Wiltshire Mental Health Partnership Trust : Learning Disability Intensive Team
- Brighton & Hove City Council
- British Institute of Learning Disabilities
- Carers Trust
- Care Management Group
- Care Through The Millennium
- Coventry City Council
- Care Quality Commission
- Crisis Prevention Institute Europe
- D.ESCAL8
- Department of Health
- Dimensions
- East London NHS Foundation Trust
- Gloucestershire County Council
- Health and Safety Executive: Health and Social Care Services Unit
- HF Trust Ltd (Hft)
- iMap Centre Limited
- Inspiration Care Ltd
- Integrate
- London Care Partnership

- Mind
- Monarch Healthcare
- NAViGO Health and Social Care CIC including Respect Training Solutions
- National Development Team for Inclusion (NDTi)
- National Voices
- NHS England
- North Bristol NHS Trust
- Nottingham County Council
- Positive Behaviour Support Consultancy Ltd
- Positive Response Training
- Royal College of Nursing
- Royal Cornwall Hospital Trust
- Scope
- Shropshire Council
- Shropshire Partners in Care (CWDP)
- Social Care Institute for Excellence
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Southern Health NHS Foundation Trust
- St Anne's Community Services
- The Avenues Group
- The Challenging Behaviour Foundation
- University of Kent - Tizard centre

# 2. Introduction

## 2.1. The purpose of this guide

This guide is aimed at commissioners and employers responsible for developing a adult social care and health workforce who are skilled, knowledgeable and competent. Organisations will have plans to reduce restrictive practices both for individuals and for their service as a whole and this guide should help them to implement these. This guide shows how workers can be developed and supported to minimise (reduce the necessity, frequency, intensity and duration of) restrictive practices and ensure they are only ever used appropriately and not misused or abused.

This guide applies to services for people with any kind of adult social care or health need, including people with longer term needs such as some people with a learning disability, autism, acquired brain injury or dementia, those with intermittent or frequently changing needs such as people with mental health or substance misuse problems, and people in an acute health crisis such as following an accident, severe infection, recovering from an anaesthetic or under the influence of alcohol or drugs. Those with intermittent or acute needs could, of course, include people who have also a learning disability, dementia or other long term condition.

Although the guide does not specifically apply to services for children and young people, those working within theses services may find it helpful. It has particular relevance to services supporting young people in transition.

Throughout this guide we refer to 'workforce'. In this context we mean everyone involved in supporting a person or persons with social care or health needs. This could include the individual and their family and friends along with paid workers, people who shape the services by providing regulation or training, those commissioning the service and senior level managers and board members.
This guide supports and complements the Department of Health's *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014), developed by the Royal College of Nursing, which provides guidance on the use of organisational models of restrictive intervention reduction and positive behavioural support in order to provide better outcomes for people.
This guide has also been written at the same time as *"Ensuring Quality Services - Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and / or autism who display or are at risk of displaying behaviour that challenges"* which has been developed by NHS England and the Association of Directors of Adult Social Services (NHSE LGA 2014 3). This guide aims to support and complement this in relevant services.

Current legislation, policy and accepted good practice are consistent that any restrictive practice should only be carried out where it is legally and ethically justified. This means it must be essential to prevent serious harm to somebody and it must be the least restrictive option.

In these circumstances you will be working within the Human Rights Act 1998 and the European Convention on Human Rights, the Mental Health Act 1983 as amended by the Mental Health Act 2007, the Mental Capacity

Act 2005 (MCA), including the Deprivation of Liberties Safeguards (DOLS), the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 and, in some circumstances, the Children Act 2004 and Common Law.

## 2.2. Why you should read this guide

Good proactive workforce planning and development will produce better outcomes for people using the services in a way that is cost effective in the long term. The reasons why you should use this guide will be different dependent upon your role. These include:

**People in need of care and support, and patients**

- The guide offers clear expectations of how people working and contributing to the service you use, should be developed.
- You should receive a higher quality service and one you can trust.
- These standards should help when purchasing your own care and support, contributing to commissioning for others or monitoring services.

**Workers**

- You should feel knowledgeable, skilled, competent, and supported to do your job to the best of your abilities.
- You will know what is expected of you.

**Employers and managers**

- Provides clear expectations of the standards expected from workers.
- Provides clear guidance on how to purchase or plan learning for workers and teams.
- Feel confident and assured that you are developing your workforce to deliver a quality service.
- Aids good staff recruitment and retention.
- Provides a baseline for negotiating contracts with commissioners of services and with learning providers.
- Provides evidence for relevant Care Quality Commission Standards and Regulations (2010, currently under review), specifically:

## Involvement and information

- Outcome 1: Respecting and involving people who use services
- Outcome 2: Consent to care and treatment

## Personalised care, treatment and support

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Cooperating with other providers

## Safeguarding and safety

- Outcome 7: Safeguarding people who use services from abuse

## Suitability of staffing

- Outcome 12: Requirements relating to workers
- Outcome 14: Supporting workers

## Quality and management

- Outcome 16: Assessing and monitoring the quality of service provision
- Outcome 21: Records

## Suitability of management

- Outcome 24: Requirements relating to registered managers

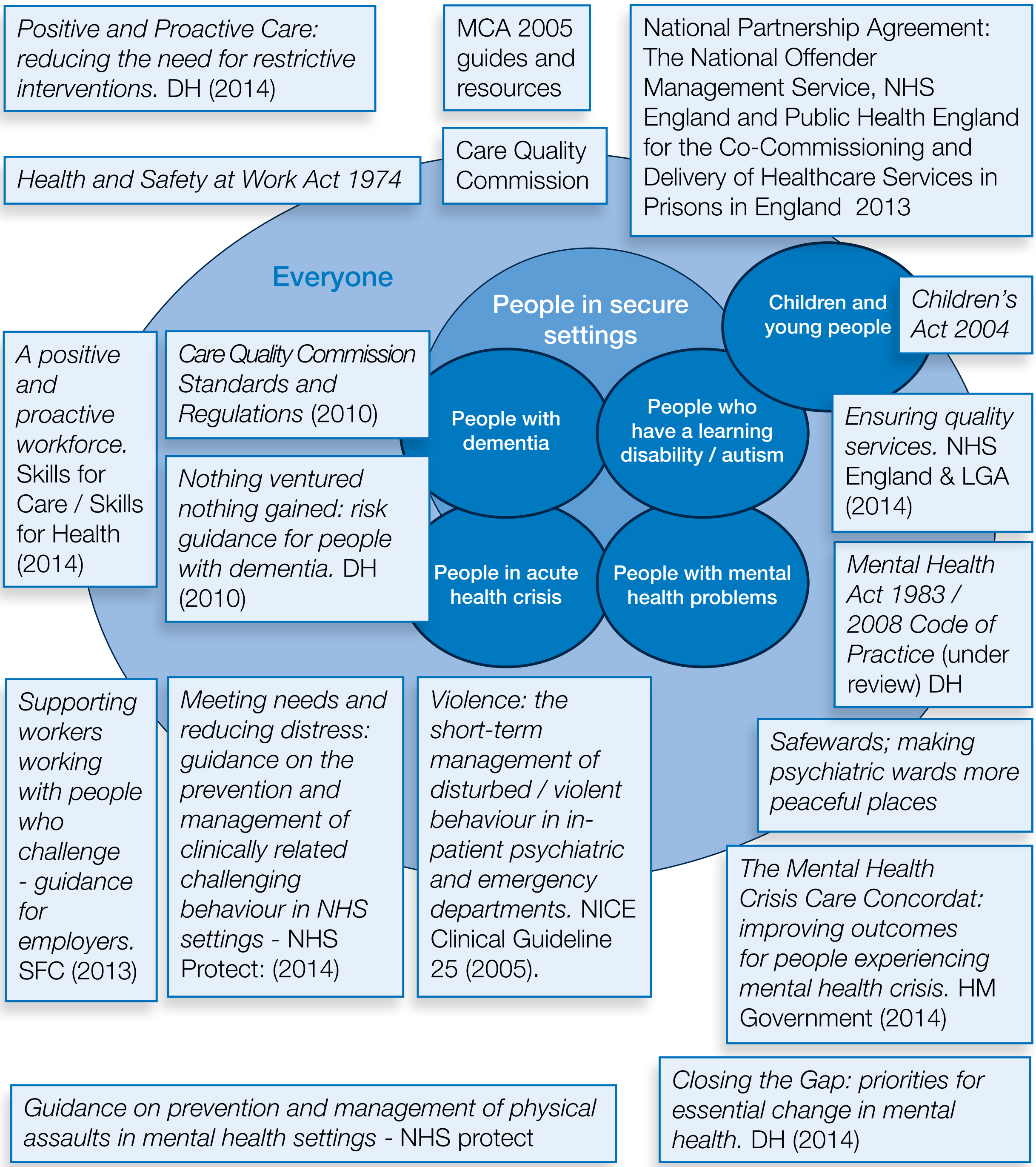
**Commissioners, regulators and inspectors**

- Outlines the standards required.
- Outlines good practice in workforce development to enable transparency in discussions with service providers.

**Safeguarding leads**

- Assists in considering situations where restrictions or interventions are used which may or may not be ethically or legally justified.

# New and current resources



*Positive and Proactive Care: reducing the need for restrictive interventions.* DH (2014)

MCA 2005 guides and resources

National Partnership Agreement: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2013

*Health and Safety at Work Act 1974*

Care Quality Commission

**Everyone**

**People in secure settings**

**Children and young people**

*Children's Act 2004*

*A positive and proactive workforce.* Skills for Care / Skills for Health (2014)

*Care Quality Commission Standards and Regulations* (2010)

**People with dementia**

**People who have a learning disability / autism**

*Ensuring quality services.* NHS England & LGA (2014)

*Nothing ventured nothing gained: risk guidance for people with dementia.* DH (2010)

**People in acute health crisis**

**People with mental health problems**

*Mental Health Act 1983 / 2008 Code of Practice* (under review) DH

*Supporting workers working with people who challenge - guidance for employers.* SFC (2013)

*Meeting needs and reducing distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings* - NHS Protect: (2014)

*Violence: the short-term management of disturbed / violent behaviour in in-patient psychiatric and emergency departments.* NICE Clinical Guideline 25 (2005).

*Safewards; making psychiatric wards more peaceful places*

*The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis.* HM Government (2014)

*Guidance on prevention and management of physical assaults in mental health settings* - NHS protect

*Closing the Gap: priorities for essential change in mental health.* DH (2014)

This guide fits with other guidance that is currently available and with work which is on-going.

## Current on-going work; allied projects and future products

**A number of additional projects are on going which include;**

- The positive and safe programme.
- New DH guidance for children and young people on restrictive interventions.
- New NICE guidelines on violence and aggression and also on challenging behaviour and learning disability. both due 14 / 15
- A place I call home; the winterbourne view joint improvement programme

## 2.3. Shared key principles

This guide and *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) are based upon a number of shared key principles which apply to adult social care and health services. These key principles underpin the need to deliver positive and proactive care, which requires rigorous governance in order to reduce excessive reliance on restrictive practices and interventions and to ensure that, when they have to be used, it is only ever as a last resort and is undertaken in a proportionate, least restrictive way.

**Shared key principles**

- **Compliance** with the relevant rights in the European Convention on Human Rights at all times.
- **Understanding people's behaviour** allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- **Involvement and participation** of people with care and support needs and their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations;
- People must be treated with **compassion, dignity** and kindness.
- Social care and health services must support people to **balance** safety from harm with freedom of **choice**.
- **Positive relationships** between the people who deliver services and the people they support must be protected and preserved.

## 2.4. What do we mean by 'restrictive practices'

This guide is concerned with developing workers so that they can work in a positive and pro-active way to minimise the use of all forms of **restrictive practices**. In everyday language we consider this to be:

**Making someone do something they don't want to do or stopping someone doing something they want to do.**

*Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) includes detailed definitions of forms of **restrictive interventions** which are used as an immediate and deliberate response to behaviours that challenge; the MCA has a broader definition of **restraint** and of **deprivations of liberty**. This guide considers restrictive interventions, **restraint** and **deprivations of liberty** as well as broader forms of restrictive practices that might be used as a routine feature of someone's care and support rather than solely in response to some form of crisis

Restrictive practices can be very obvious or very subtle; they may be planned in advance or used as a response to an emergency.

We have identified four main ways in which restrictive practices can happen, as follows.

- Restrictions that arise because of habit or blanket rules, like everyone having to be up by a certain time, rules on whether people can have their phones or doors being routinely locked. These are sometimes called "de facto" restrictions.
- Safety: these could be restrictions such as locking a room to keep household cleaning products or medicine out of someone's reach or allowing someone a planned portion of jam each day. This could also mean responding to violence or aggression towards the individual themselves, or to workers or others.
- Treatment or care: restrictive practices may be used in a planned or unplanned way in order to provide essential care, support or medical treatment. This could be in an emergency. Some prescribed medication not designed to restrict, such as sleeping tablets, can have restrictive side effects.
- Restrictions may also be used with people who are displaying or are at risk of displaying behaviour that challenges, including self-injurious behaviour. In this case, the principle of an approach called 'positive behaviour support' (PBS) should be used. More detail about this is in section 4.1 below. Other techniques are also useful with people with specific needs, this might also include those outlined within the 'Safewards Project' in mental health in-patient services or 'dementia care mapping' with people who have dementia. The NHS Protect guidance, *Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings* (2014) will be particularly useful in situations where you do not know the person in advance or do not have enough time to fully use PBS.

In all situations where restrictive practices may be used many of the principles and techniques of PBS will help to create a caring culture and a positive and proactive workforce. There should be evidence that restrictions are questioned and considered and only ever carried out when all other approaches have been considered and tried or are impractical.

**Restrictive practices** are a wide range of activities, some deliberate and some less so, which restrict people. **Restrictive interventions** lie within this and are a range of specific interventions.

For the purposes of this guide we are using the definitions of restrictive interventions as contained in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).
"'Restrictive interventions' are defined as:

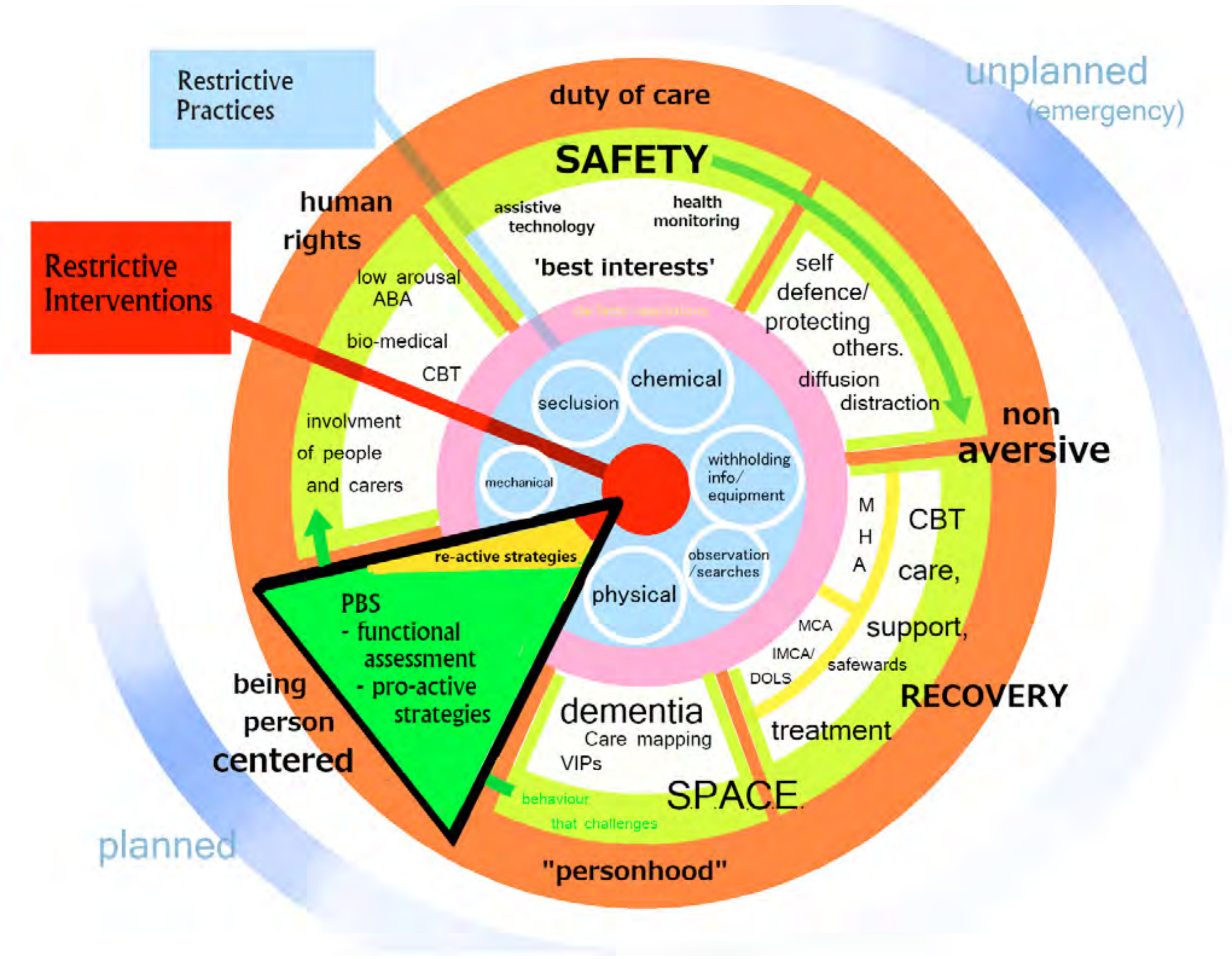
*'Interventions that restrict an individual's movement, liberty and/or freedom to act independently in order to:*
- *take immediate control of a dangerous situation: and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the patient's freedom for no longer than is necessary'."*

If carried out for any other purpose concerns about the misuse of restrictive interventions should always be escalated through local safeguarding procedures and protocols.

Within the context of this definition, restrictive interventions can take a number of forms, each defined more fully in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014):
- physical restraint (using physical contact mechanical restraint (using devices)
- chemical restraint (using medication)
- seclusion (confining or isolating people).

**Diagram illustrating how restrictive practices and restrictive interventions can be seen within a human rights-based model of positive and proactive support**

## Positive and proactive care



This diagram illustrates how restrictive interventions and/or restrictive practices may sit within a human rights-based positive and proactive system of care, treatment or support. It is not intended to be exhaustive, but shows that restrictive interventions and restrictive practices will always be a small part of an overall response to supporting people. Learning activities for workers should have a similar focus on positive ways of working in difficult situations.

## 2.5. The legal and ethical justification for restrictive practices

Workers should always strive to support and care for people in ways that are enabling and empowering. When people are distressed, ill, angry, confused or lack understanding of their situation they may need some degree of restriction to keep them or other people safe. All restrictive practices should be expressly acknowledged and must be legally and ethically justifiable. Decisions to use restrictive practices must be transparent and establish clear lines of accountability. Many of these decisions will involve assessing whether the person involved has the mental capacity to make a specific decision, for example to understand that a product or foodstuff may be unsafe, or to refuse or accept treatment. Anyone carrying out or observing any restrictive practice must be sure that it is absolutely necessary to prevent harm, that it is the least restrictive option available, that it is not done routinely for convenience, and that it is done for the shortest possible time.

It is preferable that restrictive practices should be considered and planned in advance and involve the individual (and their family where appropriate) and relevant multi-disciplinary professionals. They must ensure that monitoring, planning and reviewing takes place to find a more positive alternative on a longer term basis.

**Pain**

Workers must not cause deliberate pain to a person in an attempt to force compliance with their instructions. *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) explains that pain should only ever be used in the most extreme situations where there is an immediate risk to life.

A successful physical restrictive practice should never cause pain and if it does it needs to be reviewed. “The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of workers, service users and/or others. *NICE Clinical Guideline CG 25, Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments”*

## 2.6. How to identify when a practice is a restrictive practice or intervention

The following examples and flowchart may be a useful tool for identifying whether restrictive practices are appropriate and the legal and ethical justification for their use.

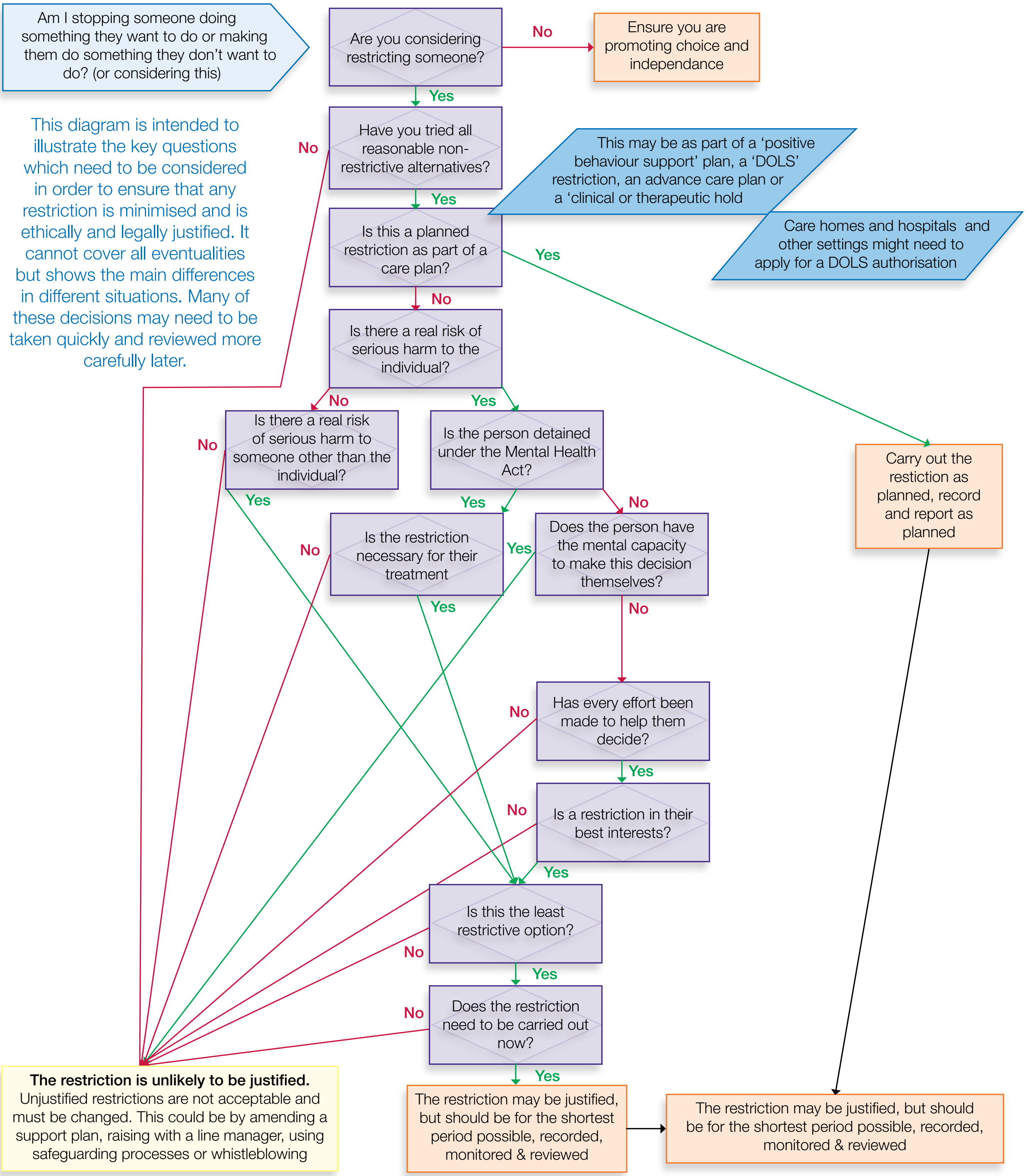
The examples illustrate the range of different restrictive practices and interventions and are based upon real life situations.

Some of these examples could be abusive, or alternately an appropriate way to support someone, some might be justifiable as a last resort, when absolutely necessary, in an extreme situation. The justification for using them is dependent upon proper care planning which includes assessment of the person’s mental capacity, the likelihood and potential severity of harm, the cultural perspective of

the individual involved, the potential for using alternatives, and the legal situation.

- A lady who lives in a care home is regularly encouraged to return to 'spend time in your room alone' because her singing upsets other residents.
- A man with dementia on a 'respite' stay brings a bottle of whisky with him. The workers keep it in the office and bring him up to two glasses per evening when he asks for it. If he asks for a third then they remind him he has already had two.
- A man is prescribed a sleeping tablet because his family are worried he may get up and wander or fall during the night.
- An ambulance crew attend to someone who is intoxicated with alcohol and has a head injury from a fall. They strap the person to a trolley to stop him climbing off.
- In a day centre, a guest is left for several hours with her dinner tray or wheelchair seatbelt on to prevent her 'wandering'.
- On a hospital ward a man's walking frame is moved out of his reach while workers are cleaning and they forget to put it back.
- A daughter wheels her dad in his wheelchair away from a crowded section in a supermarket because he is making sexually explicit comments about other customers. She tells him she won't bring him here again.
- A woman is told she can't go home 'on leave' from a mental health ward unless she shows that she is willing to take her medication.
- A member of the intensive care nursing team holds a woman's hands to stop her from removing a tracheotomy tube following surgery.
- A young woman who is detained under section 3 of the Mental Health Act is held down on her bed while nurses give her an injection of medication because she is refusing it.
- The personal assistants to a young man with severe epilepsy, learning disabilities and some mobility difficulties are told by his Mum to use his wheelchair when out even though he can walk short distances, as he is less likely to injure himself badly if he has a seizure while seated and strapped in and will be generally 'safer'.
- A person with Prader-Willi Syndrome needs to have food in his home provided to him in small portions at mealtimes. All other food needs to be locked away to prevent him overeating or eating raw food.
- During an admission under section to a mental health unit a person is denied access to blades although it is written in their care plan that they can use blades for safe & responsible self harm.

# Restrictive practices - what you should consider



Am I stopping someone doing something they want to do or making them do something they don't want to do? (or considering this)

This diagram is intended to illustrate the key questions which need to be considered in order to ensure that any restriction is minimised and is ethically and legally justified. It cannot cover all eventualities but shows the main differences in different situations. Many of these decisions may need to be taken quickly and reviewed more carefully later.

Are you considering restricting someone?

No

Ensure you are promoting choice and independance

Yes

Have you tried all reasonable non-restrictive alternatives?

No

Yes

This may be as part of a 'positive behaviour support' plan, a 'DOLS' restriction, an advance care plan or a 'clinical or therapeutic hold

Care homes and hospitals and other settings might need to apply for a DOLS authorisation

Is this a planned restriction as part of a care plan?

Yes

No

Is there a real risk of serious harm to the individual?

No

Yes

Is there a real risk of serious harm to someone other than the individual?

No

Yes

Is the person detained under the Mental Health Act?

Yes

No

Carry out the restriction as planned, record and report as planned

Is the restriction necessary for their treatment

No

Yes

Does the person have the mental capacity to make this decision themselves?

Yes

No

Has every effort been made to help them decide?

No

Yes

Is a restriction in their best interests?

No

Yes

Is this the least restrictive option?

No

Yes

Does the restriction need to be carried out now?

No

Yes

**The restriction is unlikely to be justified.** Unjustified restrictions are not acceptable and must be changed. This could be by amending a support plan, raising with a line manager, using safeguarding processes or whistleblowing

The restriction may be justified, but should be for the shortest period possible, recorded, monitored & reviewed

The restriction may be justified, but should be for the shortest period possible, recorded, monitored & reviewed

Information on assessing 'mental capacity' and 'best interests'; https://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

Seclusion is never justified except when the person is detained under the mental health act.

'Least restrictive' will depend on the likelihood of harm occuring, the severity of the harm and how proportionate the restriction is to the level of likely harm. How often is this restriction carried out? How long does it last? How intense / forceful is it? What other options are there?

**Click here** for Printable version of
Restrictive practices - what you should consider.

# Edie's story

Throughout this guide we consider briefly how a team in a residential care home learned to positively support a woman whose distress and behaviour presented the team with challenges in how they could best offer care to her.

On the Skills for Care and Skills for Health website Edie's story is available as a supporting resource for the guide as a full 'case study' along with other case studies and vignettes from other people. These are in written and video format. For more information see www.skillsforcare.org.uk/cbcasestudies

All of the case studies and vignettes are anonymous and full permission for their use has been granted.

We would encourage people to submit further examples in order to share good practice.

Edie is 82, she is widowed, has dementia, and lives in a residential care home. She was placed there reluctantly by her family as she had been assessed as not having the capacity to make the decision to move by herself.

During her first year there she became increasingly distressed and anxious. This seemed to happen most in her bedroom when she needed personal care such as help with washing and dressing. She was incontinent of both urine and faeces and workers believed that it was in her best interests to wash her and change her clothing.

She would resist any help by screaming, biting and pushing workers, and so workers became scared of going into her room to support her.

# 3. Effective workforce development to minimise the use of restrictive practices

Much of this section draws on more detailed guidance in other Skills for Care or Skills for Health guides:

- **Practical approaches to workforce planning; A guide to support workforce planning processes and plans for adult social care support services.** http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-planning/Workforce-planning-guide.pdf
- **Principles of workforce redesign.** http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-redesign/Principles-of-Workforce-Redesign-downloads-and-practical-resources.aspx
- **National occupational standards (health).** http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards
- **The NHS Knowledge and Skills Framework.** http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4090843
- **Supporting workers working with people who challenge – guidance for employers.** http://www.skillsforcare.org.uk/Skills/People-whose-behaviour-challenges/People-whose-behaviour-challenges.aspx

Commissioners and employers may find it useful to plan and deliver good workforce development on minimising restrictive practices by considering the following questions:

- **Who** are my workforce?
- **What** do we expect them to do?
- **Where** do we expect them to do it?
- **What** skills, knowledge, attitudes, values, confidence and competences do they **(a) need** and **(b) already have**?
- **When** can I assess and improve the levels of skills needed and the level that workers have?
- **How** will I develop the skills that workers have?

**See Appendix A for more detail**

The answers to these questions will in many cases come from collecting and analysing reliable data well.

## 3.1. Organisational values into practice

**How to design, recruit and retain the workforce you need**

"In order to design a workforce with very well developed knowledge and skills to support people who challenge, an employer needs to ensure that their organisational processes and systems enable workers to use their skills effectively. Training workers to a high degree of skill will not, on its own, lead to high quality support. The organisation needs to have the structures and culture in place to support the application of those skills." *Institute for Public Care, 2012*

The values of any organisation are vital to the way that services are commissioned and delivered. To ensure that workers are able to practise in a way which minimises the use of restrictive practices, organisations need to:

- recognise that the person is central to the service it delivers
- operate in a culture of openness, respect and transparency
- have organisational leadership which is fully committed to identifying and minimising the use of restrictive practices and promoting person-centred working. Management teams need to be in touch with what actually happens, and have systems in place to reduce or eliminate restrictive practices
- develop a culture of learning from incidents and mistakes, avoiding attaching blame to genuine mistakes
- promote a culture of learning from practice; sharing and promoting good practice with a pro-active response to poor practice
- ensure everyone understands the legislation, polices and requirements of their particular situation, including CQC's Essential Standards and regulations. See Appendix D.

### Edie's story: a culture of fear

Workers were scared of going to support Edie and were doing so in two's and wearing coats to protect their arms. Edie was becoming defensive; protecting her bedroom and becoming more isolated by remaining alone in her room, on her bed.

## Data collection and use

It is essential to collect and use data effectively in order to monitor how well people are being supported and to make improvements. Services should routinely collect and regularly analyse data from:

- feedback from people being supported by the service, their families, friends, visitors and advocates, ideally this should be systematically sought through satisfaction surveys, complaints or regular activities as well as being encouraged *ad hoc*
- incidents of behaviour that challenges and any other incidents which give rise to any restrictive interventions and any planned or significant restrictive practices
- the use of any restrictive interventions and any planned or significant restrictive practices, including form, intensity and duration, and any injuries sustained during them
- post-incident debrief and analysis
- safeguarding alerts, complaints, use of internal whistleblowing policies, relevant workers' grievances
- worker vacancies, turnover and sickness rates
- relevant data about the needs and wellbeing of the people being supported by the service (such as participation in meaningful activities, medication, waiting times or other health indicators).

Analysis will vary from service to service but should enable the information to:

- be triangulated (checking one source of data against another)
- be monitored over time to identify trends
- and/or be compared with comparative services or with targets set
- identify 'exceptions' to usual expectations; for example, particular times of day or particular activities which coincide with higher or lower than usual levels of restrictive practices
- highlight sudden changes
- identify individuals who are particularly at risk of experiencing restrictive practices.

The outcome of the analysis should:

- inform individual support plans
- shape learning and development activities
- be used to review worker performance
- inform organisational policies and actions such as restrictive practice reduction plans.

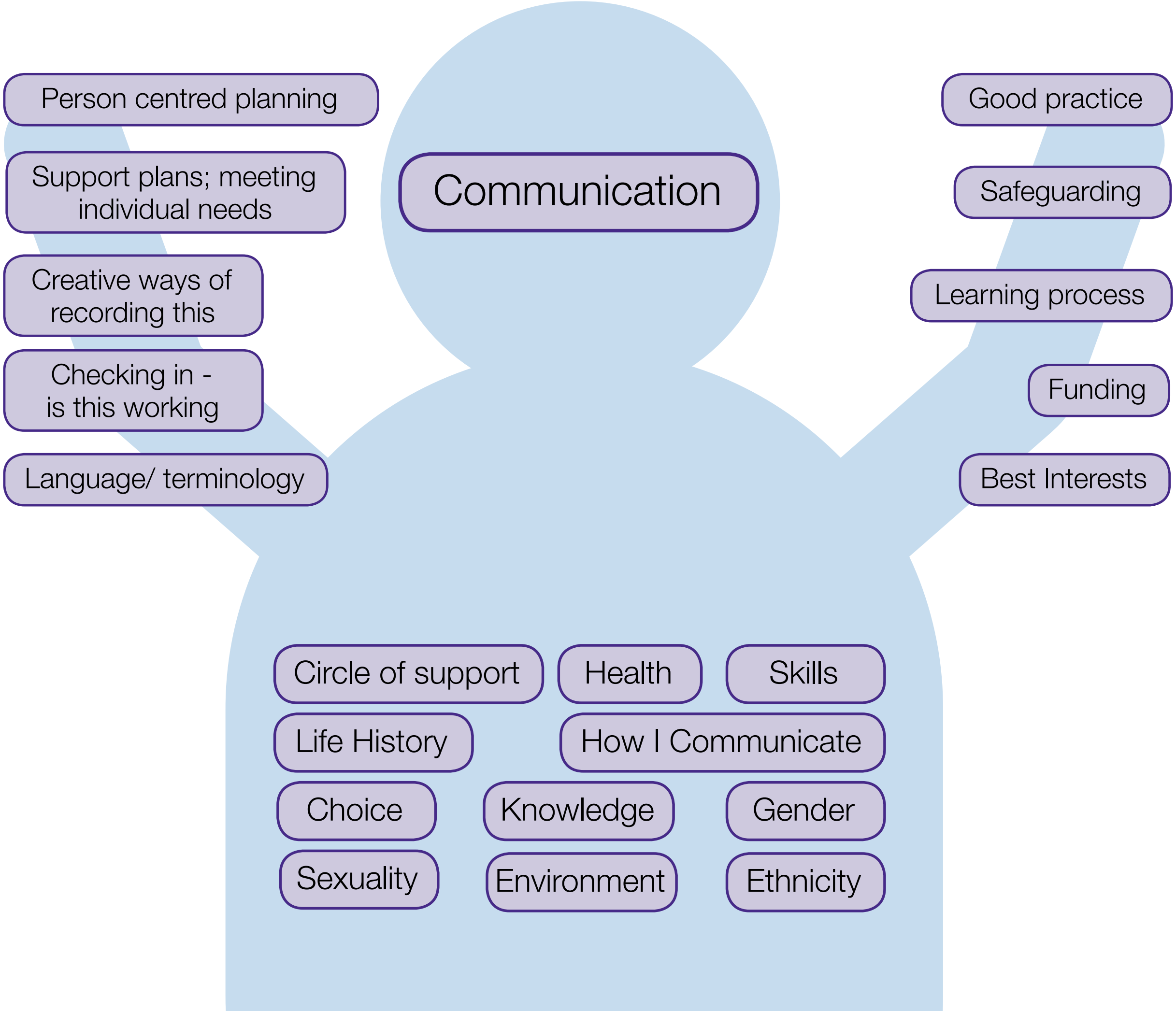
## Being a person-centred organisation

This involves adopting person-centred approaches to all areas of organisational activity in a way that recognises the person and takes a positive, solution-focused attitude. This includes the following.

- Knowing that the rights of the individual are paramount, and respecting them.
- Valuing the individual's history, skills, aspirations and knowledge.
- Involving and nurturing the individual and their support network, e.g. friends, family, community, professionals.

- Understanding that people's behaviour serves an important function for them, and is a form of communication.
- Recognising that behaviour may be influenced by a chronic, intermittent or acute physical condition such as very high temperature / effects of anaesthesia, epilepsy, pain or the influence of drugs or alcohol.
- Recognising that behaviour may be influenced by their environment and the behaviour of others.
- Promoting choice and control for individuals in all the decisions made about their lives, and involving their friends and families where this is relevant.
- Providing a space for the individuals' voices and preferences to be heard; giving access to independent accessible information, advice and advocacy to ensure that choices are well informed and current.
- Considering people's culture and belief systems at all times.
- Valuing workers and recognising their individual and team strengths.
- Developing holistic, strengths-based plans of care that encourage positive risk-taking and enable people to live less restricted lives, while maintaining a 'duty of care'.
- Where it is not possible for the individual to make a decision at the time it needs to be made or by indicating their decision in advance, then a best interests decision should be made – again involving all relevant people.
- Understanding that restrictive practices are only to be used once all other planned proactive and reactive interventions have been tried or are not practical.
- Wherever possible, working with the individual and supporting them (and their family should they choose to involve them) to understand the restrictive practices that are affecting them, preferably prior to use.
- Adopting and promoting the principles and practices of positive behaviour support in a way that suits your service and the individuals supported by it.

# Person-centred thinking



Communication

Person centred planning

Support plans; meeting individual needs

Creative ways of recording this

Checking in - is this working

Language/ terminology

Good practice

Safeguarding

Learning process

Funding

Best Interests

Circle of support

Health

Skills

Life History

How I Communicate

Choice

Knowledge

Gender

Sexuality

Environment

Ethnicity

## Edie’s story continued:

Edie became more isolated, staying in her room and with workers tending to avoid her.

With the help of the local challenging behaviour service a holistic assessment was carried out including work to capture Edie’s life story and, views from her daughter who visited her often. This revealed particular triggers for Edie, such as feeling her personal room was being “invaded” and the cultural practice in the home of getting people dressed by a certain time.

A detailed individual support plan was put in place which allowed Edie to rise and dress in her own time and allowing her to eat breakfast in her dressing gown if she chose. It also specified proactive strategies for workers to offer personal care; only entering the room individually, using and avoiding specific language (both verbal and non-verbal), and leaving if Edie indicated that she was not ready, coming back 10 minutes later.

Changes to her environment were also made; the wall behind her toilet was painted a dark colour so that she could see the toilet better and the workers played quiet background music when they offered her personal care.

## 3.2. Designing support and care that works

### Commissioning social care and health

You may be commissioning a service for a large population in a geographic area or for a known individual or small group of people.

**Anyone commissioning and purchasing social care or health services should always:**

- Understand the needs of the people for whom they are commissioning services.
- Understand the importance and role of positive behaviour support plans for the individuals concerned and commission services built around their needs.
- Engage with people being supported by services, and with their families and communities – particularly if there is a risk of someone having to move away from their home area, such as in “out of area placements”.
- Understand the settings and situations and the incidents where workers may be required to use restrictive practices—and how to provide positive and pro-active alternatives.
- Understand the implications and role of restrictive practices in the services they are commissioning.
- Consider all of the local services that can:
    - work in a positive way in partnership with providers in order to provide a good range of support and services
    - establish seamless pathways for transitions and changes (for example into adulthood or as conditions progress)
    - avoid the need for ‘out of area placements’.
- Describe the appropriate staffing levels required to deliver the service including the need for specialist advisors (for example, specialist learning disabilities liaison nurses in general hospitals).
- Use local and national service specifications that lead to good workforce development, such as *Ensuring Quality Services* (EQS) when commissioning services for people who have learning disabilities and/or autism and who display or are at risk of displaying behaviour that challenges.
- Establish contracts which include the right resources for good workforce development.
- Visit the services they commission or see them in action.
- Consider data on their local population, including that about children and young people who have special educational needs or disabilities.

**Commissioners should ensure that employers and services have clear systems for:**

- Setting outcomes and work plans that support person-centred care (including positive behaviour support) and aim to improve quality of life, physical and mental health and reduce ‘placement breakdown’.

- Measuring and monitoring service and worker performance.
- Addressing poor practice.
- Recording and reporting when restrictive practices have been used or avoided, both internally and externally.
- Defining accountability at all levels of the organisation.
- Making sure whistleblowing policies are in place, reviewed and are working.
- Organisational, team and individual learning from what works well.
- Ensuring staff capacity to respond to fluctuating or emergency situations.
- Proactive transferable knowledge between services; for example, the use of ‘hospital passports’ between care homes and A&E, between departments in acute hospitals and when people are moving into adulthood.
- Promote effective sharing of knowledge between statutory, independent and voluntary services.
- Monitoring the impact of learning and development activities.

### The right staff

The baseline of any good service is having the right workers to meet the needs of the individuals being supported by it. This will involve everything that happens throughout their employment, such as designing the staff team, finding people, recruiting and selecting them, inducting them to their role, training and supporting them, monitoring how they work, dealing with poor performance, celebrating good performance, retaining them and developing a career pathway.

Throughout these processes you should:

- involve people who are supported by the service (‘experts by experience’)
- demonstrate a commitment to equality and diversity.

### Designing staff structures to minimise restrictive practices

Employers and services must have clear systems to meet the commissioners’ requirements as outlined above and must design a staff structure capable of meeting the needs of the service at all times. This will involve considering the following.

- How to balance the need for consistency of care with realistic expectations of individual workers, including the support that workers need.
- Using a matching process to ensure the team can meet people’s needs and interests.
- The consistency and continuity that contracted workers can offer and only using ‘bank’, casual or agency workers when there is a compelling reason to do so.
- Ensuring that workers do not have to work excessively long shifts and have breaks, holidays and rest periods.
- Responsive rotas based on person-centred plans and or periods of expected high demand (times of the week, winter pressures, etc).

- The effect of workers' holidays, training and sickness.
- Ensuring workers' capacity to respond to fluctuating and emergency situations.
- Up-to-date assessment of risk, and behavioural audits.
- Staffing requirements from the service specification and as recommended by relevant national and local policies, procedures and legislation.
- Any organisation or practitioner that develops and implements behaviour support plans or restrictive practices must be able to provide evidence of their competence to do so.

**Recruiting and retaining the right workers**

In recruiting workers you should consider:

- Where and how to recruit workers including ways of recruiting from diverse groups of people with the right attitudes, physical abilities and availability.
- Using competence-based job profiles.
- At what stage to share information about what the job is in order to; build rapport, be clear about the organisational values and aims and allow people to self-select themselves out.
- Using appropriate selection techniques involving people being supported by the service, and their carers, such as scenario-based interviews and/or task-orientated assessments.
- How to ensure the candidate has the necessary skills, qualifications and experience and is registered with the relevant professional body where registration is required.
- How to recruit people with the right attitude and values, which may include:
  - a **caring*** supportive attitude
  - respect
  - **commitment*** to offer dignified care and choice and to team working
  - demonstrating unconditional positive regard
  - showing **compassion***
  - having the **courage*** to learn and to appropriately challenge,
  - having an understanding of the importance of good **communication***
  - flexibility
  - willingness to learn and develop **competence***
  - relevant interests (in very personalised services, shared characteristics with the individual)
  - a **commitment*** to equality and diversity.

* indicates the "Six 'C's":
The 6Cs strategy sets out the shared purpose of nurses, midwives and health visitors in response to the Francis report into the Mid Staffordshire NHS Foundation Trust Public Inquiry ( 2013) into the care of patients in hospital.

http://www.midstaffspublicinquiry.com/

http://www.6cs.england.nhs.uk/

## Supporting workers

It is important to support workers to find alternatives to restrictive practices. When restrictive practices are used it is essential to offer support and de-briefing to the person concerned, their families and carers, the staff team, and other people being supported, if relevant, or any witnesses.

Support and supervision should allow time for essential reflection on practice and the feelings that are brought up.

### Edie's story continued: supporting workers to minimise restrictive practices

Workers who supported Edie had become very scared of working with her and their behaviour reflected this, such as showing fear or bravado or wearing outdoor clothing to protect themselves.

In response to this culture of fear the care team worked alongside the challenging behaviour specialists and Edie's daughter to develop Edie's care plan.

Workers and Edie's daughter needed support individually and as a team to implement the plan. The manager also prepared a one page profile to help workers see Edie as an individual with a history and a range of experiences and to put her behaviour into context. For example, explaining that she likes to sing along to music, but may stop if others join in.

## Supervision

Management and clinical supervision for individuals and groups is an essential tool in minimising restrictive practices. It should be written into policies and procedures as the way of regularly monitoring an individual's performance, setting their targets and responsibilities and highlighting their development needs.

Supervision should be:

- regular—planned in advance but also available *ad hoc* when needed
- of a high quality—provided by someone who has been trained to undertake supervision, including specialists when required
- underpinned by and support the values of the organisation
- structured around a shared agreed agenda
- prioritised—all involved identify protected time for it to happen

- a way of celebrating success and achievement and addressing areas for improvement.

**Other support**

This can include support from:

- experts by experience
- peers
- coaching
- shadowing
- mentoring
- use of "champions" within the service to offer specialised support.

**De-briefing**

De-briefing is essential and can be a way of offering support and developing learning. It might identify a learning need for an individual worker or team, an amendment to a care plan or inform organisational actions through incident review, data collection and analysis. There is further advice in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).

De-briefing following an incident or a 'near miss' should:

- be led by the needs of the worker
- be undertaken by a skilled practitioner with a 'no blame' attitude, emphasising any learning and considering the psychological impact on the people involved
- identify any further or on-going support and learning that is needed.

All of the above forms of support should feed back into individual and team learning and development plans and into organisational development plans. These include restrictive practice reductions plans, stress management and reduction plans and reviews of policies and procedures.

## 3.3. Developing your workforce's skills and knowledge

In order to provide good support and services to people, employers need to know that workers have the right skills and knowledge and are competent to undertake their work. This involves understanding what is required within the service, setting or role, identifying the skills and knowledge held within the team and by the individual, putting in place learning and development plans to meet any gaps in knowledge and skills and to ensure that workers continue to develop.

**Identifying workforce skills and knowledge**

Employers can work out what knowledge and skills workers need to have, and when, from the following.

- The shared key principles and core values, vision and purpose of the organisation.
- The needs, preferences and aspirations of the people being supported by the service.
- Understanding the impact of trauma and life experience on people's behaviour and decision making. Relevant people

may include individuals supported by the service, carers, staff, board members and the public.

- Understanding the setting, situations and incidents in which staff are required to use the range of restrictive practices, and why they may be needed. This could include:
    - preventing someone from hurting themselves
    - holding a person or part of their body so that an essential health or care task or intervention can be carried out, in a planned or emergency situation
    - carrying out planned reactive physical interventions in line with a positive behaviour support plan
    - self defence
    - escaping (breakaway) from violence and aggression
    - protecting vulnerable people from violence and aggression.
- The legal and policy frameworks that apply to the service.
- Undertaking a regular skills reviews of the team.
- Completing a comprehensive training and learning needs analysis based upon appraisals, supervision, policies, standards, learning from incidents and de-briefs, feedback from learning providers, changes to the needs of people supported by the service, inspections and contract reviews, etc.
- Job descriptions and person specifications associated with the role.
- Supervision, appraisal and personal development planning.

**Skills and knowledge development**

There are a wide range of learning options available and as commissioners and employers you need to be certain that the learning solutions that you are using are right for your teams and the people that they are supporting. All workers should learn to meet the requirements of the service they provide and their role. Learning and development will vary according to role but all workers should learn to deliver a service which is person-centred and seeks to minimise the use of restrictive practices. When an individual's family are providing support to them they should be offered opportunities for learning alongside workers and the individual or other learning opportunities suitable for their situation.

Currently there are no nationally recognised or approved training standards for the minimisation of restrictive practices.

## Edie's story continued: lessons learned

The best way to develop Edie's care and support plan was by holding a staff development day with the challenging behaviour team and developing the plan during the day.

Many of the aspects of the plan appeared to not only help Edie be calm but also made it much easier and more pleasant for workers, allowing them to 'let go' of the negative emotions when an incident had occurred.

"It's been like everyone has breathed a sigh of relief," said the manager.

All training and learning activities about restrictive practices should be:

- Part of a coherent learning pathway, based on evidence of good practice in that situation and emphasising positive communication, support for fulfilling lives and dignified care, and understanding of the functions of behaviour.
- Delivered by someone who is qualified to deliver and is occupationally and clinically competent. This means people who have relevant experience and knowledge.
- Inclusive in design and delivery of the perspectives of people being supported by the service.

> "I feel that the service user input / forum was excellent, thought provoking and powerful / beneficial."
>
> Participant on 'RESPECT' training

- Realistically costed and have resources (funding, physical space and time) allocated in the context of the costs of failing to proactively develop the workforce.
- Regularly and systematically monitored and updated to meet changes to policy, practice and legislation. (At least once a year but more often as necessary.)
- Based on a commitment to minimising the use of restrictive practices throughout the organisation for people working at all levels, and applied to each job and service as appropriate.
- A priority for strategic and senior management teams (for example by CEOs and boards of trustees) who are responsible for authorising and approving the content.
- Fully understood by executive board members in regulated services, and their equivalents in non-regulated services, to ensure they are fully aware of the techniques workers are learning and that all learning reflects the therapeutic nature and purpose of social care and health settings.
- Be tailored to meet the needs of particular service users (e.g. for individuals with a learning disability, autism or dementia).
- Essential for 'bank', casual and agency workers as well as regular employees.

It should also include:

- the assessment of the impact of learning and training (McGill *et al,* 2006 & 2013).
- the teaching of *only* those physical intervention skills which have been assessed as physically and bio-mechanically suitable for the individuals concerned, as well as legally and ethically justified.

There are social care and health units, and BTEC qualifications, relevant to positive behaviour support and to restrictive practices. Units can be taken as part of a qualification and/or as part of continuing professional development. The learning outcomes from the units can help you structure bespoke training programmes. A list of relevant units and other qualifications can be found at Appendix B.

Although this guide is unable to provide a set of standards for commissioners and employers, some suggestions for content can be found at Appendix E.

### Choosing the right learning provider

You may choose to develop internal learning providers to deliver 'in-house' learning or to commission external learning provision. In some areas partnerships exist to enable smaller providers to commission with others. Larger providers who develop in-house learning may also be able to offer this externally to other providers. This choice might well depend on the size of your organisation, the capacity and capabilities of your workers and the results of your training needs analysis. The following apply to both in-house and external learning provision.

**Planning and purchasing learning and development**

The person commissioning or planning learning should:

- Understand the process of commissioning including specifying learning outcomes and the required impact on practice.
- Specify outcomes which are measurable and show how the learning will support workers to improve life outcomes for people supported by the service.
- Have direct experience of the service.
- Ensure that learning is co-produced, including the voices of people being supported, and carers, in appropriate formats in the design, production, delivery and evaluation.
- Have an understanding of approaches to minimising restrictive practices with the ability to focus strategically.
- Ensure adequate funds and resources are available.
- Ensure the content meets the needs of the service, this will include:
    - consideration of organisational policies and procedures
    - training needs analysis
    - consideration of specific roles and situations, including chief executive, management and trustee levels and possibly in-house learning providers' development
    - learning from incidents, including:
        - recording / reporting / analysis
        - discussing / debriefing
        - feedback from people being supported, and carers
    - considering how the content of bespoke learning provision can map to units, awards, certificates or diplomas (see Appendices B and E).
    - Be clear about what physical restraint techniques should be taught and in which circumstances they may be used.
    - Ensure that significantly more time is spent learning about positive and pro-active approaches, and non-restrictive alternatives, than on restrictions. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm, and are part of an ongoing learning pathway.
- Take a long-term view of the learning and development which the workers will need, including:
    - refresher and update learning when needed, and at least once a year, which takes account of the current needs of people being supported and of feedback and reflection on practice and workforce development over the previous year
    - induction training for new workers
    - changes to learning and development as needs change
    - career development
    - offering learning opportunities to

people being supported, their carers and support networks.

- Ensure that anyone delivering learning or assessing competence in restrictive practices should be occupationally competent and hold or be working towards achieving a recognised teaching or training qualification (see Appendix C for more detail).
- Have systems in place for learning providers to feed back when learners are seen as not competent to practise.
- Plan and carry out evaluation and quality assurance to ensure that learning is embedded into practice and fed back into restraint reduction plans.

If you decide to commission external learning providers you may find the Skills for Care guide to choosing a learning provider, *Choosing workplace learning*, useful. This tool is also available as an app with an interactive checklist for both iOS and Android. http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Finding-learning-providers/Finding-learning-providers.aspx

Other resources which are relevant to the issue of restrictive practices include Skills for Care's *Workforce development outcome measurement tool* http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-commissioning/Workforce-outcome-measurement-model.aspx and Skills for Health's:

- national occupational standards http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards/
- Quality mark; a new benchmark for outstanding healthcare training. http://www.skillsforhealth.org.uk/getting-the-right-qualifications/quality-mark/

At present there is no current mandatory accreditation system for learning providers. Further information on voluntary accreditation systems can be found in Appendix F.

### The learning provider's role

The learning provider must work in partnership with the person commissioning the learning and with people being supported to ensure that the learning delivered meets the requirements listed above.

Additionally the learning provider should:

- Ensure all individual learning providers and assessors are occupationally competent and have or are working towards a recognised teaching or training qualification.
- Ensure that individual learning providers and assessors are experts by practice and have knowledge relevant to the types of service to which they provide learning, including understanding:

  - the needs of the people being supported, including awareness of the needs of that group (e.g. dementia, autism, etc.), and the specific needs of individuals being supported
  - relevant legal frameworks
  - the remit and aims of the services to which they are delivering.
- Carry out or contribute to a training needs analysis.
- Ensure that assessment of learning is robust and carried out by suitably occupationally competent people.
- Feed back to employers on learners who are not competent to practise, so that this is reflected in the individual's personal development plan.
- Ensure that individual learners have the opportunity to put what has been learnt into practice.
- Develop the skills and experience of individual learning providers and the learning provision available to meet the very specific needs of services (for example a service for people with early onset dementia) and network with other learning providers to ensure that appropriate provision is available to the full range of social care and health services.
- Be willing, skilled and able to challenge existing practices when required.

## Edie's story continued: Getting the culture right

"It's about giving people choice and control, making sure we take the time to understand people. Previously it had been our fault as we had not taken the time to understand what Edie was going through or fully understand her needs. Now that we do, Edie is a lovely person and much happier."

Care worker

"I want these changes to continue; the atmosphere is much better now, and I see parts of Mam returning. I don't think she'll ever come back, which is hard, but she is improving and happier. I still find it hard, but it's been a big change, not just for Mam but for everyone."

Edie's daughter

# 4. Implementation: information for specific situations

This guide aims to show how workers can be developed and supported to minimise (reduce the necessity, frequency, intensity and duration) restrictive practices and ensure they are only ever used appropriately and not misused or abused.

It outlines key recommendations for good practice in workforce development for commissioners and employers whose role it is to ensure that restrictive practices including physical intervention are only ever used as a last resort.

Central to this is ensuring that the recommendations of this guide and of *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) are implemented, monitored and reviewed within organisations and services.

Workers in every service will need to have information about the very specific conditions, disorders and diagnoses of any of the people they are supporting.

National organisations such as Mind, Age UK and the National Autistic Society provide robust information through their websites. It is also important to find local sources of information and support.

Below are short summaries and illustrative vignettes about people who have displayed behaviour that is challenging with lists of helpful contacts that may be useful in specific situations. All of the vignettes have been anonymised and full consent to their use agreed.

Other vignettes in written and video format are available on the Skills for Care and Skills for Health websites to accompany this guide - see www.skillsforcare.org.uk/cbcasestudies

## 4.1. ‘Positive behaviour support’ (PBS)

“PBS is a framework for developing understanding of an individual’s challenging behaviour and for using this understanding to develop effective support” (NHSE LGA 2013). This is described in detail in *The International Journal of Positive Behavioural Support* (IJPBS), Volume 3, Number 2, Autumn 2013.

There is a strong evidence base for the use of PBS for people with intellectual impairment or learning disabilities and we would also advocate the use of this model for people with other needs, such as people who have dementia and people with mental health needs.

IJPBS proposes that PBS is a multi-component framework which, while flexible and adaptable for individuals, must contain the following components.

| | |
|---|---|
| **Values** | 1. Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation and the defence and support of valued social roles. |
| | 2. Constructional approaches to intervention design build stakeholder skills and opportunities and eschew aversive and restrictive practices. |
| | 3. stakeholder participation informs, implements and validates assessment and intervention practices. |
| **Theory and evidence base** | 4. An understanding that challenging behaviour develops to serve important functions for people. |
| | 5. The primary use of applied behaviour analysis to assess and support behaviour change. |
| | 6. The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system. |
| **Process** | 7. A data-driven approach to decision making at every stage. |
| | 8. Functional assessment to inform function-based intervention. |
| | 9. Multicomponent interventions to change behaviour (proactively) and manage behaviour (reactively). |
| | 10. Implementation support, monitoring and evaluation of interventions over the long term. |

Services offering positive behaviour support should meet the specifications described in EQS, including these for a well trained workforce, as follows.

1. All support workers receive training in positive behaviour support, which is refreshed at least annually.

2. All support workers with a leadership role (e.g. shift leaders, direct employers, frontline managers) should have completed or are undergoing more extensive training in PBS which includes practice-based assignments and independent assessment of performance.

3. All workers with a role (which may be peripatetic or consultant) in respect of assessing or advising on the use of PBS with individuals have completed, or are undergoing, externally-validated training in PBS which includes both practice and theory-based assignments with independent assessment of performance at National Qualifications Framework level 5 or above.

4. All workers involved in the development or implementation of PBS strategies receive supervision from an individual with more extensive PBS training and experience. Workers in consultant roles are supervised by an individual (within or outside the organisation) with a relevant postgraduate qualification, e.g. applied behaviour analysis, positive behaviour support, clinical psychology.

In addition, a core competences framework for PBS is currently being developed.

# Simon's story

## Using a PBS approach for both the person in need of care and support and the team and others around him or her: Simon's very good day at the zoo

Simon (not his real name) is young person with identified behaviour management issues around his need to feel in control of other people including his support workers. Procedures had been put in place to support workers in how to manage the demands placed on them by Simon when necessary. Simon also has an identified need to be supported to learn social rules so that he is more able to socialise with other young people without him wanting to be in control of the interaction.

Simon was having a lovely day out at the zoo. Around 40 minutes before the time to leave Simon noticed a stream in the play area. The water was around an inch deep in some places. Simon removed his shoes and paddled in the stream, then asked if his supporting workers would like to join in. They told Simon that the water was too cold for them and that they would prefer to watch instead. Simon persisted attempting to make the workers get in the water. Simon then threatened to run away if they did not join in. The workers knew Simon very well and realised that he was showing signs of irritation but felt that he wasn't showing signs of anxiety or becoming distressed.

The workers made the decision to not respond to the threats and used distractions to which they thought Simon might respond well, such as mentioning the gorillas in the pen nearby. Simon began to move away from the stream towards a quiet lane. The zoo was reasonably empty and there were no other people nearby. The workers realised that Simon would move further away if approached. Therefore the workers decided to follow slowly behind him, understanding that if they moved too fast this might make him run. Simon led himself away from the stream and into a grass clearing where he could no longer see the stream or any water. The workers realised that this meant the trigger had been removed. They then decided to sit on a bench where they could see Simon safely. After five minutes Simon approached them and continued to be unsettled. Simon re-engaged with the Workers, when they offered him a choice between two options.

As there was only fifteen minutes left at the zoo before they had to leave and return home. They explained that he could either leave and play on his ipad in the van and show them what he had been making that morning or he could choose an animal he wanted to see before they left. Simon decided to leave but wanted to pass the maze on the way back. There were no more challenging incidents.

Not engaging Simon when he made demands, but presenting alternative options that his workers knew Simon enjoyed, was easier once the main trigger had been removed, i.e. the water from the stream. Simon found it harder once the trigger had been removed to carry on with the incident with the same conviction, although it is thought that his main need was to be able to feel in control.

## 4.2. People with mental health needs

# Grace's story

We have included Grace's story here to illustrate the use of physical restraint within a mental health setting and how workers can positively undertake restrictive practices and physical interventions. Grace is not her real name. Grace is 18 and lives in North London. She has some positive experiences of restraint in healthcare settings, which she is able to compare with negative experiences of restraint by the police around the same time.

Grace spent 14 months in a mental health hospital in London and was discharged in July. The hospital has a very strict 'no touch' policy, where staff don't physically touch patients unless absolutely necessary and patients can't touch other patients under any circumstances. Restraint is very much a last resort and even then is done in a way that is very gentle and respectful.

From time to time Grace would have psychotic episodes that would see her self-harm. It was in these situations that workers might feel it necessary to restrain Grace to prevent her from harming herself. They would speak to her calmly to explain what was about to happen and then gently move her arm to prevent her from hurting herself.

At the time, she says, she may have felt angry and resentful that someone was stopping her doing what she needed to do. Coming out of a psychotic episode is scary and she would be confused about why someone was touching her, especially since she traditionally struggles with physical contact. But she can see that it was the right thing for the workers to do. She adds that because it was done in such a positive way, it actually helped to solidify the relationship between her and the workers, helping to improve trust.

Grace has witnessed others being restrained in a more forceful way—a friend of hers was restrained and injected with medication, which she says was frightening to witness. She feels strongly that restraint shouldn't be done in front of other people as it is humiliating for the person being restrained and distressing for those watching.

Grace has also been restrained by police, when on one occasion she ran away from the hospital. This was a different experience altogether and Grace was given a direct order to 'stand still' before being "grabbed and shoved in the back of the police car". She felt she was treated like a criminal."

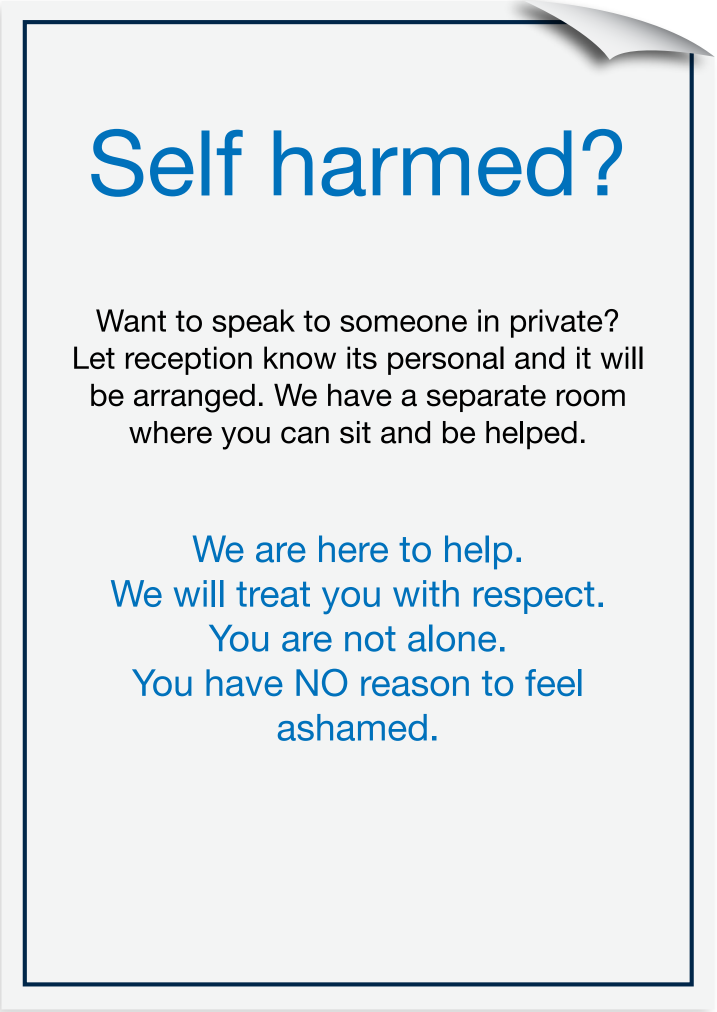
When considering the minimisation of restrictive practices within mental health settings you could make reference to the following metal health specific resources.

- Recovery-based care. Recovery-based approaches are central to mental health care. Personal recovery means different things to different people and should be defined by the person experiencing mental illness. It has become more accepted that people can and do recover from severe mental illness. However, for many people it means a way of living a satisfying and meaningful life within the limits of their mental health condition. http://www.rethink.org/living-with-mental-illness/recovery/what-is-recovery
- The Mind campaign on restraint: http://www.mind.org.uk/news-campaigns/campaigns/crisis-care/
- The 'Safewards' Project from research, model formulation, through trial to management action: Safewards project: Force Free Futures
- 'Talk well' guide for communicating with people on in-patient wards, including people who have psychosis http://starwards.org.uk/publications/187-talkwell-2nd-edition-is-ready-to-download
- ImROC (Implementing Recovery through Organisational Change). This supports mental health service providers to become more recovery oriented and its themes are very relevant to restrictive practices work, e.g. culture change, changing the approach to risk assessment and management, increasing personalisation and choice, transforming the workforce and supporting workers. A joint initiative of the Centre for Mental Health and the NHS Confederation's

Mental Health Network.
http://www.imroc.org/

- National Survivor User Network (NSUN): National Involvement Standards - 4PI http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf
- Wellness Recovery Action Plans (WRAP) http://www.mentalhealth.org.uk/help-information/mental-health-a-z/R/recovery/
- Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives.
- No health without mental health: implementation framework: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
- The Mental Health Crisis Care Concordat https://www.gov.uk/government/publications/mental-health-crisis-care-agreement
- Closing the Gap: Priorities for essential change in mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
- The Ten Essential Shared Capabilities A Framework for the Whole of the Mental Health Workforce: http://www.iapt.nhs.uk/silo/files/10-essential-shared-capabilities.pdf
- Service User Involvement in Mental Health Training, Education and Research in West Yorkshire http://eprints.hud.ac.uk/12434/1/6210.pdf
- Peer support (from other people with experience of mental health problems): http://www.imroc.org/peer-support-workers-in-mental-health-recovery-benefits-and-costs/) and ‘advance statements’ to encourage more empowering ways of working and anticipate issues that could arise.

**People who self-harm, or who are at risk of doing so**, may need extra reassurance about a service being non-judgemental and confidential, so that their own uncertainty or feelings of shame do not become, in effect, restrictive practices. RAISE mental health have produced a video by two women who self harm explaining that for them it is a way of staying alive. The video can be viewed on the skills for care website. Below is part of a series of posters offering guidance to accident and emergency staff to help them support people who come for treatments following self harming behaviour.



# Self harmed?

Want to speak to someone in private?
Let reception know its personal and it will
be arranged. We have a separate room
where you can sit and be helped.

We are here to help.
We will treat you with respect.
You are not alone.
You have NO reason to feel
ashamed.

*Source: Sam O'Brien, Service User Consultant for Mental Health, Respect Training Solutions*

## 4.3. People with dementia

We have included Ron's story here to illustrate the importance of understanding a person's life history and the function that a behaviour is serving for an individual when providing care and support. Ron is not his real name.

# Ron's story

Ron had fronto-temporal dementia diagnosed at the age of 60. He was physically fit, energetic and had always had a 'feisty' personality! As his illness progressed, he was placed in a nursing home close to his family. On hearing shouting and banging from Ron's room, the nurse entered to find him throwing things around and trying his best to push clothing out of the small gap in the open window, water had been left running in the bathroom and was slowly seeping over the carpet. Ron immediately began to shout at the nurse, his verbal skills were limited but there was no question about his mood or intention as the nurse became the focus for the flying missiles of socks and pants.

The nurse immediately called for assistance, the first to arrive in the room was the ancillary worker who had been in the next room; she had always got on well with Ron and found him helpful and polite. On seeing the situation she grabbed a refuse sack from her trolley and calmly walked up to Ron holding the bag open, saying "Here you go Ron, lets collect them all up for you so we can sort them out". The effect was instant; Ron began to stuff the clothing into the sack, muttering as he did so.

Ron was a very private person who had lived alone for many years with a few close friends; he prided himself on being self sufficient. He had dirty underwear that he couldn't work out how to wash. Having tried to do so in the sink he became more and more frustrated, which damaged

his social skills and inhibitions, Ron’s temper flared so he did what he could to get rid of the dirty clothes out of the window. The nurse coming into the room in uniform made Ron feel humiliated at not being able to do things for himself so he lashed out in temper.

The ancillary worker had got to know Ron and recognised his frustration, guessing it was something to do with the clothing. Staying calm and offering the refuse sack made Ron feel his actions were understood. Seeing the immediate response, the nurse backed out of the room but observed what was happening; once Ron was calmer she was then able to re-enter and support Ron to collect the clothing. A team meeting was called, including the ancillary worker, to update Ron’s personal profile, and his family were consulted to build a better understanding of Ron’s habits, values and principles. The care plan was updated to reflect the new information with the amount of clothing left in Ron’s room reduced to a minimum by doing twice daily checks for dirty laundry.

Good practice in patient care must involve all workers sharing information and knowledge of the individual needs. Identifying triggers for the behaviour allows for practical strategies to avoid conflict. Most importantly, manage the situation that is causing the behaviour, not just the behaviour.

## Additional resources to support people with dementia

When considering the minimisation of restrictive practices when supporting a person with dementia you could make reference to the following specific resources.

- Common Core Principles for Supporting People with Dementia: guide to training the social care and health workforce. http://www.skillsforcare.org.uk/Skills/Dementia/Dementia.aspx
- Dementia care mapping: Approaches based on the work of Professor Tom Kitwood. http://www.nursingtimes.net/dementia-care-mapping/201154.article
- Department of Health (2009). Living Well with Dementia: A National Dementia Strategy. https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
- Department of Health (2010). Quality Outcomes for people with dementia: Building on the work of the National Dementia Strategy. https://www.gov.uk/government/publications/quality-outcomes-for-people-with-dementia-building-on-the-work-of-the-national-dementia-strategy
- Department of Health (2010) Nothing ventured nothing gained: risk guidance for people with dementia. https://www.gov.uk/government/publications/nothing-ventured-nothing-gained-risk-guidance-for-people-with-dementia
- Factsheet on dementia and aggressive behaviour. http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=96
- Royal College of Nursing S.P.A.C.E. http://www.rcn.org.uk/development/practice/dementia/commitment_to_the_care_of_people_with_dementia_in_general_hospitals/make_space_for_good_dementia_care
- National Institute of Health and Clinical Excellence (NICE) (2010) Dementia Quality Standards. http://publications.nice.org.uk/dementia-quality-standard-qs1
- National Institute of Health and Clinical Excellence Public Health Intervention Guidance http://www.nice.org.uk/guidance/phg/
- Occupational therapy intervention and physical intervention to promote the mental health and well being of older people in primary care and residential care http://www.nice.org.uk/Guidance/PH16
- Life Story work http://www.dementiauk.org/information-support/life-story-work/
- VIPS tools and resources University of Worcester http://www.carefitforvips.co.uk/

## 4.4. People who have a learning disability

Positive behaviour support is widely accepted as good evidence-based practice when supporting people with learning disabilities and/or autism who display or are at risk of displaying behaviour that is challenging. We have included Jane's story here to illustrate the importance of PBS when supporting a person with a learning disability. Jane is not her real name.

# Jane's story

Jane is a woman with learning disabilities. She lives in a residential care home with three other people. Jane requires support with her personal care and wears incontinence pads. Sometimes, Jane is reluctant to go to the bathroom to have her pad changed, including when she has been doubly incontinent. This places her at risk of infection and also places her dignity at risk. The manager of Jane's home raised concerns about the level of intervention that her team were feeling was necessary in order to support Jane with this aspect of her personal hygiene, particularly as workers were lifting Jane and carrying her to the bathroom where she could have her pad changed in privacy. Jane appeared not to like this intervention and would often struggle when being carried. This was distressing and potentially dangerous for all involved. It was also a restrictive practice. Under the Mental Capacity Act (2005) Jane was deemed not to have the mental capacity to decide whether and where to have her incontinence pad changed.

The multi-disciplinary team worked with the home manager and her team to try to understand the reasons why Jane was reluctant to have her pad changed, in an approach consistent with positive behaviour support. This included a health screening (from a community nurse), a sensory assessment (from an occupational therapist) and a

communication assessment (from a speech and language therapist). The physiotherapist in the team also advised that Jane should only be lifted in 'emergency' situations.

This information led to a new care plan, agreed by all involved to be in Jane's best interests (Mental Capacity Act, 2005), which took much greater account of the reasons why Jane may have been reluctant to have her pad changed. This led to prevention strategies that meant that Jane was generally happy to accompany workers to the bathroom to have her pad changed. These included improved communication strategies so that Jane could understand what workers were asking and what would be involved. There was also a change in the décor of the bathroom, so that it was much more calming to Jane from a sensory perspective. Through constructing the plan, the team agreed much more clarity about the circumstances in which they would have to step in and change Jane's incontinence pad, even if she was refusing to go to the bathroom (based on a clear risk assessment). In this (now considerably less likely event), workers would find a way to screen Jane from others' view in whatever room she was in and change her pad there. Jane's Mum was much happier with the plan than with the previous set of circumstances and agreed that it was in Jane's best interests.

The key to success in this situation was close multi-disciplinary work including the care home workers alongside the other multi-disciplinary workers. This was facilitated by having a clear process and system through which restrictive practices could be reviewed, encouraging open and honest dialogue. All involved were agreed that being changed behind a screen is not an ideal situation, but it avoids the need for potentially damaging physical interactions while better solutions are developed.

## Additional resources to support people with a learning disability

When considering the minimisation of restrictive practices when supporting a person with a learning disability you could make reference to the following specific resources.

- "Ensuring Quality Services - Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges" http://www.local.gov.uk/documents/10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f
- Driving up quality code. https://www.drivingupquality.org.uk/home
- The Challenging Behaviour Foundation (CBF) is a charity specialising in severe learning disabilities and behaviour described as challenging. Established by a family carer, they work with families and professionals supporting children and adults across the UK. The Challenging Behaviour Foundation offers a wide range of resources about challenging behaviour and related topics. http://www.challengingbehaviour.org.uk
- Functional communication training
- Health action planning
- Use of communication tools such as objects and easy to understand language
- Total communication systems / PECS (Picture exchange communication systems)
- Think Local Act Personal – Making it real (making it real for everyone) www.thinklocalactpersonal.org.uk/Browse/mir/
- Five good communication standards: Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings http://www.rcslt.org/news/good_comm_standards
- Greenhill B., Whitehead R., Grannell M., Carney G., Williams J., Cookson A., Chapman F., Ward E. & Lee A. (2008) Human Rights Joint Risk Assessment & Management Plan. (HR-JRAMP), 2nd edn. Equality & Human Rights Commission. Available at: http://www.equalityhumanrights.com/uploaded_files/humanrights/HRO/mersey_care_hr-jramp.pdf
- Lee A., Kaur K., Cookson A. & Greenhill B. (2008) The Keeping Me Safe and Well Screen (KMSAW), 2nd edn. Equality & Human Rights Commission. Available at: http://www.equalityhumanrights.com/uploaded_files/humanrights/HRO/mersey_care_keeping_me_safe_and_well.pdf
- Active support http://www.kent.ac.uk/tizard/active/
- Prader-Willi Syndrome Association UK guidance on legal and ethical issues around restricting food. http://www.pwsa.co.uk/index.php/what-is-pws/136-ethical-and-legal-issues
- The Confidential Inquiry into the premature deaths of people with a learning disability http://www.bris.ac.uk/cipold/

## 4.4. Acute health services

We have included this vignette here to illustrate the importance of reviewing the use restraint reduction plans in a timely manner and ensuring that individual, team and organisational learning takes place and is implemented following the use of a restrictive practice or a physical intervention. The person's name is fictional.

# Mr Palmer's story

Mr Palmer was admitted to neuro-surgical ward following an operation and was assessed as being at risk of falls. He has already fallen out of bed once and banged his head and the team were concerned that he may break a limb. The ward doctor had written in the medical notes that he needed to be restrained and wrist restraints were put on him to help prevent falls.

The night nurse thought this was not the way forward but did not question it as the doctor had written it in the notes.

Mr Palmer was very distressed by the wrist restraints and kept pulling against them as they dug into him and made him very agitated. He was very strong man and was being nursed on a one-to-one ratio.

His key nurse on the next shift escalated her concerns to the bleep holder and the use of wrist restraints was reviewed and they were removed. Mr Palmer continued to receive one-to-one care but his agitation decreased without the restraints.

The situation was fed back to the medical and nursing teams. The safeguarding team became involved and they organised learning for the junior doctors on safeguards, the use of restraint and falls prevention. It was noted, too, that nurses need to feel empowered to question medical practice that they feel might not be correct at the time.

**Additional resources to support people and workers using acute health care services**

When considering the minimisation of restrictive practices when supporting a person using acute health care services you could make reference to the following specific resources:

- NHS Protect, Meeting needs and reducing distress: the prevention and management of clinically related behaviour in NHS settings www.nhsprotect.nhs.uk/reducingdistress
- How to use the knowledge and skills of families and specialist professionals to provide a holistic service.

## 4.6. Working in partnership with people in need of care and support, patients and carers

We have included Bert's (fictional name) story here to illustrate the importance of working in partnership with people in need of care and support, patients and carers to understand the individual's life story and factors that might trigger behaviour which challenges, to help minimise any need for restrictive interventions.

## Bert's story

Bert had fallen and broken his hip. Following surgery to repair it he was recovering on an orthopaedic ward. He had a catheter and an intravenous drip in place and an oxygen mask. Bert was semi-conscious and he was trying to remove these.

The ward workers tried to explain to Bert that he needed this treatment; in moments of lucidity Bert agreed that he needed and wanted the treatment but as he became drowsier he began pulling at the oxygen mask. When it was replaced Bert instantly removed it and was becoming exhausted and more agitated in the process, trying to climb out of bed.

There was a real risk that Bert would injure himself by falling out of bed or by damaging his skin, bladder or urethra. There were risks to other

patients as well as workers were distracted from their needs by taking care of Bert.

Ward workers lowered Bert's bed to the floor and placed foam mattresses either side of the bed so that if he did 'get out of bed' the chances of him being injured were greatly reduced.

Bert's son Martin arrived to visit and the nurses asked him to try and help Bert tolerate the equipment. This was very stressful for Martin as he wasn't sure how forceful to be; he wanted the best for his father and did not like to see him distressed.

Martin remembered that his father had been used to wearing breathing apparatus during his long career as a fire-fighter. He explained to Bert that the oxygen mask was just like his 'breathing apparatus' using that term and also saying "B.A." which was the acronym Bert was familiar with. This greatly alleviated Bert's distress as the concept of wearing a face mask was firmly lodged in his memory as an unpleasant but necessary thing. He did still try to remove the mask but less often and when reminded verbally he left it in place without needing it to be physically replaced. As Bert's distress lessened he was more tolerant of the catheter and the drip, and actually needed the oxygen for a shorter period of time.

In Bert's case it was fortunate that he had that experience of wearing BA in his working life; this will not be the case for everyone. However, workers and carers can always work together quickly to think about experiences and terminology that people might know (or conversely which might be particularly worrying for them) from their earlier lives to help them understand and accept treatment and interventions that they need.

**Additional resources to support partnership working with people who have care and support needs, patients and carers**

When considering the way to work in partnership working with people who have care and support needs, patients and carers to minimise the use of restrictive practices, you could make reference to the following specific resources.

- National involvement partnership Involvement standards http://www.nsun.org.uk/about-us/national-involvement-partnership/
- NHS England; Transforming Participation in Health and Care, Guidance for Commissioners http://www.england.nhs.uk/2013/09/25/trans-part/
- SCIE; The participation of adult service users, including older people, in developing social care http://www.scie.org.uk/publications/guides/guide17/participation/
- Skills for Health & Skills for Care, Carers Matter – Everybody's Business (2011) http://www.skillsforcare.org.uk/Skills/Carers/Carers.aspx

## 4.7. Individual employers

People who have care and support needs may employ or commission their own support workers using direct payments or their own savings or resources.

- http://www.skillsforcare.org.uk/Document-library/Employing-your-own-care-and-support/Working-for-personalised-care---A-framework-for-supporting-personal-assistants-working-in-adult-social-care.pdf
- http://www.thinklocalactpersonal.org.uk/Browse/mir/aboutMIR/

## 4.8. People with autism

When considering the minimisation of restrictive practices when supporting a person with autism you could make reference to the following specific resources:

- Sensory differences http://www.autism.org.uk/sensory
- National Autistic society http://www.autism.org.uk/living-with-autism/understanding-behaviour.aspx
- High functioning autism and aspergers http://www.autism.org.uk/about-autism/autism-and-asperger-syndrome-an-introduction/high-functioning-autism-and-asperger-syndrome-whats-the-difference.aspx
- The Autism strategy, rewarding and fulfilling lives http://www.autism.org.uk/autismstrategy
- Skills for Care and Skills for Health's 'Autism skills and knowledge list' http://www.skillsforcare.org.uk/Skills/Autism/Autism.aspx

# 5. Appendices

## Appendix A – More details on workforce

| **Who is my workforce?: Consider how many people are in these roles, including part time, relief, casual, bank and agency workers** | |
|---|---|
| **The individual and their family** or **representatives** | Individuals, family carers, friends, partners, neighbours advocates, peer advocates, nearest relatives, next of kin, 'relevant person's representative' (DOLS), shared lives carers, foster carers. |
| **Paid workers** | Support & care workers; registered workers including nurses, allied health professionals and social workers; managers; medical workers and doctors both community and inpatient; receptionists, administrators, housekeeping, bank and agency workers. |
| **Managers; paid and unpaid** | Chief executives, board members, senior managers, trustees and shareholders. |
| **Volunteers** | People working voluntarily within people's homes, community and hospital settings. |
| **Trainers** or **Individual learning providers** | All training / learning and development workers including assessors and specialist practitioners. |
| **Advisors / shapers** | Safeguarding leads, service commissioners, CQC, health and safety advisers, solicitors and legal advisers including MCA & DOLS leads. |
| **Students** | Any student on placement. |

| **What we expect people to be able to do is dependent upon the person's individual situation and the service setting/provision. It may include:** | |
|---|---|
| **Planned** | ■ Upholding a person's rights and dignity at all times<br>■ In partnership with individuals and their families/carers develop person centred care plans which include positive behaviour support plans and functional analysis<br>■ Developing and reviewing restrictive plans / reduction plans and programmes<br>■ Undertake risk assessments to include choice and positive risk taking in partnership with individuals and their families/carers<br>■ Carry out physical restraint as part of a person's plan of care and support<br>■ Provide hands on care and support tasks for example: bathing, dressing, help with eating and drinking and giving medication. |

| What we expect people to be able to do is dependent upon the person's individual situation and the service setting/provision. It may include: | |
|---|---|
| **Planned cont.** | ▪ Provide hands on medical and nursing care tasks for example: changing dressings, undertaking physical health checks<br>▪ Ensure that people's physical health needs are identified and met through regular and timely health checks<br>▪ Undertake controlled restraint as part of a restraint team.<br>▪ Deliver staff training and other learning and development activities including assessment for qualifications.<br>▪ Manage and supervise people delivering direct care<br>▪ Embedding new learning into culture and practice<br>▪ Work intensively in one to one situations supporting people and teams<br>▪ Write, scrutinise and interpret policy for practice<br>▪ Commission services and /or learning<br>▪ Record and report incidents of restraint as per organisational policy and procedure<br>▪ Approve strategic plans such as learning plans or policies and procedures<br>▪ Work alone |
| **Unplanned** | ▪ Upholding a person's rights and dignity at all times<br>▪ Respond to unexpected situations which pose a risk of harm to the individual and/or others<br>▪ Provide emergency lifesaving interventions<br>▪ Fill in for others when absent |

| Where | |
|---|---|
| **Where do we expect them to do it?** | In relation to restrictive practices; good practice and the law may be applied differently dependent upon different situations, these might include:<br>▪ residential care homes<br>▪ a person's own home / family home<br>▪ community / public places, e.g. accident and emergency units, in the street, cinema, etc.<br>▪ near environmental hazards, e.g. traffic, water, steep cliffs, etc.<br>▪ stimulating or calming environments, e.g. noise, heat, crowds, aromas, etc.<br>▪ where children or vulnerable adults may be present<br>▪ in a secure settings such as a secure mental health unit. |

| What | |
|---|---|
| **What skills, and knowledge, attitudes, values, confidence and competences do they (a) need, and (b) already have?** | This might be assessed by considering:<br>■ The expectations above.<br>■ The needs of people being supported which should be expressed in care plans: positive behaviour support plans / Wellness Recovery Action Plans (WRAP) / life story / advance care plans.<br>■ The appropriate level of awareness of the specific needs of people with conditions such as dementia, borderline personality disorder, autism. Either because the service is for people with these conditions or because people with these conditions may access the service as part of the general public.<br>■ The organisation’s values, purpose, policies and procedures.<br>■ Service specifications / contracts / feedback and instructions from people being supportd or their carers.<br>■ Codes of conduct / (minimum) training standards induction standards / sector skills council guidance / registration requirements.<br>■ Supervisions, appraisal, personal development plans.<br>■ Job descriptions / person specifications. |

| When | |
|---|---|
| **When can I assess and improve the levels of skills needed and the level that workers have?** | Opportunities might exist when carrying out:<br>■ Recruitment and selection.<br>■ Designing or redesigning a service or team; changes to individuals’ circumstances and roles.<br>■ Annual reviews (contract compliance / inspection / budget planning).<br>■ Debrief / learn from incident / near misses / improvements.<br>■ Induction / probation / supervision / appraisal / personal development planning.<br>■ Delivering learning/ assessing competence / refresher periods<br>■ Degree / ‘pre-registration’ training.<br>■ When data analysis suggests that skill levels need to be considered. |

| How | |
|---|---|
| **How will I develop the skills that workers have?** | By involving the voice of people being supported.<br>The following opportunities might exist:<br>■ Shadowing, mentoring, coaching, peer support.<br>■ In house or external learning; How will I ensure that learning providers are up to date, teaching evidence-based approaches that are in tune with my service?<br>■ Theory and competence; developing the relevant physical / practical skills.<br>■ As part of induction / qualification / continuing professional development.<br>■ Co-training with other partners / competitors / agencies.<br>■ How will I evaluate the learning and its impact on practice. |

## Appendix B - List of recommended units and qualifications to support the minimisation of restrictive practices

Units applicable to family carers and workers. To find detail of units visit the Ofqual site http://register.ofqual.gov.uk/ and click on 'search units'

| Unit number | Name | Level |
|---|---|---|
| H/504/2891 | Behaviour Change for health and wellbeing | 2 |
| H/601/9282 | Approaches to enable rights and choices for individuals with dementia whilst minimising risks | 2 |
| M/501/6004 | Communication, relationships and promoting mental wellbeing with older people | 2 |
| A/601/9546 | Contribute to support of positive risk-taking for individuals | 2 |
| A/502/0590 | Defusing Difficult Situations in the Workplace | 2 |
| K/501/5210 | Effective communication in mental health work | 2 |
| A/601/8140 | Implement person centred approaches in health and social care | 2 |
| Y/601/7352 | Provide active support | 2 |
| HSC 2012 | Support Individuals who are Distressed L/601/8143 | 2 |
| F/601/4056 | Support use of medication in health and social care settings | 3 |
| | | |
| MCA01 | Awareness of the Mental Capacity Act 2005 | 3 |
| K/601/2415 | Applied Psychological Perspectives for Health and Social Care | 3 |
| M/501/0591 | Contribute to the prevention and management of abusive and aggressive behaviour of individuals who misuse substances | 3 |
| L/601/9034 | Enable individuals with behavioural difficulties to develop strategies to change their behaviour | 3 |
| A/601/9191 | Enable rights and choices of individuals with dementia whilst minimising risks | 3 |
| H/601/8049 | Facilitate person centred assessment, planning, implementation and review | 3 |
| K/505/7778 | Promote positive behaviour | 3 |
| Y/602/3099 | Provide support for individuals with communication and interaction difficulties | 3 |
| M/602/4825 | Support individuals during emergency situations | 3 |
| R/503/9985 | Enable individuals with mental health problems to develop alternative coping strategies | 4 |
| HSC 3065 | Implement the positive behavioural support model | 4 |

| | | |
|---|---|---|
| L/504/7079 | Managing risk behaviour when supporting individuals with cognitive related challenge | 4 |
| J/504/6240 | Managing the risk of aggressive and challenging behaviour in the workplace | 4 |
| R/504/6239 | Managing the risks associated with crisis behaviour in the workplace | 4 |
| | | |
| A/504/2217 | Lead practice in assessing and planning for the needs of families and carers | 5 |
| H/504/2213 | Lead practice which supports individuals to take positive risks | 5 |
| K/602/2572 | Lead positive behavioural support | 7 |
| **Units applicable to social care and health workers** | | |
| Y/505/8005 | Delivering instruction in the implementation of physical interventions in the management of high risk behaviours in the workplace. | 4 |
| D/505/8006 | Delivering instruction in the use of physical interventions in the management of acute behavioural disturbance and extreme risk behaviour in the workplace. | 4 |

Other qualifications include:
BTEC Professional Diploma in Positive Behaviour Management
BTEC PBS Advanced certificate.
BTEC PBS Advanced Diploma

## Appendix C – List of qualifications suitable for those delivering learning and assessment activities in the use of restrictive practices

Currently there are no requirements for social care and health workers to hold teaching or training qualifications.

However where an individual learning provider or trainer does not hold or is not working towards a formal teaching or learning & development qualification (as outlined below) the employer should satisfy themselves that the learning provider meets the same standards of practice as set out in the Learning and Development National Occupational Standards and be occupationally competent in the area in which they are providing learning.

**Individual learning providers**

- Qualified Teacher Status
- Certificate in Education in Post Compulsory Education (PCE)
- Social Work Post Qualifying Award in Practice Teaching
- Preparing to Teach in the Lifelong Learning Sector (PTLLS)
- Certificate in Teaching in the Lifelong Learning Sector (CTLLS)
- Diploma in Teaching in the Lifelong Learning sector (DTLLS)
- Mentorship and Assessment in Health and Social Care Settings
- Mentorship in Clinical/Health Care Practice
- NOCN – Tutor/Assessor Award
- QCF Level 4 Certificate in Education and Training
- QCF Level 5 Diploma in Education and Training
- Tutor/Trainer Qualification by recognised body/association in the prevention and management of violence and aggression.
- Clinical credibility (to be evidenced by previous work related experience and working practice).

**Assessors**

Assessor must also be occupationally competent in the units they are assessing and hold a relevant assessor qualification, for example;

- Level 3 Award in Understanding the Principles and Practices of Assessment (QCF)
- 501/2212/5

- Level 3 Award in Assessing Competence in the Work Environment (QCF)
- 501/2387/7
- Level 3 Award in Assessing Vocationally Related Achievement (QCF)
- 501/2385/3
- Level 3 Certificate in Assessing Vocational Achievement (QCF)501/2388

Or pre-existing equivalent.

Please see Skills for Care and Development and Skills for Health assessment principles for definitions.

http://cdn.cityandguilds.com/ProductDocuments/Health_and_Social_Care/Care/4222/Centre_documents/Assessor%20requirements_v2.pdf

Note: the new Education and Training Foundation has a priority to refresh the professional standards and launch them by summer 2014.
http://www.et-foundation.co.uk/our-priorities/professional-standards.html

## Appendix D – Legislation and codes of practice

### Legislation

- European Convention of Human Rights and The Human Rights Act 1998, in particular;
  - Article 2; right to life
  - Article 3; prohibition of torture, inhuman or degrading treatment
  - Article 5; right to liberty and security of person
  - Article 8; right to respect for private and family life
  - Article 10; freedom of expression
  - Article 14; prohibition of discrimination
- The Mental Health Act 1983 as amended by the 2007 Mental Health Act
- Mental Capacity Act 2005 (MCA)
- Deprivation of Liberty Safeguards (under MCA 2005),
- Health and Safety at Work Act 1974 (and other H&S legislation),
- Common Law. (Offences against the person act 1861)
- Statute Law
- Care Bill (currently in draft form) 2013-2014
- The Children Act 2004 where relevant
- SEND reforms where relevant – these reform the system of supporting children and young people with special educational needs or disabilities and cover the ages 0 – 25, bringing health care and education plans together. http://www.education.gov.uk/childrenandyoungpeople/send
- Equality Act 2010 and the Disability Discrimination Act http://odi.dwp.gov.uk/disabled-people-and-legislation/equality-act-2010-and-dda-1995.php

Guidance on relevant legislation can be found here;
https://www.mind.org.uk/information-support/legal-rights/
http://www.mencap.org.uk/all-about-learning-disability/information-professionals/standards-care

### Codes of practice

- NHS Protect: Meeting needs and reducing distress
- RCN Guidance
- HCPC : Standards of conduct, performance and ethics
- NMC: (Nursing and Midwifery Council) Code of practice
- BILD code of practice / accreditation system
- National Institute for Health and Care Excellence (NICE) Guideline no. 25 Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments

- Skills for Care and Skills for Health Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England 2013
- NMC Standards for Medicines Management 2007
- Behaviour Analyst Certification Board; 1006 Guidelines For Responsible Conduct Revised, January 29, 2014 - http://uk-sba.org/?attachment_id=425

**Guidance and standards**

- The NHS Constitution
- Practical approaches to workforce planning; A guide to support workforce planning processes and plans for adult social care support services (SFC).
- Principles of workforce redesign (Skills for Care).
- National occupational standards.
- The Knowledge and Skills Framework. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4090843
- Supporting Workers working with people who challenge services - Guidance for employers, Skills for Care, February 2013
- CQC Essential Standards and Quality and Safety
- A unified approach to challenging behaviour – Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, Approved by Central Executive Committee: March 2007
- Violence, The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. http://www.nice.org.uk/nicemedia/live/10964/29715/29715.pdf
- HSE:
  - RR440 - Violence and aggression management training for trainers and managers http://www.hse.gov.uk/research/rrhtm/rr440.htm
  - RR495 - Violence management training: The development of effective trainers in the delivery of violence management training in healthcare settings http://www.hse.gov.uk/research/rrhtm/rr495.htm
- The independent restraint advisory panel
- Guidelines & policy around dealing with public & press opinion
- The Social care commitment.
- DH: Transforming care: A national response to Winterbourne View Hospital
- “Choosing workplace learning”; http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Finding-learning-providers/Finding-learning-providers.aspx.
- Whistleblower’s helpline run by Royal Mencap. www.wbhelpline.org.uk enquiries@wbhelpline.co.uk
- Francis Report

## Appendix E – Content of learning; a starting point

**Recommended content of learning**

**Learning content should:**

- Be developed and /or delivered by those who have lived experience of services and conditions and their family members and carers.
- Based upon policy and procedure, supported by culture and practice.
- Be based on current evidence-based practice.
- Be undertaken at an appropriate time so workers can work effectively from the outset.
- Be delivered using a variety of different learning methods relevant to the situation including skills practice.

| Content could/should include | To whom |
|---|---|
| ■ Value based practice.<br>■ Person-centred care and planning.<br>■ Safeguarding is all of our responsibilities. | **All workers** |
| ■ Being person centred in your work/care: Core principles and values.<br>■ Functional assessment of behaviour including triggers and the impact of the environment and trauma.<br>■ Positive risk taking.<br>■ Understand the impact of gender, ethnicity culture, life history and experiences on behaviour.<br>■ Ways of communicating: behaviour and non verbal communication, communication breakdown and aided communication.<br>■ Physiological aspects of behaviour: pain, illness, infection, substance use, epilepsy, diabetes etc.<br>■ Positive behaviour support framework where person is known with planned non aversive approaches / diffusion / distraction for individual.<br>■ Positive person centred collaborative care planning to include: active support, life story work, health actions plans, wellness recovery action plans, advance decisions and end of life planning.<br>■ Legislation and application to practice: Human Rights Act, MHA, MCA, DOLs and common law.<br>■ Role of debriefing and organisational practice. | **Care and health workers** |

| | |
|---|---|
| ■ Being person-centred in your work/care. Core principles and values.<br>■ Functional analysis of behaviour including triggers and the impact of the environment and trauma.<br>■ Understand the impact of gender, ethnicity culture, life history and experiences on behaviour.<br>■ Ways of communicating: behaviour and non verbal. communication, communication breakdown and aided communication.<br>■ Physiological aspects of behaviour : pain, illness, infection, substance use, epilepsy, diabetes etc.<br>■ De escalation techniques; non aversive approaches / diffusion / distraction for individual.<br>■ A gradient approach to restraint from:<br>▪ De-escalation.<br>▪ Seated.<br>■ The legislation and application to practice: Human rights act, MHA, MCA, DOLs and common law.<br>■ Role of debriefing and organisational practice. | **Care and health workers** |
| ■ Functional Assessment.<br>■ The role of evidence-based psychological treatments.<br>■ Reflective and sustainable practice - Learning from events and promoting ongoing learning with individuals and organisations.<br>■ Current research.<br>▪ Understanding tolerances.<br>▪ Resilience.<br>■ likely potential emergency situations where not known.<br>■ Include Prevention.<br>▪ Recognising distress.<br>▪ Common causes of needs.<br>▪ Psychological wellbeing.<br>▪ Risk assessment. | **Supervisors**<br>**Managers** |

# Appendix F – Accreditation systems and models of learning

## Voluntary accreditation systems

Although there is no current mandatory accreditation system for learning providers voluntary systems do exist. Further information on these systems can be found at:

- British Institute of Learning Disabilities (BILD) PIAS accreditation scheme www.bild.org.uk/our-services/bilds-services/
- Security Industry Authority http://www.skillsforsecurity.org.uk/index.php/questions/1/39 or http://www.sia.homeoffice.gov.uk/Pages/training.aspx

## List of learning models which participants in this project have used and recommended:

- Crisis Prevention Institute: www.crisisprevention.com
- D.ESCAL8: http://de-escalate.com
- The General Services Association (GSA): www.thegsa.co.uk
- La-Vigna
- Mapa: (Management of actual or potential aggression)
- Maybo: www.maybo.co.uk
- NHS Protect Sylabus  www.nhsprotect.nhs.uk/reducingdistress
- PROACT-SCIPr-uk ®  http://www.proact-scipr-uk.com/
- Respect training from NAVIGO  NAV. respectTraining@nhs.net
- St Anne's Community Services Positive Behaviour Support model of training
- TEACCH

## Appendix G – Questions to consider when choosing a learning provider for reducing restrictive practices

- Can they can evidence bespoke learning to meet the specific needs of the service, e.g. different content will be required for a home supporting people with dementia than one that is supporting people with autism?
- What qualifications do the people delivering the learning have – for instance if the course is a PBS introduction has the person attended a university accredited course on positive behaviour support?
- Can they provide examples of services which have previously applied the learning?
- Can you provide an overview of the background requirements of the learning to be purchased?
- Does the programme conform to the 2/3 preventative proactive, 1/3 reactive physical intervention, balance?
- Does the learning provider have a system of feedback available to all, e.g. like ‘trip adviser’ or ‘check a trade’?
- Does the learning contain an element of competence testing – for instance role play testing as well as verbal competence?
- Have the individual learning providers a system in place to feed back about learners who are unsafe in their practice?
- Can the learning provider describe the biomechanical issues of any techniques that are taught?
- Do you know how to conduct a behaviour audit in order to meet the needs of the service users receiving care and ensure the workers have the appropriate knowledge and skills after the learning?
- Do they include the functions of behaviour and positive behaviour support planning within their learning provision?
- Can the learning provider offer support to your organisation following the learning provision?
- Can they help with plans or suggestions about how training and learning should be monitored to make sure it is working in practice?
- Has the learning provider been accredited by undertaking a rigorous external process (eg BILD)?

# 6. References

- Ensuring Quality Services (EQS: *Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and / or autism who display or are at risk of displaying behaviour that challenges"* has been developed by NHS England and the Local Government Association (NHSE LGA 2014). http://www.local.gov.uk/documents/10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f
- *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).
- Safewards Project.
- Dementia care mapping' with people who have dementia.
- The NHS protect guidance *'Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings'*.
- Institute for Public Care, 2012.:see NDTi Guide for reference.
- 'RESPECT' training- Navigo : Respect training from NAVIGO NAV.respectTraining@nhs.net
- "The International Journal of Positive Behavioural Support (IJPBS)", Volume 3, Number 2, Autumn 2013.
- McGill P, Bradshaw J, & Hughes A (2006), *Impact of Extended Education/Training in Positive Behaviour Support on Staff Knowledge, Causal Attributions and Emotional Responses*. Journal of Applied Research in Intellectual Disabilities, Volume 20, Issue 1, 41–51, January 2007 http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2006.00338.x/full
- McGill P & MacDonald A (2013), *Outcomes of Staff Training in Positive Behaviour Support: A Systematic Review.* Journal of Developmental and Physical Disabilities 2013; 25(1): 17–33. http://link.springer.com/article/10.1007/s10882-012-9327-8

# Notes

70.

Skills for Care
West Gate
6 Grace Street
Leeds
LS1 2RP

tel: 0113 245 1716
fax: 0113 243 6417
email: info@skillsforcare.org.uk
web: www.skillsforcare.org.uk

Skills for Health
2nd Floor
Goldsmiths House
Broad Plain
Bristol BS2 0JP

tel: 0117 922 1155
fax: 0117 925 1800
email: office@skillsforhealth.org.uk
web: www.skillsforhealth.org.uk

NICE National Institute for
Health and Care Excellence

NICE
guideline

# Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

NICE guideline
Published: 29 May 2015
www.nice.org.uk/guidance/ng11

# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

This guideline is the basis of QS101 and QS142.

This guideline should be read in conjunction with NG93.

# Overview

This guideline covers interventions and support for children, young people and adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges, and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and intervention for family members or carers.

NICE has produced an easy read version for people with a learning disability.

## Who is it for?

- Healthcare professionals, commissioners and providers in health and social care
- Parents, family members or carers of children, young people and adults with a learning disability and behaviour that challenges

# Context

A learning disability is defined by 3 core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability. Although the term 'intellectual disability' is becoming accepted internationally, 'learning disability' is the most widely used and accepted term in the UK and is therefore used in this guideline. The amount of everyday support a person with a learning disability needs will depend mostly on the severity of the disability. It is important to treat each person as an individual, with specific strengths and abilities as well as needs, and a broad and detailed assessment may be needed.

Some people with a learning disability display behaviour that challenges. 'Behaviour that challenges' is not a diagnosis and is used in this guideline to indicate that although such behaviour is a challenge to services, family members or carers, it may serve a purpose for the person with a learning disability (for example, by producing sensory stimulation, attracting attention, avoiding demands and communicating with other people). This behaviour often results from the interaction between personal and environmental factors and includes aggression, self-injury, stereotypic behaviour, withdrawal, and disruptive or destructive behaviour. It can also include violence, arson or sexual abuse, and may bring the person into contact with the criminal justice system.

It is relatively common for people with a learning disability to develop behaviour that challenges, and more common for people with more severe disability. Prevalence rates are around 5–15% in educational, health or social care services for people with a learning disability. Rates are higher in teenagers and people in their early 20s, and in particular settings (for example, 30–40% in hospital settings). People with a learning disability who also have communication difficulties, autism, sensory impairments, sensory processing difficulties and physical or mental health problems (including dementia) may be more likely to develop behaviour that challenges.

The behaviour may appear in only certain environments, and the same behaviour may be considered challenging in some settings or cultures but not in others. It may be used by the person for reasons such as creating sensory stimulation, getting help or avoiding demands. Some care environments increase the likelihood of behaviour that challenges. This includes those with limited opportunities for social interaction and meaningful occupation, lack of choice and sensory input or excessive noise. It also includes care environments that are crowded, unresponsive or unpredictable, those characterised by neglect and abuse, and those where physical health needs and pain go unrecognised or are not managed.

Multiple factors are likely to underlie behaviour that challenges. To identify these, thorough assessments of the person, their environment and any biological predisposition are needed, together with a functional assessment. Interventions depend on the specific triggers for each person and may need to be delivered at multiple levels (including the environmental level). The aim should always be to improve the person's overall quality of life.

This guideline will cover the care and shared care provided or commissioned by health and social care, in whatever care setting the person lives.

## Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere, such as emergency departments and primary care or on home visits.

Be aware of or suspect abuse as a contributory factor to or cause of behaviour that challenges shown by children with a learning disability. Abuse may also coexist with behaviour that challenges. See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

This section has been agreed with the Royal College of Paediatrics and Child Health.

## Safeguarding adults

Adults with a learning disability are vulnerable to maltreatment and exploitation. This can occur in both community and residential settings. A referral (in line with local safeguarding procedures) may be needed if there are concerns regarding maltreatment or exploitation, or if the person is in contact with the criminal justice system.

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## 1.1 General principles of care

### Working with people with a learning disability and behaviour that challenges, and their families and carers

1.1.1 Work in partnership with children, young people and adults who have a learning disability and behaviour that challenges, and their family members or carers, and:

- involve them in decisions about care
- support self-management and encourage the person to be independent
- build and maintain a continuing, trusting and non-judgemental relationship
- provide information:
    - about the nature of the person's needs, and the range of interventions (for example, environmental, psychological and pharmacological interventions) and services available to them
    - in a format and language appropriate to the person's cognitive and developmental level (including spoken and picture formats, and written versions in Easy Read style and different colours and fonts)
- develop a shared understanding about the function of the behaviour

- help family members and carers to provide the level of support they feel able to.

1.1.2 When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members or carers:

- take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems
- aim to provide support and interventions:
  - in the least restrictive setting, such as the person's home, or as close to their home as possible, and
  - in other places where the person regularly spends time (for example, school or residential care)
- aim to prevent, reduce or stop the development of future episodes of behaviour that challenges
- aim to improve quality of life
- offer support and interventions respectfully
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person
- ensure that they know who to contact if they are concerned about care or interventions, including the right to a second opinion
- offer independent advocacy to the person and to their family members or carers.

## Understanding learning disabilities and behaviour that challenges

1.1.3 Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour that challenges (including family members and carers) should understand:

- the nature and development of learning disabilities
- personal and environmental factors related to the development and maintenance of behaviour that challenges
- that behaviour that challenges often indicates an unmet need
- the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational and occupational functioning
- the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

## Delivering effective care

1.1.4 Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

1.1.5 If initial assessment (see section 1.5) and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams providing care have prompt and coordinated access to specialist assessment, support and intervention services. These services should provide advice, supervision and training from a range of staff to support the implementation of any care or intervention, including psychologists, psychiatrists, behavioural analysts, nurses, social care staff, speech and language therapists, educational staff, occupational therapists, physiotherapists, physicians, paediatricians and pharmacists.

## Staff training, supervision and support

1.1.6 Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges, including:

- developing personalised daily activities
- adapting a person's environment and routine
- strategies to help the person develop an alternative behaviour to achieve the same purpose by developing a new skill (for example, improved communication, emotional regulation or social interaction)
- the importance of including people, and their family members or carers, in planning support and interventions
- strategies designed to calm and divert the person if they show early signs of distress
- delivering reactive strategies.

1.1.7 Health and social care provider organisations should ensure that all staff get personal and emotional support to:

- enable them to deliver interventions effectively for people with a learning disability and behaviour that challenges
- feel able to seek help for difficulties arising from working with people with a learning disability and behaviour that challenges
- recognise and manage their own stress.

1.1.8 Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff. Staff should:

- receive regular high-quality supervision that takes into account the impact of individual, social and environmental factors
- deliver interventions based on the relevant treatment manuals
- consider using routine outcome measures at each contact (for example, the Adaptive Behavior Scale and the Aberrant Behavior Checklist)
- take part in monitoring (for example, by using Periodic Service Review methods)

- evaluate adherence to interventions and practitioner competence (for example, by using video and audio recording, and external audit and scrutiny).

## Organising effective care

The recommendations in this section are adapted from the NICE guideline on common mental health disorders.

1.1.9 A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services that are:

- negotiable, workable and understandable for people with a learning disability and behaviour that challenges, their family members or carers, and staff
- accessible and acceptable to people using the services, and responsive to their needs
- integrated (to avoid barriers to movement between different parts of the care pathways)
- focused on outcomes (including measures of quality, service-user experience and harm).

1.1.10 The designated leadership team should be responsible for developing, managing and evaluating care pathways, including:

- developing clear policies and protocols for care pathway operation
- providing training and support on care pathway operation
- auditing and reviewing care pathway performance.

1.1.11 The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

1.1.12 The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve and have:

- clear and agreed goals for the services offered
- robust and effective ways to measure and evaluate the outcomes associated with the agreed goals.

1.1.13 The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services and:

- minimise the need for transition between different services or providers
- provide the least restrictive alternatives for people with behaviour that challenges
- allow services to be built around the care pathway (and not the other way around)
- establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- have designated staff who are responsible for coordinating people's engagement with a care pathway and transition between services within and between care pathways.

1.1.14 The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information:

- with people with a learning disability and behaviour that challenges, and their family members or carers (if appropriate), about their care
- about a person's care with other staff (including GPs)
- with all the services provided in the care pathway
- with services outside the care pathway.

## 1.2 Physical healthcare

1.2.1 GPs should offer an annual physical health check to children, young people and adults with a learning disability in all settings, using a standardised template (such as the Cardiff health check template). This should be carried out together with a family member, carer or healthcare professional or social care practitioner who knows the person and include:

- a review of any known or emerging behaviour that challenges and how it may be linked to any physical health problems
- a physical health review
- a review of all current health interventions, including medication and related side effects, adverse events, drug interactions and adherence
- an agreed and shared care plan for managing any physical health problems (including pain).

  See the Royal College of General Practitioners' guide for GP practices on annual health checks for people with a learning disability for further information.

## 1.3 Support and interventions for family members or carers

1.3.1 Involve family members or carers in developing and delivering the support and intervention plan for children, young people and adults with a learning disability and behaviour that challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public'.

1.3.2 Advise family members or carers about their right to carer assessment, and assessment for respite care and other support (see the NICE guideline on supporting adult carers for recommendations on identifying, assessing and meeting the caring, physical and mental health needs of families and carers).

1.3.3 When providing support to family members or carers (including siblings):

- recognise the impact of living with or caring for a person with a learning disability and behaviour that challenges
- explain how to access family advocacy
- consider family support and information groups if there is a risk of behaviour that challenges, or it is emerging
- consider formal support through disability-specific support groups for family members or carers and regular assessment of the extent and severity of the behaviour that challenges
- provide skills training and emotional support, or information about these, to help them take part in and support interventions for the person with a learning disability and behaviour that challenges.

1.3.4 If a family member or carer has an identified mental health problem, consider:

- interventions in line with existing NICE guidelines or
- referral to a mental health professional who can provide interventions in line with existing NICE guidelines.

## 1.4 Early identification of the emergence of behaviour that challenges

1.4.1 Everyone involved in caring for and supporting children, young people and adults with a learning disability (including family members and carers) should understand the risk of behaviour that challenges and that it often develops gradually. Pay attention to and record factors that may increase this risk, including:

- personal factors, such as:
  - a severe learning disability
  - autism
  - dementia
  - communication difficulties (expressive and receptive)
  - visual impairment (which may lead to increased self-injury and stereotypy)
  - physical health problems
  - variations with age (peaking in the teens and twenties)
- environmental factors, such as:
  - abusive or restrictive social environments
  - environments with little or too much sensory stimulation and those with low engagement levels (for example, little interaction with staff)
  - developmentally inappropriate environments (for example, a curriculum that makes too many demands on a child or young person)
  - environments where disrespectful social relationships and poor communication are typical or where staff do not have the capacity or resources to respond to people's needs
  - changes to the person's environment (for example, significant staff changes or moving to a new care setting).

1.4.2 Consider using direct observation and recording or formal rating scales (for example, the Adaptive Behavior Scale or Aberrant Behavior Checklist) to monitor the development of behaviour that challenges.

# 1.5 Assessment of behaviour that challenges

## The assessment process

1.5.1 When assessing behaviour that challenges shown by children, young people and adults with a learning disability follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. Start with initial assessment and move on to further assessment if, for example, intervention has not been effective or the function of the behaviour is not clear (see recommendations 1.5.4–1.5.11). Develop a behaviour support plan (see recommendation 1.6.1) as soon as possible.

1.5.2 When assessing behaviour that challenges ensure that:

- the person being assessed remains at the centre of concern and is supported throughout the process
- the person and their family members and carers are fully involved in the assessment process
- the complexity and duration of the assessment process is proportionate to the severity, impact, frequency and duration of the behaviour
- everyone involved in delivering assessments understands the criteria for moving to more complex and intensive assessment (see recommendation 1.5.8)
- all current and past personal and environmental factors (including care and educational settings) that may lead to behaviour that challenges are taken into account
- assessment is a flexible and continuing (rather than a fixed) process, because factors that trigger and maintain behaviour may change over time
- assessments are reviewed after any significant change in behaviour
- assessments are focused on the outcomes of reducing behaviour that challenges and improving quality of life
- the resilience, resources and skills of family members and carers are taken into account
- the capacity, sustainability and commitment of the staff delivering the behaviour support plan (see recommendation 1.6.1) are taken into account.

1.5.3 Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer or advocate to support the person and help them to understand the feedback if needed.

## Initial assessment of behaviour that challenges

1.5.4 If behaviour that challenges is emerging or apparent, or a family member, carer or member of staff (such as a teacher or care worker), has concerns about behaviour, carry out initial assessment that includes:

- a description of the behaviour (including its severity, frequency, duration and impact on the person and others) from the person (if possible) and a family member, carer or a member of staff (such as a teacher or care worker)
- an explanation of the personal and environmental factors involved in developing or maintaining the behaviour from the person (if possible) and a family member, carer or a member of staff (such as a teacher or care worker)
- the role of the service, staff, family members or carers in developing or maintaining the behaviour.

Consider using a formal rating scale (for example, the Aberrant Behavior Checklist or Adaptive Behavior Scale) to provide baseline levels for the behaviour and a scale (such as the Functional Analysis Screening Tool) to help understand its function.

1.5.5 As part of initial assessment of behaviour that challenges, take into account:

- the person's abilities and needs (in particular, their expressive communication and receptive communication)
- any physical or mental health problems, and the effect of medication, including side effects
- developmental history, including neurodevelopmental problems (including the severity of the learning disability and the presence of autism or other behavioural phenotypes)
- response to any previous interventions for behaviour that challenges

- the impact of the behaviour that challenges on the person's:
  - quality of life and that of their family members or carers
  - independent living skills and educational or occupational abilities
- social and interpersonal history, including relationships with family members, carers, staff (such as teachers) or other people with a learning disability (such as those the person lives with)
- aspects of the person's culture that could be relevant to the behaviour that challenges
- life history, including any history of trauma or abuse
- recent life events and changes to routine
- the person's sensory profile, preferences and needs
- the physical environment, including heat, light, noise and smell
- the care environment, including the range of activities available, how it engages people and promotes choice, and how well structured it is.

1.5.6 After initial assessment, develop a written statement (formulation) that sets out an understanding of what has led to the behaviour that challenges and the function of the behaviour. Use this to develop a behaviour support plan (see recommendation 1.6.1).

## Risk assessment

1.5.7 Assess and regularly review the following areas of risk during any assessment of behaviour that challenges:

- suicidal ideation, self-harm (in particular in people with depression) and self-injury
- harm to others
- self-neglect
- breakdown of family or residential support

- exploitation, abuse or neglect by others
- rapid escalation of the behaviour that challenges.

  Ensure that the behaviour support plan includes risk management (see recommendation 1.6.1).

## Further assessment of behaviour that challenges

1.5.8 If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services (see recommendation 1.1.5), covering any areas not fully explored by initial assessment (see recommendation 1.5.5). Carry out a functional assessment (see recommendations 1.5.9–1.5.11), identifying and evaluating any factors that may provoke or maintain the behaviour. Consider using formal (for example, the Adaptive Behavior Scale or the Aberrant Behavior Checklist) and idiographic (personalised) measures to assess the severity of the behaviour and the progress of any intervention.

## Functional assessment of behaviour

1.5.9 Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions. This should include:

- a clear description of the behaviour, including classes or sequences of behaviours that typically occur together
- identifying the events, times and situations that predict when the behaviour will and will not occur across the full range of the person's daily routines and usual environments
- identifying the consequences (or reinforcers) that maintain the behaviour (that is, the function or purpose that the behaviour serves)
- developing summary statements or hypotheses that describe the relationships between personal and environmental triggers, the behaviour and its reinforcers

- collecting direct observational data to inform the summary statements or hypotheses.

1.5.10 Include the following in a functional assessment:

- a baseline measurement of current behaviour, and its frequency and intensity, and repeated measurements in order to evaluate change
- measurements including direct observations and scales such as the Aberrant Behavior Checklist and self-reporting
- a baseline measurement of quality of life (such as the Life Experiences Checklist and the Quality of Life Questionnaire)
- assessment of the impact of current or past interventions, including reactive strategies.

1.5.11 Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach as set out below.

- Carry out pre-assessment data gathering to help shape the focus and level of the assessment.
- For recent-onset behaviour that challenges, consider brief structured assessments such as the Functional Analysis Screening Tool or Motivation Assessment Scale to identify relationships between the behaviour and what triggers and reinforces it.
- For recent-onset behaviour that challenges, or marked changes in patterns of existing behaviours, take into account whether any significant alterations to the person's environment and physical or psychological health are associated with the development or maintenance of the behaviour.
- Consider in-depth assessment involving interviews with family members, carers and others, direct observations, structured record keeping, questionnaires and reviews of case records.

- If a mental health problem may underlie behaviour that challenges, consider initial screening using assessment scales such as the Diagnostic Assessment Schedule for the Severely Handicapped-II, Psychiatric Assessment Schedule for Adults with a Developmental Disability or the Psychopathology Instrument for Mentally Retarded Adults and seek expert opinion.

### After further assessment

1.5.12 After further assessment, re-evaluate the written statement (formulation) and adjust the behaviour support plan if necessary.

## 1.6 Behaviour support plan

1.6.1 Develop a written behaviour support plan for children, young people and adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour. This should:

- identify proactive strategies designed to improve the person's quality of life and remove the conditions likely to promote behaviour that challenges, including:
  - changing the environment (for example, reducing noise, increasing predictability)
  - promoting active engagement through structured and personalised daily activities, including adjusting the school curriculum for children and young people
- identify adaptations to a person's environment and routine, and strategies to help them develop an alternative behaviour to achieve the function of the behaviour that challenges by developing a new skill (for example, improved communication, emotional regulation or social interaction)
- identify preventive strategies to calm the person when they begin to show early signs of distress, including:
  - individual relaxation techniques
  - distraction and diversion onto activities they find enjoyable and rewarding

- identify reactive strategies to manage any behaviours that are not preventable (see section 1.9), including how family members, carers or staff should respond if a person's agitation escalates and there is a significant risk of harm to them 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 person's family members, carers or staff, including managing risk, and 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 outcome data
- be reviewed frequently (fortnightly for the first 2 months and monthly thereafter), particularly if behaviour that challenges or use of restrictive interventions increases, or quality of life decreases
- identify any training for family members, carers or staff to improve their understanding of behaviour that challenges shown by people with a learning disability
- identify those responsible for delivering the plan and the designated person responsible for coordinating it.

## 1.7 Psychological and environmental interventions

### Early intervention for children and their parents or carers

1.7.1 Consider parent-training programmes for parents or carers of children with a learning disability who are aged under 12 years with emerging, or at risk of developing, behaviour that challenges.

1.7.2 Parent-training programmes should:

- be delivered in groups of 10 to 15 parents or carers

- be accessible (for example, take place outside normal working hours or in community-based settings with childcare facilities)
- focus on developing communication and social functioning
- typically consist of 8 to 12 sessions lasting 90 minutes
- follow the relevant treatment manual
- employ materials to ensure consistent implementation of the programme.

1.7.3 Consider preschool classroom-based interventions for children aged 3–5 years with emerging, or at risk of developing, behaviour that challenges.

1.7.4 Preschool classroom-based interventions should have multiple components, including:

- curriculum design and development
- social and communication skills training for the children
- skills training in behavioural strategies for parents or carers
- training on how to mediate the intervention for preschool teachers.

## Interventions for behaviour that challenges

1.7.5 Consider personalised interventions for children, young people and adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time, and consist of:

- clear targeted behaviours with agreed outcomes
- assessment and modification of environmental factors that could trigger or maintain the behaviour (for example, altering task demands for avoidant behaviours)
- addressing staff and family member or carer responses to behaviour that challenges

- a clear schedule of reinforcement of desired behaviour and the capacity to offer reinforcement promptly
- a specified timescale to meet intervention goals (modifying intervention strategies that do not lead to change within a specified time).

1.7.6 Consider individual psychological interventions for adults with an anger management problem. These interventions should be based on cognitive-behavioural principles and delivered individually or in groups over 15 to 20 hours.

1.7.7 Do not offer sensory interventions (for example, Snoezelen rooms) before carrying out a functional assessment to establish the person's sensory profile. Bear in mind that the sensory profile may change.

1.7.8 Consider developing and maintaining a structured plan of daytime activity (as part of the curriculum if the person is at school) that reflects the person's interests and capacity. Monitor the effects on behaviour that challenges and adjust the plan in discussion with the person and their family members or carers.

## 1.8 Medication

1.8.1 Consider medication, or optimise existing medication (in line with the NICE guideline on medicines optimisation), for coexisting mental or physical health problems identified as a factor in the development and maintenance of behaviour that challenges shown by children, young people and adults with a learning disability (see also recommendation 1.10.1).

1.8.2 Consider antipsychotic medication to manage behaviour that challenges only if:

- psychological or other interventions alone do not produce change within an agreed time or
- treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or

- the risk to the person or others is very severe (for example, because of violence, aggression or self-injury).

  Only offer antipsychotic medication in combination with psychological or other interventions.

1.8.3 When choosing which antipsychotic medication to offer, take into account the person's preference (or that of their family member or carer, if appropriate), side effects, response to previous antipsychotic medication and interactions with other medication.

1.8.4 Antipsychotic medication should initially be prescribed and monitored by a specialist (an adult or child psychiatrist or a neurodevelopmental paediatrician) who should:

- identify the target behaviour
- decide on a measure to monitor effectiveness (for example, direct observations, the Aberrant Behavior Checklist or the Adaptive Behavior Scale), including frequency and severity of the behaviour and impact on functioning
- start with a low dose and use the minimum effective dose needed
- only prescribe a single drug
- monitor side effects as recommended in the NICE guidelines on psychosis and schizophrenia in adults and psychosis and schizophrenia in children and young people
- review the effectiveness and any side effects of the medication after 3–4 weeks
- stop the medication if there is no indication of a response at 6 weeks, reassess the behaviour that challenges and consider further psychological or environmental interventions
- only prescribe p.r.n. (as-needed) medication for as short a time as possible and ensure that its use is recorded and reviewed

- review the medication if there are changes to the person's environment (for example, significant staff changes or moving to a new care setting) or their physical or mental health.

1.8.5 Ensure that the following are documented:

- a rationale for medication (explained to the person with a learning disability and everyone involved in their care, including their family members and carers)
- how long the medication should be taken for
- a strategy for reviewing the prescription and stopping the medication.

1.8.6 If there is a positive response to antipsychotic medication:

- record the extent of the response, how the behaviour has changed and any side effects or adverse events
- conduct a full multidisciplinary review after 3 months and then at least every 6 months covering all prescribed medication (including effectiveness, side effects and plans for stopping)
- only continue to prescribe medication that has proven benefit.

1.8.7 When prescribing is transferred to primary or community care, or between services, the specialist should give clear guidance to the practitioner responsible for continued prescribing about:

- which behaviours to target
- monitoring of beneficial and side effects
- taking the lowest effective dose
- how long the medication should be taken for
- plans for stopping the medication.

1.8.8 For the use of rapid tranquillisation, follow the NICE guideline on violence and aggression.

## 1.9 Reactive strategies

1.9.1 Only use reactive strategies for children, young people and adults with a learning disability and behaviour that challenges as a last resort and together with the proactive interventions described in section 1.7. When risks to the person with a learning disability or others are significant, or breakdown in their living arrangements is very likely, consider using reactive strategies as an initial intervention and introduce proactive interventions once the situation stabilises.

1.9.2 Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or carers to be involved in planning and reviewing reactive strategies whenever possible.

1.9.3 If a restrictive intervention is used as part of a reactive strategy, follow the NICE guideline on violence and aggression for the safe use of restrictive interventions and carry out a thorough risk assessment. Take into account:

- any physical health problems and physiological contraindications to the use of restrictive interventions, in particular manual and mechanical restraint
- any psychological risks associated with the intervention, such as a history of abuse
- any known biomechanical risks, such as musculoskeletal risks
- any sensory sensitivities, such as a high or low threshold for touch.

Document and review the delivery and outcome of the restrictive intervention and discuss these with everyone involved in the care of the person, including their family members and carers, and with the person if possible.

1.9.4 Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and need for restrictive interventions.

1.9.5 Ensure that planned restrictive interventions:

- take place within the appropriate legal framework of the Human Rights Act 1998, the relevant rights in the European Convention on Human Rights, the Mental Health Act 1983 and the Mental Capacity Act 2005, including the supplementary code of practice on deprivation of liberty safeguards
- are in the best interest of the person to protect them or others from immediate and significant harm
- are a reasonable, necessary and proportionate response to the risk presented.

1.9.6 Regularly review and reassess the safety, efficacy, frequency of use, duration and continued need for reactive strategies, including restrictive interventions (follow the NICE guideline on violence and aggression for the safe use of restrictive interventions). Document their use as part of an incident record and use this in personal and organisational debrief procedures to inform future behaviour support planning and organisational learning.

## 1.10 Interventions for coexisting health problems

1.10.1 Offer children, young people and adults with a learning disability and behaviour that challenges interventions for any suspected or coexisting mental or physical health problems in line with the relevant NICE guideline for that condition (see also recommendation 1.8.1). Adjust the nature, content and delivery of the interventions to take into account the impact of the person's learning disability and behaviour that challenges.

## 1.11 Interventions for sleep problems

1.11.1 Consider behavioural interventions for sleep problems in children, young people and adults with a learning disability and behaviour that challenges that consist of:

- a functional analysis of the problem sleep behaviour to inform the intervention (for example, not reinforcing non-sleep behaviours)
- structured bedtime routines.

1.11.2 Do not offer medication to aid sleep unless the sleep problem persists after a behavioural intervention, and then only:

- after consultation with a psychiatrist (or a specialist paediatrician for a child or young person) with expertise in its use in people with a learning disability
- together with non-pharmacological interventions and regular reviews (to evaluate continuing need and ensure that the benefits continue to outweigh the risks).

  If medication is needed to aid sleep, consider melatonin. In May 2015, this was an off-label use of melatonin in people aged 55 years and under. See NICE's information on prescribing medicines.

# Terms used in this guideline

## Adults

Aged 18 years or older.

## Behavioural phenotypes

The expression of distinctive physiological and behavioural characteristics that have a chromosomal or genetic cause.

## Carer

A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or has a disability. This does not include paid carers (care workers), who are included in the definition of staff.

## Children

Aged 12 years or younger.

## Expressive communication

The ability to express thoughts, feelings and needs verbally (using words and sentences) and non-verbally (for example, using gestures, facial expressions, gaze, signing and other methods that supplement or replace speech or writing).

## Functional assessment

An assessment of the function of behaviour that challenges, including functional analyses and other methods of assessing behavioural functions.

## Reactive strategies

Any strategy used to make a situation or a person safe when they behave in a way that challenges. This includes procedures for increasing personal space, disengagement from grabs and holds, p.r.n. (as-needed) medication and more restrictive interventions.

## Receptive communication

The ability to understand or comprehend language (either spoken or written) or other means of communication (for example, through signing and other methods that supplement or replace speech or writing).

## Reinforcer

An event or situation that is dependent on a behaviour and increases the likelihood of that behaviour happening again.

## Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including locking doors, preventing a person from entering certain areas of the living space, seclusion, manual and mechanical restraint, rapid tranquillisation and long-term sedation.

## Self-harm

When a person intentionally harms themselves, which can include cutting and self-poisoning. It may be an attempt at suicide.

## Self-injury

Frequently repeated, self-inflicted behaviour, such as people hitting their head or biting themselves, which can lead to tissue damage. This behaviour is usually shown by people with a severe learning disability. It may indicate pain or distress, or it may have another purpose, such as the person using it to communicate.

## Staff

Healthcare professionals and social care practitioners, including those working in community teams for adults or children (such as psychologists, psychiatrists, social workers, speech and language therapists, nurses, behavioural analysts, occupational therapists, physiotherapists), paid carers (care workers) in a variety of settings (including residential homes, supported living settings and day services) and educational staff.

## Stereotypy

Repeated behaviours, such as rocking or hand flapping, that may appear to have no obvious function but often serve a purpose for the person (for example, to provide sensory stimulation or indicate distress or discomfort).

## Treatment manual

Detailed advice and guidance on how to deliver an intervention, including its content, duration and frequency. A treatment manual may also include materials to support the delivery of the intervention for staff and people receiving the intervention.

## Young people

Aged 13 to 17 years.

# Recommendations for research

## Preventing behaviour that challenges from developing in children aged under 5 years with a learning disability

Can positive behaviour support provided for children aged under 5 years with a learning disability reduce the risk of developing behaviour that challenges?

### Why this is important

Behaviour that challenges is common in children with a learning disability and can have a considerable impact on them and their family members or carers. It is a common reason for residential placement with associated high costs. Positive behaviour support aims to reduce behaviour that challenges and increase quality of life through teaching new skills and adjusting the environment to promote positive behaviour changes. Early intervention with children at risk of developing behaviour that challenges offers an opportunity to significantly enhance their life and that of their family members or carers.

The question should be addressed by a programme of research that includes:

- developing interventions to prevent behaviour that challenges from developing in children aged under 5 years
- assessing the feasibility of the formal evaluation of the interventions in a randomised controlled trial
- testing the clinical and cost effectiveness of the interventions in a large scale randomised controlled trial with long-term follow-up
- evaluating the implementation of the interventions in routine care.

## Interventions to reduce the frequency and extent of moderate to severe behaviour that challenges in

# community settings

Are interventions based on the science and practice of applied behaviour analysis or antipsychotic medication, or a combination of these, effective in reducing the frequency and severity of behaviour that challenges shown by adults with a learning disability?

## Why this is important

Behaviour that challenges is common in adults with a learning disability and can have a considerable impact on them and their family members or carers. It is also a common reason for hospital or residential placement. There is limited evidence for the effectiveness of either applied behaviour analysis or antipsychotic medication, or a combination of these in community settings. Little is known about which people respond best to which interventions or about the duration of the interventions. There is considerable evidence of the over use of medication and of limited skills and competence in delivering behavioural interventions.

The question should be addressed by a programme of research evaluating these interventions that includes:

- developing a protocol for assessing moderate to severe behaviour that challenges that:
    - characterises the nature and function of the behaviour
    - assesses all coexisting problems that may contribute to the behaviour developing or being maintained
- developing protocols for delivering and monitoring the interventions to be tested (including how any currently provided interventions will be stopped)
- assessing the feasibility of the formal evaluation of the interventions in a randomised controlled trial (in particular, recruitment)
- testing the comparative clinical effectiveness (including moderators and mediators) and cost effectiveness of the interventions in a large-scale randomised controlled trial.

# Locally accessible care

Does providing care where people live compared with out-of-area placement lead to improvements in both the clinical and cost effectiveness of care for people with a learning disability and behaviour that challenges?

## Why this is important

Many out-of-area care placements for people with a learning disability and behaviour that challenges are a long way from their home. This can have a considerable impact, limiting a family member or carer's ability to care for the person and leading to poorer outcomes and increased costs. It is widely recognised that locally accessible care settings could be beneficial and could reduce costs but there is no strong empirical evidence to support this. In the absence of such evidence significant numbers of out-of-area care placements continue to be made.

The question should be addressed by a programme of research that includes:

- a needs assessment and the care costs of a consecutive cohort of 250 people who have been placed in out-of-area care in a 2-year period
- developing standards for a range of support programmes designed to meet people's needs, which would provide detailed information on:
  - the needs to be meet
  - the nature of the care environments
  - the support, including specialist staff, needed
- testing the clinical and cost effectiveness of 'close to home' or home-based care that meet the developed standards (compared with consecutive cohorts in out-of-area placements).

# Factors associated with sustained, high-quality residential care

What factors (including service organisation and management, staff composition, training and supervision, and the content of care and support) are associated with sustained high-quality residential care for people with a learning disability and behaviour that challenges?

## Why this is important

The quality of residential care for people with a learning disability and behaviour that challenges remains an issue of national concern. Reviews (most recently of Winterbourne View Hospital) have identified failings in care. Although recommendations have been made this has not led to a significant and sustained improvement in care. It is important to understand how improvement can be maintained.

The question should be addressed by a programme of research that includes:

- a systematic review of the factors associated with sustained and beneficial change in health and social care organisations
- designing service-level interventions to support the implementation of standards of care developed from the systematic review
- testing the clinical and cost effectiveness of service-level interventions in residential units through the formal evaluation of a quality improvement programme established to introduce the new standards (the follow-up period should be for a minimum of 3 years after the implementation of the intervention).

# Finding more information and committee details

NICE has produced an easy read version of this guideline for people with a learning disability.

You can see everything NICE says on this topic in the NICE Pathway on learning disabilities and behaviour that challenges.

To find NICE guidance on related topics, including guidance in development, see our topic page for mental health and wellbeing.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

# Update information

**Minor changes since publication**

**August 2020:** We have linked to the NICE guideline on supporting adult carers in recommendation 1.3.2. We have incorporated footnote text into the recommendations to meet accessibility requirements.

ISBN 978-1-4731-1232-2

# Accreditation

NICE accredited

www.nice.org.uk/accreditation

NICE National Institute for Health and Care Excellence

NICE guideline

# Violence and aggression: short-term management in mental health, health and community settings

NICE guideline
Published: 28 May 2015
www.nice.org.uk/guidance/ng10

# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

This guideline replaces CG25 and ESUOM28.

This guideline is the basis of QS154.

# Overview

This guideline covers the short-term management of violence and aggression in adults (aged 18 and over), young people (aged 13 to 17) and children (aged 12 and under). It is relevant for mental health, health and community settings. The guideline aims to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur.

## Who is it for?

- Healthcare professionals
- Adults, young people and children with a mental health problem who use services in mental health, health and community settings, and their families and carers

# Introduction

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Violence and aggression are relatively common and serious occurrences in health and social care settings. Between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England: 69% in mental health or learning disability settings, 27% against ambulance staff, 25% involving primary care staff and 26% involving acute hospital staff. Violence and aggression in mental health settings occur most frequently in inpatient psychiatric units and most acute hospital assaults take place in emergency departments.

The manifestation of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom. The impact of violence and aggression is significant and diverse, adversely affecting the health and safety of the service user, other service users in the vicinity, carers and staff. Violence and aggression can also affect public opinion about services and service users and result in a strong negative impact on the overall experience of care. Although the guideline contains recommendations on intervening before violence and aggression occur, it is not always possible to avoid violence. Therefore a graded set of interventions is needed to prevent minor violence from escalating into severe violence.

Since the publication of the previous guideline in 2005 (NICE guideline CG25) there have been some important advances in our knowledge of the management of violence and aggression, including service users' views on the use of physical intervention and seclusion, and the effectiveness, acceptability and safety of drugs and their dosages for rapid tranquillisation. The previous guideline was restricted to people aged 16 and over in adult psychiatric settings and emergency departments; this update has been expanded to include some of the previously excluded populations and settings. All areas of NICE guideline CG25 have been updated and this guideline replaces it in full.

This guideline covers the short-term management of violence and physically threatening behaviour in mental health, health and community settings. This includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes. The guideline covers anticipating and reducing the risk of violence and aggression, prevention methods (such as searching, de-escalation and pharmacological strategies, including p.r.n. medication), restrictive interventions (for example, restraint, rapid tranquillisation and seclusion), staff training, and post-incident debrief and review.

This guideline includes adults (aged 18 and over), children (aged 12 and under) and young people (aged 13 to 17) with a mental health problem who are currently service users within mental health, health and community settings. It also covers carers of service users with mental health problems in these settings.

This guideline does not cover but may be relevant to practice regarding people who do not have mental health problems, those who are not carers of people with mental health problems, people in whom the primary behaviour is self-harm and people with a primary diagnosis of learning disability.

## Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere, such as emergency departments and primary care or on home visits.

Be aware of or suspect abuse as a contributory factor to or cause of the symptoms or signs of violence or aggression in children. Abuse may also coexist with violence or aggression. See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

This section has been agreed with the Royal College of Paediatrics and Child Health.

## Medicines

The guideline assumes that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual service users.

This guideline recommends some medicines for indications for which they do not have a UK marketing authorisation at the date of consultation, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The service user (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Where recommendations have been made for the use of medicines outside their licensed indications ('off-label use'), these medicines are indicated in the recommendations.

# Person-centred care

This guideline offers best practice advice on the care of service users with mental health problems whose behaviour is violent or aggressive.

Service users and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the service user is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in the NICE guideline on patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All healthcare professionals and social care practitioners working with people using adult NHS mental health services should follow the recommendations in the NICE guideline on service user experience in adult mental health.

If a young person is moving between paediatric and adult services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with mental health problems whose behaviour is violent or aggressive. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

# Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

See implementation: getting started for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

# Anticipating and reducing the risk of violence and aggression

## Reducing the use of restrictive interventions

### Staff training

- Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:
    - a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
    - an understanding of the relationship between mental health problems and the risk of violence and aggression
    - skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors
    - skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
    - skills, methods and techniques to undertake restrictive interventions safely when these are required
    - skills to undertake an immediate post-incident debrief (see recommendations 1.4.55 to 1.4.61)
    - skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see recommendations 1.4.62 to 1.4.63).

## A framework for anticipating and reducing violence and aggression in inpatient psychiatric wards

- Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.
  - Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management (see recommendation 1.3.19) and encouraging good leadership.
  - Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.
  - Recognise possible teasing, bullying, unwanted physical or sexual contact or miscommunication between service users.
  - Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).
  - Anticipate the impact of the regulatory process on each service user (for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital).
  - Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
  - Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
  - Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

# Preventing violence and aggression

## Using p.r.n. medication

- When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:
    - do not prescribe p.r.n. medication routinely or automatically on admission
    - tailor p.r.n. medication to individual need and include discussion with the service user if possible
    - ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
    - ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation
    - only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor
    - ensure that the interval between p.r.n. doses is specified.

## De-escalation

### Staff training

- Health and social care provider organisations should give staff training in de-escalation that enables 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 a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

### General principles

- Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

# Using restrictive interventions in inpatient psychiatric settings

## Using restrictive interventions

- Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

## Rapid tranquillisation

- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

## Post-incident debrief and review

### Formal external post-incident review

- The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:
  - is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
  - uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
  - includes interviews with staff, the service user involved and any witnesses if further information is needed
  - uses the framework in recommendation 1.2.7 to:
    - evaluate the physical and emotional impact on everyone involved, including witnesses
    - help service users and staff to identify what led to the incident and what could have been done differently
    - determine whether alternatives, including less restrictive interventions, were discussed
    - determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
    - recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
    - avoid a similar incident happening in future, if possible.

## Managing violence and aggression in emergency departments

- If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1 to 1.4.45 and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

## Managing violence and aggression in community and primary care settings

- Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

# Managing violence and aggression in children and young people

## Staff training

- Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:
  - in the use of these interventions in these age groups
  - to adapt the manual restraint techniques for adults in recommendations 1.4.23 to 1.4.33, adjusting them according to the child or young person's height, weight and physical strength
  - in the use of resuscitation equipment (see recommendation 1.4.3) in children and young people.

## Managing violence and aggression

- Manage violence and aggression in children and young people in line with the recommendations for adults in sections 1.1 to 1.6, taking into account:
  - the child or young person's level of physical, intellectual, emotional and psychological maturity
  - the recommendations for children and young people in this section
  - that the Mental Capacity Act 2005 applies to young people aged 16 and over.

## Assessment and initial management

Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

# 1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## Terms used in this guideline

**Advance decision** A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

**Advance statement** A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

**Advocate** A person who represents someone's interests independently of any organisation, and helps them to get the care and support they need.

**Breakaway techniques** A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

**Carer** A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled.

**Children** People aged 12 years or under.

**De-escalation** The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation.

**Incident** Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

**Manual restraint** A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.

**Mechanical restraint** A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user.

**Observation** A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation, as defined in recommendation 1.4.11.

**Positive engagement** An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic.

**p.r.n. (pro re nata)** When needed. In this guideline, p.r.n. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression

**Rapid tranquillisation** Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

**Restrictive interventions** Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.

**Seclusion** Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

**Violence and aggression** A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

**Young people** People aged between 13 and 17 years.

## 1.1 Principles for managing violence and aggression

### Improving service user experience

1.1.1 Use this guideline in conjunction with NICE's guideline on service user experience in adult mental health and:

- work in partnership with service users and their carers
- adopt approaches to care that respect service users' independence, choice and human rights
- increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act 1983.

1.1.2 Ensure that the safety and dignity of service users and the safety of staff are priorities when anticipating or managing violence and aggression.

1.1.3 Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

1.1.4 Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty.

### Staff training

1.1.5 In any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983.

## Involving service users in decision-making

1.1.6 Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

1.1.7 Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.

1.1.8 If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side-effect profiles of the medications recommended in this guideline for rapid tranquillisation (see recommendation 1.4.37) so that they can make an informed choice.

1.1.9 Ensure that service users understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Identify and reduce any barriers to a service user exercising their rights and, if this is not possible, record the reasons in their notes.

1.1.10 Ensure that carers are involved in decision-making whenever possible, if the service user agrees, and that carers are involved in decision-making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.

## Preventing violations of service users' rights

1.1.11 Evaluate, together with the service user, whether adjustments to services are needed to ensure that their rights and those of their carers (including rights related to protected characteristics as defined by the Equality Act 2010) are respected, and make any adjustments that are needed. Adjustments might include providing a particular type of support, modifying the way services are delivered or the approach to interaction with the service user, or making changes to facilities. Record this in the service user's care plan.

1.1.12 Health and social care provider organisations should train staff in cultural awareness and in the organisation's duties under the Equality Act 2010.

## Working with the police

1.1.13 Health and social care provider organisations should work with the police, and local service user groups if possible, to develop policies for joint working and locally agreed operating protocols that cover:

- when and how police enter health or social care settings (including psychiatric and forensic inpatients, emergency departments, general health inpatients, GP surgeries, social care and community settings and 136 place-of-safety suites)
- when and how health and social care professionals enter police cells
- transferring service users between settings.

Review the operating protocols regularly to ensure compliance with the policies and update the policies in light of operational experience.

# 1.2 Anticipating and reducing the risk of violence and aggression

## Reducing the use of restrictive interventions

### Staff training

1.2.1 Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:

- a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
- an understanding of the relationship between mental health problems and the risk of violence and aggression
- skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors
- skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
- skills, methods and techniques to undertake restrictive interventions safely when these are required
- skills to undertake an immediate post-incident debrief (see recommendations 1.4.55 to 1.4.61)
- skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see recommendations 1.4.62 and 1.4.63).

### Restrictive intervention reduction programme

1.2.2 Health and social care provider organisations should ensure that all services that use restrictive interventions have a restrictive intervention reduction programme (see recommendation 1.2.3) to reduce the incidence of violence and aggression and the use of restrictive interventions.

1.2.3 Restrictive intervention reduction programmes should:

- ensure effective service leadership
- address environmental factors likely to increase or decrease the need for restrictive interventions (see recommendation 1.2.7)
- involve and empower service users and their carers
- include leisure activities that are personally meaningful and physical exercise for service users
- use clear and simple care pathways
- use de-escalation
- use crisis and risk management plans and strategies to reduce the need for restrictive interventions
- include post-incident debrief and review (see recommendations 1.4.55 to 1.4.61)
- explore the current and potential use of technology in reporting, monitoring and improving the use of restrictive interventions
- have routine outcome monitoring, including quality of life and service user experience
- be based on outcome measures (safety, effectiveness and service user experience) to support quality improvement programmes
- include regular staff training in line with recommendation 1.2.1.

1.2.4 Health and social care provider organisations should collate, analyse and synthesise all data about violent events and the use of restrictive interventions, and involve service users in the process. The information should:

- be shared with the teams and services involved
- be shared with the trust board or equivalent organisational governing body
- be linked to the standards set in safeguarding procedures.

1.2.5 Health and social care provider organisations should develop a service user experience monitoring unit, or equivalent service user group, led by service users and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.

1.2.6 Health and social care provider organisations should publish board reports on their public websites that include data about incidents of violence and aggression and use of restrictive interventions within each team, ward and service, and include reasons for the similarities and differences between services.

## A framework for anticipating and reducing violence and aggression in inpatient psychiatric wards

1.2.7 Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.

- Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management (see recommendation 1.3.19) and encouraging good leadership.
- Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.
- Recognise possible teasing, bullying, unwanted physical or sexual contact, or miscommunication between service users.
- Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).

- Anticipate the impact of the regulatory process on each service user, for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital.
- Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
- Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
- Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

## Assessing and managing the risk of violence and aggression

1.2.8 When assessing and managing the risk of violence and aggression use a multidisciplinary approach that reflects the care setting.

1.2.9 Before assessing the risk of violence or aggression:

- Take into account previous violent or aggressive episodes because these are associated with an increased risk of future violence and aggression.
- Do not make negative assumptions based on culture, religion or ethnicity.
- Recognise that unfamiliar cultural practices and customs could be misinterpreted as being aggressive.
- Ensure that the risk assessment will be objective and take into account the degree to which the perceived risk can be verified.

1.2.10 Carry out the risk assessment with the service user and, if they agree, their carer. If this finds that the service user could become violent or aggressive, set out approaches that address:

- service user-related domains in the framework (see recommendation 1.2.7)

- contexts in which violence and aggression tend to occur
- usual manifestations and factors likely to be associated with the development of violence and aggression
- primary prevention strategies that focus on improving quality of life and meeting the service user's needs
- symptoms or feelings that may lead to violence and aggression, such as anxiety, agitation, disappointment, jealousy and anger, and secondary prevention strategies focusing on these symptoms or feelings
- de-escalation techniques that have worked effectively in the past
- restrictive interventions that have worked effectively in the past, when they are most likely to be necessary and how potential harm or discomfort can be minimised.

1.2.11 Consider using an actuarial prediction instrument such as the BVC (Brøset Violence Checklist) or the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings.

1.2.12 Consider offering service users with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

1.2.13 Regularly review risk assessments and risk management plans, addressing the service user and environmental domains listed in recommendation 1.2.7 and following recommendations 1.2.9 and 1.2.10. The regularity of the review should depend on the assessment of the level of risk. Base the care plan on accurate and thorough risk assessments.

1.2.14 If service users are transferring to another agency or care setting, or being discharged, share the content of the risk assessment with staff in the relevant agencies or care settings, and with carers.

### An individualised pharmacological strategy to reduce the risk of violence and aggression

1.2.15 A multidisciplinary team that includes a psychiatrist and a specialist pharmacist should develop and document an individualised pharmacological strategy for using routine and p.r.n. medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

1.2.16 The multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

- clarification of target symptoms
- the likely timescale for response to medication
- the total daily dose of medication, prescribed and administered, including p.r.n. medication
- the number of and reason for any missed doses
- therapeutic response
- the emergence of unwanted effects.

If rapid tranquillisation is being used, a senior doctor should review all medication at least once a day.

## 1.3 Preventing violence and aggression

### Searching

#### Developing a policy on searching

1.3.1 Health and social care provider organisations should have an operational policy on the searching of service users, their belongings and the environment in which they are accommodated, and the searching of carers and visitors. The policy should address:

- the reasons for carrying out a search, ensuring that the decision to search is proportionate to the risks
- the searching of service users detained under the Mental Health Act 1983 who lack mental capacity
- the rationale for repeated searching of service users, carers or visitors, for example those who misuse drugs or alcohol
- the legal grounds for, and the methods used when, undertaking a search without consent, including when the person physically resists searching
- which staff members are allowed to undertake searching and in which contexts
- who and what can be searched, including persons, clothing, possessions and environments
- the storage, return and disposal of drugs or alcohol
- how to manage any firearms or other weapons carried by service users, including when to call the police
- links to other related policies such as those on drugs and alcohol, and on police liaison.

1.3.2 Develop and share a clear and easily understandable summary of the policy on searching, for use across the organisation for all service users, carers or visitors who may be searched.

## Carrying out searches

1.3.3 Health and social care provider organisations should ensure that searches are undertaken by 2 members of staff, at least 1 of whom should be the same sex as the person being searched.

1.3.4 When a decision has been made to undertake a search:

- provide the person who is to be searched with the summary of the organisation's policy on searching
- seek consent to undertake the search
- explain what is being done and why throughout the search
- ensure the person's dignity and privacy are respected during the search
- record what was searched, why and how it was searched, and the disposal of any items found.

1.3.5 If a service user refuses to be searched, carry out a multidisciplinary review of the need to perform a search using physical force and explore any consequences in advance. Use physical force only as a last resort.

1.3.6 If consent for a search has not been given, a multidisciplinary review has been conducted and physical force has been used, conduct an immediate post-incident debrief (see recommendations 1.4.55 to 1.4.61) and a formal external post-incident review (see recommendations 1.4.62 and 1.4.63) with the service user that includes a visit from an advocacy service or hospital manager.

1.3.7 If a service user is carrying a weapon, ask them to place it in a neutral location rather than handing it over.

1.3.8 If a service user who is at risk of becoming violent or aggressive is in a room or area where there are objects that could be used as weapons, remove the objects or relocate the service user.

1.3.9 Audit the exercise of powers of search and report the outcomes to the trust board or equivalent governing body at least twice a year.

## Using p.r.n. medication

1.3.10 When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

- do not prescribe p.r.n. medication routinely or automatically on admission

- tailor p.r.n. medication to individual need and include discussion with the service user if possible
- ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
- ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation
- only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor
- ensure that the interval between p.r.n. doses is specified.

1.3.11 The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be included in the review. If p.r.n. medication has not been used since the last review, consider stopping it.

## De-escalation

### Staff training

1.3.12 Health and social care provider organisations should give staff training in de-escalation that enables 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 a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

## General principles

1.3.13 Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

1.3.14 Separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms, gardens or other available spaces) to aid de-escalation, ensuring that staff do not become isolated.

1.3.15 Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations (such as refusing a service user's request, asking them to stop doing something they wish to do or asking that they do something they don't wish to do) without provoking aggression.

1.3.16 Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.

1.3.17 Communicate respect for and empathy with the service user at all stages of de-escalation.

## De-escalation techniques

1.3.18 If a service user becomes agitated or angry, 1 staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner.

1.3.19 Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation.

1.3.20 Use a designated area or room to reduce emotional arousal or agitation and support the service user to become calm. In services where seclusion is practised, do not routinely use the seclusion room for this purpose because the service user may perceive this as threatening.

## 1.4 Using restrictive interventions in inpatient psychiatric settings

Restrictive interventions are most likely to be used in inpatient psychiatric settings, but may be used in emergency departments, outpatient services and child and adolescent mental health services (CAMHS).

See implementation: getting started for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

### Staff training

1.4.1 Health and social care provider organisations should train staff working in inpatient psychiatric settings to undertake restrictive interventions and understand the risks involved in their use, including the side-effect profiles of the medication recommended for rapid tranquillisation in this guideline, and to communicate these risks to service users.

### Staffing and equipment

1.4.2 Health and social care provider organisations should:

- define staff:patient ratios for each inpatient psychiatric ward and the numbers of staff required to undertake restrictive interventions
- ensure that restrictive interventions are used only if there are sufficient numbers of trained staff available
- ensure the safety of staff during the use of restrictive interventions, including techniques to avoid injuries from needles during rapid tranquillisation.

1.4.3 Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and:

- include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications
- maintain equipment and check it every week.

1.4.4 Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used.

## Using restrictive interventions

1.4.5 Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention.

1.4.6 Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

1.4.7 Ensure that the techniques and methods used to restrict a service user:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the service user's preferences, if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age.

## Observation

### General principles

1.4.8 Staff should be aware of the location of all service users for whom they are responsible, but not all service users need to be kept within sight.

1.4.9 At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user. As part of the assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.

## Developing a policy on observation

1.4.10 Health and social care provider organisations should have a policy on observation and positive engagement that includes:

- definitions of levels of observation in line with recommendation 1.4.11
- who can instigate, increase, decrease and review observation
- when an observer should be male or female
- how often reviews should take place
- how service users' experience of observation will be taken into account
- how to ensure that observation is underpinned by continuous attempts to engage therapeutically
- the levels of observation necessary during the use of other restrictive interventions (for example, seclusion)
- the need for multidisciplinary review when observation continues for 1 week or more.

## Levels of observation

1.4.11 Staff in inpatient psychiatric wards (including general adult wards, older adult wards, psychiatric intensive care units and forensic wards) should use the following definitions for levels of observation, unless a locally agreed policy states otherwise.

- Low-level intermittent observation: the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30 to 60 minutes.

- High-level intermittent observation: usually used if a service user is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15 to 30 minutes.
- Continuous observation: usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.
- Multiprofessional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

## Using observation

1.4.12 Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.

1.4.13 Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

1.4.14 Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

1.4.15 Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation.

1.4.16 Record decisions about observation levels in the service user's notes and clearly specify the reasons for the observation.

1.4.17 When deciding on levels of observation take into account:

- the service user's current mental state
- any prescribed and non-prescribed medications and their effects
- the current assessment of risk

- the views of the service user, as far as possible.

1.4.18 Record clearly the names and titles of the staff responsible for carrying out a review of observation levels (see recommendation 1.4.11) and when the review should take place.

1.4.19 Staff undertaking observation should:

- take an active role in engaging positively with the service user
- be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- be approachable, listen to the service user and be able to convey to the service user that they are valued.

1.4.20 Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks.

1.4.21 When handing over to another staff member during a period of observation, include the service user in any discussions during the handover if possible.

1.4.22 Tell the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is carried out (see recommendation 1.4.11).

## Manual restraint

1.4.23 Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead.

1.4.24 When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary:

- use the supine (face up) position if possible **or**
- if the prone (face down) position is necessary, use it for as short a time as possible.

1.4.25 Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

1.4.26 Do not use manual restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.

1.4.27 Undertake manual restraint with extra care if the service user is physically unwell, disabled, pregnant or obese.

1.4.28 Aim to preserve the service user's dignity and safety as far as possible during manual restraint.

1.4.29 Do not routinely use manual restraint for more than 10 minutes.

1.4.30 Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).

1.4.31 Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible.

1.4.32 One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airway and breathing are not compromised
- able to monitor vital signs
- supported throughout the process.

1.4.33 Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

## Mechanical restraint

1.4.34 Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring service users between medium- and high-secure settings as in recommendation 1.4.36) and its use is reported to the trust board.

1.4.35 Use mechanical restraint only as a last resort and for the purpose of:

- managing extreme violence directed at other people **or**
- limiting self-injurious behaviour of extremely high frequency or intensity.

1.4.36 Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management.

## Rapid tranquillisation

Rapid tranquillisation in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

1.4.37 Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults. When deciding which medication to use, take into account:

- the service user's preferences or advance statements and decisions
- pre-existing physical health problems or pregnancy
- possible intoxication
- previous response to these medications, including adverse effects

- potential for interactions with other medications
- the total daily dose of medications prescribed and administered.

1.4.38 If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.

1.4.39 If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

1.4.40 If there is a partial response to intramuscular lorazepam, consider a further dose.

1.4.41 If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.

1.4.42 If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.

1.4.43 If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.

1.4.44 When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed.

1.4.45 After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated

- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention.

## Seclusion

1.4.46 Use seclusion in adults only if the service user is detained in accordance with the Mental Health Act 1983. If a service user not detained under the Mental Health Act 1983 is secluded in an emergency, arrange a mental health assessment under the Mental Health Act 1983 immediately.

1.4.47 Services that use seclusion should have a designated seclusion room that:

- allows staff to clearly observe and communicate with the service user
- is well insulated and ventilated, with temperature controls outside the room
- has access to toilet and washing facilities
- has furniture, windows and doors that can withstand damage.

### Carrying out seclusion

1.4.48 Record the use of seclusion in accordance with the Mental Health Act 1983 Code of Practice.

1.4.49 Ensure that seclusion lasts for the shortest time possible. Review the need for seclusion at least every 2 hours and tell the service user that these reviews will take place.

1.4.50 Set out an observation schedule for service users in seclusion. Allocate a suitably trained member of staff to carry out the observation, which should be within eyesight as a minimum.

1.4.51 Ensure that a service user in seclusion keeps their clothing and, if they wish, any personal items, including those of personal, religious or cultural significance, unless doing so compromises their safety or the safety of others.

## Rapid tranquillisation during seclusion

1.4.52 If rapid tranquillisation is needed while a service user is secluded, undertake with caution following recommendations 1.4.37 to 1.4.45 and:

- be aware of and prepared to address any complications associated with rapid tranquillisation
- ensure the service user is observed within eyesight by a trained staff member
- undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

## Post-incident debrief and formal review

In this guideline an incident is defined as any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

1.4.53 Health and social care provider organisations should ensure that wards have sufficient staff with a mix of skills and seniority levels that enable them to:

- conduct an immediate post-incident debrief (see recommendations 1.4.55 to 1.4.61)
- monitor and respond to ongoing risks, and contribute to formal external post-incident reviews (see recommendations 1.4.62 to 1.4.63).

1.4.54 The trust board or equivalent governing body should ensure that it receives regular reports from each ward about violent incidents, the use of restrictive interventions, service users' experience of those interventions and the learning gained.

### Immediate post-incident debrief

1.4.55 After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

1.4.56 Use the framework outlined in recommendation 1.2.7 to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

1.4.57 Advise the service user experience monitoring unit, or equivalent service user group, to start a formal external post-incident review.

1.4.58 Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.

1.4.59 Ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

1.4.60 Ensure that all staff involved in the incident have the opportunity to discuss their experience with staff who were not involved.

1.4.61 Discuss the incident with service users, witnesses and staff involved only after they have recovered their composure and aim to:

- acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced
- promote relaxation and feelings of safety
- support a return to normal patterns of activity

- ensure that everyone involved in the service user's care, including their carers, has been informed of the event, if the service user agrees.

  Ensure that the necessary documentation has been completed.

## Formal external post-incident review

1.4.62 The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:

- is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
- uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
- includes interviews with staff, the service user involved and any witnesses if further information is needed
- uses the framework in recommendation 1.2.7 to:
  - evaluate the physical and emotional impact on everyone involved, including witnesses
  - help service users and staff to identify what led to the incident and what could have been done differently
  - determine whether alternatives, including less restrictive interventions, were discussed
  - determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
  - recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
  - avoid a similar incident happening in future, if possible.

1.4.63 The service user experience monitoring unit or equivalent service user group should give a report to the ward that is based on the formal external post-incident review.

## 1.5 Managing violence and aggression in emergency departments

For guidance on manual restraint and rapid tranquillisation, which may be used in emergency departments, see recommendations 1.4.23 to 1.4.33 and recommendations 1.4.37 to 1.4.45 respectively. Emergency department staff may also be involved in immediate post-incident debriefs (see recommendations 1.4.55 to 1.4.61).

### Liaison mental health

1.5.1 Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.

1.5.2 Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

### Staff training

1.5.3 Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of violence and aggression, including anticipation, prevention and de-escalation.

1.5.4 Healthcare provider organisations should train staff in emergency departments in mental health triage.

1.5.5 Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).

## Staffing

1.5.6 Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline.

## Preventing violence and aggression

1.5.7 Undertake mental health triage for all service users on entry to emergency departments, alongside physical health triage.

1.5.8 Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that:

- is close to or part of the main emergency department receiving area
- is made available for mental health assessments as a priority
- can comfortably seat 6 people
- is fitted with an emergency call system, an outward opening door and a window for observation
- contains soft furnishings and is well ventilated
- contains no potential weapons.

1.5.9 Staff interviewing a person in the designated interview room should:

- inform a senior member of the emergency nursing staff before starting the interview
- make sure another staff member is present.

## Managing violence and aggression

1.5.10 If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1 to 1.4.45 and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

## 1.6 Managing violence and aggression in community and primary care settings

For guidance on manual restraint, which may be used by ambulance staff, see recommendations 1.4.23 to 1.4.33. Ambulance staff may also be involved in immediate post-incident debriefs (see recommendations 1.4.55 to 1.4.61).

### Developing policies

1.6.1 Health and social care provider organisations, including ambulance trusts, should ensure that they have up-to-date policies on the management of violence and aggression in people with mental health problems, and on lone working, in community and primary care settings, in line with this guideline.

### Staff training

1.6.2 Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

1.6.3 Health and social care provider organisations, including ambulance trusts, should ensure that staff working in community and primary care settings are able to undertake a risk assessment for violence and aggression in collaboration with service users known to be at risk and their carers if possible. The risk assessment should be available for case supervision and in community teams it should be subject to multidisciplinary review.

## Managing violence and aggression

1.6.4 After a risk assessment has been carried out, staff working in community and primary care settings should:

- share the risk assessment with other health and social care services and partner agencies (including the police and probation service) who may be involved in the person's care and treatment, and with carers if there are risks to them
- be aware of professional responsibilities in relation to limits of confidentiality and the need to share information about risks.

1.6.5 In community settings, carry out Mental Health Act 1983 assessments with a minimum of 2 people, for example a doctor and a social worker.

1.6.6 Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

# 1.7 Managing violence and aggression in children and young people

## Staff training

1.7.1 Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:

- in the use of these interventions in these age groups

- to adapt the manual restraint techniques for adults in recommendations 1.4.23 to 1.4.33, adjusting them according to the child or young person's height, weight and physical strength
- in the use of resuscitation equipment (see recommendation 1.4.3) in children and young people.

1.7.2 CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

1.7.3 CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.

## Managing violence and aggression

1.7.4 Manage violence and aggression in children and young people in line with the recommendations for adults in sections 1.1 to 1.6, taking into account:

- the child or young person's level of physical, intellectual, emotional and psychological maturity
- the recommendations for children and young people in this section
- that the Mental Capacity Act 2005 applies to young people aged 16 and over.

1.7.5 Collaborate with those who have parental responsibility when managing violence and aggression in children and young people.

1.7.6 Use safeguarding procedures to ensure the child or young person's safety.

1.7.7 Involve the child or young person in making decisions about their care whenever possible.

## Assessment and initial management

1.7.8 Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including the NICE guidelines on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, psychosis and schizophrenia in children and young people, autism diagnosis in children and young people and autism.

1.7.9 Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

1.7.10 Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.

1.7.11 Consider offering children and young people with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

1.7.12 Offer support and age-appropriate interventions (including parent training programmes) in line with the NICE guideline on antisocial behaviour and conduct disorders in children and young people to parents of children and young people whose behaviour is violent or aggressive.

## De-escalation

1.7.13 Use de-escalation in line with recommendations 1.3.12 to 1.3.20 for adults, modified for children and young people, and:

- use calming techniques and distraction
- offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area
- aim to build emotional bridges and maintain a therapeutic relationship.

## Restrictive interventions

1.7.14 Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.

1.7.15 When restrictive interventions are used, monitor the child or young person's wellbeing closely and continuously, and ensure their physical and emotional comfort.

1.7.16 Do not use punishments, such as removing contact with parents or carers or access to social interaction, withholding nutrition or fluids, or corporal punishment, to force compliance.

## Manual restraint

1.7.17 If possible, allocate a staff member who is the same sex as the child or young person to carry out manual restraint.

## Mechanical restraint

1.7.18 Do not use mechanical restraint in children.

1.7.19 Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings (as in recommendation 1.7.20), mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.

1.7.20 Consider using mechanical restraint, such as handcuffs, when transferring young people who are at high risk of violence or aggression between medium- and high-secure settings, and remove the restraint at the earliest opportunity.

## Rapid tranquillisation

1.7.21 Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight.

In May 2015, lorazepam was off label in children and young people for this indication.

1.7.22 If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.

1.7.23 Monitor physical health and emotional impact continuously when undertaking rapid tranquillisation in a child or young person.

## Seclusion

1.7.24 Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity.

1.7.25 Report all uses of seclusion to the trust board or equivalent governing body.

1.7.26 Do not seclude a child in a locked room, including their own bedroom.

# 2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

## 2.1 Medication for promoting de-escalation

Which medication is effective in promoting de-escalation in people who are identified as likely to demonstrate significant violence?

### Why this is important

Although there are studies that demonstrate the value of medication in the management of violence and aggression, there is little information on management before violence becomes overt. Often p.r.n. medication is given at this point but there is little evidence of efficacy. It is clearly preferable to avoid violence whenever possible.

This question should be addressed by a randomised controlled trial in which people at risk of becoming violent are randomised, with their consent, to 1 or more of the medications commonly used to effect rapid tranquillisation or other medication not normally used for this purpose. Outcomes should include measures of violence, degree of sedation, acceptability of the medication and adverse effects, all recorded over a suitable timescale to match the pharmacokinetic properties of the drugs.

## 2.2 Violence related to drug or alcohol misuse

What is the best environment in which to contain violence in people who have misused drugs or alcohol?

### Why this is important

There are major problems in managing drug- and alcohol-related violence. The risk of severe violence can last for many hours in people who have misused drugs and alcohol and most settings in which violence takes place (such as emergency departments) do not have the facilities needed to contain people for several hours with an adequate level of supervision. As a consequence many people are taken, often inappropriately, to police cells. It is likely that there are less expensive and more effective environments available for this purpose.

Data about the size of this problem and an epidemiological survey of its frequency and duration, as well as current methods of managing drug- and alcohol-related violence, are needed to start answering this question.

## 2.3 Advance statements and decisions

What forms of management of violence and aggression do service users prefer and do advance statements and decisions have an important role in management and prevention?

### Why this is important

There are widely differing opinions among service users about the best way of managing violence and decisions are often made according to personal preference. Advance statements and decisions are not widely used, although they might have an important role in management and prevention.

The question could be answered by randomising people who are at risk of becoming violent or who have demonstrated repeated violence into 2 groups: a control group with no advance statements and decisions, and a group who make advance statements and decisions indicating the forms of management they prefer and those they do not want. The subsequent frequency of violent episodes and their outcomes could then be compared.

## 2.4 Content and nature of effective de-escalation

What is the content and nature of effective de-escalatory actions, interactions and activities used by mental health nurses, including the most effective and efficient means of training nurses to use them in a timely and appropriate way?

### Why this is important

Although it is regularly recommended, there has been little research on the nature and efficacy of verbal and non-verbal de-escalation for adults with mental health problems who become agitated. Research is needed to systematically describe current techniques for de-escalation and develop and test these techniques with adults who have cognitive impairment or psychosis. In addition, research should be carried out to develop methods of training staff and test the outcomes of these methods.

There is a similar lack of research on the nature and efficacy of verbal and non-verbal de-escalation of seriously agitated children and young people with mental health problems. These techniques need to take account of and be adapted to the specific background, developmental/cognitive and psychiatric characteristics of this age group. Additional research should therefore be commissioned on the lines recommended for adults. The research should systematically describe expert practice in adults, develop and test those techniques in aroused children and young people with mental health problems, and develop and test different methods of training staff working with children and young people with mental health problems.

## 2.5 Long duration or very frequent manual restraint

In what circumstances and how often are long-duration or repeated manual restraint used, and what alternatives are there that are safer and more effective?

### Why this is important

Adults who are agitated and violent sometimes continue to struggle and fight during manual restraint and rapid tranquillisation may fail. This results in long periods of restraint and further doses of medication. These occurrences are used as justifications for seclusion and, very rarely, for the use of mechanical restraint if repeat episodes occur. Yet there is no information about the frequency of such events or the demography and symptomatology of the adults who are subject to such measures. Exploratory survey work should be commissioned as a matter of urgency to assess the scope of this problem and potential measures for prevention or alternative management that minimise excessive, severe and risky containment methods.

The reasons why children and young people with mental health problems need long-duration or very frequent manual restraint may be expected to vary from those in adults but have similarly been little investigated. Exploratory survey work should therefore specifically address the scope of this problem as it affects children and young people and assess potential measures for prevention or alternative management that minimise any existing excessive, severe or risky containment methods.

# Implementation: getting started

While developing this guideline, the Guideline Development Group identified 13 recommendations in 6 areas as key priorities for implementation. With input from stakeholders, experts and health professionals, 3 areas were identified as having a big impact on practice and being challenging to implement. This section highlights some important changes to practice that may result from implementing the guideline. However, other changes to practice may be needed to fully implement the guideline.

Staff working in inpatient mental health and emergency care settings may be particularly affected by these changes.

## Manual restraint

Recommendations 1.4.4 to 1.4.6 and recommendations 1.4.24 and 1.4.29.

### Potential impact of implementation

This guideline recommends that taking service users to the floor during manual restraint should be avoided, but that if it is necessary, the supine (face up) position should be used in preference to the prone (face down) position. The Winterbourne View Hospital: Department of Health review and response reported that restraint was being used to abuse service users. Mind's Mental health crisis care: physical restraint in crisis found that restrictive interventions were being used for too long, often not as a last resort, and sometimes purposely to inflict pain, humiliate or punish. Mind also reported that in 2011/12 the prone position was being used, in some trusts as many as 2 to 3 times a day. This position can, and has, caused death after as little as 10 minutes, by causing a cardiac event. Consistent implementation of these recommendations will save lives, improve safety and minimise distress for all involved.

### Challenges for implementation

- Higher staffing levels will be needed in some settings to successfully implement these recommendations, particularly ensuring that a doctor trained to use emergency equipment is immediately available if manual restraint might be used.

- Training will be needed in psychosocial interventions to avoid or minimise the use of restrictive interventions, and about why manual restraint, when used, should last no longer than 10 minutes.

## Support for implementation

- Section 1.2 of this guideline outlines how to reduce the use of restrictive interventions, including manual restraint, and other methods that can be used to reduce the risk of violence and aggression. It includes a framework for anticipating and reducing violence and aggression in inpatient psychiatric wards.
- The Department of Health's Positive and safe programme promotes a reduction in the use of restrictive interventions. Department of Health's Positive and proactive care: reducing the need for restrictive interventions and Department of Health, Skills for Care and Skills for Health's A positive and proactive workforce provide a framework to help staff working in health and social care settings to change their culture, leadership and professional practice to deliver care and support that keeps people safe and promotes recovery.
- The Mental Health Act 1983 Code of Practice provides guidance for professionals as well as guidance about for service users, their families and carers about their rights.

Return to recommendations

# Rapid tranquillisation

Recommendations 1.4.37 to 1.4.45

## Potential impact of implementation

Rapid tranquillisation is defined in this guideline as the administration of sedative medication by injection, and although a number of effective agents are available for sedation, there is no evidence showing clear superiority for any one agent. Therefore individualised treatment needs to be emphasised, taking into account the service user's view, pre-existing physical health problems, previous response to medications including adverse effects, the potential for interactions with other medications, and the total daily dose of medications prescribed and administered. Intramuscular lorazepam is recommended for service users who have not taken antipsychotic medication before because it is an effective intervention that is likely to be acceptable to the majority of service users. Prescribing the initial dose of rapid tranquillisation as a single dose will ensure that any subsequent treatment options can be individualised, taking account of both response and any emergent adverse effects of the initial treatment choice.

## Challenges for implementation

- During development of the guideline it became known that the manufacturer of intramuscular olanzapine had decided to withdraw the product from the UK market, and so the Guideline Development Group would not be able to make recommendations for its use. However, it remains a licensed product in the European Union (EU) and some organisations import the product from elsewhere in the EU.
- Local rapid tranquillisation policies and protocols will need revision and healthcare professionals will need educating in how these differ from previous versions. It may also be necessary to emphasise the need to tailor the choice of medication for rapid tranquillisation to the individual. Where rapid tranquillisation is used, adequate numbers of skilled staff should be available to monitor the outcome of the intervention in order to make an individualised decision about subsequent choice of medication and dose frequency.

## Support for implementation

- The rationale for the recommendations is described in section 6.5.1 of the full guideline.
- The cost difference between medication options is not large and the most cost-effective strategy is likely to be one that tailors treatment to the individual, taking into account their preferences, current medication and medication history.
- The use of intramuscular lorazepam for service users who have not taken antipsychotic medication before is supported because of its favourable benefit:harm profile.
- Although it is possible to import intramuscular olanzapine into the UK as an EU-licensed product, the Guideline Development Group was unable to comment on the use of this preparation because the manufacturer had withdrawn it from the UK market.

- These recommendations do not preclude the use of alternative treatment options. However, their use should be tailored to the individual in line with the recommendations for rapid tranquillisation.
- The summary of product characteristics for haloperidol recommends a baseline electrocardiogram (ECG). If an ECG is not available the prescriber should consider the risks and benefits of using this treatment and be able to justify their prescribing decision, because it may be considered an off-label use.

Return to recommendations

## Formal external post-incident reviews

Recommendations 1.4.53 to 1.4.63

### Potential impact of implementation

Formal external post-incident reviews are an important aid in identifying the causes and effects of violence if restraint is needed to contain a situation, and the impact of this on all involved. Full recording of incidents of violence and aggression is currently variable and therefore it is difficult to get a clear picture nationally. Mind's Mental health crisis care: physical restraint in crisis reported responses from freedom of information requests made to all 54 mental health trusts in England in 2013 about the use of prone restraint. Of these, 27 trusts did not record this information.

The information gathered during a review can inform future service delivery and, on an individual level, any further work with the service user involved to make it less likely that a similar event will happen again. Use of formal external post-incident reviews could lead to safety improvements for staff and service users, and save costs to the service long-term if, as a result of the review, positive changes are made to avoid such situations in the future.

### Challenges for implementation

- In organisations where formal external post-incident reviews are not carried out routinely, new policies and processes will need to be developed; staff will need to be trained to carry out the reviews and service users will need to be supported to take part in this process.

- Additional training and guidance will be needed about when and how to approach service users to include them in the process in ways that meet their needs.
- Getting all of the necessary staff, including a doctor, in addition to volunteers and service users to participate in the review process may have an impact on current workload and service capacity.
- In some settings there can be many incidents in a short time. In such circumstances implementing the 72-hour follow-up may be more challenging.

## Support for implementation

- The framework outlined in recommendation 1.2.7 can be used to determine the factors that contributed to an incident that involved using a restrictive intervention.
- No economic evidence was found on post-incident management strategies. Clear costs are incurred when considering the staff time needed to deliver comprehensive post-incident reviews. These costs may be recouped by the potential for improved relationships and better understanding of events, allowing safer and more adaptive practice in the future.

Return to recommendations

# Finding more information and committee details

You can see everything NICE says on this topic in the NICE Pathway on violence and aggression.

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on mental health services.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

## Update information

This guideline updates and replaces NICE guideline CG25 (published February 2005).

ISBN: 978-1-4731-1234-6

## Accreditation

NICE accredited

www.nice.org.uk/accreditation

Royal College of Nursing

# Three Steps to Positive Practice

## A rights based approach when considering and reviewing the use of restrictive interventions

ADVICE AND INFORMATION

# Acknowledgements

## Co-authors

Rosaline Kelly, Senior Professional Development Officer, Royal College of Nursing, Northern Ireland

Dr Heather Hanna, Consultant Psychiatrist, Executive Committee Member, Royal College of Psychiatrists in Northern Ireland

Adele Boyd, Independent Social Work Practitioner, Committee Member, Northern Ireland Association of Social Workers

Moira Scanlon, Occupational Therapist Service Lead, Learning Disability and Mental Health, South Eastern Health and Social Care Trust

Siobhan Rogan, Intellectual Disability CAMHS Manager & Advanced Practitioner, Southern Health and Social Care Trust

Endorsed by:

College of Occupational Therapists

RC PSYCH

BASW Northern Ireland
The professional association for social work and social workers

BASW

This publication is due for review in June 2020. To provide feedback on its contents or on your experience of using the publication, please email **publications.feedback@rcn.org.uk**

---

**RCN Legal Disclaimer**

This publication contains information, advice and guidance to help members of the RCN. It is intended for use within the UK but readers are advised that practices may vary in each country and outside the UK.

The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. Whilst every effort has been made to ensure the RCN provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the RCN shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this website information and guidance.

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

© 2017 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

# Contents

# Executive summary

The 21st century requires fundamental changes in how health and social care professionals deliver care. One of these changes involves embedding the delivery of care, treatment and services in a rights based approach, which places the person at the centre of all we do. The challenge for health and social care professionals is to positively manage risk and deliver care whilst navigating the complex legal and ethical processes which must guide practice.

This is particularly important in services, settings and situations where people may be subject to, or require the use of restrictive practices. It is encouraging to note the increasing number of examples of established positive practice in this area; however numerous investigations and reports which have shown historical failures and the need for ongoing reform must be acknowledged.

In the current world of health and social care, professionals are ready to embrace new ways of thinking and the creation of a new culture which uses new language. A greater emphasis on early intervention enables an understanding of why a person might behave in a certain way.

Restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practice is therapeutic, ethical and lawful.

This document was developed by a multi-disciplinary group based in Northern Ireland, involving the Royal College of Nursing, the Royal College of Psychiatrists, the Northern Ireland Association of Social Workers and the College of Occupational Therapists. It is designed to assist health and social care professionals who may be involved in practices where people in their care may be restricted in some way, particularly during the period of the local review of mental health legislation and implementation of capacity legislation.

The *Three Steps to Positive Practice* is a process to guide professional practice and therefore also helpful to health and social care professionals in Scotland, England and Wales. There are some differences in the legislation across the four countries and it is imperative that health and social care professionals are aware of and understand the legislation that is relevant to their work. Health and social care professionals should also ensure that they keep up to date with changes and developments in legislation and guidance regarding restrictive interventions and a rights based approach in a health and social care context.

*Three Steps to Positive Practice* is a framework designed to help you as a health and social care professional to think about culture and practices and guide professional, ethical and legal decision making when considering the use of potentially restrictive practices. *Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to:

- **Consider and plan** – consider if the planned intervention is a restrictive practice using the definition, consider other less restrictive measures, and consider if the planned intervention is therapeutic in its intention;
- **Implement the safeguards** – use a rights based approach within professional accountability and legal frameworks to ensure that any restrictive practice is used only when deemed to be in the person's best interests; and,
- **Review and reflect** – ensure that a regular and timely review of the use of a restrictive practice is built into a therapeutic plan to meet the person's needs, including reduction and/or removal of the restrictive practice as soon as is possible, and appropriate use of professional reflection support systems that consider the impact of the use of restrictive practices.

# Introduction

*Three Steps to Positive Practice* should be used at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment.

*Three Steps to Positive Practice* provides guidance on the new way of thinking which will support health and social care professionals to act differently. With an emphasis on a proactive, evidence based and rights based approach to practice, all health and social care professionals can ensure that wherever they are providing care, treatment and support, they are practising in the best interests of service users, and in accordance with legislation and the requirements of their professional codes of conduct. In daily practice the emphasis must include an understanding of why a person might behave in a way that presents a perceived or actual risk, and/or in a way that challenges carers and staff. This understanding is vitally important in decision making processes around the use of potentially restrictive practices.

This is not a document that tells you how to implement or when to implement a restrictive practice, nor will this document contain a "list" of restrictive practices – that would be an impossible task.

This document will be of use to any health and social care professional who works in services where individuals may be subject to restrictive practices, regardless of specialty. The principles and values discussed in the examples used can be translated and applied in the different contexts and environments in which you practise.

A range of useful guidance documents have been published which focus on the whole arena of restrictive interventions. This document provides a reference to those documents rather than repeating their content.

Historically, health and social care professionals have understood practices to be restrictive if they fell within the categories of physical or mechanical restraint, with some also including chemical restraint in their understanding of the term. Many health and social care professionals only recognise the most obvious forms of restraint as being restrictive.

Reports from health and social care regulators describe variance in understanding of the term "restrictive practice", across both hospital and community settings, and the range of services for children, adults and older people.

The Care Quality Commission (CQC) inspection findings post-Winterbourne View described confusion and concern among staff in the awareness and use of restrictive practices. This resulted in an over-reliance by some providers on physical restraint rather than positive behaviour support and managing the environment to remove or contain the triggers which could cause someone to behave in a way which could be seen as challenging.

A report by the Northern Ireland Regulation and Quality Improvement Authority (RQIA) in 2014 in relation to the use of restrictive practices noted a similar uncertainty. Staff described a lack of understanding of restrictive practices, inconsistency in the use of restrictive practices, and an absence of robust and up to date guidance. There was also little understanding of the governance arrangements in each Health and Social Care (HSC) Trust to monitor the use of restrictive practices.

### Can you list the restrictive practices that you use or have used in the past?

Bed (cot) sides; use of lap belts on wheelchair/commodes/other harness/restrictive equipment; use of "when required/prn" medication; locking doors (including the use of baffle locks) e.g. ward doors, bedroom doors, kitchen door, which restrict free movement within the ward. (RQIA, 2014)

A survey undertaken in March 2016 by the Royal College of Nursing, Northern Ireland (RCN NI), on behalf of a multi-disciplinary working group showed similar results.

The variance in understanding of the term restrictive practice means that not all health and social care professionals are clear about what restrictive practices are or what makes a practice potentially restrictive.

Some professionals demonstrate a deep and clear understanding of the term, and the need for an evidence based and rights based approach to the use of restrictive practices.

### What is your current understanding of the term "restrictive intervention"?

"Any practice which interferes with the liberty, and free choice of self-determination of any person";

"Any intervention: physical, emotional psychological, mechanical or pharmacological which restricts or prevents an individual or group of individuals from undertaking a specified range of activities that are time-limited; utilised as a last resort and which are intended to be withdrawn at the earliest opportunity";

"Any intervention which impacts on an individual's freedom to make his/her own decisions or restricts his/her freedom of movement";

"Any type of intervention (mechanical, physical, environmental or social) which is used to intentionally or unintentionally limit someone's liberty"

However, others have indicated a very narrow understanding, or even no understanding of the term.

### What is your current understanding of the term "restrictive intervention"?

"A measure taken to ensure a patient's safety when they are at risk if endangering themselves, i.e. a patient at risk of falls who is confused may be sitting in a chair and their table used as a device to stop them getting up independently";

"I am not familiar with the term restrictive intervention";

"I have no idea what it means"

"Using physical force to restrain an individual who may be endangering themselves or others".

The lack of a shared understanding of what makes a practice potentially restrictive contributes to health and social care professionals routinely implementing practices that they do not realise are restrictive and very possibly unlawful. For example, monitoring of Deprivation of Liberty Safeguards in England in 2014/15 by CQC demonstrated a continued lack of understanding in the use of the safeguards and failure to report appropriately to the regulator. Staff training and awareness of the safeguards varied across providers, as did the existence and implementation of policies and processes. CQC reported examples where some providers were potentially unlawfully depriving people of their liberty, despite the fact that the safeguards were introduced in 2009 as part of the Mental Capacity Act (2005).

If staff using restrictive practices are unclear about what restrictive practices are, or are unable to identify practice as being restrictive, it is unlikely that they will be in a position to develop and implement less restrictive practices/strategies. Nor will they be able to ensure that necessary safeguards are in place whilst the restrictive practices are being used. In some cases this has meant that professionals are making potentially unlawful decisions by imposing unnecessary or disproportionate restrictions on a person's liberty. These restrictions are often implemented without a rationale or an evidence base for their use, and without consideration of the impact on an individual's human rights, and without appropriate safeguards in place. Additionally, they are often seen as long term solutions and are not subject to regular review, meaning that consideration is not given to reducing the level of any restriction.

# What makes a practice restrictive?

Restrictive practices can be difficult to define and even more impossible to list, simply because they are not always very obvious or because the practices may be justified in the context of keeping someone "safe".

**Restrictive practices are those that limit a person's movement, day to day activity or function.**

Put very simply restrictive practice means actions that stop a person from doing something that they want to do, or doing it in the way they want to do it. Restrictive practices can also mean actions that make a person do something they do not want to do, or preventing a person from having something they want.

Some practices can be easily identified as restrictive, like physically restraining a person, or locking doors to keep a person confined to a certain area. Other restrictive practices can be more subtle, such as only allowing a person a certain amount of time watching television every day. There are also times when certain types of care, support or treatment could be considered a restrictive practice; for example, prescription of certain medications not designed to restrict, but which have restrictive side effects, like sleeping tablets.

It is important to recognise that restrictive practices can be psychological. Attempting to exert control or force compliance by what is said or how it is said, and/or the use of body language and nonverbal methods of communication, are equally restrictive.

In some cases the person will be restricted because of restrictions placed on others. This includes cases where the person's family is not allowed to have contact with them for safeguarding reasons. In other situations, where a group of individuals live in the one place, restrictions necessary for one person could impact negatively on their fellow tenants.

Restrictive practices may also involve control and/or abuse of a person's financial matters, a type of restrictive practice that is often unrecognised as such.

Health and social care professionals must consider all of the above possibilities in determining if a practice is potentially restrictive.

It is recognised that there are occasions when the use of restrictive practice is unavoidable in order to keep the person and/or others safe from harm. Restrictive practices are not inherently wrong, harmful or illegal. They can help to keep people safe and create opportunities for them to learn new skills. What might be restrictive for one person might not be restrictive for another, and what might be necessary for a particular person one day might not be needed to keep them safe the next day.

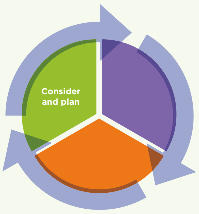
When restrictive practices are as part of a comprehensive therapeutic plan that is outcomes focused and fully embraces a person's rights, and when there is no other way to keep people safe, then they can and often should be used. In these situations health and social care professionals must ensure that the care, treatment and support they provide is safe, effective, person-centred and provided within legal, ethical and professional accountability structures.

All health and social care professionals should be able to identify whether the purpose of the proposed restriction is the protection of the person or the protection of others and clarify whether the legal framework under which the care is being provided gives authority for the proposed restriction.

The use of any restrictive practice must be a **necessity**, used only as a **last resort**, the least restrictive measure possible, proportionate to the risk and/or type of behaviour, **regularly reviewed** and used for the shortest length of time possible. It should be the **most effective and therapeutic** intervention possible with regards to reducing behaviours associated with risk and/or their impact. The need to use a restrictive practice must be agreed by a multi-disciplinary team, with input from the person and/or their representative. Before implementation there must be a pre-determined plan to regularly review the use of a restrictive practice with the aim of reducing or removing the restriction. Any use of restrictive practices should be supported by a framework of robust guidance, assessment, training, supervision, record keeping and governance, and always used in accordance with the requirements of legislation.

# Three steps to positive practice

The *Three Steps to Positive Practice* are designed to encourage careful consideration and reflection on the use of any potentially restrictive practice, before it is implemented, and throughout the entire timeline when the restrictive practice may be in use. The three step process is applicable at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment. The three steps are intended to assist health and social care professionals to ensure that the decisions they make and the actions they take are consistent with legal, ethical and professional accountability frameworks, every time a decision is made or an action is taken.

| | | |
|---|---|---|
| **STEP 1 Consider and plan**<br> | Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice?<br>Does the proposed intervention or the way in which care is being delivered:<br>• limit the person's movement, daily activity or function;<br>• result in the loss of objects or activities that the person values; or,<br>• require the person to engage in a behaviour that he/she would not engage in given freedom of choice?<br>If you answer yes to any of these questions, then the proposed intervention is potentially restrictive. | You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties.<br>Remember that some decisions may require a legal opinion. |
| | What other less restrictive options have been considered? | You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time. |
| | How will the proposed intervention reduce risk, and build or retain the person's skills and the opportunities available to them? | You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person's ability to develop and retain skills and learn through experiences. |

| | | |
|---|---|---|
| **STEP 2 Implement the safeguards**<br><br> | Is this proposed intervention considered to be in the person's best interests? | You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person's best interests.<br>Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement. |
| | How do I ensure that I am using a rights based approach? | You must ensure that the plan is fully considerate of human rights and the FREDA principles (see p.12), and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints. |
| | What professional accountability frameworks must be considered? | You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation's accountability and governance structures. |
| **STEP 3 Review and reflect**<br><br> | Has a regular and timely review of the intervention been planned? | You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented. |
| | Is there a plan to ensure that the intervention will be for the shortest length of time possible? | You must ensure that there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2. |
| | Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions? | You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues. |

# Outlining a rights based approach

A rights based approach allows health and social care professionals to formulate their decision making based on certain values, principles and the law, whilst ensuring that the person and their particular wishes and needs are at the centre of that decision making process.

A rights based approach is twofold.

In the first instance we are referring to the rights of individuals which are enshrined in the European Convention on Human Rights which was incorporated into UK law by the Human Rights Act (1998).

The Human Rights Act puts legal duties on public authorities (national and local) to respect the human rights set out in the Convention in their decisions and actions. This helps public officials deliver better services, and empowers every person to ensure they are treated fairly, and if necessary, to hold officials to account.

Human Rights are about our basic needs as human beings. They capture the core rights we are all entitled to so that we may develop our potential and live our lives in dignity and respect. They apply to everyone, adults and children, with no exceptions for any individual or groups of people.

There are however some differences in how the Human Rights articles operate.

Some rights are known as absolute rights, for example Article 3, (freedom from torture and inhumane or degrading treatment or punishment). Everyone is entitled to the full operation of this right and it cannot be interfered with under any circumstances.

Limited rights are rights that can be interfered with in explicit and finite circumstances, for example Article 5 (right not to be deprived of liberty, except in certain legal circumstances).

There are also some articles known as qualified rights, where interference may be justified in order to balance the rights of the person and the needs of the wider community or interest of the state. These rights include Article 8 (right to private and family life) and Article 9 (freedom of thought, conscience and religion).

The Articles which most frequently require consideration in relation to health and social care provision are:

| Article | What it says | How might this right be breached in practice |
|---|---|---|
| 3 | **Prohibition of torture**<br>A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhumane or degrading. | Measures used to control behaviours which in reality are shaming and humiliating, for example: not being allowed to have a meal, or being made to stand outside, as a means of managing a perceived "bad behaviour". |
| 5 | **Right to liberty and security**<br>A person has the right not to be deprived of their liberty – 'arrested or detained' – except in limited cases specified in the article (e.g. where they are suspected or convicted of committing a crime) and provided there is a proper legal basis in UK law. | Measures used to prevent behaviours perceived to be a risk to self or others, for example: improper or inappropriate admission/detention to psychiatric care; use of chairs with straps; use of 'time-out' or seclusion. |
| 8 | **Right to respect for private and family life**<br>A person has the right to respect for their private and family life, their home and their correspondence. This right can be restricted only in specified circumstances. | Measures which prevent participation in family, social and recreational activities, for example: structural adaptations to accommodation which separate/isolate the person from others they live with; preventing or limiting contact with family or friends; use of restrictive clothing to limit perceived self-harm or inappropriate touch. |
| 14 | **Prohibition of discrimination**<br>In the application of the Convention rights, a person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status, unless this can be justified objectively. Everyone must have equal access to Convention rights, whatever their status. | Reducing access to services or opportunities available because of perception of risk or lack of resources to allow for suitable adaptation and support, for example: a reduced school day; exclusion from social clubs. |

Secondly, when we talk about a rights based approach, we mean core principles and values which should shape practices and services and put the person at the centre of the delivery of health and social care.

*Three Steps to Positive Practice* uses core principles and values commonly and collectively known as FREDA – Fairness, Respect, Equality, Dignity and Autonomy which form a rights based approach to underpin the articles of the Human Rights Act.

| Core principle | What it means | What this means for health and social care staff |
|---|---|---|
| **Fairness** | Ensuring that people who use services have access to fair processes for getting their views heard and for decision-making about care and treatment. | Health and social care staff must ensure that people in their care are provided with any practicable help to understand the information about the decision to be made and to communicate their views and raise objections; for example, enabling access to independent advocacy. |
| **Respect** | Ensuring that people who use services are valued as individuals. They must be listened to, and what is important to them must be viewed as important by health and social care staff, even if this conflicts with staff's own views. | Health and social care staff must consider and support the views, wishes and feelings (as far as is practicable) of people in their care and facilitate those whenever possible, including for example, different lifestyles, religious observances, sexual orientation. |
| **Equality** | Ensuring that people who use services do not experience discrimination and are not treated differently regardless of their age, disability, gender, race, religion and belief, sexual orientation, gender identity and pregnancy and maternity status. | Health and social care staff must promote equality and non-discrimination by actively removing any potential barriers to accessing services or opportunities and enable maximum participation; for example, support to attend appointments. |
| **Dignity** | Ensuring that people who use services are always treated with compassion and in a way that values them as a human being and supports their self-respect. | Health and social care staff must ensure that the provision and delivery of care and support is provided in an individualised and holistic manner which promotes and protects the person's self-esteem and self-respect; for example, ensuring that bathroom doors are closed during personal care tasks, avoiding the use of wheelchairs for individuals who are independently mobile. |
| **Autonomy** | Ensuring that people who use services can exercise the maximum amount of choice and control possible – in their individual care and treatment, in service development and in their relationships with others. | Health and social care staff must ensure that people in their care have the opportunities and support to participate in making choices about what happens to them, based on clear, sufficient, and relevant information; for example, co-production of personal safety plans. |

Health and social care professionals may be familiar with and use alternative core principles and values known as PANEL: participation; accountability; non-discrimination; equality and empowerment; and, legality, in ensuring a rights based approach to care and treatment.

The FREDA principles (and PANEL principles) are the basis of good health and social care which should be used individually and mutually to inform decision making. They are a useful guide for health and social care staff to ensure that everyone for whom they are providing care, treatment, support and/or services is:

- treated with dignity and respect
- provided with care which best suits their individual needs
- able to live free from abuse, neglect or discrimination
- able to lead as fulfilling a life as possible
- able to participate in the choices and decisions made about their lives.

> The RCN believes that a human rights-based approach is essential, both in developing health policies and services and in individual practice and that nurses have a particular obligation to "safeguard and actively promote people's health rights at all times and in all places."
>
> RCN position statement, 2012

# Decision making

When designing/agreeing or delivering care, treatment or support which may be potentially restrictive, each individual health and social care professional must consider several areas relevant to their professional practice and their decision making.

## Professional accountability

Professional accountability means being personally answerable to the law of the land for all actions or omissions (including what is written or is not written, what advice/information/communication is given or is not given) while fulfilling a contract as a health and social care employee.

Health and social care professionals must act first and foremost to care for and safeguard those in their care. Health and social care professionals must display a personal commitment to the standards of practice and behaviours set out in their relevant codes of practice. They must show professionalism and integrity and work within professional, ethical and legal frameworks.

The values and competencies required of health and social care staff dictate an understanding of current relevant legislation which must be applied in all areas of practice. Where health and social care professionals lead teams of other staff, they must ensure that all team members understand how to apply their practice legally and ethically.

This is particularly important around the areas of capacity and consent, and essential for health and social care professionals working with children and young people, who must understand the laws around capacity, and child and parental consent, including giving and refusing consent for the implementation of any treatment or restrictive practice.

## Capacity to make decisions about care, treatment and support

Professional guidance for health and social care staff, for example, guidance issued by the General Medical Council in relation to consent, advises that all adults are presumed to have the ability to independently make decisions about any aspect of their care, treatment and/or support. The ability to make decisions independently is often referred to as “having capacity”.

> You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.
>
> *Consent: patients and doctors making decisions together*
> General Medical Council, 2008

The requirement to presume that an adult is capable of independently making decisions about any aspect of their care, treatment and/or support has been protected within relevant UK laws. In Scotland, legislation which provides safeguards in relation to capacity to make decisions independently requires the person to be encouraged to use any skills they have do so. England, Wales and Northern Ireland legislation explicitly requires that all appropriate help and support is provided to a person to enable the individual to make independent decisions about matters affecting them, before concluding that an individual is unable to do so. Whether the person has a particular condition is irrelevant to the question of whether he or she has capacity to make decisions in any matter. Country specific legislation provide guidance where a lack of capacity to make decisions independently has been established, and health and social care professionals must ensure that their practice in this area meets legislative, ethical and regulatory requirements.

The relevant legislation also provide for a person to make what health and social care professionals might consider to be an “unwise decision”, or as described in Scottish legislation, acting “as no prudent person would act”. Making unwise decisions does not amount to a “lack of capacity” to make decisions.

Capacity should be reviewed at appropriate intervals, for example, if it appears that the person's understanding of their situation has changed, or there are changes in the restrictions that health and social care professionals consider may be necessary.

It is important to recognise the concept of emerging capacity in children and young people. Cognitive and emotional skills are acquired differentially throughout adolescent development. Whilst decision-making is primarily dependent on information retention and processing, emotional maturity is needed to make balanced, unwavering decisions and to cope with the consequences of those decisions. It is important to assess the child's maturity and understanding on an individual basis, and to remember that the severity of the consequences of the decision should be taken into account.

## Consent

It is a general legal and ethical principle that informed and valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing care. These principles reflect the rights of a person to determine what happens to their own bodies or what shapes the care and support they receive and is fundamental to good practice. A health or social care professional who does not respect these principles may be liable both to legal action by the person in their care and action by their regulatory body.

A person who has capacity is able to provide or withhold consent for examination, treatment and/or care. If an adult makes a voluntary and appropriately informed decision to refuse care, treatment and/or support this decision must be respected.

Health and social care staff must be aware that a person's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some people will always be able to make simple decisions, but may have difficulty if the decision is complex or involves a number of options. Others may be able to make decisions at certain times but not others, because fluctuations in their condition impair their ability to understand, retain or weigh up information, or communicate their wishes.

For consent to be valid, it must be given voluntarily and freely, without pressure or undue influence, by an appropriately informed person who has the capacity to consent to the intervention in question.

It is important to note that there may be a requirement for consent to be obtained more than once where multiple interventions may be required. Capacity to consent must always be considered according to the specific time, situation and decision to be made.

As with capacity, the person's ability to consent to an intervention should be reviewed at appropriate intervals, for example, if it appears that the person's understanding of their situation has changed, or there are changes in the restrictions that are considered necessary.

Adults must provide consent on their own behalf. No-one can give or withhold consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

Relevant mental health legislation and capacity legislation will make provision for the possibility of detention/deprivation of liberty and/or treatment for a mental disorder and its complications without the consent of the adult, or a young person age under 18 years.

Young people aged 16-17 are entitled to provide consent for their own medical treatment in the same way as adults. Scottish legislation provides a legal basis for a young person under the age of 16 years to consent on his or her own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending them, they are capable of understanding the nature and possible consequences of the procedure or treatment. These provisions need to be considered in conjunction with the rights of those with parental responsibility and human rights law.

In other circumstances, current case law is based on the view that persons aged under 16 years, may be competent to make decisions about their care and treatment when provided with sufficient information in a suitable format. This is sometimes referred to as "Gillick" competence.

These young people can consent or refuse care, treatment and/or interventions, however, refusal to provide consent can be over-ridden by a person with parental responsibility or a court in certain circumstances.

Lucy is seven years old, has a diagnosis of autism and attends a special school. Lucy often ran about the classroom, climbed on furniture and was disruptive. For short periods during the day, Lucy's teacher used a chair with high sides and a lap strap to keep Lucy sitting in one place. The teacher says this helped to keep Lucy focused on curriculum-based table top activities and believed that Lucy "likes the chair", despite that fact that she sometimes protested when strapped into the chair. Lucy's parents agreed with the teacher's actions, which was deemed to be consent.

Lucy's CAMHS practitioner visited Lucy at school to complete an observation as part of an assessment process for ADHD. They noticed that Lucy seemed anxious and that she was more likely to move into the chair when a particular classroom assistant guided her towards the chair. She seemed to watch this person very closely, as if seeking their approval. The CAMHS practitioner was concerned that consent for the use of the chair with the lap strap had been provided on behalf of Lucy by her parents, that there was no therapeutic benefit for Lucy in the use of the chair and that in certain situations, Lucy was demonstrating compliance rather than consent to sitting in the chair.

The CAMHS practitioner arranged a multiagency meeting to review the risk assessment in relation to the use of the chair and to discuss what other types of calming activities and classroom-based approaches might help Lucy co-operate. The group reached an agreement that the use of mechanical restraint was not the least restrictive, most effective way of approaching her behavioural difficulties, and not clearly in her best interests. Lucy was diagnosed with ADHD. Treatment for this, alongside regular advice and guidance from the CAMHS practitioner and occupational therapist for her teacher on how to adapt activities and the environment (for example, use of schedules, visual cues, reducing distractions) to maximise Lucy's classroom performance, led to marked improvements in his concentration for specific activities. Lucy was more relaxed and focused during the school day and she was able to learn a range of new skills over the months ahead.

This plan supported Lucy's Article 5 and Article 8 Human Rights and the application of the FREDA principles and values.

## Best interests

There are circumstances where a person who, despite being provided with all practicable help and support, is unable to independently make decisions about his or her care, treatment and/or support. This is often referred to as "lacking capacity". In these circumstances, health and social care professionals have a duty to ensure that any decision taken in the "best interests" of or to "benefit" the person who lacks capacity. Most organisations will have established protocols which health and social care professionals must adhere to when making decisions about the care, treatment and/or support proposed for a person who lacks capacity. In applying the principles of best interests or benefit when considering the use of any restrictive practice, health and social care professionals must take into account all less restrictive alternatives to the intervention being proposed.

Relevant UK laws also provide legislative safeguards and a requirement for health and social care professionals to consider less restrictive alternatives in circumstances when acting in a person's best interests might include implementing restrictive practices. There are complex situations where it will be appropriate to seek a legal opinion.

> You are personally responsible for making sure that you promote and protect the best interests of your service users. You must respect and take account of these factors when providing care or a service...
>
> You are responsible for your professional conduct, any care or advice you provide, and any failure to act...
>
> You must be able to justify your decisions if asked to.
>
> *HCPC Standards of conduct, performance and ethics* (2008)

## Advocacy

Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, defend and safeguard their rights, and have their views and wishes genuinely considered when decisions are being made about their lives.

For those unable to articulate their views about their care and treatment, for whatever reason, advocacy is an important method by which a person can be considered and protected in what may be quite complex decision making about how they live their lives and how their care is provided.

A relative or carer can be an advocate in these situations; someone close to the person who can represent what the person would decide if they were able to make the decisions themselves. In some cases, a health and social care professional might be best placed to be an advocate for a person who has no-one else to support them in understanding what is being proposed about their care and treatment.

There are also advocacy services where an external organisation can provide a person with expertise in representing the views of those who cannot do so independently, to help in decision making processes.

Relevant legislation also include requirements for independent advocates to be made available to represent those who have been assessed as lacking the capacity to make decisions about serious interventions.

Health and social care professionals should ensure that advocacy services are made available to all people in their care, including children and young people. In some situations they are obliged by law to do so, and therefore must be aware of the legal requirements and circumstances for informal and formal independent advocacy arrangements.

# Positive practice

When we talk about positive practice we mean person centred, ethically driven practice which seeks to effectively and safely meet the needs of the person, delivered within professional and legal accountability structures.

This includes applying positive and proactive evidence based interventions in the least restrictive, most therapeutic way to promote best quality of life and maximise self-determination, with the opportunity for learning through experience. All of this must be delivered within a framework of a rights based approach.

## Evidence based, therapeutic care

Health and social care professionals have a duty to always do what is best for the people they care for and support. Doing what has always been done, bowing to resource pressures, or making life easy for staff or carers cannot get in the way of this. Unfortunately these factors often influence health and social care professionals' decision making in practice. In the current world of health and social care, professionals must embrace new ways of thinking and acting about how restrictive practices are used. This involves concentrating on the creation of a culture where safe, effective and person-centred practice is informed by best available evidence with a strong emphasis on outcomes-focused, therapeutic interventions.

One example of an outcomes focused, therapeutic and evidenced based approach is the model of Positive Behaviour Support (PBS). PBS is an empirically validated, evidence based approach which aims to find the meaning behind a person's behaviour. That is, PBS aims to understand why a person is behaving in a particular way and how that behaviour results in their needs being met (often referred to as the function of the behaviour). PBS then tries to find other (often more socially appropriate) ways to help the person achieve what they want or need, which in turn is less challenging for carers and health and social professionals. Positive behaviour support uses the techniques of applied behaviour analysis, guided by a strong values base, delivered in person centred ways.

Primarily this approach is about increasing a person's quality of life with a secondary aim of decreasing the frequency and severity of their behaviours that are described as challenging. It is a comprehensive approach to assessment, planning and intervention that focuses on addressing the person's needs, their home environment and overall quality of life. It could include changing factors such as staff attitudes, physical factors such as reducing noise levels or ensuring increased choices for the person. PBS-based approaches which enhance quality of life and reduce behaviours that challenge carers and health and social care staff can in turn lead to a reduction in the use of restrictive practices.

Michael is a seven years old and has a learning disability and Fragile X syndrome. Michael was referred to a community paediatric service for assessment of a "behavioural difficulty" which his mum described as being "unpredictable when outside and running off with no safety awareness, particularly road safety awareness". Despite Michael having no mobility problems or concerns, Michael's mum insisted that he used a wheelchair anytime he went outside the family home, at school and at the short breaks facility he sometimes stayed at, so he couldn't "run off". Michael's mum reported that she had always used a buggy when outside with Michael, which progressed to using a wheelchair as he got older. Mum felt it was the best way to ensure Michael's safety, even when he was at the park, or out shopping with her.

Staff undertaking the assessment were concerned that always using the wheelchair was potentially impacting Michael's developmental progress, independence and quality of life. He had not been given the opportunity to develop skills to walk with supervision, develop road safety awareness and, ultimately develop skills to walk outside independently. The use of the wheelchair was a way of keeping Michael safe in the short term, but staff were concerned that this could have a detrimental impact on Michael's opportunities in the medium to longer term, in areas such as accessing education, employment and social opportunities.

Using a **positive behaviour support** approach, the clinician clarified with Michael's physiotherapist and occupational therapist that he did not need the wheelchair for mobility reasons. The clinician then undertook a comprehensive assessment of Michael's behaviours. Having identified why Michael often "unpredictably ran off" when outside (the function of the behaviour), the clinician worked with Michael, his family, and staff from his school and short breaks facility to implement a skills building programme. This programme was designed to teach Michael to walk while outside under the supervision of adults (primary aim), with an overall goal being that he would eventually learn to walk outside independently and develop road safety awareness skills (secondary aim). The clinician also talked with Michael, his family and staff working with him about the importance of positive risk taking in a systematic, planned way to ensure that he could achieve his full developmental potential and his quality of life.

Michael no longer requires a wheelchair in any setting and can go for a walk with the supervision of one adult. He has learned how to cross the road using pedestrian traffic lights with 1:1 supervision. He is now working towards going out as part of a group without 1:1 supervision.

The FREDA principles underpin this **evidence based and outcomes focused** model of care and treatment. It also promotes Michael's Articles 5 and 8 Human Rights.

## Positive and proactive approaches

All too often, restrictive practices are introduced as a way of managing risk without engaging the people who use services and their representatives in decision-making, and without considering what therapeutic options might lead to better outcomes and an improved quality of life for the person. Similarly blanket restrictions may have evolved without a rationale for their use, or may have been introduced in response to a particular situation but have become custom and practice.

Health and social care professionals who start from a point of no restriction or least restriction possible and who understand the implications any level of restriction has in terms of a person's human rights and quality of life will be able to fully embrace, influence and lead the change in culture required for ethical, legal, professional practice in the 21st century.

"**Least restrictive, most effective**" is the ethos of a hospital ward for people with a learning disability who may present with behaviours that challenge carers, staff and services. This embedded culture started with a review of literature to provide a robust evidence base and to deliver a patient centred service that upholds patients' human rights. The team engaged multi-disciplinary endorsement to support the required change in culture and practice. Leadership, and belief in the delivery of positive outcomes for patients and staff, were essential in the development of this model of care and treatment.

Least restrictive, most effective involves:

- patient involvement – weekly multi-disciplinary team meetings, weekly therapeutic 1:1 with named nurse, joint decision making and patient forums
- individual assessment – no blanket restrictions
- decisions made based on the level of risk and not the behaviour, with consideration of any impact on the patient's human rights
- consideration of positive risk taking
- proportionality – the level of restriction is proportionate to the level of risk;
- consideration of any alternatives to the restriction
- clear rationale for the restriction
- regular documented review.

Staff also ensure that families/carers are involved where they wish to be and that the opportunity for independent advocacy is made available. The implementation of therapeutic activity programmes and a commitment to transparency and involvement of patients in decision making has led to a reduction in the use of physical interventions and a reduction in the number of safeguarding referrals.

The FREDA principles are clearly expressed in this proactive model of care and treatment. Least restrictive, most effective has received several commendations including a "Highly Commended" award at the national Strengthening the Commitment: Sharing Success conference in June 2015.

Patients have told staff that they feel like they are treated as individuals and "just like everyone else".

There is a growing body of evidence which supports a reduction in the use of restrictive practices and an emphasis on using a proactive approach to positively reduce the need for restrictive practices. It is widely evidenced that early intervention is key in reducing the likelihood of the use of restrictive practices.

Person centred care is fundamental to positive approaches which places the person at the centre of service provision and builds delivery of services around their individual needs.

A community children's nursing team realised that some older children with autism in their locality were sleeping in specialist beds with extra high sides designed to keep the children in bed. These beds had been recommended many years previously, often because the child might get out of bed during the night and there was a perceived risk that the child may and fall or injure themselves. In some cases, the beds had been recommended to ensure that the child remained in bed and was safe throughout the night so that other family members could sleep. In many cases the use of the specialist bed was not reviewed and it became clear that as the children grew up, the use of this type of bed had become overly restrictive. These beds prevented the child from learning how to sleep in their own bed for the whole night and in some cases, how to use the toilet independently.

The nursing team worked with the occupational therapy team to ensure that the use of the specialist beds was reviewed and in many cases the beds were deemed to no longer be necessary. Short programmes of therapeutic work to help with sleep and toileting concerns were instigated. The children can now sleep safely in standard beds for the whole night. A new protocol is in place to ensure that therapeutic programmes to address any concerns are implemented as the first line response to concerns. Therapists work collaboratively and closely with the child and family to agree and implement individualised **evidence based interventions**, which are regularly monitored and reviewed. This **early intervention** protocol reduces the need for the use of restrictive practices in the longer term.

These approaches support the FREDA principles of Respect, Dignity and Autonomy. They also promote the children's Articles 3, 5 and 8 Human Rights.

The occupational therapy department in a large hospital received six separate requests on the same day from one ward asking for "Specialised seating for restraint of a patient with dementia who is at risk of falling when mobilising". The lead occupational therapist was concerned that staff who work in the dementia assessment and treatment ward in the hospital were only considering one solution to what may be perceived risks of falling as opposed to actual risks and that a comprehensive risk assessment process may not have been followed.

The occupational therapist worked with ward staff to complete holistic and comprehensive risk assessments for each of the identified patients. In five of the six situations, the occupational therapist was able to recommend alternative strategies to mechanically restraining the patient which would reduce the risk of falls. These strategies were **person-centred, evidence based** and therapeutic, and took account of available resources, including support from the patients' families, who wanted to be involved in caring for their relative.

The occupational therapist also worked with ward staff to change attitudes and beliefs and improve awareness and skills around how to reduce risks when caring for patients with dementia. The ward staff developed their own mission statement which focuses on proactive approaches to care. Staff actively encourage the use of positive language when discussing patients' care and when developing care plans, and avoid terminology with negative connotations, such as "restraint", "wanderer" and "challenging".

These approaches support the FREDA principles of Respect, Dignity and Autonomy. They also promote Human Rights Articles 3, 5 and 8.

There are a number of principles and models which support the delivery of positive and proactive care, for example:

## Positive risk taking

Building skills and promoting strengths and independence often requires everyone involved to take positive risks. This is not about ignoring potential risk, but about allowing opportunities for people to learn and find ways of coping with adversity and learning from challenging situations. It is about sharing responsibility for positive change with a collaborative approach to decision-making and the development of carefully constructed 'person centred safety plans'. It prevents professionals from becoming risk averse or paternalistic.

Positive risk management is about shared investment in positive outcomes, and ensures risks are managed in the most therapeutic, least restrictive manner possible, promoting personal autonomy whilst enabling people to stay safe.

> Social workers' safeguarding duty incorporates the need to, "recognise the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people. This includes, recognising that service users have the right to take positive risks and helping them to identify and manage potential and actual risks to themselves and others."
>
> *Standards of Conduct and Practice for Social Workers*
> Northern Ireland Social Care Council 2015

A positive risk taking approach entitles service users to the FREDA core values and principles in the delivery of care, treatment and support.

> Lily is 14 and has a mild intellectual disability. One day Lily and her friend were in the toilets in the youth club and engaged in what was termed "sexually inappropriate behaviour". Lily was deemed to be the instigator of this behaviour. As a consequence of this one incident Lily was prevented from participating in activities with her friends and peers and was closely supervised continually outside her own home. This had a very noticeable negative impact on Lily's mental health and social development. A year later a mental health nurse became aware of this situation. A comprehensive risk assessment had not previously been carried out so the nurse completed one. This demonstrated that the risk of the behaviour recurring was low. Lily agreed to attend some therapeutic sessions about healthy relationships and sexual development. It was agreed that opportunities for Lily to be with her friends and peers contributed to her learning about relationships and behaviour, whereas isolation during adolescence increased risks of not learning about relationships and sexuality.
>
> This example of **positive risk taking** supports the FREDA principles of Equality, Dignity and Autonomy and Lily's right to a private and family life (HR Article 8).

## Recovery based approaches

The recovery model emphasises and supports a person's potential for recovery. The recovery model was originally designed to empower people who experience mental ill health to be actively involved in and take control of their individual journey through their illness. Recovery does not necessarily only mean 'clinical recovery' (usually defined in terms of symptoms and treatment response) - it also means 'social recovery' – building a life beyond illness without necessarily eliminating the symptoms of illness. Recovery is understood as being deeply personal.

Recovery principles focus on:

- health, strengths, and wellness, and encouragement of self-management;
- building a meaningful and satisfactory life, and an identity separate from illness and/or disability which is based on hope and opportunity; and,
- a clear association with social inclusion.

What is advantageous about this model is that it can be used across the wider health and social care environment, including physical ill health and disability. The recovery model compliments the use of evidence based interventions, with the FREDA core values clearly embedded in its ethos.

Where children and young people are concerned, recent developments in Child and Adolescent Mental Health Services have been based on the Thrive model. This model is needs-led, integrated and collaborative in its approach, from early-intervention through to high-intensity support. It is focused on proactive approaches to deliver better long term outcomes for children and young people, which is fundamental to positive practice. Again, the focus for children and young people should be about 'real life', positive outcomes fuelled by a strong sense of hope.

Anna has schizophrenia. Having been a hospital inpatient for several years, Anna moved into a supported living facility. After moving into her own home, Anna frequently experienced relapses and had to be detained in hospital. At these times Anna would drink heavily, not take her prescribed medication and neglect her health and personal hygiene. In order to support Anna to remain physically and mentally healthy she agreed to co-produce a Wellness **Recovery** Action Plan (WRAP) with her social worker. This plan helped Anna to identify relapse triggers and easily access the best sources of support in the community when necessary. This approach meant that Anna was able to make **positive choices** about her health care and to stay at home, even when she experienced a relapse. The number of hospital admissions significantly reduced.

This **recovery approach** promoted the FREDA principles of Respect, Dignity and Autonomy. This approach also promoted Anna's right to a private and family life (HR Article 8). Anna told her social worker, "I love my new home, and not having to go back into hospital so often. I know I can lift the phone when I need help".

## A normalised and embedded culture of reviewing and reducing restrictive practices

To support health and social care professionals in thinking and acting differently in any use of a potentially restrictive practice, a culture of reviewing, reducing and/or removing restrictive interventions will be a normal everyday process. Evidence demonstrates that when practices which have negative implications are replaced with more positive practices which build and/or retain strengths, there are much more beneficial outcomes for people who use services, carers and staff.

A supported living facility is home to four service users with a learning disability and overlapping mental ill health or physical disability who had previously lived in long stay hospital wards. Now each person lives in their own apartment, with their own front door and keys to their apartment. Staff are available to provide care and support over a 24 hour period. Staff working in this service are knowledgeable about each individual's likes/ dislikes, wishes, and preferred daily routines and are very vocal about upholding each person's human rights.

For one service user in particular, Thomas, there is evidence of an improving quality of life as a result of the regular review and reduction in the use of restrictive practices. Whilst in hospital Thomas had required supervision of three members of staff at all times and was prone to aggressive behaviours. This always resulted in the use of physical restraint and the frequent use of seclusion. Similar practices continued when Thomas first moved to his new home. However, over time in this less restrictive environment, with a **change in staff practice and approach**, the implementation of therapeutic programme of care and support, and **regular review** of the levels of restriction, a gradual reduction in the levels of supervision was achieved and aggressive behaviour significantly lessened. Thomas has developed skills that his family never thought he was capable of, such as going to the local shop for the newspaper, and calmly enjoying communal spaces with the people who live next to him. The replacement of negative approaches with rights based therapeutic care and support plainly demonstrates the application of the FREDA principles, particularly Respect, Equality and Autonomy.

Thomas' relatives commented that: "this place is proof of what can be achieved when the environment, care and support are correct. My son has evolved into a much happier, more out-going person and has achieved a level of independence we never thought possible. We are overwhelmed with the progress Thomas has made since coming to live here. There has been a significant reduction in periods when he is unsettled which we consider to be because of the environment in which he now lives and how he is cared for and supported by staff".

Any intervention or plan must either have a time limited lifespan, or be part of a stepped approach which is contextual and evolving, and which incorporate a range of strategies as opposed to being a singular solution. An outcomes focused approach which ensures that any restrictive practice has a precise and evident justification, must allow for consideration of the reduction or removal of restrictive methods once the desired outcome has been achieved.

Mr Brown had been a patient in a dementia ward for more than a year. Initially Mr Brown had been very distressed and experienced what is known as "behavioural and psychological symptoms of dementia". This resulted in some extremely aggressive and destructive behaviour. A multi-disciplinary team made the decision that Mr Brown should be physically restrained in a specially designed chair when he experienced these periods of extreme agitation. Bed rails were also used when Mr Brown was in bed. Care plans stated that the belt on the chair restraining Mr Brown should be released when he was "settled or sleeping". The use of the restrictive practice was to be reviewed on a monthly basis. There was no record of any discussion and decision making about the impact of this restrictive practice on Mr Brown's human rights, whether this intervention was deemed to be in his best interests or consideration of the FREDA core principles. There was no evidence that the actual use of restraint as the least restrictive measure available to keep Mr Brown safe had been reviewed. The practice of keeping Mr Brown restrained with a belt in a chair continued every day as normal practice, and on most days for an extended period of time, despite records demonstrating that he was often settled or sleeping. Additionally, due to the absence of a range of therapeutic approaches, there was lack of evidence to support the use of the chair, belt and bedrails as the least restrictive, and the most effective evidenced based treatment option.

An inspection by the HSC regulator highlighted that this level of restriction was not appropriate and required urgent review. Mr Brown was no longer aggressive or agitated. The multidisciplinary team agreed that mechanical restraint was no longer necessary. Subsequently staff now ensure that all alternatives to any level of restriction are considered before agreeing the use of a restrictive practice. Patients who are subject to restrictive interventions have the actual restrictive practice **reviewed regularly** throughout the day, to ensure that it remains appropriate and proportionate. Additionally, all restrictive practices are reviewed formally on at least a weekly basis by the multidisciplinary team.

These actions are more clearly person-centred. The consideration of any impact on any patient's human rights is more closely examined, and staff can now explain how any restrictive intervention may impact on any of the human rights articles. The supporting FREDA principles are now more clearly evidenced in care and treatment plans.

# Conclusion

This document, and the challenge facing all health and social care professionals, is about changing the culture and practices of the services you work in. Whilst radical change is often needed, this is about evolution rather than revolution.

Every individual health and social care professional can ask questions, bring a different perspective and do things differently.

***Three Steps to Positive Practice*** **will help structure your thinking as decisions are made which can have a major impact on the lives of people who use services, ensuring that humanity and compassion remain central to the care and support provided. It is your responsibility to do so, every time.**

# References and useful guidance documents

Allen D et al (2012) The impact of a whole organisation approach to positive behavioural support on the use of physical interventions, *International Journal of Positive Behavioural Support*, 2(1),pp.26-30.

Anna Freud National Centre for Children and Families Thrive Model **www.annafreud.org/service-improvement/service-improvement-resources/thrive**

Australian Government Department of Health and Ageing (2012, updated 2014) *Decision-making tool: supporting a restraint free environment in residential aged care*. Sydney: Commonwealth of Australia.

Bailey S and Williams R (2014) Towards partnerships in mental healthcare, *Advances in Psychiatric Treatment*, 20, pp.48-51.

British Association of Social Workers, The Policy Ethics & Human Rights Committee (Jan 2012, updated Oct 2014) *The Code of Ethics for Social Workers: Statement of Principles*, Birmingham: BASW.

British Institute of Learning Disabilities **www.bild.org.uk**

British Institute of Learning Disabilities (2016) *Code of Practice for minimising the use of restrictive physical interventions: planning, developing and delivering training*, 4th Edition, Birmingham: BILD.

Carr E G et al. (1999) *Positive behaviour support for people with developmental disabilities: a research synthesis*, Washington, American Association of Mental Retardation.

Cheshire West and Chester Council v P (2014) UKSC19 (2014) MHLO 16.

Curtice Martin J and Exworthy T (2010) FREDA: a human rights based approach to healthcare, *The Psychiatrist*, 34 (4),pp.150-156.

Department of Health, British Institute of Human Rights (2007) *Human Rights in Healthcare – A Framework for Local Action*, London: DH.

Department of Health (2010) *Nothing Ventured, Nothing Gained: risk guidance for people with dementia*, London: DH.

Department of Health (2012) *Transforming Care: a national response to Winterbourne View Hospital*, London: DH.

Department of Health (2014) *Positive and Proactive Care: reducing the need for restrictive interventions*, London: DH.

Department of Health, Skills for care and skills for health (2014) *A positive and proactive workforce*, London: DH. Available from: **www.skillsforcare.org.uk/Topics/Restrictive-practices/Restrictive-practices.aspx**

General Medical Council (2008) *Consent: patients and doctors making decisions together*, Available from: **www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp**

General Medical Council (2016) *Members' Code of Conduct*, London: GMC.

Gillick v West Norfolk & Wisbeck Area Health Authority [1986] AC 112 House of Lords.

Gore N et al. (2013) Definition and scope for positive behavioural support. *International Journal of Positive Behavioural Support* [Online] 3:14-23. Available at: **www.ingentaconnect.com/content/bild/ijpbs/2013/00000003/00000002/art00003**

Health and Care Professions Council (2016) *Standards of Conduct Performance & Ethics (SCPE)*, London: HCPC.

Joseph Rowntree Foundation (2014) *How can 'Positive Risk Taking' help build dementia friendly communities?* York: Joseph Rowntree Foundation.

Learning Disabilities Professional Senate (2016) *Challenging Behaviour: a unified approach – update. FR /1D/08*, London: Royal College of Psychiatrists and The British Psychological Society. Available from: **www.rcpsych.ac.uk/pdf/FR_ID_08.pdf**

Ministry of Justice (2006) *Making Sense of Human Rights. DCA45/06*, London, Ministry of Justice.

Montgomery v Lanarkshire Health board (2015) UKSC 11 Supreme Court.

NHS England (2016) *Stop Overmedication of People with Learning Disabilities*. Available from: **www.england.nhs.uk/wp-content/uploads/2016/06/stopping-over-medication.pdf**

National Institute for Health and Care Excellence (2015) *Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities whose behaviour Challenges* (NG11). Available from: **www.nice.org.uk**

Nursing and Midwifery Council (2010) *Standards for competence for registered nurses*, London: NMC.

Nursing and Midwifery council (2015) *The Code for Nurses and Midwives*, London: NMC.

Parliament Great Britain (2005) *Mental Capacity Act*, London, HMSO. Available from: **www.legislation.gov.uk/ukpga/2005/9/contents**

Parliament Great Britain (1998) *Human Rights Act*, London: HMSO.

Roberts G and Boardman J (2013) Understanding Recovery, *Advances in Psychiatric treatment*, 19, pp. 400-409.

Roberts G and Boardman J (2014) Becoming a recovery-oriented practitioner, *Advances in Psychiatric Treatment*, 20. pp.37-47.

Royal College of Nursing (2008) *Let's Talk About Restraint*, Pub No 003208, London: RCN.

Royal College of Nursing (2016) *Positive and Proactive Care*, London: RCN. Available from: **www.rcn.org.uk/professional-development/publications/pub-005459**

Royal College of Nursing (2017) *Ethical Impact Assessment Tool*, London: RCN. Available from: **www.rcn.org.uk/professional-development/publications/pub-006499**

Royal College of Psychiatrists (2016) *Psychiatric services for young people with intellectual disabilities* (CR200), London: Royal College of Psychiatrists.

Royal College of Psychiatrists (2016) *Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines* (FR/ID/09), London, Royal College of Psychiatrists.

Social Care Institute for Excellence (2013) *Co-production in social care: What it is and how to do it*, Belfast, SCIE. Available from: **www.scie.org.uk/publications/guides/guide51/practice-examples/you-in-mind.asp**

Stephens G, Boardman J and Slade M (2008) *Making recovery a reality*, London, Sainsbury Centre for Mental Health.

The Challenging Behaviour Foundation **www.challengingbehaviour.org.uk**

UN General Assembly (1989) Convention on the Rights of the Child, Treaty Series, vol.1577, New York: United Nations

## England and Wales specific

Department of Health (2003) *Good practice in Consent*, London, DH.

Department of Health (2015) *Deprivation of liberty safeguards – information and resources*, London, DH. Available from: **www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance**

NHS England (2015) *Building the right support: A national implementation plan*, Available from: **www.england.nhs.uk/?s=building+the+right+support**

Parliament Great Britain (2005) *Mental Capacity Act*, London, HMSO. Available from: **www.legislation.gov.uk/ukpga/2005/9/contents**

## Northern Ireland specific

Department of Health, Social Services and Public Safety Northern Ireland (2003) *Reference Guide to Consent for Examination, Treatment or Care*, Belfast, DHSSPS.

Department of Health, Social Services and Public Safety Northern Ireland (2010) Circular HSC/ MHDP – MHU 1 /10 – revised. *Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance*, Available from: **www.dhsspsni.gov.uk/publications/deprivation-liberty-safeguards-dols-%E2%80%93-interim-guidance**

Department of Health, Social Services and Public Safety Northern Ireland (2011 ) *Quality 2020 a ten year strategy to protect and improve quality in health and social care in Northern Ireland*, Belfast, DHSSPSNI.

Department of Health, Social Services and Public Safety Northern Ireland (2012) *Child and Adolescent Mental Health Services: A Service Model*, Belfast, DHSSPSNI.

Department of Health, Social Services and Public Safety Northern Ireland (2012) *Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability*, Belfast, DHSSPSNI. Available from: **www.health-ni.gov.uk/publications/promoting-quality-care-good-practice-guidance-assessment-and-management-risk-mental**

Department of Health Social Services and Public Safety (2015) *Adult Safeguarding: Prevention and Protection in Partnership*, Belfast, DHSSPS.

Department of Health, Social Services and Public Safety (2016) *Co-operating to safeguard children and young people in Northern Ireland*, Belfast, DHSSPS. Available from: **www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland**

Health & Social Care Board (2016) *Mental Health/You in Mind – a range of regional mental health care pathways*, Belfast, HSC. Available from: **www.hscboard.hscni.net/our-work/social-care-and-children/mental-health**

Northern Ireland Assembly (2016) *Mental Capacity Act (Northern Ireland)*. Available from: **www.legislation.gov.uk/nia/2016/18/contents/enacted**

Northern Ireland Social Care Council (2015) *Standards of Conduct and Practice for Social Workers*, Belfast, NISCC.

The Regulation and Quality Improvement Authority (2013) *A Baseline Assessment and Review of Community Services for Children with a Disability*, Belfast, RQIA.

The Regulation and Quality Improvement Authority Mental Health & learning Disability Directorate (2014) *Awareness and Use of Restrictive Practices in Mental Health & Learning Disability Hospitals*, Belfast, RQIA.

## Scotland specific

Mental Welfare Commission for Scotland (2010) *Consent to treatment: a guide for mental health practitioners*, Edinburgh, MWCSCOT.

Mental Welfare Commission for Scotland (2013) *Good Practice Guide: Rights, Risks and Limits to Freedom*, Edinburgh, MWCSCOT.

Scottish Government (1991) *Age of legal capacity (Scotland) Act*, Edinburgh, Scottish Government.

Scottish Government (2000) *Adults with Incapacity (Scotland) Act*, Edinburgh, Scottish Government.

Scottish Government (2003) *Mental Health (Care and Treatment) (Scotland) Act*, Edinburgh, Scottish Government.

Scottish Government (2007) *Adult Support and Protection (Scotland) Act*, Edinburgh, Scottish Government.

Scottish Government (2014) *Children and young people (Scotland) Act*, Edinburgh, Scottish Government.

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

RCN Online
**www.rcn.org.uk**

RCN Direct
**www.rcn.org.uk/direct**
0345 772 6100

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

020 7409 3333

June 2017
Review Date: June 2020
Publication code 006 075

Royal College
of Nursing

RC PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS

CR220

# Restrictive interventions in in-patient intellectual disability services:

## How to record, monitor and regulate

COLLEGE REPORT

# College Report CR220

December 2018

Approved by: The Policy and Public Affairs Committee (PPAC)

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

# Contents

# Authors and contributors

## Author[1]

Verity Chester, Research and Projects Associate, St Johns House, Diss, Norfolk; and PhD Candidate, University of East Anglia, Norwich, Norfolk

## Editors

Dr John Devapriam, Chair, Quality Network for Learning Disability (QNLD), Royal College of Psychiatrists, London; Executive Medical Director, Worcestershire Health and Care NHS Trust; National Professional Advisor for Learning Disabilities, Care Quality Commission

Dr Regi Alexander, Consultant Psychiatrist, Hertfordshire Partnership NHS Foundation Trust & Honorary Senior Lecturer, University of Leicester

## Working group

Dave Atkinson, Independent Consultant Nurse, Dave Atkinson Associates Ltd; Senior Programme Manager, NHS Improvement.

Jonathan Beebee, Chief Enablement Officer & Nurse Consultant, PBS4.

Guy Cross, Regulatory Policy Officer – Mental Health, Strategy and Intelligence Directorate – Policy and Strategy,Care Quality Commission

Dr Daniel Dalton, Consultant Psychiatrist & Clinical Director, Hertfordshire Partnership University NHS Foundation Trust.

Ann Norman, Professional Lead for Criminal Justice and Learning Disability Nursing, Royal College of Nursing.

Prof Peter Langdon, Professor of Clinical and Forensic Psychology, Tizard Centre, University of Kent, and Clinical Psychologist, Broadland Clinic.

David Kitchen, Retired Behaviour Support and Practice Development Coordinator, Partnerships in Care Intellectual Disability Services; Specialist Adviser for Intellectual Disabilities, Care Quality Commission.

---

[1] Commissioned by the Faculty of Psychiatry of Intellectual Disability and Quality Network for Learning Disabilities, Royal College of Psychiatrists

# Consultation group

Dr Bijil Arackal, Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust

Dr Helene Barclay, Specialty Doctor, Hertfordshire Partnership University NHS Foundation Trust

Dawn Beales, Charge Nurse, Hertfordshire Partnership University NHS Foundation Trust

Mel Bowman, Interim Service Lead, In-patient services, Hertfordshire Partnership University NHS Foundation Trust

Debra Chester, Staff Nurse, Mersey Care NHS Foundation Trust

Ben Higgins, Chief Executive, British Institute of Learning Disabilities

Neil James, Senior Lecturer and Course Director for Learning Disability Nursing, University of East Anglia

Alison Mitchell, Senior Staff Nurse, Danshell Group

Fungai Nhiwatiwa, Hospital Director, St Johns House, Diss, Norfolk

Dr Jean O'Hara, National Clinical Director for Learning Disabilities, NHS England & Consultant Psychiatrist, South London & the Maudsley NHS Foundation Trust

Dr Anthony Perini, Consultant Psychiatrist, Danshell Group

Judith Pither, Matron, Agnes Unit, Leicestershire Partnership NHS Trust

Leisa Richards, Case Manager for Transforming Care, NHS England- Midlands and East

Sarah Leitch, Development Manager for the Centre for the Advancement of Positive Behaviour Support, British Institute of Learning Disabilities

Dr Kamalika Mukherjee, Consultant Psychiatrist, Hertfordshire Partnership University NHS Foundation Trust

Emma Tolhurst, Community Support Leader, Thera Group

Paul Upton, Charge Nurse, Broadland Clinic, Hertfordshire Partnership University NHS Foundation Trust

# Acknowledgements

The author and editors wish to extend their thanks to the following groups for their valuable feedback on this report during the consultation process:

- Learning Disability Professional Senate
- Royal College of Nursing
- The British Institute of Learning Disabilities Restraint Reduction Network (RRN)
- The Quality Network for In-patient Learning Disability Services (QNLD)

# Foreword

> “This report is both welcome and timely. In our report, *The state of care in mental health services 2014 to 2017*, we, the Care Quality Commission (CQC), commented on the “great variation between wards in how frequently staff use restrictive practices and physical restraint to de-escalate challenging behaviour. Those wards where the level of restraint is low or where it is reducing over time have staff trained in the specialised skill required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm”. We went on to say that “this has also been a development area for CQC – in the past we may have been too tolerant when we have seen evidence of restraint and restrictive practices (including blanket restrictions) used too readily. We now want to send a clear message to providers that we will be asking searching questions when we find services in which staff frequently resort to restrictive interventions”.
>
> When we published *The state of care in mental health services* (Care Quality Commission, 2017), we flagged up three issues that limit CQC’s ability to fulfil its commitment to regulate physical restraint better.
>
> 1. There is no widely accepted and used set of definitions of types and levels of physical restraint.
> 2. Partly linked to the lack of definitions is the issue that providers are highly inconsistent in how they report physical restraint.
> 3. There is no system for assuring the quality of training provided to staff in how to prevent, minimise and manage challenging behaviour.
>
> As a result, many training providers teach staff a wide range of approaches.
>
> This means that as things stand, we cannot safely conclude that it is of more concern that provider A reports 100 uses of physical restraint each month than provider B who reports 10 uses each month. It could be the case that staff in provider A are highly attuned to the issue and that the great majority of incidents reported involve them gently redirecting a person from possible harm; whereas staff in provider B only report instances where they have held a person on the ground.
>
> In response to CQC’s concerns, and at the request of the Secretary of State for Health and Social Care, NHS England and partners are working to develop common definitions, improve reporting and establish a mechanism for accrediting training. This report will greatly inform and influence this work.
>
> I welcome the emphasis that this report places on the importance of the culture of care. Research into the factors that contribute to aggressive behaviour in residential settings find that most instances are not caused directly by the person’s ‘psychopathology’. Most are fully understandable at the human and interpersonal level; and are due to everyday frustrations that come from communal living in a setting where the people lack autonomy and control over their lives. If staff can create an environment that minimises these general frustrations and work with individuals to identify and anticipate specific triggers that cause them distress, they will reduce the need to resort to restrictive interventions.”

**Dr Paul Lelliott**
Deputy Chief Inspector of Hospitals (Lead for Mental Health)
Care Quality Commission

# Executive summary and recommendations

This report is concerned with the standards of recording, monitoring, and regulating **restrictive interventions** involving people with **intellectual disabilities with mental health and/or challenging behaviour** within **in-patient services**.

Restrictive interventions, a central concern for all stakeholders of intellectual disability services, have come under increased scrutiny following the abuse scandal at Winterbourne View. Current efforts to monitor them rely almost exclusively on the numbers of such incidents. This approach is fundamentally flawed because numbers alone do not assess the quality of a service's overall restrictive interventions practice and cannot be used to infer good or poor standards of practice and abuse. Further, there are problems with the variable use of definitions, the failure to distinguish between various degrees of physical restraint, the impact of outliers, the failure to capture individual patient progress and the absence of meaningful benchmarking.

Service providers and regulators must therefore rely on other methods to evaluate the use of restrictive interventions and move from basing their conclusions on just the total number of restrictive interventions to one of examining a wider range of quality parameters.

With representative examples, this document makes recommendations on how restrictive interventions should be recorded, monitored, regulated and published.

### Recommendations on recording

1. Services should have a good quality system of recording incidents of restrictive interventions, which incorporates variables specified by government guidance (Department of Health, 2014; 2015).
2. Incident records within this system should be well written and present a cohesive representation of the events leading to, and during, the restrictive intervention, particularly focusing on justification for their use, and stating how the intervention represented the least restrictive option and what physical health observations were undertaken.

3 Services should consider moving away from paper-based recording systems, which have limited utility in the monitoring of restrictive interventions, in favour of IT software packages or databases. IT software systems are the preferred mode of recording due to being more robust and their potential to improve the quality of quantitative and qualitative restrictive interventions data.

4 Such systems should be developed in conjunction with all stakeholders of the software, including the individuals who will be entering incident reports, and those who will access the data for monitoring/regulation.

5 Software developers should consider ‘forced response’ formats to ensure that all required data is completed within incident report entries.

6 Software should be kept up to date, with new patient details recorded on their admission to the service, new staff member information recorded on their appointment, and particular MVA techniques taught in the service.

7 Software should prompt users entering data to ensure their incident report demonstrates compliance with current government guidance (Department of Health, 2014; 2015), with statements such as ‘Describe how this intervention represented the least restrictive response to the patient’s behaviour’ or ‘Describe the physical health observations which were undertaken during the restrictive intervention’.

8 The system should be reviewed and updated on an ongoing basis, to maintain its quality and utility.

9 It is recommended that staff who are required to write incident reports as a requirement of their role are given full training in the correct process. This training must emphasise the importance of quality incident reports, and cover government requirements (Department of Health, 2014; 2015).

10 Services should provide supervision and mentoring to staff in this element of their role.

11 Incident reports should be checked and signed off by a senior member of staff.

12 Services should regularly audit incident reports to ensure they meet the required standard.

### Recommendations on monitoring and regulation

13 Services should generate statistics/reports on restrictive interventions as defined by the Department of Health (2014; 2015), for any reasonably requested timeframe on a whole service, ward, and individual patient level.

**14** Service or ward level reports should include:

- **a** Total frequency of each restrictive intervention
- **b** Total number, level and type of incidents which do not result in restrictive intervention
- **c** Duration of restrictive interventions, with a full categorical breakdown in addition to average and range
- **d** Holds/techniques used for physical restraint, with a full categorical breakdown (this figure is likely to be higher than the total frequency of restrictive interventions, due to incidents of restraint which utilise more than one holding technique)
- **e** Trends in rates over time, day of the week, week in the month, and month of the year. If incidents peak on particular days or at certain times, this can direct the exploration of the activities, procedures, staffing levels and interventions of an individual/ward/service, as necessary
- **f** An investigation or analysis of decreases, increases and/or maintenance
- **g** Total number and extent of any patient injuries sustained within restrictive interventions
- **h** The number of individual patients represented within the data, expressed as a percentage of total patients treated within this timeframe
- **i** Progress of all patients against the aims of the services chosen restrictive intervention programme, ideally using the ‘traffic light audit’
- **j** The contribution of individual patient rates to the overall total for the ward or the service. If there are any outlier(s) which significantly affect the overall total, or trends, report rates with and without the outlier data
- **k** Details of how rates compare to a national benchmark
- **l** Number of beds, and occupancy level of service for timeframe
- **m** Cohort characteristics, such as gender, ethnicity, diagnoses, behavioural and/or offence profile.

**15** Individual patient level reports should include:

- Items a–m, as above
- A brief description of a patient’s demographic information, and psychiatric and forensic history (where relevant)
- Services should be able to generate statistics on the levels of restrictive interventions for the entirety of a patient’s admission and, if available, pre-admission
- Reports should include details of the patient’s management plan, e.g. level of observation, medication, level of engagement, assessments and treatment plans.

### Recommendations to overcome some of the identified limitations with current restrictive interventions data

**16** To truly capture the quality of a service's restrictive intervention practice, there must be less focus on the number of restrictive interventions, and more on a service's adherence to the standards outlined by government guidance (Department of Health, 2014; 2015). This is likely to encompass restrictive intervention factors such as:

- **a** Staff training in primary and tertiary strategies, training in safe restrictive intervention techniques, restrictive intervention reduction programme, the quality of advance statements and individualised restrictive intervention care plans, physical health observations and debriefing processes
- **b** Wider practice quality issues, such as leadership, staffing levels, environmental considerations, engagement, patient assessment, therapies and management.

### Assessing the principles of last resort and least restrictive practice

**17** It is recommended that qualitative incident accounts, or a representative subsample thereof, are inspected on an incident-by-incident basis in order to assess whether the record adheres to the principles of least restrictive practice. For example: Was the decision-making process for restrictive intervention by staff described? Was this decision justified for the patient's own or others' safety? Was it reasonable and proportionate? Was it the least restrictive way the behaviour described could have been managed? Was the intervention subject to regular review by staff and curtailed as quickly as possible? This is a much more time-consuming task but a much more meaningful one and is dependent on a good standard of written incident reports.

### Uncovering poor practice or abuse of restrictive interventions

**18** If it appears that restrictive interventions are being carried out for any other purpose than to take immediate control of a dangerous situation, it is recommended that concerns should be escalated through local safeguarding procedures and protocols.

**19** It is recommended that regulators request information on the number patient injuries sustained during restrictive interventions, except where these relate primarily to instances of self-harm/injury.

**20** Regulators should cross reference data on restrictive interventions with information from other sources, including their observations, patient and carer reports, safeguarding referrals, police reports, etc.

## Definitions and degrees of restrictive interventions

**21** It is recommended that policymakers develop a framework of restrictive intervention severity/intensity. This should encompass the full range of physical restraint techniques used by multiple training providers, as well as the duration of physical restraint, seclusion, and long-term segregation. This would provide an element of standardisation, move towards more consistent recording between service providers, and support the comparability of data.

**22** It is recommended that in the interim, services should record, monitor, and report the full framework of techniques used.

**23** Services which report comparatively lower numbers of restrictive interventions should have their practice inspected as rigorously as those which report higher numbers.

## Establishing individual patient progress

**24** It is recommended that services provide a breakdown of restrictive intervention data from the total number for a whole service, to the ward level, and individual patient level. This can be done utilising widely available software, Microsoft Excel, using the Pivot Table function, which can facilitate the analysis of a large, detailed datasets quickly and easily. This function can also be used to view the proportion of restrictive interventions accounted for by individual patients, and ward or service level data can be viewed and presented with and without the data of individual outlier patients.

**25** Service providers can also report multiple measures of central tendency, such as the median, in addition to the mean, which is particularly susceptible to the effects of outliers.

## Establishing individual patient progress

**26** Services should analyse the progress of individual patients for a clearly specified timeframe. This can be achieved using the ‘traffic light’ audit method. The traffic light method involves viewing the restrictive interventions rates of all patients within the service, and then categorising them into one of the three categories. This can be useful through the audit cycle or, ideally, the whole duration of a patient’s admission. This should include the number of patients treated in the timeframe specified, and the proportion who have been involved in restrictive interventions.

**27** Service providers should report multiple measures of central tendency, such as the median – not just the mean which is particularly susceptible to the effects of outliers.

## Capturing the whole picture of patient care and restrictive interventions

**28** Services should monitor and report all types of restrictive interventions used with an individual patient, using visual aids. This should take into account any patient preferences as specified in advance statements or similar, and recognise that this data represents only one element of patient care, and does not capture other domains, such as wellbeing, quality of life, physical health, engagement with friends and relatives, occupational activities, etc.

## The absence of a publicly available benchmark

**29** National benchmarking data must be strengthened via the inclusion of a wider range of variables and be publicly available to all.

**30** Benchmarking processes must consider the highlighted issues with restrictive interventions data and take steps to counter these in reports.

## Using data to support the reduction of restrictive interventions

**31** Services must demonstrate the use of data to support restrictive intervention reduction.

- **a** This might involve regular reviewing of incidents and subsequent debriefs, identifying any triggers or learning points and feeding these back into care plans. It could involve viewing of restrictive intervention rates in team meetings and care reviews, identifying patterns of use, and addressing any underlying reasons for these. This could involve highlighting particular times of day where incidents peak, particular days of the week, differences between shift patterns, etc. When reviewing individual patients, these factors are likely to be highly personalised and their care plans should reflect this.
- **b** Services may also choose to record a wider range of measures in addition to restrictive intervention rates, as identified by Bowring (2015). These might include behaviour rating scales, quality of life measures, patient satisfaction etc.

## Publishing

**32** Any publication of restrictive intervention data should adhere to the above guidance.

**33** Reports should relate to a clearly specified timeframe.

# Definitions and scope

The scope of this report includes standards of recording, monitoring, and regulation of **restrictive interventions** involving people with **intellectual disabilities with mental health and/or challenging behaviour** within **in-patient services**, terms which are defined in the below subsections.

## Intellectual disability (ID)

Within this report, we will use the term ‘intellectual disability’ or ‘ID’. Intellectual disability is known by a number of terms which are often used interchangeably. The UK government uses the term ‘learning disability’ (Parkin et al, 2018). The previous version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) used the term ‘mental retardation’, but have adopted the term ‘intellectual disability’ in the current edition (DSM-V, American Psychiatric Association, 2013).

The ICD Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines are also planning to change their terminology from ‘mental retardation’ in the current edition (ICD-10, World Health Organization, 1992) to ‘disorders of intellectual development’ in the forthcoming version, ICD-11 (Cooray, Bhaumik, Roy, Devapriam, Rai and Alexander, 2015).

Regardless of the exact terms used, intellectual disability is characterised by significant degrees of cognitive impairment together with deficits in adaptive behaviour manifest from childhood (Carulla, 2011), and has an onset before the age of 18 (World Health Organization, 1992). The degree can be mild, moderate, severe or profound, with over 90% of those with ID falling within the mild range (Department of Health, 2001).

## In-patient services

People with ID are reported to suffer from a higher prevalence of mental health problems when compared with the general population (Cooper et al., 2007; Bhaumik et al., 2008). When a person with ID develops co-morbid mental health issues, there is an emphasis on providing care within the community, but in-patient settings remain a necessity for some patients (Xenitidis, Gratsa, Bouras, Hammond, Ditchfield, Holt, Martin, & Brooks, 2004). This may be provided in mainstream mental health services, or in specialist ID services (Chaplin, 2009).

In 2012, the NHS Confederation defined in-patient mental health services as units with ‘hospital beds’ that provides 24-hour nursing care. A unit is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician, but not all patients will be detained. Such a unit may be in a hospital campus or a community setting, and may be provided by the NHS or the independent sector. The document stated that in-patient beds should be distinguished from placements registered for the provision of care, such as those provided by local authorities. The report described the scope, typical care pathways and patients treated within:

- Acute in-patient beds
- Psychiatric intensive care unit (PICU)
- Forensic services
- Child and Adolescent Mental Health Services (CAMHS).

The purpose and functions of the different types of specialist in-patient beds for people with ID in the United Kingdom, within the context of a tiered model of service provision have been described (Royal College of Psychiatrists’ Faculty of Psychiatry of Intellectual Disability, 2013). Tier 1 (enabling role working with other agencies) to tier 3 (intensive case management in the community) constitute community ID services, and tier 4 constitutes the in-patient element of care. Within tier 4, there are subcategories:

- Category 1: high, medium and low secure forensic beds
- Category 2: acute admission beds within specialized ID units
- Category 3: acute admission beds within generic mental health settings
- Category 4: forensic rehabilitation beds
- Category 5: complex continuing care and rehabilitation beds
- Category 6: other beds including those for specialist neuropsychiatric conditions.

## Challenging behaviour

*“Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to*

*responses that are restrictive, aversive or result in exclusion."* (Royal College of Psychiatrists et al., 2007, p.10).

Challenging behaviour is a socially constructed, descriptive concept that has no diagnostic significance, and makes no inferences about the aetiology of the behaviour, covering a heterogeneous group of behavioural phenomena across different groups of people (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013). Among many causes, challenging behaviour has been reported to (Koritsas & Iacono, 2012):

- represent a form of communication
- be caused by skills deficits
- be associated with psychiatric disorder or symptoms or physical illness, or
- develop through operant conditioning and reinforcement.

### Restrictive practices

The terms 'restrictive practices' and 'restrictive interventions' are often used interchangeably, despite their different meanings. Restrictive practices are defined as *"making someone do something they don't want to do or stopping someone doing something they want to do"* (Skills for Care & Skills for Health, 2014, p.9).

Restrictive practices therefore include, but are not limited to, restrictive interventions. In addition to restrictive interventions, restrictive practices also include deprivations of liberty, as well as broader activities which restrict people. These restrictions might be used as a routine feature of someone's care and support, rather than solely in response to some form of crisis, may be deliberate or less so, and tend to occur in one of the following ways (Skills for Care & Skills for Health, 2014):

1. *Restrictions that arise because of habit or blanket rules*: e.g. everyone having to be up by a certain time, rules on whether people can have their phones or doors being routinely locked. These are sometimes called 'de facto' restrictions.

2. *Safety:* restrictions such as locking a room to keep household cleaning products or medicine out of someone's reach. This could also mean responding to violence or aggression towards the individual themselves, or to workers or others.

3. *Treatment or care:* restrictive practices may be used in a planned or unplanned way in order to provide essential care, support or medical treatment.

## Restrictive interventions

Restrictive interventions are defined as *"deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken"* (Department of Health, 2014, p.14).

Restrictive interventions include; physical restraint, mechanical restraint, rapid tranquillisation, seclusion and long-term segregation (Department of Health, 2015, p.281).

# Chapter 1: Background and context

In England, which has a population of about 53 million people, around 900 000 adults have an ID (Devapriam, Rosenbach & Alexander, 2015). Of those, approximately 191 000 (21%) are in contact with ID services (Emerson 2010) and 3 035 (0.3%) are receiving treatment in in-patient psychiatric units at any point in time (Health and Social Care Information Centre 2013). The latter number tends to fluctuate and includes secure or forensic services provided for those with offending behaviour, whose presentation is currently above a threshold that can be safely managed in the community. Individuals within in-patient ID services have predominantly mild levels of ID, and have a number of co-morbidities in addition to their primary diagnosis, with high rates of autism spectrum disorder (ASD), epilepsy, schizophrenia and delusional disorders, bipolar affective disorder, depressive disorder, anxiety disorders and personality disorders (Xenitidis et al, 2004; Alexander et al, 2011).

People with ID in in-patient settings can display behavioural challenges that may present risks to themselves or others (Department of Health, 2015). Challenging behaviour within in-patient services arises from a complex interaction between factors intrinsic to the individual patient, and factors intrinsic to the service. Individual factors may include anger issues (Chilvers & Thomas, 2011), difficulties with social problem-solving (Larkin, Jahoda & MacMahon, 2013), and communication issues (McNamara, 2012). Service factors might include excessive noise and general disruption, overcrowding, boredom, lack of clear communication by staff with patients, and the excessive or unreasonable application of demands and rules (Department of Health, 2015). Services which care for people who are liable to present with challenging behaviour should focus primarily on providing a positive and therapeutic culture, which focuses on preventing behavioural disturbances, early recognition, and deescalation[2]. Organisational responses to challenging behaviour should include primary, secondary and tertiary strategies which are defined in Table 1.

---

[2] De-escalation is defined as a secondary preventative strategy within the Mental Health Act Code of Practice (Department of Health, 2015). It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance. De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

**Table 1: Primary, Secondary and Tertiary responses to behavioural disturbance defined by the Mental Health Act Code of Practice (Department of Health, 2015)**

| | |
|---|---|
| Primary | Primary preventative strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances. |
| Secondary | Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm. Secondary strategies include de-escalation. |
| Tertiary | Tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient. |

## Statement of principles

This report is primarily concerned with ensuring and evidencing that the use of restrictive interventions is in line with the following principles. The principles are derived from values outlined in best practice documents such as *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014) and the *Mental Health Act 1983: Code of Practice* (Department of Health, 2015):

1. Restrictive interventions should only be used to:
    a. take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken.
    b. end or reduce significantly the danger to the person or others.

    They should not contain or limit the person's freedom for longer than is necessary.

2 When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner.

3 The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.

4 Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.

5 Restrictive interventions should be used in a transparent, legal and ethical manner:

   a Restrictive interventions must comply with the relevant rights in the European Convention on Human Rights.

   b People must be treated with compassion, dignity and kindness.

   c What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.

6 Providers who treat people who are liable to present with behavioural disturbances should have individualised, ward and service level restrictive intervention reduction programmes which emphasise primary and secondary strategies and involve patients, (family) carers/advocates.

When restrictive interventions are carried out without a clear ethical basis and appropriate safeguards, such acts may be unlawful, and should always be escalated through local safeguarding procedures and protocols. The Panorama documentary 'Undercover Care: The Abuse Exposed' depicted appalling scenes of abuse in an in-patient unit for patients with intellectual disability and mental health or behavioural problems (Winterbourne View, BBC, 2011). Much of the abuse was committed under the guise of restrictive interventions, and particularly, physical restraint. Yet it is important to recognise that the 'physical restraint' observed at Winterbourne View would not be recognised as a lawful restrictive intervention. Not only were patients subjected to clearly illegal actions (e.g. sitting on a chair placed on top of a vulnerable patient), there were instances of staff provocation prior to restraint being initiated (Flynn, 2012) and instances of restraint being used to bully, punish and humiliate. Patients sustained numerous significant physical injuries following restraint, such as broken bones, loss of teeth, and carpet burns (Flynn, 2012). Due to their actions, the staff involved subsequently faced criminal charges and in some cases, prison sentences (BBC News, 2012).

A core area of the response to Winterbourne View has been a focus on restrictive interventions, particularly physical restraint. The regulatory body of health and social care services in the UK, Care Quality Commission (CQC), undertook 150 unannounced inspections of care providers for people with intellectual disabilities and challenging behaviours, including 71 NHS trusts, 47 private services and 32 care homes (Care Quality Commission, 2012). In *Transforming care: a national response to Winterbourne View Hospital* (Department of Health, 2012, p.44), the government outlined their response not only to the Winterbourne View abuse scandal, but also on the wider issues highlighted by the subsequent review of services by the CQC. This led to the publication of *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014).

Following the scandal, emotions relative to restrictive interventions, particularly physical restraint, have remained high. Citarella (2013) repeatedly likened physical restraint to the combative sport of wrestling, and stated that there was *"no justification for pinning learning disabled to the ground"*. Other headlines have said that physical restraint should be banned altogether (e.g. Calkin, 2012). While the wrestling comparison may hold up when referring to the illegal 'restraints' undertaken at Winterbourne View, the inference that there is no justification whatsoever for physical restraint does not. There is a long-established legal framework surrounding the use of physical restraint, and other restrictive interventions, within the Mental Health Act (1983, amended 2007) and the accompanying Code of Practice (Department of Health, 2015) which outlines the most common reasons for needing to consider the use of restrictive interventions:

- physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- extreme and prolonged over-activity that is likely to lead to physical exhaustion
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the Mental Capacity Act).

The Department of Health's (2014) definition of restrictive intervention also indirectly highlights the need for its use where necessary:

*"deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently **in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken**"* (Department of Health, 2014, p.14).

A number of such situations have been outlined – for example, a patient running out into a busy road. At such times, the physical restraint by staff is likely to save a patient from serious injury. Furthermore, in a statement for a Royal College of Nursing report (2008) the then Chief Executive of the National Patient Safety Agency, Martin Fletcher, noted serious problems in services which would not tolerate restraint in their organisation in any circumstances. These problems included allowing delirious or suicidal clients get into risky situations, because staff thought it was wrong to stop a client doing what they wanted to do. He stated:

*"if an organisation takes the position 'it doesn't happen here' any problems just get hidden… if staff don't have a clear understanding of the circumstances where restraint is justified or positively required, they won't be able to recognise the circumstances where restraint is wrong or abusive."*

In these situations, the presence of a diagnosis of ID should not preclude intervention from staff members. The abuse observed in the Winterbourne View documentary has driven a universal desire to protect and keep patients within services safe, to avoid such tragedies happening again. It also reignited widespread criticism on the use of restrictive interventions within in-patient services. But in condemning those who abuse patients, we must be careful not to reject all forms of restrictive interventions. If restrictive interventions are applied safely and appropriately, they can form part of a responsible provider's care package and an individual's personal care plan. Rather than banning restrictive interventions, which risks driving the practice underground and potentially placing patients at further risk, focus should instead be shifted onto strengthening the process of recording and monitoring of restrictive interventions practice. While there have been welcome efforts to adequately monitor and inspect services in which such interventions take place, this approach has been flawed because of an almost exclusive reliance on restrictive interventions statistics and data. It has become increasingly clear that this strategy is not providing an accurate picture of restrictive interventions practice within in-patient ID services and that there is a need for further guidance in this area.

The report will go on to:

1. Critique the current, predominantly data-centric, approach to assessing restrictive interventions practice, and describe some specific issues which should be considered when interpreting restrictive intervention data.

2. Describe current guidance on recording, monitoring, publishing and regulation of restrictive interventions data.

3. Make recommendations and set standards for services wishing to self-assess their restrictive intervention recording and monitoring processes, and for regulators wishing to inspect such processes.

4. Promote the use of safe and legal restrictive interventions.

# Chapter 2: Relying on numbers:

## The current approach to reporting, monitoring and regulating restrictive intervention practices

At present, the monitoring and inspecting of practice largely focuses on the total number of restrictive interventions at the ward or service level, via service provided data and statistics. Since the Winterbourne View scandal, these statistics have received unprecedented interest among the multiple stakeholders of services; patients, families, staff, clinicians, academics, commissioners, charities, government, the media and the general public. The complexity of this data is often unappreciated, and in the best-case scenario references have been simplistic, reductionist, emotive, and subjective, and in the worst case, biased, misrepresentative, and sensationalist.

In 2013, Mind published the report Mental Health Crisis Care: Physical Restraint in Crisis; following freedom of information requests to 51 NHS mental health trusts. Widely reported within the media, and featured within Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, 2014), the report concluded there were:

- *excessive and disturbing* levels of restraint, with 39 883 incidents of restraint reported across mental health services in the UK in one year
- *significant variations* in the use of restraint across the country, with one trust reporting 38 incidents while another reported over 3 000 incidents.

However, the report fails to include important context regarding the figures quoted. For example, although 39 883 restraints sounds exceptionally high, a key contextual factor is the number of patients treated in services during this timeframe. Taking data from the 2010

Count Me In Census (Care Quality Commission and National Mental Health Development Unit, 2011), there were 29 840 in-patients within the mental health services of 261 NHS and independent health-care organisations in England and Wales. Dividing the number of restraints (39 883) by the number of patients (29 840), equates to 1.3 incidents of restraint per patient through the year. However, the census stated that not all patients are subject to physical restraint, with 12% of patients experiencing one or more episodes in the year. This suggests that 3 581 patients accounted for the 39 883 incidents of restraint and, assuming this is equally distributed among those patients, approximately 11 incidents of restraint per patient per year.

Mind (2013) referred to the significant variations in restraint levels across the country as "appalling". However, the report took no account of the differential bed capacity of services. This was reflected on in a statement by Tees, Esk and Wear Valleys NHS Foundation Trust, who reported the highest number of incidents at 3 346 (The Guardian, 2013): *"The number of incidents may seem high. However, we are one of the largest mental health and intellectual disability trusts in the country, with over 1 000 beds and a high proportion of specialist units caring for people with extremely challenging behaviour."* There is caution therefore needed in interpreting and responding to figures that may lack a critical appraisal and contextualisation. The following sections will describe a number of issues which should be taken into consideration when interpreting and reporting data on restrictive interventions.

## Issue 1: Practice quality, the last resort, least restrictive, poor practice and abuse

Numbers and statistics are often used alongside headlines or statements that suggest that due to their frequency of usage, restrictive interventions are not used as a last resort or that they are over relied upon. For example, Agenda (2017) stated that *"Around 1 in 5 women (6 393 female patients) admitted to mental health facilities were physically restrained, despite guidance it should be used as a last resort"*. Guidance states that if a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need (Department of Health, 2014).

Unfortunately, looking at numbers alone does not actually provide evidence as to whether physical restraint was the least restrictive option or used as a last resort, nor does it uncover poor practice or abuse. One of the most important figures when establishing whether a service uses restrictive interventions as a last resort is the number of incidents that are not managed using restrictive interventions but by using primary or secondary strategies. Numbers alone do not indicate anything about the standard of a service's wider restrictive intervention practice, such as robust policies, training programmes, care plan quality, safety processes, debrief procedures, as outlined by the Department of Health (2014; 2015). An example of this in Box 1, below.

**Box 1: Do numbers correlate with poor practice or abuse? – an illustrative example**

**Service A and Service B care for a similar patient population and have the same number of beds and occupancy level. Service A reports five restraints, while for the same timeframe, Service B reports 50. Using numbers alone, Service A 'sounds better' than Service B. However, upon further investigation of the incident accounts, the five restraints reported by Service A were 'heavy handed', carried out by untrained staff using non-approved techniques, and were 'unjustified' in the eyes of the Mental Health Act Code of Practice (2015), i.e. in response to low level behaviour which could have been managed via de-escalation. On the other hand, the 50 restraints reported by Service B, were justified in response to high-risk behaviour that was unmanageable by any other short-term method, and fully in accordance with the Mental Health Act Code of Practice (2015).**

The factors which support the development of a culture not reliant on restrictive interventions have been the subject of extensive research in healthcare settings internationally. Many of these factors are highlighted in Colton's (2004) nine domain checklist, which provides organisations with a systematic approach to the reduction of seclusion and physical restraint, as detailed in Box 2. When these areas are systematically addressed, restrictive interventions have been successfully reduced in services (Bjorkdahl, Hansebo, & Palmstierna, 2013). An example of how this manifests in clinical practice is detailed in Box 3. Factors considered might include the quality of the service's restrictive intervention reduction programme, individualised care plans and advance statements, the programme of educational and occupational activities, among many others.

### Box 2: Summary of Colton's (2004) checklist

1. Leadership
2. Orientation and training
3. Staffing
4. Environmental factors
5. Programmatic structure
6. Timely and responsive treatment planning
7. Processing after the event (debriefing)
8. Communication and consumer involvement
9. Systems evaluation and quality improvement

### Box 3: Colton's (2004) checklist in clinical practice – an illustrative example

Rachel, a 42-year-old lady admitted to an in-patient intellectual disability service, is sitting in an armchair on the corner of a ward, occasionally muttering to herself and biting her nails.

| **Scenario 1** | **Scenario 2** |
|---|---|
| Service A has strong leadership and management. Staff are confident that their managers will support them with their decisions. There is an experienced nursing team who all know Rachel well. The ward is well staffed, and therefore staff have time to spend with patients and respond to their needs. Her key nurse developed an extensive care plan which detailed how Rachel presents when she is upset or agitated, and how to respond to her in these situations. The team know that when she behaves in this way, Rachel is experiencing a problem she needs help with, as after a previous incident was reviewed, in which Rachel became violent and destroyed property on the ward, trigger factors were identified and strategies put in place.<br>One of Rachel's support workers notices she has withdrawn, and approaches her sensitively, asking if she would like a chat. Rachel confides that she has had an argument with her mum over the phone and is feeling a bit low and upset. They talk it through and Rachel calls her mum back to resolve things. Rachel feels better and reengages with everyone on the ward. There is no further incident. | Service B is currently experiencing a staffing crisis. Leadership is poor, staff are experiencing stress and burnout, and there is a high rate of sickness. The ward is currently being staffed by agency workers. Many of them have never worked on this ward before, and didn't get a very good handover. They haven't had any time to read the care plans and, as Rachel's key nurse has been off sick for 6 months, the plans haven't been reviewed and updated. The nurse in charge assumes her mutterings are due to psychosis, and, as she is being quiet and not causing any trouble, pays no further attention.<br>Another patient approaches Rachel and makes a comment about how miserable she looks. This is the last straw for her and she becomes even more agitated, verbally abusing the other patient. This escalates further into a huge argument. Nurses begin to approach the situation. One asks if she could move into a quiet room to calm down and places a hand on her arm to direct her. Rachel perceives this as a threat and becomes physically violent, requiring the initiation of physical restraint and seclusion. |

The ‘last resort’ concept has gained prominence in recent years. The Department of Health (2014, p.9) states that services should be developing cultures where restrictive interventions are only ever used when all other alternatives have been exhausted and deemed ineffective (Bonner et al, 2002; Moran et al, 2009; Riahi, Thomson, & Duxbury, 2016). This makes sense in many scenarios in which restrictive interventions could be used, such as when staff observe early signs of a behavioural incident developing, which may be unique to an individual patient, and initiate early interventions. However, some scenarios are too high risk to attempt to use a restrictive intervention as a last resort, for example if a patient runs out into a busy road. In this instance, physical restraint is likely to be the first resort. Deveau and McDonnell (2009) argue that the ‘last resort’ principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge (p.175). This opinion was echoed by Citarella (2013, p.1) who noted that all policies concerning physical restraint emphasise that it should be the *“last resort response, indeed Castlebeck Ltd’s* [the service provider of Winterbourne View] *own policy concerning physical restraint was no exception and yet it bore no resemblance to the practice filmed by an undercover journalist”.*

## Uncovering poor or abusive practice

The Department of Health (2014) states that if restrictive interventions are carried out for any other purpose than to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, concerns should always be escalated through local safeguarding procedures and protocols. Without a clear ethical basis and appropriate safeguards, such acts may be unlawful. Again, establishing the presence of poor practice, or indeed abuse, is not possible from figures and data. Lower numbers are meaningless, if the interventions forming those low numbers were either unjustified or disproportionate to the risk posed. Establishing poor or abusive practice is challenging, especially if people are deliberately hiding their wrongdoing, as was the case at Winterbourne View.

A current oversight is the lack of focus on routinely collected data on patient [and staff] injuries resulting from physical restraint, despite the findings of the Serious Case Review, which highlighted that patients at Winterbourne View sustained numerous significant injuries following restraint, including broken bones and teeth (Flynn, 2012), which was certainly a missed indicator of the level of abuse.

# Issue 2: Definitions and degrees of restrictive interventions

One of the main problems with restrictive interventions data, particularly relating to physical restraint, is that the data is self-reported by service providers who are utilising their own definitions which may not be aligned with the definitions provided by the government (Department of Health, 2014; 2015). This is partially related to the volume of Management of Violence and Aggression (MVA) training providers commissioned by care services, all of which use different techniques and terminology. This currently precludes the meaningful pooling and comparison of data between services.

Commentators tend to perceive the term 'physical restraint' as always involving patients being held on the floor, for example *"pinning learning disabled to the ground"* (Citarella, 2013, p.1). However, this is not the case. The Mental Health Act Code of Practice (Department of Health, 2015, p.295) provide the following definition, *"Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person"*. Mind (2011) found that the vast majority (91.4%) of physical restraints were not in the prone (face down) position.

Within most programmes of taught MVA techniques, there are levels of restraint from a lower to a higher intensity which are initiated depending on a number of factors, most importantly the level of behaviour demonstrated by the patient. Table 2 details an example of the levels/intensity of physical restraint. As is evident, a stage 1 hold looks very different and is much less restrictive than a physical restraint in the prone or supine position. Another important factor is the duration of the physical restraint, and the interaction between duration and the holds/techniques used, as there are demonstrated links between long instances of physical restraint in the prone position, and patient death (Duxbury, Aiken, & Dale, 2011). The example in Box 4 demonstrates this point. Little attention is given to these nuances within the reporting of physical restraint statistics, which means that all types are collated and reported together.

**Table 2: Example of MVA hold/ technique levels/intensity**

| MVA hold/technique | Description |
|---|---|
| Stage 1 hold | Patient held at elbow. |
| Stage 2 hold | Patient held at elbow and wrist. |
| Figure-of-four hold | Patient held at wrist and by over reaching arm. |
| Finger and thumb hold | More containing hold. Patient held by arm placed inside the patient's, and finger and thumb held without flexion beyond 45°. |
| Forearm hold | Inside arm hold with hand upon patient's wrist. |
| Palm hold | Inside arm hold with hand hold mirroring patient's thumb. |
| Restraint in chair | Patient restrained in a chair by staff in adjacent seats. |
| Supine | Restraint on the ground in a face-up position. |
| Prone | Restraint on the ground in a face-down position. |

**Box 4: Intensity and duration of physical restraint – an illustrative example**

**Service A reports five restraints, and Service B reports 50 restraints for the same timeframe. It is assumed that Service A is demonstrating better practice. However, on further investigation, all of Service A's five restraints are in the prone position, for 2 to 3 hours each. On the other hand, 40 of Service B's restraints are in the stage 1 hold detailed in Table 2, nine are in a stage 2 hold, and one is in the prone hold for 2 minutes, prior to turning the position into supine at the earliest opportunity.**

A further area of confusion within recording and reporting is how to deal with more than one instance of physical restraint occurring within one overall incident. An example of this is where a person within restraint appears to be becoming calm, leading to the physical restraint being ended, but who then begins to become aggressive again as soon as holds are released. Some services may report this as one incident in which physical restraint was used twice, while another may report this as two incidents of physical restraint. This can contribute to wide discrepancies in rates between services. In such instances, the antecedent to the physical restraint is likely to be the same as that immediately prior, with the same staff members involved etc. As such, it makes sense to have one overall incident report, in which multiple restraints can be recorded to reduce the burden of paperwork and from which the exact numbers of physical restraint used can be identified.

## Failure to record or under-reporting

There are also instances of staff and services either unintentionally or intentionally under reporting rates of restrictive interventions. This can range from poor or inconsistent record-keeping, to the intentional misrepresenting of events within incident records or failing to report incidents, in order to keep levels looking low. In 2012, the CQC (2012, p.42–43) found that not all service providers recognised that their practices constituted restrictive interventions, and were therefore not documented as such:

- *“We were advised by the registered manager that figure of four and thumb holds are used… the registered manager did not recognise this as restraint… it was evident there was not a clear plan or understanding of… what constituted restraint and what was reportable as restraint.”*

- *“We found a number of incidents where seclusion had been used and not recognised… a patient was being cared for separately by two staff in the management suite... While it was clear that this patient needed to be cared for in segregation due to the threat she posed to other patients and staff, the service was not managing this as seclusion. The service stated that the patient was in ’therapeutic segregation’.“*

This issue was reported as an ongoing concern in the recent Care Quality Commission report (2017). ‘The state of care in mental health services 2014 to 2017’, which stated that a number of instances were found where staff were not recording all incidents of restraint, seclusion or long-term segregation. Box 5 provides a transcript from the ‘Undercover Care: The Abuse Exposed’ Panorama documentary (BBC Panorama, 2011), where the undercover journalist and Wayne Rogers, the ring leader of the abusive group of staff at Winterbourne View, are discussing the fraudulent record-keeping of an incident of physical restraint. A similar transcript could be included from a more recent documentary which highlighted widespread abuse within a youth custody centre (BBC Panorama, 2016), in which staff were deliberately concealing their behaviour out of sight of CCTV and covering up violent incidents to avoid investigation (Horn, 2016). Clearly, this practice happens to an unknown extent, and has proved difficult for regulators to highlight, as noted by Flynn (2012, p.91): *“How the recommendation rendering restraint the intervention of last resort will address the falsified recording of restraint events witnessed during the Panorama broadcast is not clear.”*

### Box 5: Transcript from the “Undercover care: The abuse exposed” Panorama documentary (2016)

| | |
|---|---|
| **Commentator:** | **“Physical restraint, restraint, is such a serious step that each time it is used, official records must be kept.”** |
| **Undercover reporter:** | **“I need to go write that statement from earlier. What were you saying about it?”** |
| **Commentator:** | **“Wayne has to describe exactly what led to him dragging a patient from her bed. His account could be inspected by the bosses, or even the regulator, to make sure patients aren’t being abused.”** |
| **Wayne:** | **“…was reluctant to rise this morning and refused to attend to her personal hygiene. At 8:30 and despite staff’s efforts to direct her and offer of female support, myself and Joe attended and she became aggressive and started hitting out at myself. As a result, she was led her from her bedroom by myself and Joseph.”** |
| **Commentator:** | **“That’s not what happened. But a lot goes on at this hospital that doesn’t go into official records.”** |

Services which operate in this way are likely to have substantially lower rates of reported restrictive interventions, despite using interventions at a similar rate to other services. This could further explain some of the wide variation in reported rates. The most worrying aspect of such cases is that restrictive interventions are happening in the absence of any of the relevant governance processes and safeguards which should accompany their use, as described in Box 6.

### Box 6: Consequences of lack of recognition of restrictive interventions

**Service A reports 0 physical restraints, while Service B reports 15. The physical restraints reported by Service B are thoroughly documented, following the guidance set out in the Mental Health Act Code of Practice (Department of Health, 2015). Having access to these records means that the manager can look at the statistics and accurately review the care plans of patients involved, training needs for staff, and assess whether recommended processes are being followed, such as conducting a debrief and physical health observations. The managers of Service A think that their service doesn’t use any physical restraint because their statistics are so low. Due to this, they don’t offer relevant training or audit whether procedures are being followed and are out of touch with practices happening on the ward. However, a patient’s family member complains that their relative has hand-print bruises on his forearms and that none of the staff will say how they got there. Upon further investigation, it appears that this person is regularly being restrained by staff to stop him from hitting himself when distressed.**

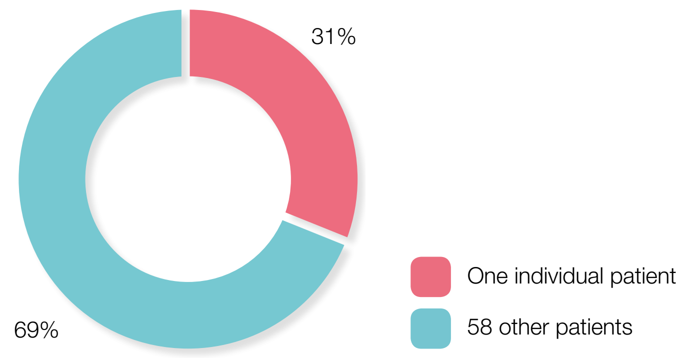
# Issue 3: Outliers

The way total rates of restrictive intervention are reported tends to assume an even, overall level for a ward or a service. However, this total figure is contributed to by the rates of individual patients, and the representation of these individuals' rates within the overall data do not tend to follow this even distribution. Rather, there is often one, or a small number of individuals who utilise the highest level(s) of restrictive interventions (outliers), followed by a few patients who utilise slightly more, while some patients are not involved in any incidents at all. So, a ward may have a relatively low level of restrictive interventions overall, yet have an outlier that inflates the overall rate, skews data, and masks underlying trends. Box 7, below, demonstrates the effect of an outlier.[3]

### Box 7: The effect of an outlier on service-level physical restraint data

**Commissioners and regulators raised concerns about the high level of physical restraint in a service. However, the service demonstrated that large proportions of the rate related to one individual patient, who as seen in the pie chart, accounted for 31% of physical restraint for the total service. This patient had a counterintuitive relationship with restraint, which for them served a containing function.**

**Figure 1: Distribution of physical restraint within the total service**



This effect was also reported in a statement issued by Northumberland, Tyne and Wear NHS trust following publication of the MIND report (2013): *"A small percentage of patients require high levels of restraint due to the complex nature of their illness. Analysis of our figures has shown that a small group of less than 50 patients, who demonstrate very complex and high-risk behaviours, account for over two thirds of the recorded incidents of restraint"* (The Guardian, 2013).

---

[3] Data used in Box 7, and in Box 8 which follows on, are from unpublished research conducted as part of a restrictive intervention audit conducted in 2015. More information is available from the author on request.

### Box 8: The effect of an outlier on ward-level physical restraint data

**The restraint rates of the individual patient from Box 7 had a pronounced effect on ward-level data, accounting for 75% of physical restraint on the ward.**

**Figure 2: Distribution of physical restraint within the ward**

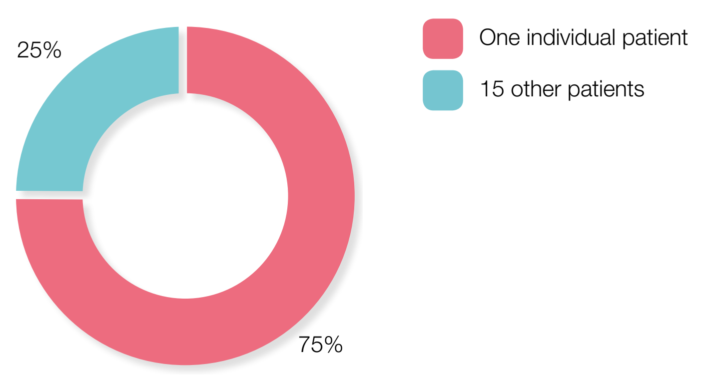


**Figure 3 below shows the total number of physical restraints for the ward by month, including the outlier patient's data. Figure 4 shows the rate without this patient's data. Evidently, the picture of physical restraint usage for the ward is completely different with this patient's data removed, demonstrating how one patient can inflate and skew the overall picture of practice in wards and services. Despite this, and as shown in Figure 3, the rates of such patients can improve over time, as longer-term interventions begin to take effect.**

**Figure 3: Total number of physical restraints for the ward by month, including the outlier patient's data**

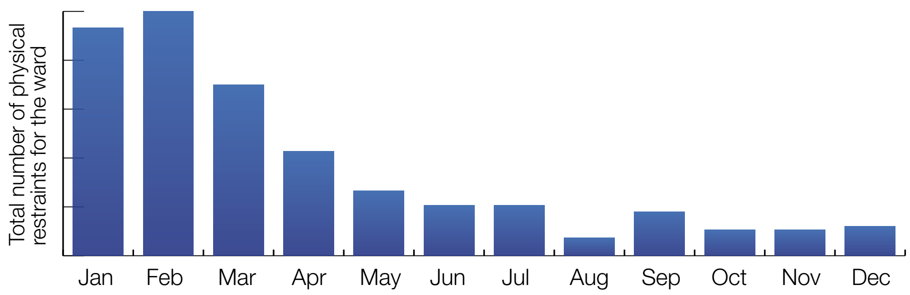
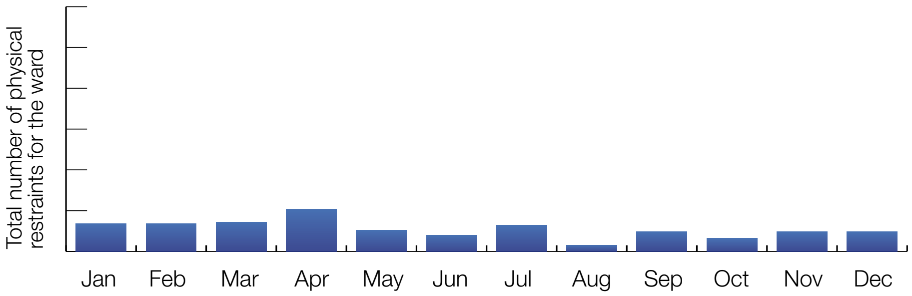


**Figure 4: Total number of physical restraints for the ward by month, excluding the outlier patient's data**

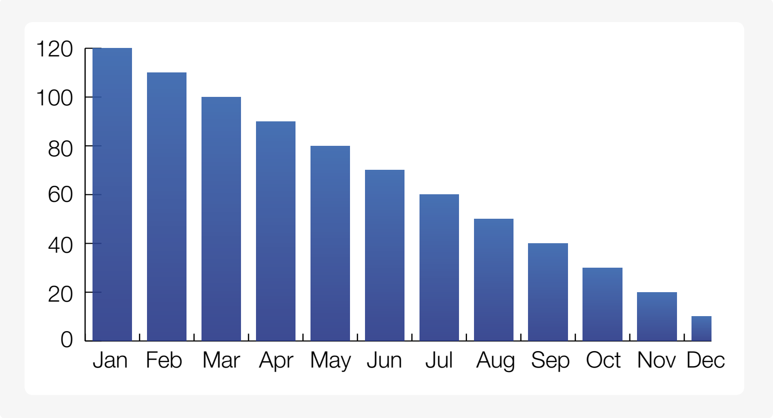


# Issue 4: Capturing individual patient progress, the whole picture of patient care, and restrictive interventions

## Capturing patient progress

Most providers audit their restrictive intervention reduction programmes at the service level, looking for a downwards trend on a bar chart, as seen in Figure 5. This is a useful approach if services are attempting to measure the effect of a new programme, such as Positive Behaviour Support (PBS) on overall service restrictive intervention rates.

**Figure 5: An illustrative example of a decline in restrictive interventions**



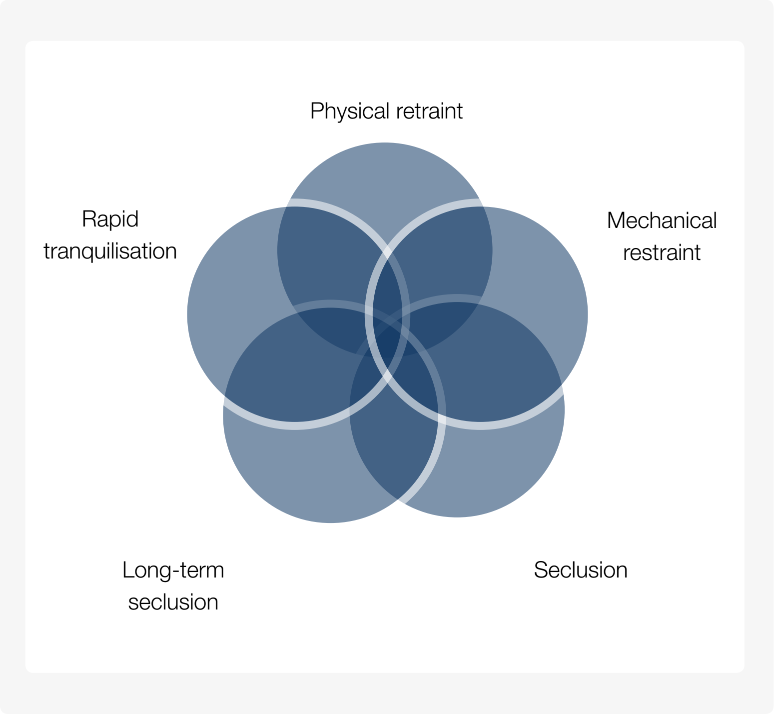
However, these rates are contributed to by many patients, all at differing stages of the care pathway. Therefore, these graphs overlook the progress of individual patients within the service.

## The whole picture of patient care and restrictive interventions

A further consideration when interpreting data is that restrictive interventions should only be used in instances where staff have to take immediate control of a dangerous situation in which there is a real possibility of harm to the person or others if no action is undertaken. Therefore, this data represents only one element of patient care and does not capture other domains, such as wellbeing, quality of life, physical health, engagement with friends and relatives, and occupational activities.

Furthermore, there are often intertwined relationships between different forms of restrictive interventions, such as physical restraint, mechanical restraint, seclusion, long-term segregation and rapid tranquilisation, as detailed in Figure 6. The positive behaviour support model aims to improve quality of life by better understanding the function behind challenging behaviour and implementing positive approaches to address this, thus reducing restrictive interventions. However, this progression is not always linear. For example, in order to support the reduction of long-term segregation, an individual patient is often exposed to a wide range of possible environmental stressors and this may increase behavioural incidents in the short term, which may necessitate physical restraint. Yet the patient may simultaneously experience improved quality of life through the environmental access, interacting with other people, increased levels of activities, etc.

**Figure 6: Inter-related forms of restrictive interventions**



It is therefore important to use data to establish the whole picture of restrictive interventions being utilised for an individual patient or within a service, such as physical restraint, seclusion and long-term segregation, alongside other aspects of care. This is to ascertain that certain restrictive interventions are not being used in place of another, and to ensure that positive aspects of patients' care are also being measured and reported on. This effect is depicted in Box 9 – Figure 7, which illustrates a seemingly positive decline in restrictive interventions when viewing physical restraint data in isolation. In this illustrative example, it appears that seclusion is being used in the place of physical restraint. Therefore, aggregating data on all restrictive interventions being used with an individual or within a service provides a more accurate reflection of practice, or the whole picture of restrictive interventions used with an individual.

Box 9: Aggregating data on all types of restrictive intervention

**Figure 7: An illustrative example of a decline in the number of physical restraints**

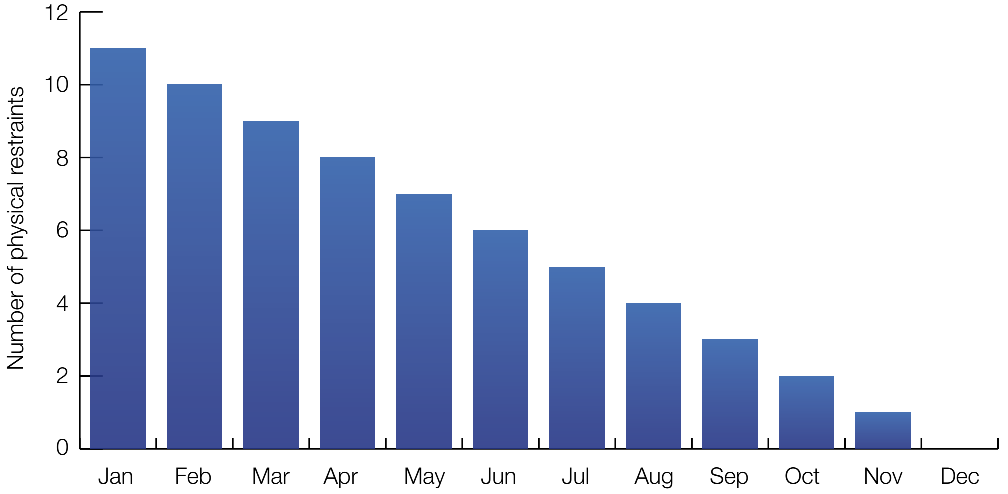
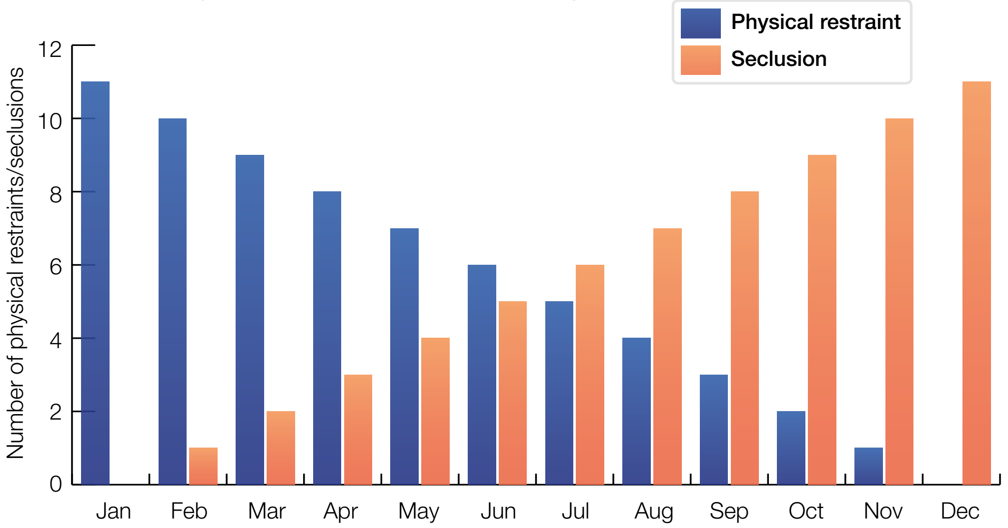


**Figure 8: An illustrative example of how aggregating data on all restrictive interventions provides a more accurate reflection of practice**



The consideration of patients' wishes is key in the interpretation of their rates of restrictive interventions, as the experience is highly subjective. For example, some people with ASD may find the touch experienced during a physical restraint extremely aversive. Others may be hypo-sensitive to touch and carry out actions in order to obtain the deep pressure of physical restraint, or find that physical restraint provides a 'containing' function (Steckley, 2012). For some, the use of medication may be preferred to physical restraint, for others the sedative side effects may be too debilitating for them. For some, the withdrawal of staff during seclusion may be a good outcome, for others this may be highly aversive. As such, attention must be paid to individual patients' preferences in the interpretation of their restrictive intervention rates, which may be recorded in care plans or advance statements.

## Issue 5: Lack of a benchmark

There is currently limited restrictive intervention benchmarking data available in the public domain. Benchmarking has a number of advantages in healthcare (Royal College of Nursing, 2017), including:

- providing a systematic approach to the assessment of practice
- promoting reflective practice
- providing an avenue for change in clinical practice
- ensuring pockets of innovative practice are not wasted
- reducing repetition of effort and resources
- reducing fragmentation/geographical variations in care
- providing evidence for additional resources

Benchmarking is essential in order to ensure references to restrictive intervention rates are not subjective. There is a tendency in official reports to say that the rate of restrictive interventions is 'high'- e.g.: Department of Health (2012). The word 'high' is problematic because it is subjective. What a staff nurse working on a high need medium secure ward perceives as high may be different to a care worker employed in a supported living service. A service may appear to have 'high rates' but these are all accounted for by one patient at the beginning of their care pathway. A service may have high rates, but these are all restrictive interventions at a lower degree, for example physical restraints for short durations of time, in low level holds. To more accurately assess which services truly have the highest levels (bearing in mind the many reasons why this may be the case), a benchmark is required which regularly compares rates of restrictive interventions across services.

A benchmarking exercise was undertaken in 2015 which investigated the use of restraint in mental health, child and adolescent, and intellectual disability services (NHS Benchmarking Network, 2015). Data was contributed by 51 NHS trusts and six independent sector organisations, on 23 415 beds in total, with 2 431 intellectual disability beds for Phase 2 which captured data for January 2015. Importantly, the benchmark uses the figure of restraint and prone restraint per 10 beds for one month, which takes service size/capacity into account.

The exercise reported a number of interesting findings. For example, rates of intervention between secure intellectual disability services followed a somewhat counterintuitive pattern, see Table 3 and Figure 9. The highest rates of restraint were observed in low secure services caring for lower risk patients, and the lowest levels of restraint were reported for high secure services caring for highest risk patients. There are a number of possible explanations for this. One is that patients in low secure services demonstrate lower risk but higher frequency behaviours, and are therefore involved in more restraints. Another is that patients in high secure services are in a more restrictive physical and procedural environment, under high levels of observation, or that higher proportions of patients are treated within conditions of long-term segregation, all of which affects rates of restraint.

This links back to the point made earlier, about assessing all aspects of patient care holistically.

Within intellectual disability services of the same category, there were also significant variations in restraint levels, as evidenced by the ranges in Table 3. In acute admission, although there was a mean rate of 17.5 restraints per month, individual service rates ranged from 0 to 120. This was raised by the CQC (2017, p.5): *"…we are concerned about the great variation across the country in how often staff physically restrain patients whose behaviour they find challenging. This wide variation is present even between wards that admit the same patient group."* It is unclear why services of the same category have such varying rates of intervention. Is the service with the highest rate one to worry about? Perhaps, but it is also possible they are treating one or a small number of individuals with high levels of restraint, which has skewed their service level figure. Or the service may be caring for more complex patients than other services within the same category. Although services share broad categories, such as 'acute admission', or 'low secure', their patient populations may not be directly comparable.

A number of patient factors have an impact on restrictive intervention rates, which are rarely considered in the interpretation of data. Recent analysis of restrictive intervention rates have been reported between patients of differential characteristics within forensic intellectual disability services. Women had significantly higher rates than men (Chester et al., 2018), and those with ASD had higher rates than people without ASD (Esan et al., 2015). If service configuration means that one service has more female patients, or an ASD specific ward, it might be that rates of restrictive intervention are higher in that service. While the relationship between mental health problems and 'challenging behaviour' in people with ID is complex, multifaceted, and potentially bidirectional, a more recent study reported that diagnostic co-morbidity is significantly correlated with aggression, self-injurious behaviour, and overall challenging behaviour ratings (Painter, Hastings, Ingham, Trevithick & Roy, 2018). People with more severe mental health problems exhibited more challenging behaviours, and people with more severe ASD exhibited more stereotyped behaviours and challenging behaviour overall.

Occupancy is another factor. If a service has been operating at 80% capacity, it is likely to have fewer incidents than a comparable service operating at 100% capacity. Another often-cited disparity between services of the same category is between those ‘within area’ and ‘out of area’. Out of area services relate to a patient using medium to long-term services away from their home area (Royal College of Psychiatrists, 2011) when demand for beds outstrips capacity or where specialist services are not available locally (Department of Health, 2012). A number of studies have found that patients sent to out of area placements are significantly different to those treated within area. McGill and Poynter (2012) found that out of area patients were largely young, male, with high rates of challenging behaviour and/or ASD. Allen, et al. (2007) found that predictors of out-of-area placement included behaviours resulting in physical injury, exclusion from service settings, a history of formal detention under the Mental Health Act, the presence of mental health problems, a diagnosis of ASD and higher rates of behavioural problems. Again, it may be that services with a high proportion of out of area patients have higher rates of restrictive interventions.

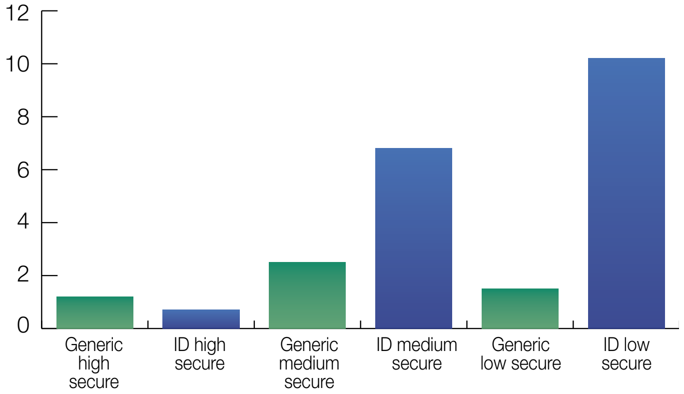
There were also differences between generic medium and low secure services, and ID specific secure services, where ID services reported much higher rates of restraint, see Table 3. This is not an isolated finding, as a number of research studies have reported increased rates of incidents among in-patients with ID (O’Shea, et al., 2015; Fitzgerald et al.; 2013; Uppal & McMurran, 2009). The reasons for this are unclear. One explanation is that the patients with ID display more challenging behaviours, or present with increased risks than patients without ID. This is supported by studies which report elevated risk assessment scores total and subscale scores among in-patients with ID, as compared to those without (e.g. Alexander et al., 2012; Morrissey, Milton & Beeley, 2014).

**Table 3: Mean and between service ranges of restraint per 10 beds for one month in ID services***

| Service category | Mean | Range | N services reporting above mean |
|---|---|---|---|
| Acute admission | 17.5 | 0 – 120 | 5 |
| Low secure | 10.2 | 0 – 33 | 5 |
| Medium secure | 6.8 | 0 – 25 | 4 |
| High secure | 0.7 | n/a* | n/a* |

*As there is only one high secure ID service, there is no comparison data.

**Figure 9: Rates of restraint for one month, per 10 beds, ID vs. generic secure services**



Throughout chapter 2, we have demonstrated a number of problems when attempting to assess restrictive interventions practice by solely relying on total numbers. These problems are summarised in Box 10.

**Box 10: Problems with using numbers to assess restrictive interventions practice**

**Numbers alone:**

- **do not demonstrate over-reliance on restrictive interventions, last resort/least restrictive practice, correlate with the overall standard of a service's restrictive intervention practices, or uncover poor practice or abuse**
- **are largely self-reported by services, using their own definitions of restrictive interventions, and do not discriminate between degrees of restrictive intervention**
- **do not account for the impact of 'outliers'**
- **do not capture the whole picture of care and individual patient progress**
- **are difficult to interpret due to the absence of a publicly available benchmark.**

# Chapter 3: Critique of current guidance on the recording, monitoring and regulation of restrictive interventions

It has become clear that there are problems with relying on data and statistics alone when assessing restrictive intervention practices within ID services, and that there is a need for further guidance in this area. This chapter will summarise and critique current guidance on the recording, monitoring and publishing of restrictive intervention data.

## Recording

The primary function of incident records are to document on a micro level, the behaviour displayed by a particular patient on a given day, and the way in which this behaviour was managed. These documents contain critical information on how the staff and service caring for an individual patient contribute to a developing knowledge of the patient's triggers to aggression and violence, the ongoing process of the assessment and management of risk, and safeguarding. These documents are kept for a number of years and can be referred to in the case of litigation by the patients and staff members involved in the incident.

Regarding the recording of restrictive intervention incidents, the Department of Health (2014) emphasises the need for rigorous reporting arrangements and is quite prescriptive about the need for a combination of quantitative and qualitative data:

*"Following any occasion where a restrictive intervention is used… a full record should be made. This should be recorded as soon as practicable (always within 24 hours of the incident). The record should allow aggregated data to be reviewed and should indicate:*

- *the names of the staff and people involved*
- *the reason for using the specific type of restrictive intervention (rather than an alternative and less restrictive strategy)*

- *the type of intervention employed*
- *the date and the duration of the intervention*
- *whether the person or anyone else experienced injury or distress*
- *what action was taken."*

*The Mental Health Act Code of Practice* (Department of Health, 2015) provides slightly different recording guidelines for each type of restrictive intervention, as detailed in Table 4. It also makes suggestions, such as evidencing that:

a verbal de-escalation is maintained through restrictive interventions

b a doctor attended in response to staff requests concerning a psychiatric emergency, whether in relation to medication, restraint or seclusion (if relevant) (p.295)

c family members were informed in accordance with any prior agreements (p.295).

The quality and standards of restrictive intervention records completion has been criticised. Citarella (2013, p.1) highlighted that at Winterbourne View, references to patients "having an unsettled day" were frequently used as justifications for physical restraint. The CQC (2012, p.23) stated the incident reports they inspected during their national review of services; *"Incident reports were not always completed appropriately… There was no evidence that the poor recording of incidents was picked up at any level in the organisation."* This is not acceptable.

| Table 4: Department of Health (2015) restrictive intervention recording guidelines | |
|---|---|
| Physical restraint | Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response (p.296). A member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded (p.295). |
| Mechanical restraint | The patient's clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews (p.297). |
| Rapid tranquillisation | Records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient (p.299). |
| Seclusion | The seclusion record should provide the following details (pp.307–308):<br>• who authorised the seclusion<br>• the date and time of commencement of seclusion<br>• the reason(s) for seclusion<br>• what the patient took into the seclusion room<br>• if and when a family member, carer and/or advocate was informed of the use of seclusion<br>• 15-minute recordings by the person undertaking continuous direct observation<br>• details of who undertook the independent Multidisciplinary team (MDT) review, their assessment and a record of the patient's condition and recommendations<br>• details of who undertook the scheduled MDT reviews, their assessment and a record of the patient's condition and recommendations<br>• the date and time seclusion ended<br>• details of who determined that seclusion should come to an end. |
| Long-term segregation | No specific instructions provided on recording instances where a patient is cared for in long term segregation. |

# Monitoring

There has been a recent initiative to move beyond simply recording or documenting incidents at the micro level, to using this data at the macro level to monitor and minimise restrictive interventions. Therefore, ideally, a services' system of recording will also allow the exploration of incident reports to facilitate the monitoring of restrictive interventions. The Department of Health (2014) also emphasises the importance of collation and monitoring of data on restrictive interventions, however, the guidance is much less prescriptive here. The document states that restrictive reduction programmes should be based on the principles of 'data-driven quality assurance' (p.22) and 'data informed practice' (p.32). But that is where the guidance ends, leaving the question, how exactly should restrictive interventions be monitored in services?

The use of data to support restrictive intervention reduction is a practice which is patchy across services. Data has been described as a vital component of the PBS approach, which is concerned with the science of behaviour change, thus requiring observable measurements (Bowring, 2015). Bowring describes five purposes of data in relation to PBS:

1. To determine the relevance of PBS interventions, and intervention should only occur following detailed consideration of the issue and whether it warrants any intervention.
2. To analyse the function or purpose of any problem behaviour objectively which helps select the most appropriate, person-centred intervention.
3. To measure changes in behaviour and study the impact and effectiveness of interventions, by maintaining direct and continuous contact with the behaviour under investigation.
4. To measure the acquisition of new skills and to assess whether these last and are being used in different settings (they have generalised).
5. To measure lifestyle changes and the achievement of quality of life outcomes.

Following their national review of services, the CQC (2012, pp.42–43) highlighted that the services which were compliant with their inspection criteria recorded incidents of restrictive interventions and analysed them to look for trends. Services learned from this and fed information back into people's care plans to reduce the chances of restraint being needed in the future. For example: *"The care plans we looked at showed us that incidents of challenging behaviour had been reviewed and analysed at each weekly meeting. When triggers* *to a young person's challenging behaviour were identified, the care plan was amended and this was confirmed by the young people we spoke to."*

## Publishing

Further to the guidance on reporting, and recommendations on monitoring, the guidance states that *"Accurate internal data must be published by providers including progress against restrictive restraint reduction programmes… in annual quality accounts or equivalent"* (Department of Health, 2012, p.11). Again, however, the document gives no guidance as to exactly what services should be publishing. Few services routinely publish this data, and as such, there is very limited information in the public domain. On the other hand, in the absence of prescriptive guidance on exactly what to publish, services are currently free to set their own reporting parameters, which could lead to misleading reports, and further difficulties in comparing rates between services.

## Inspection/regulation

While regulators always ask questions about restrictive interventions (Kelsall and Devapriam, 2015), inspectors largely rely on data and statistics to make assumptions about restrictive intervention practice. This fails to take into account a number of the problems with this data that have been described earlier in this report. This is a critical challenge facing regulators. Table 5 describes and critiques the data typically requested by the CQC prior to and during inspections of intellectual disability services.

| Table 5: Information on restrictive interventions requested by the CQC | |
|---|---|
| **Total incidents for a whole service in the last 6 months:**<br>• **Seclusion**<br>• **Long-term segregation**<br>• **Restraint**<br>• **Prone restraint**<br><br>**How many of the 'prone restraints' resulted in rapid tranquilisation?**<br><br>**On how many different service users was restraint used?** | **Does not capture:**<br>☒ **Whole service change over time**<br>☒ **Proportion of restrictive interventions accounted for by individual patients, particularly the impact of outliers/new admissions**<br>☒ **Individual patient progress**<br>☒ **Information on intensity of the holds used or intervention duration**<br>☒ **Any comparison to a publicly available benchmark**<br>☒ **Information on injuries.** |

# Chapter 4: Recommendations on recording, monitoring and regulation of restrictive interventions

In chapters 2 and 3, the current approach to monitoring of restrictive interventions in ID services, which relies mainly on the analysis of service defined and provided data, is critiqued. A number of recommendations are made relating to the recording, monitoring, publishing, and regulation of restrictive interventions practice.

## Recording

Recording recommendations relate to improving the quality of incident reporting systems and information technology (IT) software/ databases and implementing processes to ensure the quality of information entered into incident reports. We make the following recommendations:

1. Services should have a good quality system of recording incidents of restrictive interventions, which incorporates variables specified by government guidance (Department of Health, 2014; 2015).

2. Incident records within this system should be well written and present a cohesive representation of the events leading to, and during, the restrictive intervention, particularly focusing on justification for their use, and stating how the intervention represented the least restrictive option and what physical health observations were undertaken.

3. Services should consider moving away from paper-based recording systems, which have limited utility in the monitoring of restrictive interventions, in favour of IT software packages or databases. IT software systems are the preferred mode of recording due to being more robust and their potential to improve the quality of quantitative and qualitative restrictive interventions data

4 Such systems should be developed in conjunction with all stakeholders of the software, including the individuals who will be entering incident reports, and those who will access the data for monitoring/regulation.

5 Software developers should consider 'forced response' formats to ensure that all required data is completed within incident report entries.

6 Software should bte kept up to date, with new patient details recorded on their admission to the service, new staff member information recorded on their appointment, and particular MVA techniques taught in the service.

7 Software should be set up to prompt users entering data to ensure their incident report demonstrates compliance with current government guidance (Department of Health, 2014; 2015), with statements such as 'Describe how this intervention represented the least restrictive response to the patient's behaviour' or 'Describe the physical health observations which were undertaken during the restrictive intervention'.

8 The system should be reviewed and updated on an ongoing basis, to maintain its quality and utility.

9 It is recommended that staff who are required to write incident reports as a requirement of their role are given full training in the correct process. This training must emphasise the importance of quality incident reports, and cover government requirements (Department of Health, 2014; 2015).

10 Services should provide supervision and mentoring to staff in this element of their role.

11 Incident reports should be checked and signed off by a senior member of staff.

12 Services should regularly audit incident reports to ensure they meet the required standard.

## Monitoring and regulation

In this section, we make recommendations which will assist services, regulators, and other stakeholders to analyse, interpret and report restrictive interventions data, and to assess wider restrictive intervention practice quality.

13 Services should generate statistics/reports on restrictive interventions as defined by the Department of Health (2014; 2015), for any reasonably requested timeframe on a whole service, ward, and individual patient level.

14 Service/ward level reports should include:

- a Total frequency of each restrictive intervention
- b Total number, level and type of incidents which do not result in restrictive intervention
- c Duration of restrictive interventions, with a full categorical breakdown in addition to average and range
- d Holds/techniques used for physical restraint, with a full categorical breakdown (this figure is likely to be higher than the total frequency of restrictive interventions, due to incidents of restraint which utilise more than one holding technique)
- e Trends in rates over time, day of the week, week in the month, and month of the year. If incidents peak on particular days or at certain times, this can direct the exploration of the activities, procedures, staffing levels and interventions of an individual/ward/service, as necessary
- f An investigation or analysis of decreases, increases and/or maintenance
- g Total number and extent of any patient injuries sustained within restrictive interventions
- h The number of individual patients represented within the data, expressed as a percentage of total patients treated within this timeframe
- i Progress of all patients against the aims of the services chosen restrictive intervention programme, ideally using the 'traffic light audit'
- j The contribution of individual patient rates to the overall total for the ward or the service. If there are any outlier(s) which significantly affect the overall total, or trends, report rates with and without the outlier data
- k Details of how rates compare to a national benchmark
- l Number of beds, and occupancy level of service for timeframe
- m Cohort characteristics, such as gender, ethnicity, diagnoses, behavioural and/or offence profile.

15 Individual patient level reports should include:

- Items a–m, as on the previous page
- A brief description of a patient's demographic information, and psychiatric and forensic history (where relevant)
- Services should be able to generate statistics on the levels of restrictive interventions for the entirety of a patient's admission and, if available, pre-admission
- Reports should include details of the patient's management plan, e.g. level of observation, medication, level of engagement, assessments and treatment plans.

We also make a number of recommendations in order to overcome some of the identified limitations with restrictive interventions data.

## Overcoming issue 1: Assessing practice quality, over-reliance, the last resort, least restrictive, poor practice and abuse

**Assessing the quality standard of a service's restrictive intervention practices:**

16 To truly capture the quality of a service's restrictive intervention practice, there must be less focus on the number of restrictive interventions, and more on a service's adherence to the standards outlined by government guidance (Department of Health, 2014; 2015).

This is likely to encompass restrictive intervention factors such as:

a Staff training in primary and tertiary strategies, training in safe restrictive intervention techniques, restrictive intervention reduction programme, the quality of advance statements and individualised restrictive intervention care plans, physical health observations and debriefing processes

b Wider practice quality issues, such as leadership, staffing levels, environmental considerations, engagement, patient assessment, therapies and management.

### Assessing the principles of last resort and least restrictive practice

17 It is recommended that qualitative incident accounts, or a representative subsample thereof, are inspected on an incident-by-incident basis in order to assess whether the record adheres to the principles of least restrictive practice. For example: Was the decision-making process for restrictive intervention by staff described? Was this decision justified, for the patient's own, or others' safety? Was it reasonable and proportionate? Was it the least restrictive way the behaviour described could have been managed? Was the intervention subject to regular review by staff and curtailed as quickly as possible? This is a much more time-consuming task, but a much more meaningful one, and is dependent on a good standard of written incident reports.

### Uncovering poor practice, or abuse of restrictive interventions

18 If it appears that restrictive interventions are being carried out for any other purpose than to take immediate control of a dangerous situation, it is recommended that concerns should be escalated through local safeguarding procedures and protocols.

19 It is recommended that regulators request information on the number patient injuries sustained during restrictive interventions, except where these relate primarily to instances of self-harm/injury.

20 Regulators should cross reference data on restrictive interventions with information from other sources, including their observations, patient and carer reports, safeguarding referrals, police reports, etc.

## Overcoming issue 2: Definitions and degrees of restrictive interventions

21 It is recommended that policymakers develop a framework of restrictive intervention severity/intensity. This should encompass the full range of physical restraint techniques used by multiple training providers, as well as the duration of physical restraint, seclusion, and long-term segregation. This would provide an element of standardisation, move towards more consistent recording between service providers, and support the comparability of data.

22 It is recommended that in the interim, services should record, monitor, and report the full framework of techniques used.

23 Services which report comparatively lower numbers of restrictive interventions should have their practice inspected as rigorously as those which report higher numbers.

## Overcoming issue 3: Accounting for the impact of outliers

24 It is recommended that services provide a breakdown of restrictive intervention data from the total number for a whole service, to the ward level, and individual patient level. This can be done utilising widely available software, Microsoft Excel, using the Pivot Table function, which can facilitate the analysis of a large, detailed datasets quickly and easily. This function can also be used to view the proportion of restrictive interventions accounted for by individual patients, and ward or service level data can be viewed and presented with and without the data of individual outlier patients.

25 Service providers can also report multiple measures of central tendency, such as the median, in addition to the mean, which is particularly susceptible to the effects of outliers.

## Overcoming issue 4: Capturing the whole picture of patient care and restrictive interventions

### Establishing individual patient progress

26 Services should analyse the progress of individual patients for a clearly specified timeframe. This can be achieved using the 'traffic light' audit method. The traffic light method involves viewing the restrictive interventions rates of all patients within the service, and then categorising them into one of the three categories outlined in Box 11. This can be useful through the audit cycle or, ideally, the whole duration of a patient's admission as detailed in Table 7. This should include the number of patients treated in the timeframe specified, and the proportion who have been involved in restrictive interventions.

27 Services should request information about the levels of restrictive interventions and management plans from the referring service, report these alongside current levels, and pass on this information when discharging patients, with clear reporting parameters, if this information is available.

### Box 11: ‘Traffic light’ restrictive intervention audit method: categories

**Table 6: ‘Traffic light’ restrictive intervention audit method: categories**

| | |
|---|---|
| 🔴 | Increase/new admission |
| 🟡 | Low or stable |
| 🟢 | Decrease/discharged |

**Table 7: An illustrative example of the ‘traffic light’ restrictive intervention audit method demonstrating an individual patient focus**

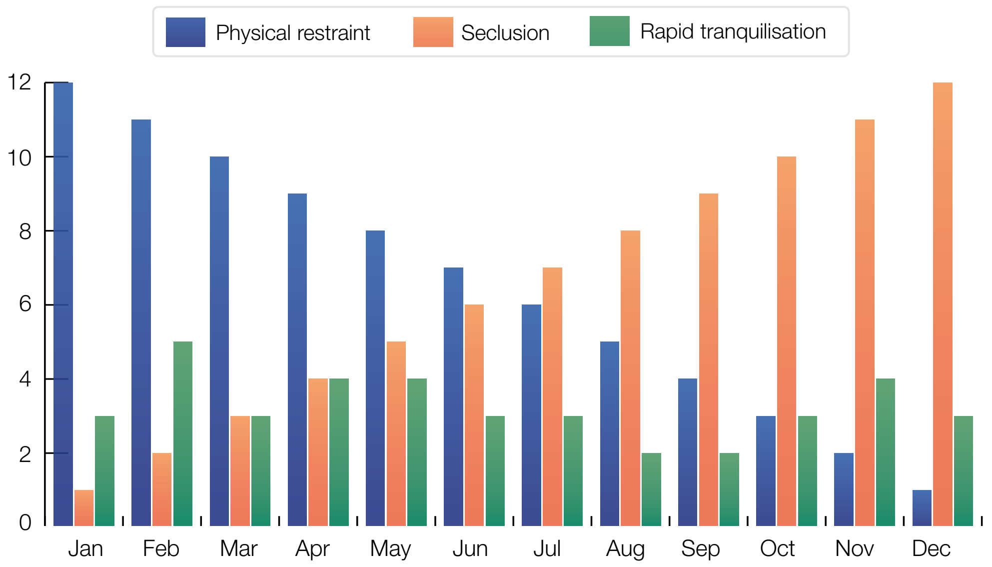
| Patient name | Jan | Feb | Mar… | …Oct | Nov | Dec | Status |
|---|---|---|---|---|---|---|---|
| Isabelle | | | | 1 | 1 | | Increase |
| Emma | 1 | | | | 3 | 15 | Increase |
| Pauline | | | | | 9 | 4 | New admission |
| Justine | | | | 4 | 2 | | New admission |
| Fauzia | 3 | | 3 | 1 | 2 | 2 | Low/stable |
| Joanne | 1 | 1 | | | | | Low/stable |
| Julia | | | | | | | Low/stable |
| Jessica | 34 | 19 | 10 | 16 | 9 | 16 | Decrease |
| Kerry | 9 | 9 | 11 | 6 | 4 | 5 | Decrease |
| Michelle | 52 | 82 | 35 | 14 | 7 | 14 | Decrease |
| Alia | 18 | 18 | 11 | 2 | 4 | 2 | Decrease |
| Jeanette | 22 | 27 | 30 | 16 | 12 | 19 | Decrease |

## Capturing the whole picture

28 Services should monitor and report all types of restrictive interventions used with an individual patient, using visual aids such as the example depicted in Figure 10.

This should take into account any patient preferences as specified in advance statements or similar, and recognise that this data represents only one element of patient care, and does not capture other domains, such as wellbeing, quality of life, physical health,

Figure 10: An illustrative example of how restrictive intervention rates for an individual



## Overcoming issue 5: The absence of a publicly available benchmark

29 National benchmarking data must be strengthened via the inclusion of a wider range of variables, and be publicly available to all.

30 Benchmarking processes must consider the highlighted issues with restrictive interventions data, and take steps to counter these in reports.

### Using data to support the reduction of restrictive interventions

31 Services must demonstrate the use of data to support restrictive intervention reduction.

a This might involve regular reviewing of incidents and subsequent debriefs, identifying any triggers, or learning points and feeding these back in to care plans. It could involve viewing of restrictive intervention rates in team meetings and care reviews, identifying patterns of use, and addressing any underlying reasons for these. This could involve highlighting particular times of day where incidents peak (as demonstrated in Figure 10), particular days of the week (as demonstrated in Figure 11), differences between shift patterns, etc. When reviewing individual patients, these factors are likely to be highly personalised and their care plans should reflect this.

Figure 11: An illustrative example of incident patterns at different times of the day

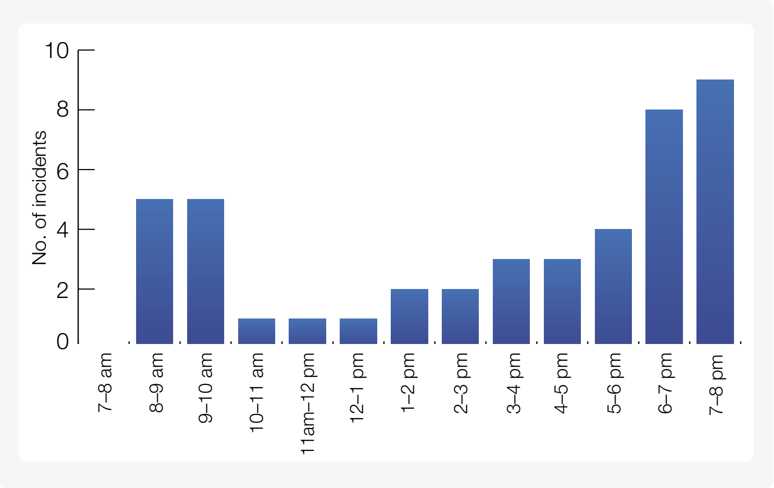
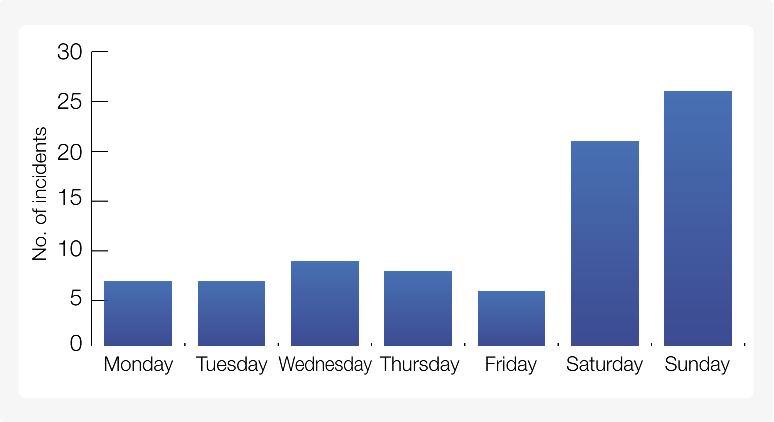


Figure 12: An illustrative example of incident patterns at different times of the week



b Services may also choose to record a wider range of measures in addition to restrictive intervention rates, as identified by Bowring (2015). These might include behaviour rating scales, quality of life measures, patient satisfaction etc.

## Publishing

32 Any publication of restrictive intervention data should adhere to the above guidance.

33 Reports should relate to a clearly specified timeframe.

# Conclusions

In the years following the Winterbourne View abuse scandal, there has been an understandable level of concern surrounding the use of restrictive interventions involving people with mental disorders and intellectual disabilities, and a call to reduce such interventions. This concern has been evident in the reporting of statistics and data pertaining to such practices, characterised by emotive headlines and reports. This reporting has arguably contributed to an increasing contrast between the public face of these interventions, compared to clinical reality. These points are not intended to downplay concerns about restrictive intervention use, but to highlight the importance of transparent, ethical and authentic data reporting (Marco and Larkin, 2000) to support the shared aim of all stakeholders in restrictive intervention reduction.

Data monitoring has numerous benefits, including the potential to support restrictive intervention reduction, but needs to be recognised as one tool in the toolbox, of a long-term, multicomponent, whole service approach, such as that described by Colton (2004). Progress has been made in the form of rigorous recommendations relating to recording of restrictive interventions at the service level, in *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014). However, the monitoring of data on restrictive interventions appears to be a neglected and underdeveloped area within services (CQC, 2012), and guidance on data monitoring has been less prescriptive. Furthermore, the complexity of this data is often unappreciated, and its interpretation needs to be approached in a considered way. This report has highlighted a number of contextual factors to consider when reporting and interpreting restrictive interventions data, for all stakeholders. There is clearly a need for guidance pertaining to the monitoring and communication of physical restraint and other restrictive intervention data, for both service providers and regulators, and starting points are offered in the form of recommendations. These points can be treated both as self-assessment audit standards for services and guidance for regulators.

NHS England and partners are currently working to develop common definitions, improve recording, monitoring and regulation of restrictive interventions in in-patient settings for people with ID. The recommendations made in this report will be useful to build on existing guidance especially for people with ID in in-patient settings.

# References

Agenda (2017). *Agenda briefing on the use of restraint against women and girls.* https://weareagenda.org/wp-content/uploads/2017/03/Restraint-FOI-research-briefing-FINAL1.pdf (Accessed 13 March 2018).

Alexander, R. T., H*iremath, A., Chester, V., Green, F. N., Gunaratna, I. J., & Hoare, S.* (2011). Evaluation of treatment outcomes from a medium secure unit for people with intellectual disability. *Advances in Mental Health and Intellectual Disabilities*, 5(1) 22-32.

Alexander, R.T., Chester, V., Gray, N.S. & Snowden, R.J. (2012). Patients with Personality Disorders and Intellectual Disability – Closer to Personality Disorders or Intellectual Disability? A Three-way Comparison. *Journal of Forensic Psychiatry and Psychology*, 23(4) 435-45.

Allen, D. G., L*owe, K., Moore, K., & Brophy, S.* (2007). Predictors, costs and characteristics of out of area placement for people with intellectual disability and challenging behaviour. *Journal of Intellectual Disability Research,* 51(6) 409-416.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5).* Arlington: American Psychiatric Publishing.

BBC News (2012). W*interbourne View: Care workers jailed for abuse. Available from:* http://www.bbc.co.uk/news/uk-england-bristol-20092894 (Accessed 13 March 2018).

BBC Panorama. (2011). Un*dercover care: the abuse exposed. Available from:* www.bbc.co.uk/programmes/b011pwt6 (Accessed 13 March 2018)

BBC Panorama. (2016). T*eenage Prison Abuse Exposed. Available from:* http://www.bbc.co.uk/programmes/b06ymzly (Accessed 13 March 2018)

Bhaumik, S., Tyr*er, F. C., McGrother, C., & Ganghadaran, S. K.* (2008). Psychiatric service use and psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research,* 52(11) 986-995.

Bjorkdahl, A., Ha*nsebo, G., & Palmstierna, T.* (2013). The influence of staff training on the violence prevention and management climate in psychiatric in-patient units. *Journal of Psychiatric and Mental Health Nursing,* 20, 396–404.

Bonner, G., Lo*we, T., Rawcliffe, D., & Wellman, N.* (2002). Trauma for all: a pilot study of the subjective experience of physical restraint for mental health in-patients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9, 465–473.

Bowring, D. (2015). *Reducing Restrictive Practice through data informed Positive Behaviour Support. Available from:* https://www.researchgate.net/publication/317070313_Reducing_Restrictive_Practice_through_data_informed_Positive_Behaviour_Support (Accessed 25 April 2018)

Calkin, S. (2012). Winterbourne view report calls for ban on physical restraint. *Nursing Times.* Available from: www.nursingtimes.net/nursing-practice/clinical-zones/learning-disability/winterbourne-viewreport-calls-for-ban-on-physical-restraint/5048058.article (Accessed 13 March 2018)

Care Quality Commission (2012). *Learning disability services inspection programme: National overview. Newcastle upon Tyne: Author.* https://www.cqc.org.uk/sites/default/files/documents/cqc_ld_review_national_overview.pdf (Accessed 14 March 2018)

Care Quality Commission (2015). *Inspection Report: Vista Healthcare Independent Hospital.* Available from: http://www.cqc.org.uk/sites/default/files/1-131732638_Vista_Healthcare_Independent_Hospital_INS1-1919565242_Responsive_-_Follow_Up_24-04-2015.pdf (Accessed 14 March 2018)

Care Quality Commission (2017). *The state of care in mental health services 2014 to 2017.* http://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017 (Accessed 14 March 2018)

Care Quality Commission and National Mental Health Development Unit (2011). *Count me in 2010.* Available from: http://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf (Accessed 14 March 2018)

Carulla, L. S., Reed, G. M., Vaez-Azizi, L. M., Cooper, S., Leal, R. M., Bertelli, M. et al. (2011). *Intellectual developmental disorders: toward a new name, definition and framework for "mental retardation/intellectual disability" in ICD-11.* World Psychiatry, 10, 175–80.

Chaplin, R. (2009). New *research into general psychiatric services for adults with intellectual disability and mental illness. Journal of Intellectual Disability Research, 53*(3) 189-199.

Chester, V., Alexander, R. T, & Lindsay, W. R. (2018). Women with Intellectual Disabilities and Forensic Involvement. In W. R. Lindsay and J. L. Taylor (Eds). *The Wiley Handbook on Offenders with Intellectual and Developmental Disabilities.* John Wiley and Sons Ltd.

Chilvers, J., & Th*omas, C.* (2011). Do male and female forensic patients with learning disabilities differ on subscales of the Novaco Anger Scale and Provocation Inventory (NAS-PI)? *Journal of Learning Disabilities and Offending Behaviour,* 2(2) 84-97.

Citarella, V. (2013). *No justification for pinning learning disabled to the ground.* Available from: http://www.socialcareworker.co/2013/02/06/no-justification-for-pinning-learning-disabled-to-the-ground/ (Accessed 4 March 2018)

Colton, C. (2004). Ch*ecklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint.* https://www.crisisprevention.com/getattachment/ed8b28ff-e352-4e2e-98ef-c7dc2c7342f4/Colton-checklist-readiness.pdf (Accessed 25 April 2018)

Cooper, S.A., S*miley, E., Morrison, J., Williamson, A., & Allan, L.* (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *British Journal of Psychiatry,* 190(1) 27-35.

Cooray, S.E., B*haumik, S., Roy, A., Devapriam, J., Rai, R. and Alexander, R.* (2015). Intellectual disability and the ICD-11: towards clinical utility? *Advances in Mental Health and Intellectual Disabilities*, 9(1) 3-8.

Council of Europe (1950) The European Convention of Human Rights.

Department of Health (2001). *Valuing People: A New Strategy for Learning Disability for the 21st Century (White Paper).* London: Author. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf (Accessed 14 March 2018)

Department of Health (2012). *Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report. London: Author.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf (Accessed 14 March 2018).

Department of Health (2014). *Positive and Proactive Care: reducing the need for restrictive interventions. London: Author.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf (Accessed 14 March 2018)

Department of Health (2015). *Mental Health Act 1983: Code of Practice. Norwich: The Stationary Office.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF (Accessed 14 March 2018)

Devapriam, J., Ro*senbach, A. & Alexander, R.* (2015). In-patient services for people with intellectual disability and mental health or behavioural difficulties. *BJPsych Advances,* 21(2) 116-123.

Deveau, R., & Mc*Donnell, A.,* (2009). As the last resort: reducing the use of restrictive physical interventions using organisational approaches. *British Journal of Learning Disabilities,* 37(3) 172-177.

Emerson, E., & Baines, S. (2010). Health Inequalities & People with Learning Disabilities in the UK: 2010. Learning Disability Observatory. https://pure.strath.ac.uk/portal/files/7402206/vid_7479_IHaL2010_3HealthInequality2010.pdf (Accessed 10 March 2018)

Emerson, E., Hatton, C., Robertson, J., Roberts, H., Baines, S., & Glover, *G.* (2011) *People with Learning Disabilities in England 2010: Services & Supports.* Improving Health and Lives: Learning Disabilities Observatory. www.researchgate.net/publication/265072288_People_with_Learning_Disabilities_in_England_2010 (Accessed 10 March 2018)

Esan, F., Che*ster, V., Alexander, R. T., Gunaratna, I. J., & Hoare, S.* (2015). An analysis of the clinical, forensic, and treatment outcome factors of those with Autistic Spectrum Disorders treated in Forensic Intellectual Disability Settings. *Journal of Applied Research in Intellectual Disabilities,* 28(3) 193-200.

Fitzgerald, S., Gra*y, N. S., Alexander, R. T., Bagshaw, R., Chesterman, R., Huckle, P., Jones, S. K., Taylor, J., Williams, T., & Snowden, R. J.* (2013). Predicting Institutional Violence in Offenders with Intellectual Disabilities: The Predictive Efficacy of the VRAG and the HCR-20. *Journal of Applied Research in Intellectual Disabilities,* 26, 384–393.

Flynn, M. (2012). *South Gloucestershire Safeguarding Adults Board Winterbourne View Hospital A Serious Case Review.* http://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/ (Accessed 12 March 2018).

Health and Social Care Information Centre (2013). *Learning Disabilities Census Report – England, 30th of September 2013. London: Author.* https://digital.nhs.uk/catalogue/PUB19428 (Accessed 14 March 2018).

Horn, J. (2016). I*nvestigation into abuse at Medway Secure Training Centre in Rochester sparks parliamentary debate. Kent Online. Available from:* http://www.kentonline.co.uk/medway/news/youth-offender-staff-punched-and-48854/ (Accessed 15 February 2016)

Kelsall, A., & De*vapriam, J.* (2015). Regulation of intellectual disability services. *Advances in Mental Health and Intellectual Disabilities,* 9(3) 101-107.

Koritsas, S. & Ia*cono, T.* (2012). Challenging behaviour: the causes (part II). *Advances in Mental Health and Intellectual Disabilities,* 6(5) 236-248.

Larkin, P., Ja*hoda, A. & MacMahon, K.* (2013). The Social Information Processing Model as a Framework for Explaining Frequent Aggression in Adults with Mild to Moderate Intellectual Disabilities: A Systematic Review of the Evidence. *Journal of Applied Research in Intellectual Disabilities,* 26, 447–465

Mail Online (2015). *Mental health patients evacuated from private hospital after 'disturbing' number of violent incidents and wrongful restraint.* Available from: http://www.dailymail.co.uk/health/article-2955646/Mental-health-patients-evacuated-private-hospital-disturbing-number-violent-incidents-wrongful-restraint.html (Accessed 13 March 2018)

Marco, C.A. & L*arkin, G.L.* (2000). Research Ethics: Ethical Issues of Data Reporting and the Quest for Authenticity. *Academic Emergency Medicine*, 7(6) 691 – 694.

McGill, P. & Poynter, J. (2012). High Cost Residential Placements for Adults with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities,* 25(6) 584-587.

McNamara, N. (2012). *Speech and language therapy within a forensic support service. Journal of Learning Disabilities and Offending Behaviour, 3*(2) 111-117.

Mind (2013). *Mental Health Crisis Care: Physical Restraint in Crisis. Available from:* https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf (Accessed 13 March 2018)

Moran, A., Cocoman, A., Scott, P.A., Matthews, A., Staniuliene, V., & Valimaki, M. (2009). Restraint and seclusion: a distressing treatment option? *Journal of Psychiatric & Mental Health Nursing,* 16, 599–605.

Morrissey, C., Beeley, C., & Milton, J. (2014). Longitudinal HCR-20 scores in a high-secure psychiatric hospital. *Criminal Behaviour and Mental Health,* 204(3) 169-80.

NHS Benchmarking Network (2015). *Use of Restraint in Mental Health, CAMHS and LD Phase 2 Data Collection: Participant Feedback. Available from:* http://mhforum.org.uk/upload/file/documents/NHSBNRestraint110315FINALZP.pdf (Accessed 13 March 2018)

O'Shea, L., Picchioni, M., McCarthy, J., Mason, F., & Dickens, G. (2015). Predictive validity of the HCR-20 for inpatient aggression: the effect of intellectual disability on accuracy. *Journal of Intellectual Disability Research,* 59(11) 1042–1054.

Painter, J., Ingham, B., Trevithick, L., Hastings, R.P., & Roy, A. (2018). Correlates for the risk of specialist ID hospital admission for people with intellectual disabilities: development of the LDNAT inpatient index. *Tizard Learning Disability Review*, 23(1) 42-50.

Parkin, E., Kennedy, S., Bate, A., Long, R., Hubble, S., & Powell, A. (2018). Learning Disability - policy and services. London: House of Commons Library. Available from: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07058 (Accessed 27 November 2018)

Riahi, S., Thomson, G., & Duxbury, J. (2016). An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint. *Journal of Psychiatric and Mental Health Nursing,* 23(2) 116-28.

Royal College of Nursing (2008). *"Let's talk about restraint": Rights, risks and responsibility. London: Author.* https://www.rcn.org.uk/professional-development/publications/pub-003208 (Accessed 13 March 2018)

Royal College of Nursing (2017). *Understanding benchmarking: RCN guidance for nursing staff working with children and young people. London: Author.* https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2017/ocotber/pdf-006333.pdf (Accessed 9 November 2018)

Royal College of Psychiatrists (2011). *In Sight and in Mind: a Toolkit to Reduce the Use of Out-of-Area Mental Health Placements. London: Author.* http://www.rcpsych.ac.uk/pdf/insightandinmind.pdf (Accessed 13 March 2018)

Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists (2007). *Challenging Behaviour: A Unified Approach* (CR144). London: Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr144.pdf (28 Novemeber 2018)

Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability (2013). *People with learning disability and mental health, behavioural or forensic problems: the role of in-patient services. London: Author.* https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf (Accessed 28 Novemeber 2018)

Skills for Care and Skills for Health (2014). *A positive and proactive workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.*

*Leeds: Skills for Care.* http://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf (Accessed 13 March 2018)

Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *British Journal of Social Work, 42*(3) 537-555.

The Guardian (2013). *Use of physical restraint on mental health patients at 'disturbing levels'.* Available from: http://www.theguardian.com/society/2013/jun/19/physical-restraint-mental-health-patients (Accessed 13 March 2018)

Uppal, G., & Mc*Murran, M.* (2009). Recorded incidents in a high-secure hospital: a descriptive analysis. *Criminal Behaviour and Mental Health*, 19(4) 265-76.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.*

Xeniditis, K., Ru*ssell, A., & Murphy, D.* (2001). Management of people with challenging behaviour. *Advances in Psychiatric Treatment*, 7, 109–116.

Xenitidis, K., Gr*atsa, A., Bouras, N., Hammond, R., Ditchfield, H., Holt, G., Martin J., & Brooks D.* (2004). Psychiatric inpatient care for adults with intellectual disabilities: generic or specialist units? *Journal of Intellectual Disability Research*, 48(1) 11-18.

# #LetsMo

## How to cite this

Royal College of Psyc
*Restrictive interventio
disability services: Ho
regulate*

For full details of reports available, please visit the College website at www.rcpsych.ac.uk/publications/collegereports.aspx

Equality and Human Rights Commission

# Human rights framework for restraint:

## principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions

Equality and
Human Rights
Commission

# Introduction

This framework reflects the requirements of Article 3 (prohibition on torture, inhuman and degrading treatment, Article 8 (respect for autonomy, physical and psychological integrity) and Article 14 (non-discrimination) of the European Convention on Human Rights[1] as incorporated into domestic law by the Human Rights Act 1998.[2]

## Why has the Commission produced this human rights framework for restraint?

To support our work to tackle the unlawful use of restraint in education, healthcare and detention settings, we have produced this human rights framework for restraint. The development of the framework has been informed by discussion with Government departments; regulators, inspectorates and ombudspersons; and the third sector.

## What does this framework do?

This framework:

- sets out key principles of articles 3, 8 and 14 of the European Convention on Human Rights (ECHR), incorporated into domestic law by the Human Rights Act 1998, which govern the use of restraint across all settings, and
- provides examples from a range of settings to illustrate the principles.

## What this framework is not intended to do?

This framework is not intended to:

- set out the specific legal frameworks which govern the use of restraint in different settings
- set out all of the regional and international human rights obligations and standards which relate to the use of restraint, or
- serve as a tool to guide frontline practice without supplementary guidance.

## How should the framework be used?

This framework is intended to be used as:

- a basis for building consensus and consistency on the use of restraint within and between all sectors in which restraint is used, including criminal justice, health, adult and social care and education sectors
- a starting point for developing more comprehensive sector-specific guidance and training on restraint, and
- a checklist which can be used to help evaluate compliance of law, policy and practice on restraint with articles 3, 8 and 14 ECHR.

# Human rights framework for restraint

An act of restraint must comply with the basic legal principles below when carried out by a person performing a public function or providing a public service, whether they are employed by the state or private contractors. This includes restraint by teachers, police, prison and immigration detention officers, NHS and social care professionals.

The principles in this framework serve to protect and respect the safety and dignity of people being restrained, as well as those around them, including staff or members of the public.

## A | What is 'restraint'?

In some settings 'restraint' only means use of force. This framework covers all forms of restraint covered by the following definition:

> **'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently.**[3]

Restraint includes chemical, mechanical and physical forms of control, coercion and enforced isolation, which may also be called 'restrictive interventions'.

Example: A young person with learning disabilities is prescribed high doses of an anti-psychotic drug with sedative properties solely to help control their challenging behaviour. They do not have the underlying condition that the medication is designed to treat. This may be chemical restraint.

The key issue is the nature of the act, not how it is described. If an act or series of acts are intended to restrict a person's freedom to move or act then the human rights principles set out in this framework apply.

Example: Isolation may be enforced by locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area, for example, by the use or threat of force. Enforced isolation is therefore restraint, but it may be described as seclusion, segregation, separation, time out or solitary confinement.

Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference.

Example: A carer takes away a disabled person's walking frame so that they cannot get out of their chair and walk around. This is an act of restraint.

## B | Unlawful restraint

It is **never** lawful to use:[4]

1. restraint with intent to torture, humiliate, distress or degrade someone[5]
2. a method of restraining someone that is inherently inhuman or degrading, or which amounts to torture
3. physical force as a means of punishment, or
4. restraint that unnecessarily humiliates or otherwise subjects a person to serious ill–treatment or conditions that are inhuman or degrading.

Example: Handcuffing a prisoner to a hospital bed, or during a medical examination, is humiliating and diminishes their dignity. It may be unlawful if the prisoner does not pose such a risk of harm to the public or escaping that the handcuffing is necessary.

Restraint is more likely to amount to inhuman and degrading treatment when it is used on groups who are at particular risk of harm or abuse, such as detainees, children and disabled people.[6]

Restraint that amounts to inhuman or degrading treatment can never be justified.

Subject to the absolute prohibitions in this section, the use of restraint may be lawful provided the legal framework, safeguards and its use in practice comply with the requirements set out below.[7]

## C | Legal framework

There must be a legal framework governing the use of restraint that complies with the following principles:

1. The legal framework must include a legal power authorising the use of restraint:[8]
    a) in the individual's circumstances, and
    b) for the intended purpose of the restraint.

The legal power to restrain may be contained in primary or secondary legislation, or derived from the common law.

Examples: Section 6 of the Mental Capacity Act 2005 provides lawful authority for restraint to be used (a) on a person who lacks capacity, where (b) it is reasonably believed to be necessary and proportionate to protect them from harm.

1. The purpose of the legal power to restrain granted by the legal framework must be for a legitimate and sufficiently weighty purpose that falls within one of the following grounds:
    a) the interests of national security, public safety or the economic well-being of the country
    b) for the prevention of disorder or crime
    c) for the protection of health or morals, or
    d) for the protection of the rights and freedoms of others.[9]
2. The legal framework must:
    a) be public and widely available
    b) clearly define the circumstances in which restraint may be used and how it can be exercised, and
    c) provide procedural safeguards, including sanctions for unlawful use of restraint.[10]
3. The rules and safeguards in the legal framework must be sufficient to guarantee against the risk of abuse, arbitrary interference with an individual's rights,[11] and prevent risks to health and well-being.[12]
4. The legal framework should comply as fully as possible with the UK's obligations under international law and be informed by international human rights standards, such as those listed in the Annex to this framework.[13]

5. The legal framework may include relevant statutory provisions, codes of practice, official guidance, policies and equality and human rights legislation.[14]

Example: The 'Mental Health Act 1983: Code of Practice' statutory guidance and Department of Health policy guidance, 'Positive and Proactive Care; reducing the need for restrictive interventions' both form part of the legal framework for restraint in psychiatric hospitals.

## D | The use of restraint

Where restraint does not amount to inhuman and degrading treatment it may be lawful if used in accordance with the legal framework, ensuring that:[15]

1. the aim of the restraint meets the purpose of the power in the legal framework, and
2. there is a rational connection between the method of restraint used and the aim.[16]

The following principles must also be complied with:

1. the means of restraint and its duration must be necessary, and no more than necessary, to accomplish the aim. This requires consideration of whether there is a less intrusive measure that could reasonably achieve the aim, and
2. the end must justify the means. A fair balance has to be struck between the severity and consequences of the interference for the individual being restrained and the aim of the restraint.[17] This requires consideration of any reasons why an individual may be particularly vulnerable to harm, such as their age, experience of trauma, health conditions or disabilities.
3. Minor acts of physical interference such as a guiding hand may not breach rights, but the use of more significant physical force may only be used to restrain:
    a) as a last resort, where there is no viable alternative[18]
    b) where there is a genuine belief[19] that it is strictly necessary to prevent serious harm including the risk of injury to the person or others, or in limited cases, preventing a crime, disorder or damage to property,[20] and

c) due to the level of control the state has over people in detention and therefore their vulnerability to abuse, force must only be used to restrain a detainee where they have made it strictly necessary by their own conduct.[21]

The ‘use of force’ principles above are likely to apply to other forms of restraint, such as chemical restraint, which carry a similarly high risk of harm and interference with human dignity.

**Children**

When a decision is being made on whether and how to restrain a child:

1. Their best interests must be a primary consideration. This does not mean that the child’s best interests automatically take precedence over competing considerations, such as other people’s rights, but they must be given due weight in the decision to restrain.[22]
2. Children are developing physically and psychologically which makes them particularly vulnerable to harm. The potentially serious impact of restraint on them will require weighty justification.[23]
3. Techniques intended to inflict pain as a means of control must not be used.[24]

A person entrusted with the care of a young child may be required to restrict the child’s action to ensure their welfare and safety. If the restraint is consistent with ordinary acceptable parental restrictions upon the movements of a child of that age and understanding this will generally be lawful.

Example: A teaching assistant takes hold of a five-year-old pupil’s hand to restrain the child when they are walking near a busy road. This is lawful.

## E | Procedural safeguards

Where restraint is used, protective steps must be taken to ensure legality and prevent harm.[25] The level of detail and scrutiny required by these procedural safeguards will increase in line with the gravity of the interference with the individual’s rights and the risk of harm occurring.

The following are key procedural safeguards:

1. All persons using restraint must be adequately trained.
2. Any anticipated use of restraint must be planned and regularly reviewed. This must include active consideration of:
    - reasonable adjustments, or other measures that could be taken, to avoid or minimise the use of restraint and the risk of harm resulting for the individual or others in their situation,[26] and
    - the risks to the person's physical and mental well-being, taking into account matters such as disability and age.[27]
3. To the extent that urgency permits, a person must be consulted and involved in a decision to restrain them, or to continue restraint for a prolonged period.[28]
4. Use of restraint should be recorded in proportionate detail to enable the lawfulness of the restraint to be assessed.[29]

Example: A student in a residential special school with autism and learning disabilities is repeatedly physically restrained due to challenging behaviours. An expert assessment of their sensory needs is required so that their environment can be adjusted to avoid distress that may lead to the use of restraint, and to ensure that it is strictly necessary.

In addition, if restraint results in death, life threatening injury,[30] or may arguably amount to torture, inhuman or degrading treatment, an effective, independent investigation is required that complies with the legal principles outlined in our human rights framework for adult deaths in detention.

## F | Discrimination

1. The disproportionate use of restraint on an identifiable section of the population without justification is evidence that unnecessary and discriminatory restraint may be occurring.[31]

Example: A prison segregates black prisoners twice as often as white prisoners. This indicates that the segregation of a black prisoner may be due to discrimination rather than necessity, in which case it would be unlawful.

2. To know whether discrimination is occurring, public bodies should collect and analyse data on their use of restraint, to identify if restraint is being used disproportionately against people with particular protected characteristics under the Equality Act 2010, or who share other identifiable group characteristics, for example, women, ethnic minorities, or people with particular impairments such as learning disabilities.[32]

Example: A review of monitoring data at a mental health unit shows that ethnic minority women are more likely to be restrained than white women or men. The hospital is concerned that this might be a result of discriminatory attitudes and decides to investigate the cause of this disparity.

## G | Rights must be effective

Appropriate assistance must be provided where necessary to ensure that the rights outlined in this framework are effective in practice.[33] This may include interpreters for people who require them, or independent advocacy support for people who face other communication barriers or difficulties asserting their legal rights, including those who lack capacity.

# Annex

## International legal obligations, standards, monitoring and complaints systems relating to restraint

### Introduction

The UK Government has signed and ratified a number of UN human rights treaties which are relevant to the use of restraint. These treaties form part of its obligations under international law and inform the interpretation of rights under the European Convention on Human Rights.[34]

### Relevant UN human rights treaties

The UK has ratified the following UN human rights treaties which are relevant to restraint:

International Convention on the Elimination of All Forms of Racial Discrimination (CERD) especially articles 1 (definition of racial discrimination), 2 (obligation to act against all racial discrimination), 5 (equality before the law) and 7 (obligation to combat prejudice and promote understanding).[35]

International Covenant on Civil and Political Rights (ICCPR) especially articles 3 (equal enjoyment of rights for men and women), 7 (prohibition of torture, inhuman or degrading treatment or punishment), 9 (right to liberty and security of the person), 10 (right to be treated with humanity and respect for dignity in detention), 16 (right to legal personhood), 17 (right to respect for privacy and family).[36]

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) especially articles 1 (definition of discrimination against women) and 2 (obligation to act to eliminate discrimination against women).[37]

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) especially articles 1 (definition of torture), 2, (obligation to prevent acts of torture), 4 (criminal sanctions for torture), 10 (training for personnel in law enforcement and detention contexts), 11 (systematic review of rules of detention, etc.), 12 (obligation to investigate), 13 (right of complaint), 16 (application of articles 10–13 to cruel, inhuman or degrading treatment or punishment).[38]

Convention on the Rights of the Child (CRC) especially articles 3 (best interests of the child), 12 (right to be heard), 16 (right to privacy and family), 19 (protection from physical or mental violence and abuse), 23 (disabled children), 28 (school discipline), and 37 (protection from torture, cruel, inhuman or degrading treatment or punishment).[39]

Convention on the Rights of Persons with Disabilities (CRPD) especially articles 12 (equal recognition before the law), 14 (liberty and security of the person), 15 (freedom from torture, cruel, inhuman or degrading treatment or punishment) and 17 (protecting the integrity of the person).[40]

UN human rights treaty bodies produce general comments on the rights contained in the treaties.[41] General comments can be used to help understand these rights and what they require.

## Other international instruments

In addition to the UN treaties, there are international standards that should underpin domestic standards. These include:

- Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.
- Standard Minimum Rules for the Treatment of Prisoners ('the Nelson Mandela Rules').
- United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders ('the Bangkok Rules').

## Concluding observations and recommendations

The UK has agreed to undergo periodic examination by UN committees to assess its compliance with the treaties it has ratified. These examinations result in concluding observations and recommendations from the UN committee for each treaty. To date, these include concluding observations from the committees for CAT (2013), CERD (2016), CRC (2016) and CRPD (2017), which all highlighted serious concerns about the use of restraint.

## Monitoring obligations and complaint mechanisms under international law

As required by the Optional Protocol for CAT (OPCAT), the UK Government has created a National Preventive Mechanism (NPM), the function of which is to inspect places of detention and report on ill-treatment. The NPM has a website, with useful studies and guidance on standards relevant to particular forms of restraint, such as segregation.[42]

The CRPD has a complaints procedure, which may be used by individuals if domestic remedies have been exhausted, to obtain redress from violation of CRPD rights. The CRPD committee also has a power to launch an inquiry into potential grave and systemic breaches of the CRPD. To date, the UK is the only nation in the world to have been subject to such an inquiry, on the impact of the UK's austerity programme on disabled people.

Under CEDAW, women can complain directly to the UN if their rights under this treaty have been violated and they cannot obtain redress in domestic law. As with CRPD, there is also an inquiry procedure.

As a member of the Council of Europe (CoE), and a party to the European Convention on Human Rights, the UK Government has agreed to submit to inspections from the CoE's Committee for the Prevention of Torture (CPT), which periodically examines places of detention in the UK and produces reports and recommendations.

**Public bodies should take the views of the UN treaty bodies and CPT into account when reviewing and developing policies and practices.**

# Notes

The notes below provide additional information about the principles in the framework, and case law examples that help to illustrate them.

[1] Restraint is likely to raise issues under Article 8 as well as Article 3.

[2] Human Rights Act 1998 Schedule 1.

[3] Taken from the MHA Code of Practice definition of 'restrictive intervention'. This is consistent with the Oxford English Dictionary which defines restraint, as 'a restraining force or influence; a means of restraining a person from a course of action, or of keeping a person under control'.

[4] The prohibition in Article 3 ECHR against torture, or inhuman or degrading treatment is absolute and permits no justification for an interference with that right.

[5] Article 3 ECHR. See eg. *Uyan v Turkey* (App 7496/03) at [37].

[6] *Kalashnikov v Russia* (2003) 36 EHRR 34 at [95]: *'… ill-treatment must attain a minimum level of severity if it is to fall within the scope of Art.3. The assessment of this minimum is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim'; Bouyid v Belgium (2016)* 62 EHRR 32 at [81].

[7] Article 3 contains a positive obligation on the state to have in place 'effective measures' to prevent breaches, including an appropriate legislative and administrative framework (see for example, *R (ota Howard League for Penal Reform) v SSHD v SSfH* [2002] EWHC 2497 (Admin) at [36], in particular at [62] and [66]-[68]; *R (ota FI) v SSHD [2014]* EWCA Civ 1272 at [36]; Article 8 has a similar positive obligation: *Howard League ibid* at [54]-[69], and requires any interference with that right to be 'in accordance with the law' (Art 8(2)).

[8] *Malone v United Kingdom* (1985) 7 EHRR 14 at [66] to [68].

[9] Article 8(2) ECHR.

[10] *A v United Kingdom* (1999) 27 EHRR 611 at [24] re Art 3 ECHR; *Őneryildiz v Turkey* (2005) 41 EHRR 20 at [91] to [92] re Art 2 ECHR. Art 3 breaches must be punishable by a criminal offence: *A v United Kingdom* (1998) 27 EHRR 611.

[11] *MM v UK* (App 24029/07) at [195]; *R (FI) v Secretary of State* [2014] HRLR 30 at [41].

[12] *Smith v Ministry of Defence* [2013] UKSC 41 at [68].

[13] ECHR rights must be construed in light of relevant international law: *Demir v Turkey (2009) 48 EHRR 1272*, in particular at [85]-[86. The common law should also be developed and informed by obligations under international law: *A v SSHD (No. 2)* [2006] 2 AC 221 at [27], and *R (K) v. Parole Board* [2006] EWHC 2413 (Admin) at [30].

[14] *R (Roberts) v Commissioner of the Metropolis* [2016] 1 WLR 210 at [42]-[43].

[15] Article 8(2) ECHR: use of restraint must be 'in accordance with the law'.

[16] *Huang v Secretary of State* [2007] 2 AC 167 at [19].

[17] *R (Lord Carlile) v SSHD* [2015] AC 945 at [19]; *Huang v SSHD* [2007] 2 AC 167 at [19].

[18] *Kurnaz v Turkey* (Application no. 36672/97) at [56].

[19] *De Silva v United Kingdom* (2016) 63 EHRR 12 at [248].

[20] *Tali v Estonia* (Application no. 66393/10) at [59].

[21] *Bouyid v Belgium* (2016) 62 EHRR 32 at [88].

[22] *ZH (Tanzania) v Secretary of State* [2011] UKSC 4 at [23].

[23] *R (C) v Secretary of State* [2009] QB 657 at [58].

[24] *Ibid*, at [60] to [61]; UN CRC General Comment 8 at [15].

[25] See *fn* 6 above. The state is under a positive duty to take reasonable and appropriate measures to secure the applicant's rights under article 8: *Lopes-Ostra v Spain* (1994) 20 EHRR 277 at [51]); *R(ota Howard League)* (ibid) at [54] to [69].

[26] *Y v UK* (1992) 17 EHRR 238 at [44] – [45]; *R (FI) v Secretary of State* [2014] HRLR *30* at [42]; *Kemal Bas v Turkey* (App 38291/07) at [30]; *Thlimmenos v Greece* (2001) 31 EHRR 15 at [44]; Equality Act 2010, in particular ss.20 and 149.

[27] *R (C) v Secretary of State* [2009] QB 657 at [58].

[28]*R (Bourgass) v SSJ* [2016] AC 384 at [98]; *Blĕcic v Croatia*, app 59532/00 at [68].

[29] (R (Quila) v Secretary of State [2012] 1 AC 621 at [44].

[30] *R (Amin) v Secretary of State* [2004] 1 AC 653 at [31].

[31] Discriminatory use can imply that restraint is not necessary, as required by Articles 3 and 8 ECHR: *A and Others v SSHD, X and Another v SSHD* [2004] UKHL 56 at [231] to [234]. The discriminatory use of restraint may also be unlawful under the provisions of the Equality Act 2010, and/or Article 14 in conjunction with Articles 3 and/or 8 ECHR.

[32] The Public Sector Equality Duty (s.149 Equality Act 2010) includes a proactive duty of enquiry in order to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations.

[33] *Clift v UK* ECHR 13 Jul 2010 at [60], *McCann and Others v UK* (1996) 21 E.H.R.R. at [146].

[34] *Neulinger v Switzerland* (2010) 28 BHRC 706 at [131].

[35] CERD (1969) [ONLINE] (accessed 2 July 2018)

[36] ICCPR (1976) [ONLINE] (accessed 2 July 2018)

[37] CEDAW (1986) [ONLINE] (accessed 2 July 2018)

[38] CAT (1988) [ONLINE] (accessed 2 July 2018)

[39] CRC (1991) [ONLINE] (Accessed 2 July 2018)

[40] CRPD (2009) [ONLINE] (Accessed 13 March 2019)

[41] See: Human Rights Treaty Bodies - General Comments.

[42] See: National Preventive Mechanism - Publications and Resources.

Published March 2019

**Equality and**
**Human Rights**
Commission

# Reducing the Need for Restraint and Restrictive Intervention

**Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings**

Published: 27 June 2019

# Contents

# Foreword

Every child and young person has a right to be treated with respect and dignity, and deserves to have their needs recognised and be given the right support. Some children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties may react to distressing or confusing situations by displaying behaviours which may be harmful to themselves and others and are at heightened risk of restrictive intervention to minimise the impact of their behaviour, on them and on other people.

Children and young people, their families and carers have said that restraint and restrictive intervention are traumatising. These children and young people also recognise that there may be times when these approaches may need to be used for their protection and to keep them, and others, safe. We know that use of restraint and restrictive intervention can have long-term consequences on the health and wellbeing of children and young people, and that it can have a negative impact on staff who carry out such intervention. Using positive behaviour support and other alternatives which can de-escalate challenging behaviour, and tackle the reasons for it at source, should be the preferred approach.

There will, however, be times when the only realistic response to a situation will be restraint or restrictive intervention. In a school, if a young child is about to run into a busy road, for example, or a pupil is attacking a member of staff or another pupil and refuses to stop when asked, then reasonable force to stop this may be necessary. And the same would be true in, say, a hospital if a child were attacking staff. But wherever possible, it should be avoided; and proactive, preventative, non-restrictive approaches adopted in respect of the behaviour that challenges.

Restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution, and we are particularly concerned about long-term or institutionalised uses of restrictive interventions.

This advice is designed to support relevant education, health and care settings and services in putting in place measures which will help them:

- understand the needs of children and young people, including the underlying causes of and triggers for their behaviour;
- develop strategies and plans to meet those needs and regularly review them as children change
- adapt the environments in which children and young people are taught and cared for so as better to meet their needs; and

- provide appropriate support for children and young people whose behaviour challenges, without the use of restraint or restrictive intervention.

It sets out relevant law and guidance and provides a framework of core values and key principles to support:

- a proactive approach to supporting children and young people whose behaviour challenges; and

- a reduction in the need to use restraint and restrictive intervention.

At any particular time, the key question for everyone involved with children and young people whose behaviour challenges should be:

"What is in the best interests of the child and/or those around them in view of the risks presented?"

This guidance sits alongside a range of other work to help ensure that children and young people with the relevant conditions receive the support they need. Supporting the appropriate use of restraint and restrictive intervention is one element of a much wider range of measures to safeguard the human rights of, and to provide effective support for, these vulnerable individuals in relation to their education, health and care.

We hope this advice helps settings and services to reflect on and develop their practice, have confidence to provide better support for children and young people whose behaviour challenges, and provide safe environments in which they can thrive.

Caroline Dinenage
Minister of State for Health and Social Care

Nadhim Zahawi, Parliamentary Under-Secretary of State for Children and Families

# 1. Introduction

## About this Guidance

1.1 This guidance is non-statutory.

1.2 Where the text uses the word ‘must’ in this guidance, it refers to a legal requirement under primary legislation, regulations or case law. Where the text uses the word ‘should’ it refers to a recommendation, advice or good practice.

## Aims of this Guidance

1.3 This guidance aims to help settings and services take action to understand:

- the underlying causes of children and young people’s behaviour that challenges;
- the times and situations when behaviour that challenges is more likely to occur; and
- the steps settings and services can take to support children and young people, including through the development of behaviour support plans

so as to reduce the incidence and risk associated with that behaviour, promote and safeguard the welfare of children and young people in their care and improve their quality of life. Eliminating unnecessary and inappropriate use of restraint is vital in achieving this. It is particularly important in relation to children, who are still developing both physically and emotionally, and for whom any potentially traumatic experience at this formative stage in their development could be very damaging and have long-term consequences.

1.4 Use of restraint carries risks and can be damaging to children and young people. It may, however, be the only realistic response in some situations (for example, to prevent a child running into a busy road or to prevent a violent act against another person). But wherever possible, it should be avoided; and proactive, preventative, non-restrictive approaches adopted in respect of behaviour that challenges. The personal costs to children and young people’s development and welfare and to staff from the use of restraint are well documented.[1] These include damage to children’s physical, psychological, social and emotional wellbeing and to their neuro-cognitive, behavioural and emotional development. Restraint can be traumatising for children and repeated use of restraint can have damaging, re-traumatising effects. Research[2] has shown that restraint and seclusion increase the daily cost of care and contribute to significant workforce turnover. Conversely, it also shows how hospitals and residential programmes have achieved significant savings by redirecting existing resources to support additional staff training, implementing prevention-oriented alternatives, and enhancing the environment of care.

1.5 Children and young people with learning disabilities,[3] autistic spectrum conditions[4] and mental health difficulties[5] may often respond with behaviour that challenges (verbal or non-verbal) when they are in pain, or experiencing sensory overload, or when confronted with situations they do not understand or environments in which they cannot easily cope, which cause anxiety or fear, and for which they are unprepared. Such behaviour may be perceived as ‘naughty’ or ‘bad’ if the child or young person is unable to follow instructions or fit in with existing rules and structures and it can be a form of communication for children and young people who are unable to communicate verbally. The likelihood of such behaviour can often be anticipated by those who know the child or young person well. Measures to understand the range of communication used by children and young people to express emotions, including distressed behaviour, should be put in place. Measures to identify triggers of distressed behaviour and to prevent or address it should also be developed with the involvement of the child or young person and their family, and careful assessment, with multi-agency planning and support to create the right environment for education, care and support.

1.6 Like the physical use of force, the threat of using force can also impact on the emotional development and well-being of a child or young person. It should only be made where it will be understood by the child or young person; and where there is a real possibility of injury or harm to the child, young person or others (or in other scenarios where restraint can be used that are prescribed in legislation applying to particular settings).

1.7 This guidance is not intended to address actions which are intended as a disciplinary penalty. Such practice is outside the scope of this guidance.[6] This guidance is designed to help settings and services adopt a preventative approach to supporting children and young people whose behaviour challenges. It highlights action to improve assessment and understanding of the range of communication used by children and young people including the reasons for and nature of distressed behaviour, including behaviour that challenges, planning of support, and assessment and management of risks. It promotes the use of evidence-based practice to create an environment in which the likelihood of the need for restraint is reduced. Where restraint and restrictive interventions are used they should be used appropriately, only where necessary and for the minimum time required, by trained staff and in line with the Human Rights Act 1998, relevant international obligations such as the UN Convention on the Rights of the Child and the UN

Convention on the Rights of People with Disabilities, core values and key ethical principles.

# Definitions

1.8 The terms restrictive intervention and restraint are used interchangeably in this guidance to refer to:

- planned or reactive acts that restrict an individual's movement, liberty and/or freedom to act independently; and
- the sub-categories of restrictive intervention using force or restricting liberty of movement (or threatening to do so).

1.9 Law and guidance set out the permitted purposes for which restraint and restrictive intervention can be applied in different settings and services, such as preventing injury, protecting property and reducing danger (see Annex A for details). Health, education, and care professionals will often have a common law duty of care towards children and young people who are under their care or supervision. If someone has such a duty, it means they must take reasonable care to prevent foreseeable harm coming to the child or young person.

1.10 In this guidance restrictive interventions and restraint can include, depending on the circumstances:

- Physical restraint: a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- Restricting a child or young person's independent actions, including removing auxiliary aids such as a walking stick or coercion, including threats involving use of restraint to curtail a child or young person's independent actions.
- Chemical restraint: the use of medication which is prescribed and administered (whether orally or by injection) by health professionals for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
- Mechanical restraint: the enforced use of mechanical aids such as belts, cuffs and restraints forcibly to control a child or young person's individual's movement.
- Withdrawal: removing a child or young person involuntarily from a situation which causes anxiety or distress to themselves and/or others and taking them to a safer

place where they have a better chance of composing themselves. We also refer to this concept below as Imposed Withdrawal.

- Seclusion: supervised confinement and isolation of a child or young person, away from others, in an area from which they are prevented from leaving, where it is of immediate necessity for the purpose of the containment of severely disturbed behaviour which poses a risk of harm to others. (Schools can use seclusion or isolation rooms appropriately as a disciplinary penalty without this constituting a form of restraint or restrictive intervention. Separate guidance is provided on this issue for schools).[7]

- Segregation: where a child or young person in a health setting is not allowed to mix freely with others on a long-term basis.

1.11 Further information and advice on these types of restraint and restrictive intervention is provided in Chapter 5.

1.12 The term ‘parent’ used throughout this guidance refers to all those with parental responsibility, including parents and those who care for the child. Where there is a Care Order in force, the local authority has the power to restrict the exercise by the child’s parents of their parental responsibility, if the welfare of the child so requires.[8]

## Status of this Guidance

1.13 This guidance is non-statutory and advisory. The guidance applies to the following settings and services:

- local authorities;
- Clinical Commissioning Groups;
- maintained and non-maintained special schools, special academies and special free schools;
- independent educational institutions which have applied to the Secretary of State for Education for approval under section 41 of the Children and Families Act 2014;
- special post-16 institutions;
- children’s homes (including secure children’s homes);
- residential holiday schemes for disabled children;

- local authority and independent fostering service providers; and
- NHS-commissioned health services.

1.14 This advice is intended for those responsible for providing education, health and social care to children and young people under 18 years of age with learning disabilities, autistic spectrum conditions and mental health difficulties in these settings. Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties are at greater risk of displaying behaviours that challenge and are therefore at heightened risk of experiencing restraint and restrictive intervention.

1.15 It is intended for the following, where they have responsibilities for the care of children and young people under 18 with learning disabilities, autistic spectrum conditions or mental health difficulties who may present behaviour that challenges:

- those involved in local authorities; clinical commissioning groups; maintained and non-maintained special schools, special academies and special free schools; special post-16 institutions; independent educational institutions which have applied to the Secretary of State for Education for approval under section 41 of the Children and Families Act 2014;[9] children's homes; residential holiday schemes for disabled children; local authority and independent fostering service providers; and all settings providing health care commissioned by the National Health Service.

1.16 It will also be of interest to but is not intended for:

- mainstream schools (including Academies and Free Schools), particularly those with Special Education Units and Special Educational Needs resourced provision;
- general further education colleges;
- independent mainstream schools and colleges;
- providers of alternative provision (AP) including Pupil Referral Units (PRUs), AP Academies and AP Free Schools;
- Early Years providers (maintained or independent that are not part of special schools); and
- the police and staff working within Young Offenders Institutions and Secure Training Centres, for whom other guidance applies.

## The Legal Framework

1.17 The use of all forms of physical intervention and physical contact, or even imminent threat of force, are governed by criminal and civil law. The unnecessary or inappropriate use of force may constitute an assault and may also infringe the rights of a child or young person under the Human Rights Act 1998. The use of restraint can be justified for purposes set out in relevant legislation. Different settings and services will need to abide by any legislation which applies to them. Annex A sets out the legal framework for different settings and services in more detail and lists relevant guidance. It is important for settings and services to be familiar with the legislation and any associated guidance on the use of restraint that applies to them, not least as in some cases the requirements and expectations will go beyond what is in this guidance.

## Relationship to Other Advice and Guidance

1.18 The guidance reflects, as appropriate:

- The principles set out in the guidance Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, 2015) produced for services supporting adults; and
- The advice in the Association of Directors of Children's Services: Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People (ADCS, 2009).

1.19 It does not replace other current and relevant guidance that applies to the relevant service or setting and should be read alongside the documents referred to in Annex A.

## Inspections

1.20 The Care Quality Commission (CQC) and Ofsted will have regard to this guidance when assessing whether relevant institutions and service providers are providing safe and appropriate education and care. Where restraint practice fails to meet the expectations or requirements of relevant regulations, statutory guidance or standards CQC or Ofsted will take action as appropriate. This may, where appropriate, include enforcement action.[10]

1.21 In November 2018 the CQC was commissioned by the Secretary of State for Health to review the use of restraint, prolonged seclusion and segregation for people with mental health problems, a learning disability and/or autistic spectrum conditions. The review will consider whether and how seclusion and segregation are used in registered social care services for these people. This will include residential services for young people with very complex needs – such as a severe learning disability and physical health needs - and secure children's homes. This aspect of the review will be undertaken in partnership with Ofsted, which has published the review's terms of reference.

1.22 The interim report of the review was published in May 2019, and the Government committed to implement its recommendations in full. The NHS Long Term plan commits NHS England to work with the CQC to implement its recommendations.[11]

## Role of Commissioners

1.23 NHS and local authority commissioners will need to assure themselves that the providers of the services they commission have the necessary knowledge, skills and competencies to support effectively those whose behaviour challenges and have arrangements in place to promote positive behaviour, reduce risk, and eliminate unnecessary or inappropriate use of restraint. This includes assuring themselves that providers of care and/or education services meet the needs of the children and young people concerned; providers are regularly and rigorously reviewed; and that failure to comply with contractual obligations leads to prompt action to safeguard and promote the welfare of children. Settings and those who commission services should ensure that the services they commission are consistent with the advice in this guidance.

# 2. A Positive and Proactive Approach to Behaviour

2.1 2.1 Behaviour is a means of communication and has a cause and a purpose. Behaviour that challenges may signal a need for support and it is essential to understand its underlying causes. It may, for example, be the result of a medical condition or sensory impairment, previous trauma or neglect, or be exacerbated by an unmet need or undiagnosed medical condition. It may reflect the challenges of communication, or the frustrations faced by children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties, who may also have little choice and control over their lives. These factors may result in behaviours that are challenging. Behaviours that challenge may reflect the impact on a child or young person of being exposed to challenging environments which they do not understand or where positive social interactions are lacking or personal choices are limited. These children and young people need support to have their needs met in different ways and to develop alternative ways of expressing themselves that achieve the same purpose but are more appropriate. Behaviour support plans, drawn up with the involvement of the children, parents and young people, help to understand better a child or young person’s experiences and behaviour and the steps that should be taken to meet their needs.

2.2 Eliminating unnecessary and inappropriate use of restraint and minimising the need for its use calls for settings and services to have a good understanding of the children and young people in their care, a strong commitment to meeting their needs and a systematic, positive and proactive approach to behaviour with:

- policies, strategies and practices which promote a positive culture and improve the quality of children and young people’s lives;
- arrangements which identify, assess and manage risk well;
- high quality training for staff;
- involvement of children and young people, parents and carers, and advocates as appropriate;
- arrangements for carefully assessing the needs of children and young people and the underlying causes of their behaviour, including through developing behaviour support plans;

- tailored support for individual children and young people that takes account of their particular wishes, vulnerabilities, learning disability, medical condition or impairments, and their interaction with the environment in which they are taught and cared for and responds to their growth and development over time; and

- clear arrangements for governance and accountability in respect of behaviour and responses to behaviour that challenges.

2.3 Settings and services should have a ‘hierarchy of responses’ to support those whose behaviour challenges. This is likely to include:

- creating a supportive environment in which children and young people are taught, treated and cared for, which seeks to address factors that are likely to increase or decrease the likelihood of restraint (illustrated particularly by case studies 1, 2, 9 and 12 in Annex B);

- deployment of approaches and techniques to maintain positive environments and de-escalate or calm situations that are appropriate to the child or young person and take account of their rights and views (illustrated particularly in case studies 3, 5, 7, 8, 11 and 12); and

- development of staff skills and expertise and the use of appropriate external expertise when needed (illustrated in case studies 3, 4, 6 and 11).

2.4 In considering their ‘hierarchy of responses’, settings and services will need to ensure they fulfil their duties under the Equality Act 2010, including the duty to think ahead and make reasonable adjustments to avoid discriminating against disabled people. Adjustments include the ways they organise themselves, deploy resources and in their day-to-day practice; alterations to physical features; and the provision of auxiliary aids and services. Speaking first to children, parents and young people will enable settings and services to gain an understanding of where reasonable adjustments may be necessary and help them to consider the nature of any adjustments to be made. Further information on the Equality Act can be found in Annex A.

2.5 Special schools, children’s homes, NHS commissioned health services and local authority approved providers of foster care have specific responsibilities to protect the welfare and safety of children and young people in their care.

2.6 Staff should have reasonable grounds for believing that restraint is necessary to justify its use. They should only use restraint where they consider it is necessary to prevent serious harm, including risk of injury to the child or young person or others. Staff should use their professional judgement to decide if restraint is necessary, reasonable and proportionate. This will involve assessing the risks involved, taking account of the needs of the child or young person (including as set out in any relevant behaviour support plans drawn up for them) and the circumstances of each case, including the availability of alternative approaches to restraint. To be confident in their judgement, staff should also ensure they know the scope of the legal powers authorising restraint and keep abreast of changes and developments in the understanding of what constitutes good practice in this area. When a decision is being made whether and how to restrain a child, their best interests are a primary consideration. This does not mean that the child's best interests automatically take precedence over other considerations such as other people's rights, but they must be given due weight in the decision.[12] Furthermore, since children are developing physically and psychologically and this makes them particularly vulnerable to harm, the potentially serious impact of restraint on them will require weighty justification.

# 3. Values and Principles

3.1 A positive and proactive approach is vital to anticipate potential triggers for behaviour that challenges, and minimise the likelihood of, or avoid the need to use, restraint (examples of practice in education and health settings and services are given case studies 1-12 in Annex B). Where use of restraint is necessary to safeguard children, young people and others from harm, it should be consistent with clear values and sound ethical principles, comply with the relevant legal requirements and case law and be consistent with obligations under the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.[13]

3.2 The following core values and principles set the ethos within which settings and services[14] should operate when carrying out the key actions set out in Chapter 4. These values and principles cannot be considered in isolation – settings and services must also follow the law and any associated guidance relating specifically to them. In some cases, the law will be more exacting than the values and principles below.

## Core Values

3.3 National reports and guidelines from professional bodies over the years have identified some overarching core values expected from those supporting children and young people whose behaviour challenges:

- uphold children and young people's rights – children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present;

- treat children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges as full and valued members of the community whose views and preferences matter;

- respect and invest in family carers as partners in the development and provision of support for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties; and

- recognise that all professionals and services have a responsibility to work together to coordinate support children and young people whose behaviour challenges and their families.

3.4 The following values relate specifically to the use of restraint. They were drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes[15] but they are relevant to all of the settings and services to which this guidance applies:

- every child or young person deserves to be understood and supported as an individual;
- the best interests of children and young people and their safety and welfare should underpin any use of restraint;
- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people, including their age, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual, affect others, including staff; and;
- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned, including other children, young people or adults present.[16]

## Key Principles

3.5 Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road. The following key principles are offered to guide settings and services in developing their policies and practice in the context of the particular legal requirements that apply to them:

- promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B);
- use of restraint is based on assessment of risk and to safeguard the individual or others;
- restraint should only be used where it is necessary to prevent risk of serious harm, including injury17 to the child or young person, other children or young people, to staff, the public or others,18 if no intervention or a less restrictive intervention were undertaken;

- an intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present;

- restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation;

- techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff;

- use of restraint, reasons for it and consequences of its use, are documented[19], monitored, open and transparent; and

- when planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved.

3.6 The nine principles underpinning the NHS England and Local Government Association guidance *Developing support and services for children and young people with a learning disability, autism or both* are also fundamental to ensuring community support for children, and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties who display behaviour that challenges and to ensuring that they have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with the same dignity and respect.[20]

# 4. Key Actions for Settings and Services

4.1 All settings and services to which this guidance applies should follow the set of key actions described and summarised below. These are based on practices which have been shown to work well in supporting children and young people whose behaviour challenges.

**Summary of Key Actions for Settings and Services**

Have a clear policy for meeting children and young people's individual needs and promoting positive relationships and behaviour. This should include measures for understanding children and young people's needs and the causes of behaviour, anticipating situations that may cause distress and taking steps to address them, assessing, managing and reducing risk, thereby reducing the likelihood of restraint.

Know the law and relevant guidance and have clear governance and accountability arrangements for supporting children and young people whose behaviour challenges and for any use of restraint, including arrangements for working across settings and services.

Involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint, and in discussing restrictive interventions and their impact, including through the development of behaviour support plans.

Use evidence-based approaches to promoting positive behaviour and supporting individual children and young people whose behaviour challenges.

Have sound measures in place for training and developing staff, including training in understanding children and young people whose behaviour challenges, developing the skills to respond to their needs and understanding when expert help is required.

Have a system in place for continually improving assessment and management of risk.

Have a system for recording and reporting incidents (distinguishing between planned and unplanned interventions) which enables children and young people who have been restrained to express their feelings about their experience as soon as is practicable, to add their views and comments to the record of restraint and offers them the opportunity to access advocacy support to help them with this.[21]

Have a system in place for reviewing how restraint is used in individual cases and patterns or trends in its use to inform changes in approach where necessary.

Recognise the impact of environment on individuals, and critically review their environment and practices, better to support children and young people and the reduction of restraint in line with best practice.

## A Clear Strategy

4.2 All settings and services will need to ensure policies on behaviour and use of restraint are consistent with relevant statutory duties and/or related guidance and standards; and will wish to ensure they are underpinned by the core values and key principles set out in Chapter 3 above.

4.3 Individual policies should be developed with regard to any wider local strategies which may have been developed in relation to use of restraint. For care and education services, this may include policies developed in response to ADCS guidance 2009.

4.4 It is good practice, and in some cases a legal requirement (see Annex A) for policies to set out:

- the measures taken to encourage effective communication and positive behaviour, including those to develop an environment which helps to reduce stress and anxiety and the likelihood of restraint being used for behaviour that challenges. This should include the ways staff interact/communicate with children and young people;
- how support is provided for those whose behaviour challenges through creating a supportive environment – including strategies for prevention or de-escalation which can avert and reduce the need for restrictive intervention, and the development and regular review of behaviour support plans for individual children and young people;
- how children, young people, parents/carers and other agencies are involved in supporting positive behaviour, including individual behaviour support plans;
- circumstances in which it may be appropriate to use restraint as set out in a behaviour support plan;
- how staff are trained in understanding behaviour, supporting positive behaviour, assessing and managing risk, and using restraint appropriately where it is necessary, including how training is maintained and reviewed;
- arrangements for reporting and recording use of restraint, including informing parents or carers;

- details of how staff restraint practice will be reviewed and evaluated;
- arrangements for providing support (emotional and, where necessary, medical) to children and young people and staff following any use of restraint, including access to advocacy;
- arrangements for monitoring the use of restraint and patterns and trends in its use, including consideration of whether interventions were reasonable and proportionate to the risks they presented and whether changes can be made to practice to reduce the use of restraint;
- arrangements for considering complaints; and
- details of how the behaviour policy will be reviewed, evaluated and where necessary amended.

# Governance and Accountability

4.5 To secure proper accountability and transparency, it is essential that those responsible for providing and commissioning services for children and young people whose behaviour challenges have clear arrangements governing the use of restraint.

4.6 Governance arrangements should include those for planning to support children and young people whose behaviour challenges and reducing the need to use restraint, and recording, monitoring and review. Aggregated information from reviews of the use of restraint should be used to consider future measures to avoid incidents which could lead to its use.

4.7 Settings and services will wish to consider identifying a lead person at governing body or executive board level with responsibility for their behaviour policy and strategy, including any specific programmes to reduce the need for restraint. They will also wish to consider appointing a member of staff to act as a champion and building networks with others pursuing such reduction programmes. It is good practice to inform children, young people, parents and carers of the role and functions of the lead person or champion.

4.8 Independent Visitors also play a useful role in residential special schools and in children's homes in supporting children and young people’s interests, including in relation to support for behaviour issues. They should be sufficiently knowledgeable to explore how well communication and behaviour support meets children’s needs.

# Involving Children and Young People, Parents and Carers

4.9 For children and young people with special educational needs and disabilities, including those with learning disabilities, autistic spectrum conditions and relevant mental health difficulties, Part 3 of the Children and Families Act 2014 (section 19) requires local authorities, when carrying out their functions under that Part, to have regard to:

- the views, wishes and feelings of the child and his or her parent, or the young person;
- the importance of the child and his or her parent, or the young person, participating as fully as possible in decisions relating to the exercise of the function concerned;
- the importance of the child and his or her parent, or the young person, being provided with the information and support necessary to enable participation in those decisions; and
- the need to support the child and his or her parent, or the young person, in order to facilitate the development of the child or young person and help him or her to achieve the best possible educational and other outcomes.

4.10 Involving children and young people in decisions about their education, health and care is essential in ensuring that their support meets their needs and enables them to achieve good outcomes. This could include giving them access to information in formats appropriate to their age and capacities; enabling guidance and support by their parents and/or advocates; and providing information and support which facilitates their involvement in decisions about plans for their support, including reviews of that support. Examples are given in Annex B of how settings and services have involved children, young people and parents in decision making, in particular case studies 2, 6, 9, 10 and 11.

4.11 It is important for children and young people to be well-informed about their rights in relation to decision-making on the use of force. This could be through an advocate where one is involved, for example in the care system, and it could be through the SEN and Disability Information, Advice and Support Services which local authorities are required to secure in order to make available information, advice and support to children and young people with SEN and/or disabilities, and their parents.

4.12 More specifically, the following advocacy is available in the health arena:

- independent mental capacity advocates (IMCAs) under the Mental Capacity Act 2005;
- independent mental health advocates (IMHAs) under the Mental Health Act 2007;
- independent complaints and advocacy services in the NHS; and
- independent advocates under the Care Act 2014.

4.13 Children and young people who have difficulties with speech, language and communication will use different ways of communicating such as augmentative and alternative communication. It is important that approaches to engaging them in decisions involve those means of communication (examples are given in Annex B – in particular case studies 6 and 12). Some children and young people may not have sufficiently developed language skills to communicate verbally and may not be able to understand or respond to verbal de-escalation. This may also occur if members of staff do not speak the child or young person's first language. Verbal and/or non-verbal strategies should be used to ensure the child or young person understands what is happening and has adequate time to process information and respond. Speech and language therapy support may be required for children and young people with speech, language and communication needs.

4.14 Involving parents, who have detailed knowledge and experience of their child, can help to improve understanding of what helps to support the child and contribute positively to the development of behaviour support plans (see case studies 6, 7, 9 and 10 in Annex B).

## Evidence-Based Approaches

## Behaviour Strategies

4.15 All settings should aim to develop proactive strategies which help reduce the likelihood of behaviours that challenge, leading to the use of restrictive interventions and focus on improving the safety and well-being of children and young people. Such strategies should be based on a good understanding of learning disabilities, autistic spectrum conditions and mental health difficulties and of how children and young people affected by them are at heightened risk of displaying behaviours that challenge. Strategies should be consistent with the core values and key principles in Chapter 3 and support the setting or service's own behaviour policy.

4.16 Children and young people, parents and carers should be asked for their views on the use of restraint and the development of any strategies for reducing its use. Settings and services should work with children, young people and parents to develop behaviour support plans for individual children and young people.

4.17 Effective behaviour strategies address how staff will be trained and developed in developing positive behavioural support and include provision for behaviour support plans to be made for individual children and young people whose behaviour challenges. It is essential that strategies and staff practice are kept under review so that changes can be made based on evidence of what has worked and what has not worked in practice. Settings and services should identify where expert help may be needed to inform their behaviour and support strategies for example, from a qualified behaviour specialist, a therapist with expertise in communication or sensory needs, or from a medical consultant on epilepsy.

4.18 It has been shown in some settings that it is possible to achieve significant reductions in the need to use restraint and restrictive intervention through specific reduction programmes. Many services are reducing the incidence of aggressive behaviour with less restrictive approaches. Settings and services should consider developing their own explicit restraint reduction programmes as part of their broader behaviour strategies and, as part of those programmes, should pay particular attention to securing appropriate training and development for staff. In implementing a restraint reduction strategy, settings and services will need to address concerns of staff who may feel that it would reduce their levels of safety. It may be helpful to share with staff evidence from other settings and services who have successfully implemented such a strategy that it results in a calmer environment for all. A range of examples in education and health contexts are given in Annex B - see case study 1 in particular.

## Positive Behavioural Support

4.19 The term positive behavioural support is used here to describe a framework to better understand, and so reduce, behaviour that challenges among children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties. It is based on an assessment of the context in which behaviour occurs and uses that information to develop interventions to support children and young people. These may include practice changes such as changing their environment, developing their skills, providing focused support and developing reactive strategies for use where necessary. Evidence has shown that approaches using such a framework can:

- build skills – for example communication skills, so that a child may learn a sign for 'finished' rather than throwing a cup, or resilience skills to gradually learn to cope with demands which were once too much for them;

- enhance quality of life – for example, by identifying pain and enabling medical intervention for an earache which is causing a child to bang their head on the wall or by changing the environment so that a child that needs to run around a lot is taken outdoors regularly, reducing the need for them to run away; and

- reduce the likelihood of behaviours that challenge – development of proactive strategies such as avoiding sensory overload for a child where this is known to increase anxiety by allowing them to move to the next session a few minutes before others, will reduce the need for reactive strategies such as trying to intervene in an incident in a crowded corridor when anxiety levels are high.

4.20 Positive behavioural support focuses on preventative strategies to ensure needs are met and secure improvements in quality of life. It also includes strategies to ensure that early signs of anxiety and agitation are recognised and responded to and strategies for when a child or young person's agitation escalates to a point where they place themselves and/or others at serious risk of harm. Positive behavioural support involves:

- Person-centred planning – the needs of the child or young person are central to the development of plans for their support and their views should be obtained. Helping children and young people to develop personal relationships and helping staff to understand them as individuals supports better person-centred planning.

- Skilled assessment – to understand why a child or young person presents behaviours that concern or challenge; and what helps predict their occurrence or causes the child to continue presenting them or regularly reverting to them. This can help to identify areas of unmet need. Assessment requires consideration of a range of contextual factors including personal factors, mental and physical health, communication skills and the child or young person's ability to influence the world around them. For children and young people displaying significant levels of behaviour that challenges, assessment should be conducted by a psychologist or behaviour specialist with relevant training and qualifications. Assessment should take account of the views of the child or young person and parents.

- *Behaviour support plans* – informed by the assessment, these describe how the child or young person is to be supported, address aspects of their environment which they find challenging, and support them in developing new skills and strategies better to communicate their needs and become more independent in meeting them. Plans should be developed with children and young people and parents.

4.21 Behaviour support plans should be based on a shared understanding of the reasons for a child or young person's behaviour and:

- identify proactive strategies designed to improve the child or young person's quality of life and seek to remove the conditions likely to promote behaviour that challenges, including changing the environment (for example, reducing noise and increasing predictability) and promoting active engagement through structured and personalised activities;
- identify adaptations to a child or young person's environment or routine and help them to develop alternatives to behaviour that challenges to achieve their goals, for example improved communication, emotional regulation or social interaction;
- identify preventative strategies to calm the child or young person when they begin to show early signs of distress, such as relaxation techniques and diversion into activities they find enjoyable and rewarding;
- identify reactive strategies to manage behaviours that are not preventable, including how family members, staff or carers should respond if a child or young person's agitation escalates and there is a significant risk of harm to themselves and/or others;
- be reviewed frequently – particularly if behaviour that challenges or use of restrictive interventions increases or quality of life deteriorates;
- identify any training to help family members, staff or carers improve their understanding of behaviour that challenges; and
- identify those responsible for delivering the behaviour support plan and the person responsible for coordinating it.

4.22 Behaviour support plans may form part of the provision specified in Education, Health and Care plans for children and young people with special educational needs; care plans and other forms of personalised planning for social care; and plans in Child and Adolescent Mental Health Services provided through the Care Programme Approach. The name of the plan is less important than the quality of assessment, intervention and review underpinning it which should, wherever possible, include involvement of the child or young person, and their family or advocates. Examples of successful positive behavioural support are given in Annex B, in particular case studies 3 – 6, 11 and 12).

# Training and Development of Staff

4.23 Training and development play a crucial role in promoting positive behaviour and supporting those whose behaviour challenges. Settings and services should ensure they enable staff to develop the understanding and skills to support children and young people and help parents to secure a consistent approach (examples of effective training and development are given in Annex B – in particular case studies 3, 9, and 11). Guidelines from the National Institute for Clinical Excellence (NICE) recommend that local authorities and clinical commissioning groups jointly designate a lead commissioner to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing behaviour that challenges.[22] Where local authorities and clinical commissioning groups have jointly designated a lead commissioner to strategically commission health, social care and education services for people with learning disabilities, or those who are at risk of developing behaviour that challenges, the commissioner might have a role in coordinating this staff development.

4.24 Training should be tailored to take account of the needs of the children and young people being taught and/or cared for and the role and specific tasks that staff will be undertaking. It should cover approaches to meeting children and young people's needs more effectively, preventing the escalation of crisis situations, and reducing and minimising the need for restraint through positive behavioural support. In children's homes, the registered person is responsible for ensuring that all their staff have been adequately trained in the principles of restraint and any restraint techniques appropriate to the needs of the children the home is set up to care for.

4.25 Staff should only use restraint techniques for which they have received training and can demonstrate competence. The setting or service should record the methods that a member of staff has been trained to use.

4.26 Training could usefully include knowledge, understanding and skills in relation to:

- considering the views and experiences of children, young people and their families;
- communicating with (and listening to) children and young people whose way of communicating is non-verbal, including those with speech, language and communication needs;

- identifying the causes of and triggers for behaviour that challenges, including those that may stem from medical conditions, sensory issues, or an unmet need or undiagnosed medical condition;

- the thoughts and feelings of staff on being exposed to behaviour that challenges;

- the assessment and management of risks, including dynamic risk assessment;

- building positive relationships, involving children, young people and parents in planning, developing individual behaviour support plans and reviewing support;

- alternatives to restraint, including effective use of techniques to calm a situation or de-escalate it and obviate the need to use restrictive options;

- safe implementation of restraint, including how to minimise associated risks, particularly in respect of the growth and development of children and young people;

- use of planning tools and advanced decision-making to promote safety in the use of restraint; and

- examples of effective practice in meeting the needs of children and young people whose behaviour challenges.

4.27 Settings and services will also wish to consider whether it would be helpful to provide appropriate training to parents alongside staff to promote consistent approaches and aid communication between home and the setting. This approach has been found to be beneficial in some contexts.

4.28 It is up to settings and services to commission the training they require to meet the needs of those they educate or care for and the training and development needs of staff. As employers, settings and services should conduct due diligence before commissioning any training, including checking that the training has been devised by experts with a successful track record of working in the relevant specialism. They should look for evidence that any restraint techniques promoted by the training have been medically assessed to demonstrate their safety for use with children who are still developing, physically and emotionally. Settings and services should routinely review the effectiveness of any training commissioned.

4.29 The British Institute of Learning Disabilities (BILD ACT) certifies training providers complying with the Restraint Reduction Network Training standards. The Restraint Reduction Network (RRN) – a charity and subsidiary of BILD – has worked with Health Education England to develop quality standards for training providers delivering training with a restrictive intervention component.[23] The standards offer a benchmark for training which includes restrictive intervention in health settings and are mandatory in NHS commissioned services. Although primarily designed for health, the standards reference education and social care settings. The RRN framework sets out any specific considerations or adaptations to the standards that should be taken into account for different populations (including learning disabilities, autistic spectrum conditions and mental health difficulties) or settings (including schools and foster carers). The standards are designed to ensure that training improves staff skills and confidence in how to understand people’s behaviour, keep them safe and better meet their needs. They aim to ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills, goes beyond the application of restraint and restrictive interventions to focus on human rights, prevention, de-escalation of crisis situations and encourages reflective practice. The UK Accreditation Service (UKAS) accredits certification bodies against internationally recognised standards to demonstrate their competence, impartiality and performance capability. Bodies certifying compliance with RRN training standards, including BILD ACT, must be accredited by UKAS.

4.30 Other accrediting bodies have also expressed an interest in providing certificated accreditation schemes through universities. The Institute of Conflict Management (ICM) has also developed a Quality Award Scheme, established with the support of the Health and Safety Executive. Education and child care specialists are working with the ICM to produce national standards for providers of training in mainstream and special schools which take account of the particular circumstances and legislation that apply in those settings. All settings and services should ensure that any training and development commissioned is consistent with the core values and key principles in Chapter 3. When commissioning training, settings and services are advised to consider UKAS accredited training as UKAS is the government recognised national accreditation service.

## Assessing and Managing Risks

4.31 In most settings where restraint takes place a child or young person is known and behaviours that challenge are often foreseeable, though it may be difficult to predict exactly when they will occur or the degree of challenge they will pose. Settings and services can seek to reduce risk and improve foresight by following the advice in this guidance and:

- exploring why children or young people behave in ways that pose a risk;
- trying to understand the factors that underlie or influence the behaviour and the triggers for it – some of these may stem from the environment created by the service or setting itself;

- recognising the early warning signs which indicate that the behaviour is beginning to emerge;
- developing the skills to manage difficult situations competently and sensitively; and
- understanding and developing alternatives to restrictive intervention such as de-escalation techniques.

4.32 A decision on whether or not to use restraint will always require consideration of individual circumstances and is a matter of professional judgement. Decisions should be made within the framework of core values and key principles in Chapter 3 and be subject to monitoring and review.

4.33 Any use of restraint carries risks. Risks may be to the child or young person whose behaviour challenges, other children and young people, staff, other adults or property. They may arise as a result of interactions between the child or young person and their environment, the direct impact of their behaviour that challenges, or measures and interventions used to limit or manage risks to the child or young person and/or others.

4.34 Those risks need to be balanced against the risks associated with other courses of action, including the risks of taking no action at all. Risks associated with applying restraint or deciding not to do so include causing physical injury, causing a flight response, psychological trauma, distress and emotional disturbance to the child or young person and to staff.

4.35 Assessing risk involves using what is known from experience to make rational judgements about risks and weighing up options. It is about trying to predict the situations in which risks may occur, estimating the likelihood of the risk and potential harm that may occur, and gauging the seriousness of any harm that could result.

4.36 Sound assessment of risks will enable decisions to be made which:

- respect children and young people’s rights;
- limit the level of inherent risk to which the child or young person and others are exposed;
- avoid unreasonable risks for the child or young person and others; and
- ensure that an intervention is necessary, appropriate and proportionate to the risks that it presents. The end should justify the means. A fair balance has to be struck between the severity and consequences of the intervention for the child or young

person being restrained and the aim of the restraint. This requires consideration of the reasons why they may be particularly vulnerable to harm, such as their age, experience of trauma, health problems or disabilities. The means of restraint and its duration should be no more than necessary to accomplish its aim.

4.37 When considering whether to use restraint with a child or young person, staff should ask themselves: “At this moment what is in the best interests of the child and/or those around them, taking account of the risks presented?”.

4.38 In assessing risk, staff should take into account:

- the size, age and understanding of the child or young person;
- the specific hazards they face;
- their particular vulnerabilities, learning disabilities, medical conditions and impairments;
- the relative risks of not intervening;
- the child or young person’s previously sought views and experiences, and those of parents and carers, on strategies and approaches they considered might de-escalate or calm a situation;
- the method of restraint that would be appropriate in the circumstances; and
- the impact of the restraint on the future relationship with the child or young person

4.39 Options for reducing risks should be thoroughly explored, and the benefits and drawbacks of each considered and, where possible, recorded. Where there are concerns that the risk reduction options being considered may themselves give rise to risks to the child or young person or others, settings and services should consider whether to seek advice from others such as:

- local safeguarding partners and other relevant agencies;
- the Health and Safety Executive;
- medical advisers;
- legal advisers;
- local authority; and
- Local Health and Wellbeing Board.

4.40 Measures agreed for managing identified risks should be set out in an agreed behaviour support plan for the child or young person. The child and their parent or the young person should be fully involved in the process. The plan should be shared with all those with a role in implementing it and monitoring its impact. Appropriate training should be provided for staff to ensure that they have the competence and skills to implement it. In some cases, training may be required as a matter of urgency so that the plan can be implemented without delay.

4.41 Regular reviews of risk assessment and management measures, including arrangements for staff training and development should inform future planning and help to improve day-to-day practice.

4.42 *Minimising and Managing Physical Restraint*[24] is guidance intended for secure training centres (STCs) and under-18 young offender institutions (YOIs) but has valuable information on ensuring appropriate accountability for use of restraint.

## Planned and Unplanned Interventions

4.43 Planned interventions are when staff employ, where necessary, planned and agreed approaches to behaviour that challenges that have been set out in a child or young person's behaviour support or care plan and detail any action to restrain a child or young person. Planned interventions will be based on a careful risk assessment, including an understanding of their needs (including their particular vulnerabilities, learning disabilities, medical conditions and impairments), their best interests and evidence about the risks faced.

4.44 Unplanned interventions require professional judgement to be exercised in difficult situations, often requiring split-second decisions in response to unforeseen events or incidents where trained staff may not be on hand. Such decisions, known as dynamic risk assessments, will include a judgement about the capacity of the child or young person at that moment to make a safe choice. Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should seek assistance from appropriately trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should use the minimum force necessary in order to achieve the aim of the decision to restrain.

4.45 When children and young people are known to the service or setting, they will have had their needs carefully assessed, and support for their behaviour should be in place through their individual behaviour support plans. Such plans should include planned and agreed approaches to managing behaviour that challenges and prevent it from escalating and, ifs appropriate, any agreed approaches to restraint. An unplanned intervention for a child or young person with a support plan should prompt discussion about whether the plan needs to be changed.

## Settings and Services where Children and Young People May Not Be Known

4.46 The core values and key principles in Chapter 3 above apply to the management of unforeseen behaviours that challenge, even in contexts where they cannot be anticipated or responses pre-planned such as Accident and Emergency departments, the ambulance service, or mental health services that admit patients with little or no knowledge of their background.

4.47 In services like these, where people's histories and care needs may not be known or understood, individual planning will not be possible. Nonetheless, a range of whole-service approaches can promote therapeutic engagement, avoidance of conflict situations and the safe support of people at times of behavioural crisis. These can address potential triggers for behaviour that challenges, including oppressive environments, the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments and poor or confusing environmental design. At national level, the Mental Health Crisis Care Concordat[25] has brought a range of national organisations together to make a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England. The Concordat covers policy making and spending decisions, anticipating and preventing mental health crises wherever possible, and making sure effective emergency response systems operate in localities when a crisis does occur. The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations containing commitments and actions to deliver services meeting the principles of the National Concordat.

4.48 There are a number of resources which support settings or services to adopt a whole-service approach to the reduction of the need for restraint. The NICE guideline *Violence and Aggression: short-term management in mental health, health and community settings*[26] contains guidance for specific settings including Accident and Emergency and primary care. Where the Safewards[27] model has been implemented in adult acute mental health settings, they have demonstrated significant reductions in conflict situations, use of physical restraint and restrictive intervention, seclusion and rapid tranquillisation. Settings and services may wish to consider whether similar approaches could be replicated in their own context.

4.49 A number of health and voluntary and community sector organisations have developed 'hospital passports' or 'communication passports' for people with learning disabilities or autistic spectrum conditions. These passports provide useful information for hospital staff who will not have previous knowledge of the person and can include information about managing and preventing behaviour that challenges.[28] Communication passports typically include information on who should be contacted, how the person communicates and shows pain, and what should be done if they become anxious. While these passports have been developed for use in health contexts, other settings and services may wish to consider this approach.

# Escalation

4.50 Every behaviour support plan should have a process for supporting a child or young person to avoid crisis and a protocol for escalation. If the individual is at risk of admission as a mental health inpatient, or has been subject to an emergency admission, a Care Education and Treatment Review must be undertaken to identify the factors that are preventing adequate and safe support being provided where they live, or preventing their discharge. The Review is an essential element to ensuring children and young people with learning disabilities, autistic spectrum conditions or both, who are likely to be admitted to or stay too long in mental health / learning disability wards in hospitals, are supported to remain in the community. Detailed guidance on the review process has been issued by NHS England.[29]

4.51 Police may exceptionally be called upon to help manage a dangerous situation and will use techniques and act in accordance with their professional training. Staff of the setting or service are responsible for alerting police officers to any specific risks or health problems that a child or young person may have ('hospital passports' may be helpful here), as well as monitoring the child or young person's physical and emotional wellbeing and alerting police officers to any specific concerns. Staff of the setting or service and police officers have a responsibility to ensure that situations do not unnecessarily escalate. Staff should be alert to the risk of any health condition which could be exacerbated by restraint, continue to monitor the young person's physical and psychological wellbeing throughout the incident of restraint, and respond to any signs of, for example, respiratory or cardiac distress.

4.52 Guidance for the police is available in the Association of Chief Police Officers and National Policing Improvement Agency's Guidance on Responding to People with Mental Ill Health or Learning Disabilities.[30]

# Safeguarding the Welfare of Staff

4.53 Employers have a duty under section 2 of the Health and Safety at Work etc Act 1974 (1974 Act) to ensure, so far as is reasonably practicable, that the health, safety and welfare at work of their employees. Section 3 of the 1974 Act places a duty on employers to conduct their undertaking in such a way as to ensure, so far as is reasonably practicable, persons who are not their employees and who are affected by the employer's undertaking are not exposed to risks to their health and safety. Employers must:

- assess the risks to employees and others (including the risk of reasonably foreseeable violence) and implement steps to reduce these risks;

- provide adequate information, instruction, training and supervision to ensure the health and safety of employees;

- monitor and review arrangements put in place to reduce the risks to ensure they are effective; and

- establish transparent processes to acknowledge the hazardous nature of any foreseeable incidents and of any restrictive interventions.

The duty includes risks arising from both violence and the use of restrictive interventions.

# Recording and Reporting

4.54 Settings and services will wish to consider when to record occasions where restraint is used, whether planned or unplanned. (Depending on the type of setting or service, this may be a requirement.) Information should be open and transparent and enable consideration to be given to the appropriateness of use of restraint.[31]

4.55 CQC and Ofsted will take into account the quality and impact of the recording of restraint in their inspection activity. Where this fails to meet the requirements or good practice expectations set out in the relevant regulations, guidance or standards they will take action as appropriate, including enforcement action.

4.56 In health services, record keeping should be consistent with the requirements of the Mental Health Services Dataset[32] and the National Reporting Learning System.[33] Services must publish an annually updated, accessible report on their behaviour support planning and restrictive intervention reduction programmes. This must outline the training strategy, techniques used, with what frequency and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.

4.57 In children's homes, record keeping should be consistent with regulation 35 of the Children's Homes (England) Regulations 2015 which, amongst other things, requires reporting of restraint within set time periods. However, regulation 35(4) allows exemption from the recording requirement for specific types of restraint used within some children's day-to-day routine if that restraint is included as a provision in those children's Education, Health and Care plans.

4.58 In residential special schools, the National Minimum Standards require a written record for any use of reasonable force within 24 hours of the incident. Other non-residential special schools are not covered by such a specific statutory requirement but must have behaviour policies. It is good practice for all special schools to set out, in their behaviour policy, the circumstances in which force might need to be used. Any policy on the use of reasonable force should acknowledge schools' legal duty to make reasonable adjustments for disabled children. Any use of reasonable force should be followed by a post-incident review, with the child and parents and a staff debrief (see below).

## Post-incident Support

4.59 After incidents, the child or young person and the staff involved should be given emotional support and basic first aid for any injuries as soon as possible. Immediate action should be taken to secure medical help for injuries that require other than basic first aid. All injuries should be recorded in accordance with the setting or service's procedures and reported as appropriate to the Health and Safety Executive. Action taken in respect of post-incident support could include trauma support for children, young people and their families affected by the use of restraint.

## Reviewing Actions to Improve Support

4.60 Settings and services should ensure that appropriate lessons are learned from instances where restraint has had to be used, including any patterns and trends, and consider how use of restraint might be avoided in future. This will usually involve de-briefing and post-incident review and monitoring of the use of restraint and restrictive intervention. The process should consider all types of individual plans that reference behaviour support, including behaviour support plans, and wider policies.

4.61 It is good practice to involve the child or young person and, wherever possible, parents, advocates and other relevant representatives in planning, monitoring and reviewing how and when restrictive interventions are used. If the child, young person and parents are not involved this should be documented and reasons given.

## De-briefing and Post-incident Review

4.62 As soon as possible after the use of restraint, the member of staff involved should be de-briefed by an appropriate manager to allow for reflection, and for the manager to deal with the emotions raised by the incident. This improves staff learning and contributes to professional development.

4.63 Whenever restraint has been used, staff and the child/young person should have separate opportunities to reflect on what happened, and wherever possible a choice as to who helps them with this. Those with cognitive and/or communication impairments may need specific help to engage in this process, for example, use of simplified language, visual imagery or Alternative and Augmentative Communication.

4.64 Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews. Someone appropriate and trusted by the child/young person and their family or, where appropriate, the individual's advocate, could also play a role. Reviews could involve a facilitated staff team discussion about the warning signs of an impending incident, whether any previously agreed behaviour plans were followed, what de-escalation strategies were used and how effective they were, and what might be done differently in future.

4.65 Someone who was not involved in the incident should be involved in post-incident reviews in order to seek to understand – from the points of view of the child or young person and family – whether the setting or service did not understand what was needed, what upset the individual most, whether and how staff actions were helpful or unhelpful, and how things could be better in the future, including any changes which might be made, e.g. to the care environment.

4.66 If a pattern of persistent use of restraint emerges, and if a setting or service considers they do not have sufficient expertise themselves, an expert assessment should be sought, to identify the triggers for the behaviour that leads to use of restraint. The reviewer should consider, with the child or young person, and as appropriate, their parents and/or advocates, revising their individual support plan. Consideration should also be given to improving staff training and development as part of action to address the issue.

# Monitoring

4.67 Managers or staff should use aggregated information from reviews to consider improvements to policies and practices, including the setting or service's approach to reducing potential triggers to behaviour that challenges or conflict situations. They should take action to change policies or practices where approaches have been used for some time but they have not been found effective. Such action may contribute to fulfilling a setting or service's duties under the Equality Act 2010. This process is especially important in services where young people's histories and needs may not be known or well understood and individual planning is not possible, such as Accident and Emergency departments or primary healthcare settings. To fulfil the Public Sector Equality Duty, settings and services should consider monitoring restraint practice and identifying any disproportionate use of restraint in relation to particular groups who share one of the relevant protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation). Such monitoring and reviewing enable continuous improvement of practice supporting children and young people whose behaviour challenges.

# Transitions

4.68 Children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties whose behaviour challenges face difficult transitions when moving from settings with which they have become familiar – in particular, those they have been attending daily or where they are resident. Settings and services should therefore cover expected transitions in children and young people's behaviour support plans. When young people are moving on to adult provision, for instance, early planning is essential to share approaches that work with the new service or setting, to enable familiarisation for the young person, involving them and where appropriate, their parents or carers.

# 5. Different Forms of Restraint

5.1 Any form of restraint must be lawful and based on individual circumstances. It should be consistent with the core values and key principles in Chapter 3, including an appropriate assessment of risks, be proportionate to those risks and be used for no longer than is necessary.

5.2 For children and young people detained under the Mental Health Act 1983, the Mental Health Act Code of Practice 2015 provides detailed statutory guidance on the different types of restraint and the relevant considerations that apply to the use of such techniques (Chapter 26). Where those that are bound by the Code are working with children and young people in any of the settings also covered by this guidance, such as Learning Disability Assessment and Treatment Units or a children and adolescent mental health ward, they must follow the procedures in that document.

5.3 Restraint can take different forms. Some forms of restraint may amount to a deprivation of liberty, although it should be noted that a restriction of liberty is not the same as a deprivation of liberty but depends on the degree or intensity of the restrictions.[34] Article 5 of the European Convention on Human Rights states that ‘everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law’. There are various routes to deprive individuals of their liberty. This includes when individuals aged 16 and above lack mental capacity, as defined by the Mental Capacity Act 2005, and are deprived of their liberty for care and treatment purposes.

5.4 Legislation and case law are currently evolving for 16 and 17-year olds who lack mental capacity and cannot consent to their care and treatment arrangements which give rise to a deprivation of liberty. Where settings think they may be depriving anyone in this group of their liberty, they should seek legal advice to ascertain the most up to date position and the processes they must follow so that this deprivation is necessary, proportionate and lawful.[35]

5.5 For children aged 15 and below, the Mental Capacity Act does not generally apply and cannot be used to determine mental capacity, but the same legal tests apply for whether the arrangements amount to a deprivation of liberty as for those aged 16 and 17. For children aged 15 and below, those with parental responsibility can generally consent to deprivations of liberty on behalf of their child. Where parental consent cannot be used, local authorities and other bodies/individuals must apply to the High Court for authorisation under the Court’s inherent jurisdiction to deprive the child of their liberty. There is currently no central guidance to advise local authorities or others on decisions relating to deprivation of liberty orders.

Responsible bodies are expected to use their professional judgement, taking into consideration the individual needs of the child.

5.6 The independent review in 2018 of the Mental Health Act has made a series of recommendations intended to deliver a system which is more responsive to the wishes and preferences of the patient, which takes more account of a person's rights, and to improve as much as possible the ability of patients to make choices. It emphasises that care should be delivered safely in the least restrictive way.[36]

5.7 The different forms of restraint described below apply generally and not only to children and young people detained under the Mental Health Act or subject to deprivations of liberty, including through the Mental Capacity Act.

## Physical Restraint

5.8 Staff must not intentionally cause pain to a child or young person in an attempt to force compliance with their instructions. Any period of restraint can be dangerous, particularly where it occurs on the ground. People should not be deliberately restrained in a way that affects their airway, breathing or circulation, for example by covering the mouth and/or nose or applying pressure to the neck region or abdomen. If a child or young person is unintentionally held on the ground, staff should release their holds or reposition into a safer alternative or standing position as quickly as possible. For any form of restraint, including seated and standing, there is a risk of physical and psychological harm, and it should be avoided where possible. Staff should be aware of any specific regulations and guidance that govern the use of restraint in their settings.

5.9 A member of staff should take responsibility for communicating with the child or young person throughout any period of restraint in order to attempt continually to de-escalate the situation. Staff should also continue to monitor the child or young person for signs of emotional or physical distress following any such period of restraint.

## Mechanical Restraint

5.10 Mechanical restraint involves use of a device to prevent, restrict, or subdue movement of a person’s body with the aim of controlling their behaviour. Mechanical restraint may be used to manage extreme aggressive behaviour directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity. This contingency is most notably encountered with small numbers of children and young people who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard them from the consequences of their behaviour. Any such devices should only be put in place by people with relevant training, qualifications, skill and experience. Wherever mechanical restraint is used as a planned contingency, it should be identified within a support plan which aims to obviate the need for its continued use.

## Medication (Chemical Restraint)

5.11 Chemical restraint refers to the use of medication prescribed and administered by health professionals for the purpose of quickly controlling or subduing disturbed/aggressive behaviour and inappropriate prescription of substances for non-medical reasons, where it is not prescribed for the treatment of a formally identified physical or mental illness. It should be used only for a child or young person who is both (a) highly aroused, agitated, overactive, aggressive, is making serious threats towards others or themselves, or is being destructive to their surroundings, and (b) when other therapeutic or restrictive interventions have failed to contain the behaviour. An antipsychotic, an antidepressant, or both should not be prescribed in response to behaviour that challenges without an appropriate clinical reason.

5.12 Chemical restraint should only be used by health professionals as part of an agreed support plan and should be delivered in accordance with evidence-based best practice guidelines and by staff with the relevant qualifications, skills and experience to administer it. Prescribers should provide information to those who provide care and support about any physical monitoring that may be required in addition to information about the medication to be used and how it should be administered (the route of medication).

5.13 *Stopping over-medication of people with a learning disability, autism or both* (STOMP) is a project led by NHS England which aims to reduce the use of medication, promoting non-drug therapies and making sure that people, families and staff are fully informed and involved. All health care providers who prescribe psychotropic medicine to people with a learning disability, autism or both are asked to adopt the STOMP health care pledge:

- We will actively explore alternatives to medication.
- We will ensure people with a learning disability, autism or both, of any age and their circle of support are fully informed about their medication and are involved in decisions about their care.
- We will ensure all staff within the organisation have an understanding of psychotropic medication including why it is being used and the likely side effects.

- We will ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication.

- We will maintain accurate records about a person’s health, wellbeing and behaviour.

- We will ensure that medication, if needed, is started, reviewed and monitored in line with the relevant NICE guidance.

- We will work in partnership with people with a learning disability, autism or both, their families, care teams, healthcare professionals, commissioners and others to stop over medication.

5.14 The Voluntary Organisations Disability Group (VODG) has developed a similar pledge for social care organisations.[37]

## Withdrawal (Imposed and Autonomous) and seclusion

5.15 This section refers to withdrawal and isolation as a method of removing a child or young person from a situation which causes them anxiety or distress and taking them to a safer place where they have a better chance of composing themselves. It does not refer to actions which are intended as a disciplinary penalty. Such practice is outside the scope of this guidance.[38]

5.16 Where withdrawal is against the individual’s will (‘imposed withdrawal’), it is a form of restraint carried out under a setting’s duty of care to protect the child from harm, or risk of harm, to themselves and/or others. Any use of force by staff in those circumstances must be reasonable.

5.17 In some cases, because of the effects of their impairment or condition, a child or young person may actively choose to move to a quiet space for a period, for example when their anxiety levels rise and they become agitated, in order to calm down and ‘self-regulate’ their behaviour, averting the need for restraint. We describe this practice as ‘autonomous withdrawal’. Staff should take steps to support them and monitor their progress. Where this is the case, appropriate provision should be made for this in the child or young person’s support plan and kept under review with the child, parents and/or young person. This would not constitute restraint as the child or young person is free to leave the quiet space. Settings and services should take care to ensure that their use of language is clear regarding when withdrawal is autonomous or imposed.

5.18 Seclusion (which may be described alternatively in different settings, for example single separation in secure children’s homes) is a form of restraint referring to the supervised containment and isolation of a child or young person away from others, in a room/area from which they are prevented from leaving. It should only be used to contain severely disturbed behaviour, including which is likely to cause harm to others, and for the minimum time necessary. Staff would normally stay with the individual to support them and monitor their progress until they are ready to resume their usual activities.

5.19 Seclusion should never be used solely as a means of managing self-harming behaviour. It should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the individual's health or safety arising from their own self-harm and that any such risk can be properly managed.

5.20 All settings should adopt consistent, transparent, and fair procedures for the use of such measures. They should publish rules or policies setting out when measures will be used, what they consist of, and what will happen in case of non-compliance. Schools in particular should also consider whether parents and children could be given the opportunity to express views about these measures.

5.21 Schools could also ask parents to state explicitly that they are aware of these rules or policies, and to accept that sending their children to the school means their children will be subject to them, and that they have granted consent.

5.22 Parents can make decisions about their children's lives within certain bounds. This includes the power, within certain limits, to consent to their child being confined by others.[39] This consent must be reasonable. Schools should note that if a child or young person is being treated to greater levels of restriction than their peers, especially without parental consent, that is likely to be a deprivation of liberty. As a rule of thumb, case law suggests that from about age 12 onwards, extensive or total confinement is increasingly likely to be a deprivation of liberty and therefore unlawful (see Annex A for further detail).

5.23 If staff anticipate that withdrawal and seclusion are likely to be necessary, the circumstances and methods used should be discussed with the child or young person, their parents and other relevant adults as appropriate, and should be noted in the individual's support plan.

5.24 Any use of force to get the child or young person into, or prevent them leaving, a place must comply with the requirements of section 93 of the Education and Inspections Act 2006.

5.25 For children detained and treated under the Mental Health Act 1983 (MHA), the use of seclusion must follow the guidance in the MHA Code of Practice. If an emergency situation arises involving someone who is being treated for a mental disorder and who is not detained under the MHA (an informal patient) and seclusion is necessary to protect themselves and/or others from risk of injury or harm, it should be used for the shortest possible period to manage the situation and an assessment for detention under the MHA should be undertaken immediately.

## Long-term Segregation under the Mental Health Act 1983 in Hospital Settings

5.26 Long-term segregation, where a child or young person is prevented from mixing freely with other children or young people, should only be used in hospital settings; and by health professionals for those who present an almost continuous risk of serious harm to others and for whom it is agreed there would be benefit from a period of intensive care and support in a discrete area that minimises their contact with other children or young people. Particular attention should be paid to the potential risks of segregation as a form of restraint, considering the needs and behaviours of the child or young person. Segregation should not be undertaken for someone presenting, or at risk of, self-harm. Long-term segregation must never take place outside of hospital settings and should never be used with children or young people except those who are detained under the Mental Health Act 1983. It must only ever be undertaken in conjunction with the safeguards for its use in the MHA Code of Practice.

5.27 The Care Quality Commission thematic review has a particular focus on how hospital and residential care providers can protect the welfare and rights of those who are subject to prolonged seclusion or segregation. Its initial report, published in May 2019, focused on NHS and independent child and adolescent mental health wards, and NHS and independent sector wards for people of all ages with learning disabilities and or autism. Its recommendations include that 'all parties involved in providing, commissioning or assuring the quality of care of people in segregation, or people at risk of being segregated, should explicitly consider the implications for the person’s human rights. This is likely to lead to both better care and better outcomes from care.' Blanket Restrictions

5.28 Oppressive environments and the imposition of blanket restrictions such as permanently locked doors, or removal of access to outdoor space or refreshments can have a negative impact on children and young people’s behaviour and may breach requirements under the Human Rights Act 1998 or other legislation, for example relating to secure accommodation of children. Where, exceptionally, blanket restrictions are considered necessary, they should be governed by a clear policy which indicates how such restrictions comply with the Human Rights Act

1998 and other relevant legislation and the reasons for them should be explained to children and young people and to their families.

## Summary

5.29 The negative impact that the use of restraint has on children and young people and those that care for them has been well documented.

5.30 The aim for all services and settings should be to improve the safety and well-being of children and young people in their care by developing proactive strategies to reduce the likelihood of behaviours that challenge and reduce and minimise use of restraint and restrictive intervention.

5.31 Settings and services covered by this guidance should know the law and relevant guidance that applies to them and:

- use evidence-based approaches to behaviour support;
- have policies in place for promoting positive relationships and behaviours and eliminating unnecessary and inappropriate use of restraint;
- have clear arrangements for governance and accountability in respect of behaviour and responses to behaviour that challenges;
- involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint, including through the development and review of behaviour support plans;
- ensure staff are suitably trained in understanding the range of communication used by children and young people, minimizing the need for, and safely and appropriately using, restraint where necessary and provide opportunities for regular staff development;
- understand when expert help is required from specialists;
- have a system in place for continually improving assessment and management of risk;
- have a system for recording and reporting incidents where required, which enables children and young people who have been restrained on those occasions to express their feelings about their experience; and

- have a system in place for reviewing how restraint is used in individual cases and patterns and trends in its use, changing practice where necessary to reduce and minimise its use.

# 6. Annex A. Legal Duties and Relevant Guidance

6.1 Alongside this guidance, readers will also need to be familiar with the law and good practice guidance that relates to their service or setting. In some cases this will set out requirements or expectations that go beyond the guidance in this document

6.2 The following is a summary of the purposes for which restraint or force may be used lawfully and the legislation relevant to their use. It does not give a precise statement of the law. That can only be found in the legislation and case law. Annex A does not provide an exhaustive list of legal requirements and provisions.

6.3 If organisations and staff use restraint on those in their care they must have a lawful basis for doing so. The law in respect of issues continues to evolve. Settings and services should review and update their local policies on an ongoing basis in light of legal developments.

## Human Rights Act 1998

6.4 All services must abide by the Human Rights Act 1998 (HRA). The HRA imposes a duty on public authorities (including NHS Trusts, state-funded schools and colleges and local authorities) and other services exercising functions of a public nature not to act in a manner that is incompatible with the European Convention on Human Rights (ECHR).[40] The rights that are most likely to be infringed by improper use of restraint are:

- the prohibition of torture and inhuman or degrading treatment (Article 3);
- the right to liberty and freedom (Article 5);
- the right to a fair trial and no punishment without law (Article 6);
- the right to respect for private and family life (Article 8);
- freedom of thought, religion and belief (Article 9); and
- no discrimination (Article 14).

6.5 Settings and services and their staff should help all children and young people and their families to understand the legal authority for any proposed action and their rights. No restrictive intervention should be used unless it is justified in all the circumstances of the case and is in line with the legislation and relevant statutory guidance that applies to specific settings and services.

6.6 Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for Article 3 may nevertheless breach Article 8 rights if it has a sufficiently adverse effect on the child or young person's private life, including their moral and physical integrity.

6.7 Restrictions that alone, or in combination, deprive children and young people of their liberty, without lawful authority, will breach Article 5 of the ECHR (the right to liberty).

## Equality Act 2010

6.8 All settings and services must ensure that they comply with the Equality Act 2010 which requires that they do not discriminate against individuals in relation to protected characteristics (these are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation). The Act makes different provision for different settings, with the basic requirement that settings and services must ensure they do not:

- treat individuals less favourably because of a protected characteristic (direct discrimination);
- apply a provision, criterion or practice that puts an individual with a given protected characteristic, and others who share that characteristic, at a disadvantage compared to someone who does not share that protected characteristic, for example by having a blanket behaviour policy that is applied in the same way to all but in practice causes special problems for disabled children (indirect discrimination);
- behave in an unwanted way which relates to a relevant protected characteristic and which violates or is meant to violate the dignity of an individual or creates an intimidating, hostile, degrading, humiliating or offensive environment for that person (harassment); and
- single out individuals for unfair treatment because they (or in some circumstances their parents or siblings) complain about discrimination or try to seek redress under the Equality Act (victimisation).

6.9 Public authorities are subject to the Public Sector Equality Duty. This means that they must have 'due regard' to the need to eliminate unlawful discrimination, to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic and those who do not.

6.10 Having 'due regard' to the need to advance equality of opportunity is defined further in the Equality Act 2010 as including having due regard to the need to:

- remove or minimise disadvantages;
- take steps to meet different needs; and
- encourage participation when it is disproportionately low.

## Deprivation of Liberty

6.11 The Mental Capacity Act 2005 empowers individuals to make their own decisions where possible and protects the rights of adults and young persons (aged sixteen and over) who lack the mental capacity to make a specific decision at a particular time. The Act provides a legal framework for others to act in the best interests, and make decisions on behalf, of persons who lack capacity to make a specific decision at a particular time and provides for Court authorisation of certain decisions and treatment. It also includes a system for authorising deprivations of liberty.

6.12 The Mental Capacity Act Code of Practice[41] provides statutory guidance on the use of the Act, including issues around care and treatment (including restraint). Arrangements around deprivations of liberty for care and treatment purposes for individuals lacking mental capacity aged sixteen and over will change when the Liberty Protection Safeguards system is introduced. Where settings think they may be depriving anyone in this group of their liberty, they should seek legal advice to ascertain the most up to date position and the processes they must follow so that this deprivation is necessary, proportionate and lawful.

## Health Services

6.13 Mental Health Act 1983 The Mental Health Act 1983 (as amended) covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes.

6.14 Statutory guidance on the use of the Mental Health Act can be found in the *Mental Health Act 1983 Code of Practice 2015*. This includes the following definition of restrictive interventions:

‘Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient’s movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.’

6.15 Chapter 26 of the Code of Practice includes guidance on the use of such interventions, including guidance at paragraphs 26.52 – 26.61 on the use of restraint on children and specific guidance for those under 18 at Chapter 19. It also addresses who can consent to such treatment.

# Mental Health Units (Use of Force) Act 2018

6.16 The aim of the Mental Health Units (Use of Force) Act 2018 is to reduce the use of force by increasing the oversight and management of use of force in mental health units. It identifies use of force as:

(a) the use of physical, mechanical or chemical restraint on a patient, or

(b) the isolation of a patient.

  - “physical restraint” means the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient’s body;
  - “mechanical restraint” means the use of a device which—
  - (a) is intended to prevent, restrict or subdue movement of any part of the patient’s body, and
  - (b) is for the primary purpose of behavioural control;

- “chemical restraint” means the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient’s body;
- “isolation” means any seclusion or segregation that is imposed on a patient.

- The Act is accompanied by statutory guidance from Department of Health and Social Care which sets out in more detail the requirements for health organisations, and their staff, that operate mental health units.

# Health and Social Care

# NICE Guidelines

6.17 NICE Guidelines make evidence-based recommendations on a wide range of topics and represent best practice. Settings and services will wish to have regard to the following NICE Guidelines:

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- Autism in under 19s: support and management
- Antisocial behaviour and conduct disorders in children and young people: recognition and management
- Violence and aggression: short-term management in mental health, health and community settings
- Looked-after children and young people
- Psychosis and schizophrenia in children and young people: recognition and management
- Managing Medicines in Care Homes
- Learning disabilities and behaviour that challenges: service design and delivery

# Schools

# Use of Restraint

6.18 Section 93 of the Education and Inspections Act 2006 allows the use of reasonable force to:

- prevent or stop the committing of any offence by a pupil;

- prevent or stop personal injury to, or damage to the property of any person (including the pupil themselves) by a pupil; or

- prevent or stop a pupil prejudicing the maintenance good order and discipline.

6.19 There are separate powers for schools to conduct a search for prohibited items and separate provisions governing the lawfulness of disciplinary penalties including detentions.

6.20 Guidance on the use of reasonable force by is provided by the non-statutory guidance *Use of reasonable force: Advice for head teachers, staff and governing bodies* (Department for Education, 2013).

6.21 The Department for Education's guidance Mental Health and Behaviour in Schools (November 2018) provides non-statutory advice to help schools support pupils whose mental health problems manifest themselves in behaviour.

6.22 Residential special schools must also have in place policies on behaviour as set out in Standard 12 of *the Residential Special Schools: National Minimum Standards* (Department for Education, in force from April 2015). Those boarding schools also registered as children's homes also need to adhere to the *Children's Homes (England) Regulations 2015* (see below). Both these documents contain specific material on restraint which complements this document.

## Use of Medicines

6.23 Many of the children and young people covered by this guidance will have known medical conditions. Under section 100 of the Children and Families Act 2014, governing bodies of community special and foundation special schools and proprietors of special academies are among the bodies that must ensure that arrangements are in place to support pupils with medical conditions. These arrangements may include drawing up individual healthcare plans for children and young people at the school. Staff undertaking risk assessment and planning for children at heightened risk of restraint should also refer to their individual healthcare plans for information about their medical condition, associated risks and agreed actions.

6.24 In implementing their duty under section 100 of the Act, relevant schools must have regard to the statutory guidance *Supporting pupils at school with medical conditions* (December 2015).

# Children’s Homes

6.25 Children’s homes are governed by the Children’s Homes (England) Regulations 2015 which cover:

- behaviour management and discipline (regulation 19);
- use of restraint (regulation 20);
- employment of suitably trained and qualified staff (regulation 32(3)(b)); and
- behaviour policies including monitoring, reporting and recording (regulation 35).

6.26 The Care Planning, Placement and Case Review (England) Regulations 2010 are relevant to children placed in children’s homes and in foster care (see below). They confirm that the care plan should be provided to the relevant persons. Those making decisions about the use of restraint should therefore be in possession of the circumstances around a particular child, including where the care plan may refer to restraint.

6.27 Guidance for services on meeting the regulations are set out in the Guide to the Children’s Homes Regulations including the quality standards (Department for Education, April 2015). This contains specific material on restraint to which children’s homes must have regard. In addition, secure children’s homes may use restraint for preventing a child or young person from running away from the home.

# Fostering Services

6.28 Fostering service providers are governed by the Fostering Services (England) Regulations 2011. Regulation 13 requires fostering services to have a written policy about acceptable measures of control, restraint and discipline. The regulations are complemented by statutory guidance, including the National Minimum Standards in Fostering Services (the NMS). Together these form the basis of the regulatory framework under the Care Standards Act 2000 (CSA).

6.29 NMS 3 sets out how fostering services should support foster parents to manage appropriately and de-escalate challenging behaviour, including the provision of specialist training where necessary. All fostering service providers are expected to follow the NMS. Compliance is monitored via Ofsted’s inspection regimes (the Social Care Common Inspection Framework for independent fostering providers and the ILACS framework for local authority fostering services).

6.30 Private fostering differs from most other forms of fostering in that the local authority has no role in choosing who will accommodate the child. In most cases the child will not have a care plan and is not a looked after child. There are, however, national minimum standards with which authorities must comply. There is no expectation that someone accommodating a child under private fostering arrangements should have a written policy about restraint.

## Residential Holiday Schemes for Disabled Children

6.31 These schemes are governed by the Residential Holiday Schemes for Disabled Children (England) Regulations 2013 which include:

- use of restraint (regulation 15); and
- behaviour management policy, recording of restraint and reviews (regulation 16).

## Relevant Guidance

6.32 For completeness, a list of the guidance applicable to the settings to which this guidance applies is set out below and in the section above on NICE guidelines:

- Mental Capacity Act Code of Practice: Protecting the Vulnerable (2007)
- Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People (Association of Directors of Children's Services, 2009).
- The Children Act 1989 Regulations and Guidance – Volume 2: Care planning, placement and case review (2015)
- Working Together to Safeguard Children (2015)
- 0-25 Special Educational Needs and Disability Code of Practice (2015)
- The National Minimum Standards for Residential Special Schools (2015)
- Behaviour and Discipline in Schools (2016)
- Use of reasonable force [in schools] (2013)
- Guide to the Children's Homes Regulations including the quality standards (2015)
- Positive and Proactive Care: reducing the need for restrictive interventions (2015)

- The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services (2011)
- Supporting pupils at school with medical conditions (2015)
- Residential holiday schemes for disabled children: National minimum standards (2013)
- Mental Health and Behaviour in Schools (2018)
- Positive environments where children can flourish: a guide for inspectors about physical intervention and restriction of liberty – Office for Standards in Education (March 2018)
- NHS England: Developing support services for children and young people with a learning disability, autism or both (2017)
- Mental Health Services Data Set (MHSDS) v3.0 User Guidance

# 7. Annex B. Positive and Proactive Approaches to Supporting Children and Young People Whose Behaviour Challenges

7.1 The following case studies illustrate essential features of good practice, thorough assessment, understanding behaviour in context, consultation with children and their families, multi-disciplinary planning and review. They demonstrate how to reduce the chances of an incident occurring which may trigger use of a restrictive intervention.

## Case Study 1. A whole school approach to reducing restraint and risk - from the Principal of a Special School

*How a whole-school policy change is reducing use of restraint.*

7.2 At our school we made the decision to change our practice after I attended a conference where HMI was explaining the new inspection process and the need for special schools to think about the number of interventions that had been taking place in our schools. We were also told about the impact that the use of intervention rooms/quiet rooms or time out rooms on can have on the child and the member of staff.

7.3 On returning to school I was faced with quite a difficult task as staff felt, initially, that by removing Ground Recovery holds and informing staff that the holds should be the absolute minimum, I was not keeping them safe. The removal of our intervention areas also caused some consternation as again there was, perceived, no place of safety. However, this is something that I had struggled with for a long time. Why should we have intervention areas? What does that tell the child? The debates were quite wide-ranging and, for a short period, staff were in turmoil about whether they should or should not intervene.

7.4 However, I removed Ground Recovery straightaway and started to investigate the reasons for interventions as a formal process, internally, so that we could understand the mechanisms and choices that had been made prior to any incident taking place. We quickly realised, through this analysis, that we could identify incidents that could have been handled in a different way and that staff reactions could have resulted in a more positive outcome for the child. Amazingly, staff were accepting of the outcomes and fully participated in the process.

7.5 At first the children also found this difficult because we had removed their sense of safety. That is the safety they felt when they knew staff would intervene. In fact, some of the children advised that the staff had 'gone soft'. I gave the children a small budget and asked them to design a chill out zone for themselves. As it turned out, we did not need this for our children and now have reading areas, sensory rooms and phonic suites. We have also developed a therapy suite where our Speech and Language Therapists, School Counsellor and Massage Therapists work. We have developed Thrive across the school and use different interventions such as fishing and horse riding for children when they find the curriculum difficult, but again, these are now used as forms of accreditation for the children so they serve a purpose.

7.6 We worked extensively with the staff teams to ensure that they understood why the changes were being made. I shared lots of examples of cases where issues had arisen and resulted in litigation. I also worked with parents at parents' meetings and coffee mornings explaining the new ethos. Parents were relieved that we had taken this stance as they did not like the idea of staff holding their child.

7.7 We continue to analyse interventions and staff are readily open to questions and answers about their reactions and the outcomes. The numbers of interventions are very low and rare and the children no longer expect this to be the first reaction from staff. As a result of all of the action we have taken the school is now a much calmer and happier place and in fact both staff and children have commented on the positive ethos here. We have also had a lot of positive comments from visitors about how happy the children look.

## Case Study 2. Open-Door: patient involvement to reduce admissions due to crisis

*The following shows action taken in respect of adults, but the approach for better patient involvement to manage hospitals could, if suitably adapted, be used in relation to children and young people.*

7.8 Cambridge and Peterborough NHS Foundation Trust, with Promise Global Initiative, have developed a 'bottom-up' approach to reducing the need for restraint and restrictive intervention. This involves over 200 initiatives in their wards, themed around the concept of space and enhancing the physical environment.

7.9 Changes range in scale from small to large - from replacing the traditional ‘mug shots’ of staff on wards with ‘know me profiles’ using informal photos and including short personal notes to encourage dialogue between patients and staff, to the Open Door initiative which aims to encourage patients to have more control over their care.

7.10 Open Door is a mutual agreement made in advance with patients who are identified as ‘frequent attenders’ at Accident and Emergency Units, Crisis Teams or out of hours GPs. Mostly these patients will have a diagnosis of personality disorder. Their repeat attendance is associated with going through an extremely difficult phase, with high levels of distress. Traditionally, services spent considerable energy trying to keep such patients out of hospitals since this has usually escalated risk in the long run as patients learn to seek help in distress through self-harm or crisis presentations.

7.11 Open Door seeks to put patients in the driving seat. Through prior agreement, patients are offered a two to three-night stay in an assessment unit. This can be requested at any time, the only condition being that they must not have self-harmed in the previous 48 hours. Personalised plans are drawn up following positive risk assessment which seeks to understand the specific drivers for their behaviour. Plans can factor in conditions such as the patient engaging with the community PD (Personality Disorder) service. The service must also uphold its commitment.

7.12 Patient feedback has been positive. Admissions have decreased since the introduction of the initiative and the relationships between patients and services have changed. Patients have reported that it is helpful when thinking about potential future crisis points to know that admission is possible. One patient said, “It has helped me to see that I don’t need to be in hospital for every crisis I experience”.

## Case Study 3. In-depth needs analysis and staff training support a child in school and hospital

*A multi-disciplinary approach to planning for behaviour.*

7.13 J came to his current special school at age fourteen on a 52-week residential placement, having previously been in a local authority special school for children with emotional and behavioural difficulties. He has an autistic spectrum condition and foetal alcohol syndrome.

7.14 J is a very affectionate boy who thrives on positive attention from adults. He enjoys creative role play, football, video games, cookery and art. He also shows interest and care in animals.

7.15 J experienced trauma and neglect from a very young age. During his first few months at his current school, J was very withdrawn and aggressive and had difficulty in forming trusting relationships, struggling to regulate his emotions, feeling anxious and angry at times.

7.16 The school took a systematic approach involving:

- A review of J’s history and background information
- Discussion and review with residential staff and his social worker regarding family contact
- A multi-disciplinary approach, with early observation and identification of need
- Direct work with education and residential staff to increase understanding of needs and share effective strategies and approaches
- Development of a detailed support plan, including individual therapeutic work with consistent structure and staff
- Regular discussion with a behaviour analyst regarding any incidents, triggers and outcomes
- Review and update of support plans – including a personal handling plan (PHP)

7.17 The school’s Therapy Team reviewed J’s history and background information, before providing initial advice and strategies to relevant staff. Initial assessments of J were carried out, including observations, baseline screening for emotional development, review of information from previous placements and consultation with staff. Assessments concluded that staff would benefit from training in Attachment Disorder. This was subsequently delivered to residential and key education staff by an Educational Psychologist (EP) and Assistant Psychologist (AP).

7.18 The EP and AP discussed J’s needs with staff and agreed ongoing strategies, the key to which was building trusting relationships with him and boosting his own self-esteem and self-worth through positive praise and nurturing approaches.

7.19 Staff became able to read non-verbal signs of anxiety and intervened early with positive interaction and reinforcement of positive behaviours. They built relationships with J, allowing him to share his feelings and validating them. Use of Social Story for hospital appointments reduced anxiety, and adults working with J modelled calm and verbal and visual prompting which enabled him to be calm. A multi-disciplinary approach was adopted, including Occupational Therapy and drama therapy input. J had an individual programme which allowed him to explore narratives through drama, use of puppets and creative materials. Through drama therapy J's confidence and self-expression developed and he gained a greater sense of trust and confidence to share his ideas. His personal handling plan was regularly updated to increase staff awareness of triggers and reflect changes to the strategies and approaches to be used.

7.20 J is now much more settled and appears much happier. There has been a significant reduction in instances of physical aggression and he has formed positive relationships with staff, becoming less reliant on one or two key adults. His engagement in lessons has improved and he is more willing to accept positive praise. His English and Mathematics have improved and the number of incidents of physical aggression fell from twelve to none in just three months.

## Case Study 4. A local authority meeting needs through positive behavioural support

*How a positive behavioural needs-approach and analysis uncovers unspoken needs.*

7.21 L is a 9 year old boy with an autistic spectrum condition and a learning disability. It was getting difficult for L to live at home as he was displaying a number of high-risk behaviours, including regularly running away. He was also displaying a lot of self-injury and some aggression. L travelled to and from school via a taxi and would often escape when leaving the taxi.

7.22 A functional assessment showed that L's life was very limited; and the more he ran away, the more he was restricted. L had limited communication skills with which to express his needs. The function of his behaviour was to escape from the boredom and social isolation the restrictions created; the ability to be outdoors and to run, which was not available to him in his everyday life was therefore very valuable to him.

7.23 Following intervention from the Halton Positive Behaviour Support Service, L stopped running away altogether and his other behaviours have reduced. He is now able to move freely around and his functional communication skills and activity have increased. [Case study adapted from material published by the Challenging Behaviour Foundation]

## Case Study 5. Multi-disciplinary team around the child to plan routine medical visits

*Multi-disciplinary team working around the child.*

7.24 B is fourteen and weighs thirteen stone. He has an autistic spectrum condition, a severe learning disability, and does not speak. He is fearful of new situations and being touched. As he becomes more frightened and is confronted by events he does not understand, he becomes aggressive and may injure himself and others. This inhibits his access to health procedures such as visits to the dentist, blood tests or X-rays.

7.25 The multi-disciplinary team working with B provides a range of interventions to address this. B's keyworker, the learning disability nurse, is advised in advance of any procedures he requires. She ensures that the family and the team are fully aware of the nature of the intervention and the practicalities involved in enabling B to be treated.

7.26 B has a Positive Behavioural Support plan which includes provision to help accustom him to essential procedures such as blood tests, dental checks and X-rays. This has reduced his anxiety. The team working with B communicates with those carrying out any procedures about the most suitable venue, time of day, and people who should be present. Adjustments are agreed in advance to help B to access the tests. Even with such preparation, there are times when B will be distressed. The strategy for managing these is planned and agreed in advance, with the family, clinicians and therapists. Options considered included undertaking the procedure with the use of distraction or behavioural strategies or whether restraint or sedation is acceptable and, if so, how to ensure sufficient and appropriately trained staff are available and supported in order to administer this.

7.27 In practice, use of general anaesthetic has rarely needed to be considered. Full paediatric/anaesthetic assessment is arranged in advance of the procedure with risks assessed and understood by all involved.

## Case Study 6. Positive behavioural support helps a child to communicate their needs

*How a child or young person can learn to express needs without aggression.*

7.28 A is an 11 year old boy with a severe learning disability. He likes watching videos and practical tasks such as gardening or DIY with his father. Placing demands on A could lead to aggressive incidents, particularly at school. As aggressive incidents increased, A was permanently excluded from school. His mother had to leave work and his aggression at home increased.

7.29 A functional analysis of A’s behaviour was carried out and a Positive Behavioural Support programme, developed with the Bristol Positive Behaviour Support Service, was used to help A label his emotions so he could express his feelings through Makaton signs rather than aggression. A was supported to develop his emotional literacy and to reintegrate into school.

7.30 A’s family learned new skills so they could help him with his emotional literacy and communication skills. A was much calmer and happier by the time he was discharged from the Bristol Positive Behaviour Support Service and staff described him as “a joy to work with”. [Case study adapted from material published by the Challenging Behaviour Foundation]

## Case Study 7. Preparing an accessible environment and practice for a medical examination

*Adapting the environment and the approach taken by practitioners.*

7.31 D, a twelve year old child with moderate learning difficulties and an autistic spectrum condition, is referred as part of his Education, Health and Care needs assessment to his local paediatrician because of concerns over physical aggression.

7.32 D and his parents arrive on time for his appointment and sit in a very busy waiting room. The clinic is running late and after thirty minutes, when they get into the clinic room, D is highly agitated. The doctor starts asking D questions. He gets up and tries to leave the room, rattling the door knob, then escalates to throwing furniture before starting to strip off his clothes. The doctor cannot examine him and the appointment ends.

7.33 D is then referred to a child psychiatrist for children with learning difficulties. Knowing that he has autistic spectrum conditions and finds clinics difficult, she arranges for him to be directed to a quiet waiting area on arrival and makes sure that the appointment starts on time.

7.34 On entering the room, the doctor focusses initially on talking to parents and allows D to settle before trying to engage him. D initially goes to the back of the room but after ten minutes comes and sits with his parents. The doctor gently tries to engage D, but stops if he seems disengaged or anxious.

7.35 She is eventually able to explain that she would like to examine him and shows what she is going to do by examining his dad. D then allows himself to be examined.

7.36 Arrangements are then made for members of the community learning disability team to visit the family at home to follow up to discuss their concerns about D’s behaviours.

## Case Study 8. A multi-disciplinary therapeutic team prepare a child for complex medical tests

*How a hospital multi-disciplinary team share strategies to manage treatments.*

7.37 O is a ten year old child with Downs Syndrome, an autistic spectrum condition and severe learning disability. He attends a special residential educational placement and is known to a highly specialist Multi-disciplinary Behaviour Team for children with learning disabilities. O has complex medical difficulties and ongoing medical needs. In the past he has experienced painful and invasive medical procedures and has been held down to have blood tests or injections. His mother is taking him to a large hospital for an eight hour specialist assessment of bladder and kidney function involving an injection, drinking a lot, a series of blood tests at hourly intervals, regular scans and a special X-ray and bladder pressure assessment.

7.38 O will need to move between the children’s ward to the urology department ten times, going in lifts, walking in corridors with other patients and visitors and meeting a new team of professionals. O is able to talk, but finds it difficult to express his feelings verbally or process information unless it is presented using a Total Communication Approach (signing, visual support and single to two word level verbal communication). He has a range of behaviours that challenge, including self-injury. He is highly sensitive to the sensory environment and is often chaotic.

7.39 Multi-disciplinary assessment – involving input from highly specialist Speech and Language Therapy, Specialist Occupational Therapy, Psychiatry and Learning Disabilities staff – has identified strategies to support O. A member of the team will accompany O throughout the day. Considerable discussion and planning takes place between the team and named nurse at the hospital, including sharing behaviour plans and strategies, to support the appointment.

7.40 O is given a day room as his base away from the ward and other children to reduce unpredictable occurrences and provide a quiet environment. He has a Social Story, using symbols the night before, which is referred to across the day.

The use of schedules within schedules shows O what is happening, and what he is doing now and next. Reduced verbal input, consistent scripting, a Total Communication Approach with ample time for processing information, and the use of therapeutic sensory strategies achieve the right level of arousal for each activity. This allows O to undergo the whole assessment in a single day without need of restraint.

## Case Study 9. Adapting the classroom and lessons to help a child with acquired brain injury remain in school

*Adapting communications to suit individual needs.*

7.41 T is fourteen. He sustained a brain injury at age eleven following treatment for a brain tumour. T attended a local school. Occupational Therapy (OT) worked together with T, his family and school staff to prevent his behavioural challenges and keep him in school.

7.42 T could not remember the school or home routine. This made him extremely anxious and led to him lashing out at his teachers and parents as he could not verbalise how he was feeling. This led to frequent restraint. He was excluded from school and had regular involvement with the police.

7.43 The OT worked with T, his parents and school staff to help them to recognise that T’s needs from his brain injury were often ‘hidden’. Discussion highlighted how T required a lot of energy to remember what was happening in a day and how to organise himself to be able to do the things he needed to do. Greater understanding of T’s needs changed the way people interacted with him as they could see his behaviour as a response to his challenges, rather than a deliberate way to get attention.

7.44 T used a personal calendar on his mobile phone which he, his teachers and his parents updated to ensure he had a reminder of what was happening in his day. This reduced his anxiety, improved his behaviour and supported his participation in school.

7.45 School staff scheduled in some ‘down time’ for T during the school day, where he used a specific space created in the back of a classroom when he needed to rest for a few minutes; and a ‘pass card’ signed by the head teacher which he could show to his teacher to give him permission to do so.

7.46 Class instructions were given orally and in writing so T could refer back to them. Some activities were broken down into manageable sections so he could focus on one thing at a time. T created a checklist, which he attached to his bag so that he would remember the items he needed to take with him. The teacher also placed T to the side of the classroom and towards the front, so that he was less distracted by the other pupils.

7.47 T's behaviour improved significantly, enabling him to remain in full-time education. Preventative strategies and the increased understanding of teachers and parents meant that restrictive interventions were no longer necessary.

## Case Study 10. Short breaks provider working with parents for greater stability of support

*How working with parents can help with behavioural support.*

7.48 T is a fifteen year old boy with complex learning and behaviour needs and has been diagnosed with severe autistic spectrum condition. T has been coming to the short break project since 2011 and generally enjoys his visits. His package is 24 overnight and 49 sessions throughout the year. He currently attends a special school and is thriving with their support.

7.49 At his previous school T was in a classroom with other young people and attending classes such as English, Maths and Science.

7.50 The structured environment started to become a problem for T and his behaviour began to break down. He started to display unusual behaviour such as hair pulling and biting, often without any known triggers. Eventually his behaviour became too difficult for his previous school to support.

7.51 As a short break service it is good practice for Key Workers to be in contact with parents.

7.52 The short break service were aware of what had been going on at school, but had never seen any of these behaviours and decided to continue with T's visits. Unfortunately, T's behaviour began to break down and he had a couple incidents involving staff. He was provided with 2:1 staffing to help support him.

*7.53* Staff knew how much the service meant to T and his family; not only did it provide T with somewhere to go other than school or home, but it allowed his parents to spend time with their daughter. So, rather than stopping service completely they asked the family about the best course of action. They decided to get T enrolled into his current school, a special school for children with autistic spectrum conditions. While he was settling in, T’s Keyworker also looked at his behaviour support plan and decided on the best way to support him during this time. It was decided that phasing T back into his visits would allow him to gain confidence within the project.

7.54 This was achieved by:

- having T’s mum come in with him for the first few visits and allowing T to decide how long he wanted to stay;
- moving on to have T’s mum sitting in another room while he played;
- arranging for T’s mum to begin bringing him into the project and leaving him with staff to play;
- after a while, arranging for T’s mum to drop him at the door; and
- eventually working up to T having transport to and from school, with overnight visits.

7.55 The service is now continuing routinely on this basis for T and his family.

## Case Study 11. Art-Psychotherapy and multi-disciplinary team involvement help a child in care with Attachment disorder

*A multi-agency approach to in-depth behaviour planning.*

7.56 S was in Year 5 when she was admitted to her current school as a day pupil and is now in Year 8. The school is a special day and residential school for boys and girls aged eight to eighteen with behavioural, emotional and social difficulties who may also have a high functioning autistic spectrum condition. S is looked after by the local authority. Prior to admission she had been living in a local authority children’s home with significant levels of support, including a behaviour support plan in which front Ground Recovery physical intervention was a main form of intervention. S’s behaviour had resulted in exclusions, absences and time out of class.

7.57 S presented as extremely challenging, with high levels of aggression. The school took immediate steps to better understand why, speaking with the NHS Clinical Psychologist involved with her, to get an insight into the underlying causes of her behaviour. It became apparent that she had a significant Attachment Disorder, so the school focussed on addressing Attachment issues as a means of de-escalating aggressive behaviours. This helped staff to understand S better and S to understand herself and her circumstances more clearly.

7.58 The school developed and agreed with S a behaviour support plan to build her self-esteem and self-confidence. It was clear and unambiguous, with definite strategies and identified personnel to implement them. It included significant levels of support, promoted consistency and security and was reviewed regularly. Her Keyworker was carefully chosen to ensure S could identify with her and form a trusting relationship.

7.59 The support plan enabled S to improve her learning and her attainments in both literacy and numeracy and had an extremely positive impact on her self-esteem and self-confidence. From the start the school ensured that S felt very much part of the school. She was encouraged to join after-school clubs and this has enhanced her relationships with other pupils and staff. The improvements led to significant reductions in aggressive outbursts in school. In her time at school, front Ground Recovery holds have never been used and physical intervention has only been used with her on two occasions, neither of them in the last twelve months.

7.60 Multi-agency working was very important. An Art Psychotherapist with specialism in Attachment Disorders worked under the supervision of the NHS Clinical Psychologist, who spent a day at the school evaluating her practice. The Art Psychotherapist worked directly with S and spent time with her Form Tutor, Classroom Support Assistant and Keyworker, providing them with valuable insight into her emotional wellbeing and undertaking extensive training with them. This enabled staff who worked with S on a daily basis to adapt and alter their approaches, creating a warm and secure environment with low anxiety; and helped them deal with aggressive behaviour without raising the stakes and de-escalate situations.

## Case Study 12. Community facing therapeutic school: improving transition from school to work

*Creating a therapeutic environment from school to work.*

7.61 St. John’s comprises a special school in Seaford, East Sussex and an Independent Special Further Education College in Brighton supporting the educational, residential and therapeutic needs of a wide range of young people (aged 5-25) with complex communication and behaviour needs.

7.62 Action to reduce use of restraint and restrictive interventions is based on the premise that behaviour is a form of communication and involves a strong focus on staff training and development and a positive response to complex and challenging behaviours. Resources, time and energy have been invested in five key priorities:

1. Developing a repertoire of communication strategies

   A lead practitioner has been appointed to the teaching staff to increase the education team's skill base in communicating with non-verbal learners and to work alongside the Speech and Language Therapy Team. A therapy outcomes measure approach to interventions improves the communication skills of learners through clearly defined and measured time-limited outcomes.

2. Investing heavily in Positive Behavioural Support (PBS)

   Each Monday morning all learner facing staff, middle and senior leaders and the chief executive take an hour to plan, write and review behaviour support plans for every learner in the college. Those plans are reviewed six weeks later. A Level 5 trained PBS Leader has been appointed to be a key member of the charity's senior leadership team to give behaviour the status it deserves within the strategic development of our work.

3. Developing a mental health team to sit alongside therapists and counsellors

   Many learners have undiagnosed mental health needs or needs that have been over-ridden by their learning difficulty and increased numbers have mental health as a primary or secondary need. Three assistant psychologists with oversight from clinical psychologists have been appointed to improve medical support and improve liaison with local CAMHS and Adult Mental Health Services. The work of the pre-existing counselling team has also been refocussed around an outcomes and shorter-term intervention model.

4. Making significant adaptations to learning environments

   Much of St. John's learning is community learning and a small group of behaviourally complex learners have programmes which are solely community-based. Where classrooms don't work for specific learners purpose-built safe spaces have been created in the grounds that meet their specific needs. The Employability Team has worked closely with employers to ensure that work placements are available for the most complex learners, as well as those for whom conventional employment is the destination. For the last six years an annual city-centre conference has been held with local employers to take learners with complex behaviours into the heart of the tourist hot spots of the city and enable them to develop their adaptive skills in situ.

5. Simplifying the curriculum offer to focus on five placement outcomes

   The whole curriculum is based around five sequential placement outcomes:

   well-being > communication > skills > independence > employability

   Through consistent and unrelenting focus on these outcomes the aim is to reduce restrictive physical interventions by 90% by 2020. The overall aim is to enable learners with complex and challenging communication methods to take more control and ownership of their own behaviours.

Since learner behaviours affect the well-being of staff a rich and varied programme of staff support is in place, including morning meditation.

# Endnotes

[1] Children's Views on Restraint, reported by the Children's Rights Director for England (Ofsted, 2012); *Mental health crisis care: Physical Restraint in Crisis* (MIND, 2012). https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

[2] *The Business Case for Preventing and Reducing Restraint and Seclusion Use* (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2011). https://edsource.org/wp-content/iframe/seclusion-restraint/Businesscaseagainstrestraint.pdf

[3] A learning disability is defined by three core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability (*Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges,* NICE Guideline 11, 2015) https://www.nice.org.uk/guidance/ng11

[4] Autism is defined as a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. A term often used to cover a range of conditions on the autistic spectrum (and the one used in this guidance) is autistic spectrum conditions (ASC).

[5] Mental health difficulties could include emotional disorders, e.g. phobias, anxiety states and depression; conduct disorders, e.g. stealing, defiance, fire-setting, aggression and antisocial behaviour; hyperkinetic disorders, e.g. disturbance of activity and attention; developmental disorders, e.g. delay in acquiring certain skills such as speech, social

ability or bladder control, primarily affecting children with ASC and those with pervasive developmental disorders; attachment disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care givers; and other mental health problems including eating disorders, habit disorders, post-traumatic stress syndromes, somatic disorders and psychotic disorders e.g. schizophrenia and manic depressive disorder.

[6] See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf

[7] See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf

[8] Under section 33 of the Children Act 1989.

9 This includes unpaid volunteers or parents accompanying students on a school organised visit whom the head teacher has temporarily put in charge of pupils.

[10] *Positive environments where children can flourish: A guide for inspectors about physical intervention and restrictions of liberty* (Ofsted, 2018). https://www.gov.uk/government/publications/positive-environments-where-children-can-flourish

[11] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[12] *R(c) v Secretary of State* [2009] QB 657 at [58]

[13] Relevant legal duties and guidance are set out for each sector in Annex A of this guidance.

[14] The core values and principles apply to the settings and services listed in paragraph 1.13 and will be of interest to those listed in paragraph 1.16.

[15] *A review of restraint systems commissioned for use with children who are resident in secure children's homes* (Independent Restraint Advisory Panel, 2014). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376933/irap-restraint-in-youth-custody-report.pdf

[16] Legislation covering schools, children's homes and fostering services allows restraint to protect property under specified circumstances, schools to use reasonable force to stop pupils compromising good order and discipline, and children's homes to prevent children from running away from the home.

[17] Terminology varies according to the different pieces of legislation.

[18] Legislation covering schools, children's homes and fostering services also allows restraint to protect property under specified circumstances, schools to use reasonable force to stop pupils compromising good order and discipline, and secure children's homes to prevent children from running away from the home.

[19] The law and guidance on the recording of restraint differs depending upon the setting or service concerned. See Annex A.

[20] https://www.england.nhs.uk/publication/developing-support-and-services-for-children-and-young-people-with-a-learning-disability-autism-or-both/

[21] *The Children's Home Regulations 2015*. Regulations 35(3) and 7(2)(b)(iii)) and associated guidance.

[22] *Learning disabilities and behaviour that challenges: service design and delivery*, NICE guideline 93 (NICE, 2018). https://www.nice.org.uk/guidance/ng93

[23] James Ridley, Sarah Leitch, Restraint Reduction Network. Training Standards 2019, (British Institute for Learning Disabilities, 2019) http://restraintreductionnetwork.org/wp-content/uploads/2016/11/BILD_RRN_training_standards_2019.pdf

[24] *Minimising and Managing Physical Restraint. Safeguarding Processes, Governance Arrangements, and Roles and Responsibilities* (National Offender Management System, Ministry of Justice *et al*, 2012). https://www.gov.uk/government/publications/minimising-and-managing-physical-restraint

[25] *The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis* (HM Government, 2014). https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

[26] https://www.nice.org.uk/guidance/ng10

[27] http://www.safewards.net/

[28] For an example of a hospital passport for children with lifelong conditions, see http://www.uhbristol.nhs.uk/hospital-passport.

[29] https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/

[30] http://library.college.police.uk/docs/acpo/Guidance-mental-ill-health-2010.pdf

[31] The law and guidance on the recording of restraint differs depending upon the setting or service concerned. See Annex A.

[32] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

[33] https://report.nrls.nhs.uk/nrlsreporting/

[34] *Guzzardi v Italy* (1980) 3 EHRR 333

[35] See further https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance

[36] *Modernising the Mental Health Act. Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983* (December 2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf

[37] https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/how-to-support-stomp/#health-care

[38] See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf

39 Nielsen v Denmark (1988) 10929/84, as discussed in HL v United Kingdom (2004) 45508/99, P v Cheshire West and Chester Council [2014] UKSC 19, Re D (Parental Responsibility: Consent to 16-Year-old Child's Deprivation of Liberty [2017] EWCA Civ 1695.

[40] http://www.echr.coe.int/Documents/Convention_ENG.pdf

[41] *Mental Capacity Act 2005 Code of Practice* (Department of Health, 2016). https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice Useful information on the Mental Capacity Act is also available at http://www.scie.org.uk/mca-directory/

Published to GOV.UK in pdf format only.

Community Care / Mental Health, Dementia and Disabilities / DDU / 11168 and Department for Education

www.gov.uk/dhsc

bild Restraint Reduction Network

Ethical training standards
to protect human rights
and minimise restrictive
practices

# Restraint Reduction Network (RRN)

# Training Standards 2019

## First edition

James Ridley
Sarah Leitch

Ethical training standards
to protect human rights
and minimise restrictive
practices

# Restraint Reduction Network (RRN)

# Training Standards 2019

## First edition

James Ridley
Sarah Leitch

**British Library Cataloguing in Publication Data**

A CIP record for this book is available
from the British Library

Version 1.1 (August 2019)

**BILD Publications is the imprint of:**

British Institute of Learning Disabilities
Birmingham Research Park
97 Vincent Drive
Edgbaston
Birmingham B15 2SQ

Telephone: 0121 415 6960

E-mail: RRN@bild.org.uk

Website: Restraint Reduction Network

ISBN 978 1 905218 44 8

Printed in the UK by
Latimer Trend and Company Ltd, Plymouth

Copy editing by Helen Fairlie

Design by Sarah McCall

# Contents

# Foreword

You may not know us, but we want to tell you about something very personal that shattered our lives and changed our family forever.

This is a photo of our son Seni with his grandmother. Everything you need to know about him is here in this beautiful picture. He was our baby and a gentle giant. He hated bullying and was always looking out for the less able and vulnerable people in society.

Seni was just 23 years old – an IT graduate – when he died in hospital on 3 September 2010. He died because of prolonged restraint, when he was held down by 11 police officers while he was a patient in a mental health hospital.

Seni had never had any mental health issues before, but over that bank holiday weekend in 2010 he seemed agitated and his behaviour became odd. We took him to A&E and, after an assessment, we were told to take him to Bethlem Royal Hospital. We took him there, to what we thought would be the best place for him to get help.

Seni agreed to stay overnight at the hospital as a voluntary patient. We were asked to leave him at the end of visiting hours, and we did so reluctantly. Shortly afterwards, he became agitated when he was stopped from leaving the hospital because he wanted to come home. The hospital staff 'sectioned' him and called the police who came and agreed to take Seni to a seclusion room in the hospital. He was co-operative until he stopped at the threshold of the seclusion room. As soon as he stopped, the police officers pushed him inside and forced him face down to the floor.

The police officers held Seni face down, shackled his hands with two sets of handcuffs and put his legs in two sets of restraints. They held him down like that over a period of some 45 minutes altogether, in a restraint they knew was dangerous, until he went limp. And even then, instead of treating him as a medical emergency, they simply walked away: they believed he was faking it! They left our son on the floor of a locked room, all but dead. All of this happened in the presence of hospital staff including nurses and a doctor who stood by and looked on, unable or unwilling to intervene. Seni never regained consciousness and died four days later. That is how we lost our beloved son.

At the inquest into his death, the jury found Seni died as a result of excessive, disproportionate and unreasonable restraint and force. To this day, we struggle to comprehend that our son died as he did, simply because those who were responsible for his care – police officers and medical staff alike – failed in their duty to treat him with the respect that he deserved as a human being.

In a signed statement after these events, one doctor described how the officers treated our son: 'I felt like it wasn't a human being that they were trying to restrain … it was like trying to contain an animal … after they had tied him up with the straps it seemed like when a hunter has tied the animal … it was an uneasy feeling that I had that it was not a human being that they were restraining'. That is how he was seen and treated at that point: as an animal, rather than a petrified young man, terrified at the prospect of being put in a padded seclusion room.

We don't want anyone else to go through this. We have been fighting for over eight years to get answers and justice for Seni. Now, through initiatives in his name – such as Seni's Law, a parliamentary bill with cross party support designed to open up the system to greater transparency and accountability to stop the disproportionate use of force and restraint – we feel that our son may not have died in vain. If we can make sure this never happens to anyone else, that would be an amazing legacy for Seni.

That is why we are really pleased to see the publication of these new standards, but this must be just the beginning. There is so much more to do in view of the increasing number of deaths in the context of restraint. In addition to health, education and social care services, we need to get law enforcement agencies involved in these standards concerning the use of restraint. We need to ensure these standards are not just implemented, but also regulated. And we need to make sure that the use of force and restraint is not just reduced but prevented altogether when dealing with vulnerable individuals who may find themselves in Seni's position in the future.

Aji and Conrad Lewis

"The NHS welcomes the publication of the Restraint Reduction Network Training Standards. These Standards have been written to focus on ensuring training promotes human rights and supports cultural change necessary to reduce reliance on restrictive practices (rather than purely focus on technical skills). Certification of compliance with these Standards will be a requirement in NHS commissioned and CQC regulated services from April 2020"

(Professor Tim Kendall, National Clinical Director for Mental Health, NHS England 2019)

"CQC has been concerned about the use of restrictive practices for some time so we are pleased to see the launch of the new Restraint Reduction Network Training Standards. The Standards will support staff in health and social care services to understand and apply the principles of minimising use of force with the aim of promoting human rights and person centred care of the people they are caring for"

(Dr Paul Lelliott, Deputy Chief Inspector at CQC 2019)

# Introduction

## Background

**The Restraint Reduction Network welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings. The number of organisations endorsing these standards is testament to this.**

The UK has many excellent education, health and social care services that provide person centred therapeutic care. However, there have also been too many shocking scandals exposing the unnecessary and inappropriate use of restrictive interventions on people with mental health conditions, dementia, learning disabilities, and autistic people. Such scandals include Winterbourne View, exposed by the BBC *Panorama* programme, the recent cases of people like Bethany, who was secluded for years resulting in the Secretary of State ordering a serious incident review, and the tragic case of Seni, highlighted within the Foreword, who was restrained by police in a mental health service. (Whilst this case is unusual as it involved the police, it has been highlighted because of its tragic nature, and the fact that it resulted in the Mental Health Units (Use of Force) Act 2018.)

Restraint by its nature restricts a person's liberty, but the frightening, overwhelming and traumatising nature of this experience can amount to degrading treatment, which is never lawful. *'Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others'* (Campbell, 2018).

It is therefore vital that all services sufficiently understand and apply the principles of restraint reduction. However, minimising the use of restrictive practices and interventions is only one part of ensuring that vulnerable adults and children have a good quality of life. Providing therapeutic environments where treatment and recovery can take place is essential. As well as a safe comfortable environment to live in, people also need choice, control, supportive relationships, interesting things to do and learn, and opportunities to be involved in community activities. These are fundamental elements of good quality preventative support and these are the same things we would want for ourselves and our own families.

When these Standards refer to restraint reduction or minimisation it is in the context of a shared commitment and belief that the use of all restrictive interventions and practices should be minimised.

## Why are the Restraint Reduction Network Training Standards required?

**Providing high quality evidence based support to vulnerable adults and children in all settings, across education, health and social care, is a highly skilled activity. The workforce do an important and challenging job (that requires balancing risk, welfare, and safety) and sometimes require specialist training to understand and meet the needs of the people they are supporting so people are less likely to become distressed, but they also need training in how to support people when they are distressed.**

Typically, restrictive interventions are used by staff, carers or family members with the intention of averting harm, minimising the potential for pain or injury and to keep people safe.

There are a number of organisations providing training in supporting people in crisis, and there is a range in the quality of their provision. The lack of quality assurance and oversight of such training programmes leads to a concern that staff may be trained to use a range of restrictive interventions that may not necessarily be appropriate or properly risk assessed for use. These concerns have been highlighted on many occasions through service reviews, and by training commissioners, families and staff who have been through training. These Standards aim to address these concerns.

Poor quality training focuses primarily on reactive approaches such as physical restraint and places insufficient emphasis on human rights, meeting needs, prevention, de-escalation and recovery. Most importantly, it fails to sufficiently explain the traumatic nature of restraint.

If training places insufficient emphasis on restraint prevention and de-escalation, staff will understandably be more likely to use restrictive interventions as a first resort, rather than last resort, resulting in an over reliance on restrictive interventions.

Whilst there is some great practice across education, health and social care, there are still too many services that focus on management of behaviour or risk rather than on prevention and better meeting needs. A positive and proactive approach is vital to anticipate potential triggers for behaviour that challenges, and minimise the likelihood of, or avoid the need to use, restraint (DHSC, DfE 2019).

An over reliance on restrictive practices in services can create toxic culture characterised by the cycle of trauma for both staff and patients (Paterson, 2013). To be in the position of being restrained or to be part of a team that is implementing a restraint is likely to be traumatising. It is also 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.

In addition, restraints may be employed against some degree of active (physical) resistance. This can result in potentially damaging stresses being imposed upon systems and structures such as the respiratory system, heart, joints and muscles (Aiken et al, 2011). Any restrictive intervention must be based on an assessment that intervention is likely to cause less harm than not intervening. Training that includes restrictive interventions is potentially dangerous and distressing for everyone involved and therefore quality standards are essential.

Eliminating inappropriate use of restraint is particularly vital in relation to children, who are still developing both physically and emotionally and for whom any potentially traumatic experience at this formative stage in their development could be very damaging and have long term consequences to their welfare. Where use of restraint is necessary to safeguard children, young people and others from harm, it should be consistent with clear values and sound ethical principles, comply with the relevant legal requirements and case law and be consistent with obligations under the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities. (DHSC, DfE 2019)

# Aims of the Standards

The Standards will provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

In addition to improving training and practice, the Standards will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

# Who are the Standards for?

This document provides cross sector quality standards that can be applied to training provision where restrictive interventions are included in the curriculum. It is important they are applied consistently to services:

- across education, health and social care
- across children and adult services
- across the UK and internationally
- for all populations, including people with mental health conditions, dementia, learning disabilities and autistic people
- in order to consistently minimise the risk of physical and psychological harm to all people in all settings in all nations in the British Isles

These Standards support the human rights of all populations and may be useful to the private security industry, but are not specifically designed for training providers outside of education, health and social care sectors.

Staff must have face to face training in preventative/primary strategies and secondary strategies before they are taught to use restrictive interventions. In some organisations it may be more appropriate that a different training provider manages the face to face training in a preventative model such as Safewards.

The Standards can apply to all training providers, including:

- commercial training providers who deliver training to a range of organisations
- in-service training providers who develop and deliver the training within their own organisation and may or may not deliver training to other organisations such as other NHS trusts

These Standards will be mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2020. This includes services in the independent, private and voluntary sectors. Other UK countries may benefit from following the principles and standards, albeit within a devolved legislative context, where country specific legislation applies.

Health Education England (HEE) welcomes the fact that the Restraint Reduction Network has delivered training standards suitable for use within mental health and learning disability NHS commissioned units. It is our sincere hope that the use of these Standards in an accredited certification scheme will reduce the number of occasions restraint is required and help to make those occasions that restraint is unavoidable safer and dignified.

The standards apply across the lifespan. However, it will be vital that a developmental perspective is taken and that the fragility of some individuals is given proper consideration – for example, pre-pubescent young people, people with severe eating disorders, and those who are living with dementia and at end of life who often have significant weight loss.

Whilst these Standards focus on training, it is important to recognise the significant responsibilities of service providers in ensuring these principles are applied in practice and a positive culture of care and support is promoted. Training alone is not human rights based nor is it sufficient to facilitate cultural change. Therefore these Standards complement new guidance for service providers in minimising restrictive interventions: *Towards Safer Services*. There is an important role for the regulator in ensuring services implement these Standards.

The implementation, embedding and maintenance of these Standards will also be viewed by regulators and inspectors, as well as concerned family members, to be indicative of an organisation committed to best practice and characterised by therapeutic care and support.

Although the Standards are designed primarily to support training providers, they may also be useful to:

- commissioners of training
- commissioners of services
- regulators of services
- individuals who have lived experience of services
- families, carers and advocates

For more information on (UKAS accredited) certification of compliance with the Standards (including a list of certified training organisations), please visit the Restraint Reduction Network website. Only certified training organisations will be licenced to use the Restraint Reduction Network certified™ logo.

# How have the standards been developed?

The Restraint Reduction Network was initially established to bring together those passionate about reducing reliance on restrictive practices across education, health and social care. The Restraint Reduction Network is a registered charity and is free to join. All members pledge their commitment to reduce reliance on restrictive practices. The Restraint Reduction Network steering group includes representation from government departments, professional bodies and regulators, as well as charitable organisations and representatives who have lived experiences of restraint.

The Restraint Reduction Network started to develop training standards in 2017. In 2018 there was increased focus on restraint reduction within government departments and arm's length bodies. This included a significant cultural change programme within the NHS. As part of this programme of work Health Education England were asked to ensure quality standards were in place for training and that training was certificated as complying with these Standards. Rather than reinventing the wheel, Health Education England (on behalf of the NHS) commissioned the Restraint Reduction Network to develop these Standards for training in the prevention and use of restrictive interventions to support best practice in supporting people (across the lifespan) who may become distressed and meet the requirements of training within the Mental Health Units (Use of Force) Act 2018.

Health Education England has worked with the Restraint Reduction Network and the United Kingdom Accreditation Service to develop a process for certifying training with a view to all providers of NHS funded mental health, learning disability and autism services being required to use accredited training services. In addition, local authority commissioners intend to make UKAS accredited training services a requirement of social care contracts. *For more information on (UKAS accredited) certification of compliance with the standards please visit the Restraint Reduction Network website.*

These Standards are evidence based and informed by government policy, guidance and the consensus views of professionals and experts in the field.

A wide range of critical readers have contributed to the development of these Standards including representatives from a number of professional bodies, government departments and arm's length bodies. (For more details please see Acknowledgements.)

The standards will be updated at least every three years and will reflect the burgeoning knowledge base and developments in research, policy and practice. (This version will be reviewed by 2022 – feedback can be sent to RRN@bild.org.uk)

This edition considers physical, mechanical and environmental restraint. The next edition will increase the focus on social restraint, chemical restraint, specific physical restraint techniques and risk assessments, and consider a wider range of settings including mainstream schools, criminal justice services and accident and emergency services. Changes and adaptations to this version will be announced on the website.

# How to use these Standards

The first part of this document is a rights based framework, in which all training must be delivered. Training providers seeking certification for their programmes will need to use the framework when designing their curriculum.

The curriculum standards focus on the fundamental principles across all settings and populations. These include prevention, de-escalation, reactive strategies and recovery.

There are specific standards to ensure that trainers have the appropriate levels of expertise, experience and competence.

There are also a number of appendices which document any specific considerations or adaptations to the standards that should be taken into account for different populations or settings. The appendices will be subject to a continuous review timetable, therefore the most up to date versions will be available online.

Any text in **bold** or regular text font is a requirement of the standard and is therefore mandatory, and *any text in italics offers extra explanation or guidance.*

The next edition will increase the focus on social restraint, chemical restraint, specific physical restraint techniques and risk assessments, and consider wider range of settings including mainstream schools, criminal justice services and accident and emergency services.

# Reviewing and updating the Standards

The review process will be facilitated by the Restraint Reduction Network director with support and scrutiny from the Trustees of the Restraint Reduction Network who represent professional bodies, arm's length bodies and people with lived experience.

The Standards will be updated within three years and a review of research will start in the second year and will follow the process set out below. Ongoing public feedback will be gathered through email and consultation on the Restraint Reduction Network website. Feedback will also be sought from all certification bodies and certified training providers. The appendices will be updated as part of an ongoing process over the three years – through small expert reference task and finish groups.

1 Review of related research, evidence and (NHS) data in second year of publication

1 month

2 Survey Monkey to elicit views of stakeholders on any updates or changes needed

1 month

3 Independent thematic review of Survey Monkey and research

1 month

4 Changes indicated and logged with rationale for inclusion or non inclusion

1 month

5 Critical readers from endorsing organisations review changes through Survey Monkey

1 month

6 Independent thematic review of critical reader feedback

1 month

7 Final changes proposed and logged with rationale for inclusion or non inclusion

1 month

8 Restraint Reduction Network steering group and endorsing organisation approval and sign off

1 month

9 Proof reading, design and publication

within 2 weeks of publication

10 Certification bodies informed of changes

# A rights based framework for training

This section covers the overall context and framework of law and values within which any training in the use of restrictive interventions must be provided.

## Contents

## Training must be provided with clear reference to supporting an overall human rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.

Human rights apply to any person receiving care and treatment, and these rights must be at the centre of decision-making. The Human Rights Act 1998 applies to all public authorities, and all training must be informed by the legal duties of staff to respect and protect these human rights. Training must also make clear that human rights apply to the person's family and carers, and others receiving treatment (eg patients on a ward) and staff involved in the person's care and support.

The training must support the reduction of the use of restrictive interventions and ensure consideration of alternative responses to distress or behaviours of concern, including a focus on prevention and secondary responses such as de-escalation.

Any use of lawful restrictive intervention must be rights-respecting. This means it must not cause harm, including unintended harm, which amounts to degrading treatment, which is never lawful (see Article 3). All reasonable steps must be taken to protect a person's right to life, including stopping the use of an intervention or intervening to protect a person from themselves or others; failure to protect life is likely to be unlawful (see Article 2). Importantly, a human rights approach also means involving the person in decision making and taking the least restrictive option (see Article 8).

Training must make it clear that some human rights cannot be interfered with (whether by restrictive intervention or otherwise) and some can be restricted by professionals, but this can only occur when the correct balancing exercise has been undertaken. This balancing exercise, which is required by the law, is an important tool to ensure the proper consideration of the rights of all people involved in restrictive interventions, including staff.

Restrictive practices, including physical restraint, can be characterised as an exercise of power over another individual. In order to ensure this power is never abused, comprehensive safeguards must always be in place. It is essential that such safeguards eliminate any risk of discrimination, harassment or victimisation.

Organisations must ensure that no individual is exposed to any restrictive practice because of their age, mental health status, mental capacity, physical impairment, race/ethnicity, religion and belief, gender (including transgender), HIV/AIDS status, sexual orientation, political opinion, socio-economic background, spent convictions, or on any other grounds which are irrelevant to a decision-making process leading up to any application.

The following will also be important in supporting a rights based approach:

- understanding which human rights cannot, and which can, be lawfully interfered with by staff, including in situations where restrictive interventions are used
- understanding the positive obligation of staff to take action to protect human rights, including safeguarding against serious harm arising from the use of restrictive interventions
- respecting people's right to autonomy (see Article 8) by assuming capacity and ensuring involvement in care decisions, including ascertaining current/previous/future views on the use of restrictive interventions as set out in the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act (Northern Ireland) 2016*
- using restraint as a last or emergency response
- treating distress or behaviours of concern as communicative acts and exploring what this means for the person to help avoid the use of restrictive interventions
- identifying the risks associated with restrictive interventions including, but not limited to, children who are developing physically and psychologically
- understanding the impact of trauma (historic or otherwise) on an individual's mental and physical health and therefore their experience of restrictive interventions – this will be especially important in determining whether an intervention risks being degrading
- considering the impact of restrictive interventions on an individual's physical and mental health, their development and/or recovery, including how this may affect those with sensory processing differences, eg autistic people
- commitment to co-production with individuals with lived experience in the planning, development and delivery of care and treatment
- commitment to ensuring people's needs to participate in decisions are met, eg access to interpreters, appropriate information, advocates, etc
- avoiding blanket policies or standardised responses that do not allow consideration of the person's situation
- demonstration of processes and practices to avoid or minimise the use of restrictive interventions

* NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target (RCN 05/09/2018)

Training organisations must show how they have embedded a rights based approach within their curriculum. One example is the 'PANEL' framework (Donald, 2012; BIHR, 2013) which supports using a rights based approach:

- **P**articipation
- **A**ccountability
- **N**on-discrimination
- **E**mpowerment
- **L**egality

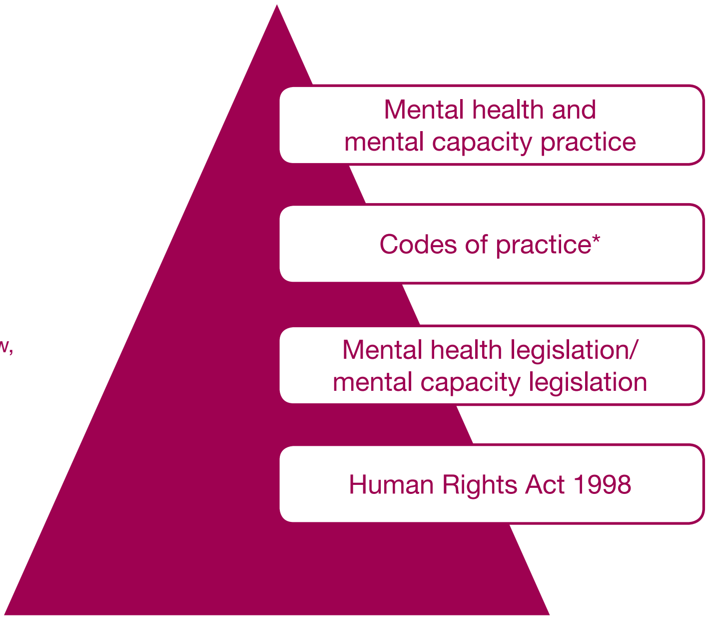
See also BIHR's guide *The Difference It Makes: Putting Human Rights at the Heart of Health and Social Care* (2013) which explains the benefits of using a rights based approach, using PANEL (available at BIHR ).

## The relationship between legislative frameworks involved in restrictive interventions

**Training must ensure that the relationship between the Human Rights Act and other legal frameworks relevant to the use of restrictive interventions is understood and those laws are applied in a way that is compatible with the person's rights.**

Training must make clear reference to how the Human Rights Act 1998 and other key legislation work together in practice. Essentially, other legislation should be interpreted and applied in a way that is compatible with people's human rights. Figure 1 (BIHR, 2016) illustrates how the Human Rights Act operates as a foundation for other law, policy, guidance and practice.

Figure 1: **The Human Rights Act 1998 as a foundation for other law, guidance and practice**



* This can be for any codes of practice. The HRA is the foundation, then the next levels up – the law, the codes of practice, the practical decision-making and service delivery – sit on top of that foundation. The same process could be applied to any other statute, eg Mental Health Act, Care Act, statutory guidance etc

The following legislative frameworks must be included in training, as they may provide legal authority to interfere with a person's rights when restrictive interventions are being used in situations, or may otherwise be relevant:

- Mental Health Act 1983 (amended 2007)
- The Children's Act 1989 (as amended) and the Children and Families Act 2014
- Criminal Law Act 1995
- Criminal Justice Act 1995
- Adults with Incapacity (Scotland) Act 2000
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards (DOLS) or its equivalents)
- Equality Act 2010
- The Care Act 2014
- Mental Health Act Code of Practice 2015, Chapter 26
- Mental Capacity Act (Northern Ireland) 2016.

  NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target ( RCN 05/09/2018)

Training must also include relevant devolved legislation and/or legislation focused on specific groups of people.

## Training must be person centred, focusing on the human rights of the person involved in the use of the restrictive intervention, preventing unlawful breaches of rights, and taking positive steps to protect rights.

A person's wishes and feelings must be respected. Human rights law, together with mental capacity law, starts from the presumption that people have the capacity to make decisions about their own care and treatment. Where there are doubts about a person's capacity to make a specific decision, a mental capacity assessment must be conducted, and if needed a substituted decision can be made following a best interests assessment. However, the rights of that person to have their wishes and feelings considered during this process remain central and this process must be clearly recorded in their care plan. Even where a Mental Capacity Act assessment finds a person does not have capacity to make a specific decision (eg about treatment or refusal of treatment), the law requires respect for their right to autonomy (see Article 8). This means ensuring participation and involvement as far as possible, which may include providing specific support, eg interpreters, information in specific formats, etc. This will be important when staff are deciding whether or not to use a restrictive intervention, determining the least restrictive option, and how to make interventions. Training must make it clear that compliance with the Human Rights Act 1998 means both:

- refraining from taking action which unlawfully breaches rights, eg not using restrictive interventions that cause serious harm and safety risks (Article 3), and
- taking positive steps to protect rights, eg using proportionate restrictive measures (Article 8) to protect someone in care from taking their own life (Article 2)

The Human Rights Act 1998 sets out 16 rights (‘Articles’) which belong to all people in the UK in all situations. Training is expected to cover those Articles likely to be relevant to the use of restrictive interventions, for example:

**Rights which cannot be lawfully restricted (including by use of restrictive interventions):**

- The right to life (Article 2): in health and care settings this right is absolute; any restrictive intervention that compromises this right will not be lawful
- The right to not be treated in an inhuman or degrading way (Article 3): the use of some restrictive interventions may breach this right, including where serious physical or mental harm results either deliberately (abuse) or where it is not intended (neglect). The focus is primarily on the impact on the individual rather than the intentions of staff

**Rights which can be lawfully restricted (including by use of restrictive interventions):**

- The right to liberty (Article 5): whether this right can be restricted will depend on the legal basis for the action (see standard 1.2) and ensuring that the safeguards in the right have been met (eg knowing why liberty is being restricted and being able to challenge the decision)
- The right to respect for private and family life (Article 8): this ensures a person's physical and mental wellbeing and their personal autonomy, including involvement in care and treatment decisions. Restrictive interventions can significantly interfere with this right; this will only be permissible if actions are: (1) permitted by a legislative framework; (2) for a legitimate aim set out in the right way (usually protecting the person or others); and (3) proportionate (ie least restrictive option)

**Rights of children:**

- The United Nations Convention on the Rights of the Child (UNCRC) ensures all children have the right to be heard and protected from harm and provides guidance for best interests test
- Children and young people with learning disabilities and/or autism, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present (DHSC, DfE 2019)

**Rights of people with disabilities:**

- The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 12 ensures equal opportunities of people with disabilities to exercise their legal capacity and rights to liberty as well as freedom from degrading treatment and exploitation

**Non-discrimination:**

- The right to not be discriminated against in relation to the above human rights (Article 14): this could include use of restrictive interventions which restrict liberty for discriminatory reasons, eg on the basis of ethnicity, age or other status, and any combination of these characteristics. The Equality Act also protects against discrimination on the basis of one (not a combination) of nine protected characteristics (all also covered by human rights law). Additionally, the Equality Act also sets out the public sector equality duty on services to consider how their policies and decisions affect people who may be discriminated against due to one of the nine protected characteristics ( EHRC).

Training must make reference to contexts in which the use of a restrictive intervention may or may not be a lawful restriction on a person's human rights. For example:

- The right to liberty may be restricted if permitted by law for the purposes of mental health/capacity care (Article 5, Schedule 1, Human Rights Act 1998). The Mental Capacity Act 2005 can provide authority for restraint under Section 6, where (a) a person lacks capacity and (b) it is reasonably believed to be necessary and proportionate to protect them from harm. Additionally, Chapter 26 of the *Mental Health Act Code of Practice* (England and Wales) sets out guidance related to the use of restrictive practices for people detained under the Mental Health Act 1983 (Department of Health, 2015). (See also Mental Health (Care and Treatment) (Scotland) Act 2003; *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a); Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016*

*NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target (RCN 05/09/2018)

Opportunities for discussion and analysis of scenarios related to the use of restrictive interventions in a range of settings must be provided in any training, and the potential impact of this on a person's human rights must be explored. Examples covering various service models and the relationship between human rights, mental health and mental capacity law can be found in the British Institute of Human Rights (BIHR) *Practitioner Toolkit Series* (BIHR, 2016b), BIHR Practitioner Toolkits

# Training standards

The next four sections cover the process from engagement with an organisation to development of the curriculum, its delivery and the cycle of feedback afterwards. Figure 2 (on page 35) displays this process.

Training providers must show that they have a process which meets the standards and they must be able to provide evidence needed at all the different stages.

Section 1: Standards 1.1–1.8

**These standards cover the part of the process that needs to be completed before a curriculum is developed.**

Section 2: Standards 2.1–2.15

**These standards cover what must be included in the curriculum.**

Section 3: Standards 3.1–3.6

**These standards relate to post-delivery processes.**

Section 4: Standards 4.1–4.7

**These standards relate to trainers.**

# Section 1

# Standards supporting pre-delivery processes

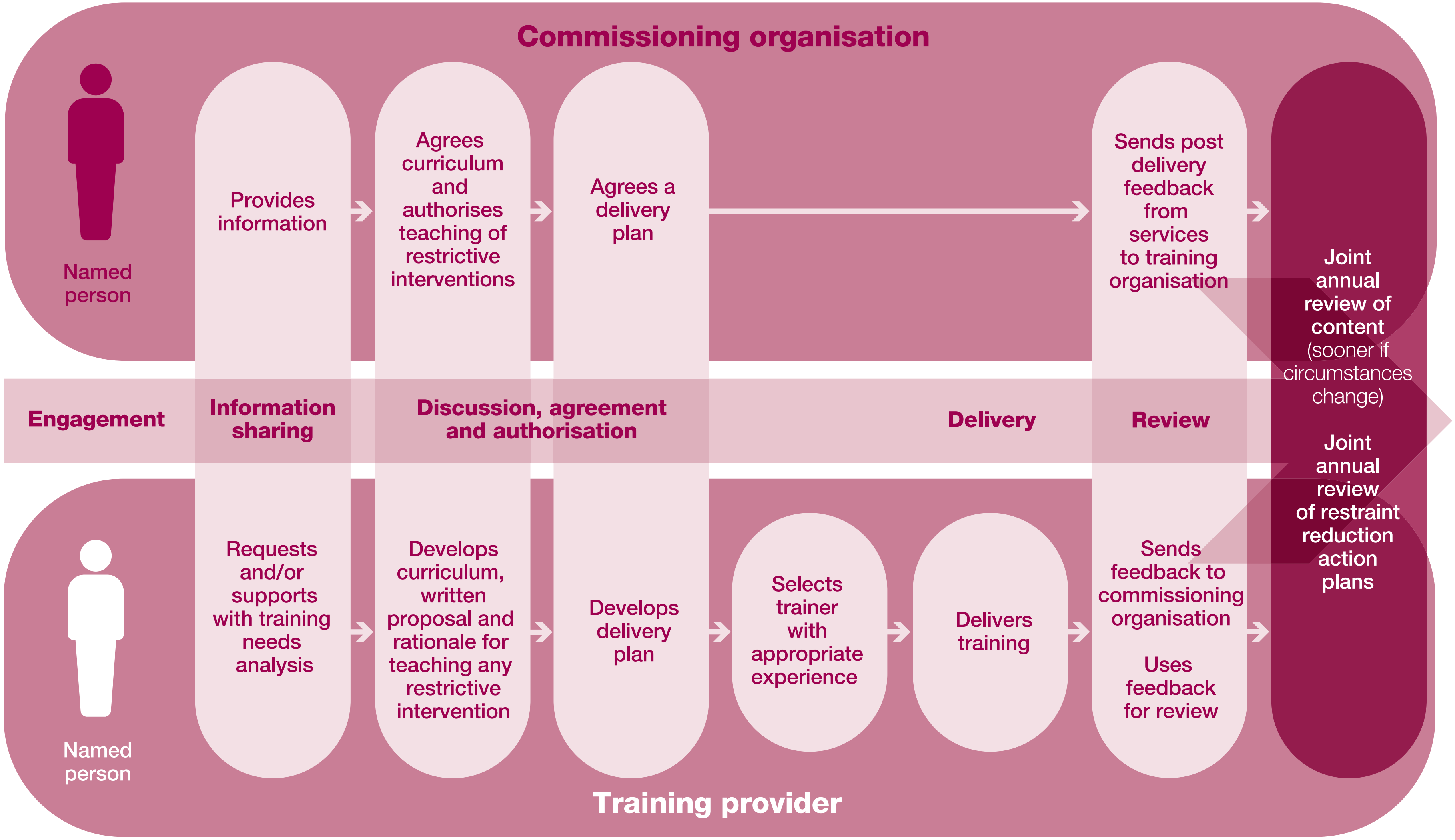
Standards 1.1–1.8 cover the part of the process that needs to be completed before a curriculum is developed and authorised.

Alongside these standards, please refer to Figure 2 (on page 35), which depicts the process for the commissioning, development, delivery and review of training with a restrictive intervention component.

# Standards

| | |
|---|---|
| Standard 1.1: | **Training needs analysis** |
| Standard 1.2: | **Developing and authorising the content of the training curriculum** |
| Standard 1.3: | **Independent risk assessment of techniques** |
| Standard 1.4: | **Committing to the reduction of use of all restrictive interventions and practices** |
| Standard 1.5: | **Involving people with lived experience** |
| Standard 1.6: | **Agreeing delivery plans** |
| Standard 1.7: | **Providing accessible information** |
| Standard 1.8: | **Responding to concerns and complaints** |

Figure 2: Process for the commissioning, development, delivery and review of training with a restrictive intervention component



# Introduction

Before developing and delivering any training, a good training provider engages with the organisation or service that needs training and finds out as much information as possible about the needs and characteristics of the staff and the people they support. This means they are confident that the training they provide is appropriate, proportional, meets identified needs, and any elevated risks are highlighted and adjustments made where needed.

Figure 2 illustrates the process for the development, delivery and review of training. It shows how the commissioning organisation and the training provider should work together to ensure all training is safe and designed to meet the needs of the people being supported by the commissioning organisation and the people who are receiving the training. Both parties must be responsible for ensuring the training is developed and delivered within a framework that is person centred and minimises the use of restrictive practices and that there is evidence that the training is monitored, reviewed at a minimum annually and adjusted where needed.

In the commissioning organisation the named person responsible for restraint reduction is usually the restrictive practices reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation. Both people are responsible for the annual review of the curriculum.

Where training is both developed and delivered in-house, the same process of development, delivery and review must be followed although there may only be one named person.

## Standard 1.1

### The curriculum must be based on a training needs analysis (TNA) which must be completed by the commissioning organisation before the curriculum is developed and delivered.

1.1.1 **As part of the commissioning process the training provider must request a training needs analysis (TNA) from the commissioning organisation.**

The TNA must include the current needs and risks posed to everyone based on current evidence and the past two years of incident data. It must be authorised by someone in the commissioning organisation who holds responsibility for restrictive intervention governance and reduction.

*In some cases the training provider will need to support the commissioning organisation to complete the TNA as part of the commissioning process or may need to request extra information. A TNA checklist can be found here* RRN Training Standards 2019 – materials to download

1.1.2 **The data that training providers request and receive from the commissioning organisation must be managed in line with the Data Protection Act 2018 (the UK implementation of the General Data Protection Regulation (GDPR)). Any data relating to specific individuals must be in an anonymised form.**

1.1.3 **As part of the agreement to provide any training in physical restraint and before commencing the training, both the training provider and the trainer who delivers the programme must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see Resuscitation Council (UK)).

In some cases this training will be provided by the training provider as part of the content of training and in other cases another provider will have delivered this.

1.1.4 **The training provider must ensure that the curriculum takes account of elevated risks to populations and individuals.**

The training provider must ensure any and all restrictive interventions take into account any known factors that may cause an elevated risk of harm at population and service level, and that arrangements are in place to ensure that any known risks are considered at the individual level.

Therefore agreement must be reached between the training commissioner and the training provider about how the information needed to support this process is transferred from one to the other. An anonymised summary of information must be received as part of the TNA. This should include any population or person-specific characteristics for people who are likely to be in receipt of restrictive interventions by the staff undergoing training. As a minimum, this information must include:

- range of age, gender identity, cultural heritage, diagnosis
- any known sensory processing issues that may elevate the risk of harm to a person if a restrictive intervention is used
- any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used
- any known emotional or psychological characteristics or current and potential issues and problems that may elevate the risk of harm to a person if a restrictive intervention is used. This should include, if known, reference to any past trauma
- any known developmental issues that may elevate the risk of harm to a person if a restrictive intervention is used

*A good practice checklist for personalised wellbeing risk assessments for use by commissioning organisations can be found at:* RRN Training Standards 2019 – materials to download

1.1.5 **The training provider must receive the TNA from the commissioning organisation at least one month before delivery of the training.**

## Standard 1.2

### A named person in the training provider organisation must develop a written proposal for a curriculum including the rationale for teaching specific restrictive interventions.

1.2.1 **The training provider (a named person) must develop a written proposal for the curriculum that covers both theory and practical elements.**

If restrictive interventions are being taught, participants must have completed a minimum of two days' training (12 hours) in the underpinning theory, including training in preventative and secondary strategies, as specified in standards 2.1–2.15, prior to participating in a practical, physical skills training session. The majority of these two days must be face to face to ensure that discussion and demonstration can take place, and blended learning could be considered for some elements where it enhances understanding. Training providers must be able to evidence that the training methods they choose are effective in supporting learning and cultural change. Participants must not be taught to use restrictive interventions unless they have received prior training in primary preventative strategies.

*In some cases, training that covers primary preventative strategies (see standard 2.5) have been covered on separate training courses, for example, Safewards or Positive Behaviour Support. In this case the underpinning theory requirement can be reduced to a minimum of one day (6 hours) but must include all elements of theory specified in standards 2.1 to 2.15 with the exception of standard 2.5.*

*If this is the case as part of the agreed delivery programme the training provider must clarify with the commissioner that this training will be provided to any staff before they attend training with a restrictive intervention component. This should be clearly documented in the agreement to provide training.*

*In some cases training may be delivered as part of a modular programme.*

1.2.2 **The proposal must be based on information in the TNA provided by the commissioning organisation.**

The written proposal must include as a minimum:

- who the training is intended for
- aims, objectives and learning outcomes for each programme
- training methods

- timings
- assessment methods
- rationale that justifies the inclusion of each restrictive intervention in the programme. This may be in any format but must include the following as a minimum ( RRN Training Standards 2019 ):
    - name and description of restrictive intervention (diagram or photo)
    - rationale for use (why and in what situation)
    - how the intervention will be taught to staff and how competence will be tested
    - general safety issues for staff during teaching and practice
    - any person specific safety issues for staff during teaching and practice (where information has been provided, and adjustments need to be made)
    - any issues that may compromise the fidelity of the technique between the taught version in the classroom and its application in practice. This must include a description of how any identified issues may compromise both safety and effectiveness
    - general safety guidelines, supporting those restrictive interventions authorised for use at population level
    - person centred safety guidelines, supporting personalised restrictive interventions
    - a statement that the restrictive intervention must be used as taught and not modified, unless authorised by the training provider

1.2.3 **The training provider must also provide a ‘training information sheet’ that must be made available to participants in advance.**

It must include:

- an overview of the theory training
- an overview of the practical training, including the length of the session
- a brief description of the nature of the training sessions, and any specific physical requirements – for example, most techniques are passively practised in a standing or occasionally seated position, or there is a requirement for learners to be able to move from a kneeling to standing position during one procedure
- any specific requirements in terms of suitable clothing or footwear
- how to find out any more information prior to the training taking place

## Standard 1.3

### Any physical restraint technique that is included in the curriculum must be risk assessed by an independent professional or organisation with relevant expertise.

1.3.1 **The training provider must ensure that the commissioning organisation receives a current risk assessment for each physical restraint being taught.**

1.3.2 **The individual or organisation commissioned to complete the risk assessment on behalf of the training provider must be able to demonstrate that they are competent and experienced in order to make an accurate determination of the risks, as they relate to the specified population.**

The risks identified must include:

- moving and positioning/manual handling risks
- physical and physiological risks
- psychological risks

The experience and competencies required may be held by one individual or distributed across a team who each contribute to the final risk assessment.

1.3.3 **The risk assessment for each physical restraint must be reviewed every two years minimum, and any time that an adaptation is made to it, or a risk assessment is requested in the context of an investigation. Records of reviews must be documented.**

1.3.4 **The risk assessment for each physical restraint must ensure the suitability of the physical restraint for the population it is intended for.**

The risk assessment for each physical restraint must record any potential of risk in the following areas:

- psychological or emotional harm, as well as reference to potential risk factors such as prior trauma experiences
- physical harm, as well as reference to any general potential risk factors such as illness, impairment or injury, or issues specific to a named individual which may elevate risk

- restricted breathing, as well as reference to any general potential risk factors such as obesity, positioning and intoxication or issues specific to a named individual which may elevate risk
- circulation, as well as reference to any general potential risk factors such as limb position and bodyweight being used to hold someone, or issues specific to a named individual which may elevate risk
- joint functioning, as well as reference to any general potential risk factors such as the hyperextension and hyperflexion of joints, and the unauthorised adaptation of techniques or issues specific to a named individual which may elevate risk

Safety guidance accompanying risk assessments must:

- ensure that any physical restraint avoids vulnerable parts of the body (such as neck, chest and sexual areas)
- emphasise the need to minimise absolutely the time any individual is subject to any form of restraint
- include recommendations on the level and type of observation that accompanies any application and post-application monitoring period. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe the signs of distress which should be actively monitored for. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe those aftercare arrangements that are required to maximise recovery and minimise any potential traumatising effects of any restraint

1.3.5 **All trainers must have access to authorised information about the risks or elevated risks for any restrictive interventions they are teaching.**

This may include anonymised information, as well as risk assessments supporting the use of restrictive interventions at both population level and person centred level (standard 1.1.4).

1.3.6 **Training providers must ensure that all physical restraint included in the curriculum complies with guidance relevant to country, setting and population** (see appendices 17–20)**. Evidence must be provided throughout the self assessment process to show that the training covers any specific adaptations to the standards or special considerations.**

1.3.7 **These standards do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply** (see also appendices 21A and 21B)**.**

## Standard 1.4

### Training must be provided within the context of an explicit commitment to the reduction of all restrictive practices.

1.4.1 **Training providers must be clear in all their communications with any commissioning organisation, ensuring that training is provided within the context of reduction** (see glossary).

1.4.2 **Training providers must use feedback from training programmes as part of both a continuous review and the annual review process.**

1.4.3 **Training providers must review the rationale and continuing need for specific interventions to be included in the programme with the commissioning organisation at a minimum annually and each time the TNA is reviewed.**

1.4.4 **Training providers must have a restraint reduction plan which details measurable outcomes and actions that support the reduction of the use of restrictive practices.**

The plan must be updated at least annually and shared with commissioning organisations. *Restraint reduction resources, including six core strategies and self-assessment tools, are available at* RRN Training Standards 2019 – materials to download

## Standard 1.5

### Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions.

1.5.1 **Training providers must ensure that the views and experiences of people with lived experience of being in receipt of restrictive interventions should both inform and be explicit in training content.**

Co-production of materials and training with people who have lived experiences may include the use of monologues, video diaries or other forms to support discussion and interaction with participants. It is recognised that access to the views and experiences of people with lived experience may be through the training provider or in direct partnership with commissioners of training who may have developed opportunities and networks which support participation.

1.5.2 **Training providers must ensure that any direct engagement with people with lived experiences is managed sensitively and safely and is viewed in the context of a professional relationship.**

People with lived experience involved in the training must also receive adequate recompense. People with lived experience must be acknowledged as subject matter experts who are able to enrich and enhance training programmes, and play a valuable role in supporting restraint reduction measures.

1.5.3 **Training providers must ensure proper consideration and planning is given to any co-produced training sessions, if any sessions are to be co-produced and/or co-delivered with a person with lived experience. Sharing lived experiences can be an emotionally intensive experience for both the person with lived experience and the participants. The appropriate support arrangements must be in place.**

## Standard 1.6

### The training provider must agree delivery arrangements with the commissioning organisation before delivery takes place.

1.6.1 **Plans for competency testing and refresher programmes must be agreed with the commissioning organisation in advance and be part of the agreed delivery plan.**

Refresher training must take place as a minimum annually and must include competence testing for minimum content requirements (see standard 3.1.1). Refresher training must have an annual core content and an additional rolling programme of remaining content (see 3.1). Refresher or update cycles may in some circumstances be increased in frequency if individual or service circumstances change.

1.6.2 **Training providers must specify and agree the requirements for the training venue with the commissioning organisation as part of the delivery plan.**

1.6.3 **The training provider must describe the physical fitness level required for each programme it is commissioned to deliver as part of the delivery plan.** (See also standard 1.2.3 on the training information sheet.)

1.6.4 **The training provider must agree in advance with the commissioning organisation before any training is developed and delivered how the information needed for record keeping will be held and shared, in line with GDPR data protection rules and legislation.**

1.6.5 **The ratio of trainers to participants when teaching people theory and when teaching people practical skills must be part of the agreed delivery plan. When teaching people to use restrictive interventions, including breakaway techniques that have a restrictive component, a minimum of 2 trainers must always be present and a maximum ratio of 1 trainer to 9 participants must be maintained.**

In exceptional circumstances (for example in a social care service with a small staff team), some restrictive interventions could be taught at a maximum ratio of 1 trainer to a group of 6. (This does not include floor holds, but could include breakaway techniques that have a restrictive component.)

Justification for this ratio would need to be supported by:

- a robust training needs analysis that has not identified any elevated risks to people being supported by the service or the staff
- a risk assessment for the training delivery that takes into account the hazards and risks of only having one only trainer present

Theory, non-restrictive breakaway techniques and other interventions that provide non-restrictive support that present only very minimal physical risks to the person or the staff member can be delivered in a group at a maximum ratio of 1 trainer to 18 people.

Training providers should take into consideration the likely gender balance of participants and trainers.

1.6.6 **Training providers must request in advance any information about reasonable adjustments that need to be made so that participants with additional support needs can maximise their participation in the training event.**

This information must be received at least two weeks before the delivery date. If participants are added to the programme nearer the time, training providers must request that the commissioning organisation also include any information about additional support needs for those participants.

1.6.7 **All training providers and any trainers who are employed by them must as part of the commissioning process provide evidence of both professional indemnity and public liability insurance.**

## Standard 1.7

### The training provider must provide accessible information about the content of the training programme.

1.7.1 **Accessible information must be available to everyone who will be directly or indirectly impacted by the training. The information must:**

- be available to the commissioning organisation to disseminate and also readily available for any individual or representative of an individual who makes a request
- be in a format that best suits people's communication requirements and needs
- cover both the theory and practical aspects of the training. All restrictive interventions that are to be taught must be described, alongside potential risks and the rationale for their inclusion in the programme

## Standard 1.8

### The training provider must have a policy for responding to concerns and complaints.

1.8.1 **The training provider must have a policy that clearly describes how questions, concerns and complaints will be processed and dealt with. The policy must be:**

- available on request
- publicly available, eg through the training organisation's website
- presented in an accessible information sheet (see standard 1.2.3) which should contain the training organisation's contact information

**The policy must include:**

- a time frame for acknowledgment of the complaint to the complainant
- details of how an investigation will take place to determine if the complaint is justified or not
- a process for a root cause analysis of the complaint, and corrective actions
- details of the closure of the complaint and feedback to the complainant

# Section 2

# Standards supporting curriculum content

Standards 2.1–2.15 describe areas that the curriculum must cover.

# Standards

| | |
|---|---|
| Standard 2.1: | **Placing the curriculum within a rights based framework** |
| Standard 2.2: | **Duty of candour and duty of care** |
| Standard 2.3: | **Attitudes and attributions** |
| Standard 2.4: | **Considered decision making** |
| Standard 2.5: | **Primary and preventative strategies** |
| Standard 2.6: | **Teaching secondary strategies** |
| Standard 2.7: | **Teaching non-restrictive tertiary strategies** |
| Standard 2.8: | **Teaching restrictive tertiary strategies** |
| Standard 2.8.A: | **Use of mechanical restraint** |
| Standard 2.9: | **Factors that contribute to risk and elevated risk** |
| Standard 2.10: | **Emergency procedures** |
| Standard 2.11: | **Identifying the range of restrictive practices** |
| Standard 2.12: | **Use of data to inform minimisation** |
| Standard 2.13: | **Post-incident support, review and learning** |
| Standard 2.14: | **Trauma informed care and support** |
| Standard 2.15: | **Restraint reduction theory** |

# Introduction

Well-designed training programmes can influence learning, and behaviour change programmes that teach people to restrain may inadvertently reinforce the use of restrictive practices. A good training programme will teach the restrictive interventions as only one small part of a whole range of person centred working practices that aim to prevent and minimise distress and crisis rather than the primary focus being on management.

## Standard 2.1

### Training content must support a person centred and rights based approach.

Training providers must reference the rights based framework found at the front of these standards when developing this part of the curriculum.

*Figure 3 illustrates how training must consider the rights and needs of people who are being trained* ***and*** *the rights and needs of people who are being supported and may be in receipt of restrictive interventions. These rights and needs include universal human rights and are also person specific, setting specific and country specific.*

2.1.1 **Training content must ensure participants understand the importance of adopting a person centred approach at all times.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

2.1.2 **Training content must ensure participants understand the legislation that supports individual rights.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through. Reference in training must be made to:

- the Human Rights Act 1998
- the Equality Act 2010
- the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act (Northern Ireland) 2016*
- where relevant, the Mental Health Act 1983 and the Mental Health (Care and Treatment) (Scotland) Act 2003

*NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target (RCN 05/09/2018)

Figure 3: **Diagram demonstrating the layers of guidance and legislation to be considered when developing a training syllabus that has a restrictive intervention component**

2.1.3 **Training content must include an overview of relevant legislation, regulations and guidance designed to uphold human and individual rights as they relate to specific populations, settings and nations** (see Appendices 1–20).

## Standard 2.2

### Training content must cover duty of candour and duty of care in all settings.

2.2.1 **Training content must:**

- explore participants' obligations related to duty of candour and duty of care
- include a definition of both duties (for example Care Quality Commission (Regulation 20), 2015) and reference to guidance from the appropriate specific professional bodies for the participants
- explore how both duties relate to practice through examples and show how they contribute to a culture of safety for everyone
- explore where reflective practice can support both duties
- reference and direct participants to the commissioning organisation's whistle-blowing policy and procedures

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

## Standard 2.3

### Training content must cover how attitudes to and attributions of distress or concerning behaviours can impact directly on responses to the people being supported.

2.3.1 **Training content must cover:**

- how a range of factors can affect staffs' conscious and unconscious responses to the people they support
- how the language used to describe people, behaviours and restrictive interventions can negatively influence personal and service responses
- how negative attitudes and attributions can contribute to discrimination, power imbalances and the perpetuation of a culture of control
- how staff perceptions of authority and control and team relationships can impact on responses to the people they support (entrenched team cultures – 'the way that things are done here' – or influential team members can impact on the behaviour and practice of others). Please also refer to standard 2.10.

## Standard 2.4

### Training content must cover the use of decision making in response to distress or behaviours of concern.

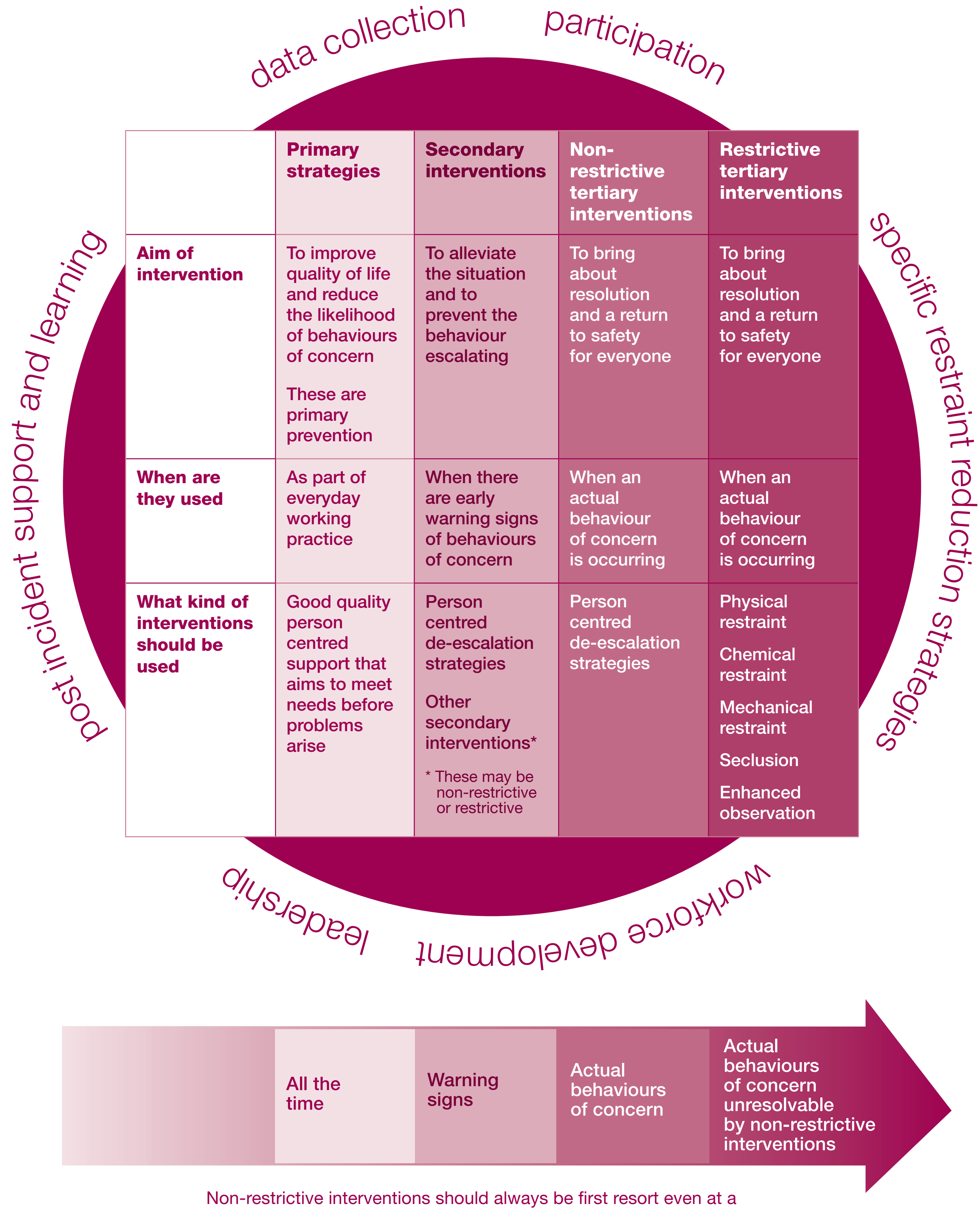
2.4.1 **Training content must:**

- define the concept of least restriction and this principle must be reinforced through the whole programme
- explore the impact of staff decision making and choices in relation to the use or non-use of any strategies or interventions. This must cover when, where and how to replace, reduce or release those that they have selected. The decision must be safe, lawful and effective
- include discussion about the influences of team culture or relationships with other staff or authority figures as impact factors on staff decision-making processes or the ability to challenge other people's decisions
- cover advanced directives and consent. It is vital that the person themselves is involved in discussions and decisions about what happens and when, and that directives should take into account preferences and wishes of the person
- draw a direct link between decision making and accountability
- refer to organisational protocols and guidance for calling the police to assist in crisis situations. The rationale for police involvement must be explored in detail

*Over reliance on police involvement is not likely to contribute to a culture of therapeutic treatment. Please refer to the memorandum of understanding drawn up by the College of Policing, available at* Protocol for Police and Mental Health Staff

*Figure 4 supports standards 2.5 to 2.8, illustrating the purpose of primary, secondary and tertiary strategies and when they should be used.*

Figure 4: **Minimisation matrix showing the different types of interventions and when they should be used within a restraint reduction framework** (NASMHPD, 2008)



| | **Primary strategies** | **Secondary interventions** | **Non-restrictive tertiary interventions** | **Restrictive tertiary interventions** |
|---|---|---|---|---|
| **Aim of intervention** | To improve quality of life and reduce the likelihood of behaviours of concern<br>These are primary prevention | To alleviate the situation and to prevent the behaviour escalating | To bring about resolution and a return to safety for everyone | To bring about resolution and a return to safety for everyone |
| **When are they used** | As part of everyday working practice | When there are early warning signs of behaviours of concern | When an actual behaviour of concern is occurring | When an actual behaviour of concern is occurring |
| **What kind of interventions should be used** | Good quality person centred support that aims to meet needs before problems arise | Person centred de-escalation strategies<br>Other secondary interventions*<br>* These may be non-restrictive or restrictive | Person centred de-escalation strategies | Physical restraint<br>Chemical restraint<br>Mechanical restraint<br>Seclusion<br>Enhanced observation |

All the time

Warning signs

Actual behaviours of concern

Actual behaviours of concern unresolvable by non-restrictive interventions

Non-restrictive interventions should always be first resort even at a tertiary stage when an actual behaviour of concern is occurring

## Standard 2.5

### The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff).*

2.5.1 **Training content must:**

- reference evidence-based frameworks, for example Positive Behaviour Support, Safewards, Recovery models etc for understanding the root causes of distress and the communicative function of behaviours of concern, meeting needs, and creating supportive environments
- support participants' understanding of the potential causes and vulnerabilities associated with the risk of developing distressed behaviours or behaviours that are concerning for the specific populations being supported. *Potential causes and vulnerabilities may include (but are not restricted to) communication difficulties, sensory differences, physical and mental health problems, social exclusion and lack of social relationships, and history of trauma and abuse (Hastings, 2013)*
- include activities and discussion relating to creating cultures of support and developing primary strategies designed to proactively meet people's needs so they are less likely to develop distress or behaviours of concern. *Primary strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of harmful behavioural disturbances (Department of Health, 2015, 26.19–26.22); these strategies may also be referred to as proactive strategies* (see Figure 4)
- explore the impact of the environment and factors that have a negative impact both on the people being supported and staff. The relationship between enhancing quality of life and reduction of restrictive practices must be emphasised
- refer to the role of relationships within the context of meeting need and preventing the development of behaviours of concern. It must also explore what constitutes healthy and helpful therapeutic relationships

* examples of frameworks may include Positive Behaviour Support, Safewards, No Force First, the Recovery model, and/or specific strategies such as Safety Huddles.

- include identifying triggers or events that may increase the likelihood that people will become distressed. Participants must be encouraged to think about the individual people they support and how these personalised triggers can be both identified and managed. Participants must also be encouraged to reflect on their own personal triggers and responses to those triggers

## Standard 2.6

**The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating.**

2.6.1 **Training content must:**

- cover a definition and examples of secondary strategies and when they should be considered for use. Secondary strategies may be non-restrictive or restrictive and examples should be given of both (see Figure 4)
- refer to any evidence-based frameworks or models that are used by the commissioning organisation
- include enough time for demonstrating, practising, and assessing participants as competent to use general de-escalation and other secondary strategies
- emphasise the importance of developing person centred, individualised de-escalation techniques and secondary strategies. Participants must be encouraged to relate the use of secondary strategies directly to the people they support
- refer to the importance of keeping records of successful secondary strategies, in line with organisational systems, and how this information can be used to inform reduction plans

## Standard 2.7

### The curriculum must give proportional time to covering the use of non-restrictive tertiary strategies.

2.7.1 **Training content must cover a definition of tertiary strategies (see glossary) and examples of both non-restrictive and restrictive tertiary strategies and when they should be considered for use** (see Figure 4, p56).

Tertiary strategies are used to bring potentially unsafe situations under control. Tertiary strategies do not aim to prevent the situation from occurring again in the future but are used for the exclusive aim of bringing about a safe and timely resolution.

2.7.2 **The curriculum must allow time for discussion and consideration of the safe use of non-restrictive tertiary strategies when there is an actual behaviour of concern occurring. Some interventions used at the secondary stage (early warning stage) can also be used when someone is in distress or there is a risk of harm occurring.**

The interventions may need adapting as the risk presented at this time is greater. These are referred to as non-restrictive tertiary strategies and should always be considered for use before a restrictive intervention is applied. The primary aim is to bring about safe and timely resolution in the least restrictive way.

2.7.3 **The curriculum must have time factored in for demonstration and practice for each strategy and time factored in for each participant to have an assessment of competence in the safe use of each strategy.**

2.7.4 **The trainer must refer to the importance of recording the use of non-restrictive tertiary strategies and how successful the de-escalation attempt was. This information will help support the minimisation plan.**

2.7.5 **Training content must cover any non-restrictive breakaway or disengagement techniques as identified by the Training Needs Analysis.**

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive, or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

Training content must draw attention to potential communicative function of the unwanted physical contact, particularly if the person is unable to verbalise their distress or make themselves understood clearly. The curriculum must have time factored in for demonstration and practice for each technique, and time factored in for each participant to have an assessment of competence in the safe use of each technique.

## Standard 2.8

### Teaching the use of restrictive interventions (may include physical restraint, physical restraint to facilitate seclusion or long term segregation, clinical holding, or mechanical restraint).

*The following restrictive interventions are covered by these standards:*

- *physical restraint*
- *physical restraint used to facilitate seclusion*
- *physical restraint used to facilitate long term segregation*
- *physical restraint used to facilitate rapid tranquilisation*
- *mechanical restraint*
- *clinical holding*

2.8.1 **Training in the use of restrictive interventions must only be provided within the context of an explicit commitment to reduction of the use of all restrictive interventions** (see standard 1.4) **and the provision of person centred support.**

2.8.2 **Training content should refer to any elevated risks identified in the TNA** (see standard 1.1).

Any restrictive interventions which are to be taught to training participants must have been assessed as suitable for the needs of that population. Where TNAs have highlighted elevated risks to individuals or populations, training must reflect any additional safeguards, limitations or restrictions. There must not be blanket training of any restrictive intervention techniques (see Appendix 10 for emergency admission services).

2.8.3 **Training content must define the type of restrictive intervention being taught, and this must include a definition of the purpose of the intervention and the context in which it is to be used.**

Reference must be made to terminology used in local policy documents, as well as authorised procedure. If breakaway/disengagement techniques are taught that have a restrictive component the restrictive element must be highlighted. Breakaway techniques are used to breakaway/disengage from unwanted physical contact and may also be used to assist another person to disengage from unwanted physical contact. Training content must also draw attention to potential communicative function of the unwanted physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

2.8.4 **Training content must be clear that restricting someone's movement for clinical or personal care purposes is a form of physical restraint and should be recorded as such. This is sometimes referred to as clinical holding.**

Training must refer to the use of person centred approaches and less restrictive alternatives to the use of clinical holding or holding for personal care that can decrease the traumatic impact of the experience.

2.8.5 **The trainer facilitating the session must be competent to safely teach and manage those training sessions covering the use of specific restrictive interventions. In addition to meeting the criteria in** standard 3**, trainers must have been formally assessed to be competent to deliver those specific interventions by the training provider.**

Clinical experience of participating in certain procedures such as rapid tranquilisation and long term segregation would also enhance their understanding.

2.8.6 **Training must cover the specific circumstances in which the restrictive intervention under consideration may lawfully be used.**

As a minimum the following must be covered:

- an overarching definition of restraint/restrictive intervention must be discussed in training so delegates gain a clear understanding of when any intervention becomes restrictive and is categorised as a restraint. These standards recommend reference to the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019)

  > *'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around* (EHRC, 2019)

- the legislation and guidance that legitimises the use of the specific restrictive intervention being taught, as well as the rationale, legislation and guidance relating to any clinical or statutory function that the intervention (eg physical restraint) is being used to support (eg rapid tranquilisation or detention under the MHA 1983 or the Mental Health (Care and Treatment) (Scotland) Act 2003)
- any national or service specific guidance that applies to the specific restrictive intervention being used
- relevant sections of the local organisational policy along with procedures relating to the use of the specific restrictive intervention
- that the intervention under consideration must only be considered when all other available and appropriate methods of primary and secondary prevention and non-restrictive tertiary interventions have been explored and found ineffective
- that the intervention must only be used for its intended and agreed purpose
- that it must be the least restrictive option available
- that it must employ the minimum amount of force for the minimum amount of time
- that it must never be used as a threat or as punishment, or in a way that curtails the rights and freedoms of the individual

- that if it is used as a planned intervention, it must be accompanied by the consent of the individual, or based on a best interests decision (Mental Capacity Act 2005) or in consultation with relevant others (Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016. NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target (RCN 05/09/2018)) unless the person is detained under the Mental Health Act 1983, or the Mental Health (Care and Treatment) (Scotland) Act 2003

**Physical restraint** is any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

**Seclusion** involves 'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.103).

NB the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019) refers to enforced isolation:

> Example: Isolation may be enforced by locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area, for example by the use or threat of force. Enforced isolation is therefore restraint, but it may be described as seclusion, segregation, separation, time out or solitary confinement (EHRC, 2019).

**Rapid tranquilisation** refers to 'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.91).

**Long term segregation (LTS)** involves 'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.150).

**Mechanical restraint** involves 'the use of a device (eg belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (CQC, 2015b).

**Clinical holding** involves 'immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children (and adults), with their permission, to manage a painful procedure quickly or effectively' (RCN, 2010).

2.8.7 **The training content must cover all of the risks that are associated with the use of the specific intervention under consideration, before any practical component is delivered. Training must cover the safeguards in place to manage any risks that may arise as well as the planned contingencies in place in the event of a medical emergency developing** (see standard 2.10).

As a minimum it must cover:

- general risks associated with the specific intervention (standard 1.3)
- specific risks associated with the use of the intervention under consideration on any individuals
- warning signs to look out for, which reveal distress, pain or a deterioration in any individual medical condition (refer to standard 2.10)
- action to be taken in the event that warning signs are detected (see standard 2.10)

2.8.8 **Before delivering the practical components of the programme the trainer must highlight those risks that are potentially present within the training environment and during training practice** (see standard 1.3)**.**

These include:

- general safety issues for staff during teaching and practice
- person specific safety issues for staff during teaching and practice

2.8.9 **The training session must allow enough time for demonstration and practice for each technique and time factored in for each participant to have an assessment of competence in the safe use of each restrictive intervention that has been approved** (see standard 2.6)**.**

2.8.10 **The training session must be structured in such a way as to contextualise the use of the specific restrictive intervention. For example structuring scenarios that integrate the restrictive interventions into operational or clinical situations.**

2.8.11 **Where simulated resistance is used during training sessions the risks it poses must be managed:**

- only trainers must role play resistant service users
- role plays must be directly managed by a separate trainer who should immediately stop the scenario if there is any likelihood of injury

2.8.12 **The training content must emphasise that the application of any restrictive intervention will be within the context of a therapeutic or supportive relationship with that person.**

Training must recognise that the use of restrictive interventions can traumatise people and damage relationships. It must explore how relationships can be maintained during and after the use of any restrictive interventions.

2.8.13 **The training content must emphasise the need to comply with reporting requirements and participate in any review processes designed to learn from experience and reduce the need for future restrictive interventions.**

## Standard 2.8.A

### Teaching the use of mechanical restraint.

### Due to the highly restrictive nature of some mechanical restraints, additional training standards are required to complement standard 2.8.

2.8.A.1 **Training providers must ensure that any form of mechanical restraint that they are requested to teach the use of has been agreed at a board level. There must be clear documentation as to how this has been deemed the least restrictive option for that person and why alternative approaches would not be suitable for them (CQC, 2016). Training content must explicitly cover this point.**

2.8.A.2 **Mechanical restraint must only be considered for use in exceptional circumstances in specific settings and under specific circumstances. Training content must clearly identify what these are and refer to organisational policy and protocol for their use.**

2.8.A.3 **Training content must refer to specific legislation and guidance on the use of mechanical restraint. This must include:**

- ***Brief Guide: Restraint (Physical and Mechanical)* (CQC, 2015)**
- ***MHA 1983 Code of Practice* (Department of Health, 2015), and the *MHA 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)**
- ***NICE guidance NG10* (NICE, 2015a)**

2.8.A.4 **Training content must refer to the *Mental Health Act Code of Practice* (Department of Health, 2015, 26.8026.81, 26.82), and the *Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a) which specifies requirements for safety reviews and observation protocols.**

2.8.A.5 **Training content must refer to any other general and specific safety guidance around the use of the specific mechanical restraint.**

2.8.A.6 **If appropriate, training must cover the protocol for the use and recording of mechanical restraint such as splints or cat paws which sometimes are used in services for people with learning disabilities and autistic people who have self injurious behaviours.**

The principle of least restrictive intervention must apply. The function of the self injury for the person must be identified and alternative ways of meeting the person's needs must be implemented. The clinical team, family, carers and advocates would need to be in agreement about the parameters of the use of the device (*MHA 1983 Code of Practice*, Department of Health, 2015, 26.87).

2.8.A.7 **Training must cover protocols for the use and recording of mechanical restraint in services for older people and people with disabilities. Belts and straps in chairs etc must be used lawfully for intended purpose only and not used to restrict liberty for the convenience of staff.**

## Standard 2.9

### Training must cover the factors that contribute to risk and elevated levels of risk in the application of restrictive interventions.

2.9.1 **Training content must make clear that *all* restrictive interventions contain an element of risk even when in accordance with training approved techniques and guidance.**

Training content must cover:

- physical, psychological or emotional risks
- factors that may elevate risk – these may include:
  - personal factors – of both the person being restrained and the people who are carrying out the restraint
  - environmental factors
  - service factors that may include, among other things, inadequate policies, poor leadership, lack of appropriate training and supervision, inadequate staffing levels, negative team or organisational cultures, power imbalances, and lack of opportunity or encouragement for reflective practice
  - the types of restrictive interventions being used as well as how long they are applied for and how they are applied

2.9.2 **Training content must make clear that staff have a responsibility for the safety of those individuals on whom they are applying restrictive interventions.**

Training content must cover participant responsibilities for ensuring:

- restrictive interventions are only ever used as a last resort, and always in line with policy and guidance
- any and all general safeguards are implemented
- any and all person centred safeguards are implemented
- active monitoring of the person is undertaken (see standard 1.3.4)
- emergency procedures are implemented immediately in the event that relevant warning signs are detected (see standard 2.10)

2.9.3 **Training content must make clear that staff have a responsibility for their own safety and that of their colleagues involved in applying restrictive interventions, as well as for others involved in the incident.**

This would include organisational policies in place that are designed to keep staff safe. These include lone working procedures, safe systems of work and any guidelines relating to personal safety.

## Standard 2.10

### Training in restrictive interventions must include contingencies to reduce the likelihood of medical emergencies arising; and the provisions to manage any that do.

2.10.1 **Training should include arrangements for monitoring a person's health status whilst under restraint, including: the integrity of their airway; their breathing and circulation; any deformity of limbs; and complications associated with any pre-existing medical condition or injury. (In some service settings local arrangements may include discrete monitoring of pulse and respiration, the use of pulse oximetry etc.)**

This requires participants to be trained to recognise warning signs which indicate some form of medical emergency may be emerging; and especially signs and symptoms which may be associated with conditions of particular concern, including asphyxiation, cardiac arrest, cerebral vascular accident and myocardial infarction, and fractures.

2.10.2 **Training must be explicit that if, whilst attempting to manage a behavioural crisis, a medical emergency arises, participants have a clear responsibility to take immediate action to ensure the patient's safety.**

Examples of medical emergencies include a person experiencing breathing difficulties or some form of cardiac or circulatory event, as well as injury to limbs or joints, including fractures or dislocations.

2.10.3 **Training must include consideration and reflection on how social and human factors, including high levels of expressed emotion, can influence the objectivity of interpretations of a patient's condition and associated decision making in emergency situations.**

2.10.4 **It must be made clear to training participants that any/all staff involved in a restraint have a responsibility immediately to raise any concerns they have about the patient's health status.**

2.10.5 **Training must include recognition of the need, in some instances, immediately to discontinue the use of restrictive holds (albeit possibly whilst retaining an ability to recommence them, in a modified form, based on the person's presentation).**

This must also include consideration of the degree of urgency with which restrictive interventions should cease in a medical emergency; arrangements, in accordance with local policies and procedures, for immediately summoning emergency medical assistance; and how the person should be supported until assistance arrives.

2.10.6 **Training must include recognition of situations where staff involved in restraining a patient need to instigate immediate life support measures, based on training that is compliant with the guidelines of the UK Resuscitation Council.**

Training content must take full account of the available resources and environment within which care is provided. In particular, in accordance with any organisational policies and procedures, this should include arrangements for summoning assistance of colleagues with more advanced life support expertise; and the availability and use of emergency medical devices that may be required for immediate life support, such as Automated External Defibrillators (AEDs).

2.10.7 **Training must cover measures required to prevent postural/positional asphyxia developing; as well as how to recognise when it may be occurring.**

Training must include identification of factors such as obesity and stature, pre-existing medical conditions, pressure to the chest or abdomen, obstructing a person's airway etc, that increase the likelihood of postural/positional asphyxia developing; and steps that should be taken to reduce the risks, including vigilant monitoring, avoidance of specific holds.

This must also include recognition of signs that positional asphyxia may be developing and in particular: monitoring the content of a person's speech; vocalisations that might indicate a blockage of the airway; discolouration (cyanosis) of the lips, hands or face; increased panic/resistance; and/or a person suddenly becoming more tranquil.

2.10.8 **Training content must cover procedures for recording and reporting medical emergencies associated with situations where restrictive interventions have been used. Relevant organisational policies in support of Health and Safety obligations must be referenced and clarified.**

## Standard 2.11

### The curriculum must identify the full range of restrictive interventions and restrictive practices and their application.

2.11.1 **Training content must identify and prompt discussion about all forms of restrictive interventions, including seclusion, rapid tranquilisation, chemical restraint, mechanical restraint, clinical holding, physical restraint and psychological restraint.**

This must include:

- definitions of key terms
- reference to blanket restrictions
- identification of other restrictive practices imposed by staff on people, such as dietary restrictions, lack of choice, restricting access to activities and personal items and locked doors
- restrictive intervention and practices that may be used covertly, such as not identifying opportunities or options, or influencing people’s choices, eg ‘you don’t want to go out this afternoon do you?’, or secreting medication in preferred food

2.11.2 **Training content must define coercion and trainers must allow time for discussion about how, if unchecked or unregulated, restrictive interventions can become coercive and potentially harmful (physically, emotionally and psychologically).**

## Standard 2.12

### The curriculum must cover the requirements for recording and analysing data from restrictive interventions and occurrences of distress or concerning behaviour.

2.12.1 **Training content must cover:**

- the regulatory and organisational requirements for recording the use of any restrictive interventions and injuries associated with the use of restrictive interventions. It is recommended that an independent review should take place if any injuries occur during the use of any restrictive interventions
- the importance of accurate and objective recording. Activities that enable participants to practice and reflect on elements of good recording must be used. Different types of data collection tools and their uses must be covered
- the use and analysis of data to support restraint reduction. Analysis should support the identification of trends such as frequency and seriousness of different types of restraint over time and across different areas of the provider's work. Analysis of data must be used to inform individual and organisational restraint reduction plans. Analysis of data can help identify patterns that inform preventative working – by highlighting the conditions in which incidents are more or less likely to occur it should be possible to develop primary strategies that meet people's needs before behaviours of concern arise. Reference should be made to *Towards Safer Services* (DoH, in development) and *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate* (Chester et al, 2018, available at: University of Kent Academic Repository )

## Standard 2.13

### The curriculum must include reference to the importance of required procedures that are related to post-incident review.

2.13.1 **Training content must include reference to the need for, and the understanding of, the purpose of both components of post-incident review for individuals and staff.**

With reference to a review of current available evidence, these standards support a clear separation of these two components (Baker, 2017). Best practice and review of the limited evidence base suggest there are two main components of post-incident review, each with a distinct purpose:

1. Post-incident support – attention to physical and emotional wellbeing of the individuals involved
2. Post-incident reflection and learning review

Post-incident review requirements for staff, service users, carers and others involved in incidents where restrictive physical interventions are used are outlined in NICE guidance NG10 and QS154 (NICE, 2015a, 2017b).

2.13.2 **Training content must cover the need for post-incident support.**

This is the support that is immediately offered to an individual who has been involved in an incident. It should be available after any incident where a restrictive intervention has been used and after any incident that may have had an impact on the individuals involved. It should be available and proactively offered to all individuals who have been involved in the incident or who have witnessed the incident. The support should include assessment and treatment of any medical needs and provision of immediate emotional support. The trainer should discuss the importance of staff seeking and accepting this support.

2.13.3 **The training content must indicate what future options for emotional support are available through the commissioning organisation. The training must identify how participants and individuals who use services can access this either within the service or independently of the service. (NB: This should have been identified as part of the TNA and overall commissioning.)**

This may include individual and/or group supervision/debriefing and individual psychological therapy delivered by a trained professional.

2.13.4 **Training content must also cover the second component of a post-incident review: a reflective and learning review. The training content must cover the essential elements of the learning and reflective review which should be triggered by the use of any planned or unplanned restrictive intervention or any other event specified in organisational policy.**

The review should examine the factors that led to the restrictive intervention being used and consider if:

- future incidents could be either avoided or the impact could be minimised – this might mean the service or environment could be altered to better meet the needs of the person or that the staff could respond differently to the person
- personalised triggers can be identified and either minimised or avoided in the future and/or the person could be supported to learn coping or alternative skills
- the risk assessment and support plan need to be reviewed
- a less restrictive approach could be used in the future

Reflective reviews should be led by experienced facilitators and should be a learning and reflection forum and not about blaming individuals. There should be clear actions taken forward from the review. Views of the individuals who were involved in the incident should be part of the review process using whatever method is most appropriate and supportive to them. There should be recognition that some individuals may be distressed by recalling the incident.

## Standard 2.14

### The curriculum must have content that enables participants to understand the meaning of 'trauma' and how it can impact on people's experience of restrictive interventions.

2.14.1 **Training content must cover:**

- the definition of 'trauma' including post-traumatic stress disorder (DSM 5) and complex trauma disorder (ICD 11) and the basic principles of trauma informed care
- how trauma may impact on the experience of use of restrictive interventions. This can apply both to people who may be in receipt of the restrictive intervention and to those who apply the restrictive interventions. Experiencing a restrictive intervention such as seclusion or physical restraint is in itself potentially traumatising. The experience could also trigger a trauma memory.
- how a person's trauma history, if it is known, must form part of the personalised wellbeing risk assessments needed for the use of any restrictive interventions. There may be considerations that could lessen the impact of the experience should it become necessary. A person's trauma history may not be known so training should also cover the importance of the recognition of potential symptoms of trauma and how these can sometimes be overshadowed by autism or learning disability, and also the fact that behavioural symptoms could potentially be linked to past trauma. It is possible that people who have care histories may have had multiple traumatic experiences of restraint – it is important that the training considers people's past experiences and how these might impact on any present experience. It would be important for participants to consider the types of restraint that people who have had histories of restraint and/or abuse may find particularly traumatising
- an affirmation that a trauma informed approach must be provided to everyone whether trauma is known or not
- an understanding of trauma through a developmental perspective that applies to all ages not just children

## Standard 2.15

### The curriculum must contain reference to and explore understanding of restraint reduction theory.

2.15.1 **Training content must include reference to evidence based models of restraint reduction.**

These may be with reference to resources, among others, from the Restraint Reduction Network Restraint Reduction Network, the Restrain programme (The Health Foundation), or other population specific programmes. Trainers are recommended to refer to the 'six core strategies' as identified by Huckshorn (NASMHPD, 2008). Other evidence based models include Safewards and No Force First Restraint.

2.15.2 **Training content must make reference to any policy, procedure or commitments which have been made by the commissioning organisation related to restraint reduction.**

Section
3

# Standards supporting post-delivery processes

## Standards

| | |
|---|---|
| Standard 3.1: | **Competence, assessment and feedback** |
| Standard 3.2: | **Record keeping** |
| Standard 3.3: | **Reporting concerns** |
| Standard 3.4: | **Evaluation** |
| Standard 3.5: | **Quality assurance** |
| Standard 3.6: | **Refresher training** |

## Introduction

Good training providers will have a range of different processes for monitoring the quality and effectiveness of their training that feed into a cycle of continuous improvement. This is so they can be confident the training they provide is having a positive impact on the quality of life for people who are supported in the organisations they provide training for.

## Standard 3.1

### Training must include a competence based assessment within each programme, with participants being assessed for both knowledge and skills. It is recognised that such assessments can only assess participant's skills within a training environment.

3.1.1 **Training providers must establish assessment criteria which are consistent with the level of training which has been commissioned.**

The criteria must identify and distinguish between introductory level, refresher training, and train the trainer programmes.

Areas that must be included are:

- values and attitudes, as reflected in the language and behaviour used during the course
- knowledge of appropriate theoretical concepts, approaches and strategies (eg rights based approaches, person centred care, primary, secondary and tertiary strategies)
- the ability to describe a range of primary interventions
- the ability both to describe and demonstrate a range of secondary strategies
- the ability both to describe and demonstrate non-restrictive tertiary strategies
- the ability both to comprehensively describe and demonstrate all component parts of any restrictive interventions and the safety parameters for them that have been taught
- participants should be able to clearly articulate the rationale for the use of these interventions
- knowledge relating to the legal and ethical implications of using restrictive intervention

3.1.2 **The training provider must have assessment methods which take into account any reasonable adjustments that people need.**

(NB: When testing the competence to apply a restrictive intervention any reasonable adjustments must not compromise the safety of the restrictive intervention when it is applied in practice.)

3.1.3 **The curriculum must have time factored in for demonstration and practice of each intervention that has been taught, as well as time factored in for the assessment of competence for each participant.**

3.1.4 **The training provider must allow time within the programme so that the participants can be given verbal feedback about their performance.**

3.1.5 **If participants fail to reach the level of competency required by the training provider, the training provider must agree with the commissioning organisation (service provider) the necessary actions for the participant.**

This may for example involve a personal learning plan, a repetition of the training within six months, a bespoke training programme or a coaching intervention. The training provider must recommend that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence.

If a trainer has serious concerns during the programme about a participant's ability to complete the programme successfully they must refer to the identified manager in the commissioning organisation as soon as is practical (also refer to standard 4.6.6).

3.1.6 **The training organisation must provide the commissioning organisation (service provider) with written feedback on the assessed performance of each course participant.**

This must include:

- the areas they have demonstrated competence in
- any identified areas in which they have demonstrated excellence

- if a participant has failed to demonstrate competence in all areas of the curriculum. In this case, feedback must also include:
    - any actions that can be taken to enable them to achieve competence in these areas
    - a recommendation that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence for the whole of the curriculum

## Standard 3.2

### Training records for each programme delivered must be maintained by the training organisation.

3.2.1 **Training providers must ensure that their trainers maintain complete, accurate and up to date records of each course they deliver.**

This must include the following:

**General information**

- date and title of the course, duration and details of the trainers involved

**About the participants**

- names of the participants, their employing organisation and service/setting
- confirmation of each participant's fitness to attend the programme

**About the programme**

- learning aims and objectives of the programme
- brief description of curriculum content
- details of secondary strategies that have been taught
- details of non-restrictive tertiary strategies that have been taught
- details of any restrictive tertiary strategies that have been taught
- date when refresher training due

**Assessment information**

- assessment records for each participant for each part of the syllabus (with reference to standard 3.1.1) with any reasonable adjustments that have been made
- assessment records must clearly indicate who has successfully completed the programme and demonstrated the required level of competence and who has not
- written feedback for each participant (see standard 3.1.5), including any recommended actions in respect of participants who failed to demonstrate competence
- any concerns related to the conduct or values of any of the participants (please refer to standard 3.1.1)
- evaluation information (please refer to standard 3.4.1)
- health and safety information, details of any injuries or accidents reportable under health and safety legislation occurring during the training, in compliance with Health and Safety Executive *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) (HSE, 2013b)

3.2.2 **Records must be maintained and retained by the training organisation for a period of time that is consistent with legislative requirements.**

3.2.3 **Training providers must have a data storage and destruction policy that is compliant with GDPR regulations.**

## Standard 3.3

### Training providers must have a policy for dealing with concerns that arise during training.

3.3.1 **Training providers must have a policy that outlines the procedure for handling any concerns about the conduct of participants arising during training sessions. This policy must be available to the trainer before any training is delivered.**

The policy must include:

- examples of behaviours that may constitute a concern or amount to inappropriate conduct
- an outline of the procedure for informing participants how inappropriate conduct will be managed within the context of the training session
- an outline of the informal procedures for resolving matters, where the trainer seeks to address the issue during the training session
- an outline of the procedure for escalating concerns formally to the training commissioner if the concern cannot be resolved informally
- details of any formal record that must be completed by the trainers

## Standard 3.4

### All training must be evaluated post-delivery using an evidence based framework.

3.4.1 **Training providers must collect evaluation responses for each programme that they run.** The evaluations must inform both the training provider's internal quality assurance processes and a review with the training provider about the effectiveness of the programme. They must also inform the annual review with the commissioning organisation (service provider) and the review of the restrictive intervention reduction plan.

## Standard 3.5

**Training providers must have internal quality assurance systems and be able to provide evidence that they effectively monitor the quality and consistency of all of their training services. Training providers must be able to evidence that their training services are being consistently delivered and that they routinely adhere to all the training standards. Training providers must use their quality assurance process to identify and action improvement priorities.**

3.5.1 **Training providers must be able to demonstrate how their quality assurance cycle supports improvements.**

The quality assurance process for training providers must feed into the annual review with commissioning organisations as well as their own processes that support improvement.

Analysis of evaluation information will assist the training provider to identify priorities and create an action plan.

Areas that must be evaluated:

- ensuring delivery is consistently in line with the Restraint Reduction Network Training Standards
- how training programmes are developed and delivered
- the performance of trainers
- the administration of the programmes
- the feedback to the commissioning organisations

There are a number of methods that can be used to gain evaluation information:

- evaluation forms from participants on the training programme
- verbal or written feedback from people who are being supported
- direct observation of training programmes
- verbal or written feedback from managers of staff who have attended the training

- verbal or written feedback from the commissioning organisation about how the training provider has performed during different stages of syllabus development and delivery of the programme
- self-assessment against these standards
- peer review – working with other providers to peer review
- independent reviews of training programmes and impact

## Standard 3.6

**Training providers must develop refresher training curricula that take into account the current needs of the organisation, service or individuals, using information from an updated TNA** (see also standard 1.6.1).

3.6.1 **Training providers must follow the same process for the development of refresher programmes as for the development of the original programme curriculum.**

3.6.2 **Training providers must ask the commissioning organisation to update the information in the TNA and must review the TNA together to check each restrictive intervention is still needed or if the level of restrictiveness can be reduced.**

3.6.3 **The training content of a refresher programme must be based upon an updated TNA agreed with the commissioner/organisation restraint reduction lead.**

Refresher training must have an annual core content (see 3.1) and an additional rolling programme of remaining content. The rolling programme may have a different focus each year but all curriculum areas must be covered at least every three years.

Refresher training must include the following:

- revision of key areas of the original syllabus – all curriculum content must be studied/revised over a three year period
- a reassessment of the competence to apply primary/preventative strategies, secondary strategies, and non-restrictive tertiary strategies must take place at least once a year
- an update on relevant legislation or guidance on good practice and organisational policies must take place at least once a year
- further development of skills to apply primary/ preventative strategies at least once a year
- a reassessment of competence to apply any of the taught restrictive tertiary strategies must take place at least once a year
- any additional safety advice or modifications needed relating to the use of tertiary strategies with the individuals in the service or that need to be considered because of changes in the services must be highlighted in every training programme

Refresher training must be a minimum of one day. It is expected that sufficient time is allocated to both theory, teaching physical skills and competence assessment. Refresher training is likely to be more than one day if there are multiple interventions and/or they are complex or high risk interventions and/or when the TNA has identified areas that need extra support.

# Section 4 Trainer standards

## Standards

| | |
|---|---|
| Standard 4.1: | **Quality assurance** |
| Standard 4.2: | **Training competence** |
| Standard 4.3: | **Professional competence** |
| Standard 4.4: | **Delivering relevant content** |
| Standard 4.5: | **Insurance** |
| Standard 4.6: | **Safety** |
| Standard 4.7: | **Professional development** |

# Introduction

Good restrictive intervention trainers have the potential to change practice, win hearts and minds, and have an important role in supporting a system wide approach to the reduction of the use of unnecessary restrictive practices. They have a range of skills and are confident in their knowledge of all the training content, how it fits within the human rights framework, and best practice for the sector and population they are training in. They are able to assess competency, encourage potential, and appropriately challenge unhelpful attitudes.

For certification purposes there are two kinds of trainers referred to in these standards:

**Senior trainers** who deliver training across multiple organisations and/or deliver train the trainer programmes. They may be employed (or paid) by a commercial training provider, or be employed within a service provider organisation such as an NHS Trust.

**Associate trainers** who are employed by (and deliver training only within their own) service provider organisation which may be an affiliate organisation linked to the trainer provider (eg NHS Trusts, schools or care homes). They do not deliver train the trainer programmes.

When a standard refers to all trainers it means both senior trainers and associate trainers.

The certification scheme does not certificate providers, curricula or trainers separately. Valid certification only applies when all three are in combination, though the certification scheme trainers are **authorised** to deliver **approved** curricula on behalf of the training provider.

Trainers are **not** authorised under the certification scheme to deliver any other programmes that have not been through the certification process. Trainer certification is not transferable to other organisations.

## Standard 4.1

### Training providers must have effective internal quality assurance systems that effectively monitor the consistency of delivery and adherence to all the standards across all training services. This includes monitoring all curricula and all trainers delivering their programmes across all services including affiliated satellite services. Training providers should use their quality assurance process to identify improvement priorities.

**Quality assurance must include regular observation in situ of training delivery. The training provider must be able to provide evidence that it has been checking its own compliance against its own quality assurance system. This must include evidence that there is checking of the compliance of all quality systems in place that monitor the quality and fidelity of training delivered by associate trainers in satellite organisations.**

4.1.1 **Training providers must keep up to date records of both professional and training competence for all trainers.**

4.1.2 **Training providers must keep records of all trainers and all training programmes that are delivered.**

4.1.3 **Training providers must be able to show evidence that they conduct regular quality assurance checks to ensure that accredited authorised curricula are being delivered as intended and that no unauthorised adaptations are being made.**

## Standard 4.2

### All trainers who are delivering training must be able to demonstrate that they are qualified and competent to train.

4.2.1 **Training providers must be satisfied that trainers they recruit have the capability to train effectively and have appropriate levels of teaching and training skills.**

Training providers must evidence they have robust processes to assess this aspect of the trainers' performance. Training and teaching skills may be assessed through a combination of qualifications, scrutiny of evaluations, peer reviews and formal assessment by the provider.

4.2.2 **All trainers delivering training in restrictive interventions must hold current first aid certification including immediate life support.**

As a minimum requirement this must be the Emergency First Aid at Work one day programme which includes immediate life support. Different premises may require different levels of training.

## Standard 4.3

### All trainers must be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training.

4.3.1 **All trainers must be able to evidence that they have a professional qualification (with current up to date registration) or have completed a programme of relevant vocational training, having received a qualification within health, education or social care. Training providers must have mechanisms in place so that they can demonstrate that all trainers are able to evidence professional competence and understanding of the sector in which they are delivering training.**

This may include:

- vocational qualification (health, education or social care)
- social work qualification (Diploma, BSc, BA)
- teaching or education-based qualification
- nursing qualification (with current registration) (NMC)
- other health professional qualification (with current HCPC or equivalent registration)

4.3.2 **All trainers must have been continuously employed in a support or care role within social care, education or a health care environment for a period of not less than two years. Training providers must be satisfied that trainers are able to evidence professional competence and understanding of the needs of the populations and settings in which they are delivering training. This may be evidenced in a number of ways, including a portfolio that shows professional development and competence.**

4.3.3 **All trainers must be able to demonstrate that they have the required level of knowledge and underpinning values to competently deliver all elements of the curriculum** as specified in Section 2.

This would include:

- a commitment to upholding human rights and to working within a restraint reduction framework
- an appropriate level of knowledge in all areas of the curriculm, not just in demonstrating restrictive intervention techniques
- a commitment to working within the Restraint Reduction Network training standards

It is the responsibility of the training provider to have mechanisms in place that include criteria for assessment of trainers so they can provide evidence of competence and underpinning values.

When recruiting trainers the training provider must have a robust process for selecting trainers that includes references, previous evaluations and appropriate criminal disclosure checks.

All trainers must have successfully completed a face to face train the trainer programme of a minimum of 30 hours or 5 days in length (which may be an accredited qualification for example a diploma or BTEC). The competence to deliver the whole of the curriculum must be assessed during and at the end of the train the trainer programme.

Training providers must have mechanisms in place to evidence the underpinning values. Trainer competence must be assessed and quality assurance checks completed at a minimum annually by the training organisation and should cover the whole curriculum not just restrictive interventions.

In some circumstances a commissioning organisation will already have a model of preventative working in place, such as Safewards or Positive Behaviour Support, and this training may be delivered by another agency. Staff must receive preventative training before they receive any training in restrictive interventions (see standard 1.2.1). In this circumstance the training programme that is commissioned with a restrictive intervention component may not need to include the content covered in standard 2.5, but the trainer must have the knowledge to teach all the other areas of the curriculum covered in the standards.

4.3.4 **All senior trainers must successfully complete a minimum of two days' refresher training annually.**

4.3.5 **Training providers must specify CPD requirements for all trainers who deliver their programmes.**

CPD hours are not set in these standards. However, trainers must collect a portfolio of evidence to demonstrate to the training provider that they meet the provider requirements and the Restraint Reduction Network standards. Evidence of relevant CPD records of trainers must be kept by the training provider to ensure quality, knowledge and skills are maintained.

Where employing or commissioning organisations make stipulations that professional registration is maintained then this remains the responsibility of the trainer.

## Standard 4.4

### All trainers must ensure that the delivery of any programme is informed by the training needs analysis (TNA) (see standard 1.1).

4.4.1 **All trainers must familiarise themselves with the TNA that has been agreed between the training provider and the commissioning organisation before they deliver any programme of training.**

The curriculum must reflect the specific needs identified in the TNA.

4.4.2 **A trainer must only teach the restrictive interventions that have been previously identified and agreed between the commissioning organisation and the training provider and highlight any identified person specific risks during training.**

Before delivering any restrictive intervention component the trainer must familiarise themselves with the written rationale for the use of any restrictive intervention and any elevated risks that have been highlighted.

4.4.3 **Before delivering any physical restraint training the trainer must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see UK Resuscitation Council).

In some cases this training will be provided by the trainer as part of the content of training and in other cases another provider or trainer will have delivered this programme.

## Standard 4.5

### All trainers must be covered by professional indemnity and public liability insurance.

4.5.1 **Trainers must have appropriate insurance cover for the work they are undertaking.**

Trainers working as consultants for a training provider under a franchise agreement or as self-employed trainers must ensure that they have insurance comparable with that of the training provider for the activities they undertake. Valid insurance documentation should be submitted annually for review to the organisation for which they deliver training.

## Standard 4.6

### Trainers must manage training sessions safely and professionally.

4.6.1 **Trainers must undertake an environmental risk assessment that has been provided to them by the training provider.**

Before any training occurs, trainers must undertake a formal risk assessment of the training environment to satisfy themselves that the space is free from hazards, provides enough room to move around safely and is suitable and conducive to successful training delivery.

4.6.2 **Trainers must give out information to participants at the start of any programme.**

All trainers must, as a minimum, at the start of any programme, clearly outline:

- training ground rules and safety rules
- the process for reporting any concerns about the conduct of the participants or the trainer
- fire safety requirements, access to toilets and refreshments etc
- timings for the programme
- learning outcomes, topics to be covered and assessment criteria
- the process for managing participants who don’t reach the assessment criteria

4.6.3 **Trainers must outline participants' personal responsibilities before teaching any restrictive intervention component.**

This must include:

- guarding against the risk of injury during the training and immediately reporting to the trainers any subsequent injury
- reporting any existing injuries and disabilities that may pose health and safety risks to their own safety and welfare and those of other participants during training
- their responsibility to adhere to safety guidelines issued by the trainer
- reporting all injuries or adverse events in accordance with the commissioning organisation's own reporting policy and statutory guidance *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) to the purchasing organisation, including any injuries sustained during the training

4.6.4 **Trainers must use respectful language and conduct themselves professionally.**

All trainers must adhere to a code of conduct, as specified by the training organisation.

4.6.5 **Trainers must be mindful of the emotional impact of some of the topics on participants and must provide opportunities for individual discussions if needed.**

4.6.6 **Trainers must exclude any participant from the course whom they believe to be unsuitable for training.**

Participants may be unsuitable on grounds of:

- their attitudes, values and beliefs as displayed on the course
- their behaviour towards the trainer and/or other participants
- their time keeping and attendance throughout the course

Any exclusions must be confirmed in writing to the commissioning organisation or the participant's manager if it is an in-house course.

4.6.7 **Before commencing any training event, the trainer must confirm that suitable first aid facilities and equipment are readily accessible at the training venue.**

4.6.8 **Trainers must have the knowledge, means and ability to summon emergency services to the venue should a serious injury occur during a training session.**

## Standard 4.7

### All trainers will be expected to maintain accurate training records which support an agreed quality assurance system.

4.7.1 **All trainers must be able to demonstrate how they use participant evaluations to improve the programme or further their professional development.**

4.7.2 **All trainers must have at least one peer evaluation per year.**

Trainers must be able to show evidence of having one peer evaluation per year and be able to demonstrate how they have used it to further their professional development.

# Appendices

## Preface to the appendices

The appendices are included to show that the standards will need to be adapted according to some specific considerations. These relate to:

- which specific population is being supported by staff or carers who are accessing training
- the setting that the staff/carers who are receiving the training provide the support in
- the country that the service or setting is operating in

It is likely that training providers will need to refer to more than one appendix when developing a person centred curriculum for a commissioning organisation.

Please follow the link to the relevant current guidance and legislation on the Restraint Reduction Network website: RRN Training Standards 2019. These appendices will be subject to a continuous review timetable; therefore the most up to date versions will be available online. Please let us know if any relevant guidance or legislation is missing from the website.

# Contents

There is a timetable of review for the appendices and they will be updated to reflect changes in policy and new guidance, but please be advised that you should refer to other more frequently updated sources of sector specific information in addition to these.

The reviews will be informed by experts in each area. Please refer to the online version of this publication for the latest versions of the appendices.

## Populations being supported

## Settings in which the staff/carers provide support

## Country in which the service or setting is operating

## Other appendices

## Examples and checklists

The following templates are available to download at RRN Training Standards 2019 – materials to download:

- Sample checklist for a training needs analysis
- Information needed for a personalised wellbeing risk assessment checklist
- Sample template for a written rationale for the inclusion of a restrictive intervention in a curriculum

# Appendix 1 Specific considerations and adaptations to the training standards for services supporting people who have acquired brain injury

## Type of service

Services for people who have acquired brain injury. Such injuries arise from accidents, assaults, infections, tumours and strokes and can result in physical, cognitive, emotional and behavioural impairments. (This list is not exhaustive.)

Specific considerations when delivering training in this setting:

- Mood swings, stress, frustration and anger are often experienced by individuals with acquired brain injury. These, and the difficulties in understanding, processing and responding to information and events, coupled with the potential loss in insight and impulse control, should not lead to a person being characterised as 'violent' or 'high risk', and routinely managed as such
- An acquired brain injury can lead to changes and impairments which should be considered as risk factors in the context of any physical restraint. These include:
    - issues with memory, including a struggle with the retention of information in both short and long term
    - changes in muscle tone (low tone – hypo; and high tone – hyper)
    - impairments in receiving and processing sensory information, which may manifest in hypo- or hyper-sensitivity to touch, and to pain in particular
    - difficulties with speech and language
    - difficulties with swallowing, which should be treated as a risk to breathing
    - increased risk of epileptic seizures or fits

- The stress associated with the application of a physical restraint technique should be considered as a risk factor in and of itself
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations, eg attempting to remove catheters, arterial lines and breathing tubes. The removal of an arterial line is potentially life threatening in a very short period of time, hence why such an extreme form of restraint may be advocated. The use of mechanical interventions is likely to give rise to additional risks, such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed
- These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely

Specific adaptations to the standards for this setting:

- Physical restraint plans must:
    - be personalised and reflect the unique impairments of the person
    - have multi-disciplinary input from relevant health professionals
    - contain an explicit rationale for the use of techniques which should be centred on safety and the prevention of harm, not simply behaviour management
    - include explicit monitoring protocols which cover those safety criteria upon which any physical restraint techniques should be relinquished and these should be linked to relevant emergency medical support protocols, eg responses to breathing difficulties or seizures
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release
- Additional time should be spent during training sessions to discuss the local protocols in place for ambulance services to manage the heightened risks involved in the rapid admission/assessment process

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 2

# Specific considerations and adaptations to the training standards for services supporting autistic people

## Type of service

Services and settings are inclusive of education, residential, social care, and individuals' tenancies working within family home and health or hospital service settings. Children with autism and autistic adults may or may not also have a learning disability and/or mental health diagnosis and may be in generic services as well as specialised settings.

The National Autistic Society (NAS) defines autism as a lifelong developmental disability that affects how people perceive the world and interact with others. Identity first language is in general the preference of autistic adults (though not always), so it is used here but the person's preference should always be ascertained.*

Specific considerations when delivering training in this setting:

- All autistic people are different and have a range of individual strengths and needs but it is important to consider the following during training

  Autistic people and children with autism:
  - may have some difficulties understanding what's happening around them, or understanding social cues
  - may at times find it difficult to express or communicate their needs
  - may not be able to process or understand instructions and other communications and need extra time and cues – it is important not to perceive this as ignoring instructions, or as rude or non-compliant behaviour

---

* **Identity-first language** places the disability-related word **first** in a phrase. People who prefer **identity-first language** for themselves often argue that their disability is an important part of who they are, or that they wouldn't be the same person without their disability. However, personal preference should always be identified and used

  - may at times be very anxious and tense and want to escape from stressful situations or activities
  - are likely to have sensory differences, eg an over-sensitivity to noise or touch or a need for stimulation. Sensory sensitivities can lead to extreme levels of stress and anxiety in unfamiliar or over-stimulating environments. Environmental considerations are extremely important when supporting an autistic person and as much information as possible should be gathered about the person's preferences and needs
  - may have differences in experiencing levels of pain
  - may have a different awareness of personal space and may seem to be unusually intolerant
  - are likely to have concomitant health problems that may be undiagnosed
  - are vulnerable to the full range of mental health issues experienced by people without autism but may be particularly vulnerable to anxiety related conditions

- It is very likely that a restrictive intervention could be a frightening, painful and traumatising experience and consideration should be made of the individualised support needed during any restrictive intervention and afterwards. It would be especially important to consider the person's individual communication needs and preferences and understand how the environment may impact upon their emotional state. Identification of any comforting object or routines to support recovery should be in the personalised wellbeing risk assessments
- If it is suspected that a person is deliberately seeking sensory stimulation through physical restraint, the advice of a psychologist should be sought so that alternative methods of stimulation can be provided
- In the event that there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safe-guards in place to minimise its use and its physical, psycho-logical impact on the individual, and review mechanisms

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 3 Specific considerations and adaptations to the training standards for services supporting children (including residential schools and children's homes)

## Type of setting/service

Services for children including residential child care, respite care, residential special schools, secure children's homes, residential holiday schemes for disabled children and NHS comissioned health services as well as local authority and independent fostering service providers:

- Children are defined by NICE as *'people aged 12 years or under'*
- Young people are defined by NICE as *'people aged between 13 and 17 years'*
- For additional information on Fostering and adoption settings see Appendix 11: Family homes

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

# Key Principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

Specific considerations when delivering training in this setting:

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken
- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent; and
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved

# Other considerations

Education, Health and Care plans should be developed after suitably wide consultation which may involve the co-ordination of the assessment process where relevant across education, health and care domains. In addition to the child/young person themselves and his or her family, those consulted may include:

- Education professionals such as nursery staff, teachers, Special Educational Needs and Disabilities Co-ordinators (SENDCOs) and educational psychologists
- Physical health professionals such as GPs, community based paediatricians, paediatric neurologists, specialist community nurses, physiotherapists, occupational therapists, dentists, opticians, speech and language therapists and health visitors
- Mental health professionals including clinical psychologists with expertise in learning disability and functional analysis, behavioural therapists, psychiatrists with training in child and adolescent psychiatry/learning disability/autism and specialist nurses
- Social care professionals such as social workers, care managers, care staff and support workers
- Individualised behaviour support plans should also be formulated after suitably wide consultation. The management of risk in its widest sense should form a key part of any plan (see risk below within the context of physical restraint*). Every behaviour support plan should have an explicit process for supporting a child or young person to avoid crisis and a protocol for escalation
- Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible, and an emphasis placed on working in a child/young person centred way with reference to relevant plans

# ‘Best Practice Guidelines’ relating to physical responses to escalated behaviours of concern: Physical Restraint (are applicable across all groups of children and young persons):

Restrictive interventions (and in particular physical restraint) can be planned or unplanned. Each type of intervention presents a unique set of practical challenges and risks to be recognised and managed.

Planned interventions involve staff following agreed approaches to behaviour that challenges that have been set out in the child or young person’s behaviour support or care plan, and will detail any procedures, strategies or techniques authorised for use as a last resort physical restraint. Planned interventions will be formulated following suitably wide consultation and based on careful assessment of the potential risks (including any particular vulnerabilities, communication difficulties, medical conditions and/or impairments – see risks below*)

Unplanned interventions by contrast are responses for unforeseen and unpredicted behaviours of concern. Such situations require highly skilful responses from staff based on the fullest appraisal of the individual, the behaviour and its likely impacts. Such decisions, known as dynamic risk assessments, will include a judgement about the capacity of the child or young person in that moment to make safe choices. Any physical response (physical restraint) should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time.

The right core values and key principles should be used to underpin the management (including the physical management) of all behaviours of concern, including unforeseen behaviours that challenge, even in those settings and contexts where they cannot be anticipated or responses pre-planned. This is particularly relevant to those services that admit children and young persons with limited, or little or no knowledge of their background.

A core set of such values were presented in the recent document titled ‘*Reducing the Need for Restraint and Restrictive Intervention*’ (HM Government, 2019). They included

- upholding all children and young people’s rights – children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present

- treating all children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges as full and valued members of the community whose views and preferences matter
- respecting and investing in family carers as partners in the development and provision of support for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties; and
- recognising that all professionals and services have a responsibility to work together to coordinate support for children and young people whose behaviour challenges and their families

The same document (HM Government, 2019) also provides a set of key principles that relate specifically to the use of physical restraint. They were drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes but were held to be relevant to all of the settings and services covered in the guidance. The principles hold true across all children's and young person's services where physical restraint may be used:

- Every child or young person deserves to be understood and supported as an individual
- The best interests of children and young people and their safety and welfare should underpin any use of restraint
- The risk of harm to children, young people and staff should be minimised
- The needs and circumstances of individual children and young people, including their age, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual, affect others, including staff; and
- A decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned, including other children, young people or adults present

When considering whether to use restraint with a child or young person, staff should ask themselves: “At this moment what is in the best interests of the child and/or those around them, taking account of the risks presented?”

When assessing risk, staff involved should take into account:

- the types of technique used, and how it will likely interact with, and impact on, the child/young person
- the size, age and understanding of the child or young person;
- their particular history, vulnerabilities, learning disabilities, medical conditions and impairments;
- the relative risks of not intervening;
- the child or young person’s previously sought views and experiences, and those of parents and carers, on strategies and approaches they considered might deescalate or calm a situation;
- the impact of the restraint on the future relationship with the child or young person (HM Government, 2019).

It must be recognised that any and all restrictive interventions (including physical restraint in particular) carry the risk of inadvertent distress, pain, injury and re-traumatisation. Examples of specific risk factors include:

- communication impairments which may reduce the ability of the child or young person to express their feelings or enter into a two-way problem solving and/or de-escalatory dialogue
- sensory processing or integration disorders which can be significant within the context of understanding and managing triggers, as well as with the context of understanding and managing any physical touch, holding or physical restraint which may be used. Staff should be aware that all forms of sensory stimulation above and beyond physical contact may be distressing so need to be carefully considered
- underdeveloped anatomy, eg bone size, shape and density, which will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques, and the force with which they are applied
- underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, which may have implications for a child/young person’s ability to breathe and how suddenly they can become exhausted
- underdeveloped psychological and emotional capacities which are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one

There is a significant incidence of Adverse Childhood Experiences (ACEs) which may be higher amongst some populations such as 'looked after' children, but nether the less prevalent across society. Such experiences can heighten the risk of trauma/re-traumatisation being experienced.

ACEs may mean that some children have attachment disorders or have developed emotional and physical responses to adults that may be unsafe or unhelpful. This may have implications for the use of physical restraint and other restrictive interventions such as seclusion (which may be extremely distressing). If it is suspected that a child or young person is deliberately seeking contact through physical restraint the advice of a psychologist should be sought.

Options for eliminating and/or reducing all forms of risk should be thoroughly explored, and the benefits and drawbacks of each considered and, where possible, recorded in plans (as discussed above).

Organisations should consider when to record occasions where restrictive interventions and physical restraint in particular is used (whether planned or unplanned). Depending on the type of setting or service, this may be a mandatory requirement. (HM Government, 2019).

Good practice is to record why restraint was used, by whom, for how long and what the outcomes were in terms of any injuries to children and young person and/or staff (organisations should refer to national guidelines and organisational policy for local recoding criteria) (HM Government, 2019). NB. this is likely to be supported by information about antecedent or setting conditions as well as behaviour consequences which will be used to support PBS/preventative planning.

After all incidents (including the use of physical restraint), the child or young person as well as the staff involved should be given emotional support and basic first aid for any injuries as soon as possible (HM Government, 2019).

Immediate action should be taken to access medical help for injuries that require more than basic first aid. All injuries should be recorded in accordance with the setting or service's procedures and reported as appropriate to the Health and Safety Executive (HM Government, 2019).

Action taken in respect of post-incident support could include trauma support for children, young people and their families affected by the use of restraint as well as staff (HM Government, 2019).

Organisations should ensure that appropriate lessons are learned from instances where restrictive interventions and physical restraint in particular have had to be used, including any patterns and trends, and consider how use of restraint might be avoided in future. This will usually involve de-briefing and post-incident review and monitoring of the use of procedures, strategies or techniques. The process should consider all types of individual plans that reference behaviour support and crisis management, including behaviour support plans. (HM Government, 2019).

Whenever restraint has been used, staff and the child/young person should have separate opportunities to reflect on what happened, and wherever possible a choice as to who helps them with this. Those with cognitive and/or communication impairments may need specific help to engage in this process, for example, use of simplified language, visual imagery or Alternative and Augmented Communication. (HM Government, 2019).

Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews. Someone appropriate and trusted by the child/young person and their family or, where appropriate, the individual's advocate, could also play a role.

Reviews could involve a facilitated staff team discussion about the warning signs of an impending incident, whether any previously agreed behaviour plans were followed, what de-escalation strategies were used and how effective they were, and what might be done differently in future (HM Government, 2019). The same reflective process should be used to consider the appropriateness, suitability and safety of physical restraint.

If a pattern of persistent use of physical restraint emerges, and if a setting or service considers they do not have sufficient expertise themselves, an expert assessment should be sought, to identify the triggers for the behaviour that leads to use of restraint. The reviewer should consider, with the child or young person, and as appropriate, their parents and/or advocates, revising their individual support plan. Consideration should also be given to improving staff training and development as part of action to address the issue. (HM Government, 2019).

Wherever there are security procedures such as search and confiscation that involve physical restraint the physical restraint technique should be considered as a risk factor in and of itself.

Where attendances and responses from the police become a feature of any management of seriously escalated behaviours it can be appropriate to agree joint response protocols. A discussion of the likely risks of any restraint should be considered to ensure such risks can be effectively managed.

Specific adaptations to the standards for this setting:

- Factors such as in-utero exposure to alcohol and/or drugs, pre, peri and post-natal trauma, poor attachment experiences, and complex home circumstances as well as the implications of such experiences on the developing brain will need to be covered during training
- Trainers would typically be expected to discuss the multi-agency and multi-level of support required for children/ young persons with complex needs
- Primary preventative strategies should be prioritised. This should include evidence based models such as Positive Behaviour Support (suitable for all settings) and setting specific programmes such as Safewards (healthcare)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behaviour support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person-centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- Staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically
- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults

- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019, UN Committee on the Rights of the Child, 2006)
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- Trainers should discuss ‘intervention creep’ as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as “any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement”, but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as ‘embrace’, ‘prompt’, ‘guide’ or even referred to erroneously under euphemisms such as ‘physical support’, ‘manual handling’ or as a ‘first aid technique’
- Staff working in healthcare settings such as Child and Adolescent Mental Health Services (CAMHS) should undertake training designed specifically for teams working with physically frail or emotionally fragile children and/or young people. In such settings clinical holding may be necessary and the increased risks associated need to be recognised and managed

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 4 Specific considerations and adaptations to the standards for services supporting people who are deaf and have mental health conditions

## Type of service or setting

Specialist mental health services for deaf people. These include inpatient non-secure and secure psychiatric care, emergency and urgent care, community mental health teams, early intervention teams and crisis resolution and home treatment teams, community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- Training should emphasise the need to uphold and support the statutory rights of all deaf and hard of hearing service users under the Mental Health Act 1983 (amended 2007), the Mental Health (Care and Treatment) (Scotland) Act 2003, and the Equality Act 2010. The Equality Act 2010 states that deaf people who use British Sign Language (BSL) constitute an officially recognised, minority cultural group in the UK and are a population with 'protected characteristics'. There is a public sector duty to ensure that service provision does not discriminate against treatment
- Training must emphasise the need to ensure effective communication at all times in order to minimise distress, confusion, frustration and any delays in receiving vital treatment. BSL is the first language of 100,000 deaf people in the UK. NB: The *Mental Health Act Code of Practice*, section 14, states that an approved mental health professional involved in the assessment must be responsible for booking and using registered Qualified Interpreters with expertise in mental health interpreting (Department of Health, 2015; see also Welsh Assembly Government, 2016a)

- Training must emphasise that a person centred approach involves optimising and maintaining effective communication channels, providing deaf service users with the means to communicate expressively or receive communication visually
- The trainer must be familiar with the presentation of specific conditions in the service in which they are providing training. This is to ensure that all staff are able to understand the various causes of deafness, any impact on a person's cognitive abilities, and the practicalities of ensuring communication channels are maintained
- It would be a valuable experience for any Qualified Interpreters operating within the unit to attend and/or participate in training courses relating to prevention and management of behaviours of concern, and in particular sessions covering restrictive interventions including physical restraint
- Trainers must actively involve the Qualified Interpreters in the delivery of sessions in order to deepen staff members' understanding of the patient's perspective. For any deaf members of staff, trainers must take time in advance to prepare with any Qualified Interpreter who may be supporting the session. Key terms and concepts must be clarified in advance
- The instruction model used for teaching physical restraint skills in some organisations is: Demonstrate–Participate–Explain. Deaf participants must have the opportunity to observe the demonstration and then receive a further demonstration during which they can concentrate on the qualified interpreter in order to receive an explanation of the demonstration before practising
- Qualified Interpreters must be provided with the flexibility to position themselves effectively to provide a clear visual field to deaf participants in order that they might receive information

Specific adaptations to the standards for this setting:

- Deaf service users can experience a range of mental health conditions which may present in different ways. Therefore an accurate assessment of their needs will be key when considering the use of restrictive practices, planned or unplanned. NB: Additionally, people with mental health conditions who are deaf may also have concomitant diagnoses such as autism or a learning disability

- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
    - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments (which may include access to suitable interpreter services or staff with BSL fluency) supporting the authorisation of physical restraint techniques
    - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculo-skeletal disorders
    - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
    - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
    - In addition to a higher incidence of exposure to traumatising events amongst this population, individuals who are deaf and rely upon BSL may be additionally traumatised where services are not able to support their communication needs. Trauma history may not always be known. If a person displays signs that may indicate past abuse the personalised wellbeing risk assessment should be updated
    - Additional consideration must be given to any evidence of recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else
    - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 5 Specific considerations and adaptations to the standards for services supporting people who have eating disorders

## Type of service

Specialist eating disorder (ED) services provide support to individuals with a range of different mental health disorders that involve disordered eating behaviour and a disordered perception of body image. Behaviours can include restriction of dietary intake, binging, purging (including vomiting and laxative misuse) and excessive exercise, or a combination of these behaviours. The majority of inpatient services provide short term treatment offering a more recovery focused programme, focusing on refeeding, weight maintenance and recovery.

Refeeding may include naso-gastric (NG) tube feeding and may need to be completed with the use of physical interventions.

Specific considerations when delivering training in this setting:

- The individual's age and specific eating disorder pathology will have a bearing on their psychological and emotional resilience. Reduced psychological and emotional reserves are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern

- Eating disorders are also often associated with low weight and can cause serious physical health issues including poor bone health, low energy levels, and interruption to or cessation of menstruation, all of which can impact on internal organs such as the heart. Inpatient treatment is often needed for patients with significant weight loss, chronic or complex conditions and a large part of treatment focuses on controlled refeeding. This will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Training must promote the importance of providing a positive and safe therapeutic environment. For example, specific attention needs to be paid to the use of language and effective communication when working with ED, avoiding the misuse of praise and references to 'lifesaving treatment'
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- If training covers assisting there must be a focus on using the least restrictive interventions

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/ physical restraint techniques authorised in recognition of under-developed anatomy/physiology and psychological/emotional abilities to cope with such experiences
- Procedures need to account for the space, time and understanding required to justify and support prolonged restraint due to the natural delivery time of NG feed
- More staff may be required in order to safely manage an incident involving treatment resistance
- Physical adjuncts may be required to maintain safety and reduce prolonged restraint
- Possible items used in the management of NG feed restraint may include neck collar protection, cushions or beanbags, as well as the possible use of soft cuffs to reduce physical restraints and the use of bespoke 'feeding sofas'
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with individuals in psychological and emotional distress, in particular around NG feed restraints

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 6 Specific considerations and adaptations to the training standards for services supporting people who have learning disabilities

## Type of service

Services for people with a learning disability are also referred to as intellectual disability services. Services are inclusive of residential, social care, and individual's tenancies working within family home and health or hospital service settings.

People with a learning disability have reduced intellectual ability and may therefore take longer to learn and may need support to develop new skills or understand complicated information. People with a learning disability can also have concomitant mental illness and other neuro-developmental disorders such as autism and ADHD, as well as sensory and communication difficulties.

Specific considerations when delivering training in this setting:

- Interventions aimed at minimising any restrictive practices are more comprehensive when they arise from multi-disciplinary consultation
- Psychosocial interventions include a broad range of therapeutic approaches designed to support the person. They are generally non-pharmacological and aim to identify underlying factors for behaviour, reduce the person's distress and increase their skills. Approaches include communication interventions, applied behaviour analysis, positive behaviour support and cognitive behavioural therapy

- A multi-disciplinary team, care managers and social care providers should ensure that staff are trained in the management of escalating behaviours of concern using a training programme designed specifically for staff working with people with a learning disability. Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible
- The communication needs of people with a learning disability, particularly the needs of people who are unable to communicate through speech, should be taken into account in any assessment
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one
- People with a learning disability are at significantly increased risk of exposure to events with the potential to result in trauma symptoms, but such symptoms may be less likely to be recognised
- The link between restrictive interventions/physical restraint and security procedures such as search and confiscation should be noted
- Identification of any comforting object or routines to support recovery should be part of individual assessment
- People with a learning disability have an increased incidence of physical health conditions, but such issues may not always be recognised. Any risk assessment for the use of restrictive physical interventions should include a full medical review if one has not been undertaken recently in response to the presentation of behaviours of concern. The presentation of any behaviours of concern and/or distress may be a response to an underlying health problem and should always be investigated fully
- As with people who have mental health conditions, people with learning disabilities are not a homogeneous group and are likely to have suffered a range of adverse psychosocial experiences that may include bullying, abuse, trauma, over-medication and unnecessary use of restrictive practices

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped psychological/emotional abilities to cope with such experiences
- There are processes in identifying health or sensory problems early
- There must be a focus on providing strategies and interventions to support communication

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 7 Specific considerations and adaptations to the training standards for services supporting people who have mental health conditions

## Type of service

Includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- People with mental health conditions are not a homogeneous group. They may have a range of mental health conditions that present in different ways – the training provider should be familiar with the presentation of specific conditions in the service in which they are providing training. Additionally people with mental health conditions may have concomitant diagnosis such as autism and a learning disability
- Any behaviour management strategies stand within broader programmes that focus on recovery and care. Use of restrictive interventions will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
  - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
  - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders

  - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
  - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
  - A higher incidence of exposure to traumatising events may be evidenced by recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else. Trauma history may not always be known if a person displays signs that may indicate past abuse. The personalised wellbeing risk assessments should be updated
  - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. Training should also cover advance decisions and advance statements and the legal obligation attached to both
- The training should consider the legal issue of consent to the use of restrictive interventions and should take into account current legislation and guidance

Specific adaptations to the standards for this setting:

- Community mental health teams should not use physical restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 8

# Specific considerations and adaptations to the training standards for services supporting older people and people who are living with dementia

## Type of service

Specialist dementia services which are designed to offer care and support to older adults experiencing mental health problems and cognitive decline as a result of the changes associated with Alzheimer's disease, vascular dementia, Lewy Body dementia, fronto-temporal dementia and other forms of dementia. People with dementia can also have learning difficulties, as well as concomitant diagnoses including other functional mental health issues as well as autism.

Specific considerations when delivering training in this setting:

- Support provided within older adult/dementia services will aim to continue to promote personal independence whilst ensuring safety of the individual and those around them
- People with dementia can benefit from a high level of input from family carers or family members. They can both help the individual make sense of what is happening around them and provide insight and information that can be invaluable to the care team. The individual can have a complete lack of comprehension and therefore find it impossible to understand and follow instructions from staff. They are in a different reality and the use of restrictive practices including physical or mechanical restraint is likely to be terrifying and dangerous
- Any behaviour management strategies are likely to be supplemented/supported by personalised programmes/plans of care which should reflect the needs and wishes of the individual, as well as considering any advance directives which may have been agreed. Physical restraint will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for older people and people who are living with dementia, within the context of any restrictive interventions, include the following:
    - A rapid admission of a service user is likely to reduce the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
    - Where a person has experienced long term mental health difficulties leading into older adulthood, a higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. Consideration must also be given to ‘age-related’ health conditions such as arthritis and osteoporosis which may also increase the risks within the areas above or develop in later life

  - Where a person is experiencing cognitive decline related to their mental health or potential dementia, the impact can be significant. The development of multiple higher cortical deficits, including those associated with perceiving, understanding, problem solving, remembering, learning and making judgements can be both frightening and disorientating. This may be considered a risk factor in respect to the presentation of behaviours of concern, as well as within the context of any physical restraint technique
  - A higher incidence of personal neglect may be evidenced in patterns of personal care, taking of fluids/drinking, poor diet or the refusal of food. This can increase the likelihood of poorer general health and increase the risk of infection and malnutrition
  - Difficulties with swallowing, that raise the risk of choking or aspiration, would add to any distress experienced during a restraint
  - The development of 'delirium' (a treatable condition which can be over-shadowed by diagnosis such as dementia, as the person can experience memory loss, confusion and/or hallucinations) could give rise to behaviours of concern, as well as compromising the ability of the individual to make sense of what is happening and communicate effectively with those in a position to help
  - The potential for a higher incidence of psychological impairment amongst the population with dementia could be manifested in a perceived unwillingness to co-operate with staff. This may lead to staff considering decisions that might need to be made based on best interests. This in turn may be linked to staff decisions to use restrictive practices
  - An increased likelihood of a person experiencing 'poly-pharmacy' or the prescribing of more than one medication may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. There is also the complication of drugs interacting with each other

- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors described above. The process of identifying potential risks and agreeing suitable safeguards will require cross disciplinary collaboration with input potentially being required from dieticians, speech and language therapists, psychologists, physiotherapists, occupational therapists and pharmacists
- Consideration must be given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Where staff may be required to use restrictive practices/restraint techniques as part of personal care, the emphasis must be placed on personalised planning and support, including additional emphasis on therapeutic/clinical holding
- In emergency assessment units, wherein staff may be required to use restrictive practices/restraint techniques as part of the rapid admission/assessment process, additional time should be spent during training sessions to discuss the local protocols in place to manage the heightened risks
- Personalised wellbeing risk assessments should be completed and the training provider should be proactive in acquiring the most current anonymised information available about individual patients

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 9 Specific considerations and adaptations to the training standards for adult acute psychiatric wards and PICUs

(Please also refer to Appendix 7: Services supporting people who have mental health conditions)

## Type of setting

Acute services including those referred to as PICUs (Psychiatric Intensive Care Units), are likely to be required to provide rapid assessment and therapeutic psychiatric services for individuals who may be experiencing a mental disorder, an acute episode of mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public. Acute services as part of their commissioning may be expected to provide care and support within acute medical areas such as Accident and Emergency. This care could be considered emergency, or unplanned. Individuals accessing a PICU should be detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the patient usually requires an associated level of security (NAPICU, 2016).

Specific considerations when delivering training in this setting:

- Support provided within acute/PICU services will aim to continue to promote recovery as well as personal independence whilst ensuring protection of the public. However, within a PICU environment this may be superseded by actions which seek to offer stabilisation through psychological, psychosocial or pharmacological means. Both areas will require the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users to acute or PICU services is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. It is recommended that within these circumstances a plan be developed within 48 hours (admission dependent) with a maximum timeframe of seven days. This is an individual risk factor to be considered within the context of any physical restraint technique
- Behaviour management strategies may in some circumstances be accessible and therefore should be utilised to supplement/support an admission by ensuring that care offered is based on an individual's personalised recovery-oriented programmes/plans, understanding of a person's trauma journey, recognition of any self-injury reduction programmes, managing emotions programmes and communication development programmes. It may not always be possible to identify internal triggers but review may identify conditions and factors that make people's distress more likely to occur or impact on the severity of distress.
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual's safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Additional time should be spent during training sessions to discuss the local protocols in place in emergency assessment to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider should be proactive in acquiring the most current anonymised information available about individual patients. Advice is that this should be developed within the first 48 hours; however, where information is being collated then up to seven days should be seen as a maximum time frame
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019.

# Appendix 10 Specific considerations and adaptations to the training standards for Emergency Departments

## Type of setting

Emergency Departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Emergency Departments often manage patients who may exhibit behaviours of concern. These are often associated with mental health problems, a learning disability, dementia, intoxication (alcohol/drugs) and autism.

Specific considerations when delivering training in this setting:

- Specific training regarding the causes and management of behaviours of concern in a busy Emergency Department environment should be at the core of any training programme. It is important to note that many Emergency Department staff receive only minimal training in the care of patients with mental health problems, learning disability, dementia, or other intellectual impairments. Additionally, patients who are intoxicated through alcohol or substances may also present in Emergency Departments with behaviours of concern

- Organic disease may hide behind a psychiatric disorder and full biological assessment is essential to avoid diagnostic overshadowing (where signs and symptoms are ignored or not fully assessed and are attributed to the primary condition, eg learning disability or mental health problem). Reactive psychiatric symptoms and behavioural responses may occur as a response to pain, fear, infection or chronic disease. This is more common in older adults, paediatrics, immunosupressed and cancer patients. Recognition of physical deterioration in patients is essential and the relevant NICE guidelines should be included in training (Clinical Guideline CG50) (NICE, 2007). An assessment that considers the potential biological, psychological, pharmacological and social causes of behaviour will help to prioritise appropriate actions. The pharmacological domain should explore street drugs, alcohol, legal highs and over the counter medication as well as prescribed medications

Specific adaptions to the standards for this setting:

- Training must cover supporting patients coming from prison or low (such as psychiatric intensive care), medium or high secure mental health settings, who must arrive with their own staff who should take responsibility for any restrictive interventions. On-site security teams should be alerted at the time of admission of these patients, should support be needed, and this should be reflected in organisational policy. Where possible a separate space aside from the main Emergency Department should be allocated for specific use by this patient group. This space may also be used for other disturbed patients (including intoxicated patients) or those needing psychiatric assessment by the psychiatric liaison team (PLT). The space should be risk assessed, ligature free and not contain any objects that could be used as weapons.

  It is also important to check that the patient is not carrying potential weapons or illicit substances on their person. This can be discreetly performed by replacing outdoor clothing with a hospital gown. NICE guidelines on violent and aggressive behaviours in people with mental health problems (QS154) (NICE, 2017b) should be alluded to in training

- If the on-site security team (or in some cases, the police) are called and physical intervention is considered necessary as a last resort, medical and senior nursing staff must remain present throughout to monitor the patient's physical health and ensure that the least force is utilised for the shortest space of time
- Any form of restrictive intervention must be recorded in the patient's notes, including the duration of the intervention and description of which body part(s) were held. An incident form must also be completed using the organisation's reporting systems detailing all aspects of the event
- Any use of mechanical restraint such as mittens must be prescribed in writing by senior medical staff (Consultant or Senior Registrar) and the care team informed
- Chemical restraint may be given when prescribed by senior medical staff, as per organisational policy, should rapid tranquilisation be considered necessary. Oral medication shall be offered in the first instance where not contra-indicated due to medical condition
- Psychiatric emergencies (including S136 MHA, 1983) and transfers to mental health facilities shall be accompanied by staff and a risk assessment must be in place, as per organisational protocol (see also the Mental Health (Care and Treatment) (Scotland) Act 2003)
- Relationships with psychiatric liaison teams are crucial to the functioning of Emergency Departments and where possible integrated training should take place with both staff teams included

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards 2019

# Appendix 11 Specific considerations and adaptations to the training standards for family homes

(Please also refer to Appendix 14: Lone working)

## Type of setting

Family homes. The training could be delivered to family members and friends, other carers paid or unpaid, personal assistants, home tutors and other professionals.

Specific considerations when delivering training in this setting:

- Lone working arrangements relating to personal assistants*/carers, home tutors, and other health/social care professionals working in these settings (see Appendix 14: Lone working)
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when staff are working alone. (See Appendix 14: Lone working)

---

* The Health and Safety at Work Act 1974 does not apply to activities classed exclusively as 'domestic services' carried out in 'private households'. Personal care provided within someone's own home may be 'domestic service' and therefore may fall within this disapplication. Clarity would need to be sought.

- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decisions are made only after full and thorough multidisciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training, and recording protocols should be manageable for family members. These should be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 12

# Specific considerations and adaptations to the training standards for forensic and high secure services

(Please also refer to Appendix 4: Services for people who have mental health conditions)

## Type of service

Forensic and high secure mental health services, specifically those providing a therapeutic psychiatric service for individuals with a mental disorder, mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public.

Specific considerations when delivering training in this setting:

- Training in high secure services must be delivered in accordance with the NICE-approved Positive and Safe training manual: *Violence Reduction and Management Programme* (West London Mental Health Trust, 2016 – for further information visit Promoting hope and wellbeing together)
- Support provided within forensic/secure services will aim to promote recovery as well as personal independence whilst ensuring protection of the public. This will involve the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. This is an individual risk factor to be considered within the context of any physical restraint technique
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual's safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Within high secure/forensic settings the appointment of an overall lead (or response 'controller') within the context of any restrictive intervention/physical restraint is recommended
- Additional time must be spent during training sessions to discuss the local protocols in place in emergency assessment units to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider shall be proactive in acquiring the most current anonymised information available about individual patients
- It is expected that information about existing medical conditions can be accessed very quickly. Other information needed to complete the personalised wellbeing risk assessment must be gathered within 48 hours, with seven days being the limit for a completed assessment. When they have received the anonymised information the training provider must advise on any adaptations or contra-indications to the range of techniques that can be used on that person as soon as the information is received. It is expected that the training provider has a protocol for dynamic personalised wellbeing risk assessments which has been agreed with the commissioning organisation
- Additional risk assessments will be required to cover the application of any mechanical restraints. These must cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure so any risk assessments must be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 13 Specific considerations and adaptations to the training standards for foster care

## Type of setting

Foster carers/foster caring. One of a number of care options that offers children a home when they are unable to live with their birth family.

Specific considerations when delivering training in this setting:

- Only behaviour management strategies and policies agreed by local authorities and fostering agencies must be authorised for use
- Distinctions shall be made between caring and supportive touch, and coercive touch; and between caring and supportive holding, and coercive holding
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services
- In those settings where an adult may apply a restrictive intervention/physical restraint technique on a child without direct support or supervision the practicalities and limitations of 1:1 practices must be considered. It is vital that there are robust processes and procedures in place so as to ensure that the child's voice can be heard in relation to any safeguarding issues/concerns
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments and should be part of initial assessment made at point of referral

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when foster parents/carers are working alone. See Appendix 14: Lone working
- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decision is made only after full and thorough multi-disciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- In the event that a 1:1 intervention is considered, a risk assessment covering this dynamic must be undertaken before any strategy or technique is authorised for use
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training and recording protocols should be manageable for foster carers. These must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 14 Specific considerations and adaptations to the training standards for lone working

## Type of setting

Lone workers are those who work by themselves without close or direct supervision. This may include those working outside of normal hours, or within satellite locations. Lone workers may include personal assistants, home tutors, social workers, healthcare professionals and mental health workers.

Specific considerations when delivering training in this setting:

- The need for staff to be able to conduct dynamic risk assessments in support of formal risk assessments and agreed safety procedures
- How the assessment and management of risk is impacted by lone working status
- The role of tracking, communication and alarm systems in mitigating against harms

Specific adaptations to the standards for this setting:

- A prohibition on restrictive interventions/ restraint techniques is likely, based on lone working arrangements
- A strong emphasis on responses likely to ensure safety, keeping personal distance, de-escalation and strategic capitulation
- Arrangements for post-incident support and review for all parties should be agreed prior to delivering training and must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 15 Specific considerations and adaptations to the training standards for schools

## Type of setting

This includes local authority maintained schools, academies and free schools, pupil referral units, non-maintained special schools, independent schools and sixth form colleges.

Other settings for which the following may have some relevance to include Special Education Units, Special Educational Needs resourced provision, Pupil Referral Units and Early Years providers

Specific considerations when delivering training in this setting:

- Teachers have the power to discipline pupils for misbehaviour and this includes the power to use reasonable force to prevent pupils from hurting themselves or others
- Joint Select Committee on Human Rights stated that use of restraint of children for discipline and good order (where there is not an imminent risk of serious harm) must be prohibited as it contravenes the ECHR
- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment

- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, ‘physical restraint’ may be referred to as ‘physical intervention’ or even simply as the ‘use of force. Alternatively, reference may be made to the function of the force, such as its use ‘to control pupils or to restrain pupils’. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds

- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to *‘restrict, or subdue movement of the body (or part of the body) of the student or pupil’* should be seen as amounting to *‘physical restraint’* (Department of Education, 2013b)

- Underdeveloped anatomy, eg bone size, shape and density, will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques

- Underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, will impact on the selection of techniques to be included in any training syllabus

- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one

- There may be children within the school, often those who display behaviours of concern, who may have been exposed to Adverse Childhood Experiences (ACEs). As a result children can be traumatised, and at risk of re-traumatisation. The nature and presence of such prior experiences will have significant implications on how behaviours of concern are managed, in particular with restrictive interventions including physical restraint

- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors

- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making

- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that *'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safeguarding and pupil welfare'* (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms.Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment

Specific adaptations to the standards for this setting:

- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- There should be limitations on the types of restrictive interventions/ physical restraint techniques authorised in recognition of under-developed anatomy/physiology, underdeveloped psychological/ emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults

- The gender of staff and that of pupils needs to be considered, with safeguards in place to avoid traumatising/re-traumatising experiences, as well as avoid any scope for allegations of inappropriate physical contact
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*

Training providers delivering training in other countries must refer to country specific legislation.

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

## Key Principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken

- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent; and
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved.

## Other considerations

- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment
- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, 'physical restraint' may be referred to as 'physical intervention' or even simply as the 'use of force'. Alternatively, reference may be made to the function of the force, such as its use 'to control pupils or to restrain pupils'. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds

- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to 'restrict, or subdue movement of the body (or part of the body) of the student or pupil' should be seen as amounting to 'physical restraint' (Department of Education, 2013b)
- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making
- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that 'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safe-guarding and pupil welfare' (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms. Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment
- See 'Best Practice Guidelines' contained' in the section 'Specific considerations when delivering training' in Appendix 3 Specific considerations and adaptations to the training standards for services supporting children' for detailed information about general best practice in particular regard to the use of physical restraint

Specific adaptations to the standards for this setting:

- Training providers may need to adapt their delivery model to accommodate school INSET days where appropriate
- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise, the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*
- Primary preventative strategies should be prioritised. This should include evidence based models such as Positive Behaviour Support (suitable for all settings)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behavior support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person-centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically

- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time

- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint

- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults

- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors

- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019, UN Committee on the Rights of the Child, 2006)

- Trainers should discuss ‘intervention creep’ as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as “any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement”, but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as ‘embrace’, ‘prompt’, ‘guide’ or even referred to erroneously under euphemisms such as ‘physical support’, ‘manual handling’ or as a ‘first aid technique’

Training providers delivering training in other countries must refer to country specific legislation.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 16 Specific considerations and adaptations to the training standards for Tier 4 Child and Adolescent Mental Health Services (CAMHS)

## Type of service or setting

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Children's Services deliver specialist inpatient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH services. Many of the children and young people who are admitted to these services have experienced unsuccessful treatment regimes in tier 1 to 3 community or other services and may be detained under the Mental Health Act 1983 (Amended 2007) see also the Mental Health (Care and Treatment) (Scotland) Act 2003.

Specific considerations when delivering training in this setting:

- There must be an emphasis on working collaboratively with parents/carers to provide family centred care. To this end, there must be effective communication between service users and their families, health providers and other involved agencies using the Care Planning Approach, so that families and professionals are fully involved in decisions related to treatment as well as any planned responses to behaviours of concern

- Training must emphasise the need for, and value of, investing in a meaningful engagement process with patients and family members in order to enhance the therapeutic alliance between patient and staff
- Training must also consider providing an understanding of how to recognise and respond to those children/ young people who may be affected by being involved in or witnessing physical interventions, especially those with a history of trauma and abuse
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- Underdeveloped and over-developed anatomy, eg bone size, shape and density, underdeveloped physiology, and disparities in size between children and adults will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern
- The safety of any restrictive interventions, in particular physical restraint techniques, is contingent upon the impact of such techniques being carefully considered and managed
- The psychological, emotional and physical vulnerabilities linked to the presentation of any of the following should be considered risk factors: psychosis, eating disorders, affective disorders, developmental disorders including autism, neurodevelopmental disorders such as learning disability and autism, attention deficit hyperactivity disorder (ADHD), tic disorders, obsessive compulsive disorders, anxiety and emotional disorders, self-harming behaviours, attachment and emotional regulation disorders, as well as a primary diagnosis of mental illness with co-morbid learning difficulties. In order to manage the risks arising, collaboration with, and input from, allied health professionals is likely to be necessary

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped anatomy/physiology, underdeveloped psychological/emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with children and adolescents
- Training programmes for this setting must be flexible, and kept under review, in order to ensure they are able to adopt changes in line with clinical evidence-based practices supported by incident data analysis
- Children and young people in these settings should be involved in developing certain aspects of training in relation with primary, secondary and tertiary strategies
- There should be a framework/processes in place to involve children/young people/parents in making decisions on the use of unavoidable restrictive interventions offered by services, and in the use of least restrictive intervention as part of their treatment plans (eg PILRIMP – Patient Inclusion in Least Restrictive Intervention and Management Plan)
- The framework (such as PILRIMP) must be part of the training programme for staff to understand the value of positive engagement with children and young people in order to reduce and to manage their emotions, anxieties and trauma related concerns when using restrictive interventions
- The training provider must provide a list of all restrictive interventions that are taught to staff so that the commissioning organisation can make this information available to children/young people/parents with the information as to why, when and how these restrictive interventions can be used as part of treatment plans
- Photos/leaflets of restrictive interventions techniques must be provided to children/young people/parents as part of an admission pack to help them to manage their emotions, anxieties and trauma related concerns in the use of possible unavoidable restrictive interventions

Specific guidance/legislation relating to delivering training in this setting/service:

- Mental Health Act 2007 and Code of Practice
- Mental Health (Care and Treatment) (Scotland) Act 2003
- *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)
- Mental Capacity Act 2005 and Code of Practice
- Adults with Incapacity (Scotland) Act 2000
- Mental Capacity Act (Northern Ireland) 2016*
- Deprivation of Liberty Act 2010
- The Children Act 1989 and Children Act 2004
- Department of Health Guidance for Restrictive Physical Interventions (July 2002)
- United Nations Convention on the Rights of the Child 1989
- Protection of Children Act 1999
- NICE (2015) *Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings*. NICE guideline NG10
- NICE (2004) *The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care.* NICE clinical guideline 16
- Royal College of Nursing (2010) *Restrictive Physical Intervention and Therapeutic Holding for Children and Young People. Guidance for Nursing Staff.* London: RCN
- Department of Health and Social Care and Department for Education (2017) *Reducing the Need for Restraint and Restrictive Intervention: Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties* (Consultation document)
- National Decision-Making Model (NDM), College of Policing

*NB: The working date for full implementation of this Act is 2020, although the current absence of devolved government in Northern Ireland may affect this target (RCN 05/09/2018)

# Appendix 17 Specific considerations and adaptations to the training standards for services in England

Specific adaptations to the standards:

The Department of Health's document *Positive and Proactive Care* (2014) relates to health and social care services where individuals who are known to be at risk of being exposed to restrictive interventions are cared for. Such settings may provide services to people with mental health conditions, autistic spectrum conditions, learning disabilities, dementia and/or personality disorders, older people and detained patients. It is more broadly applicable across general health and social care settings where people using services may on occasion present with behaviour that challenges, but which cannot reasonably be predicted and planned for on an individual basis. This may include homes where individuals employ their own support staff, and community-based primary and secondary care settings. 'Restrictive interventions' are defined within the guidance as: *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:*

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the person's freedom for no longer than is necessary.'*

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles:

1. Restrictive interventions shall never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
2. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
3. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
4. Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
5. Any restriction must be imposed for no longer than absolutely necessary
6. What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
7. Restrictive interventions must only ever be used as a last resort
8. The involvement of people who use services, carers and advocates is essential when reviewing plans for restrictive interventions

A panel of experts identified that certain restraint techniques presented an unacceptable risk when used on children and young people (Physical Control in Care Medical Panel, 2008; quoted in Department for Education, 2013b). The techniques in question are:

- the 'seated double embrace' which involves two members of staff forcing a person into a sitting position and leaning them forward, while a third monitors breathing
- the 'double basket-hold' which involves holding a person's arms across their chest and
- the 'nose distraction technique' which involves a sharp upward jab under the nose

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 18 Specific considerations and adaptations to the training standards for services in Northern Ireland

Specific adaptations to the standards:

Physical restraint has been defined within ‘health and personal social service settings’ as: *‘The use of any part of one’s body, or mechanical method, to prevent, restrict or subdue movement of any part of another person’s body. It can be employed to achieve a number of different outcomes:*

- *to break away or disengage from dangerous or harmful physical contact initiated by a service user*
- *to separate the person from a “trigger”, for example, removing one service user who has responded to another with physical aggression*
- *to protect a service user from a dangerous situation – for example, the hazards of a busy road’* (Human Rights Working Group On Restraint And Seclusion, 2005)

Within educational settings the term ‘reasonable force’ is used, with the following qualification: *‘the working definition of “reasonable force” is the minimum force necessary to prevent a pupil from physically harming him/herself or others or seriously damaging property, but used in a manner which attempts to preserve the dignity of all concerned’* (Department of Education Northern Ireland, 2004)

Training content must refer to the Royal College of Nursing guidance: *Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions* (2017) Royal College of Nursing Three Steps to Positive Practice

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

Appendix
19

# Specific considerations and adaptations to the training standards for services in Scotland

Specific adaptations to the standards:

- The Mental Welfare Commission for Scotland is concerned with ensuring the 'welfare of individuals with mental illness, learning disability and related conditions'. In their good practice guide they define 'restraint' as *'taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a person [or other person] from doing what he or she wishes to do and as a result places limits on his or her freedom. Restraint is defined in relation to the degree of control, consent and intended purpose of the intervention'* (Mental Welfare Commission for Scotland, 2013a)
- In *Holding Safely* (guidance produced for residential child care practitioners, which covers children and young people), 'physical intervention' was defined as *'an action involving using a worker's body, for example blocking the path of a child or any guiding of him or her away from a harmful situation. It includes physical restraint'* (The Scottish Institute for Residential Child Care (SIRCC), 2005, updated 2013)
- In the same document 'physical restraint/restraining a child' was defined as *'an intervention in which staff hold a child to restrict his or her movement and should only be used to prevent harm. We have largely avoided simply using the term restraint and instead have referred to restraining a child as just that – restraining a child. We deliberately chose to change this language to avoid losing sight of the child, who might otherwise be overlooked by the more clinical and depersonalised use of the term "restraint"'* (SIRCC, 2005, updated 2013)

- *Holding Safely* defines certain techniques that should never be used: ‘neck holds’; those involving any ‘obstruction of the mouth or nose’; and those relying on ‘pain compliance’
- *Holding Safely* also defined high risk practices that required strong justification and comprehensive safeguards: ‘prone restraint’; ‘supine restraint’; ‘seated holds’ and ‘basket holds’
- *Holding Safely* was produced in 2004, when SIRCC were asked by the Scottish Executive to produce guidance on restraining children and young people in residential child care establishments. The *Holding Safely* guidance was originally specifically targeted at the residential child care sector, and not at schools
- In 2013 additional guidance was issued, designed to complement *Holding Safely*. The purpose of this additional guidance was to ensure that the key principles and practice of *Holding Safely* were adopted in all residential child care establishments across Scotland. This included secure care and establishments which provided services for children affected by a disability. The Scottish Executive published its refreshed national guidance, *Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions* on 19 June 2017. This refreshed guidance includes information and advice for education authorities on de-escalation and physical intervention

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 20

# Specific considerations and adaptations to the training standards for services in Wales

Specific adaptations to the standards:

The Welsh Assembly Government considers that guidance it issues on restrictive physical intervention policy and practice for professionals who work with children, young people, adults and older people in health, education and social care settings should share a common framework of principles and expectations. The Welsh Assembly Government has therefore elected to use the term ‘restrictive physical intervention’ to describe direct physical safeguarding action: *‘Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual’* (Welsh Assembly Government, 2005)

Within education settings the term ‘use of force’ has been used. A distinction is made between its use for ‘control’, and for ‘restraint’:

- Control can mean either passive physical contact (eg standing between pupils or blocking a pupil’s path) or active physical contact (eg leading a pupil by the hand or arm, or ushering a pupil away by placing a hand in the centre of the back)
- When members of staff use ‘restraint’ they physically prevent a pupil from continuing what they were doing after they have been told to stop. Restraint techniques are usually used in more extreme circumstances, such as when two pupils are involved in a fight and physical intervention is needed to separate them (Welsh Assembly Government, 2010)

In 2005, the Welsh Assembly Government published the *Framework for Restrictive Physical Intervention Policy and Practice* which stated that, *'Under no circumstances, should any individual ever be restrained in a (prone) face down position.'*

In 2008 this guidance was revised in recognition of the fact that the prone restraint position was used in mental health services across the Welsh NHS. The position is recognised as one of last resort, and one which needs to be carefully managed to ensure the patient's safety. If prone (face down) restraint is used it will need to be justified and documented.

In 2013, the Welsh Assembly Government published further guidance on the use of physical intervention: *Safe and Effective Intervention – Use of Reasonable Force and Searching for Weapons* (097/2013). This guidance does not refer to the use of face down (prone) restraint. However, the guidance recognises that in exceptional circumstances staff have to do whatever is necessary to keep a pupil safe.

In 2016, *Positive Approaches: Reducing Restrictive Practices in Social Care* was published by the Care Council for Wales.

The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides a framework for the delivery of violence and aggression training within the NHS in Wales. It also provides guidance on the development of documentation to ensure the effective assessment and maagement of violence and aggression. The scheme has four modules:

| | |
|---|---|
| Module A | Induction and awareness raising |
| Module B | Theory of personal safety and de-escalation |
| Module C | Breakaway techniques |
| Module D | Restrictive physical interventions (this has been developed specifically for specialist areas such as mental health services, and is currently being reviewed and revised by the all Wales Proactive Reduction of Restrictive Interventions Clinical Effectiveness (PRRICE) group) |

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards 2019

# Appendix 21A The use of pain to gain compliance

- The cross sector Restraint Reduction Network steering group does not endorse the use of pain based techniques
- The Restraint Reduction Network is committed to the specification, and implementation, of person centred care planning. This may include the development of individualised behaviour support plans, which may include reactive strategies, providing carefully considered guidance on how to respond to those behaviours of concern that represent a risk to safety. Such plans may include physical restraint as a last resort. In addition to being lawful, such interventions must also be ethical and safe
- The Restraint Reduction Network believes that the planned, or intentional, application of pain to elicit behavioural compliance runs counter to the primary role of staff which is to provide individualised therapeutic care and support. Techniques, which are often referred to as ‘pain compliance techniques’, are also potentially dangerous and likely to be damaging to the development and maintenance of vital ongoing therapeutic/supportive relationships
- The European Committee for the Prevention of Torture advise that pain must never be used to gain compliance
- The European Commission for Human Rights takes the view that pain inducing restraint must be prohibited on children and many professional codes of practice clearly define that the deliberate application of pain is not acceptable

# Appendix 21B

# The use of pain for escape or rescue purposes

- The Restraint Reduction Network does acknowledge that where there is an immediate risk to life, the NICE Guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life
- In this case, the training provider must present a clear, written rationale for the inclusion of such techniques in training and the reasons why staff require such training. The rationale must be supported by risk assessments and should include recommended criteria for monitoring, minimising and reducing the use of these techniques
- It must be clear in the rationale which staff need the training. The rationale must be authorised by the most senior official responsible for restraint in the commissioning organisation and must be reviewed with the senior official before any training event that includes the techniques
- Training must cover safety advice, reporting requirements and review arrangements for the use of these techniques

# Appendix 22

# Self-assessment tool template

Name of Training Service:

As part of the assessment, quality checks will be carried out on a minimum of 20% of:

- senior trainers
- curriculums
- all affiliated Service Providers (see glossary)

Therefore please list below

- all senior trainers to be authorised

- all curriculum to be approved

- all affiliated Service Providers that use your train the trainer model to provide in-house training

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Training standards** | | | |
| **Section 1: Standards 1.1–1.8**<br>This covers the part of the process that needs to be completed before a curriculum is developed | | | |
| **Standard 1.1:**<br>The curriculum must be based on a training needs analysis (TNA) which must be completed by the commissioning organisation before the curriculum is developed and delivered | 🟩 | | |
| **Standard 1.2:**<br>A named person in the training provider organisation must develop a written proposal for a curriculum including the rationale for teaching specific restrictive interventions | 🟩 | | |
| **Standard 1.3:**<br>Any physical restraint technique that is included in the curriculum must be risk assessed by an independent professional or organisation with relevant expertise | 🟥 | | |
| **Standard 1.4:**<br>Training must be provided within the context of an explicit commitment to the reduction of all restrictive practices | 🟥 | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 1.5:**<br>Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions | 🟥 | | |
| **Standard 1.6:**<br>The training provider must agree delivery arrangements with the commissioning organisation before delivery takes place | 🟥 | | |
| **Standard 1.7:**<br>The training provider must provide accessible information about the content of the training programme | 🟥 | | |
| **Standard 1.8:**<br>The training provider must have a policy for responding to concerns and complaints | 🟥 | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Section 2: Standards 2.1–2.18**<br>This covers what must be included in the curriculum | | | |
| **Standard 2.1:**<br>Training content must support a person centred and rights based approach | | | |
| **Standard 2.2:**<br>Training content must cover duty of candour and duty of care in all settings | | | |
| **Standard 2.3:**<br>Training content must cover how attitudes to and attributions of distress or concerning behaviours can impact directly on responses to the people being supported | | | |
| **Standard 2.4:**<br>Training content must cover the use of decision making in response to distress or behaviours of concern | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 2.5:**<br>The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff) | | | |
| **Standard 2.6:**<br>The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating | | | |
| **Standard 2.7:**<br>The curriculum must give proportional time to covering the use of non restrictive tertiary strategies | | | |
| **Standard 2.8:**<br>Teaching the use of restrictive interventions (may include physical restraint, physical restraint to facilitate seclusion or long term segregation, clinical holding, or mechanical restraint) | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 2.8A:**<br>Teaching the use of mechanical restraint | | | |
| **Standard 2.9:**<br>Training must cover the factors that contribute to risk and elevated levels of risk in the application of restrictive interventions | | | |
| **Standard 2.10:**<br>Training in restrictive interventions must include contingencies to reduce the likelihood of medical emergencies arising; and the provisions to manage any that do | | | |
| **Standard 2.11:**<br>The curriculum must identify the full range of restrictive interventions and restrictive practices and their application | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 2.12:**<br>The curriculum must cover the requirements for recording and analysing data from restrictive interventions and occurrences of distress or concerning behaviour | | | |
| **Standard 2.13:**<br>The curriculum must include reference to the importance of required procedures that are related to post-incident review | | | |
| **Standard 2.14:**<br>The curriculum must have content that enables participants to understand the meaning of ‘trauma’ and how it can impact on people’s experience of restrictive interventions | | | |
| **Standard 2.15:**<br>The curriculum must contain reference to and explore understanding of restraint reduction theory | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Section 3: Standards 3.1 – 3.6**<br>This relates to post delivery processes | | | |
| **Standard 3.1:**<br>Training must include a competence based assessment within each programme, with participants being assessed across both theory and practice elements | | | |
| **Standard 3.2:**<br>Training records for each programme delivered must be maintained by the training organisation | | | |
| **Standard 3.3:**<br>Training providers must have a policy for dealing with concerns that arise during training | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 3.4:**<br>All training must be evaluated post delivery using an evidence based framework | | | |
| **Standard 3.5:**<br>Training providers must use a quality assurance cycle and be able to show how they have measured effectiveness in order to make improvements or adjustments to programmes or processes where needed | | | |
| **Standard 3.6:**<br>Training providers must develop refresher training curricula that take into account the current needs of the organisation, service or individuals using information from an updated TNA (see also standard 1.6.1) | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Section 4: Trainer standards** | | | |
| **Standard 4.1:**<br>Training providers must have quality assurance systems in place to monitor the competency of all trainers delivering their programmes, including both senior and associate trainers | | | |
| **Standard 4.2:**<br>All trainers who are delivering training must be able to demonstrate that they are qualified and competent to train | | | |
| **Standard 4.3:**<br>All trainers must be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Standard 4.4:**<br>All trainers must ensure that the delivery of any programme is informed by the training needs analysis (TNA) | | | |
| **Standard 4.5:**<br>All trainers must be covered by professional indemnity and public liability insurance | | | |
| **Standard 4.6:**<br>Trainers must manage training sessions safely and professionally | | | |
| **Standard 4.7:**<br>All trainers will be expected to maintain accurate training records which support an agreed quality assurance system | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| The appropriate appendices must also be selected for population, setting and country.  Evidence must be provided as to how the training covers any specific adaptations to the standards or special considerations. | | | |

| **Appendices: Populations** | | | |
|---|---|---|---|
| 1: Services supporting people who have acquired brain injury | | | |
| 2: Services supporting autistic people | | | |
| 3: Services supporting children (including residential schools and children's homes) | | | |
| 4: Services supporting people who are deaf and have mental health conditions | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| 5: Services supporting people who have eating disorders | | | |
| 6: Services supporting people who have learning disabilities | | | |
| 7: Services supporting people who have mental health conditions | | | |
| 8: Services supporting older people, and people living with dementia | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Appendices: Settings** | | | |
| **9: Adult acute psychiatric wards and PICUs** | | | |
| **10: Emergency departments** | | | |
| **11: Family homes** | | | |
| **12: Forensic and high secure services** | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| 13: Foster care | | | |
| 14: Lone working | | | |
| 15: Schools | | | |
| 16: Tier 4 Child and Adolescent Mental Health Services (CAMHS) | | | |

## Training service:

| Self assessment | RAG | Evidence | Actions |
|---|---|---|---|
| **Appendices: Country** | | | |
| **17: England** | | | |
| **18: Northern Ireland** | | | |
| **19: Scotland** | | | |
| **20: Wales** | | | |
| **Appendices: Other** | | | |
| **21: Use of pain** | | | |

# Glossary

### Accreditation

The official recognition of a particular status or qualification to provide or perform a particular activity. Training providers can demonstrate compliance with these standards through certification. Contact BILD Association of Certified Training for information regarding certification.

### Advance decision

A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

### Advance statement

A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

### Affiliated service providers

These are service provider organisations that deliver certified training services within their own organisations on behalf of the training provider.* Quality assurance and training for the associate trainers who are delivering the approved programmes within the service provider organisation are provided directly by the training provider which will be sampled in the continuous assessment process for certification.

* these may be known as in-house or in-service training models

### Behavioural overshadowing

This is when behaviours of concern are attributed to the person's learning disability, mental health, differential diagnosis, age or gender.

### Breakaway techniques

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive. or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

It would be important to assess the communicative function of the physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

### Certificated training service

Certificated training services are the combination of approved curriculum and authorised trainers that meet the Restraint Reduction Network training standards 2019.

### Children

People aged 12 years or under.

### Coercion

Any action or practice undertaken which is inconsistent with the wishes of the person in question (ie undertaken without the person's informed consent) – also see psychological restraint.

### Commissioning organisation

This is an organisation who commisions training – usually a service provider – and in some cases this might be through an in-house provider.

## De-escalation

The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is not de-escalation. De-escalation techniques can include verbal strategies, such as maintaining a calm tone of voice and not shouting or verbally threatening the person; and non-verbal techniques, including an awareness of self, body stance, eye contact, and personal safety (Cowin et al, 2003; Spencer and Johnson, 2016). Effective de-escalation approaches are personalised and include openness, honesty, support, self-awareness, coherent communication, non-judgemental approaches, and confidence (without arrogance) (Price and Baker, 2012). They have the aim of preventing escalation and supporting the person to be calm.

## Diagnostic overshadowing

This is when symptoms of physical ill health are mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disabilities.

## Distressed behaviours

Distress can result in challenging behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (adapted from the definition in Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007). They may also be referred to as challenging behaviours, behaviours that challenge or that can be described as challenging, and distressed behaviours or behavioural disturbances.

There are a wide range of behaviours that are considered to be concerning. These can include verbal or physical aggression, violence and aggression towards others, self-harm, withdrawal, and they can manifest verbally or physically. Distressed behaviours of concern are assumed to have a purpose and communicative meaning for the person.

## Duty of candour

The duty of professionals to be open and honest with people when something goes wrong and has the potential to cause harm or distress.

## Duty of care

The legal obligation to safeguard others from harm while they are in your care and/or exposed to activities such as training programmes.

## Escape and rescue techniques

A set of physical skills to help separate or break away from an aggressor in a safe manner. This may be completed by an individual or in extreme cases supported by another to enable escape/rescue. These techniques are not expected to involve the use of restraint. (NICE, 2015)

## Fragility

Refers to issues that may compromise the fidelity of the technique between its taught version and application in practice. Fragility issues have implications for both effectiveness and safety. A technique is deemed fragile if small adjustments (movement or pressure) to the procedure are likely to result in intentional, or unintentional injury or severe pain to an individual (Paterson, 2014; Martin et al, 2008).

## GDPR

General Data Protection Regulations 2018

## Hyperextension

An excessive joint movement in which the angle formed by the bones of a particular joint is opened, or straightened, beyond its normal, healthy, range of motion.

## Hyperflexion

Flexion of a limb or part beyond the normal limit.

## Incident

Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation).

## Named person

In the commissioning organisation this should be someone with board level/executive level responsibility as well as a practice restraint reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation.

Both people are responsible for the annual review of the curriculum. Where training is both developed and delivered in-house, the same process of development delivery and review should be followed although there may only be one named person.

## Pain compliance

Pain compliance is the use of painful stimulus to control or direct a person's actions.

### Participant

In these standards a participant is a person who attends a training programme.

### Peer review

A systematic interactive process that helps nursing staff and students evaluate their colleagues' practice and engage in constructive dialogue with them, providing feedback to peers based on specific criteria to assist in professional and/or personal growth.

### People with lived experience

People with a lived experience of receiving services and experience of having restrictive interventions applied to them. The term can also apply to families and carers.

### Personal assistants (PA)

A carer (PA) employed by an individual or a related third party without the involvement of an employment agency or employment business, and working wholly under the direction and control of that individual or related third party in order to meet the individual's own personal care requirements.

### Personalised wellbeing risk assessment (PWRA)

A process which supports the gathering of important personal information used to determine the suitability and safety of any restrictive interventions.

### Planned and unplanned restrictive intervention

These standards use the term planned restrictive intervention to mean a restrictive intervention that has been agreed and is documented as part of someone's agreed plan. An unplanned restrictive intervention is when a restrictive intervention is used as a response to an unexpected incident. The use of the restrictive intervention should be recorded and reviewed shortly afterwards.

### Post-incident review

A review that consists of two separate components:

1. Post-incident support This is the support that is immediately offered to an individual who has been involved in an incident, it should include assessment and treatment of any medical needs and provision of immediate emotional support.
2. Post-incident reflection and learning review This is a non-blaming review where the factors that led to the restrictive intervention being used are examined and actions are agreed that support the prevention of future incidents or the minimisation of impact and less restrictive response in the future.

### Primary strategies

These strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern arising.

### PRN (pro re nata)

When needed, PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to harm to the person or others.

### Reflective practice

The practice of reflecting on one's actions so as to engage in a process of continuous learning. Services and professionals can at times unintentionally provoke situations. Reflective practice helps identify how to better meet needs to prevent crisis.

### Refresher training

A programme that the participant attends within a year of attending the original programme. Its aim is primarily to refresh skills learned previously but it should also contain a developmental element.

### Restraint minimisation

Assessment, planning and review measures aimed at reducing the intensity and duration of any physical restraint techniques that are used within defined settings, or in relation to a defined population or a specific individual.

### Restraint reduction

Assessment, planning and review measures designed to reduce the number of times restraint techniques are used within defined settings, or in relation to a defined population or a specific individual.

## Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, physical restraint, mechanical restraint and rapid tranquilisation and other chemical restraint. Restrictive interventions have the potential to violate the person's human rights.

- **Chemical restraint**

Involves using medication with the intention of restricting someone's movement. This could be regularly prescribed medication – including those to be used as required (PRN) – or illegal drugs.

- **Observation**

A restrictive intervention of varying intensity in which a member of the staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation.

- **Physical restraint**

Any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement. Physical restraint can also be called manual restraint and restrictive physical intervention.

- **Long term segregation**

Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the person to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a person should not be allowed to mix freely with other patients on the ward or unit on a long term basis.

- **Mechanical restraint**

A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts. Its purpose is to immobilise or restrict movement of part(s) of the body of the person.

- **Rapid tranquilisation**

Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

- **Technological surveillance**

Tagging, pressure pads, closed circuit television, or door alarms, for example, are often used to alert staff that the person is trying to leave or to monitor their movement.

- **Psychological restraint or coercive practice**

This can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing, or keeping the person in nightwear with the intention of stopping them from leaving.

- **Seclusion**

If a person is isolated and prevented from leaving a room of their own free will, it meets the criteria for seclusion, even if it is called by a different name. Alternative names in use may be: time out, isolation, chill out, or single separation. There could be a number of methods that prevent someone from leaving a room including a perceived or real threat. In a hospital setting seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the person 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. Seclusion does not include locking people in their rooms at night in accordance with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013.

## Restrictive practices

This is an umbrella term for making someone do something they don't want to do or stopping someone doing something they want to do. In service settings it can be linked to the use of blanket rules which apply to everyone regardless, but may have a tenuous basis for application or are only necessary because of a specific individual risk.

## Secondary strategies

These strategies focus on the recognition of an individual's early behavioural signs (physical, emotional, communicative, etc) which can indicate an increase in behavioural disturbance. Strategies are developed to identify how to respond to a person's behaviours or support the person to self-manage. Secondary strategies are likely to include approaches to de-escalation. These may be referred to as reactive strategies, secondary preventative strategies or active interventions. Secondary strategies can be restrictive (such as use of PRN at an early stage) or non-restrictive. Such strategies are designed to be used when staff recognise signs of a developing behavioural disturbance, and are aimed at reducing or removing the underlying causes of the behaviour, including issues such as pain, distress or frustration.

## Tertiary strategies

These strategies are used when an actual behaviour of concern is presenting, with the primary aim to bring the incident to an end in a timely and safe manner, with due regard to the individual's rights and dignity. Examples of non-restrictive tertiary strategies include de-escalation, diversion, distraction or strategic capitulation. Examples of restrictive tertiary strategies include restrictive interventions such as physical restraint.

## Trainers

There are two kinds of trainers referred to in these standards:

- **Senior trainers**

Senior trainers are authorised under the certification scheme to deliver approved programmes across multiple organisations and/or deliver approved 'Train the Trainer' programmes. Senior trainers may be employed (or paid) by a commercial training provider or be employed within a service provider organisation such as an NHS trust. 20% of senior trainers are subject to direct quality assurance sampling processes through the certification scheme. This status is non transferrable across organisations, employers or other training organisations.

- **Associate trainers**

Associate trainers are authorised by the training provider to deliver approved programme(s) only within their own service or organisation, they are not authorised to deliver any approved 'Train the Trainer' programmes. Associate trainers are likely to be employed by affiliated service provider organisations (eg NHS trusts, schools or care homes who deliver training services on behalf of the training provider and will be expected to meet the requirements as laid out within the Restraint Reduction Network Training Standards 2019. This status is non transferrable across organisations, employers or other training organisations. Direct quality assurance for these trainers is the responsibility of the training provider who will be expected to provide evidence of quality assurance monitoring processes as part of the certification of their training services, which will be sampled in the continuous assessment process for certification

## Training curriculum

A list of subjects that make up the training programme.

## Training needs analysis (TNA)

The first step in the training process. Designed to identify performance gaps that can be remedied by training. It consists of surveillance, investigation, and data analysis (Thomas, 2004)

## Training providers

There are two kinds of training provider referred to in these standards:

- **Commercial training organisation**

who are commissioned to provide training to a range of organisations

- **In-house training providers**

who deliver training within their own organisation, for example, an NHS trust or a care organisation

## Trauma informed care

An organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma.

## Written rationale

Written explanation of the logical reasons or principles for arriving at a decision to include particular restrictive interventions in the training curriculum.

## Young people

People aged between 13 and 17 years.

# References

Aiken, F, Duxbury, J, Dale, C and Harbison, I (2011) *Review of the Medical Theories and Research Relating to Restraint Related Deaths*. Caring Solutions (UK) and University of Central Lancashire, Preston. Available at: https://bit.ly/2E8ktQL (accessed 21 July 2018).

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (5th edn). Arlington, VA: American Psychiatric Publishing.

Association of Chief Police Officers and National Policing Improvement Agency (2010) *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*. Available at: https://bit.ly/2xZ9mnm (accessed 21 July 2018)

Action on Hearing Loss (2018) *Facts and Figures*. Available at: https://bit.ly/2zQSocf (accessed 10 July 2018)

Association of Directors of Children's Services Health, Care and Additional Needs Policy Committee Task Group (2009) *A Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People*. Manchester: ADCS

Baker, P A (2017) Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study, *International Journal of Positive Behavioural Support*, 7(1), 38-44

Bevan, E R (2018) *Best Practice Guide for BSL/ English Interpreters Working in Mental Health*. Available at: https://bit.ly/2xY9HGX (accessed 10 July 2018)

BIHR (2013) *The Difference it Makes: Putting Human Rights at the Heart of Health and Social Care*. London: BIHR

BIHR (2016a) *Mental Health, Mental Capacity, and Human Rights*. London: BIHR

BIHR (2016b) *BIHR Toolkits: Learning Disability and Human Rights*. London: BIHR

BILD (2014) *BILD Code of Practice for Minimising the Use of Restrictive Physical Interventions: Planning, Developing and Delivering Training* (4th edn). BILD: Birmingham

BILD Centre for the Advancement of Positive Behaviour Support (2018) *Questions to Ask About the Use of Physical Restraint in Schools*. Available at: https://bit.ly/2NaIcDN (accessed 21 March 2018)

BILD Centre for the Advancement of Positive Behaviour Support (2018) *The Use of Tents or Other Confined Spaces in Schools*. Available at: https://bit.ly/2NaIcDN (accessed 21 March 2018)

Bowers, L (2014) Safe-wards: a new model of conflict and containment on psychiatric wards, *Journal of Psychiatric and Mental Health Nursing*, 21(6), 499–508

Cabral, L, Muhr, K and Savageau, J (2013) Perspectives of people who are deaf and hard of hearing on mental health, recovery and peer support, *Community Mental Health Journal*, 49(6), 649–57

Campbell, D (2018) Figures reveal 'alarming' rise in injuries at mental health units, *The Guardian* [online], 10 June. Available at: https://bit.ly/2kYBkc8 (accessed 10 July 2018)

Care Commission, Mental Welfare Commission for Scotland (2009) *Remember I'm Still Me*. Edinburgh: MWCS

Care Council for Wales (2016) *Positive Approaches: Reducing Restrictive Practices in Social Care*. Cardiff: CCW

Care Quality Commission (2015a) *Regulation 20: Duty of Candour*. Newcastle Upon Tyne: CQC

Care Quality Commission (2015b) *Brief Guide: Restraint (Physical and Mechanical)*. Available at: https://bit.ly/2RnWMX3 (accessed 21 March 2018)

Care Quality Commission (2015c) *Brief Guide: Seclusion Rooms.* Available at: https://bit.ly/2Ph8v88 (accessed 21 March 2018)

Care Quality Commission (2016) *Brief Guide: Restraint (Physical and Mechanical)*. Available at: https://bit.ly/2O2LQQx (accessed 4 July 2018)

Care Quality Commission (2017) *Brief Guide: Long-term Segregation*. Available at: https://bit.ly/2xTVAmb (accessed 21 March 2018)

Catchpole, K and McCulloch, P (2010) Human factors in critical care: towards standardized integrated human-centred systems of work, *Current Opinion in Critical Care*, 16, 618–22

Chester, V, Devapriam, J, Alexander, R, Langdon, P, Kitchen, D and James, N (2018) *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate*. London: Faculty of Psychiatry of Intellectual Disability and Quality Network for Learning Disabilities, Royal College of Psychiatrists

Children's Commissioner for England (2017) *Children's Voices: A Review of Evidence on the Subjective Wellbeing of Children in Detention.* London: CCfE

Children's Commissioner for Scotland (2018) *No Safe Place: Restraint and Seclusion in Scotland's Schools* Scottish Government

Children's Rights Director for England (2012) *Children's Views on Restraint: Reported by the Children's Rights Director for England*. London: OFSTED

College of Policing (2017) *Memorandum of Understanding: The Police Use of Restraint in Mental Health and Learning Disability Settings*. Coventry: CoP

Cowin, L, Davies, R, Estall, G, Berlin, T, Fitzgerald, M and Hoot, S (2003) De-escalating aggression and violence in the mental health setting, *International Journal of Mental Health Nursing*, 12, 64–73

Cromwell, J (2005) Deafness and the art of psychometric testing, *The Psychologist*, 18(12), 738–40

Dementia Services Development Centre (2014) *Supporting People with Dementia: Understanding and Responding to Distressed Behaviour.* Stirling: DSDC

Department for Constitutional Affairs (2013) *Mental Capacity Act Code of Practice*. London: TSO

Department for Education (2000) *Care Standards Act: National Minimum Standards for Children's Homes*. London: DfE

Department for Education (2011) *Fostering Services: National Minimum Standards*. London: DfE

Department for Education (2013a) *Residential Special Schools: National Minimum Standards*. London: DfE

Department for Education (2013b) *Use of Reasonable Force in Schools*. London: DfE. Available at: https://bit.ly/2x05WCM (accessed 31 August 2018)

Department for Education (2015a) *Children's Homes Regulations, Including Quality Standards: Guide*. London: DfE

Department for Education (2015b) *Working Together to Safeguard Children*. London: DfE.

Department for Education (2015c) *The Children's Act 1989: Guidance and Regulations Volume 4; Fostering Services*. London: DfE

Department for Education (2016) *Behaviour and Discipline In Schools: Advice for Head Teachers and School Staff*. London: DfE

Department for Education and Skills and Department of Health (2002) *Guidance for Restrictive Physical Interventions: How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder*. London: DoH

Department of Education Northern Ireland (1999) *Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils (Circular, 1999/9).* Bangor: DENI

Department of Education Northern Ireland (2004) *Regional Policy Framework on the Use of Reasonable Force/Safe Handling*. Bangor: DENI

Department of Education Northern Ireland (2017) *Safeguarding and Child Protection in Schools*. Bangor: DENI

Department of Health (2005) *Mental Health and Deafness – Towards Equity and Access: Best Practice Guidance*. London: DoH

Department of Health (2012) *Transforming Care: A National Response to Winterbourne View Hospital*. London: DoH

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

Department of Health (2015) *Mental Health Act Code of Practice*. London: TSO

Department of Health, Concordat Signatories (2014) *Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis.* London: DoH

Department of Health and Social Care and Department for Education (2017) *Reducing the Need for Restraint and Restrictive Intervention; children and young people with learning disabilities, autistic spectrum disorder, and mental health difficulties* (Consultation document). London: DoH/DfE

Department of Health and Social Care and Department for Education (2019) *Reducing the Need for Restraint and Restrictive Intervention: children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings* HM Gov

Department of Health, Social Services and Public Safety (2005*) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services*. Belfast: DHSSPS

Department of Health, Social Services and Public Safety (2012) *Day Care Settings; Minimum Standards*. Belfast: DHSSPS

Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*. Stratford Upon Avon: DRC

Donald, A (2012) *A Guide to Evaluating Human Rights-Based Interventions in Health and Social Care*. London: HRSJ

Donoghue v Stevenson [1932] AC562

Duxbury, J and Paterson, B (2005) The use of physical restraint in mental health nursing, *The Journal of Adult Protection*, 7(4), 13–24

Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint*, (2019)

Equality and Human Rights Commission (2019) *Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions*

Gore, N, McGill, P, Toogood, S, Allen, D, Hughes, J C, Baker, P, Hastings, R, Noone, S and Denne, L (2013) Definition and scope for positive behaviour support, *International Journal of Positive Behavioural Support*, 3(2), 14–23

Greenfield, D and Braithwaite, J (2008) Health sector accreditation research: a systematic review, *International Journal for Quality in Health Care*, 20(3), 172–183

Harris, J, Cornick, M, Jefferson, A and Mills, R (2008) *Physical Interventions: A Policy Framework* (2nd edn). Birmingham: BILD

Hart, D (2008) *Restrictive Physical Intervention in Secure Children's Homes*. London: NCB

Hart, D and Howell, S (2004) *National Children's Bureau: Report on the use of physical intervention across children's services*. London: NCB

Hastings, R P, Allen, D, Baker, P, Gore, H J, Hughes, J C, McGill, P, Noone, S J and Toogood, S (2013) A conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities, *International Journal of Positive Behavioural Support*, 3(2), 5–13

Health and Safety Executive (2013a) *First Aid at Work: The Health and Safety (First-Aid) Regulations 1981*. London: HSE

Health and Safety Executive (2013b) *RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013*. London: HSE. Available at: https://bit.ly/1OYsXn1 (accessed 22 July 2018)

Health and Safety Executive (2013c) *Working Alone: Health and Safety Guidance on the Risks of Lone Working*. London: HSE

HM Government (2019) *Reducing the Need for Restraint and Restrictive Intervention: children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings*. Community Care / Mental Health, Dementia and Disabilities / DDU / 11168 and Department for Education

HM Inspectorate of Prisons (2015) *Behaviour Management and Restraint of Children in Custody*. London: HMIP

Horne, N and Pennington, J (2010) The role of the nurse specialist in the highly specialized field of mental health and deafness, *Journal of Psychiatric and Mental Health Nursing*, 17, 335–8

Huckshorn, K A (2006) Re-designing state mental health policy to prevent the use of seclusion and restraint, *Administration and Policy in Mental Health*, 33, 482–91

Human Rights Working Group on Restraint and Seclusion (2005) *Guidance on Restraint and Seclusion in Health and Personal Social Services*. Available at: https://bit.ly/2uYBHb5 (accessed 23 July 2018)

Jeffrey, K (2010) Supportive holding or restraint: terminology and practice, *Nursing Children and Young People*, 22(6), 24–8

Joint Commissioning Panel for Mental Health (2017) *Guidance for Commissioners of Primary Care Mental Health Services for Deaf People*. Available at: https://bit.ly/2Bmu1Ry (accessed 21 July 2018)

Juwah, C (2003) Using peer assessment to develop skills and capabilities, *United States Distance Learning Association Journal*, 17, 1–11

Kirkpatrick, D L (1959) Techniques for evaluation training programs, *Journal of the American Society of Training Directors*, 13, 21–26

LaVigna, G W and Willis, T J (2016) The alignment fallacy, and how to avoid it, *International Journal of Positive Behavioural Support*, 6(1), 6–16

LeBel, J, Duxbury, J, Putkonen, A, Sprague, T, Rae, C and Sharpe, J (2014) Multinational experiences in reducing and preventing the use of restraint and seclusion, *Journal of Psychosocial Nursing and Mental Health Services*, 52(11), 22–9

LeBel, J, Huckshorn, K A and Caldwell, B (2010) Restraint use in residential programs: Why is best practice ignored? *Child Welfare*, 89(2), 169–87

Martin, A, Mcdonnell, A, Leadbetter, D and Paterson, B (2008) Evaluating the risks associated with physical interventions. In Allen, D (ed.) *Ethical Approaches to Physical Interventions, Volume 2: Changing the Agenda*. Worcester: BILD, pp.37–53

Mental Welfare Commission for Scotland (2013a) *Good Practice Guide: Rights, Risks and Limits to Freedom*. Edinburgh: MWCS

Mental Welfare Commission for Scotland (2013b) *Good Practice Guide: Responding to Violence in a Mental Health or Learning Disability Care Setting*. Edinburgh: MWCS

Mental Welfare Commission for Scotland (2013c) *Good Practice Guide: Human Rights in Mental Health Services*. Edinburgh: MWCS

Miller, G E (1990) The assessment of clinical skills/competence/ performance, *Academic Medicine*, 65 (Suppl. 9), S63–S67

Mind (2013*) Mental Health Crisis Care: Physical Restraint in Crisis. A Report on Physical Restraint in Hospital Settings in England*. London: Mind

Mind and NSUN (2015) *Restraint in Mental Health Settings*. London: Mind

Napier, J and Cornes, A (2004) The dynamic roles of interpreters and therapists. In S Austen and S Crocker (eds), *Deafness in Mind: Working Psychologically with Deaf People Across the Lifespan* (pp. 161–79). London: Whurr Publishers

NAPICU (2016) *Guidance for Commissioners of Psychiatric Intensive Care Units (PICUs)*. East Kilbride: NAPICU

NASMHPD (2008) *Six Core Strategies to Reduce Seclusion and Restraint Use*. Available at: https://bit.ly/2O8EI5q (accessed 21 March 2018)

NHS Confederation (2012) *Defining Mental Health Services: Promoting Effective Commissioning and Supporting QIPP*. London: NHS Confederation

NHS Education for Scotland (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*. Edinburgh: NES

NHS England (2013) *The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013*. Available at: https://bit.ly/2O0Zbc2 (accessed 23 July 2017)

NHS England (2015) *Accessible Information Implementation Plan*. Leeds: NHS England

NHS England (2016) *All About Me: Deafness Recovery Tool*. Leeds: NHS England

NHS England (2017) *Accessible Information Standard (DCB1605)*. Leeds: NHS England

NHS England (2018) *STOMP (Stopping the Over-Medication of People with a Learning Disability and Autism or both*). Available at: https://bit.ly/2qpvNB2 (accessed 17 May 2018)

NHS Protect (2013) *Meeting Need and Reducing Distress*. London: NHS Protect

NICE (2004) *The Short-Term Physical and Psychological Management and Secondary Prevention of Selfharm in Primary and Secondary Care (CG 16)*. London: NICE

NICE (2005) *Violence: Short Term Management for over 16's in Psychiatric and Emergency Departments (CG25*). London: NICE

NICE (2007) *Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration (CG50)*. London: NICE

NICE (2012) *Recognition, Referral, Diagnosis and Management of Adults on the Autistic Spectrum (CG142)*. London: NICE

NICE (2013) *Autism: The Management and Support of Children and Young People on the Autistic Spectrum (CG170)*. London: NICE

NICE (2014) *Autism (QS51).* London: NICE

NICE (2015a) *Violence and Aggression: Short Term Management in Mental Health (NG10).* London: NICE

NICE (2015b) *Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities whose Behaviour Challenges (NG11)*. London: NICE

NICE (2016) *Dementia: Supporting People with Dementia and their Carers in Health and Social Care (CG42).* London: NICE

NICE (2017a) *Eating Disorders: Recognition and Treatment (NG69).* London: NICE

NICE (2017b) *Violent and Aggressive Behaviours in People with Mental Health Problems (QS154).* London: NICE

OHCHR (2006) *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation*. Geneva: Office of the United Nations High Commissioner for Human Rights

O'Rourke, S, Gibbon, S and Hough, W (2011) *Standards for Deaf People in Medium Secure Care*. London: Royal College of Psychiatrists Centre for Quality Improvement

Page, A and Vanes, N (2018) *Evidence Based Holding of Children for Clinical Procedures* [website]. Available at: http://comslive.health.bcu.ac.uk/index.php (accessed 31 August 2018)

Patel, M X, Sethi, F N, et al. (2018) Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: de-escalation and rapid tranquillisation*,* *Journal of Psychiatric Intensive Care*, published online 8 June 2018. https://doi.org/10.20299/jpi.2018.008

Paterson, B (2014) *Risk in the use of restrictive practices - an overview of research. Keynote presentation: Reducing restrictive practices: A human rights perspective - A BILD Conference*. Available at: https://bit.ly/2zReWcU (accessed 7 September 2018)

Paterson, B, Martin, A, Nisbett, I and Leadbetter, D (2011) *The Use of Time-Out and Seclusion in Scottish Schools: A Matter for Concern?* Available at: https://bit.ly/2RqVN8D (accessed 18 March 2018)

PBS Coalition (2015) *Positive Behavioural Support Competence Framework*, [online]. Available at: https://bit.ly/2Rqf61F (accessed 20 April 2018)

Pomey, M P, Lemieux-Charles, L, Champagne, F, Angus, D, Shabah, A and Contandripoulos, A P (2010) Does accreditation stimulate change? A study of the impact of the accreditation process on Canadian health care organizations, *Implementation Science*, 5, 31–44

Price, O and Baker, J, (2012), Key components of de-escalation techniques: A thematic synthesis, *International Journal of Mental Health Nursing*, 21, 310 –19

Restraint Reduction Network (2019) *Towards Safer Services; National Minimum Standards for Restrictive Intervention Reduction.* RRN

Rooney, A L and Van Oostenberg, P R (1999) *Licensure, Accreditation, and Certification: Approaches to Health Services Quality, Quality Assurance Project.* Washington, DC: USAID

Royal College of Emergency Medicine (2016) *Guidelines for the Management of Excited Delirium/Acute Behavioural Disturbance*. London: RCEM

Royal College of Nursing (RCN) (2010) *Restrictive Physical Intervention and Therapeutic Holding for Children and Young People: Guidance for Nursing Staff*. London: RCN

Royal College of Nursing (RCN) (2016) *Personal Safety when Working Alone.* London: RCN

Royal College of Psychiatrists (2014) *Good Practice in the Management of Autism (including Asperger Syndrome) in Adults (CR191).* London: RCPsy

Royal College of Psychiatrists (2015) *Quality Network for Forensic Mental Health Services; See, Think, Act*. London: RCPsy

Royal College of Psychiatrists (2016) *Quality Network for Forensic Mental Health Services: Standards for Forensic Mental Health Services, Low and Medium Secure Care*. London: RCPsyRoyal College of Psychiatrists, British Psychological, Society and Royal College of Speech and Language Therapists (2007) *Challenging Behaviour: A Unified Approach. Clinical and Service Guidelines for Supporting People with Learning Disabilities who are at Risk of Receiving Abusive or Restrictive Practices*. London: Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists

Safewards www.safewards.net

SCIE (2009) *Report 26: Restraint in Care Homes for Older People: A Review of Selected Literature* (Due to be reviewed). London: SCIE

Scottish Executive (2004) *Protecting Children and Young People: The Charter*. Edinburgh: Scottish Government

Scottish Executive (2005a) *Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1*. Edinburgh: Scottish Government

Scottish Executive (2005b) *National Care Standards: Care Homes for Children and Young People*. Edinburgh: Scottish Government

Scottish Executive (2005c) *National Care Standards: Care Homes for Older People*. Edinburgh: Scottish Government

Scottish Executive (2005d) *National Care Standards: Care Homes for People with Learning Disabilities*. Edinburgh: Scottish Government

Scottish Executive (2013) *Physical Restraint in Residential Child Care – Leaflet for Young People*. Edinburgh: Scottish Government

Scottish Executive (2017) *Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions*. Edinburgh: Scottish Government

Scott, S and McManus, S (2016) *Hidden Hurt: Violence, Abuse and Disadvantage in the Lives of Women.* (DMSS Research for Agenda). London: Agenda

SignHealth (2017) *Sign Language.* Available at: https://bit.ly/2P9eSKT (accessed 10 July 2018)

Skills for Care and Skills for Health (2014) *A Positive and Proactive Workforce. A Guide to Workforce Development for Commissioners and Employers Seeking to Minimise the Use of Restrictive Practices in Social Care and Health*. Leeds: SFC & SFH

Smallridge, P and Williamson, A (2011) *Report on Implementing the Independent Review of Restraint in Juvenile Secure Settings.* London: Ministry of Justice

Spencer, S and Johnson, P (2016) *De-escalation Techniques for Managing Aggression. Cochrane Database of Systematic Reviews 2016, Issue 1.* Art. No.: CD012034. DOI: 10.1002/14651858.CD012034

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Available at: https://bit.ly/207FoDJ (accessed 30 August 2018)

Sweeney, A, Clement, S, Filson, B and Kennedy, A (2016) Trauma-informed mental healthcare in the UK: What is it and how can we further its development?, *Mental Health Review Journal*, 21(3), 174–92

The Health, Safety and Wellbeing Group (2018a) *Improving Safety for Lone Workers: A Guide for Managers*. Leeds: HSWG

The Health, Safety and Wellbeing Group (2018b) *Improving Safety for Lone Workers: A Guide for Staff who Work Alone*. Leeds: HSWG

The Scottish Institute for Residential Child Care (SIRCC) (2005) *Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People*. Glasgow: SIRCC

Thomas, A B (2004) *Research Skills for Management Studies*. London: Routledge

UN Committee on the Rights of the Child (2006): *The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment*. General comment No. 8

United Nations Department for Economic and Social Affairs (2006) *Convention on the Rights of Persons with Disabilities (UNCRPD).* [online] Available at: https://bit.ly/1QUdQe4 (accessed 24 July 2018)

United Nations Human Rights (1989) *Convention on the Rights of the Child*. [online] Available at: www.ohchr.org/en/professionalinterest/pages/crc.aspx (accessed 20 April 2018)

Volunteer Now (2010) *Safeguarding Vulnerable Adults: A Shared Responsibility. Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults*. Belfast: Volunteer Now

Welsh Assembly Government (2005) *Framework for Restrictive Physical Intervention Policy and Practice*. Cardiff: Welsh Assembly

Welsh Assembly Government (2013) *Safe and Effective Intervention: Use of Reasonable Force and Searching for Weapons*. Cardiff: Welsh Assembly

Welsh Assembly Government (2016a) *Mental Health Act 1983: Code of Practice for Wales*. Cardiff: Welsh Assembly

Welsh Government (2016b) *Patient Safety Notice: The Importance of Vital Signs During and After Restrictive Interventions/Manual Restraint*. Cardiff: Welsh Assembly

West London Mental Health Trust (2016) *Violence Reduction and Management Programme*. London: West London Mental Health Trust

World Health Organisation (WHO) (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organisation

World Health Organisation (WHO) (2017) *Creating Mental Health and Related Services free from Coercion, Violence and Abuse - WHO Quality Rights Training to Act, Unite and Empower for Mental Health (pilot version)* (WHO/MSD/MHP/17.6). Geneva: World Health Organisation

# Legislation

Available at: legislation.gov.uk

## Statutes

- Adults with Incapacity Act (Scotland) 2000
- Autism Act 2009
- Care Act 2014
- Care Standards Act (National Minimum Standards for Children's Homes) 2000
- Children Act (Scotland) 1995
- Children and Families Act 2014
- Children and Social Work Act 2017
- Children's Act 1989
- Children's Act 2004
- Criminal Justice Act 2003
- Criminal Law Act (Northern Ireland) 1967
- Deprivation of Liberty Act 2010
- Education Act 1996
- Education and Inspections Act 2006
- Education (Scotland) Act 1980 ch47
- Equality Act 2010
- Health and Safety at Work Act 1974
- Human Rights Act 1998
- Mental Capacity Act 2005
- Mental Capacity Act (Northern Ireland) 2016
- Mental Health Act 1983
- Mental Health Act 2007
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health Units (Use of Force) Act 2018
- National Health Service Act 2006 sch 4
- Protection of Children Act 1999
- Regulation of Care (Scotland) Act 2001

## Statutory instruments

- Child Care (Scotland) Regulations 1995, SI1995/3256
- Children (Northern Ireland) Order 1995, SI1995/755
- Children's Homes (England) Regulations 2015, SI2015/541
- Children's Homes Regulations (Northern Ireland) 2005, SI2005/176
- Children's Homes (Wales) Regulations 2002, SI2002/327
- Education (Northern Ireland) Order 1998, SI1998/274
- Foster Placement (Children) Regulations (Northern Ireland) 1996, SI1996/467
- Fostering Services (England) Regulations 2011, SI2011/581
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI2014/781
- Independent Health Care (Wales) Regulations 2011, SI2011/734
- Local Safeguarding Children's Boards (Wales) Regulations 2006, SI2006/1705
- Management of Health and Safety at Work Regulations 1999, SI1999/3242
- Mental Health (Northern Ireland) Order 1986, SI1986/595
- Nursing Homes Regulations (Northern Ireland) 2005, SI2005/161
- Regulations of Care (Requirements as to Care Services) (Scotland) Regulations 2002, SI2002/114
- Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations; Regulation 29 – The appropriate use of control and restraint 2017, SI2017/1264
- Regulation (EU) 2016/679 (General Data Protection Regulation) in the current version of the OJ L 119, 04.05.2016; cor. OJ L 127, 23.5.2018. Available at: https://bit.ly/2v1IOTM (accessed 21 July 2018)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, SI2013/1471
- Residential Care Homes Regulations (Northern Ireland) 2005, SI2005/161
- Secure Accommodation (Scotland) Regulations 1996, SI1996/325

# Acknowledgements

The completion of the Restraint Reduction Network Training Standards would not have been possible without the participation and the assistance of so many people across the sector. Their contributions are sincerely appreciated. We would like to express our deep appreciation particularly to the following:

## Authors:

**James Ridley**, Edge Hill University

**Sarah Leitch**,
BILD Restraint Reduction Network

## Contributors:

**Dave Atkinson**,
Independent Consultant Nurse

**Dr Peter Baker**, Tizard

**Dr Darren Bowring**,
States of Jersey Health and Social Services

**Dr Rina Cianfaglione**,
University of Southampton

**Louise Clark**, Kings College London

**Tom Evans**, Positive Behaviour
Support Manager, BILD

**Teresa Fenech** and **Salli Midgley**,
NHS England

**Ben Higgins**, CEO, BILD

**Lee Hollins**, Strathclyde University

**Nick Horne**,
Cygnet Healthcare

**Sanchita Hosali**,
The British Institute of Human Rights

**Linda Hume**, Edinburgh Napier University

**Andy Johnston**,
Andy Johnston Associates, NAPICU

**Aji and Conrad Lewis** (parents of Seni)

**Helen Wildbore**,
British Institute of Human Rights

## Critical readers:

**Amanda Allard**,
Council for Disabled Children

**Eric Baskind**,
Liverpool John Moores University

**Jim Blair**, Great Ormond Street Hospital

**Verity Chester**, Priory Group

**Glyn Connolly**,
BILD Association of Certified Training
Certification Manager

**Guy Cross**, Care Quality Commission

**Dr John Devapriam**, Executive Medical
Director, Worcester NHS Trust

**Roy Deveau**, Tizard

**Liz Durrant**,
Director of Mental Health, Certitude

**Professor Joy Duxbury**,
Manchester Metropolitan University

**Dr Rhidian Hughes**, VODG

**Dr Ada Hui**, Assistant Professor in
Mental Health, University of Nottingham

**Dr Edwin Jones**, Abertawe Bro
Morgannwg University Health Board

**Dr Gary LaVigna**, IABA

**Kevin McKenna**, Lecturer, School
of Health and Science, Dundalk
Institute of Technology, Ireland

**Beth Morrison**, Founder and CEO,
Positive and Active Behaviour
Support, Scotland (PABSS)

**Ann Norman**, Royal College of Nursing

**Lord Ramsbottom**

**Deborah Reading**, BILD

**Jonathan Timbers**, Equality
and Human Rights Commission

**Professor Dame Sue Bailey OBE DBE,
Rebecca Burgess-Dawson,
Dr Tim Devanney, Ellie Gordon,
and Andrew Stimpson** on behalf
of Health Education England

# Other members of Restraint Reduction Network Steering Group

| Organisation (representing) | Proposed name to represent |
|---|---|
| **Professional bodies** | |
| **British Psychological Society** | Professor John Taylor |
| **Royal College of Nursing** | Dave Atkinson, Professor Joy Duxbury, Catherine Gamble and Dr Ada Hui |
| **Royal College of Psychiatrists** | Dr John Devapriam and Amah Shah |
| **Government departments** | |
| **Department for Education** | Chris Ball and Stuart Miller |
| **Department of Health** | Angela Hawley and Rachel Whittaker |
| **Health Education England** | Dr Tim Devanney and Ray Walker |
| **NHS England** | Teresa Fenech, Salli Midgley, Dr Jean O'Hara and Hazel Watson |
| **NHSi** | Professor Oliver Shanley |
| **Public Health Wales** | Sharon Williams |
| **Regulators** | |
| **Care Quality Commission** | Guy Cross and Dr Theresa Joyce |
| **Equality and Human Rights Commission** | Libby McVeigh and Jonathan Timbers |
| **Ofsted** | Matthew Barnes |
| **VCS / Charities** | |
| **British Institute of Human Rights** | Sanchita Hosali |
| **Council for Disabled Children** | Amanda Allard |
| **Dementia UK** | Dr Hilda Hayo |
| **Learning Disability Wales** | Martyn Jones |
| **Mind** | Alison Cobb and Leila Reyburn |
| **Respond** | Dr Noelle Blackman |
| **Skills for Care** | Sharon Allen and Marie Lovell |
| **Young Minds** | Dr Marc Bush |

## Lived experience

| | |
|---|---|
| **Lived experience** | Iris Benson and Roger Sharp |

## Service providers

| | |
|---|---|
| **Abertawe Bro Morgannwg University Health Board** | Dr Edwin Jones |
| **Birmingham and Solihull** | Brendan Hayes |
| **Certitude** | Liz Durrant |
| **Cygnet** | Julie Kerry |
| **Devon Partnership NHS Trust** | Dr Paul Keedwell |
| **Mersey Care** | Dr Jennifer Kilcoyne |
| **Northumberland Tyne and Wear** | Dr Keith Reid |
| **South London and Maudsley** | Dr Faisil Sethi |
| **Voluntary Organisation Disability Group** | Dr Rhidian Hughes |
| **West London Mental Health Trust** | Jimmy Noak |

## Other relevant forums/experts

| | |
|---|---|
| **ADASS** | Helen Toker-Lester |
| **Caring Solutions** | Dr Colin Dale |
| **European Assoc. for MH in ID** | Dr Roger Banks |
| **European Network** | Dr Brodie Paterson |
| **NAPICU** | Andy Johnston |
| **National Collaborating Centre for Mental Health** | Tom Ayers |
| **NHS Confederation Mental Health Network** | Sean Duggan |
| **North London STP** | Chris Dzikiti |
| **North West AQuA** | Paul Greenwood |

# Restraint Reduction Network (RRN)

# Training Standards 2019

## First edition

James Ridley
Sarah Leitch

The Restraint Reduction Network (RRN) welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings.

The RRN is an independent network which brings together committed organisations with a shared vision of reducing reliance on restrictive practices and making a real difference in the lives of people who use services across education, health and social care services.

These standards have been developed with the support of Health Education England and the Royal College of Nursing to provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

ISBN 978-1-905218-44-8

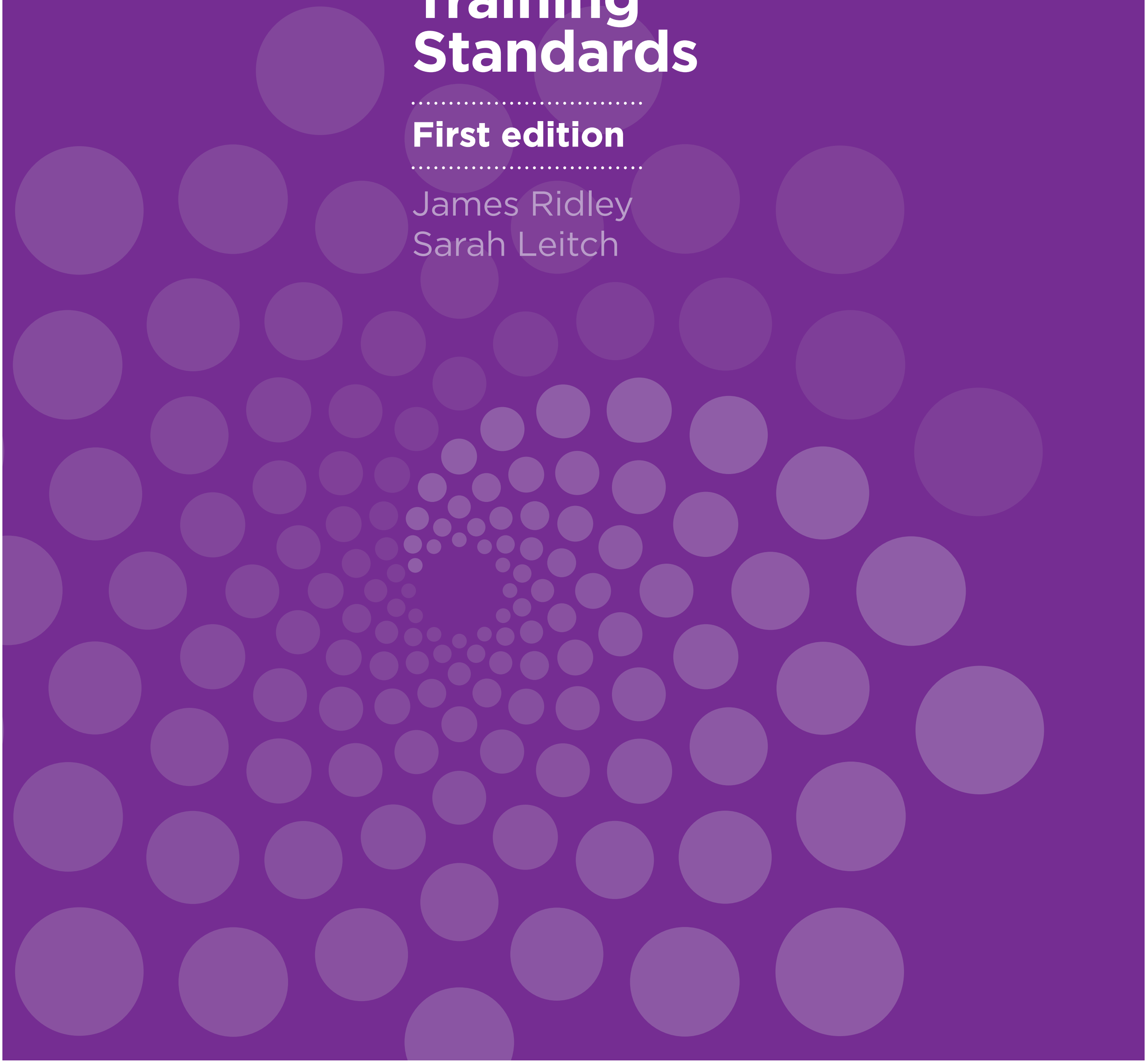
In addition to improving training and practice, the standards will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

These standards have been developed in partnership with and endorsed by

Restraint
Reduction
Network

Ethical training standards
to protect human rights
and minimise restrictive
practices



# Restraint Reduction Network (RRN) Training Standards

## First edition

James Ridley
Sarah Leitch

Ethical training standards
to protect human rights
and minimise restrictive
practices

# Restraint Reduction Network (RRN)

# Training Standards

## First edition

James Ridley
Sarah Leitch

**British Library Cataloguing in Publication Data**

A CIP record for this book is available
from the British Library

First published 2019
Version 1.2 published January 2020

**BILD Publications is the imprint of:**

British Institute of Learning Disabilities
Birmingham Research Park
97 Vincent Drive
Edgbaston
Birmingham B15 2SQ

Telephone: 0121 415 6960

E-mail: RRN@bild.org.uk

Website: Restraint Reduction Network

ISBN 978 1 905218 44 8

Printed in the UK by
Page Bros (Norwich) Ltd

Copy editing by Helen Fairlie

Design by Sarah McCall

# Contents

# Foreword

You may not know us, but we want to tell you about something very personal that shattered our lives and changed our family forever.

This is a photo of our son Seni with his grandmother. Everything you need to know about him is here in this beautiful picture. He was our baby and a gentle giant. He hated bullying and was always looking out for the less able and vulnerable people in society.

Seni was just 23 years old – an IT graduate – when he died in hospital on 3 September 2010. He died because of prolonged restraint, when he was held down by 11 police officers while he was a patient in a mental health hospital.

Seni had never had any mental health issues before, but over that bank holiday weekend in 2010 he seemed agitated and his behaviour became odd. We took him to A&E and, after an assessment, we were told to take him to Bethlem Royal Hospital. We took him there, to what we thought would be the best place for him to get help.

Seni agreed to stay overnight at the hospital as a voluntary patient. We were asked to leave him at the end of visiting hours, and we did so reluctantly. Shortly afterwards, he became agitated when he was stopped from leaving the hospital because he wanted to come home. The hospital staff 'sectioned' him and called the police who came and agreed to take Seni to a seclusion room in the hospital. He was co-operative until he stopped at the threshold of the seclusion room. As soon as he stopped, the police officers pushed him inside and forced him face down to the floor.

The police officers held Seni face down, shackled his hands with two sets of handcuffs and put his legs in two sets of restraints. They held him down like that over a period of some 45 minutes altogether, in a restraint they knew was dangerous, until he went limp. And even then, instead of treating him as a medical emergency, they simply walked away: they believed he was faking it! They left our son on the floor of a locked room, all but dead. All of this happened in the presence of hospital staff including nurses and a doctor who stood by and looked on, unable or unwilling to intervene. Seni never regained consciousness and died four days later. That is how we lost our beloved son.

At the inquest into his death, the jury found Seni died as a result of excessive, disproportionate and unreasonable restraint and force. To this day, we struggle to comprehend that our son died as he did, simply because those who were responsible for his care – police officers and medical staff alike – failed in their duty to treat him with the respect that he deserved as a human being.

In a signed statement after these events, one doctor described how the officers treated our son: 'I felt like it wasn't a human being that they were trying to restrain … it was like trying to contain an animal … after they had tied him up with the straps it seemed like when a hunter has tied the animal … it was an uneasy feeling that I had that it was not a human being that they were restraining'. That is how he was seen and treated at that point: as an animal, rather than a petrified young man, terrified at the prospect of being put in a padded seclusion room.

We don't want anyone else to go through this. We have been fighting for over eight years to get answers and justice for Seni. Now, through initiatives in his name – such as Seni's Law, a parliamentary bill with cross party support designed to open up the system to greater transparency and accountability to stop the disproportionate use of force and restraint – we feel that our son may not have died in vain. If we can make sure this never happens to anyone else, that would be an amazing legacy for Seni.

That is why we are really pleased to see the publication of these new standards, but this must be just the beginning. There is so much more to do in view of the increasing number of deaths in the context of restraint. In addition to health, education and social care services, we need to get law enforcement agencies involved in these standards concerning the use of restraint. We need to ensure these standards are not just implemented, but also regulated. And we need to make sure that the use of force and restraint is not just reduced but prevented altogether when dealing with vulnerable individuals who may find themselves in Seni's position in the future.

Aji and Conrad Lewis

"The NHS welcomes the publication of the Restraint Reduction Network Training Standards. These Standards have been written to focus on ensuring training promotes human rights and supports cultural change necessary to reduce reliance on restrictive practices (rather than purely focus on technical skills). Certification of compliance with these Standards will be a requirement in NHS commissioned and CQC regulated services from April 2020"

(Professor Tim Kendall, National Clinical Director for Mental Health, NHS England 2019)

"CQC has been concerned about the use of restrictive practices for some time so we are pleased to see the launch of the new Restraint Reduction Network Training Standards. The Standards will support staff in health and social care services to understand and apply the principles of minimising use of force with the aim of promoting human rights and person centred care of the people they are caring for"

(Dr Paul Lelliott, Deputy Chief Inspector at CQC 2019)

# Introduction

## Background

**The Restraint Reduction Network welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings. The number of organisations endorsing these standards is testament to this.**

The UK has many excellent education, health and social care services that provide person centred therapeutic care. However, there have also been too many shocking scandals exposing the unnecessary and inappropriate use of restrictive interventions on people with mental health conditions, dementia, learning disabilities, and autistic people. Such scandals include Winterbourne View, exposed by the BBC *Panorama* programme, the recent cases of people like Bethany, who was secluded for years resulting in the Secretary of State ordering a serious incident review, and the tragic case of Seni, highlighted within the Foreword, who was restrained by police in a mental health service. (Whilst this case is unusual as it involved the police, it has been highlighted because of its tragic nature, and the fact that it resulted in the Mental Health Units (Use of Force) Act 2018.)

Restraint by its nature restricts a person's liberty, but the frightening, overwhelming and traumatising nature of this experience can amount to degrading treatment, which is never lawful. *'Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others'* (Campbell, 2018).

It is therefore vital that all services sufficiently understand and apply the principles of restraint reduction. However, minimising the use of restrictive practices and interventions is only one part of ensuring that vulnerable adults and children have a good quality of life. Providing therapeutic environments where treatment and recovery can take place is essential. As well as a safe comfortable environment to live in, people also need choice, control, supportive relationships, interesting things to do and learn, and opportunities to be involved in community activities. These are fundamental elements of good quality preventative support and these are the same things we would want for ourselves and our own families.

When the *Training Standards* refer to restraint reduction or minimisation it is in the context of a shared commitment and belief that the use of all restrictive interventions and practices should be minimised.

## Why are the *Restraint Reduction Network Training Standards* required?

**Providing high quality evidence based support to vulnerable adults and children in all settings, across education, health and social care, is a highly skilled activity. The workforce do an important and challenging job (that requires balancing risk, welfare, and safety) and sometimes require specialist training to understand and meet the needs of the people they are supporting so people are less likely to become distressed, but they also need training in how to support people when they are distressed.**

Typically, restrictive interventions are used by staff, carers or family members with the intention of averting harm, minimising the potential for pain or injury and to keep people safe.

There are a number of organisations providing training in supporting people in crisis, and there is a range in the quality of their provision. The lack of quality assurance and oversight of such training programmes leads to a concern that staff may be trained to use a range of restrictive interventions that may not necessarily be appropriate or properly risk assessed for use. These concerns have been highlighted on many occasions through service reviews, and by training commissioners, families and staff who have been through training. The *Training Standards* aim to address these concerns.

Poor quality training focuses primarily on reactive approaches such as physical restraint and places insufficient emphasis on human rights, meeting needs, prevention, de-escalation and recovery. Most importantly, it fails to sufficiently explain the traumatic nature of restraint.

If training places insufficient emphasis on restraint prevention and de-escalation, staff will understandably be more likely to use restrictive interventions as a first resort, rather than last resort, resulting in an over reliance on restrictive interventions.

Whilst there is some great practice across education, health and social care, there are still too many services that focus on management of behaviour or risk rather than on prevention and better meeting needs. A positive and proactive approach is vital to anticipate potential triggers for behaviour that challenges, and minimise the likelihood of, or avoid the need to use, restraint (DHSC, DfE 2019).

An over reliance on restrictive practices in services can create toxic culture characterised by the cycle of trauma for both staff and patients (Paterson, 2013). To be in the position of being restrained or to be part of a team that is implementing a restraint is likely to be traumatising. It is also 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.

In addition, restraints may be employed against some degree of active (physical) resistance. This can result in potentially damaging stresses being imposed upon systems and structures such as the respiratory system, heart, joints and muscles (Aiken et al, 2011). Any restrictive intervention must be based on an assessment that intervention is likely to cause less harm than not intervening. Training that includes restrictive interventions is potentially dangerous and distressing for everyone involved and therefore quality standards are essential.

Eliminating inappropriate use of restraint is particularly vital in relation to children, who are still developing both physically and emotionally and for whom any potentially traumatic experience at this formative stage in their development could be very damaging and have long term consequences to their welfare. Where use of restraint is necessary to safeguard children, young people and others from harm, it should be consistent with clear values and sound ethical principles, comply with the relevant legal requirements and case law and be consistent with obligations under the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities (DHSC, DfE 2019).

# Aims of the *Training Standards*

The *Training Standards* will provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

In addition to improving training and practice, the *Training Standards* will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

# Who are the *Training Standards* for?

This document provides cross sector quality standards that can be applied to training provision where restrictive interventions are included in the curriculum. To understand what is meant by the term restraint or restrictive intervention these standards recommend reference to the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019). The terms restraint and restrictive intervention are used in these standards to mean the same thing.

> *'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around.* (EHRC, 2019)

It is important that the standards are applied consistently to services:

- across education, health and social care
- across children and adult services
- across the UK and internationally
- for all populations, including people with mental health conditions, dementia, learning disabilities and autistic people in order to consistently minimise the risk of physical and psychological harm to all people in all settings in all nations in the British Isles

The *Training Standards* support the human rights of all populations and may be useful to the private security industry, but are not specifically designed for training providers outside of education, health and social care sectors.

Staff must have face to face training in preventative/primary strategies and secondary strategies before they are taught to use restrictive interventions. In some organisations it may be more appropriate that a different training provider manages the face to face training in a preventative model such as Safewards.

The *Training Standards* can apply to all training providers, including:

- commercial training providers who deliver training to a range of organisations
- in-service training providers who develop their own training and only deliver within their organisation

(Service providers who develop and deliver their own training but also sell or deliver training to other organisations will be considered commercial)

The *Training Standards* will be mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2020. This includes services in the independent, private and voluntary sectors. Other UK countries may benefit from following the principles and standards, albeit within a devolved legislative context, where country specific legislation applies.

Health Education England (HEE) welcomes the fact that the Restraint Reduction Network has delivered training standards suitable for use within mental health and learning disability NHS commissioned units. It is our sincere hope that the use of the *Training Standards* in an accredited certification scheme will reduce the number of occasions restraint is required and help to make those occasions that restraint is unavoidable safer and dignified.

The standards apply across the lifespan. However, it will be vital that a developmental perspective is taken and that the fragility of some individuals is given proper consideration – for example, pre-pubescent young people, people with severe eating disorders, and those who are living with dementia and at end of life who often have significant weight loss.

Whilst the *Training Standards* focus on training, and support training providers, it is important to recognise the significant responsibilities of service providers in ensuring these principles are applied in practice and a positive culture of care and support is promoted. Training alone is not human rights based nor is it sufficient to facilitate cultural change. Therefore the *Training Standards* complement new guidance for service providers in minimising restrictive interventions: *Towards Safer Services*. There is an important role for the regulator in ensuring services implement the *Training Standards*.

The implementation, embedding and maintenance of the *Training Standards* will also be viewed by regulators and inspectors, as well as concerned family members, to be indicative of an organisation committed to best practice and characterised by therapeutic care and support.

The *Training Standards* may also be useful to support:

- commissioners of training
- commissioners of services
- regulators of services
- individuals who have lived experience of services
- families, carers and advocates

For more information on (UKAS accredited) certification of compliance with the *Training Standards* (including a list of certified training organisations), please visit the Restraint Reduction Network website. Only certified training organisations will be licensed to use the Restraint Reduction Network certified™ logo.

# How have the *Training Standards* been developed?

The Restraint Reduction Network was initially established to bring together those passionate about reducing reliance on restrictive practices across education, health and social care. The Restraint Reduction Network is a registered charity and is free to join. All members pledge their commitment to reduce reliance on restrictive practices. The Restraint Reduction Network steering group includes representation from government departments, professional bodies and regulators, as well as charitable organisations and representatives who have lived experiences of restraint.

The Restraint Reduction Network started to develop training standards in 2017. In 2018 there was increased focus on restraint reduction within government departments and arm's length bodies. This included a significant cultural change programme within the NHS. As part of this programme of work Health Education England were asked to ensure quality standards were in place for training and that training was certificated as complying with the *Training Standards*. Rather than reinventing the wheel, Health Education England (on behalf of the NHS) commissioned the Restraint Reduction Network to develop the *Training Standards* for training in the prevention and use of restrictive interventions to support best practice in supporting people (across the lifespan) who may become distressed and meet the requirements of training within the Mental Health Units (Use of Force) Act 2018.

Health Education England has worked with the Restraint Reduction Network and the United Kingdom Accreditation Service to develop a process for certifying training with a view to all providers of NHS funded mental health, learning disability and autism services being required to use accredited training services. In addition, local authority commissioners intend to make UKAS accredited training services a requirement of social care contracts. *For more information on (UKAS accredited) certification of compliance with the standards please visit the Restraint Reduction Network website.*

The *Training Standards* are evidence based and informed by government policy, guidance and the consensus views of professionals and experts in the field.

A wide range of critical readers have contributed to the development of the *Training Standards* including representatives from a number of professional bodies, government departments and arm's length bodies. (For more details please see Acknowledgements.)

The standards will be updated at least every three years and will reflect the burgeoning knowledge base and developments in research, policy and practice. (This version will be reviewed by 2022 – feedback can be sent to RRN@bild.org.uk)

This edition considers physical, mechanical and environmental restraint. The next edition will increase the focus on social restraint, chemical restraint, seclusion and segregation, and consider a wider range of settings including mainstream schools, criminal justice services and accident and emergency services. Changes and adaptations to this version will be announced on the website.

## How to use the *Training Standards*

The first part of this document is a rights based framework, in which all training must be delivered. Training providers seeking certification for their programmes will need to use the framework when designing their curriculum.

The curriculum standards focus on the fundamental principles across all settings and populations. These include prevention, de-escalation, reactive strategies and recovery.

There are specific standards to ensure that trainers have the appropriate levels of expertise, experience and competence.

There are also a number of appendices which document any specific considerations or adaptations to the standards that should be taken into account for different populations or settings. The appendices will be subject to a continuous review timetable, therefore the most up to date versions will be available online.

Any text in **bold** or regular text font is a requirement of the standard and is therefore mandatory, and *any text in italics offers extra explanation or guidance.*

# Reviewing and updating the *Training Standards*

The review process will be facilitated by the Restraint Reduction Network Director with support and scrutiny from the Trustees of the Restraint Reduction Network who represent professional bodies, arm's length bodies and people with lived experience.

The *Training Standards* will be updated within three years and a review of research will start in the second year and will follow the process set out below. Ongoing public feedback will be gathered through email and consultation on the Restraint Reduction Network website. Feedback will also be sought from all certification bodies and certified training providers. The appendices will be updated as part of an ongoing process over the three years – through small expert reference task and finish groups.

1. Review of related research, evidence and (NHS) data in second year of publication

1 month

2. Survey Monkey to elicit views of stakeholders, including the NHS Expert Reference Group for Restrictive Practices, on any updates or changes needed

1 month

3. Independent thematic review of Survey Monkey and research

1 month

4. Changes indicated and logged with rationale for inclusion or non inclusion

1 month

5. Critical readers from endorsing organisations, including NHS-E/I, review changes through Survey Monkey

1 month

6. Independent thematic review of critical reader feedback

1 month

7. Final changes proposed and logged with rationale for inclusion or non inclusion

1 month

8. Restraint Reduction Network steering group and endorsing organisation approval and sign off

1 month

9. Proof reading, design and publication

within 2 weeks of publication

10. Certification bodies informed of changes

# A rights based framework for training

This section covers the overall context and framework of law and values within which any training in the use of restrictive interventions must be provided.

## Contents

**Training must be provided with clear reference to supporting an overall human rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.**

Human rights apply to any person receiving care and treatment, and these rights must be at the centre of decision-making. The Human Rights Act 1998 applies to all public authorities, and all training must be informed by the legal duties of staff to respect and protect these human rights. Training must also make clear that human rights apply to the person's family and carers, and others receiving treatment (eg patients on a ward) and staff involved in the person's care and support.

The training must support the reduction of the use of restrictive interventions and ensure consideration of alternative responses to distress or behaviours of concern, including a focus on prevention and secondary responses such as de-escalation.

Any use of lawful restrictive intervention must be rights-respecting. This means it must not cause harm, including unintended harm, which amounts to degrading treatment, which is never lawful (see Article 3). All reasonable steps must be taken to protect a person's right to life, including stopping the use of an intervention or intervening to protect a person from themselves or others; failure to protect life is likely to be unlawful (see Article 2). Importantly, a human rights approach also means involving the person in decision making and taking the least restrictive option (see Article 8).

Training must make it clear that some human rights cannot be interfered with (whether by restrictive intervention or otherwise) and some can be restricted by professionals, but this can only occur when the correct balancing exercise has been undertaken. This balancing exercise, which is required by the law, is an important tool to ensure the proper consideration of the rights of all people involved in restrictive interventions, including staff.

Restrictive practices, including physical restraint, can be characterised as an exercise of power over another individual. In order to ensure this power is never abused, comprehensive safeguards must always be in place. It is essential that such safeguards eliminate any risk of discrimination, harassment or victimisation.

Organisations must ensure that no individual is exposed to any restrictive practice because of their age, mental health status, mental capacity, physical impairment, race/ethnicity, religion and belief, gender (including transgender), HIV/AIDS status, sexual orientation, political opinion, socio-economic background, spent convictions, or on any other grounds which are irrelevant to a decision-making process leading up to any application.

The following will also be important in supporting a rights based approach:

- understanding which human rights cannot, and which can, be lawfully interfered with by staff, including in situations where restrictive interventions are used
- understanding the positive obligation of staff to take action to protect human rights, including safeguarding against serious harm arising from the use of restrictive interventions
- respecting people's right to autonomy (see Article 8) by assuming capacity and ensuring involvement in care decisions, including ascertaining current/previous/future views on the use of restrictive interventions as set out in the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act (Northern Ireland) 2016*
- using restraint as a last or emergency response
- treating distress or behaviours of concern as communicative acts and exploring what this means for the person to help avoid the use of restrictive interventions
- identifying the risks associated with restrictive interventions including, but not limited to, children who are developing physically and psychologically
- understanding the impact of trauma (historic or otherwise) on an individual's mental and physical health and therefore their experience of restrictive interventions – this will be especially important in determining whether an intervention risks being degrading
- considering the impact of restrictive interventions on an individual's physical and mental health, their development and/or recovery, including how this may affect those with sensory processing differences, eg autistic people
- commitment to co-production with individuals with lived experience in the planning, development and delivery of care and treatment
- commitment to ensuring people's needs to participate in decisions are met, eg access to interpreters, appropriate information, advocates, etc
- avoiding blanket policies or standardised responses that do not allow consideration of the person's situation
- demonstration of processes and practices to avoid or minimise the use of restrictive interventions

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Training organisations must show how they have embedded a rights based approach within their curriculum. One example is the ‘PANEL’ framework (Donald, 2012; BIHR, 2013) which supports using a rights based approach:

- **P**articipation
- **A**ccountability
- **N**on-discrimination
- **E**mpowerment
- **L**egality

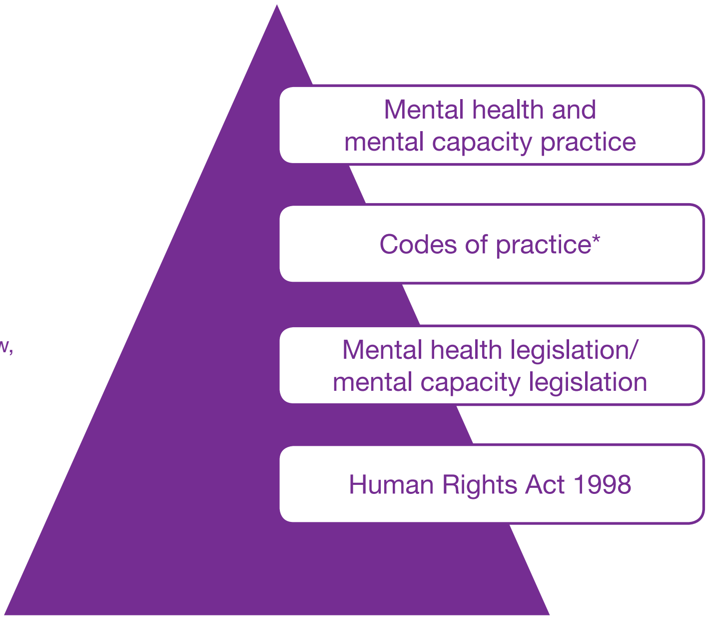
See also BIHR’s guide *The Difference It Makes: Putting Human Rights at the Heart of Health and Social Care* (2013) which explains the benefits of using a rights based approach, using PANEL (available at BIHR ).

## The relationship between legislative frameworks involved in restrictive interventions

**Training must ensure that the relationship between the Human Rights Act and other legal frameworks relevant to the use of restrictive interventions is understood and those laws are applied in a way that is compatible with the person's rights.**

Training must make clear reference to how the Human Rights Act 1998 and other key legislation work together in practice. Essentially, other legislation should be interpreted and applied in a way that is compatible with people's human rights. Figure 1 (BIHR, 2016) illustrates how the Human Rights Act operates as a foundation for other law, policy, guidance and practice.

Figure 1: **The Human Rights Act 1998 as a foundation for other law, guidance and practice**



* This can be for any codes of practice. The HRA is the foundation, then the next levels up – the law, the codes of practice, the practical decision-making and service delivery – sit on top of that foundation. The same process could be applied to any other statute, eg Mental Health Act, Care Act, statutory guidance etc

The following legislative frameworks must be included in training, as they may provide legal authority to interfere with a person's rights when restrictive interventions are being used in situations, or may otherwise be relevant:

- Mental Health Act 1983 (amended 2007)
- The Children's Act 1989 (as amended) and the Children and Families Act 2014
- Criminal Law Act 1995
- Criminal Justice Act 1995
- Adults with Incapacity (Scotland) Act 2000
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards (DOLS) or its equivalents)
- Equality Act 2010
- The Care Act 2014
- Mental Health Act Code of Practice 2015, Chapter 26
- Mental Capacity Act (Northern Ireland) 2016*.

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Training must also include relevant devolved legislation and/or legislation focused on specific groups of people.

## Training must be person centred, focusing on the human rights of the person involved in the use of the restrictive intervention, preventing unlawful breaches of rights, and taking positive steps to protect rights.

A person's wishes and feelings must be respected. Human rights law, together with mental capacity law, starts from the presumption that people have the capacity to make decisions about their own care and treatment. Where there are doubts about a person's capacity to make a specific decision, a mental capacity assessment must be conducted, and if needed a substituted decision can be made following a best interests assessment. However, the rights of that person to have their wishes and feelings considered during this process remain central and this process must be clearly recorded in their care plan. Even where a Mental Capacity Act assessment finds a person does not have capacity to make a specific decision (eg about treatment or refusal of treatment), the law requires respect for their right to autonomy (see Article 8). This means ensuring participation and involvement as far as possible, which may include providing specific support, eg interpreters, information in specific formats, etc. This will be important when staff are deciding whether or not to use a restrictive intervention, determining the least restrictive option, and how to make interventions. Training must make it clear that compliance with the Human Rights Act 1998 means both:

- refraining from taking action which unlawfully breaches rights, eg not using restrictive interventions that cause serious harm and safety risks (Article 3), and
- taking positive steps to protect rights, eg using proportionate restrictive measures (Article 8) to protect someone in care from taking their own life (Article 2)

The Human Rights Act 1998 sets out 16 rights (‘Articles’) which belong to all people in the UK in all situations. Training is expected to cover those Articles likely to be relevant to the use of restrictive interventions, for example:

**Rights which cannot be lawfully restricted (including by use of restrictive interventions):**

- The right to life (Article 2): in health and care settings this right is absolute; any restrictive intervention that compromises this right will not be lawful
- The right to not be treated in an inhuman or degrading way (Article 3): the use of some restrictive interventions may breach this right, including where serious physical or mental harm results either deliberately (abuse) or where it is not intended (neglect). The focus is primarily on the impact on the individual rather than the intentions of staff

**Rights which can be lawfully restricted (including by use of restrictive interventions):**

- The right to liberty (Article 5): whether this right can be restricted will depend on the legal basis for the action (see standard 1.2) and ensuring that the safeguards in the right have been met (eg knowing why liberty is being restricted and being able to challenge the decision)
- The right to respect for private and family life (Article 8): this ensures a person's physical and mental wellbeing and their personal autonomy, including involvement in care and treatment decisions. Restrictive interventions can significantly interfere with this right; this will only be permissible if actions are: (1) permitted by a legislative framework; (2) for a legitimate aim set out in the right way (usually protecting the person or others); and (3) proportionate (ie least restrictive option)

**Rights of children:**

- The United Nations Convention on the Rights of the Child (UNCRC) ensures all children have the right to be heard and protected from harm and provides guidance for best interests test
- Children and young people with learning disabilities and/or autism, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present (DHSC, DfE 2019)

**Rights of people with disabilities:**

- The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 12 ensures equal opportunities of people with disabilities to exercise their legal capacity and rights to liberty as well as freedom from degrading treatment and exploitation

**Non-discrimination:**

- The right to not be discriminated against in relation to the above human rights (Article 14): this could include use of restrictive interventions which restrict liberty for discriminatory reasons, eg on the basis of ethnicity, age or other status, and any combination of these characteristics. The Equality Act also protects against discrimination on the basis of one (not a combination) of nine protected characteristics (all also covered by human rights law). Additionally, the Equality Act also sets out the public sector equality duty on services to consider how their policies and decisions affect people who may be discriminated against due to one of the nine protected characteristics ( EHRC ).

Training must make reference to contexts in which the use of a restrictive intervention may or may not be a lawful restriction on a person's human rights. For example:

- The right to liberty may be restricted if permitted by law for the purposes of mental health/capacity care (Article 5, Schedule 1, Human Rights Act 1998). The Mental Capacity Act 2005 can provide authority for restraint under Section 6, where (a) a person lacks capacity and (b) it is reasonably believed to be necessary and proportionate to protect them from harm. Additionally, Chapter 26 of the *Mental Health Act Code of Practice* (England and Wales) sets out guidance related to the use of restrictive practices for people detained under the Mental Health Act 1983 (Department of Health, 2015). (See also Mental Health (Care and Treatment) (Scotland) Act 2003; *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a); Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016*

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Opportunities for discussion and analysis of scenarios related to the use of restrictive interventions in a range of settings must be provided in any training, and the potential impact of this on a person's human rights must be explored. Examples covering various service models and the relationship between human rights, mental health and mental capacity law can be found in the British Institute of Human Rights (BIHR) *Practitioner Toolkit Series* (BIHR, 2016b), BIHR Practitioner Toolkits.

# Training standards

The next four sections cover the process from engagement with an organisation to development of the curriculum, its delivery and the cycle of feedback afterwards. Figure 2 (on page 35) displays this process.

Training providers must show that they have a process which meets the standards and they must be able to provide evidence needed at all the different stages.

Section 1: Standards 1.1–1.8

**These standards cover the part of the process that needs to be completed before a curriculum is developed.**

Section 2: Standards 2.1–2.15

**These standards cover what must be included in the curriculum.**

Section 3: Standards 3.1–3.6

**These standards relate to post-delivery processes.**

Section 4: Standards 4.1–4.7

**These standards relate to trainers.**

## Section 1

# Standards supporting pre-delivery processes

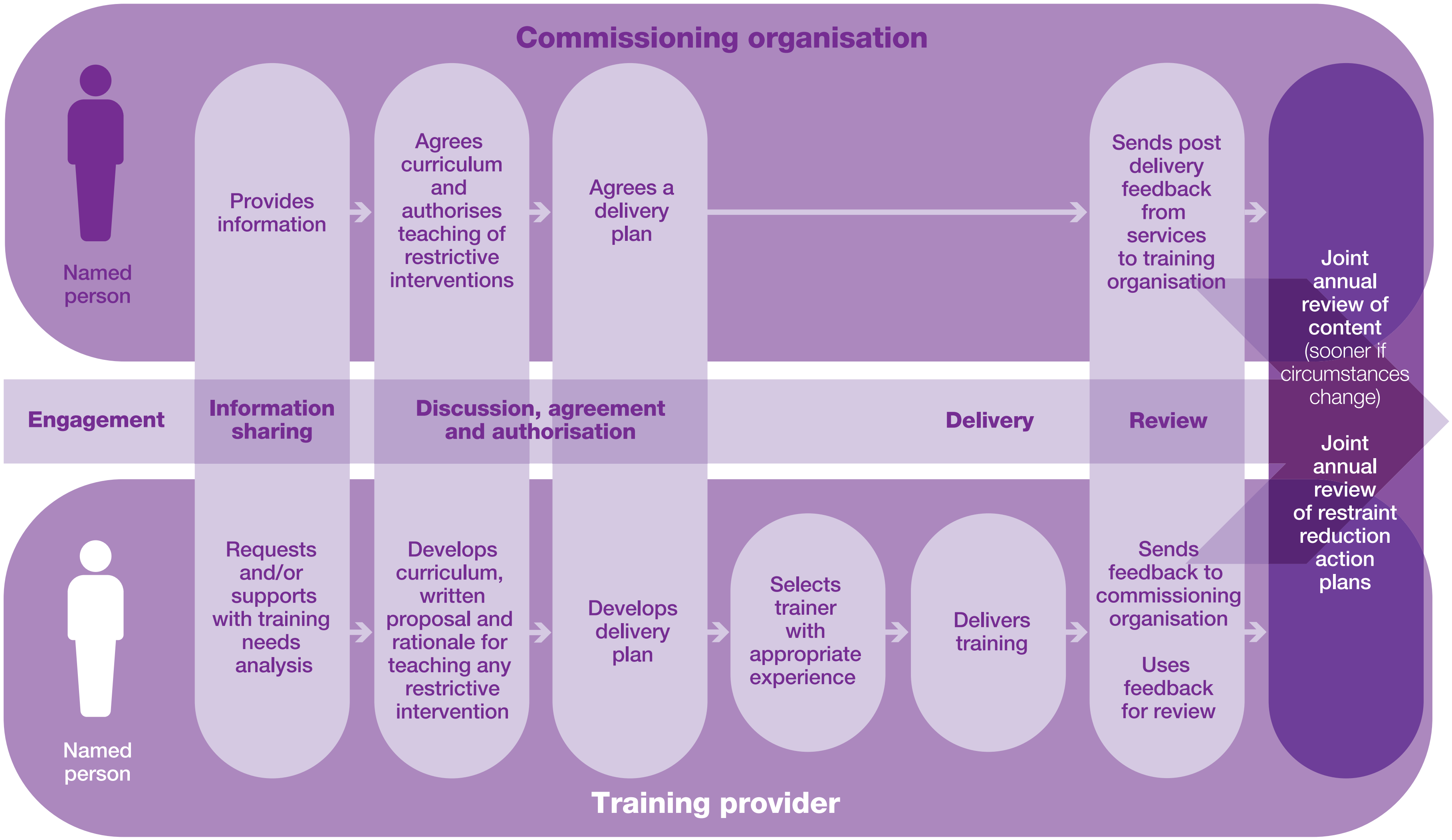
Standards 1.1–1.8 cover the part of the process that needs to be completed before a curriculum is developed and authorised.

Alongside these standards, please refer to Figure 2 (on page 35), which depicts the process for the commissioning, development, delivery and review of training with a restrictive intervention component.

# Standards

| | |
|---|---|
| Standard 1.1: | **Training needs analysis** |
| Standard 1.2: | **Developing and authorising the content of the training curriculum** |
| Standard 1.3: | **Independent risk assessment of techniques** |
| Standard 1.4: | **Committing to the reduction of use of all restrictive interventions and practices** |
| Standard 1.5: | **Involving people with lived experience** |
| Standard 1.6: | **Agreeing delivery plans** |
| Standard 1.7: | **Providing accessible information** |
| Standard 1.8: | **Responding to concerns and complaints** |

Figure 2: Process for the commissioning, development, delivery and review of training with a restrictive intervention component



## Introduction

Before developing and delivering any training, a good training provider engages with the organisation or service that needs training and finds out as much information as possible about the needs and characteristics of the staff and the people they support. This means they are confident that the training they provide is appropriate, proportional, meets identified needs, and any elevated risks are highlighted and adjustments made where needed.

Figure 2 illustrates the process for the development, delivery and review of training. It shows how the commissioning organisation and the training provider should work together to ensure all training is safe and designed to meet the needs of the people being supported by the commissioning organisation and the people who are receiving the training. Both parties must be responsible for ensuring the training is developed and delivered within a framework that is person centred and minimises the use of restrictive practices and that there is evidence that the training is monitored, reviewed at a minimum annually and adjusted where needed.

In the commissioning organisation the named person responsible for restraint reduction is usually the restrictive practices reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation. Both people are responsible for the annual review of the curriculum.

Where training is both developed and delivered in-house, the same process of development, delivery and review must be followed although there may only be one named person.

## Standard 1.1

### The curriculum must be based on a training needs analysis (TNA) which must be completed by the commissioning organisation before the curriculum is developed and delivered.

1.1.1 **As part of the commissioning process the training provider must request a training needs analysis (TNA) from the commissioning organisation.**

The TNA must include the current needs and risks posed to everyone based on current evidence and the past two years of incident data. It must be authorised by someone in the commissioning organisation who holds responsibility for restrictive intervention governance and reduction.

The TNA must consider the training needs and risks posed to all staff who may come into regular contact with distressed people or challenging situations including clinicians, teachers, and direct support staff.

*In some cases the training provider will need to support the commissioning organisation to complete the TNA as part of the commissioning process or may need to request extra information. A TNA checklist can be found here* RRN Training Standards – materials to download

1.1.2 **The data that training providers request and receive from the commissioning organisation must be managed in line with the Data Protection Act 2018 (the UK implementation of the General Data Protection Regulation (GDPR)). Any data relating to specific individuals must be in an anonymised form.**

1.1.3 **As part of the agreement to provide any training in physical restraint and before commencing the training, both the training provider and the trainer who delivers the programme must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see Resuscitation Council (UK) ).

In some cases this training will be provided by the training provider as part of the content of training and in other cases another provider will have delivered this.

1.1.4 **The training provider must ensure that the curriculum takes account of elevated risks to populations and individuals.**

The training provider must ensure any and all restrictive interventions take into account any known factors that may cause an elevated risk of harm at population and service level, and that arrangements are in place to ensure that any known risks are considered at the individual level.

Therefore agreement must be reached between the training commissioner and the training provider about how the information needed to support this process is transferred from one to the other. An anonymised summary of information must be received as part of the TNA. This should include any population or person-specific characteristics for people who are likely to be in receipt of restrictive interventions by the staff undergoing training. As a minimum, this information must include:

- range of age, gender identity, cultural heritage, diagnosis
- any known sensory processing issues that may elevate the risk of harm to a person if a restrictive intervention is used
- any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used
- any known emotional or psychological characteristics or current and potential issues and problems that may elevate the risk of harm to a person if a restrictive intervention is used. This should include, if known, reference to any past trauma
- any known developmental issues that may elevate the risk of harm to a person if a restrictive intervention is used

*A good practice checklist for personalised wellbeing risk assessments for use by commissioning organisations can be found at:* RRN Training Standards – materials to download

1.1.5 **The training provider must receive the TNA from the commissioning organisation in sufficient time so that training can be tailored appropriately and all the requirements in standards (section 1) can be met. Please note that it could take up to one month to complete all these activities, before training is delivered.**

## Standard 1.2

### A named person in the training provider organisation must develop a written proposal for a curriculum including the rationale for teaching specific restrictive interventions.

1.2.1 **The training provider (a named person) must develop a written proposal for the curriculum that covers both theory and practical elements.**

If restrictive interventions are being taught, participants must have completed a minimum of two days' training (12 hours) in the underpinning theory, including training in preventative and secondary strategies, as specified in standards 2.1–2.15, prior to participating in a practical, physical skills training session. The majority of these two days must be face to face to ensure that discussion and demonstration can take place, and blended learning could be considered for some elements where it enhances understanding. Training providers must be able to evidence that the training methods they choose are effective in supporting learning and cultural change. Participants must not be taught to use restrictive interventions unless they have received prior training in primary preventative strategies.

*In some cases, training that covers primary preventative strategies (see standard 2.5) have been covered on separate training courses, for example, Safewards or Positive Behaviour Support. In this case the underpinning theory requirement can be reduced to a minimum of one day (6 hours) but must include all elements of theory specified in standards 2.1 to 2.15 with the exception of standard 2.5.*

*If this is the case as part of the agreed delivery programme the training provider must clarify with the commissioner that this training will be provided to any staff before they attend training with a restrictive intervention component. This should be clearly documented in the agreement to provide training.*

*In some cases training may be delivered as part of a modular programme.*

### 1.2.2 The proposal must be based on information in the TNA provided by the commissioning organisation.

The written proposal must include as a minimum:

- who the training is intended for
- aims, objectives and learning
- outcomes for each programme
- training methods*
- timings
- assessment methods
- rationale that justifies the inclusion of each restrictive intervention in the programme. This may be in any format but must include the following as a minimum (RRN Training Standards):
    - name and description of restrictive intervention (diagram or photo)
    - rationale for use (why and in what situation)
    - how the intervention will be taught to staff and how competence will be tested
    - general safety issues for staff during teaching and practice
    - any person specific safety issues for staff during teaching and practice (where information has been provided, and adjustments need to be made)
    - any issues that may compromise the fidelity of the technique between the taught version in the classroom and its application in practice. This must include a description of how any identified issues may compromise both safety and effectiveness
    - general safety guidelines, supporting those restrictive interventions authorised for use at population level
    - person centred safety guidelines, supporting personalised restrictive interventions
    - a statement that the restrictive intervention must be used as taught and not modified, unless authorised by the training provider

* If simulated role play is proposed as part of the curriculum the level of force must be justifiable, appropriately risk assessed and training ratios reflected accordingly

1.2.3 **If the TNA identifies specific staff groups whose job role means there is only ever a small risk of them being involved in challenging situations (for example administrative staff or maintenance staff) they may only require a short course that covers de-escalation and breakaway skills.**

In this case a one-day programme could be developed and delivered, where the breakaway training does not have a restrictive component (ie the techniques do not use physical restraint).

The shorter programme must be framed in a human rights framework and must as a minimum meet all the standards, with the exception of the content described in standards 2.4, 2.5, 2.7, 2.8. 2.9, 2.10 and 2.12.

The programme must include enough time for demonstrating, practising, and assessing participants as competent to use general de-escalation and other secondary strategies as set out in 2.6 as well as the non-restrictive breakaway skills. It should ensure that participants are given an understanding of why people may be upset and distressed. It must also make reference to the recording and reporting requirements if an incident should occur.

The ratio for teaching theory, de-escalation and breakaway skills is a maximum of 1 trainer to 18 participants unless there is an element of physical restraint in any of the techniques. If the TNA indicates that techniques that have an element of physical restraint are needed, participants will have to complete a full programme that meets all standards.

The definition of physical restraint used by these standards is found in standard 2.8.6: '**Physical restraint** is any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also called manual restraint, physical intervention and restrictive physical intervention.'

1.2.4 **In the case of direct support staff members who are at risk because of a crisis situation and have not yet received full training, they could attend a one-day programme as described in standard 1.2.3 as an interim to learn non-restrictive breakaway skills as above.**

This programme must only ever be delivered to a minority of staff in exceptional circumstances and must never be the default course. The following criteria must be applied:

- All participants must complete a full programme that complies with all the standards within one month of completing the emergency programme
- The TNA and written proposal must indicate the date of the full programme
- Certificates of attendance for participants who attend emergency programmes must also indicate the date by which a full programme must be completed
- The training is not transferable to other settings

1.2.5 **The training provider must also provide a 'training information sheet' that must be made available to participants in advance.**

It must include:

- an overview of the theory training
- an overview of the practical training, including the length of the session
- a brief description of the nature of the training sessions, and any specific physical requirements – for example, most techniques are passively practised in a standing or occasionally seated position, or there is a requirement for learners to be able to move from a kneeling to standing position during one procedure
- any specific requirements in terms of suitable clothing or footwear
- how to find out any more information prior to the training taking place

## Standard 1.3

### Training providers must ensure that each physical restraint technique that is included in the curriculum is holistically risk assessed.

The risk assessment must include:

- trainability, complexity, effectiveness, and fragility of the technique
- risk factors to people including moving/manual handling risks physical/physiological risks, psychological risks (risk of causing or retriggering trauma) and risks to dignity

Risk assessment must consider evidence from injuries that have previously occurred in training this technique and any injuries or harm from its application in real life.

Factors that cause elevated risk must be identified. A risk assessment tool is provided. Alternatively, training providers may use their own tool that covers the required criteria.

1.3.1 **The training provider must ensure that the commissioning organisation receives a current risk assessment for each physical restraint being taught.**

1.3.2 **The training provider must identify the appropriate person or persons with relevant experience to assess risk in each area of the risk assessment.**

Different clinicians are likely to be needed to contribute to different aspects of each risk assessment (for example an expert in biomechanics would be involved in assessing biomechanical risks). The whole final risk assessment must be independently reviewed by an external person with significant experience of providing training in restrictive practices for the population the restraint is intended for use with. An external person could potentially be someone with lived experience or be a peer reviewer from another provider of certified training.

1.3.3 **The risk assessment for each physical restraint must be reviewed every two years minimum, and any time that an adaptation is made to it, or a risk assessment is requested in the context of an investigation. Records of reviews must be documented.**

1.3.4 **The risk assessment for each physical restraint must ensure the suitability of the physical restraint for the population it is intended for.**

The risk assessment for each physical restraint must record any potential of risk in the following areas:

- psychological or emotional harm, as well as reference to potential risk factors such as prior trauma experiences
- risks to dignity
- trainability and complexity of the technique, including the level of skills, coordination and fitness required to carry out the technique correctly
- the fragility of the technique – that is the extent to which risks may be elevated and safety compromised by any margin of error in application
- physical harm, as well as reference to any general potential risk factors such as illness, impairment or injury, or issues specific to a named individual which may elevate risk
- restricted breathing, as well as reference to any general potential risk factors such as obesity, positioning and intoxication or issues specific to a named individual which may elevate risk
- circulation, as well as reference to any general potential risk factors such as limb position and bodyweight being used to hold someone, or issues specific to a named individual which may elevate risk
- joint functioning, as well as reference to any general potential risk factors such as the hyperextension and hyperflexion of joints, and the unauthorised adaptation of techniques or issues specific to a named individual which may elevate risk

Safety guidance accompanying risk assessments must:

- ensure that any physical restraint avoids vulnerable parts of the body (such as neck, chest and sexual areas)
- emphasise the need to minimise absolutely the time any individual is subject to any form of restraint
- include recommendations on the level and type of observation that accompanies any application and post-application monitoring period. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe the signs of distress which should be actively monitored for. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe those aftercare arrangements that are required to maximise recovery and minimise any potential traumatising effects of any restraint

1.3.5 **All trainers must have access to authorised information about the risks or elevated risks for any restrictive interventions they are teaching.**

This may include anonymised information, as well as risk assessments supporting the use of restrictive interventions at both population level and person centred level (standard 1.1.4).

1.3.6 **Training providers must ensure that all physical restraint included in the curriculum complies with guidance relevant to country, setting and population** (see appendices 17–20)**. Evidence must be provided throughout the self assessment process to show that the training covers any specific adaptations to the standards or special considerations.**

1.3.7 **These standards do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply** (see also appendices 21A and 21B)**.**

## Standard 1.4

### Training must be provided within the context of an explicit commitment to the reduction of all restrictive practices.

1.4.1 **Training providers must be clear in all their communications with any commissioning organisation, ensuring that training is provided within the context of reduction** (see glossary).

1.4.2 **Training providers must use feedback from training programmes as part of both a continuous review and the annual review process.**

1.4.3 **Training providers must review the rationale and continuing need for specific interventions to be included in the programme with the commissioning organisation at a minimum annually and each time the TNA is reviewed.**

1.4.4 **Training providers must have a restraint reduction plan which details measurable outcomes and actions that support the reduction of the use of restrictive practices.**

The plan must be updated at least annually and shared with commissioning organisations or published via Restraint Reduction Network membership. *Restraint reduction resources, including six core strategies and self-assessment tools, are available at* RRN Training Standards – materials to download

## Standard 1.5

### Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions.

1.5.1 **Training providers must ensure that the views and experiences of people with lived experience of being in receipt of restrictive interventions should both inform and be explicit in training content.**

Co-production of materials and training with people who have lived experiences may include the use of monologues, video diaries or other forms to support discussion and interaction with participants. It is recognised that access to the views and experiences of people with lived experience may be through the training provider or in direct partnership with commissioners of training who may have developed opportunities and networks which support participation.

1.5.2 **Training providers must ensure that any direct engagement with people with lived experiences is managed sensitively and safely and is viewed in the context of a professional relationship.**

People with lived experience involved in the training must also receive adequate recompense. People with lived experience must be acknowledged as subject matter experts who are able to enrich and enhance training programmes, and play a valuable role in supporting restraint reduction measures.

1.5.3 **Training providers must ensure proper consideration and planning is given to any co-produced training sessions, if any sessions are to be co-produced and/or co-delivered with a person with lived experience. Sharing lived experiences can be an emotionally intensive experience for both the person with lived experience and the participants. The appropriate support arrangements must be in place.**

## Standard 1.6

### The training provider must agree delivery arrangements with the commissioning organisation before delivery takes place.

1.6.1 **Plans for competency testing and refresher programmes must be agreed with the commissioning organisation in advance and be part of the agreed delivery plan.**

Refresher training must take place as a minimum annually and must include competence testing for minimum content requirements (see standard 3.1.1). Refresher training must have an annual core content and an additional rolling programme of remaining content (see standard 3.1). Refresher or update cycles may in some circumstances be increased in frequency if individual or service circumstances change.

1.6.2 **Training providers must specify and agree the requirements for the training venue with the commissioning organisation as part of the delivery plan.**

1.6.3 **The training provider must describe the physical fitness level required for each programme it is commissioned to deliver as part of the delivery plan.** (See also standard 1.2.3 on the training information sheet.)

1.6.4 **The training provider must agree in advance with the commissioning organisation before any training is developed and delivered how the information needed for record keeping will be held and shared, in line with GDPR data protection rules and legislation.**

1.6.5 **The ratio of trainers to participants when teaching people theory and practical skills must be part of the agreed delivery plan.**

When teaching and assessing competence in practical (eg physical) skills with a restrictive component, the ratio (of trainers to participants) must not be more than **1:12** in line with first aid that also requires competency testing. The participant cohort size cannot be more than 18. A minimum of two trainers will be required if the cohort size is above 12.

Training organisations must evidence that they considered all relevant risks when planning training (and the ratio of trainer to participant is adjusted accordingly) including:

- the risk assessment for each physical restraint technique being taught. Training providers must be able to evidence low risk across all appropriate risk domains where one trainer is used (or that a second trainer is always in place where risks are identified as higher, eg complexity of technique or use of simulation). The certification process will be particularly rigorous in reviewing this
- the training needs analysis (and that this has not identified any elevated risks to people being supported by the service or the staff)
- a risk assessment for the training delivery that takes into account additional hazards (eg the environment)
- if resistance based simulations (or role plays) are being used, a second trainer must be present with one trainer having the responsibility for ensuring safety (see also standard 2.8.11)

Training providers should take into consideration the likely gender balance of participants and trainers.

1.6.6 **Training providers must request in advance any information about reasonable adjustments that need to be made so that participants with additional support needs can maximise their participation in the training event.**

This information must be received at least two weeks before the delivery date. If participants are added to the programme nearer the time, training providers must request that the commissioning organisation also include any information about additional support needs for those participants.

1.6.7 **All training providers and any trainers who are employed by them must as part of the commissioning process provide evidence of both professional indemnity and public liability insurance.**

## Standard 1.7

### The training provider must provide accessible information about the content of the training programme.

1.7.1 **Accessible information must be available to everyone who will be directly or indirectly impacted by the training. The information must:**

- be available to the commissioning organisation to disseminate and also readily available for any individual or representative of an individual who makes a request
- be in a format that best suits people's communication requirements and needs
- cover both the theory and practical aspects of the training. All restrictive interventions that are to be taught must be described, alongside potential risks and the rationale for their inclusion in the programme

## Standard 1.8

### The training provider must have a policy for responding to concerns and complaints.

1.8.1 **The training provider must have a policy that clearly describes how questions, concerns and complaints will be processed and dealt with. The policy must be:**

- available on request
- publicly available, eg through the training organisation's website
- presented in an accessible information sheet (see standard 1.2.3) which should contain the training organisation's contact information

**The policy must include:**

- a time frame for acknowledgment of the complaint to the complainant
- details of how an investigation will take place to determine if the complaint is justified or not
- a process for a root cause analysis of the complaint, and corrective actions
- details of the closure of the complaint and feedback to the complainant

Section

2

# Standards supporting curriculum content

Standards 2.1–2.15 describe areas that the curriculum must cover.

# Standards

| | |
|---|---|
| Standard 2.1: | **Placing the curriculum within a rights based framework** |
| Standard 2.2: | **Duty of candour and duty of care** |
| Standard 2.3: | **Attitudes and attributions** |
| Standard 2.4: | **Considered decision making** |
| Standard 2.5: | **Primary and preventative strategies** |
| Standard 2.6: | **Teaching secondary strategies** |
| Standard 2.7: | **Teaching non-restrictive tertiary strategies** |
| Standard 2.8: | **Teaching restrictive tertiary strategies** |
| Standard 2.8.A: | **Use of mechanical restraint** |
| Standard 2.9: | **Factors that contribute to risk and elevated risk** |
| Standard 2.10: | **Emergency procedures** |
| Standard 2.11: | **Identifying the range of restrictive practices** |
| Standard 2.12: | **Use of data to inform minimisation** |
| Standard 2.13: | **Post-incident support, review and learning** |
| Standard 2.14: | **Trauma informed care and support** |
| Standard 2.15: | **Restraint reduction theory** |

# Introduction

Well-designed training programmes can influence learning, and behaviour change programmes that teach people to restrain may inadvertently reinforce the use of restrictive practices. A good training programme will teach the restrictive interventions as only one small part of a whole range of person centred working practices that aim to prevent and minimise distress and crisis rather than the primary focus being on management.

## Standard 2.1

### Training content must support a person centred and rights based approach.

Training providers must reference the rights based framework found at the front of these standards when developing this part of the curriculum.

*Figure 3 illustrates how training must consider the rights and needs of people who are being trained* ***and*** *the rights and needs of people who are being supported and may be in receipt of restrictive interventions. These rights and needs include universal human rights and are also person specific, setting specific and country specific.*

2.1.1 **Training content must ensure participants understand the importance of adopting a person centred approach at all times.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

2.1.2 **Training content must ensure participants understand the legislation that supports individual rights.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through. Reference in training must be made to:

- the Human Rights Act 1998
- the Equality Act 2010
- the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act (Northern Ireland) 2016*
- where relevant, the Mental Health Act 1983 and the Mental Health (Care and Treatment) (Scotland) Act 2003

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

2.1.3 **Training providers and trainers must be aware of current Health and Safety Executive guidance around work based violence.**

Training content must be congruent with the guidance and it must also be referred to in training content.

2.1.4 **Training content must include an overview of relevant legislation, regulations and guidance designed to uphold human and individual rights as they relate to specific populations, settings and nations** (see Appendices 1–20).

## Standard 2.2

### Training content must cover duty of candour and duty of care in all settings.

2.2.1 **Training content must:**

- explore participants' obligations related to duty of candour and duty of care
- include a definition of both duties (for example Care Quality Commission (Regulation 20), 2015) and reference to guidance from the appropriate specific professional bodies for the participants
- explore how both duties relate to practice through examples and show how they contribute to a culture of safety for everyone
- explore where reflective practice can support both duties
- reference and direct participants to the commissioning organisation's whistle-blowing policy and procedures

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

Figure 3: **Diagram demonstrating the layers of guidance and legislation to be considered when developing a training syllabus that has a restrictive intervention component**

## Standard 2.3

### Training content must cover how attitudes to and attributions of distress or concerning behaviours can impact directly on responses to the people being supported.

2.3.1 **Training content must cover:**

- how a range of factors can affect staffs' conscious and unconscious responses to the people they support
- how the language used to describe people, behaviours and restrictive interventions can negatively influence personal and service responses
- how negative attitudes and attributions can contribute to discrimination, power imbalances and the perpetuation of a culture of control
- how staff perceptions of authority and control and team relationships can impact on responses to the people they support (entrenched team cultures – 'the way that things are done here' – or influential team members can impact on the behaviour and practice of others). Please also refer to standard 2.10.

## Standard 2.4

### Training content must cover the use of decision making in response to distress or behaviours of concern.

2.4.1 **Training content must:**

- define the concept of least restriction and this principle must be reinforced through the whole programme
- explore the impact of staff decision making and choices in relation to the use or non-use of any strategies or interventions. This must cover when, where and how to replace, reduce or release those that they have selected. The decision must be safe, lawful and effective
- include discussion about the influences of team culture or relationships with other staff or authority figures as impact factors on staff decision-making processes or the ability to challenge other people's decisions
- cover advanced directives and consent. It is vital that the person themselves is involved in discussions and decisions about what happens and when, and that directives should take into account preferences and wishes of the person
- draw a direct link between decision making and accountability
- refer to organisational protocols and guidance for calling the police to assist in crisis situations. The rationale for police involvement must be explored in detail

*Over reliance on police involvement is not likely to contribute to a culture of therapeutic treatment. Please refer to the memorandum of understanding drawn up by the College of Policing, available at* Protocol for Police and Mental Health Staff

*Figure 4 supports standards 2.5 to 2.8, illustrating the purpose of primary, secondary and tertiary strategies and when they should be used.*

## Standard 2.5

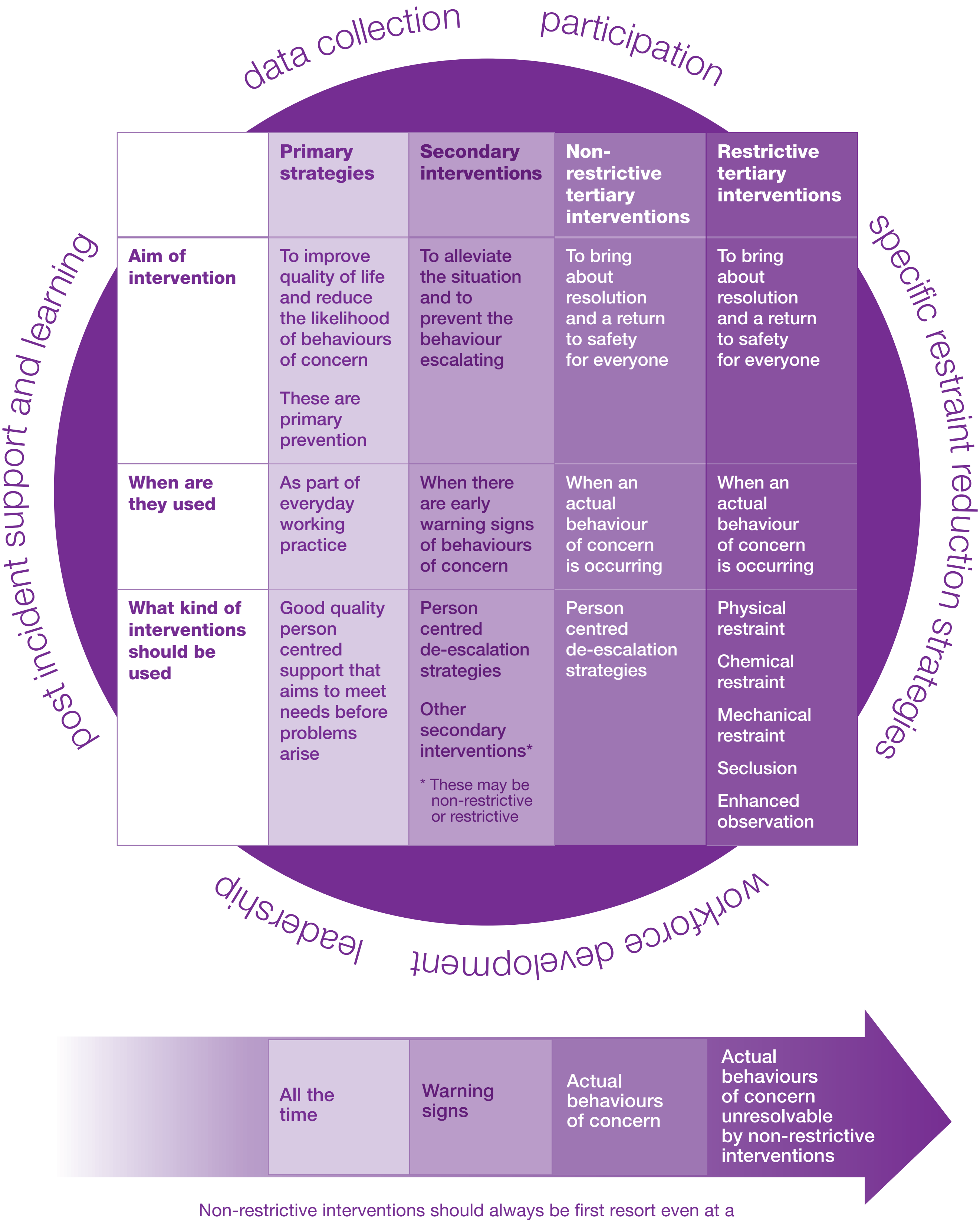
### The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff).*

2.5.1 **Training content must:**

- reference evidence-based frameworks, for example Positive Behaviour Support, Safewards, Recovery models etc for understanding the root causes of distress and the communicative function of behaviours of concern, meeting needs, and creating supportive environments
- support participants' understanding of the potential causes and vulnerabilities associated with the risk of developing distressed behaviours or behaviours that are concerning for the specific populations being supported. *Potential causes and vulnerabilities may include (but are not restricted to) communication difficulties, sensory differences, physical and mental health problems, social exclusion and lack of social relationships, and history of trauma and abuse (Hastings, 2013)*
- include activities and discussion relating to creating cultures of support and developing primary strategies designed to proactively meet people's needs so they are less likely to develop distress or behaviours of concern. *Primary strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of harmful behavioural disturbances (Department of Health, 2015, 26.19–26.22); these strategies may also be referred to as proactive strategies* (see Figure 4)
- explore the impact of the environment and factors that have a negative impact both on the people being supported and staff. The relationship between enhancing quality of life and reduction of restrictive practices must be emphasised
- refer to the role of relationships within the context of meeting need and preventing the development of behaviours of concern. It must also explore what constitutes healthy and helpful therapeutic relationships

* examples of frameworks may include Positive Behaviour Support, Safewards, No Force First, the Recovery model, and/or specific strategies such as Safety Huddles.

Figure 4: **Minimisation matrix showing the different types of interventions and when they should be used within a restraint reduction framework** (NASMHPD, 2008)



| | **Primary strategies** | **Secondary interventions** | **Non-restrictive tertiary interventions** | **Restrictive tertiary interventions** |
|---|---|---|---|---|
| **Aim of intervention** | To improve quality of life and reduce the likelihood of behaviours of concern<br>These are primary prevention | To alleviate the situation and to prevent the behaviour escalating | To bring about resolution and a return to safety for everyone | To bring about resolution and a return to safety for everyone |
| **When are they used** | As part of everyday working practice | When there are early warning signs of behaviours of concern | When an actual behaviour of concern is occurring | When an actual behaviour of concern is occurring |
| **What kind of interventions should be used** | Good quality person centred support that aims to meet needs before problems arise | Person centred de-escalation strategies<br>Other secondary interventions*<br>* These may be non-restrictive or restrictive | Person centred de-escalation strategies | Physical restraint<br>Chemical restraint<br>Mechanical restraint<br>Seclusion<br>Enhanced observation |

Non-restrictive interventions should always be first resort even at a tertiary stage when an actual behaviour of concern is occurring

- include identifying triggers or events that may increase the likelihood that people will become distressed. Participants must be encouraged to think about the individual people they support and how these personalised triggers can be both identified and managed. Participants must also be encouraged to reflect on their own personal triggers and responses to those triggers

## Standard 2.6

**The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating.**

2.6.1 **Training content must:**

- cover a definition and examples of secondary strategies and when they should be considered for use. Secondary strategies may be non-restrictive or restrictive and examples should be given of both (see Figure 4)
- refer to any evidence-based frameworks or models that are used by the commissioning organisation
- include enough time for demonstrating, practising, and assessing participants as competent to use general de-escalation and other secondary strategies
- emphasise the importance of developing person centred, individualised de-escalation techniques and secondary strategies. Participants must be encouraged to relate the use of secondary strategies directly to the people they support
- refer to the importance of keeping records of successful secondary strategies, in line with organisational systems, and how this information can be used to inform reduction plans

## Standard 2.7

### The curriculum must give proportional time to covering the use of non-restrictive tertiary strategies.

2.7.1 **Training content must cover a definition of tertiary strategies (see glossary) and examples of both non-restrictive and restrictive tertiary strategies and when they should be considered for use** (see Figure 4, p59).

Tertiary strategies are used to bring potentially unsafe situations under control. Tertiary strategies do not aim to prevent the situation from occurring again in the future but are used for the exclusive aim of bringing about a safe and timely resolution.

2.7.2 **The curriculum must allow time for discussion and consideration of the safe use of non-restrictive tertiary strategies when there is an actual behaviour of concern occurring. Some interventions used at the secondary stage (early warning stage) can also be used when someone is in distress or there is a risk of harm occurring.**

The interventions may need adapting as the risk presented at this time is greater. These are referred to as non-restrictive tertiary strategies and should always be considered for use before a restrictive intervention is applied. The primary aim is to bring about safe and timely resolution in the least restrictive way.

2.7.3 **The curriculum must have time factored in for demonstration and practice for each strategy and time factored in for each participant to have an assessment of competence in the safe use of each strategy.**

2.7.4 **The trainer must refer to the importance of recording the use of non-restrictive tertiary strategies and how successful the de-escalation attempt was. This information will help support the minimisation plan.**

2.7.5 **Training content must cover any non-restrictive breakaway or disengagement techniques as identified by the Training Needs Analysis.**

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive, or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

Training content must draw attention to potential communicative function of the unwanted physical contact, particularly if the person is unable to verbalise their distress or make themselves understood clearly. The curriculum must have time factored in for demonstration and practice for each technique, and time factored in for each participant to have an assessment of competence in the safe use of each technique.

## Standard 2.8

### Teaching the use of restrictive interventions (may include physical restraint, physical restraint to facilitate seclusion or long term segregation, clinical holding, or mechanical restraint).

*The following restrictive interventions are covered by these standards:*

- *physical restraint*
- *physical restraint used to facilitate seclusion*
- *physical restraint used to facilitate long term segregation*
- *physical restraint used to facilitate rapid tranquilisation*
- *mechanical restraint*
- *clinical holding*

2.8.1 **Training in the use of restrictive interventions must only be provided within the context of an explicit commitment to reduction of the use of all restrictive interventions** (see standard 1.4) **and the provision of person centred support.**

2.8.2 **Training content should refer to any elevated risks identified in the TNA** (see standard 1.1).

Any restrictive interventions which are to be taught to training participants must have been assessed as suitable for the needs of that population. Where TNAs have highlighted elevated risks to individuals or populations, training must reflect any additional safeguards, limitations or restrictions. There must not be blanket training of any restrictive intervention techniques (see Appendix 10 for emergency admission services).

2.8.3 **Training content must define the type of restrictive intervention being taught, and this must include a definition of the purpose of the intervention and the context in which it is to be used.**

Reference must be made to terminology used in local policy documents, as well as authorised procedure. If breakaway/disengagement techniques are taught that have a restrictive component the restrictive element must be highlighted. Breakaway techniques are used to breakaway/disengage from unwanted physical contact and may also be used to assist another person to disengage from unwanted physical contact. Training content must also draw attention to potential communicative function of the unwanted physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

2.8.4 **Training content must be clear that restricting someone's movement for clinical or personal care purposes is a form of physical restraint and should be recorded as such. This is sometimes referred to as clinical holding.**

Training must refer to the use of person centred approaches and less restrictive alternatives to the use of clinical holding or holding for personal care that can decrease the traumatic impact of the experience.

2.8.5 **The trainer facilitating the session must be competent to safely teach and manage those training sessions covering the use of specific restrictive interventions. In addition to meeting the criteria in** standard 3, **trainers must have been formally assessed to be competent to deliver those specific interventions by the training provider.**

Clinical experience of participating in certain procedures such as rapid tranquilisation and long term segregation would also enhance their understanding.

2.8.6 **Training must cover the specific circumstances in which the restrictive intervention under consideration may lawfully be used.**

As a minimum the following must be covered:

- an overarching definition of restraint/restrictive intervention must be discussed in training so delegates gain a clear understanding of when any intervention becomes restrictive and is categorised as a restraint. These standards recommend reference to the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019):

  > *'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around.* (EHRC, 2019)

- the legislation and guidance that legitimises the use of the specific restrictive intervention being taught, as well as the rationale, legislation and guidance relating to any clinical or statutory function that the intervention (eg physical restraint) is being used to support (eg rapid tranquilisation or detention under the MHA 1983 or the Mental Health (Care and Treatment) (Scotland) Act 2003)
- any national or service specific guidance that applies to the specific restrictive intervention being used
- relevant sections of the local organisational policy along with procedures relating to the use of the specific restrictive intervention
- that the intervention under consideration must only be considered when all other available and appropriate methods of primary and secondary prevention and non-restrictive tertiary interventions have been explored and found ineffective
- that the intervention must only be used for its intended and agreed purpose
- that it must be the least restrictive option available
- that it must employ the minimum amount of force for the minimum amount of time
- that it must never be used as a threat or as punishment, or in a way that curtails the rights and freedoms of the individual

- that if it is used as a planned intervention, it must be accompanied by the consent of the individual, or based on a best interests decision (Mental Capacity Act 2005) or in consultation with relevant others (Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016* unless the person is detained under the Mental Health Act 1983, or the Mental Health (Care and Treatment) (Scotland) Act 2003

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

**Physical restraint** is any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

**Seclusion** involves ‘the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving’ (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.103).

NB the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019) refers to enforced isolation:

> Example: Isolation may be enforced by locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area, for example by the use or threat of force. Enforced isolation is therefore restraint, but it may be described as seclusion, segregation, separation, time out or solitary confinement (EHRC, 2019).

**Rapid tranquilisation** refers to ‘the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place’ (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.91).

**Long term segregation (LTS)** involves ‘a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis’ (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.150).

**Mechanical restraint** involves ‘the use of a device (eg belt or cuff) to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control’ (CQC, 2015b).

**Clinical holding** involves ‘immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children (and adults), with their permission, to manage a painful procedure quickly or effectively’ (RCN, 2010).

2.8.7 **The training content must cover all of the risks that are associated with the use of the specific intervention under consideration, before any practical component is delivered. Training must cover the safeguards in place to manage any risks that may arise as well as the planned contingencies in place in the event of a medical emergency developing** (see standard 2.10).

As a minimum it must cover:

- general risks associated with the specific intervention (standard 1.3)
- specific risks associated with the use of the intervention under consideration on any individuals
- warning signs to look out for, which reveal distress, pain or a deterioration in any individual medical condition (refer to standard 2.10)
- action to be taken in the event that warning signs are detected (see standard 2.10)

2.8.8 **Before delivering the practical components of the programme the trainer must highlight those risks that are potentially present within the training environment and during training practice** (see standard 1.3)**.**

These include:

- general safety issues for staff during teaching and practice
- person specific safety issues for staff during teaching and practice

2.8.9 **The training session must allow enough time for demonstration and practice for each technique and time factored in for each participant to have an assessment of competence in the safe use of each restrictive intervention that has been approved** (see standard 2.6)**.**

2.8.10 **The training session must be structured in such a way as to contextualise the use of the specific restrictive intervention. For example structuring scenarios that integrate the restrictive interventions into operational or clinical situations.**

2.8.11 **Where simulated resistance is used during training sessions the risks it poses must be managed:**

- only trainers must role play resistant service users
- role plays must be directly managed by a separate trainer who should immediately stop the scenario if there is any likelihood of injury

2.8.12 **The training content must emphasise that the application of any restrictive intervention will be within the context of a therapeutic or supportive relationship with that person.**

Training must recognise that the use of restrictive interventions can traumatise people and damage relationships. It must explore how relationships can be maintained during and after the use of any restrictive interventions.

2.8.13 **The training content must emphasise the need to comply with reporting requirements and participate in any review processes designed to learn from experience and reduce the need for future restrictive interventions.**

## Standard 2.8.A

### Teaching the use of mechanical restraint.

### Due to the highly restrictive nature of some mechanical restraints, additional training standards are required to complement standard 2.8.

2.8.A.1 **Training providers must ensure that any form of mechanical restraint that they are requested to teach the use of has been agreed at a board level. There must be clear documentation as to how this has been deemed the least restrictive option for that person and why alternative approaches would not be suitable for them (CQC, 2016). Training content must explicitly cover this point.**

2.8.A.2 **Mechanical restraint must only be considered for use in exceptional circumstances in specific settings and under specific circumstances. Training content must clearly identify what these are and refer to organisational policy and protocol for their use.**

2.8.A.3 **Training content must refer to specific legislation and guidance on the use of mechanical restraint. This must include:**

- ***Brief Guide: Restraint (Physical and Mechanical)* (CQC, 2015)**
- ***MHA 1983 Code of Practice* (Department of Health, 2015), and the *MHA 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)**
- ***NICE guidance NG10* (NICE, 2015a)**

2.8.A.4 **Training content must refer to the *Mental Health Act Code of Practice* (Department of Health, 2015, 26.8026.81, 26.82), and the *Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a) which specifies requirements for safety reviews and observation protocols.**

2.8.A.5 **Training content must refer to any other general and specific safety guidance around the use of the specific mechanical restraint.**

2.8.A.6 **If appropriate, training must cover the protocol for the use and recording of mechanical restraint such as splints or cat paws which sometimes are used in services for people with learning disabilities and autistic people who have self injurious behaviours.**

The principle of least restrictive intervention must apply. The function of the self injury for the person must be identified and alternative ways of meeting the person's needs must be implemented. The clinical team, family, carers and advocates would need to be in agreement about the parameters of the use of the device (*MHA 1983 Code of Practice*, Department of Health, 2015, 26.87).

2.8.A.7 **Training must cover protocols for the use and recording of mechanical restraint in services for older people and people with disabilities. Belts and straps in chairs etc must be used lawfully for intended purpose only and not used to restrict liberty for the convenience of staff.**

## Standard 2.9

### Training must cover the factors that contribute to risk and elevated levels of risk in the application of restrictive interventions.

2.9.1 **Training content must make clear that *all* restrictive interventions contain an element of risk even when in accordance with training approved techniques and guidance.**

Training content must cover:

- physical, psychological or emotional risks
- factors that may elevate risk – these may include:
  - personal factors – of both the person being restrained and the people who are carrying out the restraint
  - environmental factors
  - service factors that may include, among other things, inadequate policies, poor leadership, lack of appropriate training and supervision, inadequate staffing levels, negative team or organisational cultures, power imbalances, and lack of opportunity or encouragement for reflective practice
  - the types of restrictive interventions being used as well as how long they are applied for and how they are applied

2.9.2 **Training content must make clear that staff have a responsibility for the safety of those individuals on whom they are applying restrictive interventions.**

Training content must cover participant responsibilities for ensuring:

- restrictive interventions are only ever used as a last resort, and always in line with policy and guidance
- any and all general safeguards are implemented
- any and all person centred safeguards are implemented
- active monitoring of the person is undertaken (see standard 1.3.4)
- emergency procedures are implemented immediately in the event that relevant warning signs are detected (see standard 2.10)

2.9.3 **Training content must make clear that staff have a responsibility for their own safety and that of their colleagues involved in applying restrictive interventions, as well as for others involved in the incident.**

This would include organisational policies in place that are designed to keep staff safe. These include lone working procedures, safe systems of work and any guidelines relating to personal safety.

## Standard 2.10

## Training in restrictive interventions must include contingencies to reduce the likelihood of medical emergencies arising; and the provisions to manage any that do.

2.10.1 **Training should include arrangements for monitoring a person's health status whilst under restraint, including: the integrity of their airway; their breathing and circulation; any deformity of limbs; and complications associated with any pre-existing medical condition or injury. (In some service settings local arrangements may include discrete monitoring of pulse and respiration, the use of pulse oximetry etc.)**

This requires participants to be trained to recognise warning signs which indicate some form of medical emergency may be emerging; and especially signs and symptoms which may be associated with conditions of particular concern, including asphyxiation, cardiac arrest, cerebral vascular accident and myocardial infarction, and fractures.

2.10.2 **Training must be explicit that if, whilst attempting to manage a behavioural crisis, a medical emergency arises, participants have a clear responsibility to take immediate action to ensure the patient's safety.**

Examples of medical emergencies include a person experiencing breathing difficulties or some form of cardiac or circulatory event, as well as injury to limbs or joints, including fractures or dislocations.

2.10.3 **Training must include consideration and reflection on how social and human factors, including high levels of expressed emotion, can influence the objectivity of interpretations of a patient's condition and associated decision making in emergency situations.**

2.10.4 **It must be made clear to training participants that any/all staff involved in a restraint have a responsibility immediately to raise any concerns they have about the patient's health status.**

2.10.5 **Training must include recognition of the need, in some instances, immediately to discontinue the use of restrictive holds (albeit possibly whilst retaining an ability to recommence them, in a modified form, based on the person's presentation).**

This must also include consideration of the degree of urgency with which restrictive interventions should cease in a medical emergency; arrangements, in accordance with local policies and procedures, for immediately summoning emergency medical assistance; and how the person should be supported until assistance arrives.

2.10.6 **Training must include recognition of situations where staff involved in restraining a patient need to instigate immediate life support measures, based on training that is compliant with the guidelines of the UK Resuscitation Council.**

Training content must take full account of the available resources and environment within which care is provided. In particular, in accordance with any organisational policies and procedures, this should include arrangements for summoning assistance of colleagues with more advanced life support expertise; and the availability and use of emergency medical devices that may be required for immediate life support, such as Automated External Defibrillators (AEDs).

2.10.7 **Training must cover measures required to prevent postural/positional asphyxia developing; as well as how to recognise when it may be occurring.**

Training must include identification of factors such as obesity and stature, pre-existing medical conditions, pressure to the chest or abdomen, obstructing a person's airway etc, that increase the likelihood of postural/positional asphyxia developing; and steps that should be taken to reduce the risks, including vigilant monitoring, avoidance of specific holds.

This must also include recognition of signs that positional asphyxia may be developing and in particular: monitoring the content of a person's speech; vocalisations that might indicate a blockage of the airway; discolouration (cyanosis) of the lips, hands or face; increased panic/resistance; and/or a person suddenly becoming more tranquil.

2.10.8 **Training content must cover procedures for recording and reporting medical emergencies associated with situations where restrictive interventions have been used. Relevant organisational policies in support of Health and Safety obligations must be referenced and clarified.**

## Standard 2.11

### The curriculum must identify the full range of restrictive interventions and restrictive practices and their application.

2.11.1 **Training content must identify and prompt discussion about all forms of restrictive interventions, including seclusion, rapid tranquilisation, chemical restraint, mechanical restraint, clinical holding, physical restraint and psychological restraint.**

This must include:

- definitions of key terms
- reference to blanket restrictions
- identification of other restrictive practices imposed by staff on people, such as dietary restrictions, lack of choice, restricting access to activities and personal items and locked doors
- restrictive intervention and practices that may be used covertly, such as not identifying opportunities or options, or influencing people's choices, eg 'you don't want to go out this afternoon do you?', or secreting medication in preferred food

Training content must also include discussion about how blanket restrictions and unnecessary service led restrictive practices can be identified and challenged. The use of all restrictions should be discussed in relation to human rights.

2.11.2 **Training content must define coercion and trainers must allow time for discussion about how, if unchecked or unregulated, restrictive interventions can become coercive and potentially harmful (physically, emotionally and psychologically).**

## Standard 2.12

### The curriculum must cover the requirements for recording and analysing data from restrictive interventions and occurrences of distress or concerning behaviour.

2.12.1 **Training content must cover:**

- the regulatory and organisational requirements for recording the use of any restrictive interventions and injuries associated with the use of restrictive interventions. It is recommended that an independent review should take place if any injuries occur during the use of any restrictive interventions
- the importance of accurate and objective recording. Activities that enable participants to practice and reflect on elements of good recording must be used. Different types of data collection tools and their uses must be covered
- the use and analysis of data to support restraint reduction. Analysis should support the identification of trends such as frequency and seriousness of different types of restraint over time and across different areas of the provider's work. Analysis of data must be used to inform individual and organisational restraint reduction plans. Analysis of data can help identify patterns that inform preventative working – by highlighting the conditions in which incidents are more or less likely to occur it should be possible to develop primary strategies that meet people's needs before behaviours of concern arise. Reference should be made to *Towards Safer Services* (DoH, in development) and *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate* (Chester et al, 2018, available at: University of Kent Academic Repository )

## Standard 2.13

### The curriculum must include reference to the importance of required procedures that are related to post-incident review.

2.13.1 **Training content must include reference to the need for, and the understanding of, the purpose of both components of post-incident review for individuals and staff.**

With reference to a review of current available evidence, these standards support a clear separation of these two components (Baker, 2017). Best practice and review of the limited evidence base suggest there are two main components of post-incident review, each with a distinct purpose:

1. Post-incident support – attention to physical and emotional wellbeing of the individuals involved
2. Post-incident reflection and learning review

Post-incident review requirements for staff, service users, carers and others involved in incidents where restrictive physical interventions are used are outlined in NICE guidance NG10 and QS154 (NICE, 2015a, 2017b).

2.13.2 **Training content must cover the need for post-incident support.**

This is the support that is immediately offered to an individual who has been involved in an incident. It should be available after any incident where a restrictive intervention has been used and after any incident that may have had an impact on the individuals involved. It should be available and proactively offered to all individuals who have been involved in the incident or who have witnessed the incident. The support should include assessment and treatment of any medical needs and provision of immediate emotional support. The trainer should discuss the importance of staff seeking and accepting this support.

2.13.3 **The training content must indicate what future options for emotional support are available through the commissioning organisation. The training must identify how participants and individuals who use services can access this either within the service or independently of the service. (NB: This should have been identified as part of the TNA and overall commissioning.)**

This may include individual and/or group supervision/debriefing and individual psychological therapy delivered by a trained professional.

2.13.4 **Training content must also cover the second component of a post-incident review: a reflective and learning review. The training content must cover the essential elements of the learning and reflective review which should be triggered by the use of any planned or unplanned restrictive intervention or any other event specified in organisational policy.**

The review should examine the factors that led to the restrictive intervention being used and consider if:

- future incidents could be either avoided or the impact could be minimised – this might mean the service or environment could be altered to better meet the needs of the person or that the staff could respond differently to the person
- personalised triggers can be identified and either minimised or avoided in the future and/or the person could be supported to learn coping or alternative skills
- the risk assessment and support plan need to be reviewed
- a less restrictive approach could be used in the future

Reflective reviews should be led by experienced facilitators and should be a learning and reflection forum and not about blaming individuals. There should be clear actions taken forward from the review. Views of the individuals who were involved in the incident should be part of the review process using whatever method is most appropriate and supportive to them. There should be recognition that some individuals may be distressed by recalling the incident.

## Standard 2.14

### The curriculum must have content that enables participants to understand the meaning of 'trauma' and how it can impact on people's experience of restrictive interventions.

2.14.1 **Training content must cover:**

- the definition of 'trauma' including post-traumatic stress disorder (DSM 5) and complex trauma disorder (ICD 11) and the basic principles of trauma informed care
- how trauma may impact on the experience of use of restrictive interventions. This can apply both to people who may be in receipt of the restrictive intervention and to those who apply the restrictive interventions. Experiencing a restrictive intervention such as seclusion or physical restraint is in itself potentially traumatising. The experience could also trigger a trauma memory.
- how a person's trauma history, if it is known, must form part of the personalised wellbeing risk assessments needed for the use of any restrictive interventions. There may be considerations that could lessen the impact of the experience should it become necessary. A person's trauma history may not be known so training should also cover the importance of the recognition of potential symptoms of trauma and how these can sometimes be overshadowed by autism or learning disability, and also the fact that behavioural symptoms could potentially be linked to past trauma. It is possible that people who have care histories may have had multiple traumatic experiences of restraint – it is important that the training considers people's past experiences and how these might impact on any present experience. It would be important for participants to consider the types of restraint that people who have had histories of restraint and/or abuse may find particularly traumatising
- an affirmation that a trauma informed approach must be provided to everyone whether trauma is known or not
- an understanding of trauma through a developmental perspective that applies to all ages not just children

## Standard 2.15

### The curriculum must contain reference to and explore understanding of restraint reduction theory.

2.15.1 **Training content must include reference to evidence based models of restraint reduction.**

These may be with reference to resources, among others, from the Restraint Reduction Network, the Restrain programme (The Health Foundation), or other population specific programmes. Trainers are recommended to refer to the 'six core strategies' as identified by Huckshorn (NASMHPD, 2008). Other evidence based models include Safewards and No Force First Restraint.

2.15.2 **Training content must make reference to any policy, procedure or commitments which have been made by the commissioning organisation related to restraint reduction.**

# Section 3

# Standards supporting post-delivery processes

## Standards

| | |
|---|---|
| Standard 3.1: | **Competence, assessment and feedback** |
| Standard 3.2: | **Record keeping** |
| Standard 3.3: | **Reporting concerns** |
| Standard 3.4: | **Evaluation** |
| Standard 3.5: | **Quality assurance** |
| Standard 3.6: | **Refresher training** |

## Introduction

Good training providers will have a range of different processes for monitoring the quality and effectiveness of their training that feed into a cycle of continuous improvement. This is so they can be confident the training they provide is having a positive impact on the quality of life for people who are supported in the organisations they provide training for.

## Standard 3.1

### Training must include a competence based assessment within each programme, with participants being assessed for both knowledge and skills. It is recognised that such assessments can only assess participants' skills within a training environment.

3.1.1 **Training providers must establish assessment criteria which are consistent with the level of training which has been commissioned.**

The criteria must identify and distinguish between introductory level, refresher training, and train the trainer programmes.

Areas that must be included are:

- values and attitudes, as reflected in the language and behaviour used during the course
- knowledge of appropriate theoretical concepts, approaches and strategies (eg rights based approaches, person centred care, primary, secondary and tertiary strategies)
- the ability to describe a range of primary interventions
- the ability both to describe and demonstrate a range of secondary strategies
- the ability both to describe and demonstrate non-restrictive tertiary strategies
- the ability both to comprehensively describe and demonstrate all component parts of any restrictive interventions and the safety parameters for them that have been taught
- participants should be able to clearly articulate the rationale for the use of these interventions
- knowledge relating to the legal and ethical implications of using restrictive intervention

3.1.2 **The training provider must have assessment methods which take into account any reasonable adjustments that people need.**

(NB: When testing the competence to apply a restrictive intervention any reasonable adjustments must not compromise the safety of the restrictive intervention when it is applied in practice.)

3.1.3 **The curriculum must have time factored in for demonstration and practice of each intervention that has been taught, as well as time factored in for the assessment of competence for each participant.**

3.1.4 **The training provider must allow time within the programme so that the participants can be given verbal feedback about their performance.**

3.1.5 **If participants fail to reach the level of competency required by the training provider, the training provider must agree with the commissioning organisation (service provider) the necessary actions for the participant.**

This may for example involve a personal learning plan, a repetition of the training within six months, a bespoke training programme or a coaching intervention. The training provider must recommend that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence.

If a trainer has serious concerns during the programme about a participant's ability to complete the programme successfully they must refer to the identified manager in the commissioning organisation as soon as is practical (also refer to standard 4.6.6).

3.1.6 **The training organisation must provide the commissioning organisation (service provider) with written feedback on the assessed performance of each course participant.**

This must include:

- the areas they have demonstrated competence in
- any identified areas in which they have demonstrated excellence

- if a participant has failed to demonstrate competence in all areas of the curriculum. In this case, feedback must also include:
    - any actions that can be taken to enable them to achieve competence in these areas
    - a recommendation that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence for the whole of the curriculum

## Standard 3.2

### Training records for each programme delivered must be maintained by the training organisation.

3.2.1 **Training providers must ensure that their trainers maintain complete, accurate and up to date records of each course they deliver.**

This must include the following:

**General information**

- date and title of the course, duration and details of the trainers involved

**About the participants**

- names of the participants, their employing organisation and service/setting
- confirmation of each participant's fitness to attend the programme

**About the programme**

- learning aims and objectives of the programme
- brief description of curriculum content
- details of secondary strategies that have been taught
- details of non-restrictive tertiary strategies that have been taught
- details of any restrictive tertiary strategies that have been taught
- date when refresher training due

**Assessment information**

- assessment records for each participant for each part of the syllabus (with reference to standard 3.1.1) with any reasonable adjustments that have been made
- assessment records must clearly indicate who has successfully completed the programme and demonstrated the required level of competence and who has not
- written feedback for each participant (see standard 3.1.5), including any recommended actions in respect of participants who failed to demonstrate competence
- any concerns related to the conduct or values of any of the participants (please refer to standard 3.1.1)
- evaluation information (please refer to standard 3.4.1)
- health and safety information, details of any injuries or accidents reportable under health and safety legislation occurring during the training, in compliance with Health and Safety Executive *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) (HSE, 2013b)

3.2.2 **Records must be maintained and retained by the training organisation for a period of time that is consistent with legislative requirements.**

3.2.3 **Training providers must have a data storage and destruction policy that is compliant with GDPR regulations.**

## Standard 3.3

### Training providers must have a policy for dealing with concerns that arise during training.

3.3.1 **Training providers must have a policy that outlines the procedure for handling any concerns about the conduct of participants arising during training sessions. This policy must be available to the trainer before any training is delivered.**

The policy must include:

- examples of behaviours that may constitute a concern or amount to inappropriate conduct
- an outline of the procedure for informing participants how inappropriate conduct will be managed within the context of the training session
- an outline of the informal procedures for resolving matters, where the trainer seeks to address the issue during the training session
- an outline of the procedure for escalating concerns formally to the training commissioner if the concern cannot be resolved informally
- details of any formal record that must be completed by the trainers

## Standard 3.4

### All training must be evaluated post-delivery using an evidence based framework.

3.4.1 **Training providers must collect evaluation responses for each programme that they run.** The evaluations must inform both the training provider's internal quality assurance processes and a review with the training provider about the effectiveness of the programme. They must also inform the annual review with the commissioning organisation (service provider) and the review of the restrictive intervention reduction plan.

## Standard 3.5

**Training providers must have internal quality assurance systems and be able to provide evidence that they effectively monitor the quality and consistency of all of their training services. Training providers must be able to evidence that their training services are being consistently delivered and that they routinely adhere to all the training standards. Training providers must use their quality assurance process to identify and action improvement priorities.**

3.5.1 **Training providers must be able to demonstrate how their quality assurance cycle supports improvements.**

The quality assurance process for training providers must feed into the annual review with commissioning organisations as well as their own processes that support improvement.

Analysis of evaluation information will assist the training provider to identify priorities and create an action plan.

Areas that must be evaluated:

- ensuring delivery is consistently in line with the *Restraint Reduction Network Training Standards*
- how training programmes are developed and delivered
- the performance of trainers
- the administration of the programmes
- the feedback to the commissioning organisations

*There are a number of methods that can be used to gain evaluation information:*

- evaluation forms from participants on the training programme
- verbal or written feedback from people who are being supported
- direct observation of training programmes
- verbal or written feedback from managers of staff who have attended the training

- verbal or written feedback from the commissioning organisation about how the training provider has performed during different stages of syllabus development and delivery of the programme
- self-assessment against these standards
- peer review – working with other providers to peer review
- independent reviews of training programmes and impact

## Standard 3.6

### Training providers must develop refresher training curricula that take into account the current needs of the organisation, service or individuals, using information from an updated TNA (see also standard 1.6.1).

3.6.1 **Training providers must follow the same process for the development of refresher programmes as for the development of the original programme curriculum.**

3.6.2 **Training providers must ask the commissioning organisation to update the information in the TNA and must review the TNA together to check each restrictive intervention is still needed or if the level of restrictiveness can be reduced.**

3.6.3 **The training content of a refresher programme must be based upon an updated TNA agreed with the commissioner/organisation restraint reduction lead.**

Refresher training must have an annual core content (see standard 3.1) and an additional rolling programme of remaining content. The rolling programme may have a different focus each year but all curriculum areas must be covered at least every three years.

Refresher training must include the following:

- revision of key areas of the original syllabus – all curriculum content must be studied/revised over a three year period
- a reassessment of the competence to apply primary/preventative strategies, secondary strategies, and non-restrictive tertiary strategies must take place at least once a year
- an update on relevant legislation or guidance on good practice and organisational policies must take place at least once a year
- further development of skills to apply primary/ preventative strategies must take place at least once a year
- a reassessment of competence to apply any of the taught restrictive tertiary strategies must take place at least once a year
- any additional safety advice or modifications needed relating to the use of tertiary strategies with the individuals in the service or that need to be considered because of changes in the services must be highlighted in every training programme

Refresher training must be a minimum of one day. It is expected that sufficient time is allocated to teaching both theory and physical skills and to competence assessment. Refresher training is likely to be more than one day if there are multiple interventions and/or they are complex or high risk interventions and/or when the TNA has identified areas that need extra support.

# Section 4 Trainer standards

## Standards

| | |
|---|---|
| Standard 4.1: | **Quality assurance** |
| Standard 4.2: | **Training competence** |
| Standard 4.3: | **Professional competence** |
| Standard 4.4: | **Delivering relevant content** |
| Standard 4.5: | **Insurance** |
| Standard 4.6: | **Safety** |
| Standard 4.7: | **Professional development** |

# Introduction

Good restrictive intervention trainers have the potential to change practice, win hearts and minds, and have an important role in supporting a system wide approach to the reduction of the use of unnecessary restrictive practices. They have a range of skills and are confident in their knowledge of all the training content, how it fits within the human rights framework, and best practice for the sector and population they are training in. They are able to assess competency, encourage potential, and appropriately challenge unhelpful attitudes.

For certification purposes there are two kinds of trainers referred to in the *Training Standards*:

**Senior trainers** who deliver training across multiple organisations and/or deliver train the trainer programmes. They may be employed (or paid) by a commercial training provider, or be employed within a service provider organisation such as an NHS Trust.

**Associate trainers** who are employed by (and deliver training only within their own) service provider organisation which may be an affiliate organisation linked to the trainer provider (eg NHS Trusts, schools or care homes). They do not deliver train the trainer programmes.

When a standard refers to all trainers it means both senior trainers and associate trainers.

The certification scheme does not certificate providers, curricula or trainers separately. Valid certification only applies when all three are in combination, though the certification scheme trainers are **authorised** to deliver **approved** curricula on behalf of the training provider.

Trainers are **not** authorised under the certification scheme to deliver any other programmes that have not been through the certification process. Trainer certification is not transferable to other organisations.

## Standard 4.1

### Training providers must have effective internal quality assurance systems that effectively monitor the consistency of delivery and adherence to all the standards across all training services. This includes monitoring all curricula and all trainers delivering their programmes across all services including affiliated satellite services. Training providers should use their quality assurance process to identify improvement priorities.

**Quality assurance must include regular observation in situ of training delivery. The training provider must be able to provide evidence that it has been checking its own compliance against its own quality assurance system. This must include evidence that there is checking of the compliance of all quality systems in place that monitor the quality and fidelity of training delivered by associate trainers in satellite organisations.**

4.1.1 **Training providers must keep up to date records of both professional and training competence for all trainers.**

4.1.2 **Training providers must keep records of all trainers and all training programmes that are delivered.**

4.1.3 **Training providers must be able to show evidence that they conduct regular quality assurance checks to ensure that accredited authorised curricula are being delivered as intended and that no unauthorised adaptations are being made.**

## Standard 4.2

### All trainers who are delivering training must be able to demonstrate that they are qualified and competent to train.

4.2.1 **Training providers must be satisfied that trainers they recruit have the capability to train effectively and have appropriate levels of teaching and training skills.**

Training providers must evidence they have robust processes to assess this aspect of the trainers' performance. Training and teaching skills may be assessed through a combination of qualifications, scrutiny of evaluations, peer reviews and formal assessment by the provider.

4.2.2 **All trainers delivering training in restrictive interventions must hold current first aid certification including immediate life support.**

As a minimum requirement this must be the Emergency First Aid at Work one day programme which includes immediate life support. Different premises may require different levels of training.

## Standard 4.3

### All trainers must be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training.

4.3.1 **All trainers must be able to evidence that they have a professional qualification (with current up to date registration) or have completed a programme of relevant vocational training, having received a qualification within health, education or social care. Training providers must have mechanisms in place so that they can demonstrate that all trainers are able to evidence professional competence and understanding of the sector in which they are delivering training.**

This may include:

- vocational qualification (health, education or social care)
- social work qualification (Diploma, BSc, BA)
- teaching or education-based qualification
- nursing qualification (with current registration) (NMC)
- other health professional qualification (with current HCPC or equivalent registration)

4.3.2 **All trainers must have been continuously employed in a support or care role within social care, education or a health care environment for a period of not less than two years. Training providers must be satisfied that trainers are able to evidence professional competence and understanding of the needs of the populations and settings in which they are delivering training. This may be evidenced in a number of ways, including a portfolio that shows professional development and competence.**

4.3.3 **All trainers must be able to demonstrate that they have the required level of knowledge and under-pinning values to competently deliver all elements of the curriculum** as specified in Section 2.

This would include:

- a commitment to upholding human rights and to working within a restraint reduction framework
- an appropriate level of knowledge in all areas of the curriculm, not just in demonstrating restrictive intervention techniques
- a commitment to working within the *Restraint Reduction Network Training Standards*

It is the responsibility of the training provider to have mechanisms in place that include criteria for assessment of trainers so they can provide evidence of competence and underpinning values.

When recruiting trainers the training provider must have a robust process for selecting trainers that includes references, previous evaluations and appropriate criminal disclosure checks.

All trainers must have successfully completed a face to face train the trainer programme of a minimum of 30 hours or 5 days in length (which may be an accredited qualification for example a diploma or BTEC). The competence to deliver the whole of the curriculum must be assessed during and at the end of the train the trainer programme.

Training providers must have mechanisms in place to evidence the underpinning values. Trainer competence must be assessed and quality assurance checks completed at a minimum annually by the training organisation and should cover the whole curriculum not just restrictive interventions.

In some circumstances a commissioning organisation will already have a model of preventative working in place, such as Safewards or Positive Behaviour Support, and this training may be delivered by another agency. Staff must receive preventative training before they receive any training in restrictive interventions (see standard 1.2.1). In this circumstance the training programme that is commissioned with a restrictive intervention component may not need to include the content covered in standard 2.5, but the trainer must have the knowledge to teach all the other areas of the curriculum covered in the standards.

4.3.4 **All senior trainers must successfully complete a minimum of two days' refresher training annually.**

4.3.5 **Training providers must specify CPD requirements for all trainers who deliver their programmes.**

CPD hours are not set in these standards. However, trainers must collect a portfolio of evidence to demonstrate to the training provider that they meet the provider requirements and the Restraint Reduction Network standards. Evidence of relevant CPD records of trainers must be kept by the training provider to ensure quality, knowledge and skills are maintained.

Where employing or commissioning organisations make stipulations that professional registration is maintained then this remains the responsibility of the trainer.

## Standard 4.4

### All trainers must ensure that the delivery of any programme is informed by the training needs analysis (TNA) (see standard 1.1).

4.4.1 **All trainers must familiarise themselves with the TNA that has been agreed between the training provider and the commissioning organisation before they deliver any programme of training.**

The curriculum must reflect the specific needs identified in the TNA.

4.4.2 **A trainer must only teach the restrictive interventions that have been previously identified and agreed between the commissioning organisation and the training provider and highlight any identified person specific risks during training.**

Before delivering any restrictive intervention component the trainer must familiarise themselves with the written rationale for the use of any restrictive intervention and any elevated risks that have been highlighted.

4.4.3 **Before delivering any physical restraint training the trainer must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see UK Resuscitation Council).

In some cases this training will be provided by the trainer as part of the content of training and in other cases another provider or trainer will have delivered this programme.

## Standard 4.5

### All trainers must be covered by professional indemnity and public liability insurance.

4.5.1 **Trainers must have appropriate insurance cover for the work they are undertaking.**

Trainers working as consultants for a training provider under a franchise agreement or as self-employed trainers must ensure that they have insurance comparable with that of the training provider for the activities they undertake. Valid insurance documentation should be submitted annually for review to the organisation for which they deliver training.

## Standard 4.6

### Trainers must manage training sessions safely and professionally.

4.6.1 **Trainers must undertake an environmental risk assessment that has been provided to them by the training provider.**

Before any training occurs, trainers must undertake a formal risk assessment of the training environment to satisfy themselves that the space is free from hazards, provides enough room to move around safely and is suitable and conducive to successful training delivery.

4.6.2 **Trainers must give out information to participants at the start of any programme.**

All trainers must, as a minimum, at the start of any programme, clearly outline:

- training ground rules and safety rules
- the process for reporting any concerns about the conduct of the participants or the trainer
- fire safety requirements, access to toilets and refreshments etc
- timings for the programme
- learning outcomes, topics to be covered and assessment criteria
- the process for managing participants who don't reach the assessment criteria

4.6.3 **Trainers must outline participants' personal responsibilities before teaching any restrictive intervention component.**

This must include:

- guarding against the risk of injury during the training and immediately reporting to the trainers any subsequent injury
- reporting any existing injuries and disabilities that may pose health and safety risks to their own safety and welfare and those of other participants during training
- their responsibility to adhere to safety guidelines issued by the trainer
- reporting all injuries or adverse events in accordance with the commissioning organisation's own reporting policy and statutory guidance *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) to the purchasing organisation, including any injuries sustained during the training

4.6.4 **Trainers must use respectful language and conduct themselves professionally.**

All trainers must adhere to a code of conduct, as specified by the training organisation.

4.6.5 **Trainers must be mindful of the emotional impact of some of the topics on participants and must provide opportunities for individual discussions if needed.**

4.6.6 **Trainers must exclude any participant from the course whom they believe to be unsuitable for training.**

Participants may be unsuitable on grounds of:

- their attitudes, values and beliefs as displayed on the course
- their behaviour towards the trainer and/or other participants
- their time keeping and attendance throughout the course

Any exclusions must be confirmed in writing to the commissioning organisation or the participant's manager if it is an in-house course.

4.6.7 **Before commencing any training event, the trainer must confirm that suitable first aid facilities and equipment are readily accessible at the training venue.**

4.6.8 **Trainers must have the knowledge, means and ability to summon emergency services to the venue should a serious injury occur during a training session.**

## Standard 4.7

### All trainers will be expected to maintain accurate training records which support an agreed quality assurance system.

4.7.1 **All trainers must be able to demonstrate how they use participant evaluations to improve the programme or further their professional development.**

4.7.2 **All trainers must have at least one peer evaluation per year.**

Trainers must be able to show evidence of having one peer evaluation per year and be able to demonstrate how they have used it to further their professional development.

# Appendices

## Preface to the appendices

The appendices are included to show that the standards will need to be adapted according to some specific considerations. These relate to:

- which specific population is being supported by staff or carers who are accessing training
- the setting that the staff/carers who are receiving the training provide the support in
- the country that the service or setting is operating in

It is likely that training providers will need to refer to more than one appendix when developing a person centred curriculum for a commissioning organisation.

Please follow the link to the relevant current guidance and legislation on the Restraint Reduction Network website: RRN Training Standards. These appendices will be subject to a continuous review timetable; therefore the most up to date versions will be available online. Please let us know if any relevant guidance or legislation is missing from the website.

New appendices currently in development include:

- Specific considerations for agency staff/flexible staff/bank staff who require certificated training
- Specific considerations for patient/pupil transport services who require certified training
- Students in work placements who require certificated training

# Contents

There is a timetable of review for the appendices and they will be updated to reflect changes in policy and new guidance, but please be advised that you should refer to other more frequently updated sources of sector specific information in addition to these.

The reviews will be informed by experts in each area. Please refer to the online version of this publication for the latest versions of the appendices.

## Populations being supported

## Settings in which the staff/carers provide support

## Country in which the service or setting is operating

## Other appendices

## Examples and checklists

The following templates are available to download at RRN Training Standards – materials to download:

- Sample checklist for a training needs analysis
- Information needed for a personalised wellbeing risk assessment checklist
- Sample template for a written rationale for the inclusion of a restrictive intervention in a curriculum
- Self assessment tool template
- Sample risk assessment template

# Appendix 1 Specific considerations and adaptations to the training standards for services supporting people who have acquired brain injury

## Type of service

Services for people who have acquired brain injury. Such injuries arise from accidents, assaults, infections, tumours and strokes and can result in physical, cognitive, emotional and behavioural impairments. (This list is not exhaustive.)

Specific considerations when delivering training in this setting:

- Mood swings, stress, frustration and anger are often experienced by individuals with acquired brain injury. These, and the difficulties in understanding, processing and responding to information and events, coupled with the potential loss in insight and impulse control, should not lead to a person being characterised as 'violent' or 'high risk', and routinely managed as such
- An acquired brain injury can lead to changes and impairments which should be considered as risk factors in the context of any physical restraint. These include:
    - issues with memory, including a struggle with the retention of information in both short and long term
    - changes in muscle tone (low tone – hypo; and high tone – hyper)
    - impairments in receiving and processing sensory information, which may manifest in hypo- or hyper-sensitivity to touch, and to pain in particular
    - difficulties with speech and language
    - difficulties with swallowing, which should be treated as a risk to breathing
    - increased risk of epileptic seizures or fits

- The stress associated with the application of a physical restraint technique should be considered as a risk factor in and of itself
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations, eg attempting to remove catheters, arterial lines and breathing tubes. The removal of an arterial line is potentially life threatening in a very short period of time, hence why such an extreme form of restraint may be advocated. The use of mechanical interventions is likely to give rise to additional risks, such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed
- These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely

Specific adaptations to the standards for this setting:

- Physical restraint plans must:
  - be personalised and reflect the unique impairments of the person
  - have multi-disciplinary input from relevant health professionals
  - contain an explicit rationale for the use of techniques which should be centred on safety and the prevention of harm, not simply behaviour management
  - include explicit monitoring protocols which cover those safety criteria upon which any physical restraint techniques should be relinquished and these should be linked to relevant emergency medical support protocols, eg responses to breathing difficulties or seizures
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release
- Additional time should be spent during training sessions to discuss the local protocols in place for ambulance services to manage the heightened risks involved in the rapid admission/assessment process

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards

# Appendix 2 Specific considerations and adaptations to the training standards for services supporting autistic people

## Type of service

Services and settings are inclusive of education, residential, social care, and individuals' tenancies working within family home and health or hospital service settings. Children with autism and autistic adults may or may not also have a learning disability and/or mental health diagnosis and may be in generic services as well as specialised settings.

The National Autistic Society (NAS) defines autism as a lifelong developmental disability that affects how people perceive the world and interact with others. Identity first language is in general the preference of autistic adults (though not always), so it is used here but the person's preference should always be ascertained.*

Specific considerations when delivering training in this setting:

- All autistic people are different and have a range of individual strengths and needs but it is important to consider the following during training

  Autistic people and children with autism:

  - may have some difficulties understanding what's happening around them, or understanding social cues
  - may at times find it difficult to express or communicate their needs
  - may not be able to process or understand instructions and other communications and need extra time and cues – it is important not to perceive this as ignoring instructions, or as rude or non-compliant behaviour

* **Identity-first language** places the disability-related word **first** in a phrase. People who prefer **identity-first language** for themselves often argue that their disability is an important part of who they are, or that they wouldn't be the same person without their disability. However, personal preference should always be identified and used

  - may at times be very anxious and tense and want to escape from stressful situations or activities
  - are likely to have sensory differences, eg an over-sensitivity to noise or touch or a need for stimulation. Sensory sensitivities can lead to extreme levels of stress and anxiety in unfamiliar or over-stimulating environments. Environmental considerations are extremely important when supporting an autistic person and as much information as possible should be gathered about the person's preferences and needs
  - may have differences in experiencing levels of pain
  - may have a different awareness of personal space and may seem to be unusually intolerant
  - are likely to have concomitant health problems that may be undiagnosed
  - are vulnerable to the full range of mental health issues experienced by people without autism but may be particularly vulnerable to anxiety related conditions

- It is very likely that a restrictive intervention could be a frightening, painful and traumatising experience and consideration should be made of the individualised support needed during any restrictive intervention and afterwards. It would be especially important to consider the person's individual communication needs and preferences and understand how the environment may impact upon their emotional state. Identification of any comforting object or routines to support recovery should be in the personalised wellbeing risk assessments
- If it is suspected that a person is deliberately seeking sensory stimulation through physical restraint, the advice of a psychologist should be sought so that alternative methods of stimulation can be provided
- In the event that there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 3 Specific considerations and adaptations to the training standards for services supporting children (including residential schools and children's homes)

## Type of setting/service

Services for children including residential child care, respite care, residential special schools, secure children's homes, residential holiday schemes for disabled children and NHS comissioned health services as well as local authority and independent fostering service providers:

- Children are defined by NICE as *'people aged 12 years or under'*
- Young people are defined by NICE as *'people aged between 13 and 17 years'*
- For additional information on Fostering and adoption settings see Appendix 11: Family homes

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

# Key principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

Specific considerations when delivering training in this setting:

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B, HM Government, 2019)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken
- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and serious-ness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved

# Other considerations

Education, Health and Care plans should be developed after suitably wide consultation which may involve the co-ordination of the assessment process where relevant across education, health and care domains. In addition to the child/young person themselves and his or her family, those consulted may include:

- education professionals such as nursery staff, teachers, Special Educational Needs and Disabilities Co-ordinators (SENDCOs) and educational psychologists
- physical health professionals such as GPs, community based paediatricians, paediatric neurologists, specialist community nurses, physiotherapists, occupational therapists, dentists, opticians, speech and language therapists and health visitors
- mental health professionals including clinical psychologists with expertise in learning disability and functional analysis, behavioural therapists, psychiatrists with training in child and adolescent psychiatry/learning disability/autism and specialist nurses
- social care professionals such as social workers, care managers, care staff and support workers

Individualised behaviour support plans should also be formulated after suitably wide consultation. The management of risk in its widest sense should form a key part of any plan (see list of risk factors below, p114). Every behaviour support plan should have an explicit process for supporting a child or young person to avoid crisis and a protocol for escalation

Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible, and an emphasis placed on working in a child/young person centred way with reference to relevant plans

# ‘Best Practice Guidelines’ relating to physical responses to escalated behaviours of concern: Physical Restraint (are applicable across all groups of children and young persons)

Restrictive interventions (and in particular physical restraint) can be planned or unplanned. Each type of intervention presents a unique set of practical challenges and risks to be recognised and managed.

Planned interventions involve staff following agreed approaches to behaviour that challenges that have been set out in the child or young person’s behaviour support or care plan, and will detail any procedures, strategies or techniques authorised for use as a last resort physical restraint. Planned interventions will be formulated following suitably wide consultation and based on careful assessment of the potential risks (including any particular vulnerabilities, communication difficulties, medical conditions and/or impairments – see list of risk factors below, p114)

Unplanned interventions by contrast are responses for unforeseen and unpredicted behaviours of concern. Such situations require highly skilful responses from staff based on the fullest appraisal of the individual, the behaviour and its likely impacts. Such decisions, known as dynamic risk assessments, will include a judgement about the capacity of the child or young person in that moment to make safe choices. Any physical response (physical restraint) should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time.

The right core values and key principles should be used to underpin the management (including the physical management) of all behaviours of concern, including unforeseen behaviours that challenge, even in those settings and contexts where they cannot be anticipated or responses pre-planned. This is particularly relevant to those services that admit children and young persons with limited, or little or no knowledge of their background.

A core set of such values were presented in the recent document titled *Reducing the Need for Restraint and Restrictive Intervention* (HM Government, 2019). They included:

- upholding all children and young people’s rights – children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present

- treating all children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges as full and valued members of the community whose views and preferences matter
- respecting and investing in family carers as partners in the development and provision of support for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties
- recognising that all professionals and services have a responsibility to work together to coordinate support for children and young people whose behaviour challenges and their families

The same document (HM Government, 2019) also provides a set of key principles that relate specifically to the use of physical restraint. They were drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes but were held to be relevant to all of the settings and services covered in the guidance. The principles hold true across all children's and young person's services where physical restraint may be used:

- Every child or young person deserves to be understood and supported as an individual
- The best interests of children and young people and their safety and welfare should underpin any use of restraint
- The risk of harm to children, young people and staff should be minimised
- The needs and circumstances of individual children and young people, including their age, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual affect others, including staff
- A decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned, including other children, young people or adults present

When considering whether to use restraint with a child or young person, staff should ask themselves: ‘At this moment what is in the best interests of the child and/or those around them, taking account of the risks presented?’

When assessing risk, staff involved should take into account:

- the type of technique used, and how it will likely interact with, and impact on, the child/young person
- the size, age and understanding of the child or young person
- their particular history, vulnerabilities, learning disabilities, medical conditions and impairments
- the relative risks of not intervening
- the child or young person’s previously sought views and experiences, and those of parents and carers, on strategies and approaches they considered might de-escalate or calm a situation
- the impact of the restraint on the future relationship with the child or young person (HM Government, 2019)

It must be recognised that any and all restrictive interventions (including physical restraint in particular) carry the risk of inadvertent distress, pain, injury and re-traumatisation. Examples of specific risk factors include:

- communication impairments which may reduce the ability of the child or young person to express their feelings or enter into a two-way problem solving and/or de-escalatory dialogue
- sensory processing or integration disorders which can be significant within the context of understanding and managing triggers, as well as in the context of understanding and managing any physical touch, holding or physical restraint which may be used. Staff should be aware that all forms of sensory stimulation above and beyond physical contact may be distressing so need to be carefully considered
- underdeveloped anatomy, eg bone size, shape and density, which will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques, and the force with which they are applied
- underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, which may have implications for a child/young person’s ability to breathe and how suddenly they can become exhausted
- underdeveloped psychological and emotional capacities which are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one

There is a significant incidence of Adverse Childhood Experiences (ACEs) which may be higher amongst some populations such as 'looked after' children, but nevertheless prevalent across society. Such ACEs can heighten the risk of trauma/re-traumatisation being experienced.

ACEs may mean that some children have attachment disorders or have developed emotional and physical responses to adults that may be unsafe or unhelpful. This may have implications for the use of physical restraint and other restrictive interventions such as seclusion (which may be extremely distressing). If it is suspected that a child or young person is deliberately seeking contact through physical restraint the advice of a psychologist should be sought.

Options for eliminating and/or reducing all forms of risk should be thoroughly explored, and the benefits and drawbacks of each considered and, where possible, recorded in plans (as discussed above).

Organisations should consider when to record occasions where restrictive interventions and physical restraint in particular are used (whether planned or unplanned). Depending on the type of setting or service, this may be a mandatory requirement (HM Government, 2019).

Good practice is to record why restraint was used, by whom, for how long and what the outcomes were in terms of any injuries to a child or young person and/or staff (organisations should refer to national guidelines and organisational policy for local recoding criteria) (HM Government, 2019). NB: this is likely to be supported by information about antecedent or setting conditions as well as behaviour consequences which will be used to support PBS/preventative planning.

After all incidents (including the use of physical restraint), the child or young person as well as the staff involved should be given emotional support and basic first aid for any injuries as soon as possible (HM Government, 2019).

Immediate action should be taken to access medical help for injuries that require more than basic first aid. All injuries should be recorded in accordance with the setting or service's procedures and reported as appropriate to the Health and Safety Executive (HM Government, 2019).

Action taken in respect of post-incident support could include trauma support for children, young people and their families affected by the use of restraint as well as staff (HM Government, 2019).

Organisations should ensure that appropriate lessons are learned from instances where restrictive interventions and physical restraint in particular have had to be used, including any patterns and trends, and consider how use of restraint might be avoided in future. This will usually involve de-briefing and post-incident review and monitoring of the use of procedures, strategies or techniques. The process should consider all types of individual plans that reference behaviour support and crisis management, including behaviour support plans (HM Government, 2019).

Whenever restraint has been used, staff and the child/young person should have separate opportunities to reflect on what happened, and wherever possible a choice as to who helps them with this. Those with cognitive and/or communication impairments may need specific help to engage in this process, for example, use of simplified language, visual imagery or Alternative and Augmented Communication (HM Government, 2019).

Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews. Someone appropriate and trusted by the child/young person and their family or, where appropriate, the individual's advocate, could also play a role.

Reviews could involve a facilitated staff team discussion about the warning signs of an impending incident, whether any previously agreed behaviour plans were followed, what de-escalation strategies were used and how effective they were, and what might be done differently in future (HM Government, 2019). The same reflective process should be used to consider the appropriateness, suitability and safety of physical restraint.

If a pattern of persistent use of physical restraint emerges, and if a setting or service considers they do not have sufficient expertise themselves, an expert assessment should be sought, to identify the triggers for the behaviour that leads to use of restraint. The reviewer should consider, with the child or young person, and as appropriate, their parents and/or advocates, revising their individual support plan. Consideration should also be given to improving staff training and development as part of action to address the issue (HM Government, 2019).

Wherever there are security procedures such as search and confiscation that involve physical restraint the physical restraint technique should be considered as a risk factor in and of itself.

Where attendances and responses from the police become a feature of any management of seriously escalated behaviours it can be appropriate to agree joint response protocols. A discussion of the likely risks of any restraint should be considered to ensure such risks can be effectively managed.

Specific adaptations to the standards for this setting:

- Factors such as in-utero exposure to alcohol and/or drugs, pre, peri and post-natal trauma, poor attachment experiences, and complex home circumstances as well as the implications of such experiences on the developing brain will need to be covered during training
- Trainers would typically be expected to discuss the multi-agency and multi-level of support required for children/ young persons with complex needs
- Primary preventative strategies should be prioritised. These should include evidence based models such as Positive Behaviour Support (suitable for all settings) and setting specific programmes such as Safewards (healthcare)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behaviour support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person-centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- Staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically
- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults

- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019; UN Committee on the Rights of the Child, 2006)
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- Trainers should discuss ‘intervention creep’ as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as ‘any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement’, but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as ‘embrace’, ‘prompt’, ‘guide’ or even referred to erroneously under euphemisms such as ‘physical support’, ‘manual handling’ or as a ‘first aid technique’
- Staff working in healthcare settings such as Child and Adolescent Mental Health Services (CAMHS) should undertake training designed specifically for teams working with physically frail or emotionally fragile children and/or young people. In such settings clinical holding may be necessary and the increased risks associated need to be recognised and managed

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 4 Specific considerations and adaptations to the standards for services supporting people who are deaf and have mental health conditions

## Type of service or setting

Specialist mental health services for deaf people. These include inpatient non-secure and secure psychiatric care, emergency and urgent care, community mental health teams, early intervention teams and crisis resolution and home treatment teams, community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- Training should emphasise the need to uphold and support the statutory rights of all deaf and hard of hearing service users under the Mental Health Act 1983 (amended 2007), the Mental Health (Care and Treatment) (Scotland) Act 2003, and the Equality Act 2010. The Equality Act 2010 states that deaf people who use British Sign Language (BSL) constitute an officially recognised, minority cultural group in the UK and are a population with 'protected characteristics'. There is a public sector duty to ensure that service provision does not discriminate against treatment
- Training must emphasise the need to ensure effective communication at all times in order to minimise distress, confusion, frustration and any delays in receiving vital treatment. BSL is the first language of 100,000 deaf people in the UK. NB: The *Mental Health Act Code of Practice*, section 14, states that an approved mental health professional involved in the assessment must be responsible for booking and using registered Qualified Interpreters with expertise in mental health interpreting (Department of Health, 2015; see also Welsh Assembly Government, 2016a)

- Training must emphasise that a person centred approach involves optimising and maintaining effective communication channels, providing deaf service users with the means to communicate expressively or receive communication visually
- The trainer must be familiar with the presentation of specific conditions in the service in which they are providing training. This is to ensure that all staff are able to understand the various causes of deafness, any impact on a person’s cognitive abilities, and the practicalities of ensuring communication channels are maintained
- It would be a valuable experience for any Qualified Interpreters operating within the unit to attend and/or participate in training courses relating to prevention and management of behaviours of concern, and in particular sessions covering restrictive interventions including physical restraint
- Trainers must actively involve the Qualified Interpreters in the delivery of sessions in order to deepen staff members’ understanding of the patient’s perspective. For any deaf members of staff, trainers must take time in advance to prepare with any Qualified Interpreter who may be supporting the session. Key terms and concepts must be clarified in advance
- The instruction model used for teaching physical restraint skills in some organisations is: Demonstrate–Participate–Explain. Deaf participants must have the opportunity to observe the demonstration and then receive a further demonstration during which they can concentrate on the qualified interpreter in order to receive an explanation of the demonstration before practising
- Qualified Interpreters must be provided with the flexibility to position themselves effectively to provide a clear visual field to deaf participants in order that they might receive information

Specific adaptations to the standards for this setting:

- Deaf service users can experience a range of mental health conditions which may present in different ways. Therefore an accurate assessment of their needs will be key when considering the use of restrictive practices, planned or unplanned. NB: Additionally, people with mental health conditions who are deaf may also have concomitant diagnoses such as autism or a learning disability

- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
    - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments (which may include access to suitable interpreter services or staff with BSL fluency) supporting the authorisation of physical restraint techniques
    - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculo-skeletal disorders
    - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
    - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
    - In addition to a higher incidence of exposure to traumatising events amongst this population, individuals who are deaf and rely upon BSL may be additionally traumatised where services are not able to support their communication needs. Trauma history may not always be known. If a person displays signs that may indicate past abuse the personalised wellbeing risk assessment should be updated
    - Additional consideration must be given to any evidence of recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else
    - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 5

# Specific considerations and adaptations to the standards for services supporting people who have eating disorders

## Type of service

Specialist eating disorder (ED) services provide support to individuals with a range of different mental health disorders that involve disordered eating behaviour and a disordered perception of body image. Behaviours can include restriction of dietary intake, binging, purging (including vomiting and laxative misuse) and excessive exercise, or a combination of these behaviours. The majority of inpatient services provide short term treatment offering a more recovery focused programme, focusing on refeeding, weight maintenance and recovery.

Refeeding may include naso-gastric (NG) tube feeding and may need to be completed with the use of physical interventions.

Specific considerations when delivering training in this setting:

- The individual's age and specific eating disorder pathology will have a bearing on their psychological and emotional resilience. Reduced psychological and emotional reserves are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern

- Eating disorders are also often associated with low weight and can cause serious physical health issues including poor bone health, low energy levels, and interruption to or cessation of menstruation, all of which can impact on internal organs such as the heart. Inpatient treatment is often needed for patients with significant weight loss, chronic or complex conditions and a large part of treatment focuses on controlled refeeding. This will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Training must promote the importance of providing a positive and safe therapeutic environment. For example, specific attention needs to be paid to the use of language and effective communication when working with ED, avoiding the misuse of praise and references to 'lifesaving treatment'
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- If training covers assisting there must be a focus on using the least restrictive interventions

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of under-developed anatomy/physiology and psychological/emotional abilities to cope with such experiences
- Procedures need to account for the space, time and understanding required to justify and support prolonged restraint due to the natural delivery time of NG feed
- More staff may be required in order to safely manage an incident involving treatment resistance
- Physical adjuncts may be required to maintain safety and reduce prolonged restraint
- Possible items used in the management of NG feed restraint may include neck collar protection, cushions or beanbags, as well as the possible use of soft cuffs to reduce physical restraints and the use of bespoke 'feeding sofas'
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with individuals in psychological and emotional distress, in particular around NG feed restraints

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 6

# Specific considerations and adaptations to the training standards for services supporting people who have learning disabilities

## Type of service

Services for people with a learning disability are also referred to as intellectual disability services. Services are inclusive of residential, social care, and individual's tenancies working within family home and health or hospital service settings.

People with a learning disability have reduced intellectual ability and may therefore take longer to learn and may need support to develop new skills or understand complicated information. People with a learning disability can also have concomitant mental illness and other neuro-developmental disorders such as autism and ADHD, as well as sensory and communication difficulties.

Specific considerations when delivering training in this setting:

- Interventions aimed at minimising any restrictive practices are more comprehensive when they arise from multi-disciplinary consultation
- Psychosocial interventions include a broad range of therapeutic approaches designed to support the person. They are generally non-pharmacological and aim to identify underlying factors for behaviour, reduce the person's distress and increase their skills. Approaches include communication interventions, applied behaviour analysis, positive behaviour support and cognitive behavioural therapy

- A multi-disciplinary team, care managers and social care providers should ensure that staff are trained in the management of escalating behaviours of concern using a training programme designed specifically for staff working with people with a learning disability. Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible
- The communication needs of people with a learning disability, particularly the needs of people who are unable to communicate through speech, should be taken into account in any assessment
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one
- People with a learning disability are at significantly increased risk of exposure to events with the potential to result in trauma symptoms, but such symptoms may be less likely to be recognised
- The link between restrictive interventions/physical restraint and security procedures such as search and confiscation should be noted
- Identification of any comforting object or routines to support recovery should be part of individual assessment
- People with a learning disability have an increased incidence of physical health conditions, but such issues may not always be recognised. Any risk assessment for the use of restrictive physical interventions should include a full medical review if one has not been undertaken recently in response to the presentation of behaviours of concern. The presentation of any behaviours of concern and/or distress may be a response to an underlying health problem and should always be investigated fully
- As with people who have mental health conditions, people with learning disabilities are not a homogeneous group and are likely to have suffered a range of adverse psychosocial experiences that may include bullying, abuse, trauma, over-medication and unnecessary use of restrictive practices

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped psychological/emotional abilities to cope with such experiences
- There are processes in identifying health or sensory problems early
- There must be a focus on providing strategies and interventions to support communication

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 7 Specific considerations and adaptations to the training standards for services supporting people who have mental health conditions

## Type of service

Includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- People with mental health conditions are not a homogeneous group. They may have a range of mental health conditions that present in different ways – the training provider should be familiar with the presentation of specific conditions in the service in which they are providing training. Additionally people with mental health conditions may have concomitant diagnosis such as autism and a learning disability
- Any behaviour management strategies stand within broader programmes that focus on recovery and care. Use of restrictive interventions will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
    - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
    - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders

  - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
  - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
  - A higher incidence of exposure to traumatising events may be evidenced by recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else. Trauma history may not always be known if a person displays signs that may indicate past abuse. The personalised wellbeing risk assessments should be updated
  - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. Training should also cover advance decisions and advance statements and the legal obligation attached to both
- The training should consider the legal issue of consent to the use of restrictive interventions and should take into account current legislation and guidance

Specific adaptations to the standards for this setting:

- Community mental health teams should not use physical restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 8

# Specific considerations and adaptations to the training standards for services supporting older people and people who are living with dementia

## Type of service

Specialist dementia services which are designed to offer care and support to older adults experiencing mental health problems and cognitive decline as a result of the changes associated with Alzheimer's disease, vascular dementia, Lewy Body dementia, fronto-temporal dementia and other forms of dementia. People with dementia can also have learning difficulties, as well as concomitant diagnoses including other functional mental health issues as well as autism.

Specific considerations when delivering training in this setting:

- Support provided within older adult/dementia services will aim to continue to promote personal independence whilst ensuring safety of the individual and those around them
- People with dementia can benefit from a high level of input from family carers or family members. They can both help the individual make sense of what is happening around them and provide insight and information that can be invaluable to the care team. The individual can have a complete lack of comprehension and therefore find it impossible to understand and follow instructions from staff. They are in a different reality and the use of restrictive practices including physical or mechanical restraint is likely to be terrifying and dangerous
- Any behaviour management strategies are likely to be supplemented/supported by personalised programmes/plans of care which should reflect the needs and wishes of the individual, as well as considering any advance directives which may have been agreed. Physical restraint will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for older people and people who are living with dementia, within the context of any restrictive interventions, include the following:
    - A rapid admission of a service user is likely to reduce the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
    - Where a person has experienced long term mental health difficulties leading into older adulthood, a higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. Consideration must also be given to ‘age-related’ health conditions such as arthritis and osteoporosis which may also increase the risks within the areas above or develop in later life

  - Where a person is experiencing cognitive decline related to their mental health or potential dementia, the impact can be significant. The development of multiple higher cortical deficits, including those associated with perceiving, understanding, problem solving, remembering, learning and making judgements can be both frightening and disorientating. This may be considered a risk factor in respect to the presentation of behaviours of concern, as well as within the context of any physical restraint technique
  - A higher incidence of personal neglect may be evidenced in patterns of personal care, taking of fluids/drinking, poor diet or the refusal of food. This can increase the likelihood of poorer general health and increase the risk of infection and malnutrition
  - Difficulties with swallowing, that raise the risk of choking or aspiration, would add to any distress experienced during a restraint
  - The development of ‘delirium’ (a treatable condition which can be over-shadowed by diagnosis such as dementia, as the person can experience memory loss, confusion and/or hallucinations) could give rise to behaviours of concern, as well as compromising the ability of the individual to make sense of what is happening and communicate effectively with those in a position to help
  - The potential for a higher incidence of psychological impairment amongst the population with dementia could be manifested in a perceived unwillingness to co-operate with staff. This may lead to staff considering decisions that might need to be made based on best interests. This in turn may be linked to staff decisions to use restrictive practices
  - An increased likelihood of a person experiencing ‘poly-pharmacy’ or the prescribing of more than one medication may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. There is also the complication of drugs interacting with each other

- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors described above. The process of identifying potential risks and agreeing suitable safeguards will require cross disciplinary collaboration with input potentially being required from dieticians, speech and language therapists, psychologists, physiotherapists, occupational therapists and pharmacists
- Consideration must be given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Where staff may be required to use restrictive practices/restraint techniques as part of personal care, the emphasis must be placed on personalised planning and support, including additional emphasis on therapeutic/clinical holding
- In emergency assessment units, wherein staff may be required to use restrictive practices/restraint techniques as part of the rapid admission/assessment process, additional time should be spent during training sessions to discuss the local protocols in place to manage the heightened risks
- Personalised wellbeing risk assessments should be completed and the training provider should be proactive in acquiring the most current anonymised information available about individual patients

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 9 Specific considerations and adaptations to the training standards for adult acute psychiatric wards and PICUs

(Please also refer to Appendix 7: Services supporting people who have mental health conditions)

## Type of setting

Acute services including those referred to as PICUs (Psychiatric Intensive Care Units), are likely to be required to provide rapid assessment and therapeutic psychiatric services for individuals who may be experiencing a mental disorder, an acute episode of mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public. Acute services as part of their commissioning may be expected to provide care and support within acute medical areas such as Accident and Emergency. This care could be considered emergency, or unplanned. Individuals accessing a PICU should be detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the patient usually requires an associated level of security (NAPICU, 2016).

Specific considerations when delivering training in this setting:

- Support provided within acute/PICU services will aim to continue to promote recovery as well as personal independence whilst ensuring protection of the public. However, within a PICU environment this may be superseded by actions which seek to offer stabilisation through psychological, psychosocial or pharmacological means. Both areas will require the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users to acute or PICU services is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. It is recommended that within these circumstances a plan be developed within 48 hours (admission dependent) with a maximum timeframe of seven days. This is an individual risk factor to be considered within the context of any physical restraint technique
- Behaviour management strategies may in some circumstances be accessible and therefore should be utilised to supplement/support an admission by ensuring that care offered is based on an individual’s personalised recovery-oriented programmes/plans, understanding of a person’s trauma journey, recognition of any self-injury reduction programmes, managing emotions programmes and communication development programmes. It may not always be possible to identify internal triggers but review may identify conditions and factors that make people's distress more likely to occur or impact on the severity of distress.
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual’s safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Additional time should be spent during training sessions to discuss the local protocols in place in emergency assessment to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider should be proactive in acquiring the most current anonymised information available about individual patients. Advice is that this should be developed within the first 48 hours; however, where information is being collated then up to seven days should be seen as a maximum time frame
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 10 Specific considerations and adaptations to the training standards for Emergency Departments

## Type of setting

Emergency Departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Emergency Departments often manage patients who may exhibit behaviours of concern. These are often associated with mental health problems, a learning disability, dementia, intoxication (alcohol/drugs) and autism.

Specific considerations when delivering training in this setting:

- Specific training regarding the causes and management of behaviours of concern in a busy Emergency Department environment should be at the core of any training programme. It is important to note that many Emergency Department staff receive only minimal training in the care of patients with mental health problems, learning disability, dementia, or other intellectual impairments. Additionally, patients who are intoxicated through alcohol or substances may also present in Emergency Departments with behaviours of concern

- Organic disease may hide behind a psychiatric disorder and full biological assessment is essential to avoid diagnostic overshadowing (where signs and symptoms are ignored or not fully assessed and are attributed to the primary condition, eg learning disability or mental health problem). Reactive psychiatric symptoms and behavioural responses may occur as a response to pain, fear, infection or chronic disease. This is more common in older adults, paediatrics, immuno-supressed and cancer patients. Recognition of physical deterioration in patients is essential and the relevant NICE guidelines should be included in training (Clinical Guideline CG50) (NICE, 2007). An assessment that considers the potential biological, psychological, pharmacological and social causes of behaviour will help to prioritise appropriate actions. The pharmacological domain should explore street drugs, alcohol, legal highs and over the counter medication as well as prescribed medications

Specific adaptions to the standards for this setting:

- Training must cover supporting patients coming from prison or low (such as psychiatric intensive care), medium or high secure mental health settings, who must arrive with their own staff who should take responsibility for any restrictive interventions. On-site security teams should be alerted at the time of admission of these patients, should support be needed, and this should be reflected in organisational policy. Where possible a separate space aside from the main Emergency Department should be allocated for specific use by this patient group. This space may also be used for other disturbed patients (including intoxicated patients) or those needing psychiatric assessment by the psychiatric liaison team (PLT). The space should be risk assessed, ligature free and not contain any objects that could be used as weapons.

  It is also important to check that the patient is not carrying potential weapons or illicit substances on their person. This can be discreetly performed by replacing outdoor clothing with a hospital gown. NICE guidelines on violent and aggressive behaviours in people with mental health problems (QS154) (NICE, 2017b) should be alluded to in training

- If the on-site security team (or in some cases, the police) are called and physical intervention is considered necessary as a last resort, medical and senior nursing staff must remain present throughout to monitor the patient's physical health and ensure that the least force is utilised for the shortest space of time
- Any form of restrictive intervention must be recorded in the patient's notes, including the duration of the intervention and description of which body part(s) were held. An incident form must also be completed using the organisation's reporting systems detailing all aspects of the event
- Any use of mechanical restraint such as mittens must be prescribed in writing by senior medical staff (Consultant or Senior Registrar) and the care team informed
- Chemical restraint may be given when prescribed by senior medical staff, as per organisational policy, should rapid tranquilisation be considered necessary. Oral medication shall be offered in the first instance where not contra-indicated due to medical condition
- Psychiatric emergencies (including S136 MHA, 1983) and transfers to mental health facilities shall be accompanied by staff and a risk assessment must be in place, as per organisational protocol (see also the Mental Health (Care and Treatment) (Scotland) Act 2003)
- Relationships with psychiatric liaison teams are crucial to the functioning of Emergency Departments and where possible integrated training should take place with both staff teams included

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 11 Specific considerations and adaptations to the training standards for family homes

(Please also refer to Appendix 14: Lone working)

## Type of setting

Family homes. The training could be delivered to family members and friends, other carers paid or unpaid, personal assistants, home tutors and other professionals.

Specific considerations when delivering training in this setting:

- Lone working arrangements relating to personal assistants*/carers, home tutors, and other health/social care professionals working in these settings (see Appendix 14: Lone working)
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when staff are working alone. (See Appendix 14: Lone working)

---

* The Health and Safety at Work Act 1974 does not apply to activities classed exclusively as 'domestic services' carried out in 'private households'. Personal care provided within someone's own home may be 'domestic service' and therefore may fall within this dis-application. Clarity would need to be sought.

- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decisions are made only after full and thorough multidisciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training, and recording protocols should be manageable for family members. These should be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 12 Specific considerations and adaptations to the training standards for forensic and high secure services

(Please also refer to Appendix 4: Services for people who have mental health conditions)

## Type of service

Forensic and high secure mental health services, specifically those providing a therapeutic psychiatric service for individuals with a mental disorder, mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public.

Specific considerations when delivering training in this setting:

- Training in high secure services must be delivered in accordance with the NICE-approved Positive and Safe training manual: *Violence Reduction and Management Programme* (West London Mental Health Trust, 2016 – for further information visit Promoting hope and wellbeing together )
- Support provided within forensic/secure services will aim to promote recovery as well as personal independence whilst ensuring protection of the public. This will involve the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. This is an individual risk factor to be considered within the context of any physical restraint technique
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual's safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Within high secure/forensic settings the appointment of an overall lead (or response 'controller') within the context of any restrictive intervention/physical restraint is recommended
- Additional time must be spent during training sessions to discuss the local protocols in place in emergency assessment units to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider shall be proactive in acquiring the most current anonymised information available about individual patients
- It is expected that information about existing medical conditions can be accessed very quickly. Other information needed to complete the personalised wellbeing risk assessment must be gathered within 48 hours, with seven days being the limit for a completed assessment. When they have received the anonymised information the training provider must advise on any adaptations or contra-indications to the range of techniques that can be used on that person as soon as the information is received. It is expected that the training provider has a protocol for dynamic personalised wellbeing risk assessments which has been agreed with the commissioning organisation
- Additional risk assessments will be required to cover the application of any mechanical restraints. These must cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure so any risk assessments must be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards.

# Appendix 13 Specific considerations and adaptations to the training standards for foster care

## Type of setting

Foster carers/foster caring. One of a number of care options that offers children a home when they are unable to live with their birth family.

Specific considerations when delivering training in this setting:

- Only behaviour management strategies and policies agreed by local authorities and fostering agencies must be authorised for use
- Distinctions shall be made between caring and supportive touch, and coercive touch; and between caring and supportive holding, and coercive holding
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services
- In those settings where an adult may apply a restrictive intervention/physical restraint technique on a child without direct support or supervision the practicalities and limitations of 1:1 practices must be considered. It is vital that there are robust processes and procedures in place so as to ensure that the child's voice can be heard in relation to any safeguarding issues/concerns
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments and should be part of initial assessment made at point of referral

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when foster parents/carers are working alone.
  See Appendix 14: Lone working
- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decision is made only after full and thorough multi-disciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- In the event that a 1:1 intervention is considered, a risk assessment covering this dynamic must be undertaken before any strategy or technique is authorised for use
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training and recording protocols should be manageable for foster carers. These must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 14 Specific considerations and adaptations to the training standards for lone working

## Type of setting

Lone workers are those who work by themselves without close or direct supervision. This may include those working outside of normal hours, or within satellite locations. Lone workers may include personal assistants, home tutors, social workers, healthcare professionals and mental health workers.

Specific considerations when delivering training in this setting:

- The need for staff to be able to conduct dynamic risk assessments in support of formal risk assessments and agreed safety procedures
- How the assessment and management of risk is impacted by lone working status
- The role of tracking, communication and alarm systems in mitigating against harms

Specific adaptations to the standards for this setting:

- A prohibition on restrictive interventions/ restraint techniques is likely, based on lone working arrangements
- A strong emphasis on responses likely to ensure safety, keeping personal distance, de-escalation and strategic capitulation
- Arrangements for post-incident support and review for all parties should be agreed prior to delivering training and must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 15 Specific considerations and adaptations to the training standards for schools

## Type of setting

This includes local authority maintained schools, academies and free schools, pupil referral units, non-maintained special schools, independent schools and sixth form colleges.

Other settings for which the following may have some relevance include Special Education Units, Special Educational Needs resourced provision, Pupil Referral Units and Early Years providers

Specific considerations when delivering training in this setting:

- Teachers have the power to discipline pupils for misbehaviour and this includes the power to use reasonable force to prevent pupils from hurting themselves or others
- Joint Select Committee on Human Rights stated that use of restraint of children for discipline and good order (where there is not an imminent risk of serious harm) must be prohibited as it contravenes the ECHR
- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment

- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, ‘physical restraint’ may be referred to as ‘physical intervention’ or even simply as the ‘use of force’. Alternatively, reference may be made to the function of the force, such as its use ‘to control pupils or to restrain pupils’. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds
- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to *‘restrict, or subdue movement of the body (or part of the body) of the student or pupil’* should be seen as amounting to *‘physical restraint’* (Department of Education, 2013b)
- Underdeveloped anatomy, eg bone size, shape and density, will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, will impact on the selection of techniques to be included in any training syllabus
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one
- There may be children within the school, often those who display behaviours of concern, who may have been exposed to Adverse Childhood Experiences (ACEs). As a result children can be traumatised, and at risk of re-traumatisation. The nature and presence of such prior experiences will have significant implications on how behaviours of concern are managed, in particular with restrictive interventions including physical restraint
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making

- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that *'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safeguarding and pupil welfare'* (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms. Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment

Specific adaptations to the standards for this setting:

- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- There should be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of under-developed anatomy/physiology, underdeveloped psychological/emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults

- The gender of staff and that of pupils needs to be considered, with safeguards in place to avoid traumatising/re-traumatising experiences, as well as avoid any scope for allegations of inappropriate physical contact
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*

Training providers delivering training in other countries must refer to country specific legislation.

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

## Key principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B, HM Government 2019)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken

- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved

## Other considerations

- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment
- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, ‘physical restraint’ may be referred to as ‘physical intervention’ or even simply as the ‘use of force’. Alternatively, reference may be made to the function of the force, such as its use ‘to control pupils or to restrain pupils’. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds

- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to 'restrict, or subdue movement of the body (or part of the body) of the student or pupil' should be seen as amounting to 'physical restraint' (Department of Education, 2013b)
- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making
- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that 'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safeguarding and pupil welfare' (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms. Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment
- See 'Best practice guidelines' contained in the section 'Specific considerations when delivering training' in 'Appendix 3 Specific considerations and adaptations to the training standards for services supporting children' for detailed information about general best practice in particular regard to the use of physical restraint

Specific adaptations to the standards for this setting:

- Training providers may need to adapt their delivery model to accommodate school INSET days where appropriate
- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise, the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*
- Primary preventative strategies should be prioritised. This should include evidence based models such as Positive Behaviour Support (suitable for all settings)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behavior support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- Staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically

- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019, UN Committee on the Rights of the Child, 2006)
- Trainers should discuss ‘intervention creep’ as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as ‘any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement’, but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as ‘embrace’, ‘prompt’, ‘guide’ or even referred to erroneously under euphemisms such as ‘physical support’, ‘manual handling’ or as a ‘first aid technique’

Training providers delivering training in other countries must refer to country specific legislation.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 16

# Specific considerations and adaptations to the training standards for Tier 4 Child and Adolescent Mental Health Services (CAMHS)

## Type of service or setting

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Children's Services deliver specialist inpatient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH services. Many of the children and young people who are admitted to these services have experienced unsuccessful treatment regimes in tier 1 to 3 community or other services and may be detained under the Mental Health Act 1983 (Amended 2007) see also the Mental Health (Care and Treatment) (Scotland) Act 2003.

Specific considerations when delivering training in this setting:

- There must be an emphasis on working collaboratively with parents/carers to provide family centred care. To this end, there must be effective communication between service users and their families, health providers and other involved agencies using the Care Planning Approach, so that families and professionals are fully involved in decisions related to treatment as well as any planned responses to behaviours of concern

- Training must emphasise the need for, and value of, investing in a meaningful engagement process with patients and family members in order to enhance the therapeutic alliance between patient and staff
- Training must also consider providing an understanding of how to recognise and respond to those children/young people who may be affected by being involved in or witnessing physical interventions, especially those with a history of trauma and abuse
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- Underdeveloped and over-developed anatomy, eg bone size, shape and density, underdeveloped physiology, and disparities in size between children and adults will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern
- The safety of any restrictive interventions, in particular physical restraint techniques, is contingent upon the impact of such techniques being carefully considered and managed
- The psychological, emotional and physical vulnerabilities linked to the presentation of any of the following should be considered risk factors: psychosis, eating disorders, affective disorders, developmental disorders including autism, neurodevelopmental disorders such as learning disability and autism, attention deficit hyperactivity disorder (ADHD), tic disorders, obsessive compulsive disorders, anxiety and emotional disorders, self-harming behaviours, attachment and emotional regulation disorders, as well as a primary diagnosis of mental illness with co-morbid learning difficulties. In order to manage the risks arising, collaboration with, and input from, allied health professionals is likely to be necessary

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped anatomy/physiology, underdeveloped psychological/emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with children and adolescents
- Training programmes for this setting must be flexible, and kept under review, in order to ensure they are able to adopt changes in line with clinical evidence-based practices supported by incident data analysis
- Children and young people in these settings should be involved in developing certain aspects of training in relation with primary, secondary and tertiary strategies
- There should be a framework/processes in place to involve children/young people/parents in making decisions on the use of unavoidable restrictive interventions offered by services, and in the use of least restrictive intervention as part of their treatment plans (eg PILRIMP – Patient Inclusion in Least Restrictive Intervention and Management Plan)
- The framework (such as PILRIMP) must be part of the training programme for staff to understand the value of positive engagement with children and young people in order to reduce and to manage their emotions, anxieties and trauma related concerns when using restrictive interventions
- The training provider must provide a list of all restrictive interventions that are taught to staff so that the commissioning organisation can make this information available to children/young people/parents with the information as to why, when and how these restrictive interventions can be used as part of treatment plans
- Photos/leaflets of restrictive interventions techniques must be provided to children/young people/parents as part of an admission pack to help them to manage their emotions, anxieties and trauma related concerns in the use of possible unavoidable restrictive interventions

Specific guidance/legislation relating to delivering training in this setting/service:

- Mental Health Act 2007 and Code of Practice
- Mental Health (Care and Treatment) (Scotland) Act 2003
- *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)
- Mental Capacity Act 2005 and Code of Practice
- Adults with Incapacity (Scotland) Act 2000
- Mental Capacity Act (Northern Ireland) 2016*
- Deprivation of Liberty Act 2010
- The Children Act 1989 and Children Act 2004
- Department of Health Guidance for Restrictive Physical Interventions (July 2002)
- United Nations Convention on the Rights of the Child 1989
- Protection of Children Act 1999
- NICE (2015) *Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings*. NICE guideline NG10
- NICE (2004) *The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care.* NICE clinical guideline 16
- Royal College of Nursing (2010) *Restrictive Physical Intervention and Therapeutic Holding for Children and Young People. Guidance for Nursing Staff.* London: RCN
- Department of Health and Social Care and Department for Education (2017) *Reducing the Need for Restraint and Restrictive Intervention: Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties* (Consultation document)
- National Decision-Making Model (NDM), College of Policing

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

# Appendix 17

# Specific considerations and adaptations to the training standards for services in England

Specific adaptations to the standards:

The Department of Health's document *Positive and Proactive Care* (2014) relates to health and social care services where individuals who are known to be at risk of being exposed to restrictive interventions are cared for. Such settings may provide services to people with mental health conditions, autistic spectrum conditions, learning disabilities, dementia and/or personality disorders, older people and detained patients. It is more broadly applicable across general health and social care settings where people using services may on occasion present with behaviour that challenges, but which cannot reasonably be predicted and planned for on an individual basis. This may include homes where individuals employ their own support staff, and community-based primary and secondary care settings. 'Restrictive interventions' are defined within the guidance as: *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:*

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the person's freedom for no longer than is necessary.'*

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles:

1. Restrictive interventions shall never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
2. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
3. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
4. Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
5. Any restriction must be imposed for no longer than absolutely necessary
6. What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
7. Restrictive interventions must only ever be used as a last resort
8. The involvement of people who use services, carers and advocates is essential when reviewing plans for restrictive interventions

A panel of experts identified that certain restraint techniques presented an unacceptable risk when used on children and young people (Physical Control in Care Medical Panel, 2008; quoted in Department for Education, 2013b). The techniques in question are:

- the 'seated double embrace' which involves two members of staff forcing a person into a sitting position and leaning them forward, while a third monitors breathing
- the 'double basket-hold' which involves holding a person's arms across their chest and
- the 'nose distraction technique' which involves a sharp upward jab under the nose

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 18

# Specific considerations and adaptations to the training standards for services in Northern Ireland

Specific adaptations to the standards:

Physical restraint has been defined within ‘health and personal social service settings’ as: *‘The use of any part of one’s body, or mechanical method, to prevent, restrict or subdue movement of any part of another person’s body. It can be employed to achieve a number of different outcomes:*

- *to break away or disengage from dangerous or harmful physical contact initiated by a service user*
- *to separate the person from a “trigger”, for example, removing one service user who has responded to another with physical aggression*
- *to protect a service user from a dangerous situation – for example, the hazards of a busy road’* (Human Rights Working Group On Restraint And Seclusion, 2005)

Within educational settings the term ‘reasonable force’ is used, with the following qualification: *‘the working definition of “reasonable force” is the minimum force necessary to prevent a pupil from physically harming him/herself or others or seriously damaging property, but used in a manner which attempts to preserve the dignity of all concerned’* (Department of Education Northern Ireland, 2004)

Training content must refer to the Royal College of Nursing guidance: *Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions* (2017) Royal College of Nursing Three Steps to Positive Practice

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards.

# Appendix 19 Specific considerations and adaptations to the training standards for services in Scotland

Specific adaptations to the standards:

- The Mental Welfare Commission for Scotland is concerned with ensuring the 'welfare of individuals with mental illness, learning disability and related conditions'. In their good practice guide they define 'restraint' as *'taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a person [or other person] from doing what he or she wishes to do and as a result places limits on his or her freedom. Restraint is defined in relation to the degree of control, consent and intended purpose of the intervention'* (Mental Welfare Commission for Scotland, 2013a)
- In *Holding Safely* (guidance produced for residential child care practitioners, which covers children and young people), 'physical intervention' was defined as *'an action involving using a worker's body, for example blocking the path of a child or any guiding of him or her away from a harmful situation. It includes physical restraint'* (The Scottish Institute for Residential Child Care (SIRCC), 2005, updated 2013)
- In the same document 'physical restraint/restraining a child' was defined as *'an intervention in which staff hold a child to restrict his or her movement and should only be used to prevent harm. We have largely avoided simply using the term restraint and instead have referred to restraining a child as just that – restraining a child. We deliberately chose to change this language to avoid losing sight of the child, who might otherwise be overlooked by the more clinical and depersonalised use of the term "restraint"'* (SIRCC, 2005, updated 2013)

- *Holding Safely* defines certain techniques that should never be used: ‘neck holds’; those involving any ‘obstruction of the mouth or nose’; and those relying on ‘pain compliance’
- *Holding Safely* also defined high risk practices that required strong justification and comprehensive safeguards: ‘prone restraint’; ‘supine restraint’; ‘seated holds’ and ‘basket holds’
- *Holding Safely* was produced in 2004, when SIRCC were asked by the Scottish Executive to produce guidance on restraining children and young people in residential child care establishments. The *Holding Safely* guidance was originally specifically targeted at the residential child care sector, and not at schools
- In 2013 additional guidance was issued, designed to complement *Holding Safely*. The purpose of this additional guidance was to ensure that the key principles and practice of *Holding Safely* were adopted in all residential child care establishments across Scotland. This included secure care and establishments which provided services for children affected by a disability. The Scottish Executive published its refreshed national guidance, *Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions* on 19 June 2017. This refreshed guidance includes information and advice for education authorities on de-escalation and physical intervention

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 20

# Specific considerations and adaptations to the training standards for services in Wales

Specific adaptations to the standards:

The Welsh Assembly Government considers that guidance it issues on restrictive physical intervention policy and practice for professionals who work with children, young people, adults and older people in health, education and social care settings should share a common framework of principles and expectations. The Welsh Assembly Government has therefore elected to use the term ‘restrictive physical intervention’ to describe direct physical safeguarding action: *‘Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual’* (Welsh Assembly Government, 2005)

Within education settings the term ‘use of force’ has been used. A distinction is made between its use for ‘control’, and for ‘restraint’:

- Control can mean either passive physical contact (eg standing between pupils or blocking a pupil’s path) or active physical contact (eg leading a pupil by the hand or arm, or ushering a pupil away by placing a hand in the centre of the back)
- When members of staff use ‘restraint’ they physically prevent a pupil from continuing what they were doing after they have been told to stop. Restraint techniques are usually used in more extreme circumstances, such as when two pupils are involved in a fight and physical intervention is needed to separate them (Welsh Assembly Government, 2010)

In 2005, the Welsh Assembly Government published the *Framework for Restrictive Physical Intervention Policy and Practice* which stated that, *'Under no circumstances, should any individual ever be restrained in a (prone) face down position.'*

In 2008 this guidance was revised in recognition of the fact that the prone restraint position was used in mental health services across the Welsh NHS. The position is recognised as one of last resort, and one which needs to be carefully managed to ensure the patient's safety. If prone (face down) restraint is used it will need to be justified and documented.

In 2013, the Welsh Assembly Government published further guidance on the use of physical intervention: *Safe and Effective Intervention – Use of Reasonable Force and Searching for Weapons* (097/2013). This guidance does not refer to the use of face down (prone) restraint. However, the guidance recognises that in exceptional circumstances staff have to do whatever is necessary to keep a pupil safe.

In 2016, *Positive Approaches: Reducing Restrictive Practices in Social Care* was published by the Care Council for Wales.

The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides a framework for the delivery of violence and aggression training within the NHS in Wales. It also provides guidance on the development of documentation to ensure the effective assessment and maagement of violence and aggression. The scheme has four modules:

| | |
|---|---|
| Module A | Induction and awareness raising |
| Module B | Theory of personal safety and de-escalation |
| Module C | Breakaway techniques |
| Module D | Restrictive physical interventions (this has been developed specifically for specialist areas such as mental health services, and is currently being reviewed and revised by the all Wales Proactive Reduction of Restrictive Interventions Clinical Effectiveness (PRRICE) group) |

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

# Appendix 21A

# The use of pain to gain compliance

- The cross sector Restraint Reduction Network steering group does not endorse the use of pain based techniques
- The Restraint Reduction Network is committed to the specification, and implementation, of person centred care planning. This may include the development of individualised behaviour support plans, which may include reactive strategies, providing carefully considered guidance on how to respond to those behaviours of concern that represent a risk to safety. Such plans may include physical restraint as a last resort. In addition to being lawful, such interventions must also be ethical and safe
- The Restraint Reduction Network believes that the planned, or intentional, application of pain to elicit behavioural compliance runs counter to the primary role of staff which is to provide individualised therapeutic care and support. Techniques, which are often referred to as 'pain compliance techniques', are also potentially dangerous and likely to be damaging to the development and maintenance of vital ongoing therapeutic/supportive relationships
- The European Committee for the Prevention of Torture advise that pain must never be used to gain compliance
- The European Commission for Human Rights takes the view that pain inducing restraint must be prohibited on children and many professional codes of practice clearly define that the deliberate application of pain is not acceptable

# Appendix 21B

# The use of pain for escape or rescue purposes

- The Restraint Reduction Network does acknowledge that where there is an immediate risk to life, the NICE Guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life
- In this case, the training provider must present a clear, written rationale for the inclusion of such techniques in training and the reasons why staff require such training. The rationale must be supported by risk assessments and should include recommended criteria for monitoring, minimising and reducing the use of these techniques
- It must be clear in the rationale which staff need the training. The rationale must be authorised by the most senior official responsible for restraint in the commissioning organisation and must be reviewed with the senior official before any training event that includes the techniques
- Training must cover safety advice, reporting requirements and review arrangements for the use of these techniques

# Glossary

### Accreditation

The official recognition of a particular status or qualification to provide or perform a particular activity. Training providers can demonstrate compliance with these standards through certification. Contact BILD Association of Certified Training for information regarding certification.

### Advance decision

A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

### Advance statement

A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

### Affiliated service providers

These are service provider organisations that deliver certified training services within their own organisations on behalf of the training provider.* Quality assurance and training for the associate trainers who are delivering the approved programmes within the service provider organisation are provided directly by the training provider which will be sampled in the continuous assessment process for certification.

* these may be known as in-house or in-service training models

### Behavioural overshadowing

This is when behaviours of concern are attributed to the person's learning disability, mental health, differential diagnosis, age or gender.

### Breakaway techniques

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive. or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

It would be important to assess the communicative function of the physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

### Certificated training service

Certificated training services are the combination of approved curriculum and authorised trainers that meet the *Restraint Reduction Network Training Standards*.

### Children

People aged 12 years or under.

### Coercion

Any action or practice undertaken which is inconsistent with the wishes of the person in question (ie undertaken without the person's informed consent) – also see psychological restraint.

### Commissioning organisation

This is an organisation who commissions training – usually a service provider – and in some cases this might be through an in-house provider.

### De-escalation

The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is not de-escalation. De-escalation techniques can include verbal strategies, such as maintaining a calm tone of voice and not shouting or verbally threatening the person; and non-verbal techniques, including an awareness of self, body stance, eye contact, and personal safety (Cowin et al, 2003; Spencer and Johnson, 2016). Effective de-escalation approaches are personalised and include openness, honesty, support, self-awareness, coherent communication, non-judgemental approaches, and confidence (without arrogance) (Price and Baker, 2012). They have the aim of preventing escalation and supporting the person to be calm.

### Diagnostic overshadowing

This is when symptoms of physical ill health are mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disabilities.

### Distressed behaviours

Distress can result in challenging behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (adapted from the definition in Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007). They may also be referred to as challenging behaviours, behaviours that challenge or that can be described as challenging, and distressed behaviours or behavioural disturbances.

There are a wide range of behaviours that are considered to be concerning. These can include verbal or physical aggression, violence and aggression towards others, self-harm, withdrawal, and they can manifest verbally or physically. Distressed behaviours of concern are assumed to have a purpose and communicative meaning for the person.

### Duty of candour

The duty of professionals to be open and honest with people when something goes wrong and has the potential to cause harm or distress.

### Duty of care

The legal obligation to safeguard others from harm while they are in your care and/or exposed to activities such as training programmes.

### Escape and rescue techniques

A set of physical skills to help separate or break away from an aggressor in a safe manner. This may be completed by an individual or in extreme cases supported by another to enable escape/rescue. These techniques are not expected to involve the use of restraint (NICE, 2015).

### Fragility

Refers to issues that may compromise the fidelity of the technique between its taught version and application in practice. Fragility issues have implications for both effectiveness and safety. A technique is deemed fragile if small adjustments (movement or pressure) to the procedure are likely to result in intentional, or unintentional injury or severe pain to an individual (Paterson, 2014; Martin et al, 2008).

### GDPR

General Data Protection Regulations 2018

### Hyperextension

An excessive joint movement in which the angle formed by the bones of a particular joint is opened, or straightened, beyond its normal, healthy, range of motion.

### Hyperflexion

Flexion of a limb or part beyond the normal limit.

### Incident

Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation).

### Named person

In the commissioning organisation this should be someone with board level/executive level responsibility as well as a practice restraint reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation.

Both people are responsible for the annual review of the curriculum. Where training is both developed and delivered in-house, the same process of development delivery and review should be followed although there may only be one named person.

### Pain compliance

Pain compliance is the use of painful stimulus to control or direct a person's actions.

### Participant

In these standards a participant is a person who attends a training programme.

### Peer review

A systematic interactive process that helps nursing staff and students evaluate their colleagues' practice and engage in constructive dialogue with them, providing feedback to peers based on specific criteria to assist in professional and/or personal growth.

### People with lived experience

People with a lived experience of receiving services and experience of having restrictive interventions applied to them. The term can also apply to families and carers.

### Personal assistants (PA)

A carer (PA) employed by an individual or a related third party without the involvement of an employment agency or employment business, and working wholly under the direction and control of that individual or related third party in order to meet the individual's own personal care requirements.

### Personalised wellbeing risk assessment (PWRA)

A process which supports the gathering of important personal information used to determine the suitability and safety of any restrictive interventions.

### Planned and unplanned restrictive intervention

These standards use the term planned restrictive intervention to mean a restrictive intervention that has been agreed and is documented as part of someone's agreed plan. An unplanned restrictive intervention is when a restrictive intervention is used as a response to an unexpected incident. The use of the restrictive intervention should be recorded and reviewed shortly afterwards.

### Post-incident review

A review that consists of two separate components:

1. Post-incident support This is the support that is immediately offered to an individual who has been involved in an incident, it should include assessment and treatment of any medical needs and provision of immediate emotional support.

2. Post-incident reflection and learning review This is a non-blaming review where the factors that led to the restrictive intervention being used are examined and actions are agreed that support the prevention of future incidents or the minimisation of impact and less restrictive response in the future.

### Primary strategies

These strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern arising.

### PRN (pro re nata)

When needed, PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to harm to the person or others.

### Reflective practice

The practice of reflecting on one's actions so as to engage in a process of continuous learning. Services and professionals can at times unintentionally provoke situations. Reflective practice helps identify how to better meet needs to prevent crisis.

### Refresher training

A programme that the participant attends within a year of attending the original programme. Its aim is primarily to refresh skills learned previously but it should also contain a developmental element.

### Restraint minimisation

Assessment, planning and review measures aimed at reducing the intensity and duration of any physical restraint techniques that are used within defined settings, or in relation to a defined population or a specific individual.

### Restraint reduction

Assessment, planning and review measures designed to reduce the number of times restraint techniques are used within defined settings, or in relation to a defined population or a specific individual.

## Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, physical restraint, mechanical restraint and rapid tranquilisation and other chemical restraint. Restrictive interventions have the potential to violate the person's human rights.

- **Chemical restraint**

Involves using medication with the intention of restricting someone's movement. This could be regularly prescribed medication – including those to be used as required (PRN) – or illegal drugs.

- **Observation**

A restrictive intervention of varying intensity in which a member of the staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation.

- **Physical restraint**

Any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement. Physical restraint can also be called manual restraint and restrictive physical intervention.

- **Long term segregation**

Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the person to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a person should not be allowed to mix freely with other patients on the ward or unit on a long term basis.

- **Mechanical restraint**

A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts. Its purpose is to immobilise or restrict movement of part(s) of the body of the person.

- **Rapid tranquilisation**

Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

- **Technological surveillance**

Tagging, pressure pads, closed circuit television, or door alarms, for example, are often used to alert staff that the person is trying to leave or to monitor their movement.

- **Psychological restraint or coercive practice**

This can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing, or keeping the person in nightwear with the intention of stopping them from leaving.

- **Seclusion**

If a person is isolated and prevented from leaving a room of their own free will, it meets the criteria for seclusion, even if it is called by a different name. Alternative names in use may be: time out, isolation, chill out, or single separation. There could be a number of methods that prevent someone from leaving a room including a perceived or real threat. In a hospital setting seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the person 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. Seclusion does not include locking people in their rooms at night in accordance with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013.

## Restrictive practices

This is an umbrella term for making someone do something they don't want to do or stopping someone doing something they want to do. In service settings it can be linked to the use of blanket rules which apply to everyone regardless, but may have a tenuous basis for application or are only necessary because of a specific individual risk.

## Secondary strategies

These strategies focus on the recognition of an individual's early behavioural signs (physical, emotional, communicative, etc) which can indicate an increase in behavioural disturbance. Strategies are developed to identify how to respond to a person's behaviours or support the person to self-manage. Secondary strategies are likely to include approaches to de-escalation. These may be referred to as reactive strategies, secondary preventative strategies or active interventions. Secondary strategies can be restrictive (such as use of PRN at an early stage) or non-restrictive. Such strategies are designed to be used when staff recognise signs of a developing behavioural disturbance, and are aimed at reducing or removing the underlying causes of the behaviour, including issues such as pain, distress or frustration.

### Tertiary strategies

These strategies are used when an actual behaviour of concern is presenting, with the primary aim to bring the incident to an end in a timely and safe manner, with due regard to the individual's rights and dignity. Examples of non-restrictive tertiary strategies include de-escalation, diversion, distraction or strategic capitulation. Examples of restrictive tertiary strategies include restrictive interventions such as physical restraint.

### Trainers

There are two kinds of trainers referred to in these standards:

- **Senior trainers**

Senior trainers are authorised under the certification scheme to deliver approved programmes across multiple organisations and/or deliver approved 'Train the Trainer' programmes. Senior trainers may be employed (or paid) by a commercial training provider or be employed within a service provider organisation such as an NHS trust. 20% of senior trainers are subject to direct quality assurance sampling processes through the certification scheme. This status is non transferrable across organisations, employers or other training organisations.

- **Associate trainers**

Associate trainers are authorised by the training provider to deliver approved programme(s) only within their own service or organisation, they are not authorised to deliver any approved 'Train the Trainer' programmes. Associate trainers are likely to be employed by affiliated service provider organisations (eg NHS trusts, schools or care homes who deliver training services on behalf of the training provider and will be expected to meet the requirements as laid out within the *Restraint Reduction Network Training Standards*. This status is non transferrable across organisations, employers or other training organisations. Direct quality assurance for these trainers is the responsibility of the training provider who will be expected to provide evidence of quality assurance monitoring processes as part of the certification of their training services, which will be sampled in the continuous assessment process for certification

### Training curriculum

A list of subjects that make up the training programme.

### Training needs analysis (TNA)

The first step in the training process. Designed to identify performance gaps that can be remedied by training. It consists of surveillance, investigation, and data analysis (Thomas, 2004)

### Training providers

There are two kinds of training provider referred to in these standards:

- **Commercial training organisation**

who are commissioned to provide training to a range of organisations

- **In-house training providers**

who deliver training within their own organisation, for example, an NHS trust or a care organisation

### Trauma informed care

An organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma.

### Written rationale

Written explanation of the logical reasons or principles for arriving at a decision to include particular restrictive interventions in the training curriculum.

### Young people

People aged between 13 and 17 years.

# References

Aiken, F, Duxbury, J, Dale, C and Harbison, I (2011) *Review of the Medical Theories and Research Relating to Restraint Related Deaths*. Caring Solutions (UK) and University of Central Lancashire, Preston. Available at: https://bit.ly/2E8ktQL (accessed 21 July 2018).

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (5th edn). Arlington, VA: American Psychiatric Publishing.

Association of Chief Police Officers and National Policing Improvement Agency (2010) *Guidance on Responding to People with Mental Ill Health or Learning Disabilities*. Available at: https://bit.ly/2xZ9mnm (accessed 21 July 2018)

Action on Hearing Loss (2018) *Facts and Figures*. Available at: https://bit.ly/2zQSocf (accessed 10 July 2018)

Association of Directors of Children's Services Health, Care and Additional Needs Policy Committee Task Group (2009) *A Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People*. Manchester: ADCS

Baker, P A (2017) Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study, *International Journal of Positive Behavioural Support*, 7(1), 38-44

Bevan, E R (2018) *Best Practice Guide for BSL/ English Interpreters Working in Mental Health*. Available at: https://bit.ly/2xY9HGX (accessed 10 July 2018)

BIHR (2013) *The Difference it Makes: Putting Human Rights at the Heart of Health and Social Care*. London: BIHR

BIHR (2016a) *Mental Health, Mental Capacity, and Human Rights*. London: BIHR

BIHR (2016b) *BIHR Toolkits: Learning Disability and Human Rights*. London: BIHR

BILD (2014) *BILD Code of Practice for Minimising the Use of Restrictive Physical Interventions: Planning, Developing and Delivering Training* (4th edn). BILD: Birmingham

BILD Centre for the Advancement of Positive Behaviour Support (2018) *Questions to Ask About the Use of Physical Restraint in Schools*. Available at: https://bit.ly/2NaIcDN (accessed 21 March 2018)

BILD Centre for the Advancement of Positive Behaviour Support (2018) *The Use of Tents or Other Confined Spaces in Schools*. Available at: https://bit.ly/2NaIcDN (accessed 21 March 2018)

Bowers, L (2014) Safe-wards: a new model of conflict and containment on psychiatric wards, *Journal of Psychiatric and Mental Health Nursing*, 21(6), 499–508

Cabral, L, Muhr, K and Savageau, J (2013) Perspectives of people who are deaf and hard of hearing on mental health, recovery and peer support, *Community Mental Health Journal*, 49(6), 649–57

Campbell, D (2018) Figures reveal 'alarming' rise in injuries at mental health units, *The Guardian* [online], 10 June. Available at: https://bit.ly/2kYBkc8 (accessed 10 July 2018)

Care Commission, Mental Welfare Commission for Scotland (2009) *Remember I'm Still Me*. Edinburgh: MWCS

Care Council for Wales (2016) *Positive Approaches: Reducing Restrictive Practices in Social Care*. Cardiff: CCW

Care Quality Commission (2015a) *Regulation 20: Duty of Candour*. Newcastle Upon Tyne: CQC

Care Quality Commission (2015b) *Brief Guide: Restraint (Physical and Mechanical)*. Available at: https://bit.ly/2RnWMX3 (accessed 21 March 2018)

Care Quality Commission (2015c) *Brief Guide: Seclusion Rooms.* Available at: https://bit.ly/2Ph8v88 (accessed 21 March 2018)

Care Quality Commission (2016) *Brief Guide: Restraint (Physical and Mechanical)*. Available at: https://bit.ly/2O2LQQx (accessed 4 July 2018)

Care Quality Commission (2017) *Brief Guide: Long-term Segregation*. Available at: https://bit.ly/2xTVAmb (accessed 21 March 2018)

Catchpole, K and McCulloch, P (2010) Human factors in critical care: towards standardized integrated human-centred systems of work, *Current Opinion in Critical Care*, 16, 618–22

Chester, V, Devapriam, J, Alexander, R, Langdon, P, Kitchen, D and James, N (2018) *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate*. London: Faculty of Psychiatry of Intellectual Disability and Quality Network for Learning Disabilities, Royal College of Psychiatrists

Children's Commissioner for England (2017) *Children's Voices: A Review of Evidence on the Subjective Wellbeing of Children in Detention.* London: CCfE

Children and Young People's Commissioner Scotland (CYPCS) (2018) *No Safe Place: Restraint and Seclusion in Scotland's Schools.* Edinburgh: CYPCS

Children's Rights Director for England (2012) *Children's Views on Restraint: Reported by the Children's Rights Director for England*. London: OFSTED

College of Policing (2017) *Memorandum of Understanding: The Police Use of Restraint in Mental Health and Learning Disability Settings*. Coventry: CoP

Cowin, L, Davies, R, Estall, G, Berlin, T, Fitzgerald, M and Hoot, S (2003) De-escalating aggression and violence in the mental health setting, *International Journal of Mental Health Nursing*, 12, 64–73

Cromwell, J (2005) Deafness and the art of psychometric testing, *The Psychologist*, 18(12), 738–40

Dementia Services Development Centre (2014) *Supporting People with Dementia: Understanding and Responding to Distressed Behaviour.* Stirling: DSDC

Department for Constitutional Affairs (2013) *Mental Capacity Act Code of Practice*. London: TSO

Department for Education (2000) *Care Standards Act: National Minimum Standards for Children's Homes*. London: DfE

Department for Education (2011) *Fostering Services: National Minimum Standards*. London: DfE

Department for Education (2013a) *Residential Special Schools: National Minimum Standards*. London: DfE

Department for Education (2013b) *Use of Reasonable Force in Schools*. London: DfE. Available at: https://bit.ly/2x05WCM (accessed 31 August 2018)

Department for Education (2015a) *Children's Homes Regulations, Including Quality Standards: Guide*. London: DfE

Department for Education (2015b) *Working Together to Safeguard Children*. London: DfE.

Department for Education (2015c) *The Children's Act 1989: Guidance and Regulations Volume 4; Fostering Services*. London: DfE

Department for Education (2016) *Behaviour and Discipline In Schools: Advice for Head Teachers and School Staff*. London: DfE

Department for Education and Skills and Department of Health (2002) *Guidance for Restrictive Physical Interventions: How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder*. London: DoH

Department of Education Northern Ireland (1999) *Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils (Circular, 1999/9).* Bangor: DENI

Department of Education Northern Ireland (2004) *Regional Policy Framework on the Use of Reasonable Force/Safe Handling*. Bangor: DENI

Department of Education Northern Ireland (2017) *Safeguarding and Child Protection in Schools*. Bangor: DENI

Department of Health (2005) *Mental Health and Deafness – Towards Equity and Access: Best Practice Guidance*. London: DoH

Department of Health (2012) *Transforming Care: A National Response to Winterbourne View Hospital*. London: DoH

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

Department of Health (2015) *Mental Health Act Code of Practice*. London: TSO

Department of Health, Concordat Signatories (2014) *Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis.* London: DoH

Department of Health and Social Care and Department for Education (2017) *Reducing the Need for Restraint and Restrictive Intervention; children and young people with learning disabilities, autistic spectrum disorder, and mental health difficulties* (Consultation document). London: DoH/DfE

Department of Health, Social Services and Public Safety (2005*) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services*. Belfast: DHSSPS

Department of Health, Social Services and Public Safety (2012) *Day Care Settings; Minimum Standards*. Belfast: DHSSPS

Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*. Stratford Upon Avon: DRC

Donald, A (2012) *A Guide to Evaluating Human Rights-Based Interventions in Health and Social Care*. London: HRSJ

Donoghue v Stevenson [1932] AC562

Duxbury, J and Paterson, B (2005) The use of physical restraint in mental health nursing, *The Journal of Adult Protection*, 7(4), 13–24

Equality and Human Rights Commission (EHRC) (2019) *Human Rights Framework for Restraint: Principles for the Lawful Use of Physical, Chemical, Mechanical and Coercive Restrictive Interventions*. Available at: http://bit.ly/2uga3ty (accessed 5 January 2020)

Gore, N, McGill, P, Toogood, S, Allen, D, Hughes, J C, Baker, P, Hastings, R, Noone, S and Denne, L (2013) Definition and scope for positive behaviour support, *International Journal of Positive Behavioural Support*, 3(2), 14–23

Greenfield, D and Braithwaite, J (2008) Health sector accreditation research: a systematic review, *International Journal for Quality in Health Care*, 20(3), 172–183

Harris, J, Cornick, M, Jefferson, A and Mills, R (2008) *Physical Interventions: A Policy Framework* (2nd edn). Birmingham: BILD

Hart, D (2008) *Restrictive Physical Intervention in Secure Children's Homes*. London: NCB

Hart, D and Howell, S (2004) *National Children's Bureau: Report on the use of physical intervention across children's services*. London: NCB

Hastings, R P, Allen, D, Baker, P, Gore, H J, Hughes, J C, McGill, P, Noone, S J and Toogood, S (2013) A conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities, *International Journal of Positive Behavioural Support*, 3(2), 5–13

Health and Safety Executive (2013a) *First Aid at Work: The Health and Safety (First-Aid) Regulations 1981*. London: HSE

Health and Safety Executive (2013b) *RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013*. London: HSE. Available at: https://bit.ly/1OYsXn1 (accessed 22 July 2018)

Health and Safety Executive (2013c) *Working Alone: Health and Safety Guidance on the Risks of Lone Working*. London: HSE

HM Government (2019) *Reducing the Need for Restraint and Restrictive Intervention: Children and Young People with Learning Disabilities, Autistic Spectrum Conditions and Mental Health Difficulties in Health and Social Care Settings*. London: DoH/DfE. Available at: http://bit.ly/2kGcWzt (accessed 5 January 2020)

HM Inspectorate of Prisons (2015) *Behaviour Management and Restraint of Children in Custody*. London: HMIP

Horne, N and Pennington, J (2010) The role of the nurse specialist in the highly specialized field of mental health and deafness, *Journal of Psychiatric and Mental Health Nursing*, 17, 335–8

Huckshorn, K A (2006) Re-designing state mental health policy to prevent the use of seclusion and restraint, *Administration and Policy in Mental Health*, 33, 482–91

Human Rights Working Group on Restraint and Seclusion (2005) *Guidance on Restraint and Seclusion in Health and Personal Social Services*. Available at: https://bit.ly/2uYBHb5 (accessed 23 July 2018)

Jeffrey, K (2010) Supportive holding or restraint: terminology and practice, *Nursing Children and Young People*, 22(6), 24–8

Joint Commissioning Panel for Mental Health (2017) *Guidance for Commissioners of Primary Care Mental Health Services for Deaf People*. Available at: https://bit.ly/2Bmu1Ry (accessed 21 July 2018)

Juwah, C (2003) Using peer assessment to develop skills and capabilities, *United States Distance Learning Association Journal*, 17, 1–11

Kirkpatrick, D L (1959) Techniques for evaluation training programs, *Journal of the American Society of Training Directors*, 13, 21–26

LaVigna, G W and Willis, T J (2016) The alignment fallacy, and how to avoid it, *International Journal of Positive Behavioural Support*, 6(1), 6–16

LeBel, J, Duxbury, J, Putkonen, A, Sprague, T, Rae, C and Sharpe, J (2014) Multinational experiences in reducing and preventing the use of restraint and seclusion, *Journal of Psychosocial Nursing and Mental Health Services*, 52(11), 22–9

LeBel, J, Huckshorn, K A and Caldwell, B (2010) Restraint use in residential programs: Why is best practice ignored? *Child Welfare*, 89(2), 169–87

Martin, A, Mcdonnell, A, Leadbetter, D and Paterson, B (2008) Evaluating the risks associated with physical interventions. In Allen, D (ed.) *Ethical Approaches to Physical Interventions, Volume 2: Changing the Agenda*. Worcester: BILD, pp.37–53

Mental Welfare Commission for Scotland (2013a) *Good Practice Guide: Rights, Risks and Limits to Freedom*. Edinburgh: MWCS

Mental Welfare Commission for Scotland (2013b) *Good Practice Guide: Responding to Violence in a Mental Health or Learning Disability Care Setting*. Edinburgh: MWCS

Mental Welfare Commission for Scotland (2013c) *Good Practice Guide: Human Rights in Mental Health Services*. Edinburgh: MWCS

Miller, G E (1990) The assessment of clinical skills/competence/ performance, *Academic Medicine*, 65 (Suppl. 9), S63–S67

Mind (2013*) Mental Health Crisis Care: Physical Restraint in Crisis. A Report on Physical Restraint in Hospital Settings in England*. London: Mind

Mind and NSUN (2015) *Restraint in Mental Health Settings*. London: Mind

Napier, J and Cornes, A (2004) The dynamic roles of interpreters and therapists. In S Austen and S Crocker (eds), *Deafness in Mind: Working Psychologically with Deaf People Across the Lifespan* (pp. 161–79). London: Whurr Publishers

NAPICU (2016) *Guidance for Commissioners of Psychiatric Intensive Care Units (PICUs)*. East Kilbride: NAPICU

NASMHPD (2008) *Six Core Strategies to Reduce Seclusion and Restraint Use*. Available at: https://bit.ly/2O8EI5q (accessed 21 March 2018)

NHS Confederation (2012) *Defining Mental Health Services: Promoting Effective Commissioning and Supporting QIPP*. London: NHS Confederation

NHS Education for Scotland (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*. Edinburgh: NES

NHS England (2013) *The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013*. Available at: https://bit.ly/2O0Zbc2 (accessed 23 July 2017)

NHS England (2015) *Accessible Information Implementation Plan*. Leeds: NHS England

NHS England (2016) *All About Me: Deafness Recovery Tool*. Leeds: NHS England

NHS England (2017) *Accessible Information Standard (DCB1605)*. Leeds: NHS England

NHS England (2018) *STOMP (Stopping the Over-Medication of People with a Learning Disability and Autism or both*). Available at: https://bit.ly/2qpvNB2 (accessed 17 May 2018)

NHS Protect (2013) *Meeting Need and Reducing Distress*. London: NHS Protect

NICE (2004) *The Short-Term Physical and Psychological Management and Secondary Prevention of Selfharm in Primary and Secondary Care (CG 16)*. London: NICE

NICE (2005) *Violence: Short Term Management for over 16's in Psychiatric and Emergency Departments (CG25*). London: NICE

NICE (2007) *Acutely Ill Adults in Hospital: Recognising and Responding to Deterioration (CG50)*. London: NICE

NICE (2012) *Recognition, Referral, Diagnosis and Management of Adults on the Autistic Spectrum (CG142)*. London: NICE

NICE (2013) *Autism: The Management and Support of Children and Young People on the Autistic Spectrum (CG170)*. London: NICE

NICE (2014) *Autism (QS51).* London: NICE

NICE (2015a) *Violence and Aggression: Short Term Management in Mental Health (NG10).* London: NICE

NICE (2015b) *Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities whose Behaviour Challenges (NG11)*. London: NICE

NICE (2016) *Dementia: Supporting People with Dementia and their Carers in Health and Social Care (CG42).* London: NICE

NICE (2017a) *Eating Disorders: Recognition and Treatment (NG69).* London: NICE

NICE (2017b) *Violent and Aggressive Behaviours in People with Mental Health Problems (QS154).* London: NICE

OHCHR (2006) *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation*. Geneva: Office of the United Nations High Commissioner for Human Rights

O'Rourke, S, Gibbon, S and Hough, W (2011) *Standards for Deaf People in Medium Secure Care*. London: Royal College of Psychiatrists Centre for Quality Improvement

Page, A and Vanes, N (2018) *Evidence Based Holding of Children for Clinical Procedures* [website]. Available at: http://comslive.health.bcu.ac.uk/index.php (accessed 31 August 2018)

Patel, M X, Sethi, F N, et al. (2018) Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: de-escalation and rapid tranquillisation*, Journal of Psychiatric Intensive Care*, published online 8 June 2018. https://doi.org/10.20299/jpi.2018.008

Paterson, B (2014) *Risk in the use of restrictive practices - an overview of research. Keynote presentation: Reducing restrictive practices: A human rights perspective - A BILD Conference*. Available at: https://bit.ly/2zReWcU (accessed 7 September 2018)

Paterson, B, Martin, A, Nisbett, I and Leadbetter, D (2011) *The Use of Time-Out and Seclusion in Scottish Schools: A Matter for Concern?* Available at: https://bit.ly/2RqVN8D (accessed 18 March 2018)

PBS Coalition (2015) *Positive Behavioural Support Competence Framework*, [online]. Available at: https://bit.ly/2Rqf61F (accessed 20 April 2018)

Pomey, M P, Lemieux-Charles, L, Champagne, F, Angus, D, Shabah, A and Contandripoulos, A P (2010) Does accreditation stimulate change? A study of the impact of the accreditation process on Canadian health care organizations, *Implementation Science*, 5, 31–44

Price, O and Baker, J, (2012), Key components of de-escalation techniques: A thematic synthesis, *International Journal of Mental Health Nursing*, 21, 310 –19

Restraint Reduction Network (2019) *Towards Safer Services; National Minimum Standards for Restrictive Intervention Reduction.* Birmingham: RRN

Rooney, A L and Van Oostenberg, P R (1999) *Licensure, Accreditation, and Certification: Approaches to Health Services Quality, Quality Assurance Project.* Washington, DC: USAID

Royal College of Emergency Medicine (2016) *Guidelines for the Management of Excited Delirium/Acute Behavioural Disturbance*. London: RCEM

Royal College of Nursing (RCN) (2010) *Restrictive Physical Intervention and Therapeutic Holding for Children and Young People: Guidance for Nursing Staff*. London: RCN

Royal College of Nursing (RCN) (2016) *Personal Safety when Working Alone.* London: RCN

Royal College of Psychiatrists (2014) *Good Practice in the Management of Autism (including Asperger Syndrome) in Adults (CR191).* London: RCPsy

Royal College of Psychiatrists (2015) *Quality Network for Forensic Mental Health Services; See, Think, Act*. London: RCPsy

Royal College of Psychiatrists (2016) *Quality Network for Forensic Mental Health Services: Standards for Forensic Mental Health Services, Low and Medium Secure Care*. London: RCPsyRoyal College of Psychiatrists, British Psychological, Society and Royal College of Speech and Language Therapists (2007) *Challenging Behaviour: A Unified Approach. Clinical and Service Guidelines for Supporting People with Learning Disabilities who are at Risk of Receiving Abusive or Restrictive Practices*. London: Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists

Safewards www.safewards.net

SCIE (2009) *Report 26: Restraint in Care Homes for Older People: A Review of Selected Literature* (Due to be reviewed). London: SCIE

Scottish Executive (2004) *Protecting Children and Young People: The Charter*. Edinburgh: Scottish Government

Scottish Executive (2005a) *Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1*. Edinburgh: Scottish Government

Scottish Executive (2005b) *National Care Standards: Care Homes for Children and Young People*. Edinburgh: Scottish Government

Scottish Executive (2005c) *National Care Standards: Care Homes for Older People*. Edinburgh: Scottish Government

Scottish Executive (2005d) *National Care Standards: Care Homes for People with Learning Disabilities*. Edinburgh: Scottish Government

Scottish Executive (2013) *Physical Restraint in Residential Child Care – Leaflet for Young People*. Edinburgh: Scottish Government

Scottish Executive (2017) *Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions*. Edinburgh: Scottish Government

Scott, S and McManus, S (2016) *Hidden Hurt: Violence, Abuse and Disadvantage in the Lives of Women.* (DMSS Research for Agenda). London: Agenda

SignHealth (2017) *Sign Language.* Available at: https://bit.ly/2P9eSKT (accessed 10 July 2018)

Skills for Care and Skills for Health (2014) *A Positive and Proactive Workforce. A Guide to Workforce Development for Commissioners and Employers Seeking to Minimise the Use of Restrictive Practices in Social Care and Health*. Leeds: SFC & SFH

Smallridge, P and Williamson, A (2011) *Report on Implementing the Independent Review of Restraint in Juvenile Secure Settings.* London: Ministry of Justice

Spencer, S and Johnson, P (2016) *De-escalation Techniques for Managing Aggression. Cochrane Database of Systematic Reviews 2016, Issue 1.* Art. No.: CD012034. DOI: 10.1002/14651858.CD012034

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Available at: https://bit.ly/207FoDJ (accessed 30 August 2018)

Sweeney, A, Clement, S, Filson, B and Kennedy, A (2016) Trauma-informed mental healthcare in the UK: What is it and how can we further its development?, *Mental Health Review Journal*, 21(3), 174–92

The Health, Safety and Wellbeing Group (2018a) *Improving Safety for Lone Workers: A Guide for Managers*. Leeds: HSWG

The Health, Safety and Wellbeing Group (2018b) *Improving Safety for Lone Workers: A Guide for Staff who Work Alone*. Leeds: HSWG

The Scottish Institute for Residential Child Care (SIRCC) (2005) *Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People*. Glasgow: SIRCC

Thomas, A B (2004) *Research Skills for Management Studies*. London: Routledge

UN Committee on the Rights of the Child (2006): *The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment*. General comment No. 8

United Nations Department for Economic and Social Affairs (2006) *Convention on the Rights of Persons with Disabilities (UNCRPD).* [online] Available at: https://bit.ly/1QUdQe4 (accessed 24 July 2018)

United Nations Human Rights (1989) *Convention on the Rights of the Child*. [online] Available at: www.ohchr.org/en/professionalinterest/pages/crc.aspx (accessed 20 April 2018)

Volunteer Now (2010) *Safeguarding Vulnerable Adults: A Shared Responsibility. Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults*. Belfast: Volunteer Now

Welsh Assembly Government (2005) *Framework for Restrictive Physical Intervention Policy and Practice*. Cardiff: Welsh Assembly

Welsh Assembly Government (2013) *Safe and Effective Intervention: Use of Reasonable Force and Searching for Weapons*. Cardiff: Welsh Assembly

Welsh Assembly Government (2016a) *Mental Health Act 1983: Code of Practice for Wales*. Cardiff: Welsh Assembly

Welsh Government (2016b) *Patient Safety Notice: The Importance of Vital Signs During and After Restrictive Interventions/Manual Restraint*. Cardiff: Welsh Assembly

West London Mental Health Trust (2016) *Violence Reduction and Management Programme*. London: West London Mental Health Trust

World Health Organisation (WHO) (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organisation

World Health Organisation (WHO) (2017) *Creating Mental Health and Related Services free from Coercion, Violence and Abuse - WHO Quality Rights Training to Act, Unite and Empower for Mental Health (pilot version)* (WHO/MSD/MHP/17.6). Geneva: World Health Organisation

# Legislation

Available at: legislation.gov.uk

## Statutes

- Adults with Incapacity Act (Scotland) 2000
- Autism Act 2009
- Care Act 2014
- Care Standards Act (National Minimum Standards for Children's Homes) 2000
- Children Act (Scotland) 1995
- Children and Families Act 2014
- Children and Social Work Act 2017
- Children's Act 1989
- Children's Act 2004
- Criminal Justice Act 2003
- Criminal Law Act (Northern Ireland) 1967
- Deprivation of Liberty Act 2010
- Education Act 1996
- Education and Inspections Act 2006
- Education (Scotland) Act 1980 ch47
- Equality Act 2010
- Health and Safety at Work Act 1974
- Human Rights Act 1998
- Mental Capacity Act 2005
- Mental Capacity Act (Northern Ireland) 2016
- Mental Health Act 1983
- Mental Health Act 2007
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health Units (Use of Force) Act 2018
- National Health Service Act 2006 sch 4
- Protection of Children Act 1999
- Regulation of Care (Scotland) Act 2001

## Statutory instruments

- Child Care (Scotland) Regulations 1995, SI1995/3256
- Children (Northern Ireland) Order 1995, SI1995/755
- Children's Homes (England) Regulations 2015, SI2015/541
- Children's Homes Regulations (Northern Ireland) 2005, SI2005/176
- Children's Homes (Wales) Regulations 2002, SI2002/327
- Education (Northern Ireland) Order 1998, SI1998/274
- Foster Placement (Children) Regulations (Northern Ireland) 1996, SI1996/467
- Fostering Services (England) Regulations 2011, SI2011/581
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI2014/781
- Independent Health Care (Wales) Regulations 2011, SI2011/734
- Local Safeguarding Children's Boards (Wales) Regulations 2006, SI2006/1705
- Management of Health and Safety at Work Regulations 1999, SI1999/3242
- Mental Health (Northern Ireland) Order 1986, SI1986/595
- Nursing Homes Regulations (Northern Ireland) 2005, SI2005/161
- Regulations of Care (Requirements as to Care Services) (Scotland) Regulations 2002, SI2002/114
- Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations; Regulation 29 – The appropriate use of control and restraint 2017, SI2017/1264
- Regulation (EU) 2016/679 (General Data Protection Regulation) in the current version of the OJ L 119, 04.05.2016; cor. OJ L 127, 23.5.2018. Available at: https://bit.ly/2v1IOTM (accessed 21 July 2018)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, SI2013/1471
- Residential Care Homes Regulations (Northern Ireland) 2005, SI2005/161
- Secure Accommodation (Scotland) Regulations 1996, SI1996/325

# Acknowledgements

The completion of the *Restraint Reduction Network Training Standards* would not have been possible without the participation and the assistance of so many people across the sector. Their contributions are sincerely appreciated. We would like to express our deep appreciation particularly to the following:

## Authors:

**James Ridley**, Edge Hill University

**Sarah Leitch**,
BILD Restraint Reduction Network

## Contributors:

**Dave Atkinson**,
Independent Consultant Nurse

**Dr Peter Baker**, Tizard

**Dr Darren Bowring**,
States of Jersey Health and Social Services

**Dr Rina Cianfaglione**,
University of Southampton

**Louise Clark**, Kings College London

**Tom Evans**, Positive Behaviour
Support Manager, BILD

**Teresa Fenech** and **Salli Midgley**,
NHS England

**Ben Higgins**, CEO, BILD

**Lee Hollins**, Strathclyde University

**Nick Horne**,
Cygnet Healthcare

**Sanchita Hosali**,
The British Institute of Human Rights

**Linda Hume**, Edinburgh Napier University

**Andy Johnston**,
Andy Johnston Associates, NAPICU

**Aji and Conrad Lewis** (parents of Seni)

**Helen Wildbore**,
British Institute of Human Rights

## Critical readers:

**Amanda Allard**,
Council for Disabled Children

**Eric Baskind**,
Liverpool John Moores University

**Jim Blair**, Great Ormond Street Hospital

**Dr Tony Bleetman**
Consultant in Emergency Medicine
Honorary Associate Professor,
University of Warwick Medical School

**Verity Chester**, Priory Group

**Glyn Connolly**,
BILD Association of Certified Training
Certification Manager

**Guy Cross**, Care Quality Commission

**Dr John Devapriam**, Executive Medical
Director, Worcester NHS Trust

**Roy Deveau**, Tizard

**Liz Durrant**,
Director of Mental Health, Certitude

**Professor Joy Duxbury**,
Manchester Metropolitan University

**Dr Rhidian Hughes**, VODG

**Dr Ada Hui**, Assistant Professor in
Mental Health, University of Nottingham

**Dr Edwin Jones**, Abertawe Bro
Morgannwg University Health Board

**Dr Gary LaVigna**, IABA

**Kevin McKenna**, Lecturer, School
of Health and Science, Dundalk
Institute of Technology, Ireland

**Beth Morrison**, Founder and CEO,
Positive and Active Behaviour
Support, Scotland (PABSS)

**Ann Norman**, Royal College of Nursing

**Lord Ramsbottom**

**Deborah Reading**, BILD

**Jonathan Timbers**, Equality
and Human Rights Commission

**Professor Dame Sue Bailey OBE DBE,
Rebecca Burgess-Dawson,
Dr Tim Devanney, Ellie Gordon,
and Andrew Stimpson** on behalf
of Health Education England

# Other members of the Restraint Reduction Network Steering Group

| Organisation (representing) | Proposed name to represent |
|---|---|
| **Professional bodies** | |
| **British Psychological Society** | Professor John Taylor |
| **Royal College of Nursing** | Dave Atkinson, Professor Joy Duxbury, Catherine Gamble and Dr Ada Hui |
| **Royal College of Psychiatrists** | Dr John Devapriam and Amah Shah |
| **Government departments** | |
| **Department for Education** | Chris Ball and Stuart Miller |
| **Department of Health** | Angela Hawley and Rachel Whittaker |
| **Health Education England** | Dr Tim Devanney and Ray Walker |
| **NHS England** | Teresa Fenech, Salli Midgley, Dr Jean O'Hara and Hazel Watson |
| **NHSi** | Professor Oliver Shanley |
| **Public Health Wales** | Sharon Williams |
| **Regulators** | |
| **Care Quality Commission** | Guy Cross and Dr Theresa Joyce |
| **Equality and Human Rights Commission** | Libby McVeigh and Jonathan Timbers |
| **Ofsted** | Matthew Barnes |
| **VCS / Charities** | |
| **British Institute of Human Rights** | Sanchita Hosali |
| **Council for Disabled Children** | Amanda Allard |
| **Dementia UK** | Dr Hilda Hayo |
| **Learning Disability Wales** | Martyn Jones |
| **Mind** | Alison Cobb and Leila Reyburn |
| **Respond** | Dr Noelle Blackman |
| **Skills for Care** | Sharon Allen and Marie Lovell |
| **Young Minds** | Dr Marc Bush |

### Lived experience

| | |
|---|---|
| **Lived experience** | Iris Benson and Roger Sharp |

### Service providers

| | |
|---|---|
| **Abertawe Bro Morgannwg University Health Board** | Dr Edwin Jones |
| **Birmingham and Solihull** | Brendan Hayes |
| **Certitude** | Liz Durrant |
| **Cygnet** | Julie Kerry |
| **Devon Partnership NHS Trust** | Dr Paul Keedwell |
| **Mersey Care** | Dr Jennifer Kilcoyne |
| **Northumberland Tyne and Wear** | Dr Keith Reid |
| **South London and Maudsley** | Dr Faisil Sethi |
| **Voluntary Organisation Disability Group** | Dr Rhidian Hughes |
| **West London Mental Health Trust** | Jimmy Noak |

### Other relevant forums/experts

| | |
|---|---|
| **ADASS** | Helen Toker-Lester |
| **Caring Solutions** | Dr Colin Dale |
| **European Assoc. for MH in ID** | Dr Roger Banks |
| **European Network** | Dr Brodie Paterson |
| **NAPICU** | Andy Johnston |
| **National Collaborating Centre for Mental Health** | Tom Ayers |
| **NHS Confederation Mental Health Network** | Sean Duggan |
| **North London STP** | Chris Dzikiti |
| **North West AQuA** | Paul Greenwood |

Restraint
Reduction
Network

Restraint
Reduction
Network
(RRN)

# Training Standards

### First edition

James Ridley
Sarah Leitch

The Restraint Reduction Network (RRN) welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings.

The RRN is an independent network which brings together committed organisations with a shared vision of reducing reliance on restrictive practices and making a real difference in the lives of people who use services across education, health and social care services.

These standards have been developed with the support of Health Education England and the Royal College of Nursing to provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

In addition to improving training and practice, the standards will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

ISBN 978-1-905218-44-8

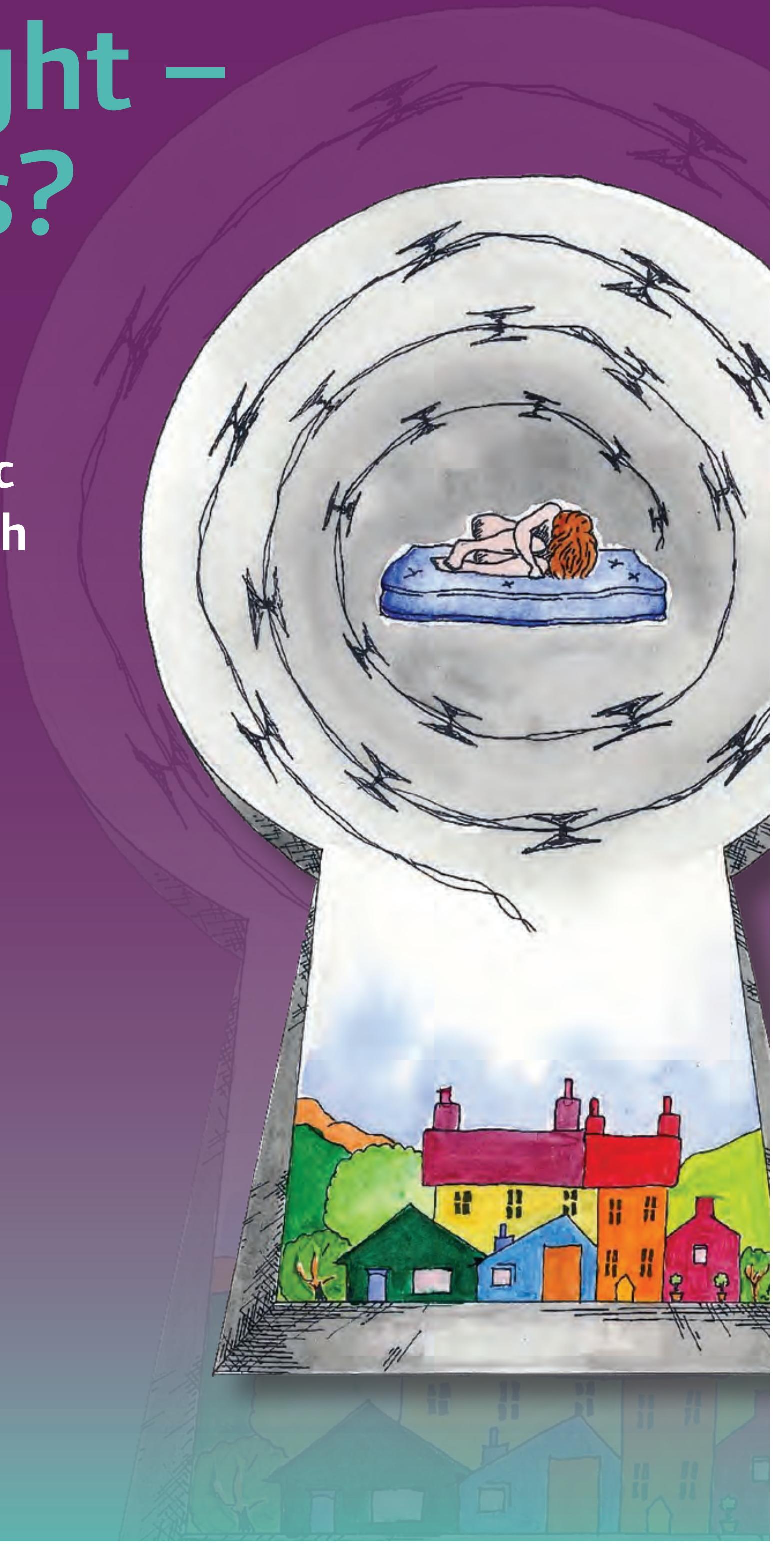
9 781905 218448

These standards have been developed in partnership with and endorsed by

Care Quality Commission

# Out of sight – who cares?

## A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition



OCTOBER 2020

# About the Care Quality Commission

## Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## Our role

We register health and adult social care providers.

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

We use our legal powers to take action where we identify poor care.

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

## Our values

**Excellence** – being a high-performing organisation

**Caring** – treating everyone with dignity and respect

**Integrity** – doing the right thing

**Teamwork** – learning from each other to be the best we can

## Notes on the report

The art on the front cover was drawn by Alexis Quinn. Alexis has lived experience of being secluded and segregated. This is her artistic interpretation about how it feels to be in seclusion and segregation.

**Trigger warning:** In this report there is content and descriptions of people's lives and experiences, which some people may find distressing.

Where we found poor care or risks to people's human rights in our review, we took regulatory action against the service; you can see the full list of the action that we took in **appendix A**.

Some of the stories included in this report are illustrative and some are real life examples. Where we have used real life examples, we asked people to give their consent to include them, and we ensured that we changed any identifiable information, such as age, gender, or location, to protect their identities.

### 'Complex care' – what do we mean?

Throughout this report we have in places referred to care as being 'complex'. For the purposes of this report, we are defining complex care as care for people with multiple and sometimes interconnected health, communication and social needs. Their care typically requires coordination and input from a range of skilled professionals who may be employed by different organisations.

# Contents

# Restrictive practice is a human rights issue

**To understand the issues around restraint, seclusion, and segregation you must hear from the people who have experienced it first-hand. This report tells the story of restrictive practices from their perspective.**

Below is the story of Alexis, an academic, international athlete, and school teacher. Alexis was restrained and secluded many times before she was able to leave the hospital system.

## ALEXIS'S STORY

I suffered a personal crisis when my brother died, and I was unable to access appropriate care in my local area. With my ability to manage my autistic reaction to trauma deteriorating, I sought help from mental health services. This proved to be my biggest mistake.

I entered hospital for an initial 72 hours' intervention. Due to a catastrophic clash between my autism and the environment, I became overloaded and entered a damaging cycle.

It felt cruel – like I was set up to fail. I would never, ever be able to tolerate the lighting, the noise, the chaos and the sensory charged box I was kept in. My different and sensitive autistic neurology was at the mercy of those who held the keys. I began to look as they described – violent and dangerous because I couldn't control myself.

In total, I was restrained 97 times and secluded 17 times. I was forcibly drugged. The drugs took over every aspect of my very being. My body was battered and bruised, and my identity was fractured. They didn't like the autistic part of me. I tried to tell them that autism is all of me, it's who I am. I argued that my autism couldn't be treated. They said I lacked insight. Knowing I couldn't change, and being labelled as "treatment resistant", I grew to hate myself and I lost hope. I'd never get out.

After three and a half years of restrictive practice in 12 different hospitals around the UK, I fled whilst on a Section 3 to Africa. There, I created a routine. I made my days predictable and my home autism-friendly. Nothing in my house aggravated my sensory system. I weaned myself off the drugs, sought private psychology for the trauma I experienced (starting with the death of my brother). After six weeks, I started work as a teacher again. The key to success is creating the right environment and treating psychological differences with dignity and respect.

# Foreword

## This review has shown that for some people who need complex care, the system lets them down. It is often seen as too difficult to get it right – they fall through the gaps.

To be clear, this is a report about the people we saw and the use of restrictive practice.[a] It is not a comprehensive overview of mental health, learning disability or autism care in England. However, the fact that some of the practices we saw were happening at all has implications for the wider health and care system.

We found too many examples of undignified and inhumane care, in hospital and care settings where people were seen not as individuals but as a condition or a collection of negative behaviours. The response to this has often been to restrain, seclude or segregate them.

We have seen how the very nature of mental health hospitals can be distressing, particularly for people with a learning disability and/or autistic people. This includes the physical ward environment as well as lack of access to psychological support. Unlike in a general hospital where you would have a plan for your treatment on admission, we saw people admitted with no assessment, treatment or discharge plans in place.

We also found that a lack of training and support for staff meant that they are not always able to care for people in a way that meets those individuals' specific needs. This increases the risk of people being restrained, secluded or segregated.

However, we did find that it is possible to get even the most complex care right. Delivering care in a system with complex funding arrangements and workforce shortages is undoubtedly difficult, but it can be done effectively.

Community services must be able to adapt and tailor care to individual needs. We found some providers could do this. People need support to be available in their community, close to where they live and accessible when needed.

Repeatedly throughout our review, families and carers told us that if they and their loved ones had received the right help and support earlier, or when in crisis, they may not have needed hospital care. Staff often echoed this.

We have seen how increased support in the community can stop people who might otherwise be labelled 'too complex' from needing to go into hospital.

While our review took place before the coronavirus pandemic reached the UK, the circumstances of people that have fallen through the gaps has not changed. Indeed, our concerns have become more pronounced. As raised by Mencap and the Challenging Behaviour Foundation in April and September 2020, coronavirus has left some people unable to access the care they needed, and has caused delays to people leaving hospital.[1,2] In some

---

[a] See '**Background**' (page 6) for details

cases, this has led to restrictions on people's movements, and services having to restrict or stop families from visiting their loved ones, as well as increasing the risk of closed cultures developing.

Comprehensive oversight of the care provided, and specifically responsibility and accountability for the commissioning of care, is lacking. The absence of this scrutiny has led to people being kept in hospital indefinitely and experiencing increasing amounts of restriction. Now, more than ever, strengthened oversight and scrutiny of these care settings is needed when people are in prolonged seclusion and segregation.

It is clear there needs to be fundamental change in the way care is planned, funded, delivered and monitored for this group of people. This change needs to be led by national and local leaders and underpinned by a firm foundation of human rights, to deliver a culture where restraint, seclusion and segregation are no longer accepted and are only used in extreme cases. We all have a part to play to ensure that this improves.

**Deborah Ivanova**

Deputy Chief Inspector, Adult Social Care

**Dr Kevin Cleary**

Deputy Chief Inspector of Hospitals and lead for mental health

# Introduction

**Concerns about the use of restrictive practices and people being segregated are not new. Since the Mansell report in 2007, there have been many reports that have highlighted similar issues, especially around the care for people with a learning disability or autistic people.[3,b]**

In October 2018, the Secretary of State for Health and Social Care asked us to carry out a review of autistic people, and people with a learning disability and/or mental health condition who may be subject to restrictive practices as a result of ongoing concerns in this area.

We asked a group of people with lived experience to evaluate the findings of previous reports about restrictive practice that related to autistic people, and people with a learning disability and/or mental health condition. These previous reports have highlighted that without the right care and support in the community early on, people were being admitted to hospital inappropriately. For example, the **Bubb report** in 2014 stated that, "for many years too many people with learning disabilities and/or autism have been, and continue to be, in inappropriate inpatient settings – often a very long distance away from family and their communities."[4]

We know if people are admitted to hospital this should be for the shortest period, with the least restrictive interventions possible. Unfortunately, many people stay too long in these settings and are subject to unnecessary restrictive interventions. In addition, our review found the length of time people spent in prolonged seclusion ranged from two days to seven months, and in long-term segregation from three days to 13 years. Almost 71% of people whose care we reviewed had been segregated or secluded for three months or longer. A few people we met had been in hospital more than 25 years.

Once admitted, a lack of joined-up thinking across the system, funding struggles and a lack of local service provision have meant that people have not been discharged back into the community. In these hospital services, high levels of restraint, seclusion and segregation, and a lack of therapeutic and social input are having a detrimental impact on individual people.

This report describes what we found about the current state of the care system for children, young people and adults who have diverse needs that are subject to restrictive interventions, and who are cared for in a range of settings. Although our review looked at a wide variety of services, the majority of people we saw had a learning disability or were autistic. As a result, we have focused this report on what we found in relation to them. However, our findings have implications and learning for settings that support people who have a mental health condition and/or who are living with dementia.

While this report tells the horrific experiences of some people's care, it also tells the story

---

b See **appendix C** for full details

of what is possible if people have the right support in place. Progress has been made with legislation such as the Mental Health Units (Use of Force) Act 2018 and community care-focused programmes such as **Transforming Care**, but this must happen at a quicker rate.[5] It is possible for people who need a lot of support from health and care services to lead fulfilling lives, close to their homes and communities.

During the course of our review, we heard from people who were subject to restrictions, their families and carers, and frontline staff about experiences of care. Their voices are at the heart of this report and underpin our findings.

# Background

## How we carried out our review

The scope of the work was broad, and included health and care settings that care for autistic people, and people with a learning disability and/or mental health condition. As a result, we have looked at people across many different services, conditions and sectors to form a view of restrictive practice.[c] Our sample size was specific, and so is not representative of all hospital or residential care for autistic people, people with a learning disability and/or mental health condition in England. We focused on the experiences of the people we saw, as well as information collected through our information requests – the majority of whom were people with a learning disability or autistic people.

When we started our thematic review, the national data collected in the Mental Health Services Data Set about the use of restrictive interventions was incomplete and inconsistent because some providers do not submit any data and others submit data that is not credible. CQC, NHS England and NHS Digital have since worked with providers to improve the quality and reliability of this data.

In compiling this report, we relied on the following evidence.

**We visited:**

- 43 hospital wards for people of all ages with a learning disability or autistic people, and specialist NHS and independent child and adolescent mental health wards
- 13 hospital mental health rehabilitation and low secure mental health wards, and 27 people in other mental health hospitals
- 27 care homes for the care of people with a learning disability or autistic people; 11 children's residential services that are jointly registered with CQC and Ofsted, and five of the 13 secure children's homes in England (two of these reviews were desktop reviews).

**We also gathered information remotely through:**

- 452 questionnaires on restrictive interventions, completed with registered managers of adult social care services, during inspections between July and October 2019
- assessing a sample of care plans at each service
- reviewing prescriptions and other medicines records
- writing to commissioners about the cost of placements.

The full list of services we visited and the scope of our review is in **appendix B.**

## The people we saw with the most restrictive care – their backgrounds

The majority of people we reviewed in-depth on our visits to hospitals were autistic; 42 out of 66 had a formal diagnosis. This mirrored the results from our information request, which showed that 67% of people in long-term segregation

---

[c] See our **Terms of Reference**

on learning disability and child and adolescent mental health service wards were autistic.

Other people we met had a learning disability or a mental health diagnosis. Often, people with a mental health condition were diagnosed with a range of disorders, including anxiety and depression, psychosis, personality disorders, schizophrenia and post-traumatic stress disorder.

However, for some people, their diagnosis was unclear due to a lack of assessment, despite their clinical notes saying that they were displaying "autism traits or sensory issues".

The people we visited often had difficult or traumatic backgrounds, which had not been considered when developing a treatment plan. For example, 21 of the 66 people we visited in hospitals had been, or were, looked after children.[d] For some, this was because their family could not access care support. Where we had concerns about people's care we escalated them.

People told us that they were more likely to experience increased distress or deterioration in their mental health after a significant life event or at a certain age. This was particularly likely between the ages of 12 and 15.

Some people we met had experienced abuse in their family or had suffered physical or emotional abuse by staff in previous care settings. For example, in the secure children's homes, five out of six children had come from families where there had been domestic violence and abuse or neglect, with three excluded from education.

In addition, members of our Expert Advisory Group (EAG) and people and their families told us that their loved ones had experienced being restrained in schools for children and young people with special educational needs and disabilities.

In low secure hospitals, there was a particularly distinct group of young women in seclusion or long-term segregation who seemed to have a very similar history, which included abuse or neglect as a child and incidents of self-harm. Before entering adult services, they had been in child and adolescent mental health services (CAMHS), sometimes on low secure wards. These women tended to have a long history of multiple hospital admissions and placements in care institutions over their relatively short lives. They were being treated in long-term segregation or frequent repeated episodes of seclusion because of the risks they presented in the ward environment. One reviewer reflected on this pattern and commented that:

> **"…this young woman has been in 14 different places since her first admission at a number of different locations […] It seems that she has just been passed from place to place, with no clear overriding plan to get her out of hospital – even though it is apparent that hospital admissions have not helped her. This, in my view, is a common experience for women in low secure care – and is especially true of the trajectory of young women coming out of CAMHS services."**

On average, people in long-term segregation and seclusion had experienced three different care settings in the previous five years, which highlights the failure of services to meet people's needs.

---

[d] A child who has been in the care of their local authority for more than 24 hours is known as a looked after child.
**NSPCC**

# Missed opportunities to avoid hospital – focus on people with autism

People often ended up in hospital because they did not have the right support, early on, in the community at the time they and their families needed it. This was particularly the case for people we saw who were diagnosed as autistic.

In this section, we explore the 'missed opportunities' for those people, and what support could have been put in place earlier to prevent admission to hospital. This includes issues around diagnosis, waiting times, transition planning and social care support.

## Difficulties with getting an autism diagnosis

Getting a diagnosis for autism was a key concern, with families often waiting for long periods or having to fight to get a diagnosis.

This is supported by the findings of the 2019 **All Party Group on Autism report** and Self-Assessment Framework (SAF), which stated that on average adults have to wait 30 weeks after referral to get a diagnosis, with people in some areas waiting two years. This is the same for children, with many waiting for two years.[6]

NHS Digital data shows that from October to December 2018, only 18% of patients referred with suspected autism had their first appointment within 13 weeks, with 4% reported as waiting over 13 weeks, and 78% reported as having no contact date.[7]

The length of time people are waiting is contrary to best practice. The NICE (National Institute for Health and Care Excellence) Quality Statement QS51 states that people with possible autism who are referred to an autism team for a diagnostic assessment should have their first diagnostic assessment started within three months of their referral.[8]

People also told us of differences in the quality of diagnoses between different clinicians, and in some cases, people were diagnosed with autism years after signs were first spotted.

## Lack of early intervention for people with autism

Many families told us that, following a diagnosis of autism, early support was not always available from health, social care and education agencies. When care was commissioned, there was not enough knowledge about autism. In addition, people's individual needs were not understood until it was too late. People and their families also told us that a lack of knowledge, understanding, and support in schools sometimes led to children being excluded.

Families told us they felt that the 'system' was broken and was being reactive and not proactive to people's needs. They told us that receiving extra support while their family member was still living at home, or in the community, could have prevented the need for them to be admitted to hospital.

> "Lucy was living at home and bi-monthly respite care had just started. However, after two months this was withdrawn as the service found it difficult [to support her]. The local CAMHS service could not offer support either."

For children and families, the onset of adolescence and puberty, as well as the transition period between child and adult services, was a key time when things could go wrong. These changes were often not planned for early enough, or were not successful because of a lack of a joined-up approach between local social care and education services, and families did not feel supported through these periods.

### HARRY'S STORY

Jane (Harry's mum) told us about the journey for 22-year Harry, who is autistic. Harry also has a moderate learning disability, and he communicates his distress and needs in a way that others may find challenging.

Harry had been to a school for special educational needs. Jane knew that she needed more support to help her care for Harry. By the time he was 14 years old, Jane was calling the police regularly. She frequently requested extra help from services but was told that how he was behaving was not concerning enough.

Things got worse, Harry was suspended from school for throwing things and becoming more aggressive with belongings and furniture. Still there was no support and Jane was left to get on with it. This started to affect her own health.

Eventually care was arranged, but Jane did not feel involved in decisions around this. Harry was moved between different child and adolescent community services and at 18 was moved to adult services. During his time in community care, Harry experienced emotional and physical abuse by staff and other residents. Harry ended up being placed in hospital and then in segregation. There was no discharge plan in place and he is still currently in hospital.

## Opportunity for the future

All of these issues present opportunities for the future. We know from our review that if families receive the right support when they need it, people have a much better chance of avoiding hospital admission. This stems from getting diagnosis as early on as possible, to getting help to look after their children in their communities and at home, as well as ensuring there is a better professional understanding of learning disabilities and autism. Greater integration between local services is needed so care can be centred around the individual.

# A culture of restrictive practice: an equality and human rights issue

In this section, we look at Anna's care and how that relates to human rights.

Human rights breaches are not inevitable in any setting. To uphold people's human rights, providers need to always assess and keep under review if there is a less restrictive option for the people they are caring for. Under the Equality Act 2010, all healthcare providers have a duty to make reasonable adjustments for disabled people.[9] This includes, for example, adjustments to the environment and communication.

The British Institute of Human Rights has highlighted that to achieve this, there needs to be a service-level culture change, where staff care for all people from a human rights perspective.[10]

We saw some services taking a human rights approach, but this was not the case across all services. Anna's story shows when this is not the case.

## ANNA'S STORY

Anna, 24, is a young woman with autism who was in long-term segregation on a mental health ward and was often secluded. Staff did not understand how her autism affected her and they did not make any reasonable adjustments. As a result, she experienced some breaches of her human rights.

Anna had difficulty speaking to staff because of her autism and did not understand metaphors or abstract concepts. The care team expected her to show that she was sorry before they ended her seclusion, even though Anna did not understand what this meant, or what the care team wanted her to say. This meant she stayed in seclusion for much longer than she needed.

She had traffic light cards to help her tell staff how she was feeling, but these were taken when her room was stripped following an incident of self-harm. Staff misplaced the cards, which meant that she was not able to communicate to let staff know when she was becoming increasingly distressed.

Staff did not take account of Anna's sensory needs. The seclusion room had a bright day light and a dim night light but nothing in between. This made her feel distressed because of her autism.

At one point, staff stopped her mum from visiting her for five months – they said it was because of her behaviour. Staff said that she was too dependent on her mum, even though both Anna and her mum wanted the visits to continue.

The physical health care that Anna received was poor, and there were times when she was prevented from using the toilet. Anna's mum told us that the service did not refer her to a specialist after an incident that caused injuries on her arm and left her in pain for several months, despite her constantly asking for help for her daughter.

## How does Anna's story have implications for human rights?

In Anna's case, there are several rights under the Human Rights Act 1998 that could have been at risk.[11]

### Article 3 – inhuman or degrading treatment

Some of Anna's experiences amount to risks to her absolute rights. This includes Article 3 – the right to not be subjected to torture or to inhuman or degrading treatment or punishment. Your right not to be tortured or treated in an inhuman or degrading way is absolute. This means it must never be limited or restricted in any way. For example, a public authority can never use lack of resources as a defence against an accusation that it has treated someone in an inhuman or degrading way.

In Anna's case, there was a risk of inhuman treatment when she was in pain for several months due to the provider failing to get her medical treatment. As Article 3 is an absolute right, if there is a risk that this right may be breached, providers must address this with the highest priority.

### Article 8 – respect for private and family life

Some of the things Anna experienced may have risked a qualified human right – a right that can be restricted if the restriction is lawful, for a legitimate aim and the least restrictive option to meet that aim. Providers must still do everything they can to ensure these rights are protected and demonstrate this.

Anna not being allowed to see her mum could have breached Article 8 rights to respect for private and family life, home and correspondence. Anna has the right to speak privately to her mum, to have choices about her possessions and her clothing, to have choice when she eats, to have privacy when using the toilet and to have support to express her needs – unless there is a legitimate reason why these things should not happen, for example a risk of self-harm or harm to other people. Even when there is a legitimate reason for a restriction, then the least restrictive option that addresses the risk should be put in place. For example, by making sure that Anna has as many choices as possible in her day-to-day life and reviewing these regularly with her.

### Article 14 and Equality Act 2010 – the right to reasonable adjustments

Anna not having reasonable adjustments because she could not communicate with the care team could risk Article 14 connected to Article 8 of the Human Rights Act – the right to be free from discrimination. This also risks breaching areas of the Equality Act 2010.

Providers have a duty to make reasonable adjustments for disabled people – from ensuring the environment they are living in is meeting their needs, to having the right tools to communicate. In Anna's case this includes her traffic light cards. Not having these things in place stops people being able to access their basic rights as a human.

The reasonable adjustment duty is 'anticipatory'. This means that providers need to think in advance what disabled people with a range of impairments, including people with a learning disability or autistic people, might need.[12] The **NHS Accessible Information Standard** can help providers meet both their reasonable adjustment duty and their public sector equality duty.

However, it is important to note that staff need to make difficult decisions on a day-to-day basis. With Anna, staff may have needed to weigh up what the potential risk of self-harm is with the possessions she had in her room, versus her rights to have access to her phone and other possessions. A human rights-based approach can help to make these difficult decisions.

## When can qualified rights be restricted?

The occasions where qualified rights, like Article 8 rights, might be restricted are when the situation is:

- lawful – for example Mental Health Act 1983 (MHA) or Mental Capacity Act 2005 (MCA) processes have been followed
- necessary – for a legitimate reason, for example to protect someone from harm or to prevent other rights being breached
- proportionate – the option that least restricts Article 8 rights, while still addressing the need, must be chosen.

This is by no means a comprehensive list of the ways Anna's rights are at risk of being breached. Providers have many other obligations, such as to the public sector equality duty. This states that if you are providing a health or care service you have a duty to consider whether you can advance equality for the people that you are serving.

## What does this mean for our review?

In too many instances in this review we found that people's human rights were at risk of being breached. We found that:

- People's human rights were potentially being breached because staff did not have the understanding, tools or support needed to make the human rights-based decisions that would have helped them to provide better, safer care.
- People were not having their needs met. Environments they were living in were not adapted to their sensory needs and they were not being offered support to communicate. Some providers were not making reasonable adjustments legally required under the Equality Act 2010.
- People were experiencing unnecessary restriction that was causing them distress. Decisions about restrictive practices were not reviewed regularly to make sure that there was the least restriction on people's rights possible at any given time.
- People were spending too long in highly restrictive situations, more likely to breach their human rights, because of failure to plan and progress long-term goals, such as discharge planning.

It can be extremely difficult for people and their families to influence changes to care so that they have their human rights upheld. People having access to independent advocacy is crucially important, but the availability and quality of advocacy was very variable. We address this later in the report.

# Part 1: Hospital-based services

**We found the poor physical environment and the restrictive practice culture of hospitals often lay the groundwork for the use of restrictive practices. They could lead to people becoming distressed and in turn being restrained. Often, people we saw did not receive specialist care or access to high-quality advocacy.**

To understand how restrictive practices have been used, it is important to first understand the wider culture and environment of the hospitals in which they are used.

## The quality of care and environment of hospitals

Most of the wards we visited were not therapeutic environments, and often people did not receive care tailored to their specific needs. We found particular issues with services not paying attention to the impact that the environment could have on people with a learning disability or autistic people. The low-quality care we saw was often due to poor physical environments and ward layouts, issues with staffing, and a lack care planning.

Reviewers found that staff were under pressure because of a high staff turnover, lack of appropriate training and high use of agency staff. In addition, we found poor staff cultures, and there was often a disconnect between the multidisciplinary team and frontline workers.

Being placed in an inappropriate environment can be damaging and creates a pattern of distress, restraint and seclusion, which often cannot be broken. In many cases, we found that the impact of the environment on people, such as the noise, heating and lights of the wards, had not been considered. In many cases staff did not understand people's individual needs and the distress that being in the wrong environment could cause, particularly for people with sensory needs. This could lead to people expressing their distress in a way that others find challenging, leading to staff resorting to using restrictive practices.

It is important to note that, specifically for people with a learning disability and autistic people, recommendations in national guidance from NICE state that these types of hospitals are only appropriate for the 'short-term' management of people.[13] But we found that many people were staying in hospital for months or years at a time. The guidelines clearly state that people should only be in hospital if "all other options have been exhausted" – we found evidence of this not being the case.[14]

## Ward environment and culture

The general ward environments and culture were often not suitable for autistic people, people with a learning disability and/or mental health condition.

- Wards could be noisy, chaotic and unpredictable, and were not conducive to creating a therapeutic environment. Sometimes they were not homely or welcoming, and lacked a quiet space or outdoor area that people could access freely.
- We were particularly concerned by blanket restrictions being in place – where rules and policies are applied to everyone without individual risk assessments. For example, on one ward we found that patients could not have access to their own bedrooms until after 10pm and that toilets had to be unlocked by staff. Patients were not allowed toiletries in their own rooms and could not have water bottles in the lounge. Staff made all hot and cold drinks, and snacks were only allowed at specific times. Snacks had to be eaten out of plastic bowls in the dining room, which had a seating plan. This was not a therapeutic environment as patients relied on staff so it was difficult to find space or do the little everyday things to comfort themselves.
- There were reports of teams not working together on the wards, with a disconnect between the nursing staff and therapy teams, friction between ward staff and management, and a lack of understanding between permanent and agency staff. Some ward staff felt they were not listened to and were not involved in the decision-making process for the people they cared for.

### Opportunity for the future

Improving hospital environments must be a priority for the future. The **Independent Review of the Mental Health Act** has recommended that the physical environment of wards needs to be improved, and that this should be done through co-production with people with lived experience to maximise homeliness and therapeutic benefit.[15]

Leaders in hospital also need to create a culture of listening to and understanding people. This includes using continual learning about how to minimise the use of restrictive interventions. It should run from creating a ward environment that meets the needs of the people being cared for, to ensuring that the staff team has been recruited using values-based recruitment. This is essential to ensuring human rights are upheld.[16]

Adaptions and reasonable adjustments must be made to enable better support, tailored to the needs of autistic people, and people with a learning disability and/or mental health condition. Being moved around the care system and in and out of hospital can be traumatic, with some of the people in the system experiencing further trauma from receiving poor quality care that does not meet their needs. We found few services offering psychological support or therapies to help them deal with any trauma they had experienced in their lives. Staff need to be trained in trauma-informed care in order to better understand people's histories, the impact of past traumas, and what may cause them further trauma.

## Staffing levels and turnover

A consistent staff team who know the people on the ward well, who have received the relevant training and who are able to work together well as a team is crucial in providing good quality and consistent care for people.

- Staff described feeling overworked because of staff shortages and, at times, that it was unsafe to leave the ward to take a break.
- There was a high turnover of staff, and many wards had a high number of vacancies. This led to the reliance on agency staff who are not part of the established staff team. This reliance on agency staff means that staff did not always know the needs of the people they are looking after. This includes their likes

or dislikes, communication needs, and their personal histories.

- Shortages of regular staff meant that the focus is on managing crisis and risk, as agency staff were not able to work more proactively because they did not know the people they were caring for.
- Issues with staffing had an impact on the quality of care that people received. For example, it could lead to patients' leave being cancelled. It also meant that people in seclusion or long-term segregation could be left for long periods without interaction with other people or access to therapeutic and meaningful activities.

## Staff training and supervision

To support a positive staff culture, staff need to feel well supported through supervision and training, and have opportunities to discuss and learn from incidents through reflective practice.

- We found that staff were not always receiving the right training, with no focus or training on human rights or value-based care. For example, in some specialist hospitals, frontline staff had not received adequate learning disability or autism training and were given e-learning instead of a full training package. The competence, skills and knowledge of staff actively involved in people's care was judged to be poor, very poor or below standard for 61% of people we reviewed in learning disability wards.[e]
- We found that staff were often not trained in different communication methods, including Picture Exchange Communication System (PECS) or Makaton, so were unable to communicate with the people they were looking after in a way they understood. Not being able to communicate in a way a person can understand is a potential breach of human rights and could lead to situations where people are unable to communicate. This, in turn, could lead to them becoming more distressed, and resorting to using restraint, seclusion or segregation.[17]
- Staff were also concerned about the quality of training. Staff described an increase in e-learning, which was seen as a 'tick box' approach to training. Some staff recognised their own shortfalls and were completing training in their own time.
- This lack of skills and knowledge of individuals affects people's rights to reasonable adjustments under the Equality Act 2010, and a lack of knowledge of human rights can lead to unnecessary restriction.[18]

## Assessments and care planning in hospital

High-quality assessments and care planning are fundamental to providing person-centred care. These are essential to help staff understand people's backgrounds and needs, and what psychological support they might need.

The Mental Health Act 1983 (MHA) Code of Practice is clear that care planning requires a thorough assessment of the patient's needs and wishes, and that it should be agreed with the person receiving care.[19] Care plans should include details of activities and support that aid a person's recovery. However, we found that assessments were often not taking place, and that the quality of care plans was often poor.

- For 54% of the people we reviewed in long-term segregation and prolonged seclusion, care and treatment were generic and were not aimed at meeting their specific needs, such as sensory needs.
- People were often not getting the right care because they were not receiving the correct assessments and therapeutic input to inform their care plans, including diagnostic, communication, sensory and physical health assessments. We saw two hospitals where there were good assessments in place, and staff had a good awareness of people's needs, which led to good outcomes for people.
- Physical health needs, such as seizures and brain injury, were sometimes not properly assessed or followed-up, and were not always

---

[e] See **appendix D**, figure 13

considered as a potential factor in why people were distressed. In other cases, physical health needs were sometimes overlooked, and care teams had not considered them or what impact they might have on a person. For example, one person was vomiting, but staff were reluctant to take them to the GP. Later investigations revealed that the vomiting was invasive gastroenteritis linked to medicine they were prescribed.

- Although a high percentage of the people we reviewed had a positive behaviour support (PBS) plan (91%), and in low secure and rehabilitation services 94% of people had an active rehabilitation plan in place, the quality of these was often poor and included minimal therapeutic activities. Family members also felt staff should be doing more to interact with their loved ones and encourage participation in therapeutic activities.
- In some instances, reviewers described care plans as “generic” and “meaningless”. For example, we found that the assessments for an autistic person, such as sensory and communication assessments, were not carried out.

  “There was no sensory assessment despite evidence [that Anna] was hypersensitive to sound and light and no plan was in place to address this...”
- Issues with staffing, including a high turnover of staff, and high use of agency staff and/or a high number of vacancies, had an impact of the quality of care people received. These issues meant that staff did not understand people’s needs and could lead to patients’ leave being cancelled. This not only has a therapeutic element, but is likely to be a breach of Article 8 of the Human Rights Act 1998, if it cannot be shown to be necessary and proportionate.[20] It also meant that people in long-term segregation or seclusion could be left for long periods without access to therapeutic and meaningful activities, and no interaction with others.

This lack of person-centred care planning, and lack of assessment and understanding of past traumas, meant there was often a focus on how the person was behaving rather than what was causing them distress, and little understanding of how that related to a failure to meet people’s needs.

### Opportunity for the future

In our review of care plans, it was difficult for reviewers to identify whether the activities outlined in the care plans were taking place, and we found examples of activities detailed in the plan that did not corroborate with what people told us had taken place in the recent weeks. We are currently working with the University of Warwick to create a tool to help reviewers identify this.

## IN-DEPTH LOOK AT 12 CARE PLANS

Positive behaviour support (PBS) is one of several types of care plans currently used for autistic people, and people with a learning disability and/or mental health condition. This must be done in collaboration with the person.

As part of the review, we looked in depth at 12 PBS plans (care plans) of people who were in long-term segregation from different hospitals and wards, to check if they followed good practice.

However, we found that:

- most of the assessments were poor; none of the care plans addressed how the person's diagnosis affected them
- for all the autistic people, the sensory assessments  were judged to be unsatisfactory or poor
- for people in long-term segregation on low secure wards, care planning and PBS plans were poor quality; people were being segregated from others – often for long periods – and were receiving care that was unlikely to do much to change their situation.

> **"The PBS plan does not show a clear picture of who the person is, what they like and do not like, and how staff should communicate with them and support them."**
>
> **"…the negative language [in the plan] makes it look like it is Toby's fault… and not how he reacts due to his learning disability, autism and history of trauma. It does not clearly specify how staff should support him."**

The importance of effective care planning is recognised as an essential element of delivering good, person-centred care. It is meant to ensure that the needs of the person are central to the development and implementation of support.

# The quality of, and access, to advocacy

Everyone in hospital who is detained under the Mental Health Act (MHA) is entitled to an independent mental health advocate (IMHA) who is specifically trained to support them.[21] Access to high-quality advocacy is vital to make sure that people can raise concerns about their care, including serious concerns that may amount to human rights breaches.

The MHA Code of Practice states that services have a duty to make sure that people understand how they can use advocates.[22] Where people lack the capacity to decide whether they want the help of an advocate, the hospital manager should ask an advocate to meet the person so they can explain directly how they can help.

We found that:

- Access to high-quality advocacy varied across the hospitals we visited and that the role of an advocate was not consistent.
- There was some confusion between the provider and commissioner about who the advocate was, or which organisation provided the services. This led to people being denied access to the service. In some cases, there was no evidence that advocacy had been offered to people. Even where people were allocated an advocate, they were not always engaged in decisions about the person's care.
- There were examples of where the advocate was not informed of certain people on the ward.
- When people did have access to advocates, there were examples where advocacy was of a poor quality, where advocates were not upholding people's rights.
- Advocates were also under pressure themselves and felt they did not have enough time to support everyone that they were responsible for. One reviewer noted:

> **"IMHAs [Independent Mental Health Advocates] feel they are not able to have enough time to advocate fully for people at [hospital]. They have been asked to increase their input by the [clinical commissioning group] but there is no additional funding available."**

## JEN'S STORY – AN OPPORTUNITY FOR THE FUTURE

*During our review, we saw a model of advocacy that had been specifically commissioned for Jen, who had been in hospital for many years. We describe Jen's story below, and have a made a recommendation that everyone should receive this level of personalised care.*[f]

Jen had been moved around different hospitals, before being transferred to a hospital over 200 miles away from her home because of the step-down pathway it offered. However, her clinical commissioning group (CCG) had serious concerns about having to place her so far from home and so commissioned their own advocate to act as their "eyes and ears".

The advocate saw Jen once a week, initially focusing on building a relationship with her, and then spending time in her company, talking to her or directly observing her care. The advocate made a point of reading Jen's notes and speaking to the ward staff before attending her ward round to ask questions of Jen's care team and advocate her wishes.

In doing this, the advocate became increasingly knowledgeable about Jen and built up a relationship whereby Jen felt safe to tell her things or she was able to act in Jen's best interests.

The advocate challenged some of the daily restrictions in Jen's environment and in her routine, and also raised safeguarding alerts where she believed the standard of her care fell short of what was required.

Because of the amount of time Jen has spent in hospital, the advocate played an active role in escalating her case to external agencies.

Access to good quality advocacy is an essential safeguard for people, especially people who are non-verbal, or extremely mentally unwell, and may be unable to speak up for themselves. It gives people someone who can champion their rights, support them to have a voice, and to promote their needs and wishes where they are not able to do this themselves. If an individual requests support from an advocate, the advocate should have oversight of their day-to-day care and care pathway, so that they can scrutinise and challenge the decisions of the care team.

As reported in our annual review of the Mental Health Act 2018/19, we welcome the recommendation of the Independent Review of the Mental Health Act that highlighted the need for better training for advocates and better-quality services.[23]

---

[f] See **recommendations** on page 47.

# How restraint was used in hospitals

Restraint is widely known to be a part of practice in inpatient hospitals, but it should only be used as a last resort in situations where people may be a risk to themselves or others.[24] There are well-known strategies that aim to reduce the reliance on restraint, such as 'No Force First' and the HOPE model, as well as new restrictive practice training standards that are working to embed this in services.[g,25] However, we found that these strategies were not always in place.

In this section, we explore the different types of restraint, how they were being used and, most importantly, the impact on the people being restrained. We specifically look at physical restraint, chemical restraint (including rapid tranquilisation) and mechanical restraint.

The use of restraint varied significantly across the services we saw, despite them caring for people with similar needs. We also saw inconsistent reporting and recording of restraint, which we have reported on previously.[26]

In some services, restraint was rarely used and every effort was being made to avoid using it as they were using restraint reduction strategies (for example, HOPE and No Force First); in others it was a daily occurrence.

The people who were subject to restraint often told us of the lasting and traumatising effects that restraint can have on wellbeing. One person said:

> "I feel absolutely f***ing sh*t about being restrained. It makes me feel …dehumanised. I don't feel like a real human being."

## Physical restraint

We found a variety of different types of physical restraint were used. These included arm wraps, and supine (face-up) and prone (face-down) restraint. While most providers had stopped using prone restraint, in line with the MHA Code of Practice and national guidance, some providers still restrained people in the prone position.[27,28] We found:

- 81% of 313 wards for children and young people, and for people with a learning disability and autistic people, had used physical restraint in the month before our information request.
- 56 out of 313 wards had used prone restraint at least once in the month before our information request.
- Physical interventions were mainly used when a person was assaulting others or was being moved into seclusion. Other reasons included when a person was at risk of serious self-harm or needed urgent medical treatment. Staff also said that there were times when they needed to use restraint to give people personal care, such as needing to brush a person's teeth. In another case, physical restraint was used daily for someone who needed hands on them to have a shower.

### Examples of good practice

- Using de-escalation techniques to pre-empt early signs that someone might be distressed.
- Several providers had introduced safety pods (large bean bags that people were laid on when restrained) to reduce the risk of harm from physical restraint, while others used an impact mat or cushion.
- Care plans that included the person's views and wishes detailing when and how to use physical restraint.
- Rather than taking a hands-on approach, staff supported people to manage their own self-harm, for example by untying their own ligatures. This was appropriately risk assessed and recorded.

### The lasting effects of restraint

People told us that when they were restrained it could often re-traumatise them and have a lasting impact on their mental health. They told us that it felt like they were at times not seen as

---

[g] See **appendix D** 'Examples of reducing restrictive practice strategies'

human or equal because they were completely powerless.

We found evidence of the impact of this on our visits. On one of the wards we visited there were no specific restraint care plans or guidance on restraining women who had experienced trauma, such as sexual abuse. For example, in one patient's notes it was noted that she preferred to be cared for by female staff – but there was no reference to this in terms of restraint. We found that male staff on the ward had occasionally been involved in restraining female patients, which could risk re-traumatising patients.

While it is important to understand that there may be extreme circumstances where restraint might be the only option for safety, providers must fully understand the impact this may have on people.

"It feels like my freedom has been taken away and I am powerless"

"There was an incident with John where they hurt him, he doesn't like anyone grabbing hold of him. The deputy ward manager said that the staff were under investigation, but they are now back."

"The provider has not escalated concerns including staff failing to treat Mo with dignity and respect – for example, ignoring him or threatening him with restraint in the prone position."

### Criminal records

We saw some examples of people being prosecuted by providers for injuring staff when resisting restraint. The trauma caused to staff must be acknowledged and addressed. However, we are concerned that people are being criminalised for their actions while distressed in hospital. In our expert opinion, failing to assess and treat their needs may have contributed to their aggression. In addition, it is then more difficult to discharge someone with a criminal record or on a forensic section, which further compounds the problem.

## Chemical restraint and rapid tranquilisation

In 2015, Public Health England reported that every day in England 30,000 to 35,000 people with a learning disability are prescribed psychotropic medicines when they do not have a mental health condition.[29] During our review, we found that several types of chemical restraint were used, from oral PRN ('pro re nata', as needed) medicines to injectable rapid tranquilisation. We found medicines were used as chemical restraint to control people's behaviour:

- Rapid tranquilisation was used in 34% (106 out of 313) of wards for children and young people and people with a learning disability and/or autism, in the month before our information request – a practice that has significant side effects and should only be used as a last resort.
- Over a one-month period, there were 720 incidences where rapid tranquilisation was used on CAMHS and learning disability/ autism wards. It was more common on CAMHS wards where almost half of the wards (49%) that responded to the information request reported using rapid tranquilisation.
- Of the learning disability and autism wards, 24% used rapid tranquilisation, which equated to 186 incidents over a one-month period. People sometimes told us they felt the staff were too quick to use rapid tranquilisation and records showed that staff did not always use the least restrictive option.
- In many of the cases we reviewed, physical monitoring of people was either not recorded or not good enough. Not only is this not in line with NICE guidelines, but it puts people at risk of cardiac and respiratory suppression and, in turn, increased risk of death, particularly if they have co-morbidities.[30]
- Many of the care plans we reviewed did not include specific individualised ways of using de-escalation techniques before using practices like rapid tranquilisation and chemical restraint.

Using medicines to restrain people is against the principles of STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines) and STAMP (supporting treatment and appropriate medication in paediatrics).[31]

People and their families described the impact of taking these medicines. Some people complained that they were "drugged up" or given medicines that made them sleep for days.

**"A father said that when he first visited [his daughter] on the ward she was 'pale, glassy eyed and not with it'. He was shocked at her appearance. He said the staff were very cagey about informing him about what they had given her."**

## Mechanical restraint

Mechanical restraint involves using a device (such as a safe suit, arm splints or harness) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of controlling how someone is behaving. While mechanical restraint was rarely used as a form of restraint, we found:

- 3% of children and adolescent wards and 5% of learning disability and autism wards were using some form of mechanical restraint in the month before our information request.
- At some services handcuffs and belts were being used. One hospital appeared to be using handcuffs routinely to move people to seclusion rooms, which was not in line with national guidance. We also saw where they had been used for people who had a history of abuse and trauma, which had not been taken into account.
- People with lived experience told us that there was a blanket approach, and many people were moved by secure transport in vehicles similar to police vans and no reasonable adjustments were made to individual needs.
- Lockable seatbelts or harnesses were sometimes used in vehicles to ensure people's safety (and the safety of others). This method of mechanical restraint was used for some people with a learning disability. During the review we found that this was used appropriately for people who needed it.
- Mechanical restraint, such as specialist clothing, was used by some providers to protect people who had a high risk of serious self-harm. For example, at one hospital, a person's care plan included using mittens to help prevent serious self-harm and staff were consistently reviewing this.

# A different service type – restrictive practices in secure children's homes

As part of our review, we gathered information from five out of 13 secure welfare children's homes in England. People in the secure children's homes had often experienced an unstable background including domestic violence, abuse and/or neglect. However, unlike mental health services, some had criminal action pending or underway. Children's stay in a secure home is subject to court scrutiny and approval through section 25 of the Children Act 1989 or the Youth Justice system with special arrangements for children aged under 13.[32]

In this section we explore the differences between these services and hospital services. Overall, we found that there were smaller numbers of people cared for in a secure home, the goals of children's time in a home were clearer, services were more closely measured against how they were achieving the outcomes, and there was stronger oversight and monitoring of restrictive practices.

## How restrictive practices were used

Services used forms of segregation, usually referred to as 'single separation' and 'managing away', depending on where it took place and for how long. However, it was unusual for children and young people to be cared for in isolation for prolonged periods (more than 48 hours).

- There was better oversight and monitoring of restrictive practices in the homes. We found that Ofsted would rate a service as requires improvement or inadequate if there were any concerns about the use of restrictive practices.
- There was a wider range of training available to prevent restrictive practices being used, for example on de-escalation, autism and attention deficit hyperactive disorder (ADHD) to training on adverse effects of childhood experiences, such as substance misuse and harmful sexual behaviour.

## Improved assessments and care planning

For all the children we reviewed in the secure children's homes, there was a clear aim for the time they were at the home. This was agreed at an initial planning meeting and then reviewed at each review meeting. These homes carried out detailed, routine assessments on admission. At least four of the five services reviewed used the CHAT (Comprehensive Health Assessment Tool). CHAT assesses:

- physical health
- mental health
- sexual health
- substance misuse
- neuro-cognitive assessment (including assessments for autism and attention deficit hyperactivity disorder (ADHD)).

"These assessments support a psychological formulation of someone's distress and focused on the person's own perception of their difficulties."

We also found that discharge planning took place early in these services. However, services told us that they frequently needed to escalate concerns about discharge planning within local authorities to get a response. It is important to note that courts will not grant to allow secure orders to continue if there is not a need for this. The staff in these homes echoed concerns that there was a national shortage of community support for young people with complex needs, which led to failure in the community before being admitted.

## OPPORTUNITY FOR THE FUTURE: A TRAUMA-INFORMED APPROACH TO CARING FOR PEOPLE

What stood out about these services was that they had a trauma-informed approach to care, whereby they provided people who had experienced trauma with an environment in which they felt safe and able to develop trust.

At four of the five locations reviewed, the secure children's homes used Secure Stairs. This is a model of care that focuses on individuals and supports a culture of compassionate care. It aims to ensure that every member of staff understands the children in their care in the context of their experiences, so that they are more informed about why the children behave as they do. The outcome is that children have a plan that guides staff on how to care for individuals according to their needs.

Staff received good training in this approach and there was a well-resourced dedicated team of staff to deliver the programme. This model of trauma-informed care was commissioned by NHS England and could be a model that is replicated in child and adolescent, learning disability and autism wards, and in low secure and rehabilitation services, to improve the assessment and treatment to better understand and meet people's needs.

# Long-term segregation or prolonged seclusion in hospital

Our review looked at a variety of restrictive practices, but we looked in detail at 66 people who were subject to prolonged seclusion or long-term segregation. This is because we were most concerned about the isolating nature of their care.

Seclusion is more short-term, and long-term segregation is a way of isolating someone away from the main ward for a longer period.[h]

The MHA Code of Practice defines **seclusion** as: "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" but there is no specific time limit.[33] **Prolonged seclusion is over a period of more than 48 hours.**

Whereas **long-term segregation** is described as required "to reduce a sustained risk of harm posed by the patient to others, which is a **constant feature of their presentation**, a multidisciplinary review and…commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a **long-term basis**".[34]

The main reason we were told that people were placed in long-term segregation or seclusion was because providers said they were a risk to themselves or to others.

Overall, we found that:

- The length of time that people spent in prolonged seclusion ranged from two days to seven months, and from three days to 13 years for people in long-term segregation.
- Out of the 66 people we reviewed in depth, we only found evidence of consistently good quality care and treatment for three people. For these people the care was individualised and they had more autonomy.
- There was a higher proportion of people from a Black or Black British background in prolonged seclusion on CAMHS wards, 24%, compared with 6% of all people on CAMHS wards in England. Similarly, for learning disability wards 11% of those in prolonged seclusion were from Black or Black British backgrounds compared with 5% of all people on these wards. This was not the same with long-term segregation, and we did not find the same across low-secure mental health wards.
- Almost 71% had been segregated or secluded for three months or longer. A few people we met had been in hospital more than 25 years, but how long they had been in segregation or seclusion had not been recorded beyond 13 years.
- While providers felt that segregation and seclusion was often necessary, their understanding of what this constituted varied. Where providers did not formally recognise their use of segregation or seclusion, people did not have the protection of the MHA Code of Practice to keep them safe.
- We were extremely concerned that people in segregation and seclusion did not have access to therapeutic and meaningful activities. What was described in people's care plans and by providers as 'therapeutic activities' were more observations of people, such as sleeping, pacing or eating.
- Standards of assessment, positive behaviour support plans and care plans were often poor, and these did not reflect people's needs.
- With a few exceptions, most of the environments we saw people living in were unacceptably poor and dignity and privacy were not maintained. Conditions were overly

---

[h] In the review we looked at people who had been secluded for 48 hours or more (prolonged seclusion) and those who had experienced frequent episodes of seclusion as well as people who had been segregated on a long-term basis.

restrictive. Liberty was deprived without clear justification or consideration for its long-term effect.

- Some people were caught in cycles of being placed in gradually higher security hospitals. For example, moving from low, to medium to high secure – where their freedoms are even more restricted – with no reflection about what was not working. For many of these people their pathway had previously included stays on medium secure units and there were no considerations about how to improve their care plans or assessments. Patients in secure care will be detained under the Mental Health Act. In many cases they may have committed an offence, although this was only the case for one person we met during our review.
- There were frequently restrictions on family or friends visiting or phone calls that people could make. For example, we saw evidence of people's leave being cancelled because of a shortage of staff. This is likely to be a breach of Article 8 of the Human Rights Act 1998.[35]
- In some cases, people in seclusion were not allowed to wear their own clothes. We found this was the case where there were risks of self-harm.

In particular, the physical environments for many people in **long-term segregation** were unacceptable and not in line with the MHA Code of Practice.[36] Issues included:

- a lack of access to outdoor space
- environments not being clean or hygienic, or that were in need of repair
- areas being too small, especially when people always had two or three members of staff with them
- lack of amenities, such as a table to eat at, crockery and cutlery, toilet paper and toiletries
- people having few belongings or having restricted access to them
- poor layouts, which did not allow staff to have full visibility
- a lack of good communication, for example, rooms without intercoms and/or staff leaving people alone.

Many of the physical environments of **seclusion areas** were also unacceptable and were not in line with the MHA Code of Practice. Issues included:

- a lack of access to personal belongings or TV/music
- hatches being used to give people food
- a lack of window providing natural daylight
- problems with lighting – while most areas had dimmable lights, or a bright day light and a dimmer night light, one seclusion room only had a full light that was left on 24 hours a day
- a lack of access to en-suite toilet, wash basin and shower.

We did find a few **examples of better-quality environments in long-term segregation:**

- some people had access to several private rooms, including a bedroom, separate lounge and bathroom or shower area, and direct access to outdoor space
- some environments had a homely feel, including personalisation, natural light and soft furnishings; and people were visible in a way that allowed staff to keep them safe at the same time as offering privacy
- we also reviewed some people in their own flats who had access to outside space and more activities.

## Lack of oversight

We found providers' understanding of what constituted long-term segregation or prolonged seclusion varied. This means some people did not have access to the proper safeguards and checks.

If providers recognise when they are using seclusion, they should be carrying out two-hourly nursing reviews and four-hourly medical reviews. These need to take place to consider whether seclusion should end.

People in long-term segregation should receive daily reviews by a doctor, weekly reviews by the care team and reviews by a senior professional not involved in the case.

We found that:

- Records about reviews and reasons for placing someone in seclusion or long-term segregation were not always clear or detailed enough, and were not always reported to the commissioner (this is required for long-term segregation).
- Long-term segregation reviews were sometimes poor quality, and sometimes did not take place. They often did not include plans for ending long-term seclusion, and rarely involved the family or mental health advocate.
- People's seclusion should have been ended sooner in some cases. For example, we found evidence of text being copied and pasted from previous reviews, which were not representative of the situation at the time. As these influence decisions as to when the patient can leave seclusion, incorrect information could have a direct impact on the person's liberty.

## The impact of seclusion and long-term segregation on people

We often found that people who were subject to long-term segregation were segregated because the noisy and chaotic ward environment was causing them distress.

Erik's story brings together what we heard from several people throughout our review. We have described these experiences through a single persona to illustrate the impact that seclusion and long-term segregation can have on people's wellbeing and human rights.

### ERIK'S STORY

Erik is autistic and doesn't like loud noises. Whenever he goes out, he wears ear defenders to reduce the noise.

Erik was placed in a busy ward with 11 other people. He couldn't cope with the noise and became very anxious so threw a chair. As a result, Erik was put in his own area of the ward away from others, in long-term segregation. Erik saw staff but no other people on the ward. This led to a deterioration in his mental and physical state.

Erik didn't get outside, and he had very little space. He lost weight because he didn't eat and drink much, he was only given food he could eat with his hands.

Staff told Erik that to keep him and them safe, he wasn't allowed things, such as his computer and guitar. Erik got very bored and lost interest in doing anything, he felt fed up.

Erik started to have aches in his legs as he never got exercise or fresh air. Staff told Erik to lie on the bed whenever they came in because they found it difficult to deal with him when he was distressed. He started to lie on the bed every day.

He got used to talking through a window so didn't want to be near people. Erik didn't want to come out of long-term segregation as he thought he was dangerous and was institutionalised by the setting he was in.

### What does Erik's story tell us about the impact of seclusion and long-term segregation?

Unfortunately, Erik's story or the others used in this chapter are not isolated incidents. People told us that the experience of being isolated had a huge effect on their psychological wellbeing years after they had experienced it.

We saw evidence of some of the long-term effects of prolonged isolation in such artificial environments. Issues included:

- people sleeping too much and getting into unhelpful sleeping patterns, which affected their opportunities to access therapeutic interventions
- people's physical health deteriorating, such as a decrease in mobility.

For some people, as they get used to being away from others, their comfort zone can shrink and it can become harder for them to be able to integrate with others because of the loss of social skills. This was particularly the case for some of the young women we saw in long-term segregation. Being isolated for long periods could reinforce a low sense of self, and that they are not good enough and should not be around other people. Often this was borne out of traumatic and abusive backgrounds and being passed around mental health services.

Providers told us that segregation or seclusion was sometimes the only option for staff when people were highly distressed. However, we have seen in the previous sections that improvements in staffing, the environment, and care planning could all help reduce the likelihood of these practices existing. Although it is currently lawful to isolate people for prolonged periods if this is the least restrictive way of keeping them safe, long-term segregation has real implications for people's human rights and long-term psychological wellbeing.

# Why it is so hard to leave long-term segregation or seclusion

Long-term segregation and seclusion units are often not caring environments. Their impact is not limited to the time that people spend in these units and is often felt for some time after. We found that if people stay in units for long periods, their chances of moving out of segregation and out of hospital are diminished.

Through our in-depth reviews of people in segregation, we found that the main reasons for staying in long-term segregation for long periods included: difficulty in being reintegrated back onto the ward; becoming institutionalised; and a lack of small bespoke community packages of support with specialist staff teams available as an alternative.

We also found that:

- Out of 66 people, three children and 28 adults had been in long-term segregation for more than a year. Despite hospital teams recognising that being in hospital was not appropriate for these people, there was often a lack of alternative community care.
- A lack of suitable care in the community prevented discharge for 60% of people we met. Most people in long-term segregation needed bespoke packages of care in the community, but this was difficult to achieve.
- The majority of people did not have a plan in place to reintegrate them into the ward, as this was felt to be an unsuitable environment. This is despite the MHA Code of Practice being clear that there should be treatment plans in place that aim to end long-term segregation.
- Some autistic people (mainly those without a learning disability) did not have Care (Education) and Treatment Reviews (CETRs). These are plans to help people be discharged. From our reviews, we found that these are not always effective, and recommendations are sometimes not followed through, but they are another lever to support people to leave hospital.[i]
- Failed discharges can lead to a deterioration in people's care. Some people had community placements but were not able to cope in these because of a lack of early enough preparation and transition. A failed discharge experience can re-traumatise people who are already anxious about their new environment, and it can make them 'not want to go back' to the community for fear of being unsafe.
- There were some successful attempts to discharge people from segregation and hospital. In one example, we saw the hospital staff team supporting the person who was leaving hospital to get to know the community staff team before their discharge so moving into the community was not a shock to them. This requires 'double-funding' from the provider and can be difficult to arrange, but is indispensable in helping the person get to know their new environment in a supportive way.

---

[i] Care Education and Treatment Reviews are a requirement under NICE guidelines for people with a learning disability or autism diagnosis

## WITH THE RIGHT SUPPORT IT IS POSSIBLE FOR THINGS TO IMPROVE – BETHANY'S STORY

*Bethany is a young woman who has experienced long-term segregation and seclusion; here her dad describes her story.*

Beth lacked a clear set of assessments and a full diagnosis, which meant her needs were never supported in the community. No-one understood that her challenging behaviour was a result of unmet needs – especially commissioning.

So, Beth was sectioned. Within days of hospitalisation she was placed in a seclusion room, a bare and sterile environment, designed to contain short-term distressed behaviour, because her autism prevented her coping with the noisy, bright environment of the ward and the sensory overload from so many other distressed patients.

Her regular staff had no training, no understanding of her diagnosis, her autism, her learning disabilities or her sensory diet. The agency staff were unable to understand her and had no desire to do so, so they just sat outside her door like security guards. No-one knew about her communication needs or processing delays. No-one understood her crippling demand avoidance profile.

So, Beth got more challenging. She self-harmed, tying ligatures and inserting items into her arms and opening wounds. She headbutted the wall in anger and frustration at hearing others being carried screaming into the rooms next to hers.

This anger and self-harm was met by regular restraint, she was held down by multiple people for up to four hours, the pain from her hypermobility feeding her futile resistance. She had her clothing forcibly removed, leaving her naked, or she was forced into thick secure clothing, which further tormented her sensory world.

Occasionally, handcuffs and leg straps were used to contain her, as well as suffocating spit hoods. Bruised, she would finally be injected and find comfort in exhaustion-fuelled sleep.

Left with no activities, she began inventing imaginary worlds and aliens to talk to. With no natural daylight or exercise, her skin suffered and her weight ballooned. An overload of unjustifiable medication was forcibly injected or slid to her under her door. Beth needs to form trusting relationships before she can engage, so her refusal to conform was seen as rebellion and another reason to keep the door locked. It stayed locked for three long years.

A media campaign, rather than commissioning or safeguarding, forced a review of her care and she was finally moved.

A new setting was created with Beth's input into the design and environment. Sensory overloads such as fluorescent lights were changed, a low stimulus layout and sole occupancy removed other triggers. Her comforts are allowed – her pets, her iPad, access to the internet and her own mobile phone with Zoom provide a means of communicating, engagement and distraction.

Her family were involved in training all of her team about her presentation and past life, and about Beth as a person, before Beth went anywhere near the new site.

All of her team are fully trained, and live and breathe autism, pathological demand avoidance (PDA) and No Force First techniques so her anxiety-driven behaviours are reduced to almost zero. Everything is about what is best for Beth, not the staff or the setting. The staff team is a constant group dedicated to her alone. She has a choice of activities that keep her constantly busy, but support therapeutic intervention and constant assessment.

It is true person-centred care.

The unnecessary medicinal straitjacket has been weaned off and replaced with compassion, understanding and a desire to move Beth to a productive, fulfilling life.

The seclusion cell has been replaced with unfettered fresh air and days out with her family and care team.

## Quality discharge planning can help people get back to their communities

We know that discharge planning should happen as soon as someone is admitted to hospital, if not before then. This is clear in NICE guidelines and the MHA Code of Practice.[j,37,38] Good discharge planning is essential to make sure that, when discharge happens, it is successful and works well for the person. We found that between 57% and 63% of people we reviewed did not have a quality plan. We found that discharge planning for transition out of hospital was often inadequate, with actions to enable discharge rated as very poor, poor or below standard for 57% of people we met. This rose to 63% when looking at just people on CAMHS and learning disability wards.

We believe that while people are still being cared for in hospital, the length of the hospital stay must be minimised and effective discharge plans are another way to ensure this. We found poor support on discharge was often one of the key reasons why a community care placement would fail. A good quality discharge plan is one that is proactive and details the individual's specific triggers and understands them. For example, if an autistic person does not receive their food at the mealtime they expect, it might cause them distress and confusion and they may feel out of control. Ensuring that everything is being done to accommodate people's specific needs to prevent them from being set back increases the likelihood of them being discharged.

Discharge plans should be created collaboratively with the person, their family or carer or advocate, and regularly reviewed. The NICE guideline for people with a learning disability and/or autistic people recommends that this happens every three months with the person, their family members and specialists.[39]

---

[j] NICE guidelines and MHA Code of Practice state that 'as soon as someone is admitted to hospital, a discharge plan should be put in place'

# Part 2: Community-based services

**In the first part of this report, we looked at the environment and culture of hospital-based services, and how restrictive interventions from physical restraint to segregation were used. In this second part, we look at these issues for community-based services for people with a learning disability and/or autistic people.**

Community-based services are widely accepted to be best placed to care for people with a learning disability and autistic people.[40] It is important to note that there is currently a joint national plan, **Transforming Care**, to move people from the hospital into the community. However, as of June 2020 there were still 2,085 people with a learning disability in hospital. Although numbers have decreased there is still a long way to go.[41] We found commissioners often struggled to locate an appropriate bespoke community package due to a combination of funding disputes and lack of appropriate housing.

During our review of community-based services we gathered evidence from:

- 452 questionnaires on restrictive interventions, completed with registered managers, during inspections between July and October 2019
- visits to 27 adult social care services identified as using restraint, for an in-depth review.

It is important to note that CQC currently only regulates supported living where personal care is provided. We do not regulate the care for people with only social or housing support.

Overall, we found that restraint was used a little less in community-based services than in hospitals, with most services promoting personalisation and a positive quality of life. However, the quality of care people received varied, and was affected by the numbers and skills of staff available.

# The quality of care and environment in adult community services

## Culture and environment

Overall, we found that people in adult social care services were experiencing better person-centred care than people in hospital. This meant that they were experiencing a better quality of life than the people we saw with comparable complex needs in hospitals. In particular, we found:

- Services were more likely to be able to personalise people's living environments to their individual styles and personalities.
- There were more services with a positive social environment, with activities that were relevant to each person's needs and interests.

  > "The home was situated on the coast with access to the beach, countryside, pubs and festivals. We saw that staff were supporting young people to go out and take part in activities that they were interested in, including long walks, attending pubs, and music events. There were sensory items scattered around the home as well as access to sensory room."

- Some examples of people receiving good physical health care within the settings, where staff were aware of any medical conditions and continuously monitored people for any changes. This was particularly important for those who had communication needs and may have struggled to communicate when they were in pain or needed help. We also found examples of comprehensive health action plans and where people were receiving regular check-ups. Good physical health care plans incorporated information from associated care plans, hospital passports and existing risk assessments.
- Where there were concerns about the quality of care, it was often because people did not have access to therapeutic or meaningful activities, and/or had little involvement in their local community. For example, some activity records showed that going out for drives or going to get takeaways was a person's main activity.

We also found examples where people were being cared for in **good physical environments**. This included:

- Single occupancy environments that could be adapted to people's needs, which gave them greater control over their environment. It also reduced the need for physical intervention as people did not experience distress because of their environment.
- People being able to personalise their walls with artwork and their hobbies.
- People being able to install underfloor heating or air conditioning.
- Safe furniture, lights that could be adjusted, and sensory items.

However, we found examples of **environments that were not suitable**. In these environments, we found:

- a lack of basic facilities and amenities, such as furniture
- people were not allowed access to their own kitchens, even with support staff
- poorly maintained buildings
- one individual whose water supply was cut off.

## MAKING THE IMPOSSIBLE, POSSIBLE: BRUCE'S STORY

Bruce is a 25-year-old man who has been diagnosed as autistic with bipolar disorder, attention deficit hyperactivity disorder (ADHD), and generalised anxiety disorder.

Bruce has had difficult experiences in many different educational, residential and hospital settings, including experiencing restraint. However, Bruce's needs are being well met by his current provider, and staff have never physically restrained him.

The provider has taken time to get to know Bruce and his needs. For example, Bruce needs to make a lot of noise, which caused issues with some of his neighbours in previous properties. Bruce's current provider was able to find him a detached property by a canal where he can make as much noise as he needs. His house has a large garden with a vegetable patch, log cabin, trampoline, seating area and hammock. Windows are unsmashable, and walls are lined with MDF inside to prevent damage to plaster.

Because of how others perceive him, Bruce can't use public transport and can be stopped from going to places. However, this has not stopped Bruce doing many activities with support from staff, including gardening, swimming the channel, hot air balloon ride and holidays.

Bruce is involved in decisions about his care. He has detailed care plans that help staff to know every aspect of his care, including how they should respond to various topics of conversation. He is involved in his staff rota as he has strong views on how often certain staff should be with him. Bruce's mother has been fully involved in all aspects of his care.

## Staffing levels and turnover

Overall, we found that there were good staffing levels in a lot of the services, and where staff were well-trained people received good quality support and access to meaningful activities. We also found examples where there was funding for one-to-one staffing, and a good understanding of individuals' needs. This contributed to more person-centred care.

However, there were instances where this was not the case. During our review, we saw:

- Some services were struggling to recruit enough staff and were using agency staff to cover vacancies. In one case, agency staff were not getting invited to supervision or team meetings, so did not have the same opportunity to contribute ideas and learn from others as permanent staff.
- The impact of restrictive interventions (which we explore in the next section) on staffing levels. In one case, this meant that people did not have the ratios of staff to resident set out in their care plans, which in turn affected their ability to engage in activities.

## Staff training and supervision

The type, quality and availability of staff training varied across providers.

- Our information request showed that there was a wide range of training available for staff in services where restraint was used. Where staff received suitable training, they said that it helped them to understand people's needs. However, we were concerned to find examples of a lack of training for staff to be able to understand people with a learning disability and/or autistic people. For example, one service had training on the Mental Capacity Act, but staff were not trained in communication tools like Makaton or Picture Exchange Communication System (PECS) to help people with a learning disability to communicate. Other services did not provide training on autism.
- Most services emphasised the use of proactive approaches and de-escalation techniques, as

well as care-planning using positive behaviour support. One service had trained all its staff in autism and communication methods.

- However, training was not standardised. As a result, each provider's training was slightly different and meant that some training was better quality than others, for example more person-centred and bespoke training courses were available and tailored to those in the service. It also meant that agency staff may not be trained in the relevant approaches for the different services they work for.

## Care planning and assessments

In most adult social care services, staff knew and understood the behaviour of the people they were working with. Staff were able to talk about people's likes and dislikes, their history, what was important to them and how to support them.

We looked in depth at the care plans and positive behaviour support plans for nine people living in restrictive environments in single accommodation, across different providers. We found that:

- Adult social care services provided more support, activities, and choice, increased the quality of life for people, and offered more person-centred care than hospital services.
- Some services needed to improve their care planning. For example, only two out of the nine people had physical health plans that included enough information about their specific needs to be satisfactory, only three had communication plans, and none of the sensory assessments were satisfactory.

# How restrictive practices were used in adult community services

Our overall assessment of community services was that they were providing higher quality care, with fewer restrictive interventions. However, it is important to note that there is no national reporting system for restrictive practice so this is limited to those that reported this to us.

At present, there is no way of collating the figures nationally for the use of seclusion or segregation in social care settings. In addition, the use of these restrictive practices and restraint is not currently notifiable to CQC. Services do not have to report on using it unless it leads to a safeguarding alert being made.

Of the services that responded to our questionnaire, 62% (out of 452 services) told us that they used at least one type of restrictive intervention. We found that restraint (chemical, physical and mechanical) was used far more commonly than seclusion or segregation.

## Physical restraint

Staff told us that stopping people from hurting themselves or others, including staff, was the main reason for using physical restraint. We found that:

- Of the sites we chose to visit (as they reported using restraint), 26 out of 27 services were using physical restraint on occasion.
- The types and levels of physical restraint used varied. These included arm holds, two-person standing escorts and supine restraint.
- Three out of the 452 services that completed the questionnaire said they used prone restraint. We did not find any evidence of the use of prone restraint on our visits to the 27 services.
- In the majority of services, when restraint was used, the methods were the least restrictive and least likely to cause harm. While physical intervention was included in many people's care plans, in a lot of cases we found that this had never been used, as staff supported people positively without needing to use restraint. If restraint was needed in an emergency, staff knew the appropriate type of restraint to use.
- One person's care plan included details of the specific physical restraint technique to be used, including photographs so that staff understood when and how this could be used as a last resort. Their mother said she could not remember the last time physical restraint was used as staff supported this person in other positive ways, but they knew how to safely restrain the person in the least restrictive way if they ever had to in an emergency.
- Although there was less use of restraint overall, when it was used for some individuals, it was used often and we found evidence of the same person being restrained 100 times in a month.

It is clear that when restraint is used frequently, services can become stuck in a cycle of repeatedly restraining people, which can be hard to get out of. The services that used low levels of restraint had much more emphasis on preventative and de-escalation methods.

## Mechanical restraint

Staff told us that mechanical restraint was mainly used to help people travel safely and enjoy going out. It was also used to minimise injury from self-harm. Types of mechanical restraint included using helmets and arm splints. We found:

- The most commonly used form of mechanical restraint was the use of harnesses or belts to transport people in vehicles. During the review we found that generally this was used appropriately by people who needed it.
- There was guidance available on when and how to use the mechanical restraints. For most people, staff tried to support them in other ways before using the mechanical restraint.
- Examples of better practice in the way staff used harnesses and vehicle adaptions; some services assessed a person's ability to

understand why they were being put into a seat with a seatbelt or harness, giving them a key to unlock their belt/harness on arrival so they had control, and using best interest decisions and reviewing these.

- Examples where mechanical restraint, such as arm splints, 'stable-doors' or a harness to stop someone from getting out of a wheelchair, was not being monitored by the service, commissioners or professionals from community teams. This lack of oversight was concerning.

## Chemical restraint

Medicines were used as chemical restraint in all services except one that we visited. Chemical restraint is where a medicine is used to restrict the freedom of movement of a person or, in some cases, to sedate people. We found that:

- In some cases, staff did not have appropriate guidance to help them decide whether to use a medicine. Care plans did not include de-escalation techniques and staff were unaware of triggers that may cause a person to become distressed.
- The outcome and effectiveness of medicines was not always recorded. This meant that staff could not be assured that future doses would be used appropriately. We saw an example where a person had repeated medicines administered and the reason recorded as "incident probable".
- It was not clear from records that medicines were always used as the last resort or were the least restrictive option. Guidance lacked detail about when a medicine was needed, and the dosage that should be given.
- Some services were taking the right precautions, involving family members, appropriately monitoring, using STOMP,[k] and using chemical restraint as a last resort. However, this should be the case for all services.

The examples of good practice we saw on our visits highlighted that in order to improve, services must provide clear guidance about when it is appropriate to use PRN and other medicines, and include details on less restrictive options and de-escalation techniques before using a medicine. They must also ensure they monitor the effects of medicines on the person's physical health.

## A better culture than hospitals?

Many adult social care services had a culture that was focused on prevention and de-escalation of distressed behaviours, including using positive behaviour support (PBS) plans.

In these services, staff had good knowledge and understanding of how to support people, there was minimal use of restraint and the services promoted openness and active learning.

Several services told us about the importance of good communication and supporting people to have choice and control in their lives. When people's communication needs were met, we found that they were less distressed and it could result in fewer incidents and restraints. This highlights the important role of communication in good quality care.

> "There was a positive culture of 'no force first' and of active learning about the young people and about how to minimise the need to use restraint."

> "Jennifer had choice and control about who she has in her living space, if she does not want a member of staff with her, she tells them, if she wants them to come back later or for another member of staff to support her, she has control over these decisions."

In one example, a new manager had created a culture where staff felt they could be open about how they felt after incidents and felt supported to raise concerns. As a result, there was a dramatic reduction in the number of restraints.

Although some services were using restrictive practices, on the whole community services were providing a more person-centred approach.

---

[k] **STOMP principles** (stopping over medication of people with a learning disability, autism or both with psychotropic medicines).

## Oversight and accountability of restrictive practices

External bodies, such as commissioners, were not always aware of the levels of restrictive interventions, sometimes due to a lack of contact with people once they had moved into the service. There was more monitoring of restrictive practices at a provider level than at a commissioner level.

### Local monitoring of services – providers

Most services had systems in place for recording and monitoring the use of restrictive interventions, but how they did this, and the quality of the systems varied.

Examples of good practice in monitoring restrictive practices included:

- Detailed records, with involvement from senior managers and external stakeholders, and data analysis that was used to inform learning and practice.
- Comprehensive recording systems, for example well-designed forms with specific measurable information that could be compared.
- Regular reflection at team meetings about learning from individual incidents of restraint.
- Debriefs with people about restraint incidents.
- Including information about post-incident support in positive behaviour support (PBS) plans and/or care plans.
- Using Talking Mats – an interactive resource that uses three sets of pictures (topics, options and a visual scale) to support people to say how they felt about incidents.

Examples of poor practice in monitoring restrictive interventions included:

- Some services not recording the use of interventions. In a rare example, a staff member told us that they did not record the use of restraint for one person because it was "so frequent (daily) and low-level", that it was seen as a part of their care.
- Ineffectual and over-complicated monitoring systems that used multiple different forms and prevented staff from entering enough information. For example, one service had a daily log, a behaviour log, a PRN record and an incident form – all of which had slightly different information recorded.
- Discrepancies and inconsistency between data sources that meant trends could not be analysed. This included, for example, different information in monitoring data and incident forms.
- A lack of involvement from external professionals or agencies, and a lack of evidence about what monitoring activities were taking place.

### Local monitoring of services – commissioners

There is no national oversight for people living in adult social care services who are subject to highly restrictive environments.

Providers are not legally required to tell commissioners or CQC about incidents of restraint or seclusion or that a person is living in a segregated setting. We found that:

- Of the 272 services that said they used restraint in response to our information request, only 44% told us that they would report episodes of restraint to their clinical commissioning group (CCG) or local authority in the current system.
- Monitoring of restraint by commissioners is often limited to an annual review. Commissioners were not always aware of the level of restrictions placed on the clients and when people had been placed in a service, the oversight of their care by the CCG or local authority was minimal.

Due to our concerns over this lack of oversight, we have recommended that there needs to be a consistent reporting and oversight system for restrictive practices in social care, as there is in hospitals, so that national trends can be identified.[l]

---

[l] See **recommendations** (page 47)

# Segregation and seclusion in community services

As there are currently no recognised definitions of restrictive practices in community services, it was often hard to identify the use of segregation and seclusion. For the purposes of this review, we used the same definitions as hospital settings, and we recommend that if a system is introduced, it mirrors hospital definitions. We did find it was used less frequently in community services, but that it was still used in some cases.

We also found that some community services were using single person accommodation that was not segregation but where people were living alone.

## Use of seclusion

The term seclusion is not common in adult social care services, and we found that different terminology was being used across the services. In some services, seclusion was referred to as "time-out" or "locked door". We found that:

- Out of the 452 services that responded to the questionnaire, 24% reported that staff sometimes ask people to go to a specific area such as their bedroom because of behaviour, but staff do not stop them from leaving these areas if they want to.
- 9% of services sometimes asked someone to go to a specific area due to their behaviour and then prevented them from leaving.
- Services used seclusion for a variety of reasons, with safety of the person or others, including staff, being the most common reason. Some of the people that we saw who were in seclusion did not have authorised Deprivation of Liberty Safeguards (DoLS) in place for this restriction, so the restriction was unauthorised and may be a breach of their human rights.
- While seclusion was being used in the care homes and supported living services we visited, not all services recognised or recorded that they were using it. For example, in one service, staff withdrew from the person's flat when their behaviour was "challenging" and effectively locked the person in. The review team identified this as seclusion by our definition,[m] but the service did not and therefore it was not recorded.

## Use of segregation versus single person accommodation

As with seclusion, the term segregation is not widely recognised in adult or children's social care services, and we found that different terminology was being used across the services.

Sometimes people were in single person accommodation but not segregated as they could leave freely. Other times we identified they were segregated as they could not leave. This made it challenging to identify when people were in segregation or not and to get a true picture of what is fully going on.

People were usually living in single person accommodation because it was distressing for them to live with other people, or their behaviour had an impact on other people.

### Use of single person accommodation as good practice

Living in a bespoke placement in a community environment that was tailored to a person's needs often led to a better quality of life. People were generally happier and less distressed, which led to fewer incidents and less use of restraint.

People, families and staff told us that they were able to go out and, with support, take part in community activities, and were generally happy with their care.

The most successful services had adapted people's environments to meet their preferences and needs with a person-centred approach.

---

[m] See **appendix E** for the glossary

People were then able to follow their own chosen activities and routines with staff support. For example, as in Bruce's case, one supported living provider found an isolated property for a person who had difficulties interacting with other people, so that they could live in a safe peaceful home and take part in community activities on their own terms.

### Use of single person accommodation as segregation

Overall, we found that most people were not left on their own all the time. Staff worked with them in their homes and supported them with their personal needs, meals and other activities.

However, some of the people we met did not have staff with them all the time and were locked into their flats at times. This was equivalent to what would be known as seclusion in hospital.

On our 27 visits to adult social care services, we met 17 people who were locked in their flats and then monitored outside of their flat or room. This meant that their human rights were not protected, and they could neither come out nor ask staff for help when they needed it.

For some people who were locked in their accommodation without staff present, there was no written clear justification or clear written best interest decisions as to why this was the case. In addition, we did not see care plans to show how staff were going to support people to move forward to being in a less restrictive environment.

# Children's residential services – restrictive practice and the environment

As part of our review, we looked at 11 children's residential homes that are registered with both CQC and Ofsted.[n] These services provide residential and respite care for children and young people who were typically aged between 10 and 18 years old at the time of our visits, and who had complex needs. This included severe learning disabilities, physical disabilities, acquired brain injuries, trauma, or other complex mental and physical health needs.

We found that the culture, use of restrictive practices and environments of these unique services differed from hospital and other community settings.

## Environment and culture

The environments of children's residential services ranged from houses on residential estates to services that looked more like hospitals.

We found that these services were in very high demand, with commissioners placing children in services from across England. One service had 48 different local authorities placing people at the service. Another provider was receiving up to 200 applications a week for children and young people with mental health difficulties. This meant people could be placed a long way from home and their families.

## Types of restraint used

### Physical restraint

This was the most common type of intervention used. Even when this was needed, we found that it was "low level" holds (holding and linking young people's arms, wrists, hands and elbows), leading young people by the hand, and controlling movements while eating. While we did find evidence of supine (face-up) restraint, there were no prone (face-down) restraints.

### Chemical restraint

This was used in six of the 11 children's services. How frequently they were used varied significantly between services. We found examples of oral PRN medicines being offered to calm young people in moments of distress, for example to manage symptoms before or after incidents of self-harming, or as a sleep aid.

However, we did also find an example of anti-psychotic medication being used on someone who did not have a mental health diagnosis, which would be classified as chemical restraint. Other uses included managing obsessional thoughts and auditory hallucinations. In a few services, we were concerned that individual protocols were not in place for PRN medicines, and that side effects were not considered.

### Mechanical restraint

This was used in four out of the 11 services we reviewed, but in these services it was rarely used as a form of restraint. As with other services, some young people were restrained by safety harnesses and ankle straps when travelling. Other examples included using high-sided beds, bed rails, and safe suits to help manage spasms. In most cases this was being recorded and in care plans.

---

[n] A small number of services need to register with both Ofsted and CQC– with Ofsted as a children's home, and with CQC for the regulated activity they provide under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (HSCA). The majority of children's homes provide some form of health service, ranging from basic first aid to high level healthcare. Where a service offers 'regulated activities' as set out in the HSCA 2008, the provider also needs to register with CQC to ensure they meet essential standards of quality and safety. The **guidelines** for joint registration are currently under urgent review, and have been withdrawn (as of December 2018).

## Use of seclusion and segregation

None of the children's residential homes we visited were using long-term segregation. However, we did find evidence that services were using seclusion, although this was not always recognised as such. For example, in two services, children and young people had been prevented from leaving their room by staff holding the door handle upright. While this was not usual practice by the service, services must recognise this as seclusion so appropriate safeguards can be put in place.

Some services were initiating periods called "time-outs". This consisted of children and young people being removed and taken to another area of the residential home (a bedroom or a quieter communal space). During a time-out, the children and young people were typically left for a few minutes while being observed (and doors left open), and then supported to re-join. The uses for this were not always clear in care plans, but was sometimes recorded as a risk of harm to themselves or others.

While there are very few of these services in the country, and they are only available to children, the fact that they were still using forms of restrictive practice highlights the need for a central reporting system, so that the use of restrictive practice in these services can be properly monitored.

# Part 3: Commissioning

**A central theme throughout the services we visited were issues and disputes about funding and commissioning placements. This often prevented people from receiving the best possible care across settings.**

We found that funding arrangements for individuals' care were complex, and it was not always clear whether commissioners had the oversight or knowledge required to ensure that this was meeting the person's needs.

Considerable amounts of money are being spent to support people in restricted environments in hospitals. However, in the view of reviewers carrying out the visits, money available would often be better spent on providing individual person-centred care in the community.

As mentioned, there are national programmes aimed at reducing the numbers of people in hospital, but there are still many people in hospital that could be cared for in the community. It is important to note that when we compare placement costs for hospital packages and community care packages, these figures are not directly comparable, as they were not at the same points in time or related to the same individual placements – we include them to illustrate the broad funding differences.

## Issues with commissioning – cost and oversight

### Hospital care packages

It was difficult to get information about the cost of care for people who are in prolonged seclusion or long-term segregation in hospital. Commissioners responsible for the care were not easy to identify and did not always respond to our requests for information.

We estimated that the cost of care for someone in prolonged seclusion or long-term segregation could range from £650 to about £2,300 a day.

There was variation in who paid for the care of people in long-term segregation. From our information request, we found that most people – both children and young people, and adults with learning disability and/or autistic people – were funded by either specialist commissioning (52), through NHS England, or clinical commissioning groups (CCGs) (49). Three adults were funded by Welsh commissioners and the funding package was not specified for two people, but it may have been a health commissioner.

For people on low secure and rehabilitation wards who were in prolonged seclusion and long-term segregation, the majority of care was funded by NHS England.

It was not always clear how commissioners monitored how people's needs are being met by the money spent on the care package. We found that people's needs were frequently not met and/or they were being cared for by staff who were not trained to meet their needs. They were also not receiving the assessment and treatment that they were admitted for. This could lead to potential breaches of people's human rights not being picked up and addressed by commissioners.

## Adult social care packages

Funding for adult social care packages in supported living or care homes also varied, with commissioning from local authorities, continuing health care and education funding streams. Some people had a combination of all of these.

We visited a range of services including supported living services, residential care homes and nursing homes. Funding was organised differently depending on the service, so it was difficult to compare service costs.

For people we visited, fees ranged from £250 to £1,400 a day. These included people who were living in single person accommodation with full staff support, and the costs were similar to the fees for caring for someone in long-term segregation in hospital. These could be covered by a combination of health and care commissioners.

## Commissioning and hospital discharge

There were mixed views about whether the availability and arrangements between different systems of funding had an impact on plans for ending segregation and discharge from hospital. Staff and family members often suggested that they "suspected funding to be an underlying issue", but many felt that the money was available, it was just difficult to access. Many had encountered difficulties with understanding how to access various funds available. Some providers and families told us that discharge to the community had been delayed or even blocked due to funding issues.

> **"The local authority commissioner said the need for "full wrap around support" makes reproducing the level of care at the hospital in the community almost impossible, especially within the same budget. Any community package would be more expensive than the current arrangement and funding is a factor in making the decisions."**

However, several commissioners did not identify that issues with funding affected discharge planning. Instead, issues with finding appropriate care and the higher risks associated with care in the community were given as common reasons for delays in discharge.

Some providers told us that replicating the person's care in the community would be more expensive. However, in most cases we found that community care packages were not more expensive than hospital care packages. If funded correctly, these provide people with person-centred care, tailored to their needs, with their own staff team, and closer to their home with access to the community.

Issues around funding arrangements seemed to be more complex than relative costs of different care options. Issues were often related to where the responsibility for funding lies, because inpatient care can be funded by NHS England or the CCG, while community care can be funded by CCG or the local authority.

We found that discharge can be delayed due to a lack of agreement about how the new placement will be funded. This can also be because at times there needs to be funding for the existing and the new placement to support the transition period. However, it is important to note that the **Community Discharge Grant** recently announced is designed to address this issue, and all Transforming Care Partnerships should have access to a pot of £20 million to support discharges for the next two years.

Furthermore, families and other organisations raised concerns about the financial incentives of independent providers discharging people in long-term segregation, as this would mean a loss of income for those providers.

## Is hospital care value for money?

Considerable amounts of money are being spent to support people in restrictive environments in hospitals. However, we found that these environments are often not appropriate to meet the needs of the people with mental health conditions or a learning disability, and/or autistic people. As a result, the people we met were being segregated and not receiving the care and treatment they required and were frequently at risk of having their human rights breached. This does not represent good value for money. The money available would be better spent on providing individual person-centred care in the community.

# Conclusion

We carried out this review in response to serious concerns about potential breaches of human rights due to the use of restraint, seclusion and segregation in care settings for people who, in some cases, cannot advocate for themselves.

Through our review, we found that time and time again people were not getting the care they need, when they need it. We have attempted to reflect what we saw and the many examples we found of care that was undignified, inhumane and that potentially breached people's basic human rights. We are grateful to those who have shared their experiences with us, and hope this will go some way to illustrate the trauma they have been through when they have sadly been failed by the system that was established to care and protect them (whether due to hospital admission from lack of crisis care, segregation or inappropriate use of restraint).

Cumulatively, the evidence that we have gathered points to a system where people with complex needs fall through the gaps. We cannot be confident that their human rights are upheld, let alone be confident that they are supported to live fulfilling lives.

We found it is possible to support people well in the community, but care packages are often not available. This failure in care started at the beginning of people's journey from the point of reaching out for help, through receiving diagnosis, to post diagnostic support and crisis intervention, when needed. The current lack of specialist providers and community housing that meets people's needs also directly contributed to people being admitted to hospital and then further delayed their discharge.

Once in hospital, we saw how the assessment and treatment that people are admitted for is failing, and how people are frequently not receiving the care that they are entitled to. The workforce is stretched with not enough skilled staff who have received the right training to be able to care for people who are vulnerable and traumatised.

We have also seen that families are often not listened to and are pushed aside by the system. In particular, families described the difficulties they experienced in accessing funding for their children. This included concerns about who should be paying for care between local authorities and NHS bodies, all of which prevent people from being put at the centre of their care.

However, we saw what is possible when people **are** put at the centre of their care, and bespoke packages of trauma-informed care are put in place that allow them to thrive. Another alternative is possible. We need to make this the reality for all autistic people, and people with a learning disability and/or mental health condition who need complex care. Having community care packages that are designed around the individual, which help prevent and de-escalate instances of behaviour that others find challenging will, in turn, prevent admission to hospital and end the cycle of institutionalisation.

These potential abuses of human rights, and the inappropriate placements people have been suffering in are not a newly emerging problem. The answers as to what good sustainable community care looks like were first set out by **Mansell** in the 1990s.[42] However, as highlighted in **the Bubb report** in 2014, when things work for the individual it is "too often despite the system not because of it".[43] We need the government, NHS organisations and local authorities to work creatively to remove the barriers that have stopped people from getting the care they need for too long, and putting in place the funding, community placements, crisis teams and skilled staff who understand the people they care for.

There have been too many missed opportunities to improve the lives of autistic people and people with a learning disability and/or mental health condition, whose behaviour others find challenging. Immediate action is needed to put an end to the abuses in human rights that we have seen throughout this review. This action must be owned and led from the top by government, delivered by local systems working together, and involve people and their families to ensure the needs of the individual are met.

# Recommendations

This report was focused on restrictive interventions, but we found many people were subject to these because of failures much earlier on in their journey of care. Autistic people, and people with a learning disability and/or mental health condition should be cared for close to their homes in community-based services in line with best practice. However, we have seen this is not always the case. The NHS Long Term Plan already has goals to increase community mental health provision, but this needs to happen as quickly as possible for people with complex needs.

## Recommendations for national system change

1) There must be a single point of ministerial ownership for the delivery of these recommendations. This will require the minister to work with delivery partners in health, education, social care, justice and local government to pool budgets locally and work together as soon as additional support needs are identified for autistic people, and people with a learning disability and/or mental health condition. This must include:
    a) Improved community-based capacity and improved capability across education, health and care.
    b) Proactive development of specialist multidisciplinary and multi-organisational teams that are focused on providing the necessary services and support in the community to prevent admission to hospital.
    c) Proactive development of appropriate housing.

**Lead organisations:** *Department of Health and Social Care, Ministry of Housing, Communities and Local Government and Ministry of Justice*
**Other responsible organisations:** *Home Office and Department for Education*

2) There must be a named national specialist commissioner for complex care who has oversight for:
    a) Ensuring commissioners are held to account for their decisions.
    b) Ensuring there is a named individual who is responsible for people with complex care in each local area, to ensure that reviews of care are carried out every three months.
    c) Developing new quality standards for commissioning specialist learning disability and autism services to ensure local commissioners of specialist services have training in learning disabilities and autism.
    d) Monitoring whether local commissioners are checking and visiting services to ensure the care being delivered is line with human rights.

**Lead organisation:** *NHS England*
**Other responsible organisations:** *Department of Health and Social Care, Department for Education, Ofsted, commissioners, local authorities*

3) Community teams across the country must have skills in caring for autistic people, and people with a learning disability and/or mental health condition to prevent them from having a crisis, and support them when they do, in line with and expanding on the NHS Long Term Plan commitment 3.35. These may be new or building on existing teams skillsets. This must include:
    a) Ensuring teams have specialist autism expertise.

  b) The development of trauma-informed care that is delivered across community teams for autistic people, and people with a learning disability and/or mental health condition, of all ages.

  c) Clear focus on support during transition periods between services and from childhood to adulthood.

  d) Respite and crisis support that is close to home to prevent admission to hospital. The service provided should be easily accessible, and inclusive of children and young people. This should include a Dynamic Support Register for all local areas.

**Lead organisations:** *Department of Health and Social Care and NHS England*
**Other responsible organisations:** *Local authorities and commissioners*

4) There must be human rights embedded in the commissioning and delivery of care for children and adults with a learning disability, autistic people and people with a mental health condition. Individuals' needs must be taken into account and reasonable adjustments made to meet these needs, thereby fulfilling the need to make adjustments that are reasonable in the context of the ward and other people.

  a) People should be given accessible information about their rights such as resources produced by the British Institute of Human Rights and the Equality and Human Rights Commission.[44]

  b) Human rights must be integral to the planning and delivery of care, this includes training in human rights and checks against whether reasonable adjustments are taking place.

**Lead organisation:** *Department of Health and Social Care*
**Other responsible organisations:** *NHS England, local authorities, commissioners, Department for Education, Ofsted, Ministry of Justice, CQC, health and care providers*

5) There must be high-quality, specialist care for people who are in hospital for short periods, which must be focused on discharge, in line with and expanding on the NHS Long Term Plan commitment 3.36.

  a) Before admission to hospital people must have assessments through community teams so that their needs are understood and they have clear and measurable objectives set for their admission to hospital, and receive care in an appropriate environment.

  b) On admission, further assessments must take place, including for autism, sensory, mental health, physical health, trauma, learning disability and any other relevant assessments. This is to ensure that the objectives and care plan are meeting people's needs. There must be a contract in place stating the timeframe for these assessments to take place.

  c) All inpatient mental health units must provide a therapeutic environment to enable the delivery of trauma-informed and person-centred care in line with existing evidence-based models such as Secure Stairs. In particular, autistic people must be cared for in small person-centred units with the right sensory environment, as recommended by the National Institute for Health and Care Excellence (NICE).[45]

  d) Discharge planning must start before admission, without fail, with a clear timeframe in place. Discharge planning must involve all relevant sectors, who will be involved in providing support in the community.

e) There must be a named budget holder for the person's care. Where a new placement is required to enable discharge, the named budget holder, which is likely to be a clinical commissioning group (CCG) or local authority, must be responsible for commissioning the identified requirements within an agreed timeframe.

f) There must be a named care coordinator and system navigator for people with complex needs and their families.

**Lead organisation:** *NHS England*
**Other responsible organisations:** *Commissioners, providers, local authorities, police and/or probation service*

6) CQC must improve its regulatory approach for providers of services for autistic people, and people with a learning disability and/or mental health condition. This will include (as well as recommendation 11):

a) Reviewing our key lines of enquiry and assessment frameworks to ensure that human rights, community-first care, and a positive culture are embedded within these.

b) Reviewing our approach to how we rate providers who have people in prolonged seclusion or are using unnecessary restraint, and ensuring that these providers are not rated as good or outstanding.

c) Tracking progress made against the recommendations from independent reviews of seclusion and long-term segregation. This includes recommendations made in Care Education and Treatment Reviews (CETRs).

d) Reviewing our registration processes to prevent services renaming or repurposing services after enforcement action has led to closure.

e) Improving how we listen to people with lived experience and their families, how we use this information in our monitoring, inspection and rating of services, and ensuring that any concerning information that is shared with us is shared with appropriate agencies for investigation.

f) Checking on how services give access to advocacy and involve people and their families in care.

g) Increasing the number of unannounced and evening/weekend inspections.

h) Checking on timely diagnosis of autism for all services.

i) Checking on timely assessments, discharge plans and person-centred care plans.

j) Ensuring that all providers of services comply with the mandatory training requirement for learning disabilities and autism.

k) Ensuring that providers are delivering all relevant training around mental health needs, trauma-informed care, human rights and restrictive interventions.

l) Using our unique position to report on all providers' efforts to reduce the use of restrictive interventions, noting good practice and highlighting where more work is required.

m) Reporting annually on our Closed Culture programme of work and ensuring that defending and upholding human rights is at the heart of our approach and that our staff have effective training in this area.

   n) Discussing with the Department of Health and Social Care the limits of our regulatory approach and what further legislative changes may be required for mental health inpatient units.

**Lead organisation:** *CQC*
**Other responsible organisations**: *Department of Health and Social Care*

7) There must be enough staff with the right skills, competencies and experience to provide high-quality person-centred care for autistic people, and people with a learning disability and/or mental health condition. We recommend the following apply for **both health and care settings**:

   a) The government and commissioners must ensure that there is enough funding for training of all staff caring for people.

   b) All providers of services must comply with the forthcoming requirement for Oliver McGowan Mandatory Training on learning disability and autism (for all health and care staff).

   c) All providers of services must train their staff in de-escalation methods and alternatives to restrictive interventions.

   d) All providers must use training providers certified by the Restraint Reduction Network where training includes the use of restrictive interventions in line with the Mental Health Units (Use of Force) Act 2018.

   e) Employers must ensure their staff's understanding of human rights and the Equality Act 2010 is kept up to date.

   f) Providers should have policies around values-based recruitment and be able to show evidence of this.

**Lead organisation:** *Department of Health and Social Care*
**Other responsible organisations:** *Commissioners, local authorities, and providers*

8) Commissioners across health and social care should encourage and support the creation of smaller, bespoke services for autistic people, and people with a learning disability and/or mental health condition, in line with *Building the Right Support* and its *supplementary guidance for commissioners*.[46,47]

**Lead organisation:** *NHS England*
**Other responsible organisations:** *Commissioners*

9) Local authorities and clinical commissioning groups must report on:

   a) The number of autism diagnostic assessments carried out in the community for children and adults.

   b) The number of people with a learning disability and/or autistic people who are admitted to hospital.

   The above information must be broken down by each local authority and clinical commissioning group, it must be shared with partner organisations and published regularly.

**Lead organisation:** *Government*
**Other responsible organisations:** *Local authorities, NHS England and NHS Digital*

10) People, their families and advocates must be involved in the development of services and care plans. Services must support families to do this, especially where families are located far away from people's placements. There must also be a way for them to escalate any concerns.

**Responsible organisations:** *NHS England, commissioners and providers*

## Recommendations on restrictive practices

11) There must be a contractual requirement on providers to inform commissioners and the NHS England regional team (depending on parliamentary approval of a regulatory requirement to inform CQC) when segregation or seclusion begins in hospitals.

**Lead organisation:** *Department of Health and Social Care*
**Other responsible organisations:** *CQC, NHS England and providers*

12) There must be enhanced monitoring by commissioners to ensure a plan for ending restrictions is in place and milestones for achieving it are met. There must be a named person in the provider with oversight for this to report to the commissioner. Where progress is not made, this should be escalated to NHS England.

**Lead organisations:** *Commissioners, local authorities and providers*
**Other responsible organisations:** *CQC and NHS England*

13) There must be guidance developed to ensure independent reviews required by the Mental Health Act (MHA) Code of Practice are of a consistently high standard and are focused on reducing the restrictions.
    a) A responsible clinician under the MHA Code of Practice must also provide regular updates on the necessity for continued use of long-term segregation and seclusion.

**Lead organisations:** *Providers, professional bodies and the Department of Health and Social Care*
**Other responsible organisations:** *CQC*

14) Care Education and Treatment Reviews (CETRs) are made statutory so that the responsible organisations are held to account. In addition:
    a) There must be a CETR for all people with a learning disability or who are autistic when they are admitted to hospital or where there is a risk of admission
    b) CETR panel members should have the relevant background and experience to match the patient's presentation.
    c) Where CETRs are complex, there should be a specialised team who can be brought in to help find resolution including ensuring joined-up commissioning.

**Lead organisations:** *Government and NHS England*
**Other responsible organisations:** *Department of Health and Social Care and CQC*

15) The Department of Health and Social Care must amend the Mental Health Act 1983 Code of Practice to change the definition of long-term segregation to include people who are segregated for reasons other than violence and to strengthen the guidance on how to safeguard people.

**Lead organisation:** *Department of Health and Social Care*

16) Providers should review their practice to ensure that restrictive interventions are used for the shortest possible time in line with *The National Institute for Health and Care Excellence (NICE) guideline on Violence and aggression: short-term management in mental health, health and community settings*, rather than using such interventions as longer term solutions.[48] This should be checked by CQC and NHS England.

**Lead organisations:** *Providers*
**Other responsible organisations:** *NHS England and CQC*

17) A national reporting mechanism must be developed for the use of restrictive interventions in children's services and adult social care services to mirror that used in hospitals.

    a) In addition, there must be a regulatory change to ensure that providers are required to notify CQC for certain restrictive practices in children's services and adult social care services.

**Lead organisation:** *Government and NHS Digital*
**Other responsible organisations:** *Department of Health and Social Care, CQC, Department for Education, and Ofsted*

## Further work that is outside of the scope of this review

- The government should consider a cross-departmental review of restrictive practice for children with special educational needs and disabilities, including schools and anywhere children are living away from home.
- Department for Education should ensure that there is a clear definition of restrictive practices, including the use of restraint, segregation and seclusion, in educational settings and children's services.
- The government should ensure that a wider system discussion takes place regarding the practice of people being prosecuted by providers for the injuries caused to staff from people who are highly distressed in hospital, leading them to have a criminal conviction that they did not have before being admitted to hospital.
- An investment and an action plan should be developed to ensure that all autistic people, and people with a learning disability and/or mental health condition have access to an independent advocate. This will need adequate resourcing and specialist training for advocates. This must expand on the recommendation of the Independent Review of the Mental Health Act and also apply to those who are informal patients and those receiving social care who have their liberty restricted under legislation.
- CQC will publish a brief report on progress that has been made on these recommendations in Winter 2021/22.

# Appendices

## Appendix A: Action we took

Where we were concerned about the quality of care, or there were potential human rights breaches, we took immediate regulatory action. Examples of concerns included people who were:

- Confined to a single room (bedroom or seclusion room) for lengthy periods (months or years) during which they had few (or no) opportunities to leave. Some of these rooms were dirty and were completely devoid of anything but a bed or mattress on the floor.
- Not able to access toilets, so having to go to the toilet on the floor.
- Left sitting naked with no attempts to support them to overcome sensory issues.
- Left on their own with no engagement from staff, no therapy or meaningful activities, or no personal possessions.
- Not able to wear their own clothes, with no clear rationale.
- Given food in polystyrene containers without cutlery.
- Not able to access to fresh air.
- Isolated from families and friends and the outside world.

During our review, we took the following action:

- For both child adolescent and mental health wards and wards for people with a learning disability or autism, we raised eight safeguarding alerts, escalated concerns about 11 people and seven wards to NHS England, escalated 13 wards or services within CQC, which resulted in seven inspections with a change of rating for six services and increased monitoring for others.
- For low secure and rehabilitation wards, we raised three safeguarding alerts, escalated concerns regarding four people to NHS England and escalated concerns about two services within CQC.
- In social care, we raised five safeguarding alerts and escalated concerns within CQC for nine locations, which resulted in three inspections.

# Appendix B: How we carried out the review

We carried out this review using our powers under section 48 of the Health and Social Care Act 2008. To make sure we looked at all settings where people with a mental health condition or a learning disability and autistic people might be subject to restrictive interventions, as requested by the Secretary of State for Health and Social Care, we divided the settings into four groups and looked at groups 1, 2 and 3 in two phases: phase 1 – November 2018 to June 2019, and phase 2 – March 2019 to November 2019.

## Group 1

We looked at group 1 settings in the first stage of our review. These were settings where we had the greatest concerns, including:

- Specialist NHS and independent sector wards for people of all ages with a learning disability and/or autistic people. These included assessment and treatment units and low and medium secure wards for people with a learning disability and/or autistic people.
- Specialist NHS and independent child and adolescent mental health wards.

We considered all forms of restrictive intervention in group 1 settings.

We sent a bespoke information request to these providers between 15 and 29 January 2019. We asked them to identify all people subject to segregation and/or prolonged seclusion during December 2018. They also reported the use of restraint for the same period. This information was used to select sites for an in-depth review of people's care.

## Groups 2 and 3

Groups 2 and 3 formed the second stage of our review. We looked at prolonged seclusion and long-term segregation only in the following (group 2) settings:

- NHS and independent sector mental health rehabilitation wards.
- NHS and independent sector low secure mental health wards.

We also carried out exploratory work to identify and describe whether and how restrictive interventions are used in the following (group 3) settings:

- Residential care homes designated for the care of people with a learning disability and/or autistic people.
- Children's residential services that are jointly registered with CQC and Ofsted. These services provide care for young people with very complex needs – such as severe learning disabilities and physical health needs.
- Secure children's homes in England (these are children's homes that provide a locked environment and restrict a child or young person's liberty). These homes are registered with Ofsted but not with CQC. As a result, we carried out this aspect of the work in close collaboration with Ofsted.

During April 2019, we sent an information request to group 2 hospital providers to identify all people subject to prolonged seclusion and long-term segregation. This was used to identify hospitals for site visits.

We sent a similar information request to adult social care services asking about the use of restraint, seclusion and segregation. We used the results of this, together with knowledge from local inspection teams, to identify the 27 services for site visits.

Reviewers also completed a questionnaire with all adult social care services for people with a learning disability and/or autistic people as part of inspection activity between July 2019 and November 2019. In total, 452 questionnaires on the use of restrictive interventions were completed and analysed.

We visited 11 children's residential homes between September and October 2019, and attended three Ofsted inspections of secure children's homes during November 2019. Two desk-based assessments were carried out alongside these visits.

## Group 4

The settings in this group were deemed out of scope for the purposes of this review and included:

- Medium secure or high secure mental health wards – secure units that admit children and young people or that are specifically designated for the care of people with a learning disability would be considered in group 1.
- Mental health admission wards for working age adults or for older people with a mental health condition.
- Residential care homes designated for any other groups of clients (for example, care homes for older people).
- Any other non-health or non-social care setting (for example, immigration detention centres).

## Our approach

As part of the in-depth reviews, we met with people who have been subject to restraint, prolonged seclusion and long-term segregation, and their families and carers. We interviewed staff including ward managers, qualified staff and support workers. Wherever possible we talked with commissioners and advocacy workers. We also reviewed the physical environments of services and people's care plans.

For hospitals, as well as the in-depth visits we:

- assessed a sample of care plans
- reviewed prescriptions and other medicines records
- wrote to commissioners regarding the cost of placements.

We visited 27 care homes for the care of people with a learning disability or autistic people; 11 children's residential services that are jointly registered with CQC and Ofsted, and five of the 13 secure children's homes in England (two of these reviews were desktop reviews).

For adult social care services, we also gathered information remotely through:

- 452 questionnaires on restrictive interventions, completed with registered managers of adult social care services, during inspections between July and October 2019
- assessing a sample of care plans at each service
- reviewing prescriptions and other medicines records
- writing to commissioners about the cost of placements.

Throughout our review, we have worked with an Expert Advisory Group (EAG). They shared their experiences, which shaped the way we have written this report. This comprised people and organisations who have expert knowledge of learning disability and autism or lived experience of restrictive interventions.

## In depth review of positive behaviour support plans

As part of our review, we conducted an in-depth review of 12 positive behaviour support plans (PBS), which focused on plans for people in long-term segregation. The aim of this review was to determine the extent to which the PBS plans complied with good practice.

A framework for analysing the plans and rating the findings was developed by a steering group, which included CQC staff and two advisors from the PBS Academy.

The framework considered the following factors:

- functional assessment
- person-centred plan
- physical health needs
- mental health needs
- communication needs
- sensory needs
- diagnoses addressed in plan
- daily activities
- skills building
- choice
- quality of life
- positive goals for future
- family involvement

The rating for each of the factors analysed was defined as:

- 0 = not present
- 1 = present but poor quality
- 2 = present but unsatisfactory
- 3 = present and good
- 4 = outstanding.

# Appendix C: Summary of the Expert Advisory Group's review of previous reports and recommendations on restrictive practices

**Written and analysed by Jeremy Harris, Alexis Quinn, Kirsten Peebles and Isabelle Garnett**

Autistic people and people with a learning disability, and/or mental health condition should have equal rights and enjoy the same opportunities as everyone else. Yet too many have had their human rights denied and have not been supported to assert themselves. Findings from numerous previous reports, investigations and documents, as discussed in this appendix, indicate a systematic disregard.

The authors of this appendix are people with lived experience who acted as members of the Expert Advisory Group (EAG) on the thematic review. We conducted an investigation that looked for, and mapped, recurrent themes in previously published health and social care reports. In the EAG, we were attempting to avoid coming up with the same old recommendations and having them ignored. Creative solutions to old problems were needed and this seemed the most effective way to see what had gone wrong in the past.

In total, more than 30 documents were analysed. We purposefully sought reports that were published after the Mansell Report in 2007, particularly focusing on those published after the Winterbourne View Scandal in 2011. The mapping exercise revealed a comprehensive collection of investigations, reports and 'reports into reports' into the poor state of health and social care for autistic and learning disabled people (see below for full list of analysed reports). Other reports, such as serious case reviews, LeDeR (Learning Disabilities Mortality Review) reviews, public and independent inquiries, safeguarding reviews, Prevention of Future Deaths reports, academic studies (including **A Trade in People**), were not considered.

From these documents, we were easily able to elicit common themes and trends that create, sustain and enable the ill treatment, human rights violations and poor life opportunities for autistic people, people with a learning disability and people with a mental illness in the very systems supposed to help them.

These recurrent themes fell into the following five categories:

- missed opportunities
- crisis point and admission
- inpatient units: quality of care and restrictive practices
- pathway out of segregation and hospital
- community support: quality of care and restrictive practice.

The themes identified resonated with us as experts by experience, particularly as they put the individual and their rights in focus. Frustratingly, the recurring themes were so ubiquitous, begging the question: "How many times do the same factors need to be identified before there is change?".

There has been no need to reinvent the wheel in this report from CQC, and those preceding it; the wheel identified has yet to be created – and here we are again. In our numerous meetings, where people with lived experience, parents, carers, CEOs, psychiatrists and other stakeholders met, we almost unanimously came up with the same ideas and themes as those identified in previous reports (as also evidenced in our mapping exercise).

The problem remains that the implementation of recommendations has been badly hampered by factors only the government and its 'big systems' can control: adequate, fit-for-purpose administration, funding, accountability and inspection regimen. Improvements in these four areas would enable departments and authorities to make transformative change.

The reports highlight tension between people's needs and the provision available. This is especially evident in the warehousing of people in institutions and the predictable reaction of autistic people and people with a learning disability to this environment. The system then responds in the only way it can – the use of restrictive practice, rather than the enablement of community living. The money is spent on extortionate inpatient placements that could benefit more people in the community. The lack of upfront community funding seems to be the key contributory factor to the failure on the part of all involved to deliver reform.

Almost every report identified the frustrating lack of accountability within the system. The EAG firmly believes that the current approach to accountability is insufficient. People with a learning disability and autistic people need CQC to implement an inspection framework that is fit for purpose, one that is focused on upholding people's rights. Without this, human rights abuses of our most vulnerable will not only continue, but also be inevitable.

Those tasked and paid to "police" the system need to do so. They also need to develop a means to find, manage and deal with unlawful practice. There must be greater oversight and accountability as we presently see the clear consequences of repeated failure to take on board the recommendations of past reports.

Many reports have highlighted a need for a culture change. The EAG unanimously agreed that people's human rights must be safeguarded. Power must be handed back to individuals (and their families), enabling them to make choices and be the rightful authors of their own destinies. If this does not occur, any additional money will be wasted and make little difference to the lives of autistic people, people with a learning disability and/or people with a mental health condition.

## Legal references

**Care Act 2014**

**Equality Act 2010**

## Reports analysed

Children's Commissioner, **Far less than they deserve: Children with learning disabilities or autism living in mental health hospitals**, 2019

Clements L, Aiello A, **Unacceptable delay: Complaints procedures for disabled children and their families**, 2019

Department of Health and Social Care, **Healthy Lives, Brighter Futures – The strategy for children and young people's health**, 2009

Department of Health and Social Care, **Transforming care: A national response to Winterbourne View Hospital**, 2012

Department of Health and Social Care, **Right to be heard': The Government's response to the consultation on learning disability and autism training for health and care staff**, 2019

Department of Health and Social Care, **Serious Incident Investigation Report Secretary of State Case Review into Beth**, 2019

Education Select Committee, **Special Educational Needs and Disability**, 2019

House of Commons Committee of Public Accounts, **Care services for people with learning disabilities and challenging behaviour**, Fifty-First Report of Session 2014-15, March 2015

Joint Committee on Human Rights, **The detention of young people with learning disabilities and/or autism**, 2019

Joint Committee on Human Rights, **Youth detention: solitary confinement and restraint**, 2019

Lenehan C, Geraghty M, **Good Intentions, Good enough? A review of the experiences and outcomes of children and young people**

**in residential special schools and colleges**, Council for Disabled Children, 2017

Lenehan C, **These are our Children**, Council for Disabled Children, 2017

NHS England, **Children and Young People Transforming Care Workforce** (CYP TCW) – Report and Recommendations, 2018

NHS England, **Ask Listen Do**, 2019

Rightful Lives, **Eight-Point Plan**, 2019

Transforming Care and Commissioning Steering Group, **Winterbourne View – Time For Change: Transforming the commissioning of services for people with learning disabilities and/or autism**, 2014

Voluntary Organisations Disability Group, **A time for action: ending the reliance on long-stay inpatient units**, VODG, 2019

# Appendix D: Supporting data

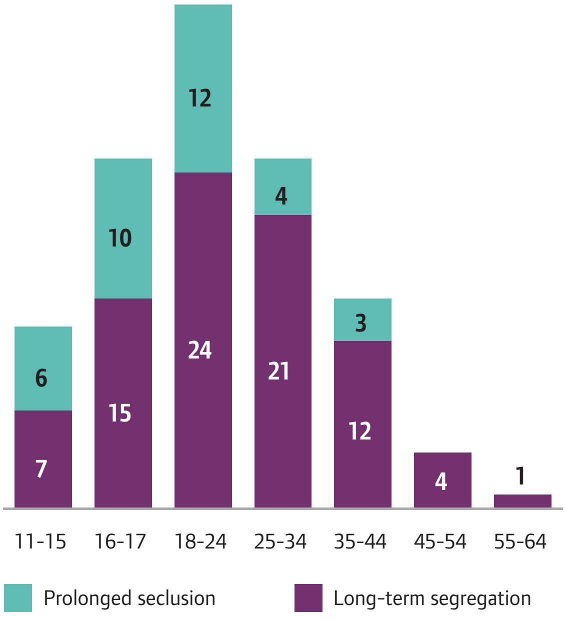
An information request was sent to wards for people with a learning disability and/or autism, child and adolescent mental health service (CAMHS) wards, and low secure and rehabilitation wards for people with a mental health condition. They were asked to provide information about the people in prolonged seclusion or long-term segregation for the most recent complete month.[o]

FIGURE 1: PERCENTAGE OF WARDS, BY TYPE, USING LONG-TERM SEGREGATION OR PROLONGED SECLUSION

| | Number of wards responding | % using LTS* | % using prolonged seclusion |
|---|---|---|---|
| People with a learning disability and/or autism and children and young people | 313 | 31% | 20% |
| People with a mental health condition on low secure/rehabilitation wards | 466 | 9% | 20% |

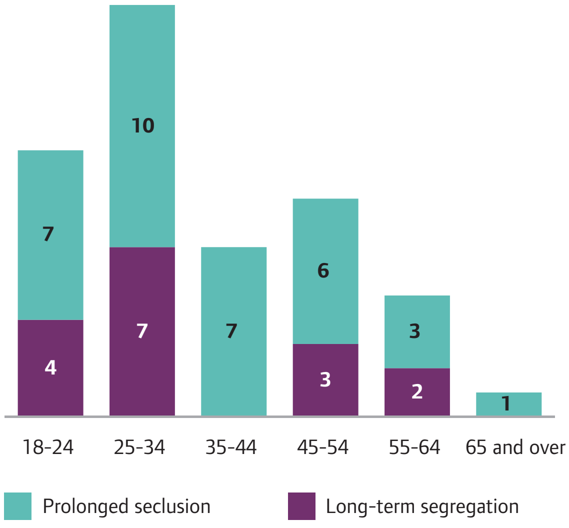
*Long-term segregation

FIGURE 2: NUMBER OF AUTISTIC PEOPLE AND/OR PEOPLE WITH A LEARNING DISABILITY AND CHILDREN AND YOUNG PEOPLE IN PROLONGED SECLUSION OR LONG-TERM SEGREGATION BY AGE BAND



Note: One person excluded from analysis due to data quality issues.

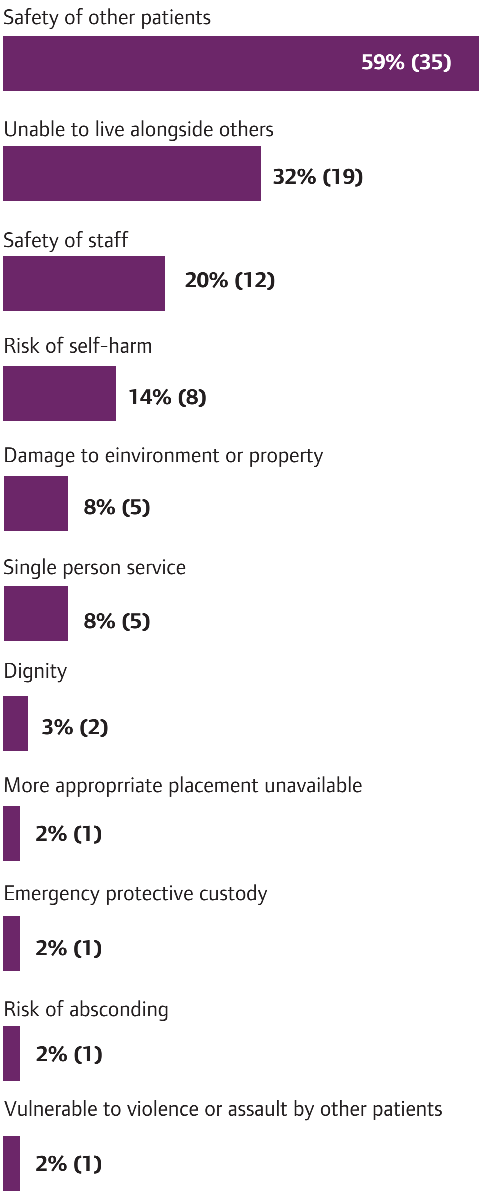
FIGURE 3: NUMBER OF PEOPLE ON A MENTAL HEALTH LOW SECURE/REHABILITATION WARD IN PROLONGED SECLUSION OR LONG-TERM SEGREGATION BY AGE BAND



---

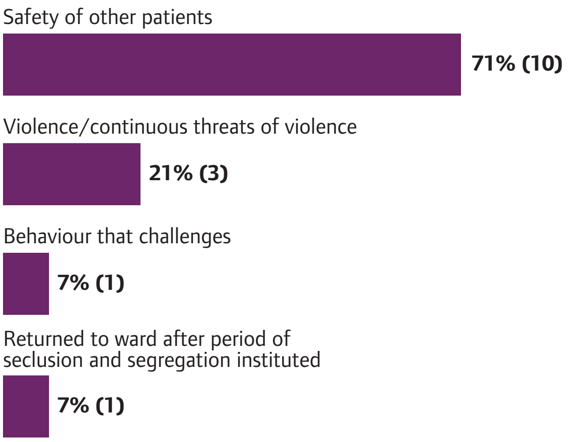
o. Whilst numbers are low in some of the charts patient confidentiality has been maintained.

## FIGURE 4: THE REASON WHY THE PERSON WITH A LEARNING DISABILITY AND/OR AUTISM AND CHILD/YOUNG PERSON IS IN LONG-TERM SEGREGATION



**Note:** The 'number of people with a given reason' does not add up to the previously reported number of people subjected to long-term segregation, as a provider may have reported multiple reasons for long-term segregation for a single person.

## FIGURE 5: THE REASON THE PERSON ON A MENTAL HEALTH LOW SECURE/REHABILITATION WARD IS IN LONG-TERM SEGREGATION



**Note:** The 'number of people with a given reason' does not add up to the previously reported number of people subjected to long-term segregation, as a provider may have reported multiple reasons for long-term segregation for a single person.

### FIGURE 6: ETHNICITY OF PEOPLE IN CHILD AND ADOLESCENT MENTAL HEALTH (CAMHS) WARDS, AT DECEMBER 2018

| Ethnicity | On CAMHS wards in England at 31/12/18 | In prolonged seclusion during December 2018 (from PIR) | In LTS* during December 2018 (from PIR**) |
|---|---|---|---|
| Asian or Asian British | 5% | 6% | 0% |
| Black or Black British | 6% | 24% | 5% |
| Mixed | 6% | 18% | 9% |
| Not known / Not stated | 6% | 0% | 0% |
| Other ethnic groups | 2% | 12% | 0% |
| White | 74% | 41% | 86% |

* Long-term segregation
** Provider information return

### FIGURE 7: ETHNICITY OF PEOPLE IN LEARNING DISABILITY WARDS, AT DECEMBER 2018

| Ethnicity | On learning disability wards in England at 31/12/18 | In prolonged seclusion during December 2018 (from PIR) | In LTS* during December 2018 (from PIR**) |
|---|---|---|---|
| Asian or Asian British | 4% | 0% | 2% |
| Black or Black British | 5% | 11% | 6% |
| Mixed | 3% | 0% | 2% |
| Not known / Not stated | 8% | 5% | 0% |
| Other ethnic groups | 1% | 0% | 0% |
| White | 80% | 84% | 90% |

* Long-term segregation
** Provider information return

### FIGURE 8: ETHNICITY OF PEOPLE IN LOW SECURE WARDS, AT MARCH 2019

| Ethnicity | On low secure wards in England at 31/03/2019 | In prolonged seclusion during March 2019 (from PIR) | In LTS* during March 2019 (from PIR**) |
|---|---|---|---|
| Asian or Asian British | 7% | 3% | 7% |
| Black or Black British | 14% | 3% | 0% |
| Mixed | 5% | 7% | 7% |
| Not known / Not stated | 5% | 7% | 0% |
| Other ethnic groups | 3% | 3% | 0% |
| White | 67% | 76% | 86% |

* Long-term segregation
** Provider information return

### FIGURE 9: HOW FAR AWAY AUTISTIC PEOPLE AND/OR PEOPLE WITH A LEARNING DISABILITY AND CHILDREN AND YOUNG PEOPLE IN PROLONGED SECLUSION AND LONG-TERM SEGREGATION ARE FROM HOME

| | Average* distance (km) | Minimum distance (km) | Maximum distance (km) | People >50 km from home | % of people >50km from home |
|---|---|---|---|---|---|
| Prolonged seclusion | 32 | 2 | 309 | 14 | 45 |
| Long-term segregation | 81 | 4 | 291 | 38 | 60 |
| Adults with a learning disability and/or autism | 72 | 2 | 291 | 33 | 57 |
| Children and young people | 56 | 4 | 309 | 19 | 53 |

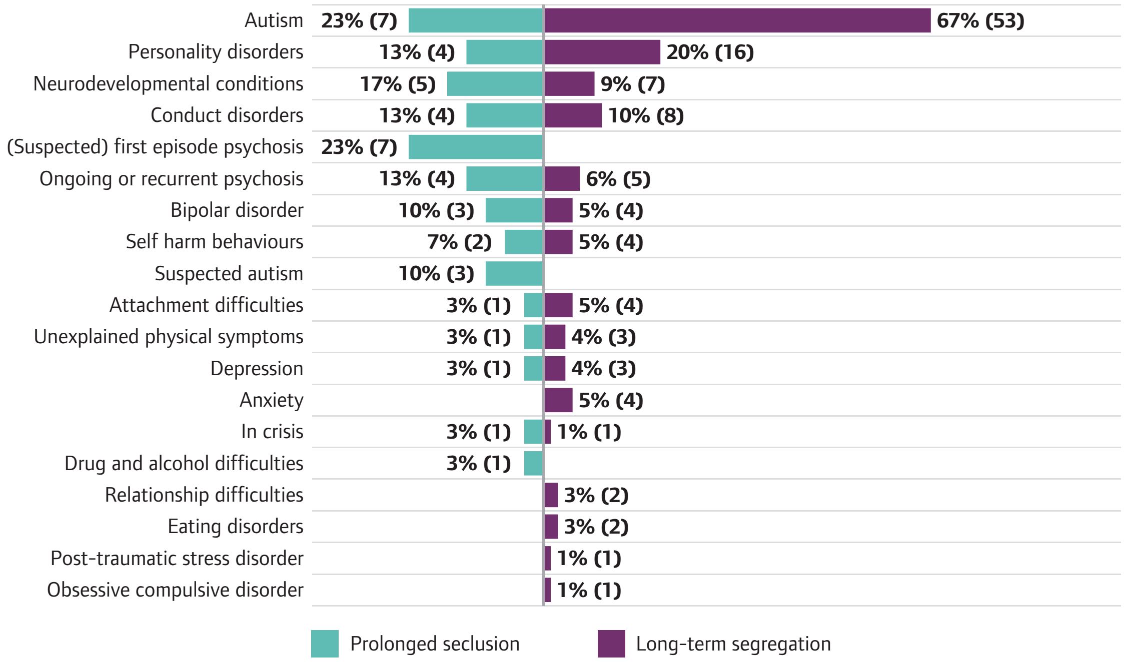
**Note:** Distance figures available for 94 out of the 120 people in long-term segregation and prolonged seclusion.
*Median average

### FIGURE 10: HOW FAR AWAY PEOPLE IN MENTAL HEALTH LOW SECURE/REHABILITATION WARDS IN PROLONGED SECLUSION AND LONG TERM SEGREGATION ARE FROM HOME

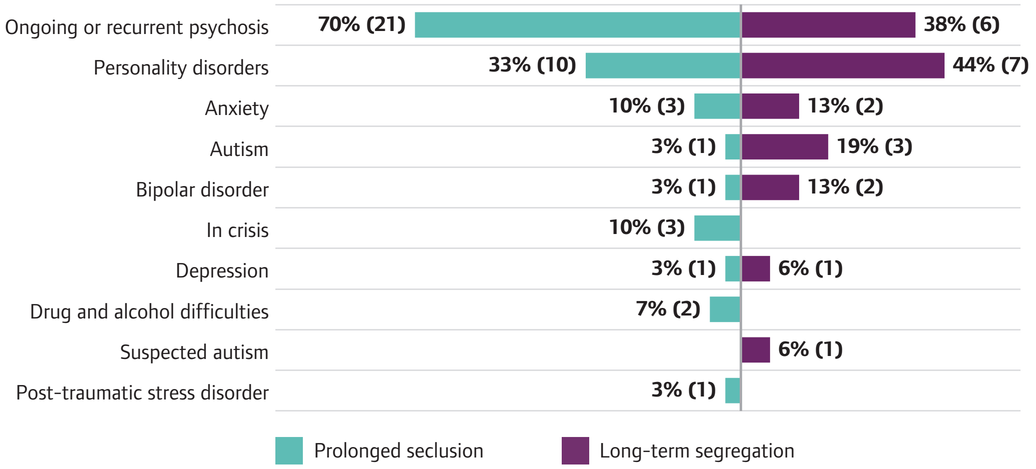
| | Average* distance (km) | Minimum distance (km) | Maximum distance (km) | People >50 km from home | % of people >50 km from home |
|---|---|---|---|---|---|
| Prolonged seclusion | 19 | 2 | 312 | 7 | 44 |
| Long-term segregation | 91 | 17 | 118 | 6 | 75 |

**Note:** Distance figures available for 24 out of the 50 people in long-term segregation and prolonged seclusion.
*Median average

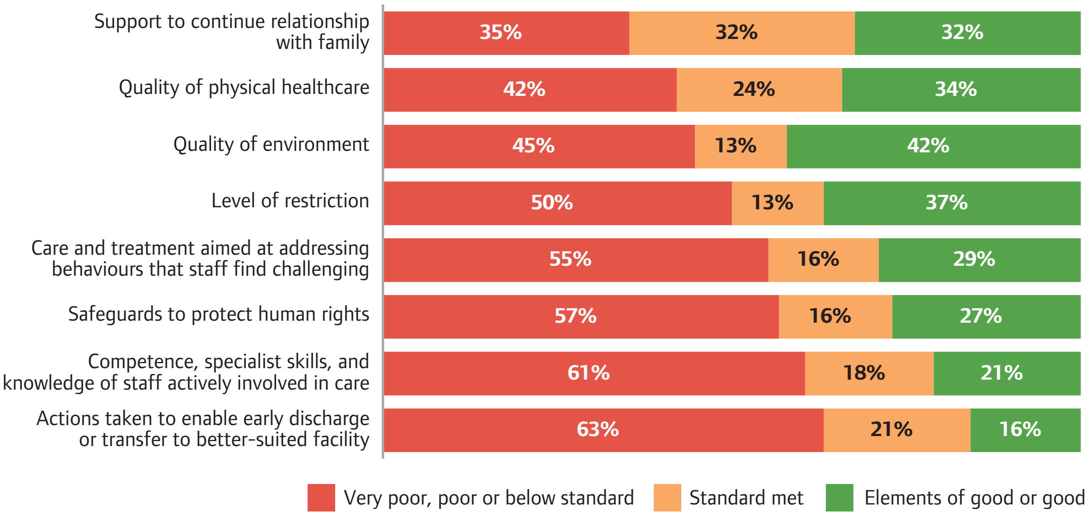
### FIGURE 11: THE PERCENTAGE (NUMBER) OF AUTISTIC PEOPLE AND/OR PEOPLE WITH A LEARNING DISABILITY AND CHILDREN/YOUNG PEOPLE IN PROLONGED SECLUSION AND LONG-TERM SEGREGATION DIAGNOSED WITH CONDITION



### FIGURE 12: THE PERCENTAGE (NUMBER) OF PEOPLE IN A MENTAL HEALTH LOW SECURE/REHABILITATION WARD IN PROLONGED SECLUSION AND LONG-TERM SEGREGATION DIAGNOSED WITH CONDITION

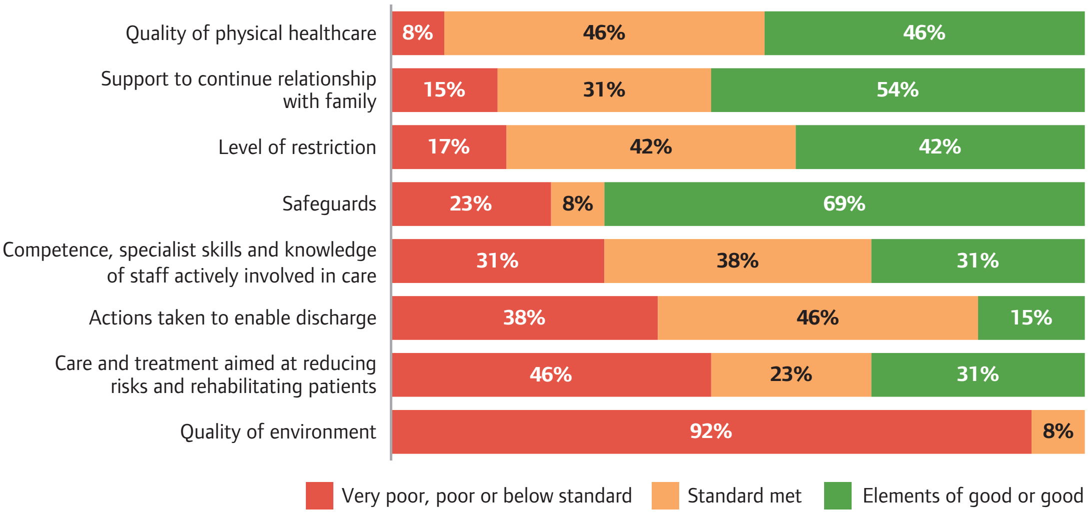


### FIGURE 13: HOW REVIEWERS JUDGED THE STANDARD OF CARE OF AUTISTIC PEOPLE AND/OR PEOPLE WITH A LEARNING DISABILITY AND AND CHILDREN AND YOUNG PEOPLE IN LONG-TERM SEGREGATION



**Note:** Reviewers ratings of key areas. Figure based on ratings completed for 38 people in long-term segregation at the time of the reviewers' visits across all questions with the exception of 'Safeguards to protect human rights' (37) and 'Support to continue relationship with family' (34).

### FIGURE 14: HOW REVIEWERS JUDGED THE STANDARD OF CARE OF PEOPLE IN MENTAL HEALTH LOW SECURE/REHABILITATION WARDS IN LONG-TERM SEGREGATION



**Note:** Figure based on ratings completed for 13 people in long-term segregation at the time of the reviewers' visits across all questions, with the exception of 'Support to continue relationship with family' (12).

## CQC ratings data

Review teams visited services with a range of ratings from CQC.

FIGURE 15: 37 HOSPITALS VISITED IN PHASE 1 AND 2

| | Number of overall rating | Percentage of overall rating |
|---|---|---|
| **Outstanding** | 6 | 16% |
| **Good** | 16 | 43% |
| **Requires improvement** | 9 | 24% |
| **Inadequate** | 6 | 16% |

FIGURE 16: 27 SOCIAL CARE SERVICES VISITED IN PHASE 2

| | Number of overall rating | Percentage of overall rating |
|---|---|---|
| **Outstanding** | 2 | 7% |
| **Good** | 21 | 78% |
| **Requires improvement** | 4 | 15% |
| **Inadequate** | - | - |

FIGURE 17: 452 SOCIAL CARE SERVICES INCLUDED IN QUESTIONNAIRE

| | Number of overall rating | Percentage of overall rating |
|---|---|---|
| **Outstanding** | 17 | 4% |
| **Good** | 345 | 76% |
| **Requires improvement** | 82 | 18% |
| **Inadequate** | 7 | 2% |
| **Not yet rated** | 1 | 0.2% |

## Examples of reducing restrictive practice strategies

**Mental Health Act – A focus on restrictive intervention reduction programmes in inpatient mental health services**, showcases good practice examples from five NHS mental health trusts where we have seen effective approaches to reduce restrictive practice.

# Appendix E: Glossary

**Advocate** – someone who helps another person to express their views, wishes and feelings, and stands up for the other person's rights. Independent Mental Health Advocates (IMHAs) provide an additional safeguard for people who are subject to the Mental Health Act. They enable people to participate in decision-making.

**Attention deficit hyperactivity disorder (ADHD) –** a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.

**Autism/autistic spectrum disorder** – a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them.

**Blanket restrictions –** rules or policies that restrict a person's liberty and other rights, which are routinely applied to everyone within a service, without individual risk assessments to justify their application.

**Care (Education) Treatment Review (CETR)** – this is a meeting about a child or young person who has a learning disability and/or autism and who is either at risk of being admitted to, or is currently detained in, an inpatient (psychiatric) service.

**Challenging behaviour** – some children and adults with severe learning disabilities typically display behaviour that may put themselves or others at risk, or that may prevent the use of ordinary community facilities or a normal home life. This behaviour may include aggression, self-injury, stereotyped behaviour or disruptive and destructive behaviours. These behaviours are not under the control of the individual concerned and are largely due to their lack of ability to communicate.

Challenging behaviour is defined as:

"Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities."[49]

**Clinical commissioning group –** a group of GP practices in a particular area that work together to plan and design health services in that area. Each CCG is given a budget from NHS England to spend on hospital care, rehabilitation and community-based health services.

**Code of Practice –** statutory guidance to health professionals on how they should carry out functions under the Mental Health Act.

**Complex care** – for the purposes of this report, complex care is defined as people with multiple, and sometimes interconnected health, communication and social needs. Their care typically requires co-ordination and input from a range of skilled professionals who may be employed by different organisations.

**Deprivation of Liberty Safeguards (DoLS) –** procedures prescribed in law to deprive a resident or patient of their liberty in order to keep them safe from harm. These procedures can only be used when the patient or resident lacks capacity to consent to care and treatment.

**Dialectical behavioural therapy (DBT) –** a type of talking treatment that focuses on how thoughts, beliefs and attitudes affect a person's feelings and behaviours. It encourages people to develop coping skills for dealing with different problems. It is used to help people who experience emotions very intensely.

**Functional assessment** – a method for understanding the causes and consequences of behaviour and its relationship to particular stimuli, and the function of the behaviour. The function of a particular behaviour can be analysed by identifying the precursor or trigger of the behaviour, the behaviour itself and the consequence of the behaviour.

**Learning disability** – a learning disability affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently.

**Long-term segregation** – a situation in which a patient is not allowed to mix freely with other people on their ward or unit on a long-term basis. Long-term segregation is used when a patient presents a high likelihood of causing serious injury to others over a prolonged period of time.

**Makaton –** a system of language that uses symbols, signs and speech to enable people to communicate. It supports the development of essential communication skills such as attention and listening, comprehension, memory, recall and organisation of language and expression.

**Mechanical restraint –** using some kind of equipment to prevent a person moving their body freely, in order to prevent them from hurting themselves or someone else.

**Medium secure unit** – a hospital providing care and treatment to people who have chronic mental disorders, present a serious risk of harm to others and whose escape from hospital must be prevented.

**Mental Health Act reviewer** – a person employed by CQC to review the use of the Mental Health Act 1983.

**Personality disorder –** a condition that causes people to think, feel, behave or relate to others differently from the average person. People with a personality disorder may have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions.

**Positive behaviour support (PBS) plan** – a person-centred framework for providing long-term support to autistic people, and people with a learning disability and/or mental health condition, who have, or may be at risk of developing, behaviours that challenge. It is a blend of person-centred values and behavioural science and uses evidence to inform decision-making. Behaviour that challenges usually happens for a reason and maybe the person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour, so we can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen.

**PRN medicines –** medicines that are taken when they are needed, as opposed to medicines that are to be taken at specific times during the day. (PRN is an abbreviation of the Latin *Pro re nata,* meaning as needed).

**Seclusion –** restricting someone's movements by leaving them alone in a room or separate space that they cannot leave, in order to prevent them hurting themselves or someone else.

**Sensory assessment** – many autistic people have difficulty processing everyday sensory information. Any of the senses may be over- or under-sensitive, or both, at different times. These sensory differences can affect behaviour and can have a profound effect on a person's life. A sensory assessment assesses individuals' sensory needs and how these may best be met.

**STOMP (Stopping over medication of people with a learning disability, autism or both with psychotropic medicines) –** a national project involving many different organisations which are helping to stop the over use of psychotropic medicines. STOMP is about helping people to stay well and have a good quality of life.

**Trauma and trauma informed care –** incidents that people experience as being physically or emotionally harmful, or life-threatening, can cause trauma. Trauma can have lasting adverse effects on an individual's functioning and mental, physical, social, emotional or spiritual wellbeing. A trauma-informed approach to healthcare aims to provide an environment where a person who has experienced trauma feels safe and can develop trust.

# References

1 Mencap, **Locked up during lockdown: Government target missed yet again to release people with a learning disability and/or autism from 'modern day asylums'**, 16 April 2020

2 Mencap, **Mencap and the Challenging Behaviour Foundation warn that COVID-19 is causing even more delays to people with a learning disability and/or autism getting out of modern-day asylums**, 17 September 2020

3 Department of Health, **Services for people with learning disability and challenging behaviour or mental health needs**, November 2007

4 Transforming Care and Commissioning Steering Group, **Winterbourne View – Time for Change. Transforming the commissioning of services for people with learning disabilities and/or autism**, 2014

5 **Mental Health Units (Use of Force) Act 2018**

6 All Party Parliamentary Group on Autism, **The Autism Act, 10 Years On. A report from the All Party Parliamentary Group on Autism on understanding, services and support for autistic people and their families in England**, National Autistic Society, September 2019

7 NHS Digital, **Autism Statistics**, November 2019

8 National Institute for Health and Care Excellence (NICE). **Quality standard [QS51]: Autism**. January 2014

9 **Equality Act 2010**

10 British institute for Human Rights, **Learning Disability, Autism and Human Rights**, 2017

11 **Human Rights Act 1998**

12 Equality and Human Rights Commission, **Using a service: reasonable adjustments for disabled people**, December 2019

13 NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), **Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Service model for commissioners of health and social care services**, October 2015

14 National Institute for Health and Care Excellence (NICE), **Learning disabilities and behaviour that challenges: service design and delivery. NICE guideline [NG93]**, March 2018

15 Department of Health and Social Care, **Modernising the Mental Health Act Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983,** December 2018

16 Care Quality Commission, **Monitoring the Mental Health Act in 2018/19**, February 2020

17 NHS England, **NHS Accessible Information Standard**, 2017

18 **Equality Act 2010**

19 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, January 2015

20 **Human Rights Act 1998**

21 **Mental Health Act 1983**

22 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, January 2015

23 Care Quality Commission, **Mental Health Act Annual Report 2018/19**, February 2020

24 Ridley J, Leitch S, **Restraint Reduction Network Standards**, Restraint Reduction Network, 2019

25 Care Quality Commission, **Mental Health Act: A focus on restrictive intervention reduction programmes in inpatient mental health services**, December 2017

26 Care Quality Commission, **The state of care in mental health services 2014 to 2017. Findings from CQC's programme of comprehensive inspections of specialist mental health services**, July 2018

27 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, January 2015, chapter 26

28 National Institute for Health and Care Excellence, **Violence and aggression: short-term management in mental health, health and community settings**, May 2015

29 Public Health England, **Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England**, June 2015

30 National Institute for Health and Care Excellence, **Violence and aggression: short-term management in mental health, health and community settings, NICE guideline [NG10]**, May 2015

31 NHS England, **Stopping over medication of people with a learning disability, autism or both (STOMP)**.

32 **Children Act 1989**, section 25

33 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, October 2017

34 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, October 2017

35 **Human Rights Act 1998**, Article 8

36 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, January 2015, paragraph 26.109

37 National Institute for Health and Care Excellence, **Transition between inpatient mental health settings and community or care home settings**, NICE Guideline [NG53], August 2016

38 Department of Health and Social Care, **Mental Health Act 1983: Code of Practice**, January 2015, paragraph 20.28

39 National Institute for Health and Care Excellence, **Transition between inpatient mental health settings and community or care home settings**, NICE Guideline [NG53], August 2016

40 NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), **Building the Right Support**, October 2015

41 NHS Digital, **Learning Disability Services Monthly Statistics**, July 2020

42 Department of Health, **Services for people with learning disability and challenging behaviour or mental health needs**, November 2007

43 Transforming Care and Commissioning Steering Group. **Winterbourne View – Time for Change. Transforming the commissioning of services for people with learning disabilities and/or autism**, 2014

44 British Institute for Human Rights, **Learning Disability, Autism and Human Rights– booklet resource**, BIHR

45 National Institute for Health and Care Excellence, **Autism and environmental adaptations within inpatient mental health units**, NICE, July 2020

46 NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), **Building the Right Support**, October 2015

47 NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), **Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Service model for commissioners of health and social care services**, October 2015

48 National Institute for Health and Care Excellence, **Violence and aggression: short-term management in mental health, health and community settings**, NICE Guideline [NG10], May 2015

49 Challenging Behaviour Foundation, **Formal Definitions of Challenging Behaviour**

Care Quality Commission

## How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter >
@CareQualityComm

Please contact us if you would like a summary of this report in another language or format.

Corporate member of Plain English Campaign
Committed to clearer communication
459

CQC-464-102020

# Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation

| | |
|---|---|
| Authors: | RT Subcommittee of the Minimising Restrictive Practice Regional Group |
| Authors Position: | |
| Responsible Director /Ownership: | Mental Health Directorate |
| Target Audience, i.e., specific staff groups: or Directors/Divisions policy to be issued to: | This Guideline is directed to all staff within the adult mental health, psychiatry of old age and intellectual disability inpatient settings, all acute hospital inpatient settings including emergency departments, dementia inpatient services and CAMHS inpatient settings. |
| Related policies, procedures and guidance | This guideline should be considered in conjunction with other relevant local and regional HSC Trust policies, procedures, guidelines, and legislation. |
| Approved by: | |
| Operational Date: | |
| Review Date: | |

## 1. Introduction

The recommendations in this regional guideline are based on the NICE NG10 Violence and aggression: short term management in mental health, health and community settings (2015). The guidance also offers guidance on prevention and de-escalation strategies which are not described in NICE NG10 which have been at arrived at after careful consideration of the evidence available. When exercising their clinical decision for the pharmacological management of acute behavioural disturbance, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients. It is not mandatory to apply the recommendations contained herein, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

This guideline adopts the definition in the British Association for Psychopharmacology / National Association of Psychiatric Intensive Care Units (BAP/NAPICU) guidelines of acute behavioural disturbance being reflective of an acute mental state associated with an underlying mental or physical disorder, symptoms of which range from agitation and distress (which may or may not lead to aggression or violence) to actual aggression or violence that causes harm or injury to another person or damage to property. The violence or aggression can be physical or verbal. Management of acute behavioural disturbance is multifaceted and in addition to medication should incorporate de-escalation techniques and non-pharmacological measures.

All staff should familiarise themselves with the NICE NG10 pathway which serves as a useful summary of the full NICE guideline and outlines other approaches to management of acute behavioural disturbance.

The focus of this guideline is on the pharmacological management in de-escalation and rapid tranquillisation (RT) only; and describes the recommended pharmacological management options that may be used to manage acute behavioural disturbance in patients cared for in Health and Social Care Trusts hospitals across Northern Ireland.

## 2. Purpose

The purpose of this regional guideline is to ensure a consistent approach to the management of acute behavioural disturbance, whilst maintaining patient safety and minimising risk. The safety and dignity of patients and staff are a priority.

This regional guideline sets out the standards of care that are expected by clinical team members when prescribing medication for the management of acute behavioural disturbance.

## 3. Scope

***This guideline DOES NOT apply to the management of delirium or acute alcohol (including psychoactive substances) withdrawal. The appropriate pathways should be followed.***

This guideline is concerned with the prescribing, administration and monitoring of oral PRN, intramuscular and intravenous medication and is intended to support the delivery of appropriate, safe and effective pharmacological de-escalation and RT. The guidance represents expected practice for hospital settings and replaces all previous local RT related guidance or procedures.

This guideline does not provide advice on non-pharmacological strategies for de-escalation and staff should refer to the NICE NG10 guideline for this information.

## 4. Definitions

Acute behavioural disturbance (ABD) is defined by British association of Psychopharmacology (BAP) as a composite term to include the concepts of ‘agitation’, ‘aggression’ and ‘violence’ in the context of an acute mental state associated with an underlying mental and/or physical disorder.

De-escalation is defined by NICE as the use of techniques (including verbal and non-verbal communication skills) aimed at diffusing anger and averting aggression. PRN medication, given orally, can be used as part of a de-escalation strategy accompanied by non- pharmacological techniques.

Oral PRN (pro re nata) is defined as when needed. In this guideline, PRN. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to PRN medication used on its own for rapid tranquillisation during an episode of violence of aggression.

Rapid tranquillisation (RT) is defined by NICE as the use of medication by the parenteral route (usually intramuscular (IM) or, exceptionally, intravenous (IV)) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Violence and aggression is defined as a range of behaviours or actions that can result in harm, hurt or injury to another person. The violence or aggression can be physical or verbal.

For the purposes of this policy and to guide safe prescribing the following are recognised:
Child is defined as a person aged between 6 and 12 years.
Young person is defined as a person aged between 13 and 17 years.
Adult is defined as a person 18 years and older.
Older adults are defined as persons 65 years and over.

Parkinsonian syndrome is defined as including those patients with idiopathic Parkinson's disease, Parkinson's disease dementia and Dementia with Lewy Bodies).

SPC is defined as Summary of Product Characteristics

Senior Doctor is defined a ST4 and above, specialty and associate specialist doctors or consultant, all with experience in the pharmacological management of ABD.

## 5. Roles and responsibilities

5.1 The Trusts will:

- Ensure that governance arrangements are in place and will include audit procedures that relate to training needs and provision, and the review of untoward incidents.
- Ensure that when the guideline is reviewed and updated that this is supported by local governance arrangements.
- Learn and react appropriately to any untoward incidents and events related to RT.
- Respond or react to any resource implications related to RT.

5.2 It is the responsibility of the relevant service area Directors and Medical Director to ensure implementation of this guidance.

5.3 All staff involved in the RT of patients presenting with ABD should be familiar with the content of this guideline and follow it when it is appropriate to do so.

5.4 Clinicians should use their own clinical judgement in each case and if they decide that a different management approach is clinically indicated then the reasons for this should be clearly documented.

## 6. Training

6.1 Staff should be trained, to a level appropriate to their role, in how to assess and manage potential and actual violence or aggression using de-escalation techniques, restraint and pharmacological management.

6.2 Appropriate staff should also be trained to Immediate Life Support (ILS) in the maintenance of patient's airways, cardio-pulmonary resuscitation (CPR), the use of defibrillators and the use of pulse oximeters.

6.3 Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including: the properties of benzodiazepines; antipsychotics; antimuscarinics and antihistamines, associated risks, including cardio-respiratory effects of the acute administration of the drugs.

6.4 The responsibility to ensure adequate training is undertaken lies with the service area Directors and Medical Director and should extend to include locum, agency and bank staff.

6.5 In addition for members of the Royal College of Psychiatrists, an e-learning module 'rapid tranquillisation of the acutely disturbed patient' may be for available.

## 7. Overview of the short-term management of ABD

Continuous risk assessment and use of non-pharmacological de-escalation techniques

**PREDICTION**
Risk Assessment
Necessary and Lawful Searches e.g. drugs/weapons
Mental Health Presentation
Behavioural Presentation
Other incidents (especially if escalating)

↓

**PREVENTION**
De-escalation techniques including oral PRN medication
Observation

↓

**INTERVENTIONS FOR CONTINUED MANAGEMENT**
**Consider, in addition to above, one or more of the following:-**

| Rapid Tranquillisation (RT) | Seclusion | Physical Intervention (PI) |
|---|---|---|
| Use to avoid prolonged physical intervention.<br>Parenteral medication is required to urgently calm acutely disturbed behaviour in a patient with either psychotic or non-psychotic symptoms. | Used to avoid prolonged physical intervention. | Better if patient responds quickly.<br>Can be used to facilitate administration of RT and/or enable RT to take effect. |

**RELATIVE CONTRA-INDICATED AS AN INTERVENTION**

| RT | Seclusion | PI |
|---|---|---|
| Refer to individual medication SPC. | Seclusion should be reviewed after rapid tranquillisation, if given, has taken effect.<br>When other interventions not yet explored. | Prolonged physical intervention. |

↓

**COMPLETE DATIX / IR1**
**POST-INCIDENT REVIEW**

## 8. Key Principles

8.1 Staff should adopt approaches to care that respect patients; independence, choice and human rights.

8.2 A multidisciplinary approach is required to manage harmful or potentially harmful behaviour and should involve the patient and their carers. The focus is towards prediction and prevention of potentially harmful events.

8.3 All staff involved in an incident requiring the use of restrictive practice should be aware of the potential for damage to the patient / professional relationship and ensure that everything possible is done to reduce the impact

8.4 All staff involved in RT need to be aware of the legal framework that authorises this intervention and this should be in line with the guidance contained within the RQIA Guidelines on the use of the Mental Health (Northern Ireland) Order 1986, the Mental Health (Northern Ireland) Order 1986 Code of Practice and the Mental Capacity Act (Northern Ireland) 2016 and its supporting Deprivation of Liberty Safeguards Code of Practice. Any departure from that guidance should be clearly recorded and clinically justified.

8.5 Documentation in patient's notes must demonstrate that administration of a particular medication for RT was justified, reasonable, proportionate and the least restrictive option to meet the need. Any incident requiring restrictive practice (e.g. physical intervention, seclusion or parenteral RT medication) **must** be recorded on the Datix Incident Reporting System.

8.6 Level 1 refers to the use of oral medication. This is indicated for patients where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, the patient is accepting of oral medication and there is not an immediate risk of violence or aggression. The NICE guideline clearly states that oral PRN medication on its own is not de-escalation.

8.7 Level 2 refers to rapid tranquillisation. It should only be considered when there is actual or clear risk of imminent violence or aggression where de-escalation and other preventative strategies including oral PRN have been unsuccessful. It is common practice for patients to be prescribed the same PRN medicine to be administered orally or if indicated intramuscularly. If the medication is administered by IM/IV injection this is not de-escalation and must be considered RT.

8.8 Level 3 describes interventions to consider if Level 2 interventions have failed to produce a sufficient response. Level 3 interventions should only be used by or after consultation with a senior doctor.

8.9 Any preference that the patient has expressed when they are well, concerning future treatment should be taken into consideration. These may include preferred treatment choices documented in the multidisciplinary team treatment and care plan known to the patients care coordinator or keyworker e.g. Wellness and Recovery Action Plan (WRAP), advance directives or behaviour support plan. WRAP plans, advance directives and behaviour support plans must be accessible and up to date.

8.10 The patient must be informed about the medications that are prescribed and administered in an emergency, as soon as possible following the administration of the medication. Where consent to share information has been previously given, the family member/carer must be informed about the medications prescribed and administered in an emergency as soon as possible following the administration of a medication.

8.11 Specific to children and adolescent services. All patients must be informed that medication is to be given and given the opportunity at any stage to accept oral medication voluntarily. In children / young people who are not Gillick competent, parent(s)/carer(s) should be informed of the situation and consent sought for treatment, in advance if at all possible. Consideration should be given to inform the child/adolescent and parent(s)/carer(s) that rapid tranquillisation has been necessary.

8.12 Specific to Intellectual disability (ID) Services. All patients must be informed (in a way that best facilitates their understanding) that medication is to be given and given the opportunity to accept oral medication.

8.13 A post-incident de-brief should take place as soon as possible after the incident and, where possible, a post-incident review should take place within 72 hours of an incident ending. (see section 15.1.2)

8.14 Resuscitation facilities must be available within three minutes in all healthcare settings where RT might be used. Suitable equipment must be available and maintained as per local resuscitation guidance.

8.15 Staff must follow local infection control policies relevant to the area at that time.

## 9. Specific risks of medications in combination with other physical practice interventions

9.1 Patients may occasionally require physical intervention to prevent violence to themselves or others. There are increased risks associated with medications used in combination with physical restraint. Effective drug treatment may be needed to allow assessment and management. Medication should be prescribed following attempts to de-escalate using non-pharmacological approaches and the least restrictive practice that is appropriate to manage any evolving incident.

9.2 Medication for RT, particularly in the context of physical intervention, should be used with caution owing to the following risks:

- loss of consciousness
- sedation with loss of alertness
- loss of airway
- cardiovascular and respiratory collapse
- interaction with medicines already prescribed or illicit substances taken
- possible damage to patient-staff relationship
- underlying coincidental physical disorder

## 10. Prescribing Principles

The following should be considered when choosing which treatment is appropriate for use, and documented in the patient's clinical notes/ management plan, according to local policy:

- The patients' preferences or advance statements and best interest decisions, where possible.
- Pre-existing physical health conditions.
- Previous response to medication, including adverse effects.
- Potential for interaction with other medications.
- The total daily dose of medication prescribed and administered.
- Whether there is a chance the patient may be pregnant, and whether this has been tested.

10.01 The aim of pharmacological de-escalation/RT is not sedation, but to achieve a state of calm so that there is minimal risk to the patient, staff and others.

10.02 When RT is being administered, a doctor should be available for advice. A junior doctor must be able to contact a senior doctor for advice if required. .

10.03 Medical notes should be reviewed, if available, to see if the patient's response and tolerability to previous medications is known. In addition current and historical physical co-morbidities that may affect drug absorption /distribution /elimination should be considered as well as recent observations and ECG (The NICE Guideline CG 178 Psychosis and schizophrenia in adults: prevention and management recommends that before starting an antipsychotic, an ECG should be offered). Any other relevant information should be taken into consideration when prescribing e.g. exclusion of substance intoxication, organic brain states or injuries, allergy status, history of severe idiosyncratic reaction to the medication or Neuroleptic Malignant Syndrome (NMS) and medication adherence if relevant, and consider any reasons for medication non-adherence or refusal.

10.04 Avoid unnecessary polypharmacy. This may necessitate careful choice of drug in relation to either current treatment or expected maintenance treatment.

10.05 When prescribing oral PRN medication for pharmacological de-escalation or medication for RT, then prescribing should be as per the medicines code, in addition:

- The indication for use MUST be clearly indicated.
- The order in which these are to be used if more than one medication is prescribed for the same indication.
- If two medicines are intended to be given at the same time this should be clearly stated.
- Frequency of administration / minimum interval between doses.
- Maximum dose in 24 hours.

10.06 The inpatient Kardexes MUST be reviewed at least once weekly by the Multidisciplinary team if pharmacological de-escalation or RT is prescribed.

10.07 If RT is being administered, a senior doctor should discuss or review all prescribed medications, at least once a day (this can be done remotely), as part of continuous risk assessment; to ensure changes in the patient's mental and physical state over time are reflected.

10.08 If an inpatient is being transferred between or within another clinical area or Trust, a full medical history, including the patient's response to medications, any adverse effects, should accompany them along with any Wellness and Recovery Action Plan (WRAP), advance directives or behaviour support plan.

## 10.1. Advice on doses

10.1.1. Prescribe the minimum effective dose and consider tolerability and previous response. For prescribing information for the drugs used in management of ABD, (see Appendix A). Consider lower maximum doses in older adults or the physically frail.

10.1.2. Frequent small doses are safer and more effective than single large doses, but this may lead to a risk of accumulation. Therefore, the medication used should have a short duration of action and the prescriber should bear in mind the pharmacokinetics of the agents used.

10.1.3. Avoid variable doses of oral PRN e.g. lorazepam 1–2mg as this leads to higher doses being administered without review.

10.1.4. Allow sufficient time following administration for therapeutic response before doses are repeated.

10.1.5. In some cases current BNF and SPC dose may be knowingly exceeded under the advice of a senior doctor (e.g. lorazepam >4mg/day), bearing in mind the overall risks.

10.1.6. Promethazine should not be used in patients suffering from CNS depression of any cause or within 14 days of administration of a monoamine oxidase inhibitor.

10.1.7. **High Dose Antipsychotic Monitoring** must be conducted if a patient is receiving more than 100% BNF maximum daily dose of antipsychotics (monotherapy or poly-therapy). Undertake frequent and intensive monitoring post incident including level of consciousness, pulse, blood pressure, respiratory rate, temperature and hydration. The rationale for prescribing high dose antipsychotics **must** be documented in the patents notes.

## 10.2. Level 1 Oral pharmacological de-escalation

10.2.1. When prescribing oral PRN medication for pharmacological de-escalation take the following points into consideration:

- Do not prescribe oral PRN medication for de-escalation routinely or automatically on admission.
- Individualise oral PRN medication and discuss with the patient if possible.

10.2.2. Lorazepam alone is encouraged as the drug of first choice, particularly in elderly and frail individuals. There is normally a delayed onset of action particularly if the patient has recently ingested food. Once the patient has been calmed, either by de-escalation techniques or use of lorazepam an alternative medication such as an antipsychotic drug may be required for maintenance of the situation. Remember that repeated use of a benzodiazepine may result in tolerance to the effect and this will probably become evident within 7 to 10 days.

10.2.3. If lorazepam is not clinically appropriate for the management of ABD and:

- If a patient is prescribed a regular antipsychotic, consider promethazine. Promethazine has anticholinergic side effects such as dry mouth, blurred vision, urinary retention and constipation. Prescription of promethazine is not recommended in individuals who are cognitively impaired or who are at risk of cognitive impairment, e.g. older and/or frail individuals and patients with dementia or delirium/history of delirium. Promethazine may also prolong the QT interval.
- If a patient is not already taking regular oral or depot antipsychotic oral haloperidol or olanzapine may be used.

10.2.4. When necessary, and in certain clinical circumstances, alternative Level 1 options such as oral risperidone or quetiapine may be considered. For dosing see Appendix A

## 10.3. Level 2 Rapid Tranquillisation

10.3.1. Intramuscular (IM) administration is recommended and should be used within mental health settings in the vast majority of cases, however intravenous (IV) administration may be considered in the non-mental health settings in certain clinical circumstances but should be avoided in elderly and frail whenever possible.

10.3.2. The recommendations below do not preclude the use of alternative treatment options. However, their use should be tailored to the individual in line with the recommendations for RT.

10.3.3. When prescribing medication for use as RT.

- Do not prescribe for ongoing use
- Prescribe oral and parenteral doses separately – do not use PO/IM abbreviation as these routes are indicated for different reasons.
- Prescribe defined doses as opposed to a dosing range where possible.
- When administering more than one parenteral medicine do not mix medications in the same syringe

10.3.4. The use of parenteral lorazepam alone is supported as the first line option in patients where there is no clear psychotic component to the presentation or where there is insufficient information to guide the choice of medication. Intramuscular (IM) formulations can take in excess of an hour before achieving full effect. Staff should take such delays into account before administering follow-up doses.

10.3.5. If there is a partial response to parenteral lorazepam, consider a further dose.

10.3.6. If there is no response to parenteral lorazepam, consider IM haloperidol combined with IM promethazine. There is some evidence to suggest that promethazine reduces the risk of movement-related side effects associated with haloperidol. If parenteral haloperidol is used, monitor for emergence of EPSEs, especially dystonia and ensure procyclidine is available.

10.3.7. If there is a partial response to IM haloperidol combined with IM promethazine, the full effect of haloperidol may not be apparent for more than 1hour and more than 2hours for promethazine. Consider repeating parenteral haloperidol WITHOUT promethazine if it is less than 2hours since the last injection.

10.3.8. The SPC for haloperidol recommends all patients must have an ECG prior to administration. If an ECG is not available, or there is evidence of cardiovascular disease, the prescriber should consider the risks and benefits of using parenteral haloperidol and be able to justify their prescribing decision, as it is considered an off-label use.

10.3.9. Simultaneous administration of parenteral antipsychotics and parenteral lorazepam may be associated with excessive sedation and cardio respiratory depression. If this combination is deemed necessary then patients must be monitored for excessive sedation and postural hypotension.

10.3.10. Patients taking regular clozapine or olanzapine require care when giving benzodiazepines especially parenteral route as potentially fatal orthostatic and cardio-respiratory dysregulation have been reported. If this combination is considered necessary, it is essential to undertake frequent monitoring of the patient.

## 10.4. Level 3: Failure to respond to Level 2 RT

10.4.1. Different strategies including medicines or combinations not included in NICE NG10. These must be tailored to the individual and might be guided by previous response in similar circumstances. The rationale and outcome must be clearly recorded.

## 10.5. Alternative options for RT outside of guidance for Emergency Departments (ED)

10.5.1. ED will be expected to use these guidelines for the majority of individuals with acute behavioural disturbance secondary to psychiatric states (e.g. psychosis and mania). However it is recognised that within ED only, a cohort of individuals will present with acute behavioural disturbance, secondary to an underlying medical condition, and may need to be treated as per The Royal College of Emergency Medicine (RCEM) guideline – Management of Excited Delirium/Acute Behavioural Disturbance.

10.5.2. Documentation in patient's notes must demonstrate that administration of a particular medication outside the regional guideline for the management of acutely disturbed behaviour though the use of pharmacological de-escalation and rapid tranquillisation was justified, reasonable, proportionate and the least restrictive option to meet the need.

10.5.3. ED staff should be involved in immediate post-incident debrief and NICE recommend that a full mental health assessment should be available within 1 hour of alert from the ED, or as soon as is appropriate.

## 10.6. Alternative options for RT outside of guidance for all other acute and mental health settings

10.6.1. All other areas will be expected to use these guidelines for the majority of individuals. However it is recognised that a small cohort of individuals may need to be treated where IM lorazepam or IM haloperidol + IM promethazine are not considered clinically appropriate, the following may be considered. See Appendix A for dosing.

- Olanzapine IM**. Olanzapine IM MUST NOT be administered within one hour of IM lorazepam**. It is not licensed for use beyond three days
- Aripiprazole IM causes less hypotension than olanzapine, but some sources suggest that it may be less effective.
- Promethazine IM alone: useful for benzodiazepine-tolerant patients.

- In very exceptional circumstances there may be indication to give medication intravenously (IV). The decision to use IV route must only be used following discussion with the consultant or senior doctor who has previous experience of using intravenous (IV) interventions for ADB. Administration may only be undertaken by a practitioner who is fully trained in IV administration, can manage medical emergencies and where resuscitation equipment is available.
- ECT may also be considered, if clinically appropriate.

10.6.2. Documentation in patient's notes must demonstrate that administration of a particular medication outside the regional guideline for the management of acutely disturbed behaviour though the use of pharmacological de-escalation and rapid tranquillisation was justified, reasonable, proportionate and the least restrictive option to meet the need.

## 11. Drugs NOT recommended for rapid tranquillisation

11.1. The following drugs are **NOT** recommended for rapid tranquillisation:

- Oral and IM chlorpromazine – IM chlorpromazine is painful and can cause severe hypotension. Chlorpromazine **MUST NEVER** be given intravenously.
- IM diazepam – absorption is erratic.
- IM depot antipsychotics- they are not fast acting.
- Zuclopenthixol acetate (Clopixol Acuphase ®) is **not** recommended for routine use in RT due to its slow onset of action.

11.2. Zuclopenthixol acetate (Clopixol Acuphase ®) may be recommended by a consultant Psychiatrist in certain circumstances for behavioural disturbance occurring over an extended time period. This MUST include a multidisciplinary review, including conducting a comprehensive case review, reviewing the appropriateness of the clinical setting for the patient and their treatment. In addition there MUST be at least one of the following:

- Past history of good/timely response.
- An advance directive indicates that it is the treatment of choice and it forms part of the patients overall management plan.
- Past history of repeated parenteral administration required.

11.3. Zuclopenthixol acetate (Clopixol Acuphase ®) **MUST NOT BE USED** on individuals who:

- Are antipsychotic (neuroleptic) naïve i.e. patients without any previous exposure to antipsychotic medication.
- Are sensitive to extrapyramidal side effects.
- Have cardiac disease, hepatic or renal impairment or are pregnant.

## 12. Precautions for rapid tranquillisation and prescribing in specific patient groups (See Appendices A,B,C,D & E)

### 12.1. General precautions for prescribing

12.1.1 The dose of medication prescribed should be adjusted and lowered according to bodyweight, and any other co-morbid medical conditions including but not limited to:

- patients with eating disorders
- physical frailty
- any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion
- organic disease
- hepatic or renal impairment

12.1.2 Antipsychotic medication (in particular haloperidol) should be avoided where possible in patients with a parkinsonian syndrome.

12.1.3 Compromised respiratory function – in general avoid benzodiazepines. Where benzodiazepines need to be considered seek advice from senior doctor.

12.1.4 History of epilepsy or at risk of seizures; caution when using antipsychotics – due to risk of lowering of seizure threshold.

12.1.5 Potential interaction with other mediations

### 12.2 Cardiovascular Safety

12.2.1 The cardiovascular health and risk factors for each patient should be assessed prior to the prescribing of medications for de-escalation and RT.

12.2.2 Antipsychotics as a group are probably associated with an increased risk of QTc prolongation. Normal limits of QTc are less than 440 ms in men and less than 470 ms in women. The risk is dose related and the risks for individual drugs are probably additive when used in combination. Therefore avoid antipsychotic medication if there is known QT / QTc prolongation or conduction abnormalities to avoid potentiation of ventricular arrhythmia or cardiac arrest. Consider risk factors for prolonged QTc interval, such as congenital long QT syndrome, family history of cardiac conduction abnormalities and previous occurrences of medication-mediated QTc prolongation. (see table 1 and 2)

## **Table 1**: Summary of the risk for QTc prolongation for common antipsychotics.

*(Adapted from the Maudsley Guideline 13th edition, 2018)*

| **No effect** | **Low Effect No or average increase <10msec at clinical doses or severe effect only reported following overdose** | **Moderate Effect Average increase >10msec at clinical doses or ECG officially recommended** | **High Effect Average increase >20msec** | **Unknown effect** |
|---|---|---|---|---|
| Brexpiprazole*<br>Cariprazine*<br>Lurasidone | Aripiprazole+<br>Asenapine<br>Clozapine<br>Flupentixol<br>Fluphenazine<br>Loxapine<br>Perphenazine<br>Prochlorperazine<br>Olanzapine++<br>Paliperidone<br>Risperidone<br>Sulpiride | Amisulpride**<br>Chlorpromazine<br>Haloperidol<br>Iloperidone<br>Levomepromazine<br>Melperone<br>Quetiapine<br>Ziprasidone | Any intravenous antipsychotic<br>Pimozide<br>Sertindole<br>Any antipsychotic or combination of antipsychotics used in doses exceeding BNF maximum dose | Pipotiazine<br>Trifluoperazine<br>Zuclopenthixol (including Clopicol Acuphase®) |

**Limited clinical experience (association with QT prolongation may emerge)*

*+ One case of torsades de pointes (TDP) reported; 2 cases of QT prolongation and an association with TDP found in database study. Recent data suggest aripiprazole causes QTc prolongation of around 8ms; it may increase QT dispersion*

*++Isolated cases of QTc prolongation and has effects on cardiac ion channel, $I_{K1}$, other data suggest no effect on QTc.*

***Torsades de pointes common in overdose, strong association with TDP in clinical doses with Amisulpride*

## **Table 2**: Other psychotropic and non-psychotropic medications associated with prolonged QTc.

(*Adapted from the Maudsley Guideline 13th edition, 2018 and crediblemeds)*

| **Antibiotics** | **Antimalarials** | **Antiarrthymics** | **Others** |
|---|---|---|---|
| Erythromycin<br>Clarthromycin<br>Ampicillin<br>Co-trimoxazole<br>Ciprofloxacin<br>Levofloxacin<br>Moxifloxacin | Chloroquine<br>Mefloquine<br>Quinine | Quinidine<br>Disopyramide<br>Procainamide<br>Sotalol<br>Amiodarone<br>Bretylium | Citalopram<br>Tricyclic antidepressants<br>Trazodone<br>Lithium<br>Promethazine<br>Methadone<br>Amantadine<br>Cyclosporin<br>Diphenydramine<br>Hydroxyzine<br>Nicardipine<br>Tamoxifen |

Refer to www.crediblemeds.org for latest and more detailed information.

12.2.3 Haloperidol is contraindicated in clinically significant cardiac disorders. A clinical risk assessment must be carried out before prescribing haloperidol. The SPC for haloperidol recommends that a baseline ECG is performed prior to treatment for all patients and also avoiding the use of concomitant antipsychotics. This may not always be possible in ABD. In such a situation, the prescribing doctor will have to balance the cardiac risks against those arising from the patient's behaviour.

12.2.4 Consider, when applicable:

- The use of lorazepam alone
- To avoid antipsychotics (particularly the use of parenteral haloperidol with IM promethazine).
- The use of any concomitant medication, which may prolong QTc interval.

### 12.3 **Intellectual Disability (ID)** (See Appendix B and Appendix A)

12.3.1 Patients will be managed as per Appendix B but staff must be familiar with the NICE guidelines for managing challenging behaviour in ID.

12.3.2 The choice between using physical intervention and RT as a method of managing violent behaviour in those with an ID should be part of an overall care plan. RT for patients lacking capacity should be undertaken in adherence with best interest protocol/ guidelines.

12.3.3 People with severe learning and communication difficulties may not be able to express discomfort or pain in usual ways.

12.3.4 Sensory impairments must be detected and remedied to minimise the consequent disability, and a specialised and sensitive approach is usually needed.

12.3.5 Caution should be exhibited for patients with ID particularly if they have conditions like epilepsy, severe ID, genetic disorders or dementia.

12.3.6 If possible avoid using parenteral RT for patients with severe ID or severe autism particularly if it is in the context of non-psychotic challenging behaviour. Benzodiazepines may be preferable to antipsychotics for challenging behaviour wherever possible.

## 12.4 **Pregnancy and Perinatal Period** (See Appendix B and Appendix A)

12.4.1 Extra care should be taken in prescribing in pregnancy and perinatal period. Pregnant women should be managed in accordance with Appendix B except that:

12.4.2 Specialist advice must be sought on the management of pregnant and perinatal women requiring emergency sedation. Over-sedation has particular risks for these women, particularly if they resume care of their infant. Effects on the foetus through the placenta or to the infant in breastmilk must be considered and appropriate precautions taken.

12.4.3 Pregnant women who are at known risk of relapse and behavioural disturbance should have a clear plan in their notes which should be shared with all relevant statutory professionals and services involved in the female's care.

12.4.4 When choosing a drug for RT, an antipsychotic or a benzodiazepine with a short half-life should be considered: if an antipsychotic is used, it should be at the minimum effective dose because of the potential for neonatal extra pyramidal symptoms: if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account. Up to date advice on the appropriateness of individual agent must always be sought from pharmacy and using appropriate sources of information such as the British Association for psychopharmacology guidelines www.bap.org.uk . The National Poisons Information Service (NPIS) can also be contacted by telephone: 0344 892 0111 for advice.

12.4.5 Intramuscular injections for RT may be administered in to the gluteal muscle or lateral thigh.

12.4.6 During the perinatal period, the woman's care should be managed in close collaboration with a psychiatrist, a paediatrician, an anaesthetist and a midwife.

12.4.7 A pregnant woman should never be secluded or left alone post rapid tranquillisation.

12.4.8 There should be particular emphasis on keeping the mother hydrated and on the regular monitoring and documentation of temperature, pulse, BP, respiratory rate and oximetry.

12.4.9 Anticholinergics for extrapyramidal side effects of antipsychotics should not be prescribed except for short term use. Instead, adjust the dose and timing of the antipsychotic or switch to another to avoid such side effects.

### 12.5 **Children and young people under 18 years of age** (See Appendix C and Appendix A)

12.5.1 The NICE Guideline NG10 on violence and aggression states that restrictive interventions (which includes RT) should only be used if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent. Staff must be familiar with and use the de-escalation techniques outlined in the NICE guideline to avoid having to use a restrictive intervention.

12.5.2 Medication can be given against a children or young persons will, with parental consent i.e. permission from a person with parenteral responsibility under The Children's Act NI and or common law. If repeated medication is required the Mental Health Order NI (1986) should be considered. Children and young people should be informed that a medication is going to be given and always given the opportunity to accept oral medication. Please note that Restraint is defined in the Mental Capacity Act (NI) 2016 Deprivation of Liberty Code of Practice as short, time-bound and reactive to an immediate event, and this may include provision of medication. For any young person requiring high or unusual levels of restraint should seek further advice from Department of Legal Services.

12.5.3 Parents or carers may have the right to stay with the child and young person before, during and after RT takes place. If the parent or carer is adversely affecting the safety and/or the efficacy of the situation, they may however be asked to leave for the benefit of the child or young person – this must be a clinical decision.

12.5.4 Junior doctors should not prescribe RT to children and young people without consultation with a senior doctor/consultant with experience in managing ABD in children and young people, unless *in exceptional circumstances*, where they must discuss directly after with a more senior doctor and record reasons for this occurring.

12.5.5 If initial drug treatment does not work then junior doctors should consider discussion with someone more senior. If a consultant has tried two or three approaches without success then it may be wise to seek a second opinion from a colleague or consult with a psychiatrist who works within the Child and Adolescent Mental Health Service (CAMHS).

## 12.6 **Older adults or physically frail without dementia** (See Appendix D or Appendix B and Appendix A)

12.6.1 When non-pharmacological measures are insufficient and medication is required, oral medication should always be offered whenever possible. Oral lorazepam, starting at a low dose, is the preferred first line treatment

12.6.2 If lorazepam alone gives an insufficient response or is inappropriate, then a low dose oral antipsychotic may be considered. There is evidence that antipsychotics are associated with increased mortality (probably by increasing the risk of cerebrovascular adverse events) even in people without dementia. A cautious approach is recommended. (See Appendix A). However, agents such as haloperidol, olanzapine, risperidone or quetiapine may be considered. Haloperidol should be avoided if the patient is antipsychotic naive, has a significant cardiac history, has had no recent ECG, or has parkinsonian syndrome. Oral promethazine may not be suitable and is usually not recommended where confusion is a concern.

12.6.3 If oral medication has failed or not possible and a patient requires parenteral medication, lorazepam should be used first line. Parenteral haloperidol may be used if there is confirmed history of previous antipsychotic use, however note contraindications detailed above. This may be in combination with parenteral promethazine, although caution should be taken due to potential for adding to the anticholinergic burden and should be avoided if confusion is present. If previous use of antipsychotics can't be confirmed and lorazepam fails to control the situation, low dose parenteral olanzapine may be given (but not within 1 hour of parenteral lorazepam). Other alternatives include parenteral aripiprazole but this should be after consultation with a senior doctor. (See Appendix A)

12.6.4 In all cases where an antipsychotic or promethazine is felt to be required (either orally or parenteral) it should be under the advice of a senior doctor experienced in the management of ABD in older people/physically frail.

## 12.7 **People with dementia** (See Appendix E)

12.7.1 Patients with dementia who present with acute behavioural disturbance should be carefully assessed for delirium and treated appropriately. This guideline does not apply to the management of behavioural disturbance in the context of delirium. If delirium is suspected or identified then the appropriate clinical guideline should be followed.

12.7.2 Non-pharmacological interventions should be offered as first-line management unless the patient is severely distressed or there is an immediate risk of harm to the patient and/or others. Always assess for pain, using a standardised pain scale e.g. Bolton Pain Scale and review the use of analgesics before considering other options. A trial of paracetamol prescribed regularly should be considered for all patients with non-cognitive symptoms of dementia, even when there are no overt symptoms of pain.

12.7.3 If non-pharmacological interventions are ineffective, then lorazepam may be considered. Risperidone is licensed for short-term use for persistent aggression in people with moderate to severe Alzheimer's dementia. If risperidone is not appropriate, and another antipsychotic is required, oral olanzapine may be considered. If on-going use of risperidone or oral olanzapine is considered necessary then the advice of a doctor experienced in the management of dementia should be sought. Oral haloperidol is not recommended, and should only be prescribed in exceptional circumstances under the supervision of a dementia specialist.

12.7.4 Covert administration of oral medication may be suitable in cases where an individual lacks the mental capacity to consent to treatment (see individual Trust guidance regarding same).

12.7.5 People with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate non-cognitive symptoms should not routinely be prescribed antipsychotic drugs because of the possible increased risk of cerebrovascular adverse events and death.

12.7.6 People with Dementia with Lewy Bodies (DLB) with mild-to-moderate non-cognitive symptoms, should not be prescribed antipsychotic drugs, because those with DLB are at particular risk of severe adverse reactions. If an antipsychotic is required for oral de-escalation, low dose oral quetiapine may be useful (outside of product license) due to its low propensity to cause extra-pyramidal side effects. Prescription of antipsychotics in such patients should only be done under the supervision of a senior doctor with experience in DLB.

12.7.7 When parenteral treatment is necessary, parenteral lorazepam or parenteral olanzapine may be used with caution. Only in very exceptional circumstances, when other treatment is impossible, low dose parenteral haloperidol may be used. In these cases, a senior doctor with experience in managing disturbed behaviour in people with dementia should be consulted.

## 13. Physical Health Monitoring, Side Effect Monitoring and Follow Up after RT (See Appendix F)

### 13.1 Medical and Nursing Support

13.1.1 When RT has been administrated, nursing staff will contact a doctor to attend the treatment setting as soon as possible when necessary.

13.1.2 If there is deterioration in the patient's physical health or clinical observations, as indicted by a change in the standard observation chart score, then the patient should be escalated for medical review.

13.1.3 The nursing staff and or doctor must also assess the patient's mental state and review the level of psychiatric observations during the post RT period.

### 13.2 Criteria for monitoring

13.2.1 Physical health and side effect monitoring is essential after an episode of RT (parenteral route).

13.2.2 Routine monitoring is not automatically required after all oral medication, but may be required in certain circumstances, such as:

- It is clinically indicated by the patient's condition.
- The patient was at the point of being administered parenteral rapid tranquillisation but accepted oral medication (individual assessment).
- BNF maximum daily dose of a drug is exceeded in RT.

### 13.3 Monitoring parameters and frequency of monitoring

13.3.1 Following each episode of RT, or in the circumstances described above for oral medication, the following physical observations should be commenced and recorded on the Trust Standard Observation chart (SOC)/NEWS 2 and the clinical notes:

- Respiratory rate
- $SpO_2$
- Temperature
- Blood pressure
- Heart rate
- Level of consciousness

13.3.2 After RT, or when clinically necessary with oral medications, carry out the required observations every 15 minutes for the first hour. After one hour, continue observations at least every hour until there are no concerns about the physical health status.

13.3.3 Consider extended or more frequent monitoring in the following circumstances:

- The BNF maximum dose of a medicine has been exceeded.
- The patient appears to be asleep or sedated.
- Concerns about possible illicit drug (including novel substances) or alcohol use.
- Pre-existing physical health problem.
- The patient experienced any harm as a result of a restrictive intervention.

### 13.4 Situations where full monitoring and assessment cannot be completed (See Appendix G)

13.4.1 There may be circumstances when taking a full set of observations according to standard observation charts (SOC) is not possible e.g. patient refuses physiological observation or if they remain too behaviourally disturbed to be approached. In these cases the Non-Contact Physical Health Observations Guidance and Assessment tool should be used to access the patients ABCDE status instead of the Trust standard observation chart. In addition to completing the Non-Contact Physical Health Observations Chart nursing staff should record the following on the Trust SOC chart:

- Respiratory rate.
- Level of consciousness.
- Temperature (using non touch thermometer).
- Pulse oximetry (may be possible if the patient is asleep/ unconscious).

13.4.2 It should be clearly documented on the Trust SOC and in the patient's notes that these are non-contact observations and the reasons for doing so documented in the notes each time they have been carried out. The use of Trust SOC, and calculation of scores, should recommence at the earliest opportunity.

13.4.3 If there is any concern regarding the patient's physical wellbeing such as indicated by a RED status in the Non-Contact Physical Health Observations Guidance and Assessment tool, then the patient MUST be escalated to a doctor and a group of staff who are MAPA trained must enter the room and check the patient's physiological observations. The patient **<u>MUST NOT</u> be left alone.**

## 13.5 Side Effect Monitoring

13.5.1 For detailed information on the management of complications and side effects associated with RT. (See Appendix F)

13.5.2 RT can be associated with risks to the patient's physical health;

- Inadequate sedation can risk patient exhaustion, dehydration and increases the risk of violence.
- Over sedation can lead to loss of consciousness or reduced alertness.
- Minor injuries and bruising may be present, especially if restraint has been used.
- Prominent side effects of medication can occur; these can be distressing and, unpleasant and include akathisia, dystonia, parkinsonian and hypotension. However side effects may be serious or life threatening and include lowered seizure threshold, respiratory depression or arrest, cardiac arrhythmias and neuroleptic malignant syndrome.

13.5.3 Respiratory depression can be a complication of administration of benzodiazepines. Treatment is with flumazenil, a benzodiazepine antagonist that must be given intravenously. If Flumazenil is being considered on a psychiatric ward, it should be used with input from general physicians whilst transfer of the patient to a medical ward is being sought. See Appendix E for more information on indications for administering flumazenil. Risk of respiratory depression is increased by:

- Underlying respiratory disease.
- Existing compromised respiratory function.
- Co-administration with other medications known to suppress respiratory function e.g. opiates.
- Administration via the parenteral route.
- Administration of higher doses.
- Physical restraint.

13.5.4 Checks for side effects after RT should be recorded in the patient's clinical notes each time they are carried out along with any actions taken to manage these.

## 13.6 Overall management of patient Electrocardiogram (ECG)

13.6.1 An ECG must be obtained after administration of a parenteral antipsychotic or dosing exceeds BNF maximum daily dose, where possible.

13.6.2 However an ECG is ESSENTIAL after administration of an antipsychotic to a child or young person.

13.6.3 The SPC for Haloperidol injection advise continuous ECG monitoring for repeated intramuscular doses.

13.6.4 Calculate QTc and if an ECG shows any cause for concern then a doctor must be contacted for advice on patient management. Record these observations and any actions in the patient's clinical notes.

## 14. Recording

### 14.1 Following administration of oral de-escalation medication

14.1.1 When oral medicines are administered for the management of acutely disturbed behaviour (either as oral PRN in anticipation of the acute disturbed behaviour or upon a prescription written at the time of the event) the following will be recorded in patient's case notes and patient's recovery care plan (where appropriate):

14.1.1.1 The nature of the acutely disturbed behaviour

14.1.1.2 The time course of events from:

- The onset of the behaviour until the offering of oral medicines
- The impact of non-drug strategies
- The acceptance or refusal of oral medicines
- The impact of the administration of oral medicines

### 14.2 Following administrating of RT

14.2.1 Following administration of RT, in addition to the points mentioned above, the following, should be undertaken and recorded in the patient's case notes and patient's recovery care plan, (where appropriate):

- Physical monitoring completed and documented.
- Prescription chart reviewed re: regular medication.
- Team debrief (see section 15.1.2).
- Handover to clinical team (if out of hours)
- Update risk assessment
- Reassure patient debrief which will include discussion on how to manage further similar incidents.
- Have a member of staff designated to record the course of events.
- Communication with carer.
- A post-incident review may be held within 72 hours.

- Datix is completed after each instance of restrictive practice i.e. rapid tranquillisation.

## 15. Ongoing Support and Learning

Post incident support and learning has benefits for both patients and staff as they may help minimise the negative impact of an event and help maintain a positive user-staff relationship especially in relation to minimising conflict and crisis events which are likely to lead to the use of restrictive interventions.

### 15.1 Post incident de-brief

15.1.1 As soon as reasonably practicable, within a supportive environment, provide the opportunity for those involved to debrief and discuss the event, preferably guided by the team leader/incident manager.

- Include involvement of patient and (where agreed by the patient) peer supports and or advocate services and significant others such as family/carer.

15.1.2 During the de-brief process opportunity should be given for:

- The patient to talk about the event from their point of view, when possible.
- Acknowledge the emotional responses to the incident and assess whether there is a need for on-going emotional support including access to counselling services for any trauma experienced.
- Consider any contributing factors to identify any elements that can be addressed quickly to reduce the likelihood of further incidents.
- Staff to reflect on what went well and didn’t go so well and what could be done differently.
- Staff to improve primary and secondary preventive approaches including preferences expressed by the patient in how they would like to be managed in future crisis events (advanced statements/directives).
- Support a return to normal patterns of activity.
- Ensure that everyone involved in the patients care, including their carers has been informed of the event, if the patient agrees.
- Complete documentation including DATIX; review and amend risk and care plans accordingly.
- Share any learning with other units as appropriate and address any training needs identified.
- Any concerns or complaints expressed by the patient must be dealt with at the point of service delivery in the first instance immediately and

directly in an attempt to resolve the matter informally, speedily and appropriately in accordance with the Trust's Policy for The Management of Complaints.

### 15.2 Post incident review

15.2.1 A formal external post-incident review should be undertaken as soon as possible and no later than 72 hours after the incident.

15.2.2 This uses the information from the post-incident debrief, the patients notes and interviews with staff, where relevant, to develop a report which will

- evaluate the physical and emotional impact on everyone involved, including witnesses
- help patients and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were discussed
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate

## 16. Monitoring and audit

Monitoring and audits will be carried out against the standards set by this guidance as per Table 3. The outcomes of which will be used in conjunction with the local, regional or national learning or feedback. This guidance needs to be reviewed every three years or in the event of a Serious Adverse Incident (SAI).

Table 3 Overview of monitoring and audit

| Aspect of compliance or effectiveness being monitored | Method of monitoring | Professional responsible for monitoring | Monitoring frequency | Group or committee who receive findings of reports | Group or individual responsible for completing any actions |
|---|---|---|---|---|---|
| Compliance with NICE guidance | Monitoring reports | Medical director | Annually | DTC | Medical director |
| Prescribing with regard to RT | Audit of kardex for patients receiving RT.<br>POMH-UK audit tool where available | MRP lead (*)<br>POMH lead (*) | Annually<br>As per POMH | Governance fora<br>Chief Executive POMH-Lead | Medical director<br>POMH lead |
| How physical health observations are recorded, when patients have received RT | Audit of documentation of post RT monitoring | MRP Lead (*) | Annually | Governance fora | Mental Health Director<br>Medical director |
| Staff have completed training associated with this guidance in line with Trust requirements e.g. MAPA, ILS, NEWS2 | Certification of completion of e-learning<br>Or<br>Attendance certificate at Trust learning | Training will monitored in line with Trust statutory and mandatory Training | | | Relevant director of service |

DTC= Drugs & Therapeutics Committee MRP = Minimising Restrictive Practice (*) Mental Health only

## 17. References

Bazire, S. Psychotropic Drug Directory. 2018. Lloyd-Reinhold Publications.

British National Formulary. Accessed 31st July 2020.

Electronic medicines compendium, Accessed 31st July 2020.

Gillines, M., Grundlingh, J. & Aw-Yong, M. The Royal College of Emergency Medicine, Best Practice Guideline, Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance (ABD). RCEM publications. 2016.

McAllister-Williams R. H, et al. British Association for Psychopharmacology consensus guidance on the use of psychotropic medication, in pregnancy and postpartum. 2017.

National Institute for Health and Care Excellence (NICE), Clinical Guideline [CG16]: Self-harm in over 8s: short-term management and prevention of recurrence. July 2004. (Last reviewed Jan 2019) (*)

National Institute for Health and Care Excellence (NICE), Clinical Guideline CG155: Psychosis and schizophrenia in children and young people: recognition and management. January 2013 (last updated October 2016). (*)

National Institute for Health and Care Excellence (NICE), Clinical Guideline [CG178], Psychosis and schizophrenia in adults: prevention and management. February 2014 (last reviewed March 2019).

National Collaborating Centre for Mental health, 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. May 2015.

National Collaborating Centre for Mental health, National Institute for Health and Care Excellence (NICE) Guideline [NG10] Violence and aggression: short-term management in mental health, health and community settings. May 2018.

Patel, M. X. 7 Sethi, F.N. with co-authors, British Association for Psychopharmacology, National Association of Psychiatric Intensive Care Units, Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation. June 2018.

Taylor, D., Barnes T.R.E. & Young A.H., The Maudsley Prescribing Guidelines in Psychiatry. 2018. 13th Edition, Wiley Blackwell.

The Children (Northern Ireland) Order 1995

The Mental Health (Northern Ireland) Order 1986.

The Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019.

The UK Teratology Information Service.

## 18. Acknownledgements

Thanks to the membership of the RT subcommittee for their work in pulling together the various Trust guidelines to produce this document.

| | |
|---|---|
| Liz McGrath | *Towards Zero Suicide Service improvement manager SHSCT* |
| Aaron Coulter | *Lead mental health pharmacist SHSCT* |
| Claire Erki | *Community mental health pharmacist BHSCT* |
| Jackie Ferris | *Mental health pharmacist WHSCT* |
| Noeleen Gribben | *Lead mental health pharmacist NHSCT* |
| Orla McGuigan | *Mental health pharmacist WHSCT* |
| Rachel McGaughey | *Mental health inpatients pharmacist SEHSCT* |
| Stephen Guy | *Lead mental health pharmacist BHSCT* |
| Suzanne O'Sullivan | *Mental health pharmacist WHSCT* |
| Una Convery | *Community mental health pharmacist SEHSCT* |

# Appendix A - Dose information for specific populations (Not applicable to delirium)

**Dose ranges highlighted as a guide only: remember to avoid variable dosing on kardex.**

| Medication | Time to Peak Plasma concentration | Child (6-12 years) | Young person (13 – 17) | Adults (18 +) | Older and Frail People | People with Dementia |
|---|---|---|---|---|---|---|
| Haloperidol oral solution and tablets<br>**If no recent ECG, consider risk/benefits as use may be unlicensed.** | 2 – 6 hours<br>(Sedation usually within 30-45 mins) | ***Not Applicable*** | *Consider risk of acute dystonia especially in the antipsychotic naïve*<br>PO 1mg up to 5mg<br>Max 10mg/24hrs | PO 5mg<br>Max 20mg/24 hours | *Only use first line if there is confirmed history of previous exposure to typical antipsychotics. Start with lower doses:*<br>PO 0.5mg up to 2.5mg<br>(Usual Max 5mg/24hrs.) | ***Not recommended.***<br>*Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative*<br>PO 0.5mg<br>(Max 2mg/24hrs) |
| Haloperidol injection<br>**If no recent ECG, consider risk/benefits as use may be unlicensed.** | IM 15 – 60 mins<br>(Sedation usually within 30 – 45 mins)<br>IV: 10 mins | ***Not Applicable*** | ***Unlicensed: Only use as part of an individualised care plan.***<br>*Consider risk of acute dystonia especially in the antipsychotic naïve*<br>IM injection 1mg up to 5mg<br>Max 10mg/24hrs | By IM/IV injection 5mg<br>Max 20mg/24 hours | *Only use first line if there is confirmed history of previous exposure to typical antipsychotics. Start with lower doses*<br>IM 0.5mg up to 2.5mg<br>(Max 5mg/24hrs) | ***Not recommended.***<br>*Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative*<br>IM 0.5mg<br>(Max 2mg/24hrs) |
| Lorazepam tablets and IM/IV injection | PO/IM 50-90 mins<br>(Sedation usually within 30-45 mins)<br>IV:2-5mins | *Unlicensed but may be justified in some cases*<br>PO or by IM injection<br>0.5 or 1mg<br>Max:2mg/24hrs | PO or IM injection<br>0.5mg, 1mg or 2mg<br>Max 4mg/24hrs | PO or IM/IV injection<br>1mg or 2mg<br>Max 4mg/24 hours | PO or IM injection<br>0.5mg<br>Max 2mg/24 hours<br>(IV route NOT recommended) | PO or IM injection<br>0.5mg<br>Max 2mg/24 hours<br>(IV route NOT recommended) |
| Olanzapine tablets/ orodispersible tablets<br>*(NB orodispersible tablets have no advantage in speed of onset but are harder to spit out/conceal)* | 5 – 8 hours | ***Not Applicable*** | ***Not Applicable*** | Initially 5mg or 10mg PO<br>Max 20mg/24 hours | *Consider as a second line option.*<br>2.5mg PO<br>Max 10mg/24hrs. | *Unlicensed but may be justified in some cases.*<br>2.5mg PO<br>Maximum 5mg//24hours |
| Promethazine oral solution, tablets & IM injection | Oral 2-3 hours<br>IM 1-2 hours<br>***IV:NOT recommended*** | ***Not Applicable*** | ***Unlicensed: Only use as part of an individualised care plan***<br>PO or IM injection<br>10mg to 25mg<br>Max 50mg/24hrs | PO 25mg or 50mg<br>Max 100mg/24 hrs | *Consider appropriateness, if confusion is a concern*<br>PO or IM injection 2.5mg.<br>Max 50mg/24hrs | ***Not recommended.***<br>*Use may be considered in those with compromised respiratory function or sensitive/tolerant to benzodiazepines.*<br>PO or IM injection 12.5mg or 25mg.<br>Max 50mg/ 24hrs |

# Appendix A - Dose information for specific populations (not applicable to delirium)

**Dose ranges highlighted as a guide only: remember to avoid variable dosing on kardex.**

| Medication | Time to Peak Plasma concentration | Child (6-12 years) | Young person (13 – 17) | Adults (18 +) | Older and Frail People | People with Dementia |
|---|---|---|---|---|---|---|
| Aripiprazole IM injection | 1 –3 hours | ***Not Applicable*** | ***Not Applicable*** | 9.75mg (1.3ml) – Consider lower dose (5.25mg) on basis of clinical status<br>Effective range 5.25 –15mg<br>Max dose 30mg/24hrs by any route | *Effectiveness in over 65's not established. Consider lower doses on basis of clinical status.*<br>Consider starting dose 5.25mg<br>Max of TWO injection in 24 hours. | ***Not Recommended*** |
| Olanzapine IM injection | 15-45 minutes<br>(peak levels up to 5 times that of oral doses) | ***Not Applicable*** | *Unlicensed but may be justified in some cases under consultant direction.*<br>2.5mg, 5mg or 10mg IM repeated after 2 hours if needed. Max IM dose is 10mg daily. Max total daily dose by all routes of 20mg not to be exceeded.<br>Max of 3 injections/ 24hrs for 3 days | 5 or 10mg IM repeated after 2 hours if needed.<br>Max combined oral/IM dose is 20mg daily NOT to be exceeded.<br>Max of 3 injections/24hrs for 3 days. | *Use may be justified in some cases under consultant direction.*<br>2.5mg IM repeated after 2 hours if needed.<br>Max combined oral/IM dose is 10mg daily NOT to be exceeded.<br>Max of 3 injections/24hrs for 3 days | ***Not recommended.***<br>*Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative*<br>2.5mg IM repeated after 2 hours if needed.<br>Max combined oral/IM dose is 5mg daily NOT to be exceeded.<br>Max of 2 injections/24hrs for 3 days |
| Quetiapine Oral tablets/Solution | 1-2 hours | ***Not Applicable*** | ***Not Applicable*** | *Unlicensed but may be justified in some cases.*<br>PO 50-100mg (suggested max 200mg/24hours) | *Unlicensed but may be justified in some cases.*<br>PO 12.5mg or 25mg (suggested Max 50mg/24hrs) | *Unlicensed but may be justified in some cases such as Lewy Body Dementia*<br>PO 12.5mg or 25mg (suggested max 50mg/24hrs) |
| Risperidone tablets / orodispersible tablets/ oral solution | 1 -2 hours | ***Not Applicable*** | 20-45kg 0.5mg, Very slow increase to Max 2.5mg<br>>45kg 0.5mg. Very slow increase to Max 3mg | *Unlicensed but may be justified in some cases.*<br>Suggested dose PO 1-2mg BD PRN<br>Max 4mg/24hours | *Consider as a second line option. Unlicensed but may be justified in some cases.*<br>Suggested dose PO 0.25mg once or twice daily PRN.<br>Max 2mg/24hours | In *Alzheimer's Disease*<br>Suggested dose *PO* 0.25mg once or twice daily PRN.<br>Max 2mg/24 hours |

## Appendix B - Pharmacological management of acute behavioural disturbance (FOR ADULTS 18 YEARS AND OVER)
## (Not applicable to delirium, also consider using Appendix D for older adults and frail)

| Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques | | |
|---|---|---|
| **LEVEL 1**<br>**Accepting oral meds and as part of de-escalation strategy** | **LEVEL 2**<br>**Actual or clear risk of violence or aggression.**<br>**De-escalation including oral PRN not possible or appropriate** | **LEVEL 3**<br>**Situation rapidly deteriorating or failure to respond to LEVEL 2 interventions** |
| Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances.<br>Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response. | Review all medication administered in the last 24 hours – be aware of BNF max doses.<br>Ensure resuscitation equipment and emergency response is readily available within 3 minutes. | If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours.<br><br>If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following:<br>• The appropriateness of current placement<br>• Age and physical presentation<br>• Check sufficient time has been allowed for response<br>• If there has been a partial response to a LEVEL 2 intervention, consider repeating that intervention<br>• If a LEVEL 2 intervention has had insufficient effect consider offering the alternative LEVEL 2 intervention<br>• Carry out a full review of treatment to date and seek a second opinion if needed.<br><br>**If LEVEL 2 interventions have had insufficient effect:**<br><br>**<u>Consider as part of an individualised care plan include:</u>**<br>• Further repeats of LEVEL 2 interventions (do not repeat promethazine if it is < 2hrs since the last injection)<br>• Haloperidol IM combined with Lorazepam IM<br>• Alternative medications (see Section 10)<br>• Zuclopenthixol acetate (Clopixol Acuphase®) (see Section 11) |
| **Consider lower doses in older adults or frail (Appendix A & D)** | | |
| **<u>Suggested Oral Medication</u>**<br>**Lorazepam 1 or 2mg**<br>(Max 4mg/24hrs)<br>**OR**<br><br>**Promethazine**<br>**25 or 50mg**<br>(Max100mg/24hrs)<br>**OR**<br><br>**Haloperidol 5mg**<br>(max 20mg/24hrs)<br>**OR**<br><br>**Olanzapine 10mg♦** (♦ Available as an orodisperible product)<br>(Max 20mg/24hr<br><br>Continue de-escalation strategy.<br><br>If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 | **<u>Suggested Medication</u>**<br>**Lorazepam IM (or IV)[a]**<br>**1 or 2mg** [b, c]<br>(Max 4mg/24hrs)<br><br>**OR**<br><br>**Haloperidol IM 5mg**<br>(Max 20mg/24hrs)<br>**Combined with**<br>**Promethazine IM**<br>**25 or 50mg**<br>(Max 100mg/24hrs)<br><br>If there is continued concern seek advice from a more senior doctor before proceeding further<br><br>***<u>NOTES</u>***<br>*a.* ***IV in certain clinical settings. NOT recommended in elderly and frail and in mental health settings***<br>*b. IM Lorazepam and IM Olanzapine must not be administered <u>within 1 hour</u> of each other*<br>*c. IV flumazenil must be readily available* | |

| When deciding which medication to use, consider: | Additional Considerations |
|---|---|
| • **Oral or parenteral lorazepam is preferred first line if:**<br>  ○ Patient is an older adult or physically frail<br>  ○ There is an uncertain history<br>  ○ Presence of cardiovascular disease<br>  ○ Current illicit drug/alcohol intoxication<br>  ○ Antipsychotic naïve<br><br>• Antipsychotics and/or promethazine preferred with:<br>  ○ Current regular benzodiazepine use<br>  ○ History of respiratory depression | • Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies)<br>• Avoid haloperidol in cardiovascular disease or if there has been no recent ECG.<br>• Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy.<br>• Previous response, including adverse effects<br>• Potential for interactions with other medicine<br>• Possible Intoxication<br>• Promethazine is contraindicated in CNS depression and those prescribed a monoamine oxidase inhibitor within the last 14 days. Promethazine may be unsuitable in older adults with confusion due to its anticholinergic effects. |

# Appendix C Pharmacological management of acute behavioural disturbance (for Children and Young People age 6 to 17 years) (Not applicable to delirium)

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques**

| **LEVEL 1**<br>**Accepting oral meds and as part of de-escalation strategy** | **LEVEL 2**<br>**Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate** | **LEVEL 3**<br>**Situation rapidly deteriorating or failure to respond to Level 2 interventions** |
|---|---|---|
| Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances.<br>Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.<br>**<u>Suggested Oral Medication</u>**<br>**Children 6-12 years**<br>**Lorazepam 0.5 or 1mg**<br>(Max 2mg/24hrs)<br>**Young People 13-17years**<br>**Lorazepam 0.5mg, 1mg or 2mg**<br>(Max 4mg/24hrs)<br>**OR**<br>**Haloperidol 1mg up to 5 mg★**<br>(max 10mg/24hrs)<br>**OR**<br>**Promethazine 10mg to 25mg**<br>(max 50mg/24hrs)<br>**OR**<br>**Risperidone♦**<br>**20kg-45kg 0.5mg**(Slowly increase to Max 2.5mg/24hrs)<br>**>45kg 0.5mg** (Slowly increase to Max3mg/24 hrs)<br><u>For both age groups</u>:<br>Continue de-escalation strategy.<br>If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2<br>♦ Available as an orodisperible product. | Consult a senior doctor/consultant before using IM medication in a child under 12 years of age.<br>Consult a senior doctor/consultant before using IM medication in a young person (13-17 years) unless IM medication is already included in the young person's care plan.<br>Check if an individual care plan recommends an approach not covered in this guideline.<br>Review all medication administered in the last 24 hours – be aware of BNF max doses.<br>Ensure resuscitation equipment and emergency bag is available within 3 minutes.<br>**<u>Suggested IM Medication</u>**<br>**Children 6-12 years**<br>**Lorazepam IM 0.5 or 1mg**<br>(Max 2mg/24hrs)<br>**Young People 13 -17 years**<br>**Lorazepam IM 0.5mg, 1mg or 2mg**<br>(Max 4mg/24hrs)<br><u>For both age groups:</u><br>If there is continued concern, seek advice from a more senior doctor/consultant before proceeding | If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor/consultant must review all treatment and response every 24 hours.<br>If one round of LEVEL 2 interventions have had insufficient effect a senior doctor/consultant should review treatment and consider the following options:<br>• The appropriateness of current placement<br>• Check sufficient time has been allowed for response<br>• If there has been a partial response to lorazepam consider repeating the dose<br>• Carry out a full review and seek a second opinion if needed.<br>**If there has been insufficient response to IM lorazepam:**<br>**<u>Consider as part of an individualised care plan include</u>** (in no particular order)<br>• Further repeats of IM lorazepam<br>• ≥13yrs, Haloperidol IM 1 - 5mg★ (Max 10mg/24hrs)<br>• ≥13yrs, Haloperidol IM combined with lorazepam IM<br>• ≥13yrs, Promethazine IM (10 to 25mg, Max 50mg/24hrs)<br>• ≥13yrs, Olanzapine 2.5mg, 5mg or 10mg (Max 10mg/24hrs IM). **<u>Do not combine</u>** with IM lorazepam and use with caution if IM lorazepam has been given within 1 hour. |

| When deciding which medication to use, consider: | Additional Considerations |
|---|---|
| • Oral or parenteral lorazepam is preferred first line if:<br>○ There is an uncertain history<br>○ Presence of cardiovascular disease<br>○ Current illicit drug/alcohol intoxication<br>○ Antipsychotic naïve<br>• Antipsychotics may be preferred with:<br>○ Current regular benzodiazepine use<br>○ History of respiratory depression | • Avoid haloperidol in cardiovascular disease or if there has been no recent ECG.<br>• Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy<br>• Previous response, including adverse effects<br>• Potential for interactions with other medicine<br>• Possible Intoxication<br>• Promethazine is contraindicated in CNS depression.<br>★Dosing for haloperidol should be a fixed dose in the range from 1mg to a max of 5mg. Please consider the available strengths of oral haloperidol 0.5mg, 1.5mg or 5mg to facilitate ease of administration; e.g. 1.5mg is easier to administer than 2mg. |

## Appendix D - Pharmacological management of acute behavioural disturbance (FOR OLDER and FRAIL ADULTS) (Not applicable to delirium, please also consider using Appendix B)

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques**

| **LEVEL 1**<br>**Accepting oral meds and as part of de-escalation strategy** | **LEVEL 2**<br>**Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate** | **LEVEL 3**<br>**Situation rapidly deteriorating or failure to respond to LEVEL 2 interventions** |
|---|---|---|
| Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances.<br>Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.<br><br>**Suggested Oral medications:**<br>***1st line:***<br>**Lorazepam 0.5mg**<br>(Max 2mg/24hrs)<br><br>***2nd line:***<br>**Haloperidol 0.5mg-2.5mg★**<br>(Usual Max 5mg/24 hrs)<br>**OR**<br>**Olanzapine 2.5mg**<br>(Max 10mg/24hrs)<br>**OR**<br>**Risperidone 0.25mg**<br>(Max 2mg/24hrs)<br>**OR**<br>**Quetiapine 12.5mg or 25mg**<br>(Max 50mg/24hrs)<br>**OR**<br>**Promethazine 25mg**<br>(Max 50mg/24hrs)<br><br>Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 | Review all medication administered in the last 24 hours – be aware of BNF max doses.<br>Ensure resuscitation equipment and emergency response is readily available within 3 minutes.<br><br>**Suggested Medication**<br>***1st line:***<br>**Lorazepam IM (or IV)[a] 0.5mg**<br>(Max 2mg/24hrs) [b, c]<br><br>***2nd line:***<br>**Haloperidol IM 0.5mg-2.5mg★**<br>(Max 5mg/24 hours)<br>**Plus or minus**<br>**Promethazine IM 25mg**<br>(Max 50mg/24hours)<br>**OR**<br>**Olanzapine IM 2.5mg** [b]<br>Max 10mg/24hrs [d]<br>(Leave at least 2hrs between injections.)<br>Max of three injections in 24hrs.<br><br>If there is continued concern seek advice from a more senior doctor before proceeding further<br><br>***NOTES***<br>*a. **IV in certain clinical settings. NOT recommended for elderly and frail and in mental health settings***<br>*b. Lorazepam and IM Olanzapine must not be administered within 1 hour of each other*<br>*c. IV flumazenil must be readily available*<br>*d. Maximum of 10mg in 24 hours from PO and IM routes combined.* | If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours.<br><br>If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following:<br>• The appropriateness of current placement<br>• Age and physical presentation<br>• Check sufficient time has been allowed for response<br>• If there has been a partial response to a LEVEL 2 intervention, consider repeating that intervention<br>• If a LEVEL 2 intervention has had insufficient effect consider offering the alternative LEVEL 2 intervention<br>• Carry out a full review of treatment to date and seek a second opinion if needed.<br><br>**If LEVEL 2 interventions have had insufficient effect:**<br><br>**Consider as part of an individualised care plan include:**<br>• Further repeats of LEVEL 2 interventions<br>• Alternative medications e.g. **Aripiprazole** (see Section 10 & 12.6) |

| When deciding which medication to use, consider: | Additional Considerations |
|---|---|
| • **Oral or parenteral lorazepam is preferred first line if:**<br>○ There is an uncertain history<br>○ Presence of cardiovascular disease<br>○ Current illicit drug/alcohol intoxication<br>○ Antipsychotic naïve<br>• Antipsychotics are associated with increased mortality<br>○ Olanzapine, risperidone and quetiapine all unlicensed but use may be justified in some circumstances<br>○ IM aripiprazole effectiveness in over 65 not established<br>• Promethazine may increase risk of confusion | • Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies)<br>• Avoid haloperidol in cardiovascular disease or if there has been no recent ECG<br>• Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy.<br>• Previous response, including adverse effects and increased risk of falls<br>• Potential for interactions with other medicine<br>• Possible Intoxication<br>★Dosing for haloperidol should be a fixed dose in the range from 1mg to a max of 2.5mg. Please consider the available strengths of oral haloperidol tablets/caps 0.5mg 1.5mg to facilitate ease of administration; e.g. 1.5mg is easier to administer than 2mg. |

# Appendix E Pharmacological management of acute behavioural disturbance (for PATIENTS WITH DEMENTIA) (Not applicable to delirium)

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques**

| **LEVEL 1**<br>**Accepting oral meds and as part of de-escalation strategy** | **LEVEL 2**<br>**Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate** | **LEVEL 3**<br>**Situation rapidly deteriorating or failure to respond to Level 2 interventions** |
|---|---|---|
| Only consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances. Ensure all risks and benefits are fully considered before prescribing antipsychotic drugs.<br>Avoid antipsychotics in patients who have parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies)<br>Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.<br>**Suggested Oral medications:**<br>***1st line:***<br>**Lorazepam 0.5mg**<br>(Max 2mg/24hrs)<br>***2nd line:***<br>**Risperidone 0.25mg ♦**<br>(Max 2mg/24hrs)<br>Oral risperidone licensed for treatment of aggression in Alzheimer's dementia<br>**OR**<br>**Olanzapine 2.5mg ♦**<br>(Max 5mg/24hrs)<br>Olanzapine licensed for agitation and disturbed behaviour in schizophrenia and mania ONLY.<br>♦ Available as an orodisperible product.<br>Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 | Check if an individual care plan recommends an approach not covered in this guideline.<br>Review all medication administered within the last 24hrs – be aware of BNF maximum doses.<br>Ensure resuscitation equipment and emergency response is readily available within 3 minutes.<br>**Suggested IM medications:**<br>**1st line:**<br>**Lorazepam 0.5mg IM**<br>(Max 2mg/24hrs)<br>(IV flumazenil must be readily available)<br>**OR**<br>**Olanzapine***<br>**2.5mg IM**<br>(Max 5mg/24hrs)<br>*(*Unlicensed, use ONLY in certain clinical circumstances)*<br>For Olanzapine, leave at least 2hrs between injections. Max of two injections in 24hrs.<br>**CAUTION**<br>• **IM lorazepam and IM olanzapine must not be administered within 1 hour of each other.**<br>If there is continued concern, seek advice from a more senior doctor before proceeding further. | If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours<br>If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following options:<br>• The appropriateness of current placement<br>• Check sufficient time has been allowed for response<br>• Carry out a full review and seek a second opinion if needed.<br>If LEVEL 2 interventions have had insufficient effect:<br>**Consider as part of an individualised care plan include:**<br>• Repeat IM injections as per LEVEL 2.<br>• Use alternative medications not yet tried **in exceptional circumstances only**<br>○ Haloperidol 0.5mg IM with caution due to known increased risk of cerebrovascular adverse events. Allow sufficient time for response before repeating to maximum of 2mg/24 hrs<br>○ Promethazine 25mg IM with caution, useful in benzodiazepine tolerant patients or if there has been a known or suspected previous paradoxical reaction to benzodiazepines. Onset of action is slow. Allow 1-2 hours to assess response before repeating to maximum of 50mg/24hrs |

| When deciding which medication to use, consider: | Additional Considerations |
|---|---|
| • **Oral or parenteral lorazepam is preferred first line:**<br>• In all cases where an antipsychotic is felt to be required (either orally or parenteral) it should be under the advice of a senior doctor experienced in the management of ABD in dementia and consider antipsychotics only when benefits outweigh risks. | • Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies )<br>• Avoid haloperidol in cardiovascular disease or if there has been no recent ECG.<br>• Pre-existing physical health problems (e.g. extra care in patients with physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion)<br>• Potential for interactions with other medicine<br>• Possible intoxication<br>• Increased risk of falls<br>• Access pain using a standardised pain scale e.g. Bolton Pain Scale and consider regular analgesia prior to sedative medication |

## Appendix F Rapid tranquillisation Monitoring

Following any IM/IV drug administered for RT, or where considered clinically necessary after oral medication, monitor and record as shown below.
Document and record on the Trust Standard Observation Chart (SOC) e.g. NEWS 2 or clinical notes as appropriate.

**The Early Warning Score should be calculated from the Trust Standard Observations Chart e.g. NEWS 2 each time and further action taken if indicated**

| Observations | Monitoring Frequency | General Comments |
|---|---|---|
| • Respiratory Rate<br>• SaO2 (if appropriate)<br>• Pulse<br>• Blood Pressure<br>• Temperature<br>• Level of Consciousness<br>• Assess for Side effects<br>• Monitor level of hydration | Every 15 minutes for first hour. After one hour, continue observations at least hourly until there are no further concerns about physical health status.<br>**Action when Observations are not possible**<br>The Non-Contact Physical Health Observations Guidance and Assessment tool (Appendix F) should be used. Record if the patient's mental state or behaviour prevents observations. Complete and record any observations possible, in Trust Standard Observational Chart e.g. NEWS 2. | • Arrange medical review of the patient after administration of IM medication<br>• Protection of the airway is paramount<br>• Ensure adequate levels of hydration are maintained<br>• Consider urgent transfer to an Emergency Department if not already in ED, if condition warrants<br>• Pay particular attention to level of consciousness and blood pressure when IM antipsychotics and IM benzodiazepines are used in combination.<br>• An ECG is recommended when antipsychotics, in particular when haloperidol or higher doses are given.<br>• An ECG is essential after IM antipsychotics are administered to Young People. |

## Management of side effects and problems that can occur during and after rapid tranquillisation (RT) (and occasionally during and after oral pharmacological de-escalation)

| Problem | Remedial Measures |
|---|---|
| **Acute Dystonia**<br>(including oculogyric crises, torticollis)<br>*NB. 10% prevalence, more common in young males, neuroleptic naïve, high potency drugs e.g. haloperidol* | Give **procyclidine 5 - 10mg Orally or IM (IV in ED Departments only)**<br>**NOTE** Do not pre-emptively administer procyclidine when IM haloperidol is combined with IM promethazine as the risk of extrapyramidal side effects (EPSE) is significantly reduced by the promethazine. If EPSE do occur after the IM haloperidol/promethazine combination, administer additional procyclidine with caution. Monitor for increased anticholinergic side effects. |
| **Reduced respiratory rate**<br>• <10/minute or<br>• Oxygen saturation <92%<br>(Note: COPD patients may have a lower baseline $SPO_2$) | Give oxygen; ensure patient is not lying face down. If induced by any agent other than a benzodiazepine the patient will require transfer for mechanical ventilation<br>***If benzodiazepine induced:***<br>Give flumazenil 200microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1mg (1000microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level. The effect of flumazenil may wear-off & respiratory depression return – monitoring must continue beyond initial recovery of respiration.<br>Clinicians should be familiar with the use of flumazenil or if being considered on a psychiatric ward, it should be used with input from general clinicians. Additional information is available from Medusa (see local Trust for details), on the treatment of benzodiazepine poisoning and flumazenil should be administered in this context.<br>*Do not use flumazenil if the patient has a history of epilepsy; co-ingested pro-convulsants including tricyclic antidepressant; or in benzodiazepine dependent patients. These patients will require transfer for mechanical ventilation, maintain airway management until transfer .* |
| **Irregular or slow pulse**<br><50 beats/min | **Refer to specialist medical care immediately.** |
| **Fall in blood pressure**<br>> 30mmHg drop in systolic BP on standing or diastolic BP <50mmHg | Lie patient flat, raise legs if possible. Monitor closely and seek further medical advice if necessary. |
| **Increased temperature** | **Withhold antipsychotics –**risk of NMS or perhaps arrhythmias. Monitor closely, cool the patient, maintain hydration and check muscle creatinine kinase**.**<br>**Refer to specialist medical care** if continued or other signs of NMS present e.g. sweating, hypertension or fluctuating BP, tachycardia, incontinence (retention/obstruction), muscular rigidity (may be confined to head and neck), confusion, agitation or loss of consciousness. |
| **Akathisia** | Review antipsychotic choice, consider propranolol 30-80mg/day prn in 2-3 divided doses (caution with asthma, bradycardia hypotension) or benzodiazepines e.g. diazepam 5-15mg/day prn in divided doses |

**Appendix G**

# Non-Contact Physical Health Observation Guidance and Assessment tool

(adapted from Southern Health NHS Foundation Trust)

Health and Social Care in Northern Ireland

**Use addressograph or write in CAPITAL LETTERS**

**Surname:** ……………………………………….

**First names:** …………………………………….

**H&C number:** …………………………….

**DOB:** ……………………. Check Identity

## Circumstances when use of Trust Standard Observations Chart (SOC) is not possible:

When taking a full set of physical observations is ***NOT*** possible or considered to pose significant risk to the patient and/or staff. For example:

- It is not safe to approach the patient
- Approaching the patient may cause significant distress or antagonise the situation
- The patient declines physical observations (the rationale for taking physical observations must be explained to the patient if appropriate)

**The use of the non-contact observations assessment tool must be documented on the SOC and a summary for the rationale of this made in the patients progress notes or clinical system**

## If it is not possible to undertake a full set of physical observations using Trust SOC you should still:

- Record respiratory rate if possible on Trust SOC
- Record Conscious level on Trust SOC
- Note on Trust SOC chart that Non-Contact physical observation assessment tool is being used
- Record in the patients progress notes or in the clinical system, the reason that the Non-Contact physical observation is being used

## Use the assessment tool overleaf to record the Non-Contact observations following the ABCDE structure

If any red box statements are true, the patient MUST be escalated to a doctor and a full ABCDE assessment should be undertaken based upon clinical judgement. Medical team/999 must be contacted if required.

**Differentiating between unconsciousness and sleep:**

- Being asleep is not the same as being unconscious
- If someone is asleep we would expect then to occasionally change position while sleeping and to have a normal complexion for them
- If you are concerned the patient is not sleeping and may be unconscious refer to the Nurse in charge and/or medical team and undertake a full Glasgow Coma Scale (GCS) assessment of conscious level

# Non-Contact ABCDE Assessment Tool

## Ensure that observations are repeated every 15mins for 1 hours post intramuscular injections

Utilise the ABCDE guidance below to assess the patient and document in the table below

**If any RED box statements are true the patient MUST be escalated to an doctor and a full ABCDE assessment should be undertaken.**

**Medical team/999 MUST be contacted if required.**
**DO NOT leave the patient.**

**Use addressograph or write in CAPITAL LETTERS**

**Surname: ……………………………………………**
**First names: ……………………………………….**
**H&C number: ……………………………….**
**DOB: …………………….** Check Identity

| | |
|---|---|
| **Airway** | Talking (not just moan and groans)<br>Airway clear- including when asleep |
| **Breathing** | Breathing is quiet and regular<br>Respiratory rate 12-10 breaths per minute |
| **Circulation** | Mobility normal for the patient<br>Presenting as normal<br>If asleep, monitor movement<br>Warm skin, normal colour for patient<br>Comfortable presentation |
| **Disability** | Alert<br>Drinking and eating as normal<br>Active |
| **Exposure** | No signs of injury, bruising, bleeding or rashes. |

| | |
|---|---|
| **Airway** | Airway obstructed? Silence? Coughing? Swelling? Gurgling?<br>If awake can they speak(not just moans and groans)<br>Risk of vomiting? Consider moving onto their side and carry out constant observations to prevent choking/aspiration if there is a risk of vomiting |
| **Breathing** | Noisy or difficult breathing even with open airway<br>Respiratory rate less than 12 or more than 20 breaths per minute<br>Shallow rapid breathing pattern<br>Struggling to breath (using additional muscles and working hard)<br>Abnormal breathing sounds? Stridor? Wheeze? Gurgling?<br>**Consider asthma, COPD, intoxication and has rapid tranquillisation been used?** |
| **Circulation** | Change in ability to mobilise<br>Flushed? Pale? Sweaty? Clammy?<br>Mottled? (purplish discolouration to skin)<br>Central cyanosis (blue tinge to lips, tip of nose or ear lobes)<br>Ashen (grey discolouration to skin)<br>Trauma/significant bleeding |
| **Disability** | Unresponsive<br>Unexpected sleepiness, drowsiness, confusion or fitting<br>Responsive to voice, pain or unresponsive<br>**Consider diabetes or epilepsy** |
| **Exposure** | Abnormal shuffling or unsteady gait<br>Muscle rigidity **THINK NMS**<br>Signs of dehydration: dry cracked lips not passing urine.<br>Signs of physical injury/bleeding/rash<br>Signs of infection: **THINK SEPSIS** |

## Record of Non-contact Physical Health Observations

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| If any RED statements are triggered tick relevant ABCDE box below. Document your concerns in the larger box provided (include when and who the patient was escalated to, what support was started, alterations to monitoring and outcomes of review). | | | | | | | | Name, Signature and role |
| Date | All green statements (circle if true) | A | B | C | D | E | | |
| Time | | | | | | | | |
| Date | All green statements (circle if true) | A | B | C | D | E | | |
| Time | | | | | | | | |
| Date | All green statements (circle if true) | A | B | C | D | E | | |
| Time | | | | | | | | |
| Date | All green statements (circle if true) | A | B | C | D | E | | |
| Time | | | | | | | | |

GREEN PARK HEALTHCARE TRUST

# POLICY AND PROCEDURAL ARRANGEMENTS

## RELATING TO

## DEALING WITH VIOLENT BEHAVIOUR AND RESTRAINT

**This policy was formally approved by:**
**Green Park Healthcare Trust in: November 2005**

Signed: ______________
Miss Hilary Boyd
Chief Executive

**Review Date:** November 2006

**(signed copies are held in the Clinical Governance Department)**

Version 3, November 2005

# GENERAL POLICY STATEMENT

The aim of the policy and guidance is to ensure a consistent approach to the management of physical violence aggression, verbal abuse and restraint across the Trust whilst recognising the requirement for differentiation across clinical and non-clinical environments.

This refers to carers/staff and visitors/staff incidents involving patients, patients/staff, it seeks to demonstrate the Trust’s commitment to its staff on the issue of violence in the workplace. The policy outlines methods to ensure that restraint is only used as a last resort for patients and most significantly to ensure that any restraint episode can be undertaken safely from the perspective of both staff and patients. In addition, the Trust has a duty of care not only for patients, but for staff who may through the nature of their work be victims of physical attack or verbal abuse.

There are a number of overall guiding principles for restraint and dealing with violent behaviour:
The patient's dignity and autonomy should be respected at all times. Violent incidents should be prevented where possible and risk assessments carried out. The risk of physical injury should be minimized. Physical restraint should only be used when all other alternatives have been ineffective or are not reasonably practical. The means of restraint used should be the least intrusive and restrictive possible in the circumstances. Agreed procedures must be followed and incidents documented at all times.

Staff should be aware that incidents involving violent or aggressive behaviour towards patients, and/or staff will be investigated with under the Trust’s disciplinary procedures.

Visitors who fail to comply with required standards of behaviour will result in the security staff and the line manager/night co-ordinator being contacted and asked to intervene.

Any visitor continuing to behave in this manner will be asked to leave the site. Failure to do so will result in the PNSI being contacted. Continued breach of the policy will result in the Trust seeking legal advice and if necessary issuing an injunction against the offending party.

“The Trust will enforce or seek the application of fixed penalties available in law. The Trust will prosecute all perpetrators of crime on or against Trust property, asserts or staff.

A number of legal considerations exist in relation to violence and restraint. These responsibilities are defined by the Health & Safety at Work (NI) Order 1978 (as amended) and the Management of Health & Safety at Work Regulations (NI) 2000 which require the Trust to assess the risks to the Health & Safety of their staff. (See Appendix IV for a risk assessment tool)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 state that the Trust must report cases in which staff have been off work for 3 days or more following a non-consensual act of physical violence assault which has resulted in injury or resulted in a major injury. The Clinical Governance Department (who co-ordinates RIDDOR reporting) should be advised of all such absences. Violent incidents are also reportable to the DHSS&PS.

The Safety Representatives and Safety Committees Regulation (NI) 1979 (as amended by the Management of Health and Safety at Work Regulations (NI) 2000 as amended) and the Health and Safety (Consultation with Employees) Regulations (1996) requires the Trust to consult with safety representatives and employees on health and safety matters.

'The Mental Capacity Act 2005 (Appendix IV) governs decision-making on behalf of adults, where they lose mental capacity at some point in their lives or where the incapacitating condition has been present since birth.'

**The Human Rights Act (1998)**

The Act has implications for the way the restraint is planned, implemented and recorded.

Human Rights judgements are made on a case-by-case basis but to date decisions have broadly centred around: -

- Evidence that Human Rights issues have been considered by organisations
- The need for clear record keeping
- The need for individual risk assessments with associated care plans

Human Rights law involves balancing the different rights an individual enjoys e.g. It is possible the right to life could conflict with the right to liberty.

A list of the Articles can be found in Appendix X

# Definitions

## Violence

Any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment' (HSAC).

## Aggression

An assertive force which may be expressed through attitude or behaviour and is usually directed to external objects, though it may be turned inward, as reflected in self destructive behaviour". Aggression can be expressed physically or non-physically (Robinson, 1983).

## Physical Restraint

Restraint is defined as restricting someone's liberty.
Methods of restraint include:

Cotsides, side rails, baffle locks
Arranging furniture to impede movement
Chairs whose construction immobilises patient

These items should not intentionally be used as a form of restraint as opposed to a safety measure. Reasons for choice should be documented as part of an individual risk assessment.

Circumstances may arise where members of staff are required to perform physical restraint on an individual.

Drugs may also be used to restrict liberty in certain circumstances, sometimes referred to as chemical restraint.

## Responsibility for Implementing the Policy

The ultimate responsibility for ensuring the Health & Safety of our staff and others who may be affected by the Trust's work activities rests with the Chief Executive. The Director of Nursing and Clinical Effectiveness (as lead Director for Health & Safety) will be responsible for co-ordinating compliance with the procedural arrangements, as detailed in this policy. However, this responsibility, as for other health and safety issues, cascades down through the Line Management structure to Heads of Departments/Line Managers, and to all staff, who should familiarise themselves with this policy on dealing with Violent Behaviour and Restraint.

### Staffs' Responsibilities

The health care professional's role is socially valued precisely because it involves the alleviation of suffering in vulnerable people and the promotion of their autonomy and self-determination. However, restraint implies the violation of other socially and professionally valued aspects of the helping relationship, such as the promotion of the client's dignity, autonomy and self-determination. This may appear to be the case even if restraint is performed to preserve life and to prevent suffering after other means of stopping the dangerous and potentially life-threatening behaviour have failed.

Good clinical decision-making is required at all times and steps taken to respect the person's dignity and autonomy as much as possible.

Staff should ensure that they:

- Clearly document the reason for and type of restraint used.
- Regularly update, amend and evaluate the plan of care.
- Inform other team members of patients who are to greater risk of displaying violence and aggression and ensure the need for increased supervision is recognised.
- Report all violent aggression and verbally abusive incidents accordance with the Trusts Accident/Incident Policy.
- Ensure co-operation with the Ward Manager and relevant staff in the investigation of all accidents.

- Consult with relatives about the use of physical restraint or increase in sedative medication as soon as possible.

- Assess a patient using a Falls Prevention Assessment Tool (see Appendix for copy) prior to planning care in relation to maintaining safety.

**Staff NO NOT have an obligation to place them in danger. Withdrawing from a situation and contacting the line manager may be the most appropriate course of action.**

## Procedural Arrangements A

The responsibilities of the Ward/Department Managers (including contracted Services) are to ensure that the following points are implemented;

1. To undertake and document a risk assessment for each patient at risk of being violent as part of the admission process.
   This includes those with physiological conditions predisposing them to violence or patients with a history of violent behaviour. There should be a multi-professional approach in establishing this. Patients may become violent or aggressive for a wide range of reasons.

2. To follow the guidance on “Mental Capacity Act 2005”; See Appendix IV. This relates to behaviours not caused by the patients clinical condition.

3. To identify and assess the risk of violence from other potential aggressors. Each visitor, contractor, out-patient or relative visiting the hospital will have their own individual needs, anxieties and expectations. Tension may be released in terms of anger, and possibly violence, towards staff or others they encounter. Factors such as waiting times for an appointment, perceived queue-jumping, bad news and inadequate information can all increase the risk of conflict and aggression.
   The purpose of assessing the risk of violence is to identify how and why conflict can occur and consider what measures can be taken to reduce the risks of such events within the workplace.

4. To devise implement and evaluate a plan of care, appropriate to the patient's risk status.

5. To keep the multi-disciplinary team informed that a patient is at risk of displaying violence and aggression.

6. To report incidents involving patients, visitors and other aggressors on the Trust's Incident Report Form in accordance with the Trust’s Accident/Incident Policy.

7. To fully investigate all accidents/incidents and to introduce preventative measures to prevent a recurrence.

8. To identify the root causes of the violence aggression and ensure that these are eliminated a far as possible.

9. To identify training opportunities for staff who may be in situations of conflict. The response of staff to situations involving aggression may be influenced by factors such as workload, stress, illness, confidence and experience. When long hours are worked or a heavy workload is undertaken, staff may feel under increased stress. It is important to consider the needs of new or agency staff who may not be aware of the activities of the department. Inappropriate expectations can also lead to conflict. Managers should identify training opportunities for staff who face situations of conflict. Training may relate to dealing with stress, diffusing aggression and customer care skills.

   Staff training in relation to the management of violence and restraint is an important factor. All staff who work within health and social services are at some degree of risk from violence. However, the level of exposure to this risk varies according to the nature of their work.

   In order to assess the level of training required, staff should carry out a general risk assessment, as required by the Management of Health and Safety at Work Regulations (NI) 2000. This will be based on the nature and area of their work. Managers must hold a record of this risk assessment and consider any training needs identified in accordance with the Trust's Training Policy.

   This may include: De-Escalation Strategies, Breakaway Techniques and Restraint Techniques

   Relevant courses can be found in the The Beeches Management Centre and Nursing and Midwifery Education Programme Brochure or by contracting the Nursing Education Facilitators or the Trust's Training and Development Manager.

10. To ensure that staff are aware of how to deal with a potentially violent situation. (Refer to Appendix I, Appendix II and III).

    Once a violent incident has occurred, medical personnel should be informed if a medical intervention is required. Some staff should be delegated to attend to the needs of remaining patients (particularly those who may have witnessed the incident).

    Following the incident, staff should be given the opportunity to discuss their feelings about what happened. This should take place as soon as possible after the incident has been resolved and with as many of the staff concerned as possible. This should initially be within the staff member's own department, but staff should be made aware of the services offered by the Trust's Occupational Health Department and support offered by Trade Unions and Professional Bodies

Discussion should not be focused on any person's performance, but address the effects on them as individuals. Staff injured as a result of their involvement in the incident may be entitled to industrial injuries benefit or a payment under the criminal injuries compensation scheme and will need to be informed of their rights by the appropriate body. Consideration must be given to the risk of infection in cases where injury has occurred. Staff should receive continuing support when returning to work after a violent incident.

The reporting of incidents / near misses through the Trust's Accident/Incident reporting procedures must always be followed.

Managers should record any interventions offered to staff members in their personal file.

11. To develop a local policy/procedure in relation to your own ward/department where relevant. (See Appendix V, VI, IX).

## Procedural Arrangements B

The responsibilities of Medical Staff are to ensure that the following points are implemented;

1. To review current medication and consider its contribution to the patient's psychological state.

2. To review the medication used for sedative purposes in accordance with the needs of the patients.

Medications for patients must only be given when prescribed by a doctor.

In circumstances when a doctor is not available to write up oral, rectal, topical, intra-muscular or intravenous medications in sufficient time to meet a patient's needs, it is possible to administer an emergency medication using the following procedure:

Following a medication order received from a doctor via the telephone the guidelines for which are contained in the Nursing Policies Manual and must be strictly adhered to. See Nursing Policy on Staff Receiving Drug Orders from Doctors via a Telephone.

Following the Policy on Nurse Prescribing for Standing Orders contained in the Nursing Policies Manual.

Controlled drugs are not permitted to be given in an emergency situation unless they have been prescribed by a doctor in writing for that particular patient.

Any occasion when emergency medication is administered should be clearly documented in the patient's case notes.

3. To include relatives in the decision making process regarding the use of restraint, where appropriate (reference: GMC: Good Practice Guidelines on consent 2004)

4. To ensure that following an incident, the patient is examined and details recorded in the patient's notes.

## Appendices

**Appendix I**

Interventions/Alternatives to Physical Restraint.

**Appendix II**

General Advice to staff faced with a potentially violent situation.

**Appendix III**

General procedures on Restraint

**Appendix IV**

Mental Capacity Act 2005

**Appendix V**

Child & Family Psychiatry and General Children’s Wards: Policy and Procedure for Restraint

**Appendix VI**

Policy and Procedure for the use of Cotsides and Side Rails

**Appendix VII**

Falls Risk Assessment Tool

**Appendix VIII**

Violence Risk Assessment Checklist

**Appendix IX**

Care of the Elderly – General Management Guidelines

**Appendix X**

Human Rights Articles

## Appendix I

## Interventions/Alternatives to Physical Restraint

The following table categorises different interventions and actions that could be taken as an alternative to restraint.

| OPTIONS | STRATEGY |
|---|---|
| **PHYSICAL INTERVENTIONS** | Escort or guide patient from the situation (or reduce stimulation).<br>Increase staff observation<br>Toilet regime as per patients schedule<br>Offer snacks and beverages<br>Pain relief<br>Repositioning<br>Ensure good body temperature<br>Monitor lab values and vital signs<br>Undertake a falls risk assessment<br>Provide rest periods (reduce impact of fatigue or irritability)<br>Provide opportunity to exercise<br>Comfortable clothing |
| **EMOTIONAL SUPPORT** | Encourage families/friends to sit with the patient<br>Orientate patient<br>Deal with patient complaints immediately (as soon as possible/ explain any delay)<br>Staff to stay with patient if warranted<br>Explanation to be given to all patients before therapeutic intervention / establish whether person is able to understand staff requests<br>Active listening and attention to concerns and feelings |
| | Respect personal space / avoid entering personal space unless absolutely necessary<br>Provide reassurance<br>Alternative therapies such as aromatherapy, music or diversional therapy / facilitated relaxation |
| **ENVIRONMENTAL CHANGES** | Room change<br>Lower bed<br>Close proximity to nursing station<br>Provide access to telephone<br>Reduce noise level<br>Reduce light level<br>Bedside commode<br>Buzzer within easy reach<br>Bed/chair sensors<br>Familiar comforting belongings<br>Visual cues to bed area<br>Pin call bell to clothes<br>Orientation / Reality links (clock / TV / radio) |
| **MEDICATION** | Monitor all drug side effects and have a multi-disciplinary evaluation of medication regime on patient's physical and cognitive capabilities |

## Appendix II

## GENERAL ADVICE TO STAFF FACED WITH A POTENTIALLY VIOLENT SITUATION

1. Remain calm, confident and objective.

2. Avoid physical intervention if possible. Talking and listening should be the first line of approach.

3. Physical restraint is justified only if the person is behaving in a manner likely to result in injury to themselves or another person.

4. Any physical force used should be minimal and in proportion to the violent situation. Try to avoid provoking aggressive reaction.

5. If physical violence is being displayed, consider using the following resources:

   Your colleagues
   Hospital Security
   Police, Telephone 999 via switchboard

6. If you are alone, you should avoid physical intervention until adequate assistance has been obtained. If immediate physical contact is unavoidable, breakaway techniques should be used if you have received training on this. **NB:** Staff who have a physical condition which prevents them from performing a breakaway technique, such as a back injury or pregnancy, should summon help at the earliest opportunity. If a staff member has a physical condition (temporary or permanent) that prevents him or her from participating in a restraint episode as part of a team, they should inform their line manager.

7. Ideally, a risk assessment of the situation should be made before taking action.

8. The duty doctor or other medical staff should be contacted immediately to consider medical intervention.

9. If physical restraint is used, members of staff who have been trained in restraint techniques should co-ordinate and time the restraint episode.

10. If limbs have to be held they should be grasped near a major joint in order to reduce the danger of fracture of dislocation. Under no circumstances grip the head, throat or fingers.

11. Only restraint moves that have been taught on an approved course should be used.

12. During the restraint episode, the restraint co-ordinator should continue to talk to the person in a calm voice, answering any questions.

13. After the violent episode, staff should be given an opportunity to debrief. Appropriate support should be offered to staff.

14. Any patients who have witnessed the violent episode should also be given the opportunity to debrief.

15. All violent, or potentially violent incidents should be documented on the Trust's Incident / Accident, Near Miss Form, which must be forwarded to the Clinical Governance Department at the earliest opportunity. The incident should also be reported to the appropriate line manager, General Manager and / or Clinical Director. The patient’s Consultant Physician should be informed of the incident.

# Appendix III

## General Procedures for Restraint

### Indications for Restraint Use

The Trust has a duty to take reasonable and precautionary measures to protect patients from injury, when because of physical or mental disability they are unable to protect themselves.

Physical restraint should only be considered when it is appropriate to protect the patient or member of staff in an unsafe situation. These include:

1. Safety of the patient to protect him/herself from injury

2. Behaviour management of a patient who is aggressively dangerous to self or others.

Prior to using a form of restraint to maintain safety, the patient's physical and psychological condition should be assessed to establish possible alternative measures to ensuring patient safety.

### Decision to use Physical Restraint

In the situation where a form of physical restraint has been used, details of the reasons for this decision and the type of restraint to be used must be clearly documented in the patient's records.

If the staff member decides that a physical restraint approach to care is warranted, then he / she will make every reasonable effort to discuss this approach with the patient and their alternative decision-maker. The staff member will document that this information has been given.

In an emergency situation i.e. where there is significant risk or anticipated risk to the patient, the staff member may make the decision to use physical restraints without informing the patient or alternative decision-maker. This decision must be documented, outlining risk, situation and details of the approach used.

## Appendix IV

## Mental Capacity Act 2005

PERSONS WHO LACK CAPACITY

### The principles

1. The following principles apply for the purposes of this Act.
2. A person must be assumed to have capacity unless it is established that he lacks capacity.
3. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
4. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
5. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
6. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

**Appendix V**

## Child & Family Psychiatry, General Children's Wards and Forest Lodge: Policy and Procedure for Restraint

Physical restraint is permitted when staff have good grounds for believing that immediate action is necessary to prevent a child significantly injuring themselves or others or causing serious damage to property. In such situations staff are acting to avert immediate damage or injury to a person or property. Staff must be clear that any other course of action is likely to fail.

Staff should take steps to advance the need for restraint e.g. through diversion and discussion. The child should be warned that physical restraint may be used unless the child stops the dangerous behaviour.

**Only appropriately trained staff should restrain and newly appointed or agency staff should only restrain in collaboration with experienced staff.**

There must be at least two members of staff restraining and one person identified as the co-ordinator who will give instructions and talk to the child.

If at all possible one member of staff should be the same sex as the child.
The nurse in charge of the shift should be notified that restraint is taking place.

When restraining staff should be aware of safe practice:

- Holding major limbs, not joints, only the minimum force necessary to prevent injury or damage should be applied.
- Checking airway and breathing regularly
- Avoidance of friction burns
- Awareness of any medical conditions that may increase risks e.g. diabetes, asthma, obesity, epilepsy
- The child's face should always be to the side, not face down

The co-ordinator must maintain calm interactions with the child. All statements should be short and in age appropriate language. Confrontations should be avoided.

Staff should be aware of their own feelings and emotions caused by the event and ask to be relieved if necessary. Staff should not feel that they need to see the incident through to its conclusion.

If restraint is lasting longer than 15 minutes there should be regular change over of staff and a new co-ordinator identified each time.

If restraint is lasting longer than 30 minutes, senior members of the multi-disciplinary team should be contacted to see if another intervention might be beneficial. The duty doctor and consultant should also be contacted. The duty doctor should be contacted at any time if staff have more immediate concerns.

If it is not possible to restrain a child away from other children, the other children should be moved from the sight of the restraint.

As soon as it is safe, restraint should be gradually relaxed to allow the child to regain self-control.

When the child is calm he/she should be given the opportunity to talk through the event, including why it was thought necessary to restrain him/her.

The child's parents or those with parental responsibility should be informed as soon as it is practically possible.

Every episode of restraint should be recorded in the child's notes indicating clearly the problem behaviour, reasons restraint was applied and positive and negative outcomes, and the subsequent discussion with the child. A Trust Accident/Incident form should also be completed.

Restraint episodes will have an effect on the other children. Staff should be available to contain and reassure them.

Staff should have the opportunity to debrief.

Pre-admission meetings should always include discussion of ward policies including restraint. Parental consent for the application of Trust policies should always be sought at the pre-admission meeting.

# Appendix VI

## Policy and Procedure for the use of Cotsides and Side Rails

Cotsides and side rails should only be used at the discretion of the health professional in charge of the ward. The rationale for this decision should be clearly recorded in the patient's care plan. The rights and dignity of the patient must be respected at all times.

The type of patients who may be suitable candidates for receiving the protection offered by cotsides is limited. Examples are listed below:

1. The patient with a disability e.g. cerebral vascular accident, amputation of limb, brain tumour, spinal cord compression, who in some circumstances may be unable to prevent themselves from falling out of bed.
2. The confused, restless patient.
3. The semi-or totally unconscious patient.
4. Children who require the protection of cotsides for reasons agreed by their care team.

The risks faced by the patient if cotsides or side rails are not used should be clearly recorded in the patient's care plan.

When cotsides or side rails are used, certain precautions and conditions should be met:

1. The use of cotsides or side rails must be reviewed on a regular basis with a time-scale specified in advance.
2. The purpose and rationale of the decision to use cotsides or side rails should be where possible, explained to the patient and their carers.
3. The use of safety pads with cotside or side rails should be considered to minimise the possibility of injury.
4. The bed must be left in a lowered position at all times when the patient is not directly supervised.
5. The bed must be in close proximity to the nurse's station, thus ensuring the patient is under close observation.

Before making the decision to use cotside or side rails there are some factors which should be considered:

1. Cotside or side rails may impede rehabilitation. This may be physical in that they restrict movement, or psychological as they encourage patient dependence.

2. Cotside or side rails can impede urgent attention. Access to the patient can be curtailed by the existence of these barriers.

3. Cotside or side rails are considered a form of restraint. Unnecessary restraint is likely to be a breach of the patient's human rights under the Human Rights Act (1998). It is vital that the use of cotside or side rails must therefore be justified as in the best interests of the patient.

4. Cotside or side rails may make a patient's fall more hazardous. They might simply increase the height from which the patient might fall, thereby increasing the likelihood of serious injury.

5. Cotside or side rails do not settle a restless patient. They might simply make the patient more unsettled and increase the likelihood of an accident.

Before deciding to use cotside or side rails, the following alternative strategies and actions should be considered:

1. Investigate the cause of the patient's restlessness e.g. pain, discomfort, wet bed, toilet needs. The resolution of these issues may make cotside or side rails unnecessary.

2. It may suffice to keep the bed lowered, thus reducing the chance of serious injury.

3. Keep the bed in close proximity to the nurse's station thus ensuring the patient is under close observation.

Provide a floor mattress, thus avoiding the chance of serious injury.

# Appendix VII

## Falls Risk Assessment

## Falls Risk Assessment Tool

| **Assessment Criteria** | | Score | Date:<br>Sig: | Date:<br>Sig: | Date:<br>Sig |
|---|---|---|---|---|---|
| HISTORY OF FALLS (in past 6 months prior to admission) | More than one fall | 3 | | | |
| | First time Fall | 2 | | | |
| | Never | 0 | | | ` |
| HISTORY OF FALLS WHILE IN HOSPITAL (Assessed by Nurse) | Three or more falls | 5 | | | |
| | One-two falls | 2 | | | |
| | No falls | 0 | | | |
| SAFETY AWARENESS (Assessed by Nurse) | No Safety Awareness | 5 | | | |
| | Variably Safety Awareness | 2 | | | |
| | Demonstrate Safety Awareness | 0 | | | |
| MENTAL STATE (Assessed by Ots) | Severe Cognitive impairment – 0-2 | 3 | | | |
| | Moderate Cognitive Impairment – 3-5 | 2 | | | |
| | Mild Cognitive Impairment – 6-8 | 1 | | | |
| | No Cognitive Impairment – 8-10 | 0 | | | |
| PRESENT LEVEL OF MOBILITY AND TRANSFERS (Assessed by Physio) | Supervision of 1-2 | 4 | | | |
| | Assistance of 1 | 3 | | | |
| | Assistance of 2 or more | 2 | | | |
| | Immobile (hoist) | 1 | | | |
| | Independent | 1 | | | |
| FOOTWEAR – After modification (Assessed by Physio) | Unsafe | 3 | | | |
| | Safe | 0 | | | |
| BALANCE STANDING (Assessed by Physio) | Supervision of 1-2 + or – Aids | 5 | | | |
| | Assistance of 1 + or – Aids | 4 | | | |
| | Assistance of 2 or more + or – Aids | 3 | | | |
| | Unable to stand | 2 | | | |
| | No problems standing | 0 | | | |
| BALANCE SITTING (Assessed by Physio) | Balance problem identified | 1 | | | |
| | No balance problem identified | 0 | | | |
| PATIENT'S VISION (Assessed by Nurse) | Visually impaired (registered) | 3 | | | |
| | Correctable visual problems (reluctant to wear glasses) | 2 | | | |
| | Correctable visual problems (wears glasses) | 1 | | | |
| | No visual problems | 0 | | | |
| ELIMINATION (Assessed by Nurse) | Frequency of elimination | 1 | | | |
| | No identified problems | 0 | | | |
| MEDICAL CONDITIONS (More than one can be selected) (Assessed by Nurse) | Neurological problem identified | 2 | | | |
| | H/O Cardiac conditions | 1 | | | |
| | H/O Hypertension | 1 | | | |
| | H/O Respiratory Conditions | 1 | | | |
| | H/O Alcohol abuse | 1 | | | |
| | H/O Recreational drugs | 1 | | | |
| | H/O Syncope or pre-syncope | 1 | | | |
| | No identified conditions | 0 | | | |
| MEDICATIONS (Assessed by Nurse) | Diuretics | 1 | | | |
| | Anti-Hypertensive | 1 | | | |
| | Neuroleptics | 1 | | | |
| | Sedatives | 1 | | | |
| | On more than 7 Medications | 1 | | | |
| TOTAL SCORE | | | | | |
| DOCUMENT RISK CRITERIA (Low, Moderate, High or Very High) | | | | | |

**Appendix VII - Continued**

## COMMUNICATION WITH RELATIVES REGARDING RISK OF FALLS

Date: …………………………………………..

The relatives of ……………………………. have today been informed of our concerns to his/her well-being due to his/her present lack of safety awareness, despite staff's best efforts to prevent future falls or injury

Name of Next of Kin ………………………………………….

Informed by:
In Person ☐
Telephone ☐
Other ……………………………….

Staff signature and Grade …………………………………..

Relatives signature …………………………………..
(If possible)

Please indicate why relatives signature not available

**Appendix VIII**

# Violence Risk Assessment Checklist

## RISK ASSESSMENT CHECKLIST

1. Brief Medical History (any particular indicators of behavioural difficulties during acute management).

2. Premorbid adjustment and coping (how was the patient before he was injured).

3. History of mental health difficulties including harm to self, harm to others, significant damage to property.

4. Pre-injury history of violence and aggression.

5. Current functional skills and abilities.

6. Current behavioural difficulties (including duration and frequency)

7. Antecedents/triggers.

8. What previous or current behaviour management approaches have been adopted?

9. Possible/potential environmental changes.

10. Staff approach advised.

**Signature:** ___________________________

**Date:** ________________

**Team Members present:** ____________________________

____________________________

## Appendix IX

## Care of the Elderly

## General Management Guidelines

Where patients are admitted to the Care of Elderly wards with a diagnosis of Dementia or acute confusion, the following advice is offered to all staff in terms of day-to-day management.

It is advisable that all staff working with particular patients are aware of an individual's present and past medical history, including premorbid adjustment and coping abilities.

In the acute phase, patients are often confused and disorientated. During this phase patients are more likely to have potential aggressive/violent outbursts. Aggressive outbursts can also occur where levels of sedation and/or pain medication are being systematically reduced.

The following general principles for effective management should in the first instance be employed prior to seeking additional behavioural management advice:

- Avoid over-stimulation (limit sources of noise or distraction within the environment).
- Use clear, precise communication - limit information. Repeat instructions.
- Orientate person to task or activity. Provide an explanation of the task or therapy to be undertaken. Ensure that the explanation for the therapy or task is clearly understood by the person.
- If there are signs of confusion, agitation or anxiety, attempt to provide appropriate level of reassurance or facilitated relaxation (breathing control).
- Consider any indicators of anxiety, pain, fear, confusion/agitation in the presenting patient.
- Analyse for potential risks of aggression in the care task activity to be undertaken.
- Be proactive and plan ahead in order to minimise potential risks.

- During care tasks/therapy provide clear and consistent approach in order to maximise patient involvement with the care task/therapy activity. Break task down into short achievable components where possible.

- Provide appropriate level of reward as often as necessary in order to indicate success to the individual patient.

- Ensure regular rest breaks before, and on occasions during, therapeutic activities in order to minimise the effects of fatigue upon performance.

- Where appropriate, attempt to ignore unwanted behaviour and redirect individual patient to an alternative task or a quiet area unless an individual patient's safety is at imminent risk.

- Ensure that all incidents of verbal or physical aggression are recorded as accurately as possible and as soon as practicable after the incident concerned.

- It is recommended that an increase or escalation in the frequency or severity of incidents should be subject to review, in conjunction with the full multidisciplinary team, as soon as practicable.

Following violent aggressive incidents staff members involved in such incidents should be made aware of provision of support by Line Management, Occupational Health or other informal channels. It is recognised that during such incidents staff may be distressed and may require either formal or informal supportive debriefing as a result.

Generally it is advisable for individual staff members to talk over their responses or reactions and involvement in such incidents with another trusted member of staff/Line Manager. Additionally it is important for both the individual's safety, and members of the public as well as staff, to put in place a realistic way of managing/minimising further physical aggression in the likelihood that such similar incidents could occur into the future.

## Appendix X

## HUMAN RIGHTS

The following are the articles and protocols of the Human Rights Act 1998

| | |
|---|---|
| Article 2 | Right to life |
| Article 3 | Right to freedom from torture, inhuman or degrading treatment or punishment |
| Article 4 | Right to freedom from slavery, servitude & forced or compulsory labour |
| Article 5 | Right to liberty & security of person |
| Article 6 | Right to a fair & public trial within a reasonable time |
| Article 7 | Right to freedom from retrospective criminal law & no punishment without law |
| Article 8 | Right to respect for private & family life, home and correspondence |
| Article 9 | Right to freedom of thought, conscience & religion |
| Article 10 | Right to freedom of expression |
| Article 11 | Right to freedom of assembly & association |
| Article 12 | Right to marry & found a family |
| Article 14 | Prohibition of discrimination in the enjoyment of the convention rights |
| Article 1, 1st protocol | Right to a peaceful enjoyment of possessions & protection of property |
| Article 2, 1st protocol | Right of access to education |
| Article 3, 1st protocol | Right to free elections |
| Article 1, 6th protocol | Abolition of the death penalty |

## References

Drummond, D.J. (1989). Hospital Violence Reduction Among High-Risk Patients. Journal of American Medical Association, 261 (17), 2531-4.

RCN (1998). Dealing with Violence Against Nursing Staff: An RCN Guide for Nurses and Managers. Royal College of Nursing, London.

Royal Marsden Hospital (1999). Violence at Work Policy. Royal Marsden Policy, London.

Stuart, G.W. & Sundeen, S.J. (1991). Principles and Practice of Psychiatric Nursing. 4th edn. Mosby. St. Louis.

Report of the violence to staff working Group DHSSPS December 2002

Violence and Aggression to staff in Health Services [1997] Guidance on Assessment and Management, Health and Safety Commission.

General Practice Guidelines on Consent, General Medical Council,

## Members of the Trust's Zero Tolerance Group

| | |
|---|---|
| Miss Patricia O'Callaghan | Director of Nursing<br>& Clinical Effectiveness |
| Mrs Karen Cunningham | Health & Safety Manager |
| C/N David Eakin | Ward 4, FGH, Staff Side Representatives |
| Mrs Sylvia Gallagher | Directorate Manager |
| Ms Nancy Scott | ISS Mediclean/Security Forum Representative |
| Mr Colin Jackson | Equality Manager |
| Sr Laurie Jones | Children's Orthopaedic Ward Manager, Staff Rep |
| Mr Patrick Keenan | Clinical Risk Manager |
| Dr Suzanne Maguire | SCIU |
| Mrs Jacqueline McGarry | Senior Social Worker |
| Sr Bernie McGurk | Occupational Health Department |
| Vacant | Complaints and Patient Liaison Manager |
| Mr Robin Arbuthnot | Deputy Director of Personnel AHP<br>Acquired Brain Injury Representative |
| Mr Colin Wilson | Neuro-Psychologist |

## Review of the Policy

The Trust will regularly review compliance with this policy and annually review this policy in Consultation with the Trust's Health & Safety Committee.

5.1 19.007

Belfast Health and
Social Care Trust

| | |
|---|---|
| TYPE OF DOCUMENT | ☐ Trust Procedure for approval by Trust Procedure Committee<br>☐ Patient based standard, guideline or procedure for approval by Standards and Guidelines Committee |
| TITLE | **Use of Physical Intervention by staff from Mental Health and Learning Disability services** |

| | |
|---|---|
| **Summary** | This procedure outlines what needs to be followed when a service user within mental health and learning disability services presents with aggressive or reckless behaviour which leads to risk of harm to himself/herself or others and it is deemed necessary to use a physical intervention. |
| **Purpose** | This procedure document encourages the use of positive person centred practices which support the needs of service users and emphasises preventing the need for physical interventions. The procedure gives specific guidance on situations where the use of physical interventions may be deemed essential in minimising the risk of injury or damage to either service users, their carers, the wider community or staff. |
| **Operational date** | June 2010 |
| **Review date** | June 2013 |
| **Version Number** | V1.0 |
| **Supersedes previous** | Legacy Policies |
| **Director Responsible** | Bernie McNally |
| **Lead Author** | Petra Corr |
| **Lead Author, Position** | Service Manager |
| **Additional Author(s)** | |
| **Department / Service Group** | Mental Health and Learning Disability |
| **Contact details** | *Mairead Mitchell, Senior Manager, Service Improvement and Governance. Telephone: 028 90 802826*<br>*Email:* [redacted] |

17 months to complete.

| | | | |
|---|---|---|---|
| Author (s) | Approval | 25/05/10 | V1.0 |
| Procedure Group | Approval | 28/05/10 | V1.0 |
| Governance | Sign Off | 28/06/10 | V1.0 |
| | | | |
| | | | |
| | | | |

## Approval – Local Procedures

| Date | Version | Author | Comments |
|---|---|---|---|
| 7/10/09 | V0.1 | P Corr | Draft 1 |
| 21/10/09 | V0.2 | P COrr | Draft 2- Comments from Olive Macleod |
| 25/5/10 | V0.3 | PCorr | Following consultation across service group |
| | | | |
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| **Reference Number** | |
| Supersedes | All legacy Trust policies on use of Physical Intervention |

**Summary** *(If required)*

**Reference No:** *This is to be assigned by the relevant committee*

Title:

**Use of Physical Intervention by staff from Mental Health and Learning Disability services**

**Purpose:**

This procedure document encourages the use of positive person centred practices which support the needs of service users and emphasises preventing the need for physical interventions. The procedure gives specific guidance on situations where the use of physical interventions may be deemed essential in minimising the risk of injury or damage to either service users, their carers, the wider community or staff.

**Objectives:**

- To ensure that all uses of physical interventions are considered only after an assessment of risk that justifies its use when other options are deemed reasonably inappropriate or to have failed.
- To promote person centred practices by working in partnership with service user and their carer (as appropriate) to review available options to minimise the potential for harm
- To increase the participation of service users and significant others with members of the health and social care team in consultation, decisions and planning care regarding appropriate use of physical interventions
- To support the development of a culture which ensures the use of the least restrictive approach for the shortest period of time.
- To ensure safe and dignified access of the patient / service user to assessment, treatment and care
- To ensure least harm to patients/service users or others.
- To reduce the likelihood of unlawful use of physical interventions.

| | |
|---|---|
| **Chief Executive/ Director**<br>*(delete as appropriate)* | **Author** |
| **Date:** | **Date:** |

## Full Description

**Contents Page** *(If required)*:

"[Click here and type]" "[Click here and type]"

| | |
|---|---|
| **Reference No:** | *To be assigned by relevant committee* |
| 1 | **Title:**<br>**Use of Physical Intervention by staff from Mental Health and Learning Disability services** |
| 2. | **Purpose:**<br>This procedure document encourages the use of positive person centred practices which support the needs of service users and emphasises preventing the need for physical interventions. The procedure gives specific guidance on situations where the use of physical interventions may be deemed essential in minimising the risk of injury or damage to either service users, their carers, the wider community or staff. |
| 3. | **The scope:** |
| 3.1 | This procedure applies to all Trust staff working with people within MH and LD Services within Belfast Health & Social Care Trust including those contracted in. |
| 3.2 | Service Users in this context refers to persons who receive health and social care from the MH and LD services of the Belfast HSC Trust. The procedure applies to staff supporting service users both on and off Trust premises. |
| 3.3 | This document does not aim to address issues related to the assessment and treatment of service users which require physical contact with the individual (e.g. dental services, physiotherapy) nor does it intend to address issues related to non compliance with treatment. |
| 4. | **Objectives:**<br>• To ensure that all uses of physical interventions are considered only after an assessment of risk that justifies its use when other options are deemed reasonably inappropriate or to have failed.<br>• To promote person centred practices by working in partnership with service user and their carer (as appropriate) to review available options to minimise the potential for harm<br>• To increase the participation of service users and significant others with members of the health and social care team in consultation, decisions and planning care regarding appropriate use of physical interventions<br>• To support the development of a culture which ensures the use of the least restrictive approach for the shortest period of time.<br>• To ensure safe and dignified access of the patient / service user to assessment, treatment and care<br>• To ensure least harm to patients/service users or others.<br>• To reduce the likelihood of unlawful use of physical interventions. |
| 5. | **Roles and Responsibilities:**<br>It is the responsibility of managers within MH and LD to ensure all staff read the procedure and sign the attached recording sheet. It is the responsibility of all staff within MH and LD to follow the procedure. |

## 6. The definition and background of the procedure:

The Mental Health and Learning Disability services within the Trust expects that physical intervention procedures will generally be used with service users only when all other options have been explored and exhausted.

## 7. Procedure statements:

**7.1** Mental Health and Learning Disability services within Belfast HSC Trust affirms that physical interventions should *only* be used for the following categories of 'aggressive or reckless behaviour:-

- Aggression or violence towards self (e.g. head-hitting)
- Reckless behaviour, in which no regard is shown for the safety of either self or others (e.g. wandering across a busy road without due care)
- Aggression or violence towards others, whether directed purposely against them or not (e.g. kicking or punching other people)
- Destructive behaviour only if the action is likely to lead to harm to self or others
- Extreme and prolonged overactivity likely to lead to physical exhaustion

7.2 Physical intervention involves the use of direct physical contact or force with the express intention of limiting or restricting a person's movement or mobility and continuing to do so against resistance. Physical Intervention is therefore qualitatively different from other forms of physical contact such as manual prompting, physical guidance or support that might be used in teaching or therapy.

Physical Intervention can be described as any method of responding to challenging behaviour which involves some degree of physical force or effort being used to limit or restrict movement or effort (BILD 2004). Physical intervention can take 2 forms:

- Such contact might be ***directly from another person*** (e.g. using physical prompts to stop someone running out onto as a busy road, or holding a person's hands to prevent him/her from causing injury to self or to another individual). Generally physical intervention can be described as disengagement or restrictive physical interventions. Disengagement techniques are used by staff to protect themselves from injury and/or to escape from a service user who is holding them by their clothing or a body part. Restrictive physical interventions are used to restrict a service users movements, with the service user in a standing, sitting, kneeling, or lying position (Southcott et al, 2002)

- Alternatively, it might involve ***imposing a physical barrier*** to a person's freedom of movement (e.g. securing a door, using splints to limit the impact of a self-injurious behaviour, or seating someone in a chair with a fixed tray attached).

7.3 Predicting and Preventing Aggressive or Reckless Behaviour -The causes of aggressive or reckless behaviour are not always apparent. However, certain factors are linked to a higher chance of their occurring and due attention to these can often prevent them. It is important that staff are aware of these factors and of prevention strategies. These should be included in the persons care plan / risk management plan.

| | |
|---|---|
| | For every service user who displays aggressive or reckless behaviour, staff in MH and LD Services of Belfast HSC Trust will update the individual's records with the aim of minimising the likelihood of such behaviour reoccurring. Individualised person centred care and treatment plans and risk management plans should be drawn up and set out clearly in written form which specify any prevention strategies which should be employed, de-escalation strategies which should be used considered and giving the conditions under which physical interventions are to be used. Consideration should be given to best practice in such plans – (e.g. consideration of gender issues, other disabilities, service user views). |
| 7.4 | All Physical Interventions should be used for the shortest period of time and using the minimum level of restriction possible. |
| 7.5 | In response to unexpected episodes of aggressive or reckless behaviour, an **'emergency'** physical intervention will need to be implemented In all such cases, staff should be reasonable and proportionate and should be guided by the doctrine of necessity and in the absence of capacity to consent the best interests of the individuals involved at the time. Emergency interventions - just like those which are planned - must always be applied using the minimum amount of force for the least amount of time required, and with a view to maximising the safety of everyone involved. |
| 7.5 | No physical intervention should ever be intended or knowingly allowed to cause pain except in extreme and life threatening situations staff may need to use disengagement techniques which cause some degree of pain briefly. For example if when alternative interventions have been considered and proven ineffective, the person needs to breakaway from an attacker and the use of such a technique is deemed the only way to safely resolve an emergency. In such circumstances the members of staff involved must record and report such action through established reporting systems. The decision and action taken needs to be justified as being the minimum use of force, which is proportionate to the risk associated with that particular set of circumstances. (NIMHE 2004) |
| 7.6 | Following any use of physical intervention full details must be recorded on the relevant Use of Physical Intervention Recording Form and placed in the service user's file and reviewed as soon as possible by the member of staff's line-manager. All use of physical intervention should be discussed at review meetings with the service user and / or carer as appropriate. |
| 7.7 | The Trust expects that physical intervention procedures will generally be used with service users only when all other options have been explored and exhausted. In most circumstances, restrictive physical interventions will be used reactively. Occasionally it may be considered in the best interest of the service user to plan for the least restrictive physical intervention to be employed preventatively as part of a balanced judgement regarding likely impact of not intervening until a later stage in the escalation. |
| 7.8 | With regard to *any* form of intervention within the Trust's Mental Health and Learning Disability service, first line managers will be responsible for ensuring the following:-<br>➢ that members of staff work at all times within the law, following professional guidelines and in line with the Trust's Values and Service Principles. |

| | |
|---|---|
| | ➢ that service users needs are properly assessed and met, having due regard to the needs of carers<br>➢ that the principle of safety is promoted at all times |
| 7.9 | Managers are responsible for ensuring that any MH and LD Trust setting has on-hand at all times a sufficient number of staff trained in physical interventions to ensure that the contents of this Procedure Document can be appropriately and safely implemented. Where staff shortages impact on the Trust's ability to manage aggressive or reckless behaviour, managers have a responsibility to notify senior colleagues at once and IR1 completed. |
| 7.10 | The line manager(s) of any staff involved in implementing a physical intervention procedure must as soon as appropriate after such an incident arrange a 'debriefing' session for their staff. Debriefing should also be available to witnesses who request this support. Following an episode involving any form of direct physical assault, debriefing sessions should also establish whether police involvement is being sought by the member(s) of staff concerned, in line with the Trust's Zero Tolerance procedure. ( ZT Procedure 2008)<br>All records and documentation in relation to an incident should be reviewed and completed as necessary in a staff debriefing session. The exact circumstances of the incident, including events that preceded it and actions taken afterwards, should be discussed and reviewed, with the dual aims of reviewing current practice and of minimising the risk of any further such incidents occurring. A record of all debriefing sessions must be kept by the line manager(s) concerned. |
| | |
| 7.11 | Managers will also be responsible for ensuring that all direct-care members of staff receive appropriate training in prevention, de-escalation and physical intervention in relation to aggressive or reckless behaviour, which is related to the needs of the service. Training in BILD Accredited Physical Intervention Strategies will be provided only by instructors with appropriate experience and qualifications. Currently the Mental Health and Learning Disability Service Group provide Training in Proact SCIPr UK and MAPA.<br>Only members of staff who have successfully completed the designated training programme for a particular intervention strategy selected by the Trust for the Service Group, should use those strategies in the course of their employment. |
| 7.12 | Restrictive physical interventions 'involve use of force to control behavior' (DoH, 2002). Staff who may be involved in 'restrictive' components of physical intervention must be trained in:<br>➢ Basic life support skills and attend annual updates.<br>➢ The physical risks associated with physical intervention, i.e. positional asphyxia/sudden collapse.<br>➢ Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.<br>➢ Use of emergency equipment.<br>➢ Knowing how to summon assistance |

| | |
|---|---|
| | |
| 7.13 | Situations involving weapons - For the purpose of this document a weapon is defined as: a*ny object that is made, adapted or intended to be used to cause physical injury to a person***.** Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgments must be made based on professional knowledge and experience, risk assessment and training in challenging behaviour and management of aggression. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police. |
| 7.14 | There may be times when the level of threat posed or the nature of the incident means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the person in charge of the unit to action appropriate assistance. As it is accepted practice within the Trust the use of the PSNI for assistance will trigger an untoward incident review. |
| **8.** | **Implementation / Resource requirements:**<br>This procedure will require all managers to ensure staff within their service have appropriate training to deliver the procedure. |
| **9.** | **Source(s) / Evidence Base:**<br>'*Physical Interventions: A Procedure Framework – Second Edition*', British Institute of Learning Disabilities (BILD, 2008);<br>'*Guidance on the Use of Restrictive Physical Interventions'* (Department of Health, July 2002*);*<br>'*BILD* Mental Health Procedure Implementation Guide. *Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings.* National Institute for Mental Health in England. 2004;<br>*Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.* National Institute of Clinical Excellence. 2005 CG25.<br>*Code of Practice for Trainers in the Use of Physical Interventions-Second Edition'* (BILD, 2006)<br>*Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002*<br>*Zero Tolerance Approach To The Prevention And Management Of Violence And Aggression In The Workplace ( ZT Procedure 2008)BHSCT 2008*<br>*Safeguarding Vulnerable Adults* |

U UTR

| | |
|---|---|
| | *Risk Management Procedure BHSCT*<br>*Incident and Accident Procedure BHSCT*<br>*Complaints Procedure BHSCT*<br>The *Mental Health (N Ireland) Order 1986* and its associated *Code of Practice*<br>*Good Practice in Consent: Implementation Guide for Health Care Professionals* |
| **10** | **References, including relevant external guidelines:**<br>Improving Patients Safety: Building Confidence (DHSSPS 2006)<br>Management of Aggression – Trust-net.<br>Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;<br>NMC Guidelines for Records and Record Keeping<br>Managing Complaints Procedures – Trust procedure<br>Incident Reporting Procedures – Trust-procedure<br>Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org<br>RCN, 2008 Let's Talk About Restraint London,<br>National Neurosciences Benchmarking Group, 2007 Use restrictive practicest Benchmark –www.nnbg.org.uk |
| **11** | **Consultation Process:** |
| **12** | **Equality and Human Rights screening carried out:**<br>In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this procedure should be subject to a full impact assessment.<br>**The Trust is required to comply with its obligations under the European Convention of Human Rights as enshrined in the Human Rights Act 1998**<br>**The trust is satisfied that this procedure is compatible with these obligations**<br>☐ Screening completed No action required. ☐ Full impact assessment to be carried out. |
| | |

**Chief Executive / Director**
*(delete as appropriate)*

**Author**

**Date:** **Date:**

Appendix A

## Legal Issues in the Use of Physical Interventions

Any physical interventions adopted within the MH and LD Service Group of Belfast Health & Social Care Trust must be in accordance with the legal responsibilities and obligations of both the Trust and its individual members of staff, and with the rights and protection which the law affords to people who have a learning disability or a mental health problem.

It is a criminal offence to use physical force or to threaten to use force unless the circumstances give rise to a lawful excuse or justification for the use of force. Physical intervention may be construed as false imprisonment, assault or battery, and as such may incur legal liability. Physical Intervention should generally be considered illegal, therefore - unless there is clear justification for its usage which can withstand legal examination Physical Intervention must not be used.

Staff should also be aware that restricting an individual's liberty, autonomy, or treating them in an inhumane manner may constitute a breach of the Human Rights Act, (1998). It could be argued that the use of any method of restrictive intervention is a potential breach of human rights. However, a breach of rights for one individual can be justified on the basis that it prevents a breach of rights for another. It could also be argued that a breach of rights for one individual is justified as it represents the least detrimental course of action measured against the failure to act. Staff should act to ensure that their actions do not represent a disproportionate interference with the individual's Human Rights.

The guiding principle in providing care is the 'best interests' of the person concerned, defined in terms of preserving or promoting a person's life, health or well-being.

Also, a 'duty of care' exists for staff, whereby 'reasonable care' must be taken to avoid acts or omissions which are likely to cause harm to a person and/or damage to property.

When deciding upon 'reasonable care', a court is likely to consider the following:-

- any risks which could have been foreseen with a particular course of action - including the risks of responding in alternative way(s), or not at all
- the least restrictive force being used for the shortest period of time
- the use of gradually increasing or decreasing levels of force in response to the person's behaviour
- the reasonableness of the response in the prevailing circumstances – ie proportionate to the harm that might otherwise be caused, and taking account of the individuals current circumstances and relevant history
- the likely response of others with a similar degree of skill and responsibilities
- the views of an appropriate body of expert opinion.

Thus staff must exercise their professional judgement in the process of determining reasonable care. Professional judgement is key to deciding upon the most appropriate course of action to ensure safer outcomes for individuals and others in situations that pose a risk of serious harm.

Appendix B

## Consent for the Use of Physical Intervention

Imposing a physical intervention procedure against an individual's wishes is illegal. Provided an individual is considered 'capable' of so doing, therefore, he/she must give 'informed consent' for a physical intervention to be used.

A high proportion of service users within the Service Group will be capable of giving informed consent. This capacity to consent should be determined by the multi disciplinary team, including the professional considering recommending a restrictive practice. Consent should be sought at the time of developing the Person Centred Care and Intervention Plan. This determination should be on the basis of the service user's:

- understanding both the nature and the reason for the proposed intervention
- understanding both the benefits and the risks of the proposed intervention
- understanding the consequences of *not* consenting to the intervention
- possessing the capacity to make the necessary choice

Physical intervention may be necessary prevent further harm to others in the environment .

## Physical Intervention with Adults deemed to lack capacity to consent

In the case of adults who are considered to lack capacity to provide informed consent, there is presently no provision for anyone else to provide consent on their behalf.

Nevertheless, any adult may be treated without consent provided the proposed intervention is demonstrably in his/her best interests. Indeed, it is important to note in this regard that *not* applying a particular intervention could, in certain circumstances, be construed as a breach of a 'duty of care'. In considering the best interests of the service user, the staff involved in this process should demonstrate consultation with appropriate professionals, carers and advocacy services.

Planned physical interventions should be developed on the basis of the following:-

- information about the service user and his/her behaviour(s) obtained through a thorough, multi-disciplinary assessment
- assessment and evaluation of all alternative approaches already introduced
- evaluation of the possible risks associated with a given intervention
- consideration of a body of expert knowledge and established good practice
- consultation with carers

Appendix C

## Health and Safety Considerations

The health and safety of everyone must remain of paramount importance throughout the application of a particular physical intervention and during the period of time following use of physical intervention. Specifically, this means that any such intervention must be stopped immediately if a service user develops any of the following:-

- breathing difficulties (including very rapid breathing)
- fits or seizures
- vomiting
- blueness of the hands or other body parts (indicating reduced blood flow)
- paleness or yellowing of the skin (suggestive of restricted blood flow)
- bone fractures or joint dislocations

At the same time, necessary medical intervention should be secured as a matter of urgency.

Consideration should be given by the team involved in working with the service user to physically monitoring the person during physical intervention process and for a period of up to 24 hours. This check may include pulse, blood pressure, respiration, temperature and fluid and food intake and output in accordance with the persons care plan. If consent and co-operation for these observations is not forthcoming from the person, then it should be clearly documented in their notes why certain checks could not be performed and what alternative actions have been taken.

The increased proneness of some vulnerable adults, including older people to negative side-effects from physical intervention procedures, due to their higher incidence of physical and medical conditions, needs especially to be included in any risk assessments that are carried out. Furthermore staff should be conscious of the potential impact of any medication, drugs and alcohol which the person may have taken. In addition there may be circumstances where an individual has been subjected to incapacitants such as CS Spray or Taser prior to coming into contact with Trust staff, it is necessary to consider their impact on the person and their reaction to any physical intervention administered. Any physical condition, which may increase the risk to the patient of collapse or injury during physical intervention should be clearly documented in the patients file and communicated to all multi-disciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate (NIMHE 2004).

The MHOR (1992) do not permit full-weight lifts of people unless the situation is exceptional or life threatening. Consequently, staff are not ordinarily expected to pick up or carry patients from one area to the other. Staff should encourage the patient to co-operate with them and wait until the service user will walk with staff. Transferring a struggling patient to a low stimulus area presents a significant risk of harm to the patient and staff through the process of the patient's struggle and/or their weight, especially if they were to be carried by staff. It is important that staff are clear about the safeguards and limitations provided by the Manual Handling Operations Regulations (MHOR 1992) and the physical intervention training provided to staff:

Belfast Health and Social Care Trust

## Standards and Guidelines Committee

| *Use of Restrictive Practices in Adults* | |
|---|---|
| **Summary** | This policy aims to provide a framework of professional practice in relation to a broad range of restrictive practices and outlines the procedures that need to be followed when a patient/service user presents a risk of harm to himself/herself or others and it is deemed necessary to use a restrictive practice. This may include restrictive environmental, social, pharmacological, mechanical and physical interventions in order to limit the adverse outcomes of such risk. |
| **Purpose** | To provide guidance to staff on the use of restrictive practices. The Trust recognizes that it may be necessary to use restrictive practices to maintain patient / service user personal safety with the intention of preventing injury and protecting patients/service users and staff to ensure the effective outcome of procedures /treatment /care. |
| **Operational date** | |
| **Review date** | |
| **Version Number** | V1 |
| **Director Responsible** | Brenda Creaney D.O.N. |
| **Lead Author** | Olive Macleod |
| **Lead Author, Position** | Co Director Nursing |
| **Additional Author(s)** | |
| **Department / Service Group** | |
| **Contact details** | *Knockbracken Health Care Park, 90565680* |

| | |
|---|---|
| **Reference Number** | SG0015/09 |
| Supersedes | Legacy policies |

| Date | Version | Author | Comments |
|---|---|---|---|
| 22/09/2008 | V0.1 | O Macleod | Draft 1 |
| 24/11/ 2008 | V0.2 | O Macleod | Comments from Legal Dept |
| Feb 2009 | V0.3 | O Macleod | Comments from Ethics committee |
| Feb 18 2009 | V0.4 | O Macleod | Comments H&S Service Group |
| Feb 22 2009 | V0.5 | O Macleod | Comments Equality Manager |
| 9 March 2009 | V0.6 | O Macleod | Comments from DON & D of MH |
| 11 March 2009 | V0.7 | O Macleod | Amended with MH and LD |
| 7/4/2009 | V0.8 | JR Johnston | Formatting; Paul Devine changes |
| 29/10.09 | VO.9 | A Brannigan | Comments management of Aggression Team |
| 10.05.10 | V 0.10 | T Patterson | Editing |
| 31/5/10 | V0.11 | O Macleod | Comments |
| 04/08/10 | V0.12 | T Patterson | Comments |
| 1/12/10 | V0.13 | O MacLeod | Review of policy |
| | | | |

**Policy Record**

| | | Date | Version |
|---|---|---|---|
| Author (s) | Approval | | |
| Director Responsible | Approval | | |

**Approval Process – Trust Policies**

| | | | |
|---|---|---|---|
| Policy Committee | Approval | | |
| Executive Team | Authorise | | |
| Chief Executive | Sign Off | | |

**Approval Process – Clinical Standards and Guidelines**

| | | | |
|---|---|---|---|
| Standards and Guidelines Committee | Approval | April 2009 | V0.8 |
| Policy Committee | Approval | May 2009 | V0.8 |
| Standards and Guidelines Committee – Review | Approval | 15/12/10 | V0.13 |
| Policy Committee - Review | Approval | 17/01/11 | V0.13 |
| Executive Team | Authorise | | |
| Appropriate Director | Sign Off | | |

## Summary

**Reference No:** *SG 15/09*

**Title:** **Use of Restrictive Practices in Adults**

**Purpose:**

This policy aims to provide a clear framework and guidance to staff on the use of restrictive practices.
The Trust recognizes that it may be necessary to use restrictive practices to maintain with the safety of patients/clients and staff to ensure the effective outcome of procedures /treatment /care, and also to reduce the likelihood of restrictive practices which are unacceptable and leave service users and/or staff vulnerable to unreasonable levels of risk or harm.

**Objectives:**

- To ensure safe and dignified access of the patient / service user to assessment, treatment and care.
- To ensure least harm to patients/clients/staff or others who come into contact with the trust and its services.
- To increase the participation of patients/clients and significant others with members of the health and social care team in the process of consultation, decision making and planning care regarding appropriate use of restrictive practices.
- To ensure that when restrictive practices are used they fall within current legal, professional and ethical boundaries of good practice and that every effort is made to ensure vulnerable people are not subjected to the inappropriate use of such practice.

- To ensure that all uses of restrictive practices are considered only after an assessment of risk that justifies its use when other options are deemed inappropriate or have failed.
- To support the development of a culture that ensures the use of the least restrictive approach for the shortest period of time.

**Policy Statement(s):**

Belfast Health & Social Care Trust is committed to ensure that methods of restrictive intervention are:

- Used as infrequently as possible

- That they are used in the best interest of the individual service user.

- That when they are used, every reasonable effort is made to minimise the risk of harm or injury to anyone involved, and that the need to maintain individual respect, dignity and welfare is maintained

- That all employees understand their obligations to use restrictive interventions in an appropriate manner.

- Restrictive interventions are not seen as a long-term solution in the management of service user behaviour. They may, in the short term, help to effectively and safely support service users achieve improved outcomes in terms of greater inclusion, choice, independence, rights and safety as part of a wider approach.

- The decision to use such approaches should only be made following an assessment of risk taking into account the possible benefits such approaches may give to the service user balanced against the possible harms that could result. Such a decision may also take account of the impact such approaches have on other people who may be affected by the service user's behaviour. This may include other service users, staff, as well as members of the community.

- Every effort is made to use skills and techniques that do not use the deliberate application of pain. – The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. NICE 2005. Where staff have a need to use such approaches, they must fully understand the legal, ethical and professional implications and be prepared to justify their actions.

- The scale and nature of restrictive practice must be **proportionate** to both the behaviour of the individual to be managed and the nature of the harm likely to be caused.

- Restrictive practices will not be used for staff convenience.

| | |
|---|---|
| **Chief Executive/ Director**<br>*(delete as appropriate)* | **Author** |
| **Date:** | **Date:** |

## Full Description

**Reference No:** *SG 15/09*

## 1 Use of Restrictive practices with Adults

**2. Purpose:**

To provide guidance to staff on the use of use of restrictive practices. The Trust recognizes that it may be necessary to use restrictive practices to maintain patient / service user personal safety with the intention of preventing injury and protecting patients/service users and staff to ensure the effective outcome of procedures /treatment /care.

**3. The scope:**

This policy is relevant for all staff caring for patients/client receiving treatment or care within BHSCT.

**4. Objectives:**

- To ensure safe and dignified access of the patient / service user to assessment, treatment and care.
- To ensure least harm to patients/clients/staff or others who come into contact with the trust and its services.
- To increase the participation of patients/clients and significant others with members of the health and social care team in the process of consultation, decision making and planning care regarding appropriate use of restrictive practices.
- To ensure that when restrictive practices are used they fall within current legal, professional and ethical boundaries of good practice and that every effort is made to ensure vulnerable people are not subjected to the inappropriate use of such practice.

- To ensure that all uses of restrictive practices are considered only after an assessment of risk that justifies its use when other options are deemed reasonably inappropriate or to have failed.
- To support the development of a culture that ensures the use of the least restrictive approach for the shortest period of time.

**5. Roles and Responsibilities:**

It is the responsibility of all Trust staff to adhere to this policy.

## 6 The definition and background of the policy:

.

The term 'restrictive intervention' is used generically to describe any strategy or intervention which restricts or limits another person's liberty. The definition of 'restrictive intervention' adopted by BHSCT is:

> 'Any form of restrictive intervention, be it a physical, mechanical, pharmacological, environmental or social/psychological intervention, which is designed and used (intentionally or unintentionally) to limit or restrict another person's liberty'.
>
> (BILD 2006)

With the exception of unforeseen or unpredicted adverse events, the use of restrictive interventions should only be seen within the context of an overall management approach necessary to manage risk and maintain everyone's safety.

Before using any form of restrictive practice staff must undertake an initial assessment that provides a clear rationale as to why the patient or service user is at risk of harm and demonstrate that they are acting in the patient or service user's best interest. This must be documented clearly in the patient's clinical notes / care plan.

Where restrictive interventions are used, they should be applied using the least restrictive option and the use of the restrictive interventions must be appropriately documented.

Persons, regardless of their mental or physical state, have the same human rights - any use of restrictive practices may lead to someone being denied these fundamental human rights.

Under <u>no</u> circumstances should the restrictive interventions described be used as a means of punishment or to force compliance where risk is either not present or could be managed in a non-restrictive way.

Knowing how and when to use restrictive practices in an ethical, safe and legally defensible way is key.

The Trust recognises that a planned approach cannot always be taken, as it is difficult to account for every eventuality that may arise. As such, staff must endeavor to account for the most likely eventualities which could occur and use their scope of professional practice to make confident and competent decisions for those events that are unforeseen or unplanned.

### Restriction definitions

| Table 1 Description | Examples |
|---|---|
| **Environmental Restriction**<br>'The use of locked doors, baffle handles, low stimulus or time out rooms, fences, gates or legal restrictions to contain or limit an individual to or from one particular room, building or area' | A service user may be managed in a quiet room away from others either to prevent the escalation of a situation or as part of a de-escalation process in order to reduce the risk of others being harmed.<br>Or to protect service users dignity when they are displaying disinhibited behaviour |
| ***Social Restriction***<br>'The use of verbal instructions or commands, withdrawal procedures, social restriction or time out from positive | A service user may be prevented from going swimming because they are so agitated the |

| | |
|---|---|
| reinforcement to limit, interrupt or stop an individuals behaviour which is viewed as potentially harmful, undesirable or socially unacceptable’ | activity itself would increase the potential risk of harm should the service user’s behaviour escalate. |
| **Pharmacological Restriction**<br>‘The use of pharmacological/pharmaceutical agents to alleviate or manage an individuals underlying psychological/psychopathological condition or behaviour disturbance’ | A service user may be prescribed ‘as required medication’ for use in emergency situations where their behaviour becomes more disturbed. The medication may have a sedating effect thereby reducing the risks. |
| **Mechanical Restriction**<br>‘The use of splints, straps, tethers, harnesses or equipment (e.g. reclining chairs, wheel chairs, bed rails) to limit or restrict an individual’s ability to move’ | Arm splints may be used where a service user engages in self injurious behaviour to protect them from serious harm or side rails where they are at risk from rolling out of bed |
| **Physical Restriction**<br>**1) Holding Skills/physical restraint**<br>‘The use of physical holds to limit or restrict an individual’s ability to move during the provision of ‘safe and supportive care’ or in the management of a ‘violent episode’<br>This would require more than one member of staff<br>**2) Disengagement Skills or escape techniques/**<br>‘The use of physical actions to limit, stop or gain a release from harmful or injurious physical contact initiated by another person during the provision of care and/or in situations requiring escape in the management of a violent episode’ | Staff may use holding skills to assist in the support and care of service users who present with challenging behaviour or in situations where service users present with behaviour which is aggressive and violent<br>Staff may employ disengagement skills for self or others to promote and/or protect well-being in the support and care of service users who present with challenging behaviour or in situations where service users who present with behaviour which is aggressive and violent. |

If any of these apply in your area of work an operational procedure must be in place.

## 7. Policy statements:

7.1

Belfast Health & Social Care Trust is committed to ensure that methods of restrictive intervention are:

- Used as infrequently as possible
- That they are used in the best interest of the individual service user.
- That when they are used, every reasonable effort is made to minimise the risk of harm or injury to anyone involved, and that the need to maintain individual respect, dignity and welfare is maintained
- That all employees understand their obligations to use restrictive interventions in an appropriate manner so as to avoid, wherever reasonably practicable, any recourse to criminal charges or action under current civil law or health and safety legislation.
- Restrictive interventions are not seen as a long-term solution in the management of service user behaviour. They may, in the short term, help to effectively and safely support service users achieve improved outcomes in terms of greater inclusion, choice, independence, rights and safety as part of a wider approach.
- The decision to use such approaches should only be made following an assessment of risk taking into account the possible benefits such approaches may give to the service user balanced against the possible harms that could result. Such a decision may also take account of the impact such approaches have on other people who may be affected by the service user's behaviour. This may include other service users, staff, as well as members of the community.
- Every effort is made to use skills and techniques that do not use the deliberate application of pain. – The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. NICE 2005. Where staff have a need to use such approaches, they must fully understand the legal, ethical and professional implications and be prepared to justify their actions.
- The scale and nature of restrictive practice must be **proportionate** to both the behaviour of the individual to be managed and the nature of the harm likely to be caused.
- Restrictive practices will not be used for staff convenience.
- In order to support this policy, the organisation is committed to ensuring all staff in those areas where there is a likelihood of restrictive interventions being used receive a sufficient level of training, supervision and instruction on such approaches.

## 8. Implementation / Resource requirements:

It is the responsibility of all service group managers to ensure risk assessment has been completed in areas where staff is expected to engage in any restrictive environmental, social, pharmacological, mechanical or physical intervention.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of their service users.

These assessments will require regular audit to determine their acceptability and efficiency.

## 9. Source(s) / Evidence Base:

Guidance on Restraint and Seclusion in HPSS, 2005)
NMC The Code 2008
HSS (MD)8-2008
Akid, M. (2002) Drugged and Caged by Cot sides. Nursing Times 98 (3) Cover Story.
Darby, S. (1990) Containing the Wanderer. Nursing Times 86 (15) 42-43
Department of Health (2001) National Service Framework for Older People Department of Health. London.
DHSSPSNI (2004) Human Rights working Group of Restraint and Seclusion. Guidance on Restraint and Seclusion in Health and Personal Social Services. DHSSPSNI.
Marr, J. (1998) Electronic Tagging. Nursing Standard 4 (9) 54.
Stirling, C. McHugh, A. (1998) developing a non-aversive intervention strategy in the management of aggression and violence for people with learning disabilities using natural therapeutic holding. Journal of Advanced Nursing. 27 503-509.
*Good Practice in Consent: Implementation Guide for Health Care Professionals Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002 Guidance on the Use of Restrictive Physical Interventions'* (Department of Health, July 2002*);*
*Code of Practice for Trainers in the Use of Physical Interventions- Second Edition'* (BILD, 2006)
Safeguarding Vulnerable Adults BHSCT
Risk Management Policy BHSCT
Zero Tolerance Approach To The Prevention And Management Of Violence Anc
Aggression In The Workplace ( BHSCT 2008)

## 10 References, including relevant external guidelines

Improving Patients Safety: Building Confidence (DHSSPS 2006)
Management of Aggression – Trust-net.
Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;
NMC Guidelines for Records and Record Keeping
Managing Complaints Procedures – Trust policy
Incident Reporting Procedures – Trust-policy
Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org
RCN, 2008 Let's Talk About Restraint London,
National Neurosciences Benchmarking Group, 2007 Use restrictive practicest Benchmark –www.nnbg.org.uk
*Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.* National Institute of Clinical Excellence.( 2005) CG25.
*Wolverson M.* Continuing Professional Development Self injurious behaviour and learning disabilities.( 2004)
Rapid Response Report. National Patient Safety Agency (2008)
*'BILD* Mental Health Policy Implementation Guide.
*Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings.* National Institute for Mental Health in England. (2004)
Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*
The Human Rights Act 1998 Guidance for Northern Ireland Departments – Office of First Minister and Deputy First Minister, Human Rights Directorate

## 11 Consultation Process:

Trust Ethics Committee
Trust Legal Department
Director of Nursing
Director of Mental Health & Learning Disability
Medical Directors Office
Standards& Guidelines Committee,
Policy Committee

## 12 Equality and Human Rights screening carried out:

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

**The Trust is required to comply with its obligations under the European Convention of Human Rights as enshrined in the Human Rights Act 1998 The trust is satisfied that this policy is compatible with these obligations**

☐ Screening completed No action required.

☐ Full impact assessment to be carried out.

**Chief Executive / Director**
*(delete as appropriate)*

**Date:**

**Author**

**Date:**

## Appendix 1
## Consent for the Use of Restrictive Practices

Provided an individual is considered ‘capable’ of so doing, he/she must give ‘informed consent’ for a restrictive practice to be used.

A high proportion of service users will be capable of giving informed consent. This capacity to consent should be determined by the multi disciplinary team, including the professional considering recommending a restrictive practice. Consent should be sought at the time of developing the Person Centred Care and Intervention Plan. This determination should be on the basis of the service users:

- understanding of both the nature and the reason for the proposed intervention
- understanding of both the benefits and the risks of the proposed intervention
- understanding of the consequences of *not* consenting to the intervention
- possessing the capacity to make the necessary choice

## Restrictive Practices in the Absence of Consent

In the case of adults who are not considered capable of providing informed consent, there is presently no provision for anyone else to provide consent on their behalf.

**Restrictive practices may be defensible without consent provided the proposed intervention is demonstrably in his/_her best interests.** Indeed, it is important to note in this regard that *not* applying a particular intervention could, in certain circumstances, be construed as a breach of a ‘duty of care’ in that the omission to act could endanger the service user, staff or others in the environment.
In considering the best interests of the service user, the staff involved in this process should demonstrate consultation with appropriate professionals, carers and advocacy services.
Planned Restrictive Practices should be developed on the basis of the following:-

- information about the service user and his/her behaviour(s) obtained through a thorough, multi-disciplinary assessment
- assessment and evaluation of all alternative approaches already introduced
- evaluation of the possible risks associated with a given intervention
- consideration of a body of expert knowledge and established good practice
- consultation with carers

## Risk Assessment

Where restrictive interventions are used staff have an obligation to assess the risks associated with such practice.
Within individual work settings, it is important that staff are aware of the appropriate risk assessments to be completed for their service area.

Consideration of the risk posed by the service user (to themselves or others) **must** be balanced against the level of restrictions, which may be applied by staff
A structured approach to risk analysis and risk management will help staff to develop safe, sound and supportive approaches. This will help avoid unnecessarily compromising the rights of others whilst promoting the welfare and safety of everyone involved.
Assessment should take into account the service users unique needs physically, socially and psychologically.

Once the appropriate risk assessments and management plans are completed these should be communicated to all relevant staff, and where appropriate the service user and/relatives/carers/advocates.

## Practical Application of Restrictive Practices

### Environmental Restrictions

Many settings use the environment to help guard, segregate or limit service user access to and from certain areas whilst enabling staff to provide a higher level of support and supervision.
Where service users present significant challenging behaviour, environmental restriction may enable staff to provide a greater level of help, support or supervision and prevent disruption to others.

This approach is not to be confused with the routine locking of doors, windows or rooms as a means of general safety and security, particularly where service users are vulnerable to harm (e.g locking a door to an electrical room, locking the main entrance door to prevent unwanted or uninvited visitors).

Frequent and prolonged use of environmental restriction should be avoided unless specific permissions are sought and specific policy and guidance is issued to ensure the practice is strictly regulated and reviewed (e.g. in the case of prescribed time out or seclusion procedures).

In order to safeguard the unnecessary and unjustified use of environmental restriction, the following guidelines should be implemented:

- Environmental restrictions should only be used as part of a wider individual care or treatment plan.
- The use of bedrooms for this purpose should be avoided, as far as possible, as this may represent the service user’s only private space. Their bedroom may become associated with an aversive event rather than an area of privacy and individual identity. Instead, staff should look to find the nearest and most appropriate place to manage the service user in terms of limiting their access to other parts of the building
- Where the environment does not allow for a flexible approach to environmental restriction, a nominated room should only be used following a full risk assessment to ensure that there are no obvious potential hazards to the service user.

- Environmental restrictions should be time limited with specific observation intervals written into the service user's interventions plan.
- Service users should still be under staff supervision.

**Social Restrictions**

Social restrictions are generally used to segregate or limit service user access to socially integrated activities where the service user's behaviour represents a significant risk to themselves or others.

A potential disadvantage of using such an approach is that the individual is prevented from exercising their choice, independence and inclusion thereby increasing the likelihood of further challenging behaviour. As such the benefits of social restriction must be demonstrated to outweigh the risk.

Social restriction should never be used to compensate for a lack of appropriate resources to support service users to access integrated community facilities. However, in situations where staff need specific knowledge and skills to support service users effectively, it may be acceptable to temporarily implement social restrictions until such time as staff have been equipped with the necessary training.

In order to safeguard the unnecessary use of social restriction, the following guidelines should be implemented:

- Social restrictions should only be used as part of a wider individual care or treatment plan.
- The service user plan must clearly outline the risks and the specific social restrictions that are to be used. A 'blanket approach' to social restriction should not be agreed unless the level of risk for all activities is significant. Wherever possible, each social event or activity should be specified within the plan.
- Staff must comply with statutory regulations where a social restriction is legally enforceable (e.g. Mental Health Order 1986).

**Pharmacological Restriction**

Pharmacological agents can only be used under the direction and prescription of a qualified prescriber. A number of medicines may be prescribed to help stabilise the service user's mood or to moderate mental ill health and other organic factors which may contribute to the individual's challenging behaviour. In addition to regularly prescribed medicines, some service users may be prescribed additional "as required" medication.

Medication should be prescribed with a clear therapeutic aim and must not be used as a means of exerting control over service users. Prescribed medication must be reviewed regularly to ensure that principle is adhered to. Staff have a responsibility to observe and report service user behaviour as accurately as possible to assist prescribers when making prescribing decisions. Once medication has been prescribed, staff have responsibility to continually observe and assess service users for the effect of medication on their mental state and for the emergence of side effects.

The administration of "as required" medication must be to the same standard as that for regular medication. The nurse must follow the guidance of the NMC with regard to the administration of medicines and comply with requirements of the Trust Medicine Code. The administration must be recorded clearly on the medicines administration record ensuring that the time of administration and the actual dose administered (where a variable dose is allowed) is clearly documented. Addition records may be needed in the patients notes detailing the reason why “as required” medicines were needed and an assessment of the effectiveness of the intervention. The follow points should be considered

- Pay attention to any instructions on the indication for the as required medication
- Check the timing of administration carefully if a range of times is permitted e.g. every 4 to 6 hours. Make sure the medication is not being given too early
- Check that any maximum dose stated will not be exceeded (calculate back 24hrs from the current time)
- Medication should not be concealed in food or drink
  Rapid tranquilisation should be viewed as a crisis intervention in the management of challenging, aggressive or violent behaviour and must be carried out in accordance with the Trust Guideline for Rapid Tranquillisation

**Mechanical Restrictions**

Mechanical restrictions are not normally used in the management of challenging, aggressive or violent behaviour.
Typically, mechanical restrictions are used for safety and protection to prevent service users sustaining injury (e.g., the use of bedrails to prevent someone falling out of bed) or to assist or improve an individual’s posture (e.g., a standing frame or wheel chair harness).

Mechanical restraint devices are on occasions used as a response for the reactive management of self-injurious behaviour. Self-injurious behaviours indicate significant, emotive and distressing phenomenon for the individual, their carers and service providers, Wolverson (2006)

The use of mechanical restrictions for the management of challenging behaviour is usually associated with arm ‘splints’ or ‘cuffs’ and head guards to prevent self-injurious behaviour. In some extreme situations, it may be considered appropriate to use mechanical restrictions if a service user is engaging in behaviour that represents a significant risk to others.

For some service users the use of a mechanical restriction may represent a lesser aversive option than physical restrictions since, once applied, staff are no longer required to maintain physical contact. Also, provided that the device has been specifically designed and built for the service user, fewer adverse outcomes or injuries may result.

However, if mechanical restrictions are being used as part of a care /treatment /behaviour plan, it is likely that staff will still need to attend training on physical interventions since they will need to know how to safely hold the service user in order to apply and remove the mechanical restriction.

Whenever mechanical restrictions are used, staff should ensure that:

- The multidisciplinary team have agreed to the approach (e.g. when used for a service user who self harms, since a broader intervention programme will be required).
- The mechanical aids used have been specifically designed and manufactured for the individual service user. Staff should avoid developing their own mechanical aids and should never use tethers or harnesses not specifically designed for purpose.
- Staff should ensure that any mechanical restriction used is routinely checked prior to use to ensure the aid remains ‘fit for purpose’ and arrange regular servicing of such equipment by the manufacturer.
- Where physical intervention is required to apply any mechanical restriction, staff should receive necessary training so as to ensure they act within legal, professional and ethical boundaries.

## Physical Restrictions

Table 1 illustrates a clear distinction between restrictive physical interventions in terms of defining ‘safe holding’/physical restraint and ‘disengagement’ skills.

As such, staff may use physical restrictions to help them deliver the appropriate level of support, or care in a safer way.
Alternatively, staff may have to safely hold a service user whose behaviour has become disruptive and poses a risk to others within the same environment.
The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All restrictive physical interventions should be applied in a manner that attempts to defuse rather than provoke further aggression.

All staff who may be involved in the application of restrictive physical interventions should receive an appropriate level of training as detailed in section 7.8

The decision to use physical interventions must be fully documented following the completion of all relevant risk assessments and where appropriate the development of an individual care/treatment/behaviour/ plan.
Where appropriate these may be shared with family members/carers/advocates and members of the multidisciplinary team so that they have the opportunity to raise any questions or concerns.

In emergency situations, staff may need to use restrictive physical interventions with an individual who has not previously been assessed as presenting a risk of aggression or violence. Following such an incident, the appropriate risk assessments and intervention plans must be completed as soon as is reasonably practicable.

## Practical Guidelines for the Application of Restrictive Physical Interventions

Staff who may be involved in carrying out physical restraint must be trained in:

- Basic life support skills and attend annual updates.
- The physical risks associated with restraint, i.e. positional asphyxia/sudden collapse/injury/ discomfort.
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.

- Use of emergency equipment.
- Knowing how to summon assistance

NPSA (2008)

Any service user subject to physical restraint should be medically assessed at the earliest opportunity but no longer than 2 hours after the commencement of physical restraint.

Any service user subject to physical restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of up to 24 hours. This check should include:

- Care in the recovery position if appropriate
- Pulse
- Blood pressure
- Respiration
- Temperature
- Fluid and food intake and output.

NICE (2005)

If consent and co-operation for these observations is not forthcoming from the person, then it should be clearly documented in their notes why certain checks could not be performed and what alternative actions have been taken.

- When ever possible, always attempt to protect the individual's head from harm and take into account the amount of energy a person may use during a disturbed episode.
- Observe for heat exhaustion, fatigue, restricted or impaired breathing, muscle cramp, and the adverse effects of medication. The safety of the individual must never be compromised – if in any doubt regarding the individual's welfare, staff must end the intervention immediately.
- Service users and carers should be treated with respect at all times and their dignity maintained.
- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users co-operation and a return to voluntary control as soon as is safely possible.
- Well-briefed, trained and co-ordinated staff will be the most effective in a physical restraint situation.
- *A* person should be nominated to co-ordinate the intervention and speak to the individual. This avoids unnecessary confusion.

- Every action taken must always be explained to the individual regardless of their ability or willingness to communicate. At all times treat the individual with the dignity and respect deserving of all human beings. Always ensure privacy is maintained by moving on-lookers away or asking the individual to move to a low stimulus area.
- Transferring a struggling service user to a low stimulus area presents a significant risk of harm to the patient and staff through the process of the patient's struggle and/or their weight, especially if they were to be carried by staff. It is important that staff are clear about the safeguards and limitations provided by the Manual Handling Operations Regulations (MHOR 1992)
- The MHOR (1992) do not permit full-weight lifts of people unless the situation is exceptional or life threatening. Consequently, staff are not ordinarily expected to pick up or carry patients from one area to the other.

Staff should encourage the patient to co-operate with them and wait until the patient will walk with staff.

- Ideally staff taking the lead in restrictive physical interventions should be those who have received training in such skills within BHSCT, as they will be able to provide advice and guidance to others.
- Never hold an individual around the neck and avoid any pressure to the chest and abdomen since this significantly increases the risk of postural asphyxiation. Never cover the mouth or screen the individual's vision.
- Avoid making contact with any part of the individual's body that could be viewed as culturally, socially or sexually unacceptable (ie face, neck, chest, abdomen, buttocks, groin, and inner thighs).
- Any physical condition, which may increase the risk to the patient of collapse or injury during physical intervention should be clearly documented in the patients file and communicated to all multi-disciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate (NIMHE 2004).

## Recording and reporting restrictive practices.

All restrictive practices should be documented in accordance with trust recording and reporting procedures.
It is the responsibility of each service area to ensure agreed service specific documentation is available and that staff are aware of this and trained in the use of such documents.
Staff must ensure that all restrictive practices are documented including the information contained in the checklist below.
Where these actions could not be taken staff should document why these could not be achieved.

## Checklist for the use of restrictive practices

The purpose of this checklist is to provide a framework for service groups whose staff may be expected to utilise restrictive practices as part of their duties. Documentation should include:

- Patient name
- Patient No.
- Unit/Ward
- Date when restrictive practice commenced
- Date restrictive practice ceased
- Name of staff member in charge at the time restrictive practice was utilised.
- Time restrictive practice commenced
- Time restrictive practice ceased
- Was service user endangering self?
- Was service user endangering others?
- What actions did staff take prior to engaging in restrictive practice, e.g. none -insufficient time, attempts to de-escalate, etc.
- Was consent for the intervention sought?
- Was a multi-disciplinary risk assessment agreed /completed?
- Was the service user/ carers /advocates/relatives involved in the decision to utilise a restrictive practice?
- Describe the restrictive practice utilised, eg side rails, physical holding.

- How was the service users physical and psychological well being monitored?
- Has the service users care/treatment/behaviour plan been updated as a result of the restrictive practice to reduce the likelihood of further restriction having to be applied?
- Is it necessary to complete an incident form?

Belfast Health and Social Care Trust

# Restriction Checklist

Patient Name: ------------------------------------------------------ Hospital Number: ---------------------------------------------- Date: -----------------------------------------

Name of assessor: -------------------------------------------------

1. **Is the patient exhibiting behaviour that:**

   Endangers his/her own safety ☐
   Endangers the safety of other patients/staff ☐

2. **Describe this behaviour (this may be a combination):**

   Wandering ☐
   Confused ☐
   Agitated ☐
   Physically or verbally aggressive ☐
   Falling (> 1 time) ☐
   Disinhibition ☐
   Disrupting Essential Therapy ☐

   Other (describe) -------------------------------------------------------------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------

3. **Identify possible causes for Altered Behaviour:**

   Direct complication of brain injury ☐
   Infection outside the CNS (eg respiratory, urinary tract) ☐
   Metabolic/Electrolyte imbalance – check blood sugar, biochemistry ☐
   Adverse effects of medication ☐
   Hypoxia due to respiratory or cardiac disease ☐
   Anxiety or situational frustration ☐
   Intracranial bleed, mass, infection ☐
   Memory Impairment ☐
   Seizure disorder (Ictal or Postictal states) ☐
   Mental handicap or illness ☐
   Drug dependency/withdrawal ☐
   Alcohol withdrawal or intoxication ☐
   Dementia or neurodegenerative disorder (eg Parkinson's) ☐
   Bowel/Bladder full ☐
   Pain ☐
   Fat emboli if poly trauma ☐

4. **Reason that use restrictive practice is required:** ----------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------
   -------------------------------------------------------------------------------------------

Belfast Health and Social Care Trust

# Restriction Checklist

Patient Name: ---------------------------------------------------- Hospital Number: -------------------------------------------- Date: ---------------------------------------

Name of assessor: -----------------------------------------------

**5. Identify minimum use restrictive practice to be used:**

Try to diffuse situation using the minimum of staff consistent with safety ☐
Remove harmful objects ☐
Optimise environment to reduce triggers ☐
Provide orientating stimuli (eg clock) ☐
Minimise distractions where possible ☐
Milieu management (eg music, video, change of room) ☐
Offer to provide comfort measures ☐
Utilize verbal de-escalation techniques ☐
Utilize direct observation, ie 1:1 specialing ☐
Provide the patient with the opportunity to control their activity ☐

Provide appropriate diversional activities – describe: --------------
-------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------
Involve family or significant others to calm the situation ☐

Unable to utilize less restrictive alternatives (explain) ---------------
-------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------
-------------------------------------------------------------------------------------

**6. Identify maximum use restrictive practice to be used:**

Use of specific limb use restrictive practicest devices eg 'Posey Mitt' ☐

Use of material to restrict movement eg bed rails ☐

Use of chair use restrictive practicest, eg chair belt, table tops, shoulder strap ☐
Pharmacological management ☐
Use of key padded/locked doors to restrict movement ☐

**7. Consultation with Patient/Relative/Carer regarding use of identified use restrictive practice:**

Name of person consulted: ----------------------------------------------

Relationship to the patient: ----------------------------------------------

By whom: ----------------------------------------------------------------------

Describe outcome: -------------------------------------------------------

-------------------------------------------------------------------------------------

-------------------------------------------------------------------------------------

**8. Ensure:**

Respiration and circulation are not compromised ☐
Hygiene and toileting offered ☐
Food and fluids offered ☐
Skin integrity checked ☐
Assess ongoing need for use restrictive practice ☐
Care plan updated

Belfast Health and Social Care Trust

# Restriction Checklist

Patient Name: ----------------------------------------------------- Hospital Number: ---------------------------------------------- Date: -----------------------------------------

Name of assessor: ------------------------------------------------

Aggravating factors such as pain are reviewed☐

**9.--Time use restrictive practice implemented**: -----------------------

**10. Evaluate use restrictive practice 2 hourly**

| | ***Signature*** | | ***Signature*** |
|---|---|---|---|
| 00.00 | | 12.00 | |
| 01.00 | | 13.00 | |
| 02.00 | | 14.00 | |
| 03.00 | | 15.00 | |
| 04.00 | | 16.00 | |
| 05.00 | | 17.00 | |
| 06.00 | | 18.00 | |
| 07.00 | | 19.00 | |
| 08.00 | | 20.00 | |
| 09.00 | | 21.00 | |
| 10.00 | | 22.00 | |
| 11.00 | | 23.00 | |
| | | 24.00 | |

Belfast Health and Social Care Trust

## Standards and Guidelines Committee

| *Use of Restrictive Practices in Adults* | |
|---|---|
| **Summary** | This policy aims to provide a framework of professional practice in relation to a broad range of restrictive practices and outlines the procedures that need to be followed when a patient/service user presents a risk of harm to himself/herself or others and it is deemed necessary to use a restrictive practice. This may include restrictive environmental, social, pharmacological, mechanical and physical interventions in order to limit the adverse outcomes of such risk. |
| **Purpose** | To provide guidance to staff on the use of restrictive practices. The Trust recognizes that it may be necessary to use restrictive practices to maintain patient / service user personal safety with the intention of preventing injury and protecting patients/service users and staff to ensure the effective outcome of procedures /treatment /care. |
| **Operational date** | Jan 2011 |
| **Review date** | Jan 2014 |
| **Version Number** | V2 |
| **Director Responsible** | Brenda Creaney D.O.N. |
| **Lead Author** | Olive Macleod |
| **Lead Author, Position** | Co Director Nursing |
| **Additional Author(s)** | |
| **Department / Service Group** | |
| **Contact details** | *Knockbracken Health Care Park, 90565680* |

| | |
|---|---|
| **Reference Number** | SG0015/09 |
| Supersedes | Legacy policies |

| Date | Version | Author | Comments |
|---|---|---|---|
| 22/09/2008 | V0.1 | O Macleod | Draft 1 |
| 24/11/2008 | V0.2 | O Macleod | Comments from Legal Dept |
| 1/02/2009 | V0.3 | O Macleod | Comments from Ethics committee |
| 18/02/2009 | V0.4 | O Macleod | Comments H&S Service Group |
| 22/02/2009 | V0.5 | O Macleod | Comments Equality Manager |
| 9/03/2009 | V0.6 | O Macleod | Comments from DON & D of MH |
| 11/03/2009 | V0.7 | O Macleod | Amended with MH and LD |
| 7/4/2009 | V0.8 | JR Johnston | Formatting; Paul Devine changes |
| 29/10/09 | V1.1 | A Brannigan | Comments management of Aggression Team |
| 10/05/10 | V1.2 | T Patterson | Editing |
| 31/5/10 | V1.3 | O Macleod | Comments |
| 04/08/10 | V1.4 | T Patterson | Comments |
| 16/08/10 | V1.5 | O MacLeod | Review of policy |
| | | | |

**Policy Record**

| | | Date | Version |
|---|---|---|---|
| Author (s) | Approval | | |
| Director Responsible | Approval | | |

**Approval Process – Trust Policies**

| | | | |
|---|---|---|---|
| Policy Committee | Approval | | |
| Executive Team | Authorise | | |
| Chief Executive | Sign Off | | |

**Approval Process – Clinical Standards and Guidelines**

| | | | |
|---|---|---|---|
| Standards and Guidelines Committee | Approval | April 2009 | V0.8 |
| Policy Committee | Approval | May 2009 | V0.8 |
| Standards and Guidelines Committee – Review | Approval | 15/12/10 | V1.5 |
| Policy Committee - Review | Approval | 17/01/11 | V1.5 |
| Executive Team | Authorise | 19/01/11 | V1.5 |
| Appropriate Director | Sign Off | 21/01/11 | V1.5 |

## Summary

**Reference No:** *SG 15/09*

**Title:** **Use of Restrictive Practices in Adults**

**Purpose:**

This policy aims to provide a clear framework and guidance to staff on the use of restrictive practices.
The Trust recognizes that it may be necessary to use restrictive practices to maintain with the safety of patients/clients and staff to ensure the effective outcome of procedures /treatment /care, and also to reduce the likelihood of restrictive practices which are unacceptable and leave service users and/or staff vulnerable to unreasonable levels of risk or harm.

**Objectives:**

- To ensure safe and dignified access of the patient / service user to assessment, treatment and care.
- To ensure least harm to patients/clients/staff or others who come into contact with the trust and its services.
- To increase the participation of patients/clients and significant others with members of the health and social care team in the process of consultation, decision making and planning care regarding appropriate use of restrictive practices.
- To ensure that when restrictive practices are used they fall within current legal, professional and ethical boundaries of good practice and that every effort is made to ensure vulnerable people are not subjected to the inappropriate use of such practice.

- To ensure that all uses of restrictive practices are considered only after an assessment of risk that justifies its use when other options are deemed inappropriate or have failed.
- To support the development of a culture that ensures the use of the least restrictive approach for the shortest period of time.

**Policy Statement(s):**

Belfast Health & Social Care Trust is committed to ensure that methods of restrictive intervention are:

- Used as infrequently as possible

- That they are used in the best interest of the individual service user.

- That when they are used, every reasonable effort is made to minimise the risk of harm or injury to anyone involved, and that the need to maintain individual respect, dignity and welfare is maintained

- That all employees understand their obligations to use restrictive interventions in an appropriate manner.

- Restrictive interventions are not seen as a long-term solution in the management of service user behaviour. They may, in the short term, help to effectively and safely support service users achieve improved outcomes in terms of greater inclusion, choice, independence, rights and safety as part of a wider approach.

- The decision to use such approaches should only be made following an assessment of risk taking into account the possible benefits such approaches may give to the service user balanced against the possible harms that could result. Such a decision may also take account of the impact such approaches have on other people who may be affected by the service user"s behaviour. This may include other service users, staff, as well as members of the community.

- Every effort is made to use skills and techniques that do not use the deliberate application of pain. – The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. NICE 2005. Where staff have a need to use such approaches, they must fully understand the legal, ethical and professional implications and be prepared to justify their actions.

- The scale and nature of restrictive practice must be **proportionate** to both the behaviour of the individual to be managed and the nature of the harm likely to be caused.

- Restrictive practices will not be used for staff convenience.

Olive Macleod

**Author** O MACLEOD

**Director**

**Date: Jan 2011** **Date: Jan 2011**

**Full Description**

**Reference No:** *SG 15/09*

## 1 Use of Restrictive practices with Adults

2. **Purpose:**
To provide guidance to staff on the use of use of restrictive practices. The Trust recognizes that it may be necessary to use restrictive practices to maintain patient / service user personal safety with the intention of preventing injury and protecting patients/service users and staff to ensure the effective outcome of procedures /treatment /care.
3. **The scope:**
This policy is relevant for all staff caring for patients/client receiving treatment or care within BHSCT.
4. **Objectives:**
    - To ensure safe and dignified access of the patient / service user to assessment, treatment and care.
    - To ensure least harm to patients/clients/staff or others who come into contact with the trust and its services.
    - To increase the participation of patients/clients and significant others with members of the health and social care team in the process of consultation, decision making and planning care regarding appropriate use of restrictive practices.
    - To ensure that when restrictive practices are used they fall within current legal, professional and ethical boundaries of good practice and that every effort is made to ensure vulnerable people are not subjected to the inappropriate use of such practice.

    - To ensure that all uses of restrictive practices are considered only after an assessment of risk that justifies its use when other options are deemed reasonably inappropriate or to have failed.
    - To support the development of a culture that ensures the use of the least restrictive approach for the shortest period of time.

5. **Roles and Responsibilities:**

It is the responsibility of all Trust staff to adhere to this policy.

## 6 The definition and background of the policy:

.

The term „restrictive intervention" is used generically to describe any strategy or intervention which restricts or limits another person"s liberty. The definition of „restrictive intervention" adopted by BHSCT is:

> „Any form of restrictive intervention, be it a physical, mechanical, pharmacological, environmental or social/psychological intervention, which is designed and used (intentionally or unintentionally) to limit or restrict another person"s liberty".
>
> (BILD 2006)

With the exception of unforeseen or unpredicted adverse events, the use of restrictive interventions should only be seen within the context of an overall management approach necessary to manage risk and maintain everyone's safety.

Before using any form of restrictive practice staff must undertake an initial assessment that provides a clear rationale as to why the patient or service user is at risk of harm and demonstrate that they are acting in the patient or service user"s best interest. This must be documented clearly in the patient"s clinical notes / care plan.

Where restrictive interventions are used, they should be applied using the least restrictive option and the use of the restrictive interventions must be appropriately documented.

Persons, regardless of their mental or physical state, have the same human rights - any use of restrictive practices may lead to someone being denied these fundamental human rights.

Under <u>no</u> circumstances should the restrictive interventions described be used as a means of punishment or to force compliance where risk is either not present or could be managed in a non-restrictive way.

Knowing how and when to use restrictive practices in an ethical, safe and legally defensible way is key.

The Trust recognises that a planned approach cannot always be taken, as it is difficult to account for every eventuality that may arise. As such, staff must endeavor to account for the most likely eventualities which could occur and use their scope of professional practice to make confident and competent decisions for those events that are unforeseen or unplanned.

### Restriction definitions

| Table 1 Description | Examples |
|---|---|
| **Environmental Restriction**<br>„The use of locked doors, baffle handles, low stimulus or time out rooms, fences, gates or legal restrictions to contain or limit an individual to or from one particular room, building or area" | A service user may be managed in a quiet room away from others either to prevent the escalation of a situation or as part of a de-escalation process in order to reduce the risk of others being harmed.<br>Or to protect service users dignity when they are displaying disinhibited behaviour |
| ***Social Restriction***<br>„The use of verbal instructions or commands, withdrawal procedures, social restriction or time out from positive | A service user may be prevented from going swimming because they are so agitated the |

| | |
|---|---|
| reinforcement to limit, interrupt or stop an individuals behaviour which is viewed as potentially harmful, undesirable or socially unacceptable" | activity itself would increase the potential risk of harm should the service user"s behaviour escalate. |
| **Pharmacological Restriction**<br>„The use of pharmacological/pharmaceutical agents to alleviate or manage an individuals underlying psychological/psychopathological condition or behaviour disturbance" | A service user may be prescribed „as required medication" for use in emergency situations where their behaviour becomes more disturbed. The medication may have a sedating effect thereby reducing the risks. |
| **Mechanical Restriction**<br>„The use of splints, straps, tethers, harnesses or equipment (e.g. reclining chairs, wheel chairs, bed rails) to limit or restrict an individual"s ability to move" | Arm splints may be used where a service user engages in self injurious behaviour to protect them from serious harm or side rails where they are at risk from rolling out of bed |
| **Physical Restriction**<br>**1) Holding Skills/physical restraint**<br>'The use of physical holds to limit or restrict an individual"s ability to move during the provision of „safe and supportive care" or in the management of a „violent episode"<br>This would require more than one member of staff | Staff may use holding skills to assist in the support and care of service users who present with challenging behaviour or in situations where service users present with behaviour which is aggressive and violent |
| **2) Disengagement Skills or escape techniques/**<br>„The use of physical actions to limit, stop or gain a release from harmful or injurious physical contact initiated by another person during the provision of care and/or in situations requiring escape in the management of a violent episode" | Staff may employ disengagement skills for self or others to promote and/or protect well-being in the support and care of service users who present with challenging behaviour or in situations where service users who present with behaviour which is aggressive and violent. |

If any of these apply in your area of work an operational procedure must be in place.

## 7. Policy statements:

7.1

Belfast Health & Social Care Trust is committed to ensure that methods of restrictive intervention are:

- Used as infrequently as possible
- That they are used in the best interest of the individual service user.
- That when they are used, every reasonable effort is made to minimise the risk of harm or injury to anyone involved, and that the need to maintain individual respect, dignity and welfare is maintained
- That all employees understand their obligations to use restrictive interventions in an appropriate manner so as to avoid, wherever reasonably practicable, any recourse to criminal charges or action under current civil law or health and safety legislation.
- Restrictive interventions are not seen as a long-term solution in the management of service user behaviour. They may, in the short term, help to effectively and safely support service users achieve improved outcomes in terms of greater inclusion, choice, independence, rights and safety as part of a wider approach.
- The decision to use such approaches should only be made following an assessment of risk taking into account the possible benefits such approaches may give to the service user balanced against the possible harms that could result. Such a decision may also take account of the impact such approaches have on other people who may be affected by the service user"s behaviour. This may include other service users, staff, as well as members of the community.
- Every effort is made to use skills and techniques that do not use the deliberate application of pain. – The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. NICE 2005. Where staff have a need to use such approaches, they must fully understand the legal, ethical and professional implications and be prepared to justify their actions.
- The scale and nature of restrictive practice must be **proportionate** to both the behaviour of the individual to be managed and the nature of the harm likely to be caused.
- Restrictive practices will not be used for staff convenience.
- In order to support this policy, the organisation is committed to ensuring all staff in those areas where there is a likelihood of restrictive interventions being used receive a sufficient level of training, supervision and instruction on such approaches.

## 8. Implementation / Resource requirements:

It is the responsibility of all service group managers to ensure risk assessment has been completed in areas where staff is expected to engage in any restrictive environmental, social, pharmacological, mechanical or physical intervention.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of their service users.

These assessments will require regular audit to determine their acceptability and efficiency.

## 9. Source(s) / Evidence Base:

Guidance on Restraint and Seclusion in HPSS, 2005)
NMC The Code 2008
HSS (MD)8-2008
Akid, M. (2002) Drugged and Caged by Cot sides. Nursing Times 98 (3) Cover Story.
Darby, S. (1990) Containing the Wanderer. Nursing Times 86 (15) 42-43
Department of Health (2001) National Service Framework for Older People Department of Health. London.
DHSSPSNI (2004) Human Rights working Group of Restraint and Seclusion. Guidance on Restraint and Seclusion in Health and Personal Social Services. DHSSPSNI.
Marr, J. (1998) Electronic Tagging. Nursing Standard 4 (9) 54.
Stirling, C. McHugh, A. (1998) developing a non-aversive intervention strategy in the management of aggression and violence for people with learning disabilities using natural therapeutic holding. Journal of Advanced Nursing. 27 503-509.
*Good Practice in Consent: Implementation Guide for Health Care Professionals Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002 Guidance on the Use of Restrictive Physical Interventions'* (Department of Health, July 2002*);*
*Code of Practice for Trainers in the Use of Physical Interventions- Second Edition'* (BILD, 2006)
Safeguarding Vulnerable Adults BHSCT
Risk Management Policy BHSCT
Zero Tolerance Approach To The Prevention And Management Of Violence Anc
Aggression In The Workplace ( BHSCT 2008)

## 10 References, including relevant external guidelines

Improving Patients Safety: Building Confidence (DHSSPS 2006)
Management of Aggression – Trust-net.
Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;
NMC Guidelines for Records and Record Keeping
Managing Complaints Procedures – Trust policy
Incident Reporting Procedures – Trust-policy
Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org
RCN, 2008 Let"s Talk About Restraint London,
National Neurosciences Benchmarking Group, 2007 Use restrictive practicest Benchmark –www.nnbg.org.uk
*Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.* National Institute of Clinical Excellence.( 2005) CG25.
*Wolverson M.* Continuing Professional Development Self injurious behaviour and learning disabilities.( 2004)
Rapid Response Report. National Patient Safety Agency (2008)
*'BILD* Mental Health Policy Implementation Guide.
*Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings.* National Institute for Mental Health in England. (2004)
Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*
The Human Rights Act 1998 Guidance for Northern Ireland Departments – Office of First Minister and Deputy First Minister, Human Rights Directorate

## 11 Consultation Process:

Trust Ethics Committee
Trust Legal Department
Director of Nursing
Director of Mental Health & Learning Disability
Medical Directors Office
Standards& Guidelines Committee,
Policy Committee

## 12 Equality and Human Rights screening carried out:

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

**The Trust is required to comply with its obligations under the European Convention of Human Rights as enshrined in the Human Rights Act 1998 The trust is satisfied that this policy is compatible with these obligations**

☐ Screening completed No action required.

☐ Full impact assessment to be carried out.

BMCreaney

Olive MacLeod.

**Director Brenda Creaney**

**Date: Jan 2011**

**Author Olive MacLeod**

**Date: Jan 2011**

## Appendix 1
## Consent for the Use of Restrictive Practices

Provided an individual is considered „capable" of so doing, he/she must give „informed consent" for a restrictive practice to be used.

A high proportion of service users will be capable of giving informed consent. This capacity to consent should be determined by the multi disciplinary team, including the professional considering recommending a restrictive practice. Consent should be sought at the time of developing the Person Centred Care and Intervention Plan. This determination should be on the basis of the service users:

- understanding of both the nature and the reason for the proposed intervention
- understanding of both the benefits and the risks of the proposed intervention
- understanding of the consequences of *not* consenting to the intervention
- possessing the capacity to make the necessary choice

## Restrictive Practices in the Absence of Consent

In the case of adults who are not considered capable of providing informed consent, there is presently no provision for anyone else to provide consent on their behalf.

**Restrictive practices may be defensible without consent provided the proposed intervention is demonstrably in his/_her best interests.** Indeed, it is important to note in this regard that *not* applying a particular intervention could, in certain circumstances, be construed as a breach of a „duty of care" in that the omission to act could endanger the service user, staff or others in the environment.
In considering the best interests of the service user, the staff involved in this process should demonstrate consultation with appropriate professionals, carers and advocacy services.
Planned Restrictive Practices should be developed on the basis of the following:-

- information about the service user and his/her behaviour(s) obtained through a thorough, multi-disciplinary assessment
- assessment and evaluation of all alternative approaches already introduced
- evaluation of the possible risks associated with a given intervention
- consideration of a body of expert knowledge and established good practice
- consultation with carers

## Risk Assessment

Where restrictive interventions are used staff have an obligation to assess the risks associated with such practice.
Within individual work settings, it is important that staff are aware of the appropriate risk assessments to be completed for their service area.

Consideration of the risk posed by the service user (to themselves or others) **must** be balanced against the level of restrictions, which may be applied by staff
A structured approach to risk analysis and risk management will help staff to develop safe, sound and supportive approaches. This will help avoid unnecessarily compromising the rights of others whilst promoting the welfare and safety of everyone involved.
Assessment should take into account the service users unique needs physically, socially and psychologically.

Once the appropriate risk assessments and management plans are completed these should be communicated to all relevant staff, and where appropriate the service user and/relatives/carers/advocates.

## Practical Application of Restrictive Practices

### Environmental Restrictions

Many settings use the environment to help guard, segregate or limit service user access to and from certain areas whilst enabling staff to provide a higher level of support and supervision.
Where service users present significant challenging behaviour, environmental restriction may enable staff to provide a greater level of help, support or supervision and prevent disruption to others.

This approach is not to be confused with the routine locking of doors, windows or rooms as a means of general safety and security, particularly where service users are vulnerable to harm (e.g locking a door to an electrical room, locking the main entrance door to prevent unwanted or uninvited visitors).

Frequent and prolonged use of environmental restriction should be avoided unless specific permissions are sought and specific policy and guidance is issued to ensure the practice is strictly regulated and reviewed (e.g. in the case of prescribed time out or seclusion procedures).

In order to safeguard the unnecessary and unjustified use of environmental restriction, the following guidelines should be implemented:

- Environmental restrictions should only be used as part of a wider individual care or treatment plan.
- The use of bedrooms for this purpose should be avoided, as far as possible, as this may represent the service user"s only private space. Their bedroom may become associated with an aversive event rather than an area of privacy and individual identity. Instead, staff should look to find the nearest and most appropriate place to manage the service user in terms of limiting their access to other parts of the building
- Where the environment does not allow for a flexible approach to environmental restriction, a nominated room should only be used following a full risk assessment to ensure that there are no obvious potential hazards to the service user.

- Environmental restrictions should be time limited with specific observation intervals written into the service user‟s interventions plan.
- Service users should still be under staff supervision.

## Social Restrictions

Social restrictions are generally used to segregate or limit service user access to socially integrated activities where the service user‟s behaviour represents a significant risk to themselves or others.

A potential disadvantage of using such an approach is that the individual is prevented from exercising their choice, independence and inclusion thereby increasing the likelihood of further challenging behaviour. As such the benefits of social restriction must be demonstrated to outweigh the risk.

Social restriction should never be used to compensate for a lack of appropriate resources to support service users to access integrated community facilities. However, in situations where staff need specific knowledge and skills to support service users effectively, it may be acceptable to temporarily implement social restrictions until such time as staff have been equipped with the necessary training.

In order to safeguard the unnecessary use of social restriction, the following guidelines should be implemented:

- Social restrictions should only be used as part of a wider individual care or treatment plan.
- The service user plan must clearly outline the risks and the specific social restrictions that are to be used. A „blanket approach‟ to social restriction should not be agreed unless the level of risk for all activities is significant. Wherever possible, each social event or activity should be specified within the plan.
- Staff must comply with statutory regulations where a social restriction is legally enforceable (e.g. Mental Health Order 1986).

## Pharmacological Restriction

Pharmacological agents can only be used under the direction and prescription of a qualified prescriber. A number of medicines may be prescribed to help stabilise the service user‟s mood or to moderate mental ill health and other organic factors which may contribute to the individual‟s challenging behaviour. In addition to regularly prescribed medicines, some service users may be prescribed additional “as required” medication.

Medication should be prescribed with a clear therapeutic aim and must not be used as a means of exerting control over service users. Prescribed medication must be reviewed regularly to ensure that principle is adhered to. Staff have a responsibility to observe and report service user behaviour as accurately as possible to assist prescribers when making prescribing decisions. Once medication has been prescribed, staff have responsibility to continually observe and assess service users for the effect of medication on their mental state and for the emergence of side effects.

The administration of “as required” medication must be to the same standard as that for regular medication. The nurse must follow the guidance of the NMC with regard to the administration of medicines and comply with requirements of the Trust Medicine Code. The administration must be recorded clearly on the medicines administration record ensuring that the time of administration and the actual dose administered (where a variable dose is allowed) is clearly documented. Addition records may be needed in the patients notes detailing the reason why “as required” medicines were needed and an assessment of the effectiveness of the intervention. The follow points should be considered

- Pay attention to any instructions on the indication for the as required medication
- Check the timing of administration carefully if a range of times is permitted e.g. every 4 to 6 hours. Make sure the medication is not being given too early
- Check that any maximum dose stated will not be exceeded (calculate back 24hrs from the current time)
- Medication should not be concealed in food or drink
  Rapid tranquilisation should be viewed as a crisis intervention in the management of challenging, aggressive or violent behaviour and must be carried out in accordance with the Trust Guideline for Rapid Tranquillisation

**Mechanical Restrictions**

Mechanical restrictions are not normally used in the management of challenging, aggressive or violent behaviour.
Typically, mechanical restrictions are used for safety and protection to prevent service users sustaining injury (e.g., the use of bedrails to prevent someone falling out of bed) or to assist or improve an individual‟s posture (e.g., a standing frame or wheel chair harness).

Mechanical restraint devices are on occasions used as a response for the reactive management of self-injurious behaviour. Self-injurious behaviours indicate significant, emotive and distressing phenomenon for the individual, their carers and service providers, Wolverson (2006)

The use of mechanical restrictions for the management of challenging behaviour is usually associated with arm „splints‟ or „cuffs‟ and head guards to prevent self-injurious behaviour. In some extreme situations, it may be considered appropriate to use mechanical restrictions if a service user is engaging in behaviour that represents a significant risk to others.

For some service users the use of a mechanical restriction may represent a lesser aversive option than physical restrictions since, once applied, staff are no longer required to maintain physical contact. Also, provided that the device has been specifically designed and built for the service user, fewer adverse outcomes or injuries may result.

However, if mechanical restrictions are being used as part of a care /treatment /behaviour plan, it is likely that staff will still need to attend training on physical interventions since they will need to know how to safely hold the service user in order to apply and remove the mechanical restriction.

Whenever mechanical restrictions are used, staff should ensure that:

- The multidisciplinary team have agreed to the approach (e.g. when used for a service user who self harms, since a broader intervention programme will be required).
- The mechanical aids used have been specifically designed and manufactured for the individual service user. Staff should avoid developing their own mechanical aids and should never use tethers or harnesses not specifically designed for purpose.
- Staff should ensure that any mechanical restriction used is routinely checked prior to use to ensure the aid remains „fit for purpose‟ and arrange regular servicing of such equipment by the manufacturer.
- Where physical intervention is required to apply any mechanical restriction, staff should receive necessary training so as to ensure they act within legal, professional and ethical boundaries.

**Physical Restrictions**

Table 1 illustrates a clear distinction between restrictive physical interventions in terms of defining „safe holding‟/physical restraint and „disengagement‟ skills.

As such, staff may use physical restrictions to help them deliver the appropriate level of support, or care in a safer way.
Alternatively, staff may have to safely hold a service user whose behaviour has become disruptive and poses a risk to others within the same environment.
The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All restrictive physical interventions should be applied in a manner that attempts to defuse rather than provoke further aggression.

All staff who may be involved in the application of restrictive physical interventions should receive an appropriate level of training as detailed in section 7.8

The decision to use physical interventions must be fully documented following the completion of all relevant risk assessments and where appropriate the development of an individual care/treatment/behaviour/ plan.
Where appropriate these may be shared with family members/carers/advocates and members of the multidisciplinary team so that they have the opportunity to raise any questions or concerns.

In emergency situations, staff may need to use restrictive physical interventions with an individual who has not previously been assessed as presenting a risk of aggression or violence. Following such an incident, the appropriate risk assessments and intervention plans must be completed as soon as is reasonably practicable.

**Practical Guidelines for the Application of Restrictive Physical Interventions**

Staff who may be involved in carrying out physical restraint must be trained in:

- Basic life support skills and attend annual updates.
- The physical risks associated with restraint, i.e. positional asphyxia/sudden collapse/injury/ discomfort.
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.

- Use of emergency equipment.
- Knowing how to summon assistance

NPSA (2008)

Any service user subject to physical restraint should be medically assessed at the earliest opportunity but no longer than 2 hours after the commencement of physical restraint.

Any service user subject to physical restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of up to 24 hours. This check should include:

- Care in the recovery position if appropriate
- Pulse
- Blood pressure
- Respiration
- Temperature
- Fluid and food intake and output.

NICE (2005)

If consent and co-operation for these observations is not forthcoming from the person, then it should be clearly documented in their notes why certain checks could not be performed and what alternative actions have been taken.

- When ever possible, always attempt to protect the individual‟s head from harm and take into account the amount of energy a person may use during a disturbed episode.
- Observe for heat exhaustion, fatigue, restricted or impaired breathing, muscle cramp, and the adverse effects of medication. The safety of the individual must never be compromised – if in any doubt regarding the individual‟s welfare, staff must end the intervention immediately.
- Service users and carers should be treated with respect at all times and their dignity maintained.
- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users co-operation and a return to voluntary control as soon as is safely possible.
- Well-briefed, trained and co-ordinated staff will be the most effective in a physical restraint situation.
- *A* person should be nominated to co-ordinate the intervention and speak to the individual. This avoids unnecessary confusion.

- Every action taken must always be explained to the individual regardless of their ability or willingness to communicate. At all times treat the individual with the dignity and respect deserving of all human beings. Always ensure privacy is maintained by moving on-lookers away or asking the individual to move to a low stimulus area.
- Transferring a struggling service user to a low stimulus area presents a significant risk of harm to the patient and staff through the process of the patient‟s struggle and/or their weight, especially if they were to be carried by staff. It is important that staff are clear about the safeguards and limitations provided by the Manual Handling Operations Regulations (MHOR 1992)
- The MHOR (1992) do not permit full-weight lifts of people unless the situation is exceptional or life threatening. Consequently, staff are not ordinarily expected to pick up or carry patients from one area to the other.

Staff should encourage the patient to co-operate with them and wait until the patient will walk with staff.

- Ideally staff taking the lead in restrictive physical interventions should be those who have received training in such skills within BHSCT, as they will be able to provide advice and guidance to others.
- Never hold an individual around the neck and avoid any pressure to the chest and abdomen since this significantly increases the risk of postural asphyxiation. Never cover the mouth or screen the individual's vision.
- Avoid making contact with any part of the individual"s body that could be viewed as culturally, socially or sexually unacceptable (ie face, neck, chest, abdomen, buttocks, groin, and inner thighs).
- Any physical condition, which may increase the risk to the patient of collapse or injury during physical intervention should be clearly documented in the patients file and communicated to all multi-disciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate (NIMHE 2004).

## Recording and reporting restrictive practices.

All restrictive practices should be documented in accordance with trust recording and reporting procedures.
It is the responsibility of each service area to ensure agreed service specific documentation is available and that staff are aware of this and trained in the use of such documents.
Staff must ensure that all restrictive practices are documented including the information contained in the checklist below.
Where these actions could not be taken staff should document why these could not be achieved.

## Checklist for the use of restrictive practices

The purpose of this checklist is to provide a framework for service groups whose staff may be expected to utilise restrictive practices as part of their duties. Documentation should include:

- Patient name
- Patient No.
- Unit/Ward
- Date when restrictive practice commenced
- Date restrictive practice ceased
- Name of staff member in charge at the time restrictive practice was utilised.
- Time restrictive practice commenced
- Time restrictive practice ceased
- Was service user endangering self?
- Was service user endangering others?
- What actions did staff take prior to engaging in restrictive practice, e.g. none -insufficient time, attempts to de-escalate, etc.
- Was consent for the intervention sought?
- Was a multi-disciplinary risk assessment agreed /completed?
- Was the service user/ carers /advocates/relatives involved in the decision to utilise a restrictive practice?
- Describe the restrictive practice utilised, eg side rails, physical holding.

- How was the service users physical and psychological well being monitored?
- Has the service users care/treatment/behaviour plan been updated as a result of the restrictive practice to reduce the likelihood of further restriction having to be applied?
- Is it necessary to complete an incident form?

Belfast Health and Social Care Trust

# Restriction Checklist

Patient Name: ------------------------------------------------------- Hospital Number: ---------------------------------------------- Date: -----------------------------------------

Name of assessor: --------------------------------------------------

## 1. Is the patient exhibiting behaviour that:

Endangers his/her own safety ☐
Endangers the safety of other patients/staff ☐

## 2. Describe this behaviour (this may be a combination):

Wandering ☐
Confused ☐
Agitated ☐
Physically or verbally aggressive ☐
Falling (> 1 time) ☐
Disinhibition ☐
Disrupting Essential Therapy ☐

Other (describe) -------------------------------------------------------
-----------------------------------------------------------------------------
-----------------------------------------------------------------------------
-----------------------------------------------------------------------------
-----------------------------------------------------------------------------

## 3. Identify possible causes for Altered Behaviour:

Direct complication of brain injury ☐
Infection outside the CNS (eg respiratory, urinary tract) ☐
Metabolic/Electrolyte imbalance – check blood sugar, biochemistry ☐
Adverse effects of medication ☐
Hypoxia due to respiratory or cardiac disease ☐
Anxiety or situational frustration ☐
Intracranial bleed, mass, infection ☐
Memory Impairment ☐
Seizure disorder (Ictal or Postictal states) ☐
Mental handicap or illness ☐
Drug dependency/withdrawal ☐
Alcohol withdrawal or intoxication ☐
Dementia or neurodegenerative disorder (eg Parkinson's) ☐
Bowel/Bladder full ☐
Pain ☐
Fat emboli if poly trauma ☐

## 4. Reason that use restrictive practice is required: ---------------

-----------------------------------------------------------------------------
-----------------------------------------------------------------------------
-----------------------------------------------------------------------------
-----------------------------------------------------------------------------

Belfast Health and Social Care Trust

# Restriction Checklist

Patient Name: ---------------------------------------------------- Hospital Number: -------------------------------------------- Date: ---------------------------------------

Name of assessor: -----------------------------------------------

## 5. Identify minimum use restrictive practice to be used:

Try to diffuse situation using the minimum of staff consistent with safety ☐
Remove harmful objects ☐
Optimise environment to reduce triggers ☐
Provide orientating stimuli (eg clock) ☐
Minimise distractions where possible ☐
Milieu management (eg music, video, change of room) ☐
Offer to provide comfort measures ☐
Utilize verbal de-escalation techniques ☐
Utilize direct observation, ie 1:1 specialing ☐
Provide the patient with the opportunity to control their activity ☐

Provide appropriate diversional activities – describe: -------------
----------------------------------------------------------------------------
----------------------------------------------------------------------------
----------------------------------------------------------------------------
Involve family or significant others to calm the situation ☐

Unable to utilize less restrictive alternatives (explain)--------------
----------------------------------------------------------------------------
----------------------------------------------------------------------------
----------------------------------------------------------------------------

## 6. Identify maximum use restrictive practice to be used:

Use of specific limb use restrictive practicest devices eg „Posey Mitt" ☐

Use of material to restrict movement eg bed rails ☐

Use of chair use restrictive practicest, eg chair belt, table tops, shoulder strap ☐
Pharmacological management ☐
Use of key padded/locked doors to restrict movement ☐

## 7. Consultation with Patient/Relative/Carer regarding use of identified use restrictive practice:

Name of person consulted: ------------------------------------------

Relationship to the patient: ------------------------------------------

By whom: -------------------------------------------------------------

Describe outcome: ---------------------------------------------------

----------------------------------------------------------------------------

----------------------------------------------------------------------------

## 8. Ensure:

Respiration and circulation are not compromised ☐
Hygiene and toileting offered ☐
Food and fluids offered ☐
Skin integrity checked ☐
Assess ongoing need for use restrictive practice ☐
Care plan updated

Belfast Health and
Social Care Trust

# Restriction Checklist

Patient Name: ---------------------------------------------------- Hospital Number: -------------------------------------------- Date: --------------------------------------

Name of assessor: -----------------------------------------------

Aggravating factors such as pain are reviewed☐

**9.--Time use restrictive practice implemented**: --------------------

**10. Evaluate use restrictive practice 2 hourly**

| | ***Signature*** | | ***Signature*** |
|---|---|---|---|
| 00.00 | | 12.00 | |
| 01.00 | | 13.00 | |
| 02.00 | | 14.00 | |
| 03.00 | | 15.00 | |
| 04.00 | | 16.00 | |
| 05.00 | | 17.00 | |
| 06.00 | | 18.00 | |
| 07.00 | | 19.00 | |
| 08.00 | | 20.00 | |
| 09.00 | | 21.00 | |
| 10.00 | | 22.00 | |
| 11.00 | | 23.00 | |
| | | 24.00 | |

Belfast Health and
Social Care Trust

**Reference No:** S&G 15/09

| | | | |
|---|---|---|---|
| **Title:** | **Use of Restrictive Interventions for Adult & Children's Services** | | |
| **Author(s)** | Anne Brannigan, Trust Advisor/Trainer on management of aggression<br>Email [redacted]<br>Tara Patterson, Trust Advisor/Trainer on management of aggression<br>Email [redacted] | | |
| **Ownership:** | Dr Cathy Jack, Medical Director | | |
| **Approval by:** | Standards and Guidelines<br>Policy Committee<br>Executive Team Meeting | **Approval date:** | 11/03/2015<br>01/04/2015<br>03/04/2015 |
| **Operational Date:** | May 2015 | **Next Review:** | May 2018 |
| **Version No.** | V3 | **Supercedes** | V2 – January 2011-2014 |
| **Key words:** | Restraint Reduction, Restrictive practice | | |
| **Links to other policies** | Adult Protection Policy & Procedures 2013 ref TP44/10<br>Being Open Policy 2011ref SG56/11<br>Whistleblowing Policy 2013 TP022/08<br>A Zero Tolerance approach to the prevention & management of aggression and violence towards staff in the workplace. 2014 ref TP002/08<br>BHSCT Policy & Procedure for the Management of Complaints & Compliments. 2013 ref TP45/10<br>Policy to be followed when obtaining consent for examination, treatment or care in adults or children 2014 ref SG 27/13<br>Rapid Tranquillisation Guideline for the immediate pharmacological management of violent and aggressive behaviour in adults and adolescent patients in the Belfast Health and Social Care Trust<br>Positive Behaviour Support Procedure<br>Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health/ Learning Disability Inpatient Settings. 2014<br>Child Protection Regional Policy & Procedure.<br>Seclusion within Learning Disability (Children & Adults) Procedure | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 26/09/2014 | 2.1 | A Brannigan | Review |
| 04/12/2014 | 2.2 | A Brannigan | Incorporating comments from consultation process. |
| 11/03/15 | 2.3 | A Brannigan | Standards & Guidelines Committee |
| 03/04/15 | 2.4 | A Brannigan | Policy Committee |
| 03/04/15 | 3 | A Brannigan | Final Draft issued. |

# 1.0 INTRODUCTION / PURPOSE OF POLICY

## 1.1 Background

The Belfast Health & Social Care Trust has a statutory responsibility to safeguard all, including the welfare of children, young people and vulnerable adults.

Patients & service users might be exposed to restrictive interventions as a response to some form of behaviour that places them or others at risk in a wide variety of different settings and situations. This may include settings where people are well known to staff and where individualised support can be planned with the aim of reducing the frequency and severity of such behaviours, in other settings where this is not possible because the individual may not be known to the service or in direct response to clinical risk.

Robust governance is essential to ensure appropriate practice with regard to the use of restrictive interventions.

Recent concerns about the inappropriate use of restrictive interventions across Health & Social Care settings including Transforming Care: a national response to Winterbourne View Hospital (DH2012), Mental Health Crisis Care: physical restraint in crisis June 2013 by MIND, recent inspections of inpatient learning disability services (England) by the Care Quality Commission and the subsequent recommendations have been considered and informed the review of this policy.

## 1.2 Purpose

The purpose of this policy is to ensure that when restrictive practices are used they fall within current legal, professional and ethical boundaries of good practice and that patient /service users are not subjected to the inappropriate use of such practice.

The policy will provide a framework within which the trust can create a culture and develop ways of working that will reduce the need for restrictive interventions based on the Six Key Restraint Reduction Strategies as defined by the Restraint Reduction Network 2014 (as detailed in objectives).

This policy is part of an overall approach to improving safety for everyone and is the foundation for high quality, safe care. Other Trust Policies that should be read in conjunction with this policy are listed on Page one of the document- Links with other policies.

## 1.3 Objectives

### 1.3.1 Leadership

1.3.1.1 The Trust will develop a mission, philosophy and build on guiding values which promote non-coercion and the avoidance of restraint. Commit to the development of a restraint reduction plan which is implemented and measured for continuous improvement.

1.3.1.2 This will be achieved by creating a positive culture where leaders & managers work alongside all staff to identify and reduce any excessive reliance on restrictive interventions, and to ensure that if they are used, it is only ever as a last resort undertaken in a proportionate and least restrictive way.

### 1.3.2 Performance Measurement

1.3.2.1 The Trust takes a ‘systems’ approach and identifies performance measures which determine the effectiveness of its restraint reduction plan and which measures key outcomes for patients and service users.

1.3.2.2 Ensures all forms of restrictive practice are recorded, reported and monitored and where necessary reviewed in and open and transparent manner in order to offer more person centred, effective services which rely less on restrictive interventions.

### 1.3.3 Learning and Development

1.3.3.1 The Trust will provide training to equip its staff with the knowledge and skills to understand and prevent crisis behaviour, make evidence based decisions regarding the use of restrictive practices to facilitate clinical procedures and provide staff with the key competencies to support the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

### 1.3.4 Providing Personalised Support

1.3.4.1 Supporting people, especially those individuals who at times may present with significant challenging behaviour, requires a commitment to develop personalised services, care and support and will be reflective of person centred approaches.

1.3.4.2 Wherever possible, the use of restrictive interventions will be assessed and planned to meet the needs of the specific individual, taking into account their history, physical and psychosocial needs in order to minimise distress or risk of harm. Unplanned interventions will only be used when no other option is available.

1.3.4.3 Staff will ensure safe and dignified access of the patient / service user to assessment, treatment and care by the use of restraint reduction tools which inform staff and shape personalised care and support to our patients and service users. Patients & service users will be supported to balance risk of harm and freedom of choice and to ensure least harm to them, staff or others who come into contact with the trust and its services.

### 1.3.5 Communication and Person Centred Focus

1.3.5.1 The Trust fully involves patient's service users, carers and patient advocates in a variety of roles within the services to identify the needs of individuals and uses these to inform service provision and development.

1.3.5.2 Staff will include patients/clients and significant others (where appropriate) in the process of consultation, decision making and planning care regarding the appropriate use of restrictive practices alongside members of the health and social care team. This will assist us in ensuring as far as is reasonable, that positive relationships between the service, patient & service users are maintained.

### 1.3.6 Continuous Improvement

1.3.6.1 The trust will ensure the principles of post incident support and learning is embedded into the organisational culture.

1.3.6.2 People who have been subjected to, or are involved in, applying restrictive interventions will have access to someone to talk to about their experiences. Patients/clients should be informed of their right to an independent advocate who can assist them should they if they feel they cannot voice their experience to staff after a restrictive intervention has been applied. This will enable vulnerable individuals to express their feelings or concerns.

1.3.6.3 People who have been subjected to, or are involved in, applying restrictive interventions will be supported to complain if they have any concerns regarding the use or misuse of the intervention through the appropriate trust policy/procedure

## 2.0 SCOPE OF THE POLICY

This policy is relevant for all services and their staff involved in caring for patients/client receiving treatment or care within Trust.

2.1 The policy will have particular significance for services that care for individuals that are known to be at risk of being exposed to restrictive interventions to support treatment & care.

2.2 The policy is more broadly applicable across general Health & Social care settings where patients and service users may on occasions present with behaviour that challenges but which cannot reasonably be predicted and planned for on an individual basis.

2.3 Training & Education Providers within this area.

## 3.0 ROLES/RESPONSIBILITIES

The Chief Executive has overall responsibility and accountability for the health, safety and welfare of all patients', services users, clients, staff and others affected by the activities of the Trust and is responsible for the following:

3.0.1 To foster a framework within which the Trust can develop a culture and ways of working that will reduce the need for restrictive interventions. When restrictive interventions are used it will be in the least restrictive way for the minimum amount of time as a last resort.

3.0.2 To appoint a senior manager at director level to take the lead responsibility for restrictive intervention reduction programmes.

### 3.1 Medical Director

The Medical Director has overall delegated responsibility for patient, service user and staff safety with an emphasis on compassionate person centred care and treatment, and is responsible for the following:

3.1.1 To ensure that appropriate arrangements are in place to demonstrate the trusts commitment to a reductive approach in the use of restrictive practices as detailed in the policy purpose. Leadership, Performance measurement, Learning & Development, Providing personalised support, Communication & Person centred Focus and Continuous improvement.

3.1.2 To ensure communication of The Use of Restrictive Interventions Policy for Adults & Children and review where appropriate.

3.1.3 To ensure adequate arrangements are in place to meet training needs identified through the regional strategy.

### 3.2 Co-Director Risk and Governance

The Co-Director for Risk & Governance supports the Medical Director and has responsibility for the following:

3.2.1 Assisting the Medical Director in the communication and ongoing review of the Trust Restraint Reduction Framework, Policy on the Use of Restrictive Practices in Adult & Children's Services and associated structures.

3.2.2 Managing the process of reporting and monitoring incidents involving the Use of Restrictive Practices and ensuring that managers and relevant agencies are kept informed of any significant implications highlighted and shared learning.

3.2.3 Alerting other senior managers to significant risk issues in relation to the use of Restrictive Practices.

## 3.3 Directors & Co-Directors

All other Directors and Co directors in the trust are responsible for the following:

3.3.1 Ensuring compliance with The Use of Restrictive Practices in Adult & Children's Services Policy and associated strategies.

3.3.2 Ensuring that the development or review of local procedures in relation to The Use of Restrictive practices within their directorate reflects the ethos of this policy.

3.3.3 Ensure that where the use of restrictive practices is reasonably foreseeable in their service area that their staff teams are equipped with the knowledge and skills to understand and prevent crisis behaviour, make evidence based decisions regarding the use of restrictive practices to facilitate clinical procedures, and provide staff training in the key competencies that supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

3.3.4 Ensure the Use of Restrictive Practices within their Service groups is appropriately recorded.

3.3.5 Ensure that all incidents involving the use of restrictive practice are appropriately reported, investigated and monitored in line with the Trust's incident reporting procedure and that learning outcomes are implemented and shared across the trust.

3.3.6 Responsibility for high level monitoring of incident patterns, to identify high-risk areas, and the subsequent development of relevant management strategies.

## 3.4 Line Managers

Line managers are responsible for fostering an environment where staff are committed to treating all services users with respect and dignity, to acknowledge unique needs of the individuals in their care, and their right to involve their carers and family where appropriate in decisions regarding the use of restrictive practices.

3.4.1 Providing local induction training for new staff which includes information on this policy and associated strategies and any subsequent reviews to all staff.

3.4.2 Ensuring that where any service user who has a behaviour support /care plan advocating the use of restrictive interventions there are clear proactive strategies including details of primary and secondary preventative strategies included within this plan and to ensure these plans are communicated to relevant members of the staff team.

3.4.3 Ensuring staff are aware that all reactive management strategies must take account of the individual's unique circumstances as far as reasonably practical.

3.4.4 Communicating appropriate information about known relevant risks associated with the application of restrictive practices to their staff and any others who may be affected.

3.4.5 Ensuring that appropriate multi-disciplinary/multi-agency risk assessments in relation to The Use of Restrictive Practices are carried out and kept under review

3.4.6 Ensuring that effective plans are in place to release staff for training, that the training provided to their staff is formally recorded and that staff attend regular updates.

3.4.7 On-going monitoring and review of staff working practices with regards to the Use of Restrictive Practices, including adequate support for staff to transfer the skills acquired in training to the workplace.

3.4.8 To report all incidents promptly in accordance with the Trust's Adverse Incident Reporting Policy and carries out timely relevant investigation of incidents.

3.4.9 To keep their Co- Director/Director informed of any significant risks or implementation difficulties.

### 3.5 All Staff

3.5.1 Are required to adhere to this policy, and associated strategies at all times whilst carrying out their role and support their line manager in achieving their role as detailed above

3.5.2 Have a responsibility to ensure that their behaviour towards clients/patients reflects an understanding of individual need.

3.5.3 Must attend appropriate Mandatory training & utilise the knowledge gained.

3.5.4 Have a responsibility to adhere to safe working practices in relation to the use of restrictive practices and report to their line manager if they are experiencing difficulties in adhering to these systems.

3.5.5 Trust staff should be aware of the potential impact of their behaviour and how this could precipitate or increase the use of restrictive practices.

3.5.6 Record and communicate appropriate information about known relevant risks to colleagues and any others who may be affected. If in doubt about which information it is appropriate to share, staff should seek guidance from their line manager.

3.5.7 Report all incidents involving the use of restrictive practices compliance with the Trust Adverse incident reporting policy & this policy.

3.5.8 Reflect with colleagues on practice and learning following an incident and seek appropriate support for themselves or their colleagues if necessary.

3.5.9 Ensure where restrictive practices are used they are appropriately recorded.

### 3.6 Management of Aggression Team.

Assist The Co. Director of Risk and Governance in the implementation, communication and on-going review of the Trust Restraint Reduction Framework, Policy on the Use of Restrictive Practices in Adult & Children's Services and associated structures

3.6.1 With the exception of the areas covered by the Muckamore Abbey MAPA, TCI & SCIP training teams, the management of aggression team are responsible for managing provision of mandatory training programmes on the management of actual and potential aggression provided by Risk & Governance to Directorates.

3.6.2 Liaising with Directorates to ensure that all training is identified through risk based training needs analysis and is delivered to an accredited/approved standard to ensure the quality and consistency of training across the Trust

## 4.0 DEFINITIONS

The term restrictive intervention is used generically to describe any strategy or intervention which restricts or limits another person's liberty. The definition of restrictive intervention adopted by BHSCT is:

"Any form of restrictive intervention, be it a physical, mechanical, pharmacological, environmental or social/psychological intervention, which is designed and used (intentionally or unintentionally) to limit or restrict another person's liberty‟.

(BILD 2006)

Restrictive interventions are further defined in 'Positive and Proactive Care – Reducing the need for restrictive interventions' (DOH 2014) as

"Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- end or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom for no longer than is necessary."

## 4.1 KEY POLICY PRINCIPLES

4.1.1 The decision to use restrictive interventions should only be made following an assessment of risk in the context of enabling safe treatment or care or to manage risk in a violent episode taking into account the possible benefits such approaches may give to the patient or service user balanced against the possible harms that could result. Such a decision may also take account of the impact their behaviour have on other people.

4.1.2 Restrictive interventions will never be used to punish or for the sole intention of inflicting pain, suffering or humiliation, unauthorised deprivations or restrictions of liberty must be avoided. The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others. NICE 2005.
Interventions will not be used to force compliance or control where risk is not present or could be managed in a less restrictive way.

4.1.3 Where restrictive interventions are used every reasonable effort is made to minimise the risk of harm or injury to those involved, and that the need to maintain individual respect, dignity and welfare is maintained. With the exception of unforeseen or unpredicted adverse events, the use of restrictive interventions will only be considered within the context of an overall management approach necessary to manage risk and maintain safety of patients/service users, staff or others.

4.4.4 Restrictive interventions are not seen as a long-term solution in the management of service user behaviour. They may, in the short term, help to effectively and safely support service users achieve improved outcomes in terms of greater inclusion, choice, independence, rights and safety as part of a wider approach.

4.1.5 Individualised care plans and support plans, incorporating behaviour plans, are implemented for all patients/service users who are known to be at risk of being exposed to restrictive interventions.

4.1.6 All employees understand their obligations to use restrictive interventions in an appropriate manner so as to avoid, wherever reasonably practicable, any recourse to criminal charges or action under current civil law or health and safety legislation.

4.1.7 The scale and nature of restrictive practice must be proportionate to both the behaviour of the individual to be managed and the nature of the harm likely to be caused. Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need. Where staff have a need to use such approaches, they must fully understand the legal, ethical and professional implications and be prepared to justify their actions. Judgements as to the acceptability and legitimacy of restrictive interventions will be based on all presenting circumstances. Without a clear ethical basis and appropriate safeguards such acts may be legally indefensible.

4.1.8 In order to support this policy, the organisation is committed to ensuring all staff in those areas where there is a likelihood of restrictive interventions being used receive a sufficient level of training, supervision and instruction on such approaches.

4.1.9 When restrictive interventions are used details must be documented indicating which intervention was used, why it was used and the outcome of the intervention. Further information in recording and reporting of restrictive interventions can be found in appendix 3.

## 5.0 IMPLEMENTATION OF POLICY

It is the responsibility of all managers to ensure risk assessment has been completed in areas where staff are expected to engage in any form of restrictive intervention as defined with the policy.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of their service users.

These assessments will require regular audit to determine their acceptability and efficiency.

### 5.1 Dissemination

This policy applies to all services and their staff involved in caring for patients/client receiving treatment or care within Trust.

Any concerns regarding the implementation of this policy should be addressed with your senior manager or further clarification can be sought from the author.

Training queries should be directed to the appropriate MAPA, SCIP or TCI training team.

### 5.2 Resources

Please refer to Roles & Responsibilities (section 3)

### 5.3 Exceptions

There are no exceptions.

## 6.0 MONITORING

This Policy will provide a framework whereby the Trust will develop Key Performance indicators in relation to restrictive practices.
This monitoring should include any section 75 implications of implementing the policy.

## 7.0 EVIDENCE BASE / REFERENCES

BILD Code of Practice (2010) for the use and reduction of restrictive physical interventions. Kidderminster: BILD Publications

British Institute of Human Rights. (2013). The Difference it makes: Putting Human Rights at the Heart of Health and Social Care. www.bihr.org.uk.

Department of Health (2002) Guidance for restrictive physical interventions: How to provide safe services for people with learning disabilities and autistic spectrum conditions London: DH

Department for Education & Skills and Department of Health (2004) National survive framework for children, young people and maternity services.

Department of Health DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance October 2010

Department of Health (2012) Transforming care: A National response to Winterbourne View hospital London: DH

Department of Health (2014) Positive and Proactive Care – Reducing the need for restrictive interventions. London: DH

DHSSPSNI (2004) Human Rights working Group of Restraint and Seclusion. Guidance on Restraint and Seclusion in Health and Personal Social Services. DHSSPSNI.

Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary. London: Stationery Office

Good Practice in Consent: Implementation Guide for Health Care Professionals

Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 London: HMSO

HM Government (2014) Closing the Gap: essential priorities for change in mental health: London: TSO

HM Government (2014) The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis. London: TSO

Human Rights Act 1998 HMSO
Mental Health Commission (2012) *Seclusion and Physical Restraint Reduction* Dublin: MHC

Mental Health (Northern Ireland) Order 1986 HMSO

Mind (2012) Mental health crisis care: physical restraint in crisis London: Mind
Our Mission, Vision, Value and Principles 2014.
www.restraintreductionnetwork.org

Ministry of Justice (2008) Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice: London: TSO

NHS Protect (2013) Meeting Needs and Reducing Distress – Guidance on the prevention and management of clinically related challenging behaviour in NHS Settings London: DH

NHS England & Local Government Association (2014) Ensuring quality services. Core Principles Commissioning Tool for the development of Local Specifications for services supporting Children, Young People, Adults and Older People with Learning Disabilities and / or Autism who Display or are at Risk of Displaying Behaviour that Challenges London: NHS England & LGA

NICE (2005) Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments London: NICE

NMC The Code 2008 HSS (MD) 8-2008

Royal College of Psychiatrists Research Unit. (1998), Management Of Imminent Violence, Clinical Practice Guidelines To Support Mental Health Services. Occasional paper, Royal College of Psychiatrists

Skills for Care & Skills for Health (2014) A Positive and Proactive Workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health London: SfH/SfC

Skills for Security (2010) Physical Intervention: reducing risk. A guide to good practice for employers of security personnel operating in healthcare settings. Worcester: Skills for Security

South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010) Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG

United Nations (1989) Convention on the Rights of the Child.

Zero Tolerance on Abuse of Staff. Regional Training Strategy For The Management Of Aggression And Violence HSS (Gen) (5): 2008 Northern Ireland: Department of Health, Social Services & Public Safety.

## 8.0 CONSULTATION PROCESS

During this policy review the following groups were consulted. CAUSE , LAMP, Bryson Group, VOYPIC,NIAMH The Management of Aggression Team, The Trust Joint Health & Safety Committee, Occupational Health, Consultant Psychiatrist, Senior Managers in Emergency Department, Mental Health, Learning Disability Services, Pharmacy, Patient Safety, Children's services, Security, Nursing and User Experience.

## 9.0 APPENDICES / ATTACHMENTS

9.1 Appendix 1 Risk Assessment and the use of restrictive practices.
9.2 Appendix 2 the Practical application of restrictive practices.
9.3 Appendix 3 Recording and reporting restrictive practices.

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** X

**SIGNATORIES**
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

______________________________ **Date: _______May 2015_______**
**Author**

Cathy Jack –

______________________________ **Date: _______May 2015_______**
**Director**

## Appendix 1

## Risk assessment and the use of restrictive practices

Within the context of this policy risk assessment is concerned with assessing the likelihood and consequences of behaviour that places service users or staff at risk of harm, and implementing appropriate measures to avoid, mitigate or manage the risk. Whilst formal, written risk assessments are the preferred option; this may not always be possible due to the nature of the service provided.

"A formal risk assessment for individual service users will not always be possible in fast paced emergency departments, admission units and intensive care, as in these settings: there is little or no lead up to situations; there is limited or no observation time; the person does not necessarily have a history of challenging behaviour (or at least one that is readily accessible to staff); lengths of stay may be short, or the person may already be in crisis and require immediate stabilisation."

(NHS Protect 2014)

Understanding why risk behaviour is occurring is essential when completing a risk assessment or management plan; these should indicate the least aversive approach to the management of the risk behaviour. A structured approach to risk analysis and risk management will help staff to develop safe and supportive approaches. This will help avoid unnecessarily compromising the rights of others whilst promoting the welfare and safety of everyone involved. Assessment should take into account the service users unique needs physically, socially and psychologically. Protective factors, such as greater collaboration, with service users, other colleagues, services, family and or advocate involvement will assist with this.

NHS Education for Scotland (2010) observed that 'Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options of the most appropriate care. The care provide is holistic and the whole person sits at the centre of the care package, which may be delivered by a range of Health & Social care professionals'

Where restrictive interventions are used staff have an obligation to assess the risks associated with such practice, and this must be documented in written form. Consideration of the risk posed by the service user (to themselves or others) must be balanced against the level of restrictions.

Within individual work settings, it is important that staff are aware of the appropriate risk assessments to be completed for their service area.

Once the appropriate risk assessments and management plans are completed these will be communicated to all relevant staff, and where appropriate the service user and/relatives/carers/advocates.

Risk assessment and management plans should be subject to regular review as stipulated on the development of the plan or if the use of restrictive interventions becomes unworkable, or the presentation of risk changes.

## Appendix 2

## The Practical Application of restrictive interventions.

### 2.1 Pharmacological/ Chemical Restriction

The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed or violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness (DOH 2014)

Pharmacological agents can only be used under the direction and prescription of a qualified prescriber. A number of medicines may be prescribed to help stabilise the service user's mood or to moderate mental ill health and other organic factors which may contribute to the individual's challenging behaviour. In addition to regularly prescribed medicines, some service users may be prescribed additional "as required" medication.

Medication should be prescribed with a clear therapeutic aim and must not be used as a means of exerting control over service users. Prescribed medication must be reviewed regularly to ensure that principle is adhered to. Staff have a responsibility to observe and report service user behaviour as accurately as possible to assist prescribers when making prescribing decisions. Once medication has been prescribed, staff have responsibility to continually observe and assess service users for the effect of medication on their mental state and for the emergence of side effects.

The administration of "as required" medication must be to the same standard as that for regular medication. The nurse must follow the guidance of the NMC with regard

To the administration of medicines and comply with requirements of the Trust Medicine Code. The administration must be recorded clearly on the medicines administration record ensuring that the time of administration and the actual dose administered (where a variable dose is allowed) is clearly documented.

Addition records may be needed in the patients notes detailing the reason why "as required" medicines were needed and an assessment of the effectiveness of the intervention. The follow points should be considered

- Pay attention to any instructions on the indication for the as required medication
- Check the timing of administration carefully if a range of times is permitted e.g. every 4 to 6 hours. Make sure the medication is not being given too early
- Check that any maximum dose stated will not be exceeded (calculate back 24hrs from the current time)
- Medication should not be concealed in food or drink

Rapid tranquilisation should be viewed as a crisis intervention in the management of challenging, aggressive or violent behaviour and must be carried out in accordance with the Trust Guideline for Rapid Tranquillisation

## 2.2 Mechanical Restrictions

The use of a device to prevent, restrict or subdue movement of a person's body, for the primary purpose of behavioural control.

(DH 2014)

Mechanical restrictions are not normally used in the management of challenging, aggressive or violent behaviour.

Typically, mechanical restrictions are used for safety and protection to prevent service users sustaining injury (e.g., the use of bedrails to prevent someone falling out of bed) or to assist in the delivery of life saving treatment e.g. whilst a patient is waking from sedation and attempting to remove necessary medical devices e.g. intravenous lines and the use of mittens is less risky than further chemical sedation. Or to assist, or improve an individual's posture (e.g., a standing frame or wheel chair harness).

The use of mechanical restrictions for the management of challenging behaviour is usually associated with arm 'splints' or 'cuffs' and head guards/protection to prevent self-injurious behaviour. In some extreme situations, it may be considered appropriate to use mechanical restrictions if a service user is engaging in behaviour that represents a significant risk to others.

For some service users the use of a mechanical restriction may represent a lesser aversive option than physical restrictions since, once applied, staff are no longer required to maintain physical contact. Also, provided that the device has been specifically designed and built for the service user, fewer adverse outcomes or injuries may result.

Whenever mechanical restrictions are used, staff should ensure that:

The multidisciplinary team have agreed to the approach (e.g. when used for a service user who self-harms, since a broader intervention programme will be required).

- The mechanical aids used have been specifically designed and manufactured for the individual service user.
- Staff should ensure that any mechanical restriction used is routinely checked prior to use to ensure the aid remains "fit for purpose" and arrange regular servicing of such equipment by the manufacturer.
- Where physical intervention is required to apply any mechanical restriction, staff should receive necessary training so as to ensure they act within legal, professional and ethical boundaries.
- That an on-going assessment of need to continue the intervention exists.

## 2.3 Physical Interventions

### 2.3.1 Holding Skills/Physical Restraint

The use of physical holds to limit or restrict an individual's ability to move during the provision of safe and supportive care or in the management of an aggressive or reckless episode. This will require more than one member of staff.

Staff may use restrictive physical interventions to help them deliver the appropriate level of support, or care in a safer way. Alternatively, staff may have to safely hold a service user whose behaviour has become disruptive and poses a risk to others within the same environment.

Staff should ensure that whenever a planned physical intervention response is developed to support an individual, a reduction plan is also included to ensure that positive behaviour support strategies can replace a restrictive physical intervention response as soon as possible.

The degree of restriction/restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All restrictive physical interventions should be applied in a manner that attempts to defuse rather than provoke further aggression.
The decision to use physical interventions must be fully documented following the completion of all relevant risk assessments and where appropriate the development of an individual care/treatment/behaviour/ plan.

Where appropriate these may be shared with family members/ carers/ advocates and members of the multidisciplinary team so that they have the opportunity to raise any questions or concerns.

In emergency situations, staff may need to use restrictive physical interventions with an individual who has not previously been assessed as presenting a risk of aggression or violence. Following such an incident, the appropriate risk assessments and intervention plans must be completed as soon as is reasonably practical.

Any service user subject to physical restraint should be medically assessed at the earliest opportunity but no longer than 2 hours after the commencement of physical restraint.

Any service user subject to physical restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of up to 24 hours. This check should include:

- Care in the recovery position if appropriate
- Pulse
- Blood pressure
- Respiration
- Temperature
- Fluid and food intake and output.

NICE (2005)

If consent and co-operation for these observations is not forthcoming from the person, then it should be clearly documented in their notes why certain checks could not be performed and what alternative actions have been taken.

**Training in the use of Holding Skills/Physical Restraint**

All staff who may be involved in the application of restrictive physical interventions should receive an appropriate level of training.

The appropriate training for staff will in the first instance be determined through the undertaking of A Zero Tolerance Risk Assessment (ZTSG 2008), then through training needs analysis with your services physical intervention training provider.

All training in the Use of Physical interventions within the Trust must be accredited

Staff who may be involved in carrying out physical restraint must be trained in:

- Basic life support skills and attend updates.
- The physical risks associated with restraint, i.e. positional asphyxia/sudden collapse/injury/ discomfort.
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.
- Use of emergency equipment.
- Knowing how to summon assistance

NPSA (2008)

**Best Practice in the application of Holding Skills/Physical Restraint**

Well-briefed, trained and co-ordinated staff will be the most effective in a physical restraint situation.

One member of staff should take responsibility for communicating with the patient or service user. This staff member should be someone who has a good relationship with the patient or service user where possible as this will enable better communication and collaboration.

Every action taken must always be explained to the individual regardless of their ability or willingness to communicate. At all times treat the individual with the dignity and respect deserving of all human beings. Always ensure privacy is maintained by moving on-lookers away or asking the individual to move to another area.

De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users co-operation and a return to voluntary control as soon as is safely possible.

Any physical condition, which may increase the risk to the patient of collapse or injury during physical intervention should be clearly documented in the patients file and communicated to all multi-disciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate (NIMHE 2004).

Always attempt to protect the individuals head from harm and take into account the amount of energy a person may use during a disturbed episode.

Observe for heat exhaustion, fatigue, restricted or impaired breathing, muscle cramp, and the adverse effects of medication. The safety of the individual must never be compromised – if in any doubt regarding the individual's welfare, staff must end the intervention immediately.

Never hold an individual around the neck and avoid any pressure to the chest and abdomen since this significantly increases the risk of postural asphyxiation. Never cover the mouth or screen the individual's vision.

Avoid making contact with any part of the individual's body that could be viewed as culturally, socially or sexually unacceptable (i.e. face, neck, chest, abdomen, buttocks, groin, and inner thighs).

It is important that staff are clear about the safeguards and limitations provided by the Manual Handling Operations Regulations (MHOR 1992)

### 2.3.2 Disengagement Skills/Escape Techniques

The use of physical actions to limit, stop or gain a release from harmful or injurious physical contact initiated by another person during the provision of care and/or in situations requiring escape in the management of an aggressive or reckless episode. The Trust provides accredited training on the use of these techniques.

## 2.4 Environmental Restrictions

Many settings use the environment to help protect, segregate or limit service user access to and from certain areas whilst enabling staff to provide a higher level of support and supervision.

Where the environment may present a risk to service user's environmental restriction may enable staff to provide a greater level of help, support or supervision and prevent disruption to others.

This approach is not to be confused with the routine locking of doors, windows or rooms as a means of general safety and security.

## 2.5 Social Restrictions

Social restrictions are generally used to segregate or limit service user access to socially integrated activities where the service user's behaviour represents a significant risk to themselves or others.

Social restriction will never be used to compensate for a lack of appropriate resources to support service users to access integrated community facilities.

In order to safeguard the unnecessary use of social restriction, the following guidelines should be implemented:

- Social restrictions will only be used as part of a wider individual care or treatment plan.
- The service user plan must clearly outline the risks and the specific social restrictions that are to be used. Each social event or activity should be specified within the plan.
- Staff must comply with statutory regulations where a social restriction is legally enforceable (e.g. Mental Health Order 1986).

## 2.6 Long Term Segregation

Long term segregation is a situation where a service user is prevented from mixing freely with other people who use a service. (DOH2014)

This form of restrictive intervention should rarely be used and only ever for hospital patients who present an almost continuous risk of serious harm to others and for whom it is agreed by the multidisciplinary team that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other users of the service.

Long-term segregation must never take place outside of hospital settings and should never be used with people who are not detained under the Mental Health Order.

The use of long term segregation must be supported by appropriate documentation and local procedures which will include clear instruction to staff regarding the timescales for review and termination of the practice.

## 2.7 Seclusion

Seclusion:
"The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving."
(DOH 2014)

The aim of seclusion is the containment of severely disturbed behaviour which is likely to cause harm to others and should be used for the shortest possible period.

The Use of Seclusion within the BHSCT is currently authorised in Muckamore Abbey Hospital and Iveagh, where a local policy has been developed.

The Mental Health Order Code of Practice lays down clear procedures for the use of seclusion including its initiation, ongoing implementation and review and termination.

## Appendix 3

### Recording and reporting restrictive practices.

It is the responsibility of each service area to ensure agreed service specific documentation is available and that staff are aware of this and trained in the use of such documents.

Services must monitor the incidence of the restrictive interventions defined in this policy.

Any person with a behaviour support plan/care plan advocating the use of restrictive interventions should have clear proactive strategies including details of primary and secondary preventative strategies.

Following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident). In some services this will be on a service specific form, although documentation in notes should also be included. The record should allow aggregated data to be reviewed and should indicate:

- Patient/service users name.
- Patient/service user's number.
- Unit/Ward.
- Date & time when restrictive practice commenced.
- Date & time restrictive practice ceased.
- Name of staff member in charge at the time restrictive practice was utilised.
- All those involved in the application of the restrictive practice.
- Was service user endangering self or others?
- What actions staff took prior to engaging in restrictive practice.
- The reason for using the specific type & level of restrictive intervention.
- Describe the restrictive practice utilised, e.g. side rails, physical holding.
- Was a multi-disciplinary risk assessment agreed /completed?
- Was the service user/carers/advocates/relatives, where appropriate, involved in the decision to utilise a restrictive practice?
- How was the patient/service user physical and psychological well being monitored?
- Has the patient/service user's care, treatment or behaviour plan been updated as a result of the restrictive practice?
- Have all appropriate forms been completed? E.g. incident form, Physical Intervention Monitoring Form.

S.2 19.008

Belfast Health and
Social Care Trust
caring supporting improving together

**Reference No:** SG 41/16

| | | | |
|---|---|---|---|
| **Title:** | **Use of Physical Intervention Procedure by staff from Mental Health and Learning Disability Services (Children and Adults)** | | |
| **Author(s)** | Davy Martin, Acting Senior Nurse Manager<br>Patricia Minnis, Jenni Armstrong, Sheila McLaughlin, Billie Hughes, Damian O'Kane, Colette Caldwell, Stephen Noble, Ken Wilson, Martin Daly, Anne Campbell | | |
| **Ownership:** | Catherine McNicholl, Director, Adult Social and Primary Care | | |
| **Approval by:** | LD Governance Committee<br>MH Governance Committee<br>Standards and Guidelines Committee<br>Policy Committee<br>Executive team Meeting | **Approval date:** | 05/11/2015<br>21/10/2015<br>19/05/2016<br>01/06/2016<br>08/06/2016 |
| **Operational Date:** | June 2016 | **Next Review:** | June 2019 |
| **Version No.** | V1 | **Supercedes** | |
| **Key words:** | Risk, harm, intervention, physical contact, reasonable force | | |
| **Links to other policies** | | | |

2y 3 m from 1st draft.

| **Date** | **Version** | **Author** | **Comments** |
|---|---|---|---|
| 14/03/14 | V0.1 | | First draft to review group for comments |
| 01/04/14 | V0.2 | | Circulated for comments |
| 13/06/14 | V0.3 | | Updated following comments |
| 08/07/14 | V0.3 | | Agreed at Hospital Management Team Meeting |
| 13/01/15 | V0.4 | | Reviewed to incorporate community services |
| 21/10/2015 | V0.4 | | Approved by Mental Health Governance Meeting |
| 05/11/2015 | V0.4 | | Approved by Learning Disability Governance meeting |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

Belfast Health and Social Care Trust Mental Health and Learning Disability Services seek to promote and maintain a caring and safe environment for patient/service users and staff. Some patients/service users will present with behaviours which pose a risk to themselves or others which may lead to a risk of harm. In such instances it may be justified to use a physical intervention. Physical intervention will only be used where it is deemed to be the most appropriate intervention.

This document encourages the use of positive person centred practices which support the needs of patient/service users and emphasises reducing the need for physical interventions through de-escalation and positive behavioural support.

Human rights will always be considered

### 1.2 Purpose

The procedure gives guidance for staff on the implementation of physical interventions.

### 1.3 Objectives

The procedure aims to: -

- Ensure all use of physical intervention is justified;
- To promote person centred practices by working in partnership with the patient/service user and their carer (as appropriate) to review available options to minimise the potential for harm;
- Promote the use of the least restrictive practices;
- Ensure safety and dignity for the people who use our service, during physical intervention ;
- Ensure least harm to the patient/service user;
- Reduce the likelihood of unlawful use of physical interventions.

This procedure should be read in conjunction with the BILD Code of Practice for minimising the use of restrictive physical interventions

## 2.0 SCOPE OF THE POLICY

This procedure applies to all staff working with people within Mental Health and Learning Disability Services within the Belfast Health and Social Care Trust. This will include staff contracted to the Trust who support patients/service users both on and off Trust premises.

## 3.0 ROLES/RESPONSIBILITIES

All staff with Mental Health and Learning Disability Services have a responsible role to play in the implementation of this procedure's objectives.

**All Managers have a responsibility to: -**

- Ensure that all staff read the procedure and sign the recording sheet.
- Ensure the full implementation of this procedure.
- Ensure all staff working in a Mental Health and Learning Disability Trust settings have, on-hand at all times a sufficient number of staff trained in physical interventions, to ensure that the contents of this procedure document can be appropriately and safely implemented. Where staff shortages impact on the Trust's ability to manage aggressive or reckless behaviour, managers have a responsibility to notify senior colleagues at once and report through the appropriate reporting systems
- Managers will also be responsible for ensuring that all direct-care members of staff receive appropriate training in prevention, de-escalation and physical intervention in relation to aggressive or reckless behaviour, which is related to the needs of the service. Training in BILD Accredited Physical Intervention Strategies will be provided only by instructors with appropriate experience and qualifications.

**First Line Managers are responsible for: -**

- Arranging a debriefing session for any staff or patient/service users involved in a physical intervention. This will take place as soon as is appropriate following the incident. Debriefing should also be available to witnesses, who request this support.
- All records and documentation in relation to an incident should be reviewed and completed as necessary in a debriefing session. The exact circumstances of the incident, including events that preceded it and actions taken afterwards, should be discussed and reviewed, with the dual aims of reviewing current practice and of minimising the risk of any further such incidents occurring. A record of all debriefing sessions must be kept by the line manager(s) and an entry included in the patients/service users record. Confidentiality will be maintained.
- With regard to *any* form of intervention, ensuring that:-
    - Members of staff work at all times within the law, following professional guidelines and in line with the Trust's Values and Service Principles.
    - Patient/service users' needs are adequately assessed in consultation with the carer where appropriate

- The principle of safety is promoted at all times

**All staff have a responsibility to follow the procedure.**

### 3.1 Training

Restrictive physical interventions ‘involve use of force to control behaviour’ (DoH, 2002). Staff who may be involved in ‘restrictive’ components of physical intervention must be trained in:

- Management of Potential and Actual Aggression (MAPA) / Strategies for Chris Intervention and prevention (SCIP)
- Basic life support skills and attend annual updates.
- The physical risks associated with physical intervention, i.e. positional asphyxia/sudden collapse.
- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.
- Use of emergency equipment.
- Knowing how to summon assistance

## 4.0 KEY PROCEDURE PRINCIPLES

**4.1** Mental Health and Learning Disability Services within Belfast Health and Social Care Trust affirms that physical interventions should *only* be used for the following categories of behaviour:-

- Where person is at risk of physical harm either to themselves or to others.
- Destructive behaviour only if the action is likely to lead to harm to self or others;
- ?? Extreme and prolonged over activity likely to lead to physical exhaustion.

**4.2** Physical intervention involves the use of direct physical contact or reasonable force with the express intention of limiting or restricting a person’s movement or mobility and continuing to do so against resistance. Physical intervention is therefore qualitatively different from other forms of physical contact such as manual prompting, physical guidance or support that might be used in teaching or therapy.

Such contact will be ***directly from another person*** (e.g. using physical prompts to stop someone running out onto as a busy road, or holding a person’s hands to prevent him/her from causing injury to self or to another individual). Generally physical intervention can be described as disengagement or restrictive physical interventions. Disengagement techniques are used by staff to protect themselves from injury and/or to escape from a patient/service user who is holding them by their clothing or a body part. Restrictive physical interventions are used to restrict a patient/service user's movements, with the patient/service user in a standing, sitting, kneeling, or lying position (Southcott et al, 2002)

### 4.3 Person centred planning for the prevention of aggressive or reckless behaviour

The causes of aggressive or reckless behaviour are not always apparent. However, certain factors are linked to a higher chance of their occurring and due attention to these can often prevent them. It is important that staff are aware of these factors and of prevention strategies. These should be included in the patient/service user's care plan/risk management plan.

The Trust expects that physical intervention procedures will generally be used with patient/service users only as a last resort. In most circumstances, physical interventions will be used reactively. Occasionally it may be considered in the best interest of the patient/service user to plan, in conjunction with the patient/service user, for the least restrictive physical intervention to be employed preventatively as part of a balanced judgement regarding likely impact of not intervening until a later stage in the escalation. As part of the care plan, staff should seek the patient/service users consent to the use of Physical Intervention.

For every patient/service user who displays aggressive or reckless behaviour, staff in Mental Health and Learning Disability Services of Belfast Health and Social Care Trust will update the individual's records (in conjunction with the patient/service user) with the aim of minimising the likelihood of such behaviour reoccurring. Individualised person centred care and treatment plans and risk management plans should be drawn up and record clearly any specific prevention strategies which should be employed, de-escalation strategies which should be used, considered and giving the conditions under which physical interventions are to be used. Consideration should be given to best practice in such plans – (e.g. consideration of gender issues, disabilities).

**4.4** All physical interventions should be used for the shortest period of time and using the minimum level of physical intervention required.

**4.5** In response to unexpected episodes of aggressive or reckless behaviour, an 'emergency' physical intervention may need to be implemented. In all such cases, staff should act in a way that is proportionate to the aim of maintaining the safety of an individual or others. The principle of acting in the best interests of an individual (or others) must be followed at all times, including after the use of physical intervention. Emergency interventions, like those which are planned, must always be applied using the minimum amount of force for the least amount of time required, and with a view to maximising the safety of everyone involved. The patients / service users care plan and risk management plan will be reviewed following an emergency intervention.

**4.6** No physical intervention should ever be intended or knowingly allowed to cause pain except in extreme and life threatening situations where staff may need to use disengagement techniques which cause some degree of pain briefly. In such circumstances the members of staff involved must record and report such action through established reporting systems. The decision and action taken, needs to be justified as being the minimum use of force, which is proportionate to the risk associated with that particular set of circumstances.

**4.7** Following any use of physical intervention full details must be reported through established reporting systems. All use of physical intervention should be discussed at review meetings with the patient/service user and/or carer as appropriate. The patients / service users care plan and risk management plan will be reviewed following

**4.8** There may be times when the level of threat posed or the nature of the incident means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. Please see local guidance for summoning PSNI assistance.

**4.9** Situations involving weapons - For the purpose of this document a weapon is defined as: ***any object that is made, adapted or intended to be used to cause physical injury to a person.***
Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgments must be made based on professional knowledge and experience, risk assessment and training in challenging behaviour and management of aggression. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This procedure will be disseminated to all staff within Mental Health and Learning Disability Services.

### 5.2 Resources

This procedure will require all managers to ensure staff within their service have appropriate training to deliver the procedure.

### 5.3 Exceptions

This document does not aim to address issues related to the assessment and treatment of patient/service users, which require physical contact with the individual (e.g. dental services, physiotherapy) nor does it intend to address issues related to non-compliance with treatment.

This procedure is only for Mental Health and Learning Disability Services (Adults and Children).

## 8.0 CONSULTATION PROCESS

Consultation for this procedure involved all managers within Mental Health and Learning Disability Services User and Carer Representatives

## 9.0 APPENDICES / ATTACHMENTS

**Appendix 1 -** Health and safety considerations

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this PROCEDURE should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this PROCEDURE is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

**SIGNATORIES**
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

______________________________ **Date: ______June 2016______**
**Author**

______________________________ **Date: ______June 2016______**
**Director**

## 6.0 MONITORING

The implementation of the procedure is recorded through established reporting systems. Physical Interventions are reviewed and reported on amonthly basis. This report is used to inform practice. X

The procedure will be reviewed on a three yearly basis.

## 7.0 EVIDENCE BASE / REFERENCES

— No reference to DHSSPS Guidance on Restraint & Seclusion 2005.

Improving Patient/service users Safety: Building Confidence (DHSSPS 2006)
Management of Aggression – Trust-net.

Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;
NMC Guidelines for Records and Record Keeping

Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org

RCN, 2008 Let's Talk About Restraint London,
National Neurosciences Benchmarking Group, 2007 Use restrictive practicest www.nnbg.org.uk

Physical Interventions: A Procedure Framework – Second Edition', British Institute of Learning Disabilities (BILD, 2008);

'Guidance on the Use of Restrictive Physical Interventions' (Department of Health, July 2002); X DoH England

'BILD Mental Health Procedure Implementation Guide. Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient/service user Settings. National Institute for Mental Health in England. 2004;

Violence -The short-term management of disturbed/violent behaviour in in-patient/service user psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005 CG25.

BILD Code of practice for minimising the use of physical interventions – 4th Edition (2014).

Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002

Safeguarding Vulnerable Adults

The Mental Health (NI) Order 1986 and its associated Code of Practice

Good Practice in Consent: Implementation Guide for Health Care Professionals

Positive and Proactive Care: reducing the need for restrictive interventions,
Social Care, Local Government and Care Partnership Directorate
April 2014

## Appendix 1

## Health and Safety Considerations

The health and safety of everyone must remain of paramount importance throughout the application of a particular physical intervention and during the period of time following use of physical intervention. Specifically, this means that any such intervention must be stopped immediately if a patient/service user/patient/service user develops any of the following:-

- breathing difficulties (including very rapid breathing)
- fits or seizures
- vomiting
- blueness of the hands or other body parts (indicating reduced blood flow)
- paleness or yellowing of the skin (suggestive of restricted blood flow)
- bone fractures or joint dislocations

At the same time, necessary medical intervention should be secured as a matter of urgency.

Consideration should be given by the team involved in working with the patient/service user/patient/service user to physically monitoring the person during physical intervention process and for a period of up to 24 hours. This check may include pulse, blood pressure, respiration, temperature and fluid and food intake and output in accordance with the persons care plan. If consent and co-operation for these observations is not forthcoming from the person, then it should be clearly documented in their notes why certain checks could not be performed and what alternative actions have been taken.

The increased proneness of some vulnerable adults, including older people to negative side-effects from physical intervention procedures, due to their higher incidence of physical and medical conditions, needs especially to be included in any risk assessments that are carried out. Furthermore staff should be conscious of the potential impact of any medication, drugs and alcohol which the person may have taken. In addition there may be circumstances where an individual has been subjected to incapacitants such as CS Spray or Taser prior to coming into contact with Trust staff, it is necessary to consider their impact on the person and their reaction to any physical intervention administered. Any physical condition, which may increase the risk to the patient/service user of collapse or injury during physical intervention should be clearly documented in the patient/service users file and communicated to all multi-disciplinary team members and regularly reviewed and evaluated with the patient/service user/patient/service user and, where appropriate, their carer/advocate (NIMHE 2004).

The MHOR (1992) do not permit full-weight lifts of people unless the situation is exceptional or life threatening. Consequently, staff are not ordinarily expected to pick up or carry patient/service users from one area to the other. Staff should encourage the patient/service user to co-operate with them and wait until the patient/service user/patient/service user will walk with staff. Transferring a struggling patient/service user to a low stimulus area presents a significant risk of harm to the patient/service user and staff through the process of the patient/service user's struggle and/or their weight, especially if they were to be carried by staff. It is important that staffs are clear about the safeguards and limitations provided by the Manual Handling Operations Regulations (MHOR 1992) and the physical intervention training provided to staff:

Belfast Health and Social Care Trust
caring supporting improving together

**Reference No:** SG 45/16

| | | | | |
|---|---|---|---|---|
| **Title:** | Seclusion within Learning Disability Inpatient Services(Children and Adults) Procedure | | | |
| **Author(s)** | Karen Humphries, Mairead Mitchell, Jenni Armstrong, Rhonda Scott, Colin Milliken, Sean Murray, Barry Mills | | | |
| **Ownership:** | Catherine McNicholl, Director, Adult Social and Primary Care | | | |
| **Approval by:** | Hospital Core Management Team LD<br>Governance Committee<br>Standards and Guidelines<br>Policy Committee<br>Executive team Meeting | | **Approval date:** | 08/07/2014<br>05/05/2016<br>17/08/2016<br>05/10/2016<br>19/10/2016 |
| **Operational Date:** | November 2016 | | **Next Review:** | November 2021 |
| **Version No.** | V1 | **Supercedes** | All previous versions | |
| **Key words** | Seclusion, behaviour | | | |
| **Links to other policies** | Belfast Health and Social Care Trust Use of Restrictive Practices in Adults<br>Good Practice in Consent for Treatment or Examination: Implementation Guide for Health Care Professionals, DHSSPS, 2007<br>Belfast Health and Social Care Trust Adult Protection Policy & Procedures<br>Belfast Health and Social Care Trust Adverse Incident Reporting and Management Procedure<br>Belfast Health and Social Care Trust Policy and Procedure for the Management of Complaints and Compliments Policy<br>Belfast Health and Social Care Trust A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace<br>Belfast Health and Social Care Trust Rapid Tranquillisation Guideline for the immediate pharmacological management of violent and aggressive behaviour in adults and adolescent patients in the Belfast Health and Social Care Trust.<br>Regional Guidelines for the Search of Patients, their Belongings and Environment of Care within Mental Health and Learning Disability Inpatient Settings<br>Use of Physical Intervention Procedure by staff from Mental Health and Learning Disability Services (Children and Adults) | | | |

| **Date** | **Version** | **Author** | **Comments** |
|---|---|---|---|
| July 2015 | 0.1 | Mairead Mitchell, Jenni Armstrong, Rhonda Scott, Colin Milliken, Karen Humphries, Sean Murray, Barry Mills | Policy reviewed |
| December 2015 | 0.2 | Mairead Mitchell, Jenni Armstrong, Rhonda Scott, Colin Milliken, Karen Humphries, Sean Murray, Barry Mills | Circulated for comment |
| 05/05/2016 | 0.3 | | Approval by Learning Disability Governance Committee |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Definitions

The Code of Practice relevant to the Mental Health (Northern Ireland) Order 1986 defines seclusion as

***" the forcible denial of the company of other people by constraint within a closed environment. The patient is usually confined alone in a room, the door of which cannot be open from the inside and from which there is no means of exit open to the patient."***

### 1.2 Background

The Code of Practice also states that

***"Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort, after all other reasonable steps to control the behaviour have been taken. The sole aim in using seclusion is to contain severely disturbed behaviour which is likely to cause harm to others. It should never be used where there is a risk that the patient may take his own life".***

The Trust recognises the importance of the Code of Practice to the Mental Health (Northern Ireland) Order 1986 and of other relevant clinical guidelines, particularly the NICE guideline on the management of violence (May 2015). The Trust will continue to review and implement best practice in the use of seclusion in inpatient learning disability settings. The Trust recognises that there are a range of different clinical situations where seclusion may be used and the different clinical context found in responses to challenging behaviour in learning disability requires policy distinct from, though closely related to, policy in mental health. While this procedure, therefore, reflects the guiding principles outlined in the Code of Practice, the Trust considers it appropriate in the clinical context pertaining in learning disability to vary the provisions relating to the doctors attending immediately where a decision to seclude has been taken by the Nurse in Charge.

### Human Rights Issues

With regards to the Human Rights Act, the key issue is to ensure that there is proper justification for seclusion whenever it is used, given that the use of seclusion may constitute a breach of an individual's right to a private life under Article 8. Similarly, unjustified seclusion may give rise to a claim for breach of the right to liberty under Article 5, when the patient is not a detained patient under the Mental Health (Northern Ireland) Order 1986.The importance of Article 3, which protects the individual from inhuman and degrading treatment and torture must be recognised and reflected in clinical practice at all times.

### 1.3 Purpose

The procedure gives guidance for staff on the use of seclusion

### 1.4 Objectives

The procedure aims to: -

- To provide clear guidance on the use of seclusion.
- To ensure that the patient's safety, rights and welfare are safeguarded during seclusion;
- To outline the responsibilities of all members of staff;
- To outline procedures for monitoring, recording, reviewing, and reporting episodes of seclusion;
- Ensure all use of seclusion is justified;
- To promote person centred practices by working in partnership with the patient and their carer (as appropriate) to review available options to minimise the potential for harm;
- Promote the use of the least restrictive practices;
- Ensure safety and dignity for the patient during seclusion;
- Ensure least harm to patient;
- Reduce the likelihood of unlawful use of seclusion.

This procedure should be read in conjunction with the: -

- BILD Code of Practice for minimising the use of restrictive physical interventions
- Positive Behaviour Support Policy

## 2.0 SCOPE OF THE POLICY

This procedure applies to all staff working with children and adults within Learning Disability inpatient Services within the Belfast Health and Social Care Trust.

## 3.0 ROLES/RESPONSIBILITIES

It is the responsibility of the Charge Nurse / Ward Sister within Learning Disability Services to ensure that all staff receive the procedure

With regard to *any* form of intervention within the Trust's Learning Disability Service, first line managers will be responsible for ensuring that:-

- Members of staff are provided with adequate knowledge and skills to work at all times within the law, following professional guidelines and in line with the Trust's Values and Service Principles.

- Patients' needs are adequately assessed in consultation with the carer where appropriate

- The principle of safety is promoted at all times

- Patients who are being placed in seclusion should be informed of the reason that seclusion is necessary.

- Once the decision to seclude has been taken by the registered nurse and following an assessment of the patients' needs and presenting risks, the patient's clothes may need to be searched (by same gender staff if possible) in order that all potentially hazardous items, for example ignitable, sharp items or any items deemed to present a risk of self-harm or harm to others can be removed.

- The patient should always be clothed, with the exception of belts, dressing gown cords, shoes or other items which could be used to cause self-harm, or harm to others, when indicated in a risk assessment, disposable gowns will be available.

- The Duty Doctor will attend, as soon as is practicable, if the Nurse in Charge considers that the attendance of a doctor is clinically indicated.

- The Duty Doctor, in conjunction with the nurse in charge, will consider and document their decisions, bearing in mind the clinical benefits which may be gained by examination of the patient's mental state, advice about medication or direct involvement in multidisciplinary discussion about approaches which may shorten the duration of seclusion.

- Where indicated and as soon as is practicable, the patients vital signs will be recorded.

- The use of seclusion within this procedure will be audited on a monthly basis and reports given to the Hospital Management Team, the clinical lead for Clinical and Social Care Governance and service managers. The Clinical Director will inform the Associate Medical Director of any adverse trends or non-compliance with this procedure.

- If the patient is under 18 years of age or secluded for the first time, the Next of Kin should be informed, with the patients consent. If the patient has capacity and indicates they do not want the NOK informed, this will be recorded in the patients seclusion plan.as soon as possible. Any subsequent notification of further episodes should be agreed with the patient/Next of Kin and the agreement recorded in the patient's record. The Duty Nurse Manager/Night Supervisor should be notified as soon as possible.

- An identified person must be within clear sight or sound of the secluded patient, as indicated in the seclusion plan, to monitor their physical and psychological well-being.

- A record of entries of observations will be documented on the seclusion record at least every 15 minutes.

- The named person for the patient requiring seclusion must be made aware if the patient has received any form of medication in advance of seclusion and also the circumstances leading to the seclusion episode.

- The named person for the patient requiring seclusion must alert the nurse in charge immediately if any concerns arise.

- The Nurse in Charge should ensure that named person for the patient requiring seclusion, does so for no more than 30 minutes without being offered a break.

- The door should only be opened when there is an adequate team present as deemed appropriate by the Nurse in Charge. .

- The seclusion record will be completed.

**All staff**

It is the responsibility of all staff within inpatient Learning Disability services to follow the procedure.

## 4.0 KEY PROCEDURE PRINCIPLES

This procedure aims to meet the following

- Seclusion must only be considered when there is a clear and identified risk that the person who is to be secluded presents a significant degree of danger to other people, and that the situation cannot be managed as, or more, safely by any other means. The decision to use seclusion will always be based on the immediate presenting risks, professional judgement and knowledge of the patient.

- Seclusion will be used in the context of clear policy. It is only ever used as a last resort undertaken in a proportionate and least restrictive way and for the shortest time possible

- Seclusion should be distinguished from the use of low stimulus / quiet area.

- A registered Nurse will initiate the seclusion episode, the Responsible Consultant or Duty Doctor will be contacted as soon as practically possible and will be involved in decisions about continuing the use of seclusion and the on-going management of the patient while in seclusion

- Seclusion will take place in a safe, secure and properly identified room where the risk of the patient harming themselves or others is reduced. It will have adequate heating, lighting, ventilation and appropriate furnishings based on individual patient assessment.

- A member of the staff will be within sight and or sound of the patient at all times during the seclusion episode. The room should offer complete observation from the outside whilst also offering the patient privacy from others.

- The patient will be offered drinks, food and toilet facilities as required for their comfort.

- The patient should be able to see a clock (outside the door).

- Seclusion should not be used as an intervention for suicidal or self-harming behaviour.

- Seclusion must never be used solely to protect property.

- Staff who may be involved in managing violence and aggression should be fully trained in MAPA.

- Any patient subject to seclusion must be told, if practicable, the reason for the seclusion and informed throughout how it might come to an end.

- Any patient who has been secluded should be supported after the event to help him or her understand why the seclusion took place.

- All use of seclusion will be reviewed at the patients, weekly MDT meeting.

- A patient with capacity will be involved, if appropriate, in planning seclusion as an emergency intervention, through their care plan and risk management plan.

## 4.1 The Seclusion Record

**The Plan**

A written Plan must be prepared immediately, the primary aim being to terminate the period of seclusion safely and swiftly, to ensure patient's safety and that the episode lasts for the shortest time whilst the safety of the patient and others is paramount.

This plan will consider:

- How many staff are required to approach a patient.
- What, if any, medication is to be offered or has been administrated..

- The clinical presentation expected from the patient in order for seclusion to be terminated and targets for measuring when it may end.

## 4.2 Review of the Seclusion Episode

**15 minute review:**

The nurse observing will make an entry on the seclusion form indicating the patient's condition, physical behaviour and verbal indicators if significant, for example, threats/demonstrations of insight into incident.

## 4.3 Hourly Review

The Nurse in Charge will review the need to continue seclusion at the end of each hour and make a written record on Seclusion Record

### 4.4 Two Hourly Review

The Nurse in Charge and Duty Officer will ensure a review is completed every two hours and make a written record on the Observation and Clinical Review sheet. The plan should be reviewed if indicated and amended as required.

### 4.4 Over 4 hours

The Duty Officer and the Nurse in Charge will consult with the Senior Nurse manager or Senior Nurse on call and Ward Consultant or Consultant on call to review.

### 4.6 The Sleeping Patient

- If the patient falls asleep the seclusion episode will end and the door is unlocked. If the patient has fallen asleep, before there has been adequate opportunity to talk about and explore with him/her the events leading up to seclusion, it must be assumed that the matter has not been adequately resolved.

- Upon wakening, the patients' mental state must be assessed to allow an appropriate Care Plan to be identified, and/or a review of nursing supervision.

### 4.7 Following Seclusion

The patient will be given opportunity to discuss the events leading to the seclusion episode. The details of the discussion will be recorded in the Care Plan, which will be amended if appropriate.

- An observation of the patient's physical state, with the patient's consent, will be completed by nursing staff and any concerns referred immediately to a Medical Officer for examination, if felt to be necessary.

- The seclusion record will be completed and uploaded to the patients electronic record.

Details of seclusion will be recorded in day/night report and entered into the Seclusion Record

## 5.0 IMPLEMENTATION

### 5.1 Dissemination

This procedure will be disseminated to all staff within Learning Disability Services (Children and Adults)

### 5.2 Resources

This procedure will require all managers to ensure staff within their service have appropriate training.

### 5.3 Exceptions

This procedure is only for in-Patient Learning Disability Services (Adults and Children).

## 6.0 MONITORING

The multidisciplinary team will monitor the use of seclusion through regular reports and incident reviews.

Monthly statistical data on the use of seclusion is provided to the Core Hospital Management Team.

An Annual Report on seclusion is presented to the Trust Board.

The procedure will be reviewed on a three yearly basis.

## 7.0 EVIDENCE BASE / REFERENCES

Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;
NMC Guidelines for Records and Record Keeping

Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org

'Guidance on the Use of Restrictive Physical Interventions' (Department of Health, July 2002);

'BILD Mental Health Procedure Implementation Guide. Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings. National Institute for Mental Health in England. 2004;

Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005 CG25.

Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002

Safeguarding Vulnerable Adults

The Mental Health (NI) Order 1986 and its associated Code of Practice

Good Practice in Consent: Implementation Guide for Health Care Professionals

Positive and Proactive Care: reducing the need for restrictive interventions,
Social Care, Local Government and Care Partnership Directorate
April 2014

## 8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: - LD Governance, Hospital Service Manager, Ward Manager, Senior Nurse Managers, Medical Staff

## 9.0 APPENDICES / ATTACHMENTS

Appendix A – Seclusion Record Form

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this PROCEDURE should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this PROCEDURE is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

________________________________ **Date: ____November 2016____**

**Author**

________________________________ **Date: ____November 2016____**

**Director**

Appendix A

## Seclusion Record

| | | | |
|---|---|---|---|
| **Patients name** | | **Date:** | |
| **Ward** | | **Paris No.** | |
| **Place of seclusion** | | | |
| **Legal status** | **Voluntary** ☐ | **Detained** ☐ | **Under 18** ☐ |
| **Secluding nurse** | | **Dr notified** | |
| **Nurse Manager/ Night Supervisor notified** | | **Time seclusion commenced** | |
| | | **Time seclusion terminated** | |
| | | **Duration** | |

## A Describe efforts and methods used to prevent placing patient in seclusion

| |
|---|
| |
| **Staff involved:** |

## B Reason for secluding patient

| |
|---|
| **Self-seclusion requested** ☐ |
| |

## C Seclusion Plan

**A written Plan must be prepared immediately, the primary aim being to terminate the period of seclusion safely and swiftly, to ensure patient's safety and that the episode lasts for the shortest time whilst the safety of the patient and others is paramount.**

| |
|---|
| **Plan** |
| **Vital Signs** **Yes** ☐ **No** ☐ |
| **NOK informed** **Yes** ☐ **No** ☐ |
| |

**Record of Observations**

| 15 minute Observations | | |
|---|---|---|
| Time | Observations | Name of Observer |
| | | |
| | | |
| | | |
| | | |

**One hour review**

**Signature of Nurse in Charge:______________________________________**

**Outcome of review**

| |
|---|
| |

| 15 minute Observations continue | | |
|---|---|---|
| Time | Observations | Name of Observer |
| | | |
| | | |
| | | |
| | | |

**One hour review**

**Signature of Nurse in Charge:______________________________________**

**Name of SNM**

**Outcome of review**

| |
|---|
| |

| 15 minute Observations | | |
|---|---|---|
| Time | Observations | Name of Observer |
| | | |
| | | |
| | | |
| | | |

**Three hour review**

**Signature of Nurse in charge**

**Outcome of review**

| |
|---|
| |

| 15 minute Observations | | |
|---|---|---|
| Time | Observations | Name of Observer |
| | | |
| | | |
| | | |
| | | |

**Four hour review**

**Signature of Nurse in Charge:______________________________________**

**Name of SNM involved in review**

**Name of Consultant involved in review**

**Outcome of review**

| |
|---|
| |

| 15 minute Observations | | |
|---|---|---|
| Time | Observations | Name of Observer |
| | | |
| | | |
| | | |
| | | |

**If seclusion lasts for more than 4 hrs, the team will decide who should be involved in subsequent reviews.**

## D Evaluation of patient following period of seclusion

| |
|---|
| |
| **Signature of Nurse in Charge:** |

| | | | |
|---|---|---|---|
| **Title:** | **Rapid Tranquillisation Guideline for the immediate pharmacological management of violent and aggressive behaviour in adults and adolescent patients in the Belfast Health and Social Care Trust.** | | |
| **Author(s)** | **Stephen Guy, Senior Clinical Pharmacist** | | |
| **Ownership:** | **Dr Tony Stevens, Medical Director** | | |
| **Approval by:** | **Drugs & Therapeutics / Standards & Guidelines** | **Approval date:** | **D&T approval 29/03/12** |
| **Operational Date:** | | **Next Review:** | **28/03/2015** |
| **Version No.** | 1 | **Supercedes** | All Legacy Policies |
| **Links to other policies** | | | |

| **Date** | **Version** | **Author** | **Comments** |
|---|---|---|---|
| 15/5/2009 | 0.1 | Stephen Guy | 1st Draft |
| 14/11/2009 | 0.2 | S Guy & S Cooper | Incorporation of comments on consultation. |
| 11/6/2010 | 0.3 | S Guy | Update in light of changes in Maudsley Guidelines. Aripiprazole IM added |
| 22/9/2010 | 0.4 | S Cooper | Changes to monitoring section. Incorporation of PEWS and SOC after consultation with Resuscitation Team |
| 30/10/2010 | 0.5 | S Guy | References added |
| 2/6/2011 | 0.6 | S Guy & Chris Kelly | Changes from D&T committee meeting 14/1/2011 |
| 20/8/2011 | 0.7 | S Guy | Change from D&T committee meeting 5th August 2011 |
| 05/04/12 | 0.8 | S Guy | Addition of training needs assessment and review date |
| 30/05/12 | 0.9 | S O'Donnell | Formatting |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

The use of psychotropic medication in acute psychiatric emergencies is with the aim of controlling agitation, aggression or excitement. As there are no drugs that produce an immediate antipsychotic effect, the principal aim is immediate sedation and tranquillisation – hence, this is often known as 'rapid tranquillisation'. Antipsychotic (neuroleptic) drugs can be used for this purpose and may then be continued for their antipsychotic effect, which may take two or three weeks to develop.

The use of antipsychotics in acute psychiatric emergencies has been linked to sudden death, the cause of which is not entirely clear. During violent struggles an injection may be inadvertently injected intravascularly or the normally clinically insignificant prolongation of QTc interval associated with some antipsychotics might be potentiated by the arrhythmogenic effect of catecholamines released during violent struggles. Monitor closely when IM antipsychotics have to been used in patients prescribed other medicines that might prolong QTc interval.

### 1.2 Purpose

To ensure a consistent approach to Rapid Tranquillisation for the management of disturbed and violent behaviour in order to minimise risk..

## 2.0 DEFINITIONS/SCOPE OF THE POLICY

This Guideline document describes the recommended pharmacological management options that may be used to manage disturbed and violent behaviour in adolescents and adult patients cared for in the Belfast Health And Social Care Trust. The physical observations and monitoring required after the use injectable medication are described.

It is expected that this Guideline will be used Primarily in Mental Health settings but it may be applicable for the acute management of known or apparently disturbed mental states in other settings. In these situations, clinicians may wish to seek further advice on management from a psychiatrist.

However, it is important to recognise that this is NOT applicable for the primary management of acute alcohol withdrawal.

## 2.0 ROLES/RESPONSIBILITIES

All staff involved in the Rapid Tranquillisation of patients with disturbed and violent behaviour should follow this guideline.

Clinicians should use their own clinical judgement in each case and if they decide that a different management approach is clinically indicated then the reasons for this should be clearly documented.

## 4.0 KEY POLICY PRINCIPLES

### Key Policy Statement

### 4.1 Policy Principles

4.1.1 Rapid Tranquillisation should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques and should only be considered when de-escalation approaches have failed.

4.1.2 Patients should only be treated with the medicines described in this guideline only after it is established that the risk of not doing so is greater than the risk of rapid tranquillisation.

4.1.3 This guideline applies to the management of acutely disturbed behaviour and not to the management of delirium.

4.1.4 Staff should be trained, to a level appropriate to their role, in how to assess and manage potential and actual violence using de-escalation techniques, restraint and the pharmacological treatment. Staff should also be trained to use Intermediate Life Support when appropriate.

4.1.5 If the patient has expressed a preference for a particular antipsychotic in an Advance Decision consider prescribing this, if appropriate to the clinical circumstances.

4.1.6 Before an intramuscular medication is administered, the patient must be given the opportunity to take oral medication if it is thought this would be effective and appropriate in the clinical circumstances.

4.1.7 In all cases the likely minimum effective dose of medication should be used.

4.1.8 Staff involved in rapid tranquillisation should be aware of the licensed indications and maximum doses of medicines (see BNF or Summary of Product Characteristics, SPC) and should endeavour to keep within these limits. In some cases current BNF and SPC dose may be knowingly exceeded (e.g. lorazepam >4mg/day), bearing in mind the overall risks. This decision should not be taken lightly or the risks underestimated. Record a risk-benefit decision and rationale in the case notes. Junior doctors must consult a more senior colleague in these cases.

4.1.9 All staff need to be aware of the legal framework that authorises the use of these interventions

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This Guideline is applicable in all Mental Health inpatient units within the Belfast Trust. All medical and nursing staff working in mental health inpatient units should be aware of this Guideline. Further Consultation is required before this Guideline is fully implemented outside mental health units

### 5.2 Resources

A training needs analysis is included in Appendix F. It is the responsibility of the Associate Medical Director and the Director of Nursing for Mental Health services to ensure training is in place

Training on Rapid Tranquillisation forms part of the Induction Training for Medical Staff on rotational training placements.
Training on Rapid Tranquillisation is part of the MAPA 5 day training for Staff working in Mental Health Inpatient units

### 5.3 Exceptions

Further Consultation is required before this Guideline is fully implemented outside Mental Health units

## 6.0 MONITORING

Compliance with this Guideline will be monitored by reviewing either

- Case notes of patients who undergo rapid tranquillisation
- Incident forms completed after rapid tranquillisation
- Physical Intervention monitoring forms completed after episodes of restraint

## 7.0 EVIDENCE BASE / REFERENCES

Maudsley Prescribing Guidelines 10th Edition, Taylor, D, Paton C, Kapur S, Informa Healthcare London 2010

National Institute for Health and Clinical Excellence 2005: Violence CG2: London: National Institute for Health and Clinical Excellence.

SPc Haloperidol tablets and Injection, Electronic Medicines Compendium, www.medicines.org.uk accessed 30/10/2010

SPc Aripiprazole Tablets and Injection, Electronic Medicines Compendium, www.medicines.org.uk accessed 30/10/2010

SPc Olanzapine tablets and Injection, Electronic Medicines Compendium, www.medicines.org.uk accessed 30/10/2010

SPc Risperidone tablets, Electronic Medicines Compendium, www.medicines.org.uk accessed 30/10/2010

SPc Lorazepam Tablets and Injection Electronic Medicines Compendium, www.medicines.org.uk accessed 30/10/2010

## 8.0 CONSULTATION PROCESS

Draft Guideline circulated for consultation to all Consultant psychiatrists in Adult Mental Health, Psychiatry of Old Age, Child and Adolescent Services and Learning Disability Services.

## 9.0 APPENDICES / ATTACHMENTS

Appendix A, Medication in Acute Psychiatric Emergencies

Appendix B, Flow chart for Pharmacological management of violent and aggressive behaviour (FOR ADULTS OVER 18 YEARS)

Appendix C, Flow Chart for Pharmacological management of violent and aggressive behaviour (FOR ADOLESCENTS from 13 to 17 years inclusive)

Appendix D, Post Rapid Tranquillisation Monitoring Guidelines

Appendix E, Dose Information for medicines used in Rapid Tranquillisation

Appendix F, Rapid Tranquillisation Training Needs Analysis

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Stephen Guy

________________________________ **Date: _________July 2012_________**

**Name**
**Title**

________________________________ **Date: ________July 2012__________**

**Name**
**Title**

## Appendix A

## Medication in Acute Psychiatric Emergencies

### 1.0 General Prescribing Principles

The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the patient and others. Patients should be able to respond throughout. With this is mind, it is important to individualise the dose and type of medication for each service user. This will depend on several factors including previous response to medication, age, physical problems (renal, hepatic, cardiovascular or neurological disease) other prescribed medication and possible use of drugs of abuse.

- Check that the patient has not had previous allergy or severe idiosyncratic reaction to the drugs to be used.
- Check there is no recent history of Neuroleptic Malignant Syndrome or hyperthermia.
- Simultaneous administration of IM antipsychotics and IM benzodiazepines (lorazepam) may be associated with excessive sedation and cardio respiratory depression. If this combination is deemed necessary then patients must be monitored for excessive sedation and for postural hypotension.
- Patients taking clozapine and olanzapine require care when giving benzodiazepines as potentially fatal orthostatic and cardio-respiratory dysregulation have been reported. If this combination is considered necessary it is essential to undertake frequent monitoring of the patient.
- If the patient has expressed a preference for a particular antipsychotic in an Advance Decision consider prescribing this if warranted by clinical circumstances.
- Avoid unnecessary polypharmacy. This may necessitate careful choice of drug in relation to either current treatment or expected maintenance treatment.
- Carefully consider the number of active PRN prescriptions operative at any one time in relation to the risk of inadvertent overdose.
- Prescribe oral and IM doses separately – do not use PO/IM abbreviation.
- Don’t mix medications in the same syringe.
- Patients entering LEVEL 2 on the protocol must have details of all medicines administered, rational of use and an assessment of effectiveness recorded in the clinical notes. All current PRN prescriptions on the kardex should be discontinued and reviewed in 6-12 hours after which they may be re-prescribed if necessary.

### 1.1 Maximum Doses

Staff involved in rapid tranquillisation should be aware of the licensed indications and maximum doses of medicines (see BNF or Summary of Product Characteristics, SPC) and should endeavour to keep within these limits. In some cases current BNF and SPC dose may be knowingly exceeded (e.g. lorazepam >4mg/day), bearing in mind the overall risks. This decision should not be taken lightly or the risks underestimated. Record a risk-benefit decision and rationale in the case notes. Junior doctors must consult a more senior colleague in these cases. If BNF doses are exceeded, it is particularly important to undertake frequent and intensive monitoring of a calmed patient. Pay particular attention to regular check of airway and intensive monitoring of level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. (Appendix D).

**Cardiovascular Safety**

Antipsychotics as a group are probably associated with an increased risk of QTc prolongation. Normal limits of QTc are less than 440 ms in men and less than 470 ms in women. The risk of arrhythmia increases exponentially beyond normal limits, with strong evidence that QTc greater than 500 ms is clearly linked to an increased risk of arrhythmia. The risk is dose related and the risk for individual drugs is probably additive when they are used in combination.

The table below summarises the risk for common antipsychotics

| **Low Effect** | **Moderate Effect** | **High Effect** |
|---|---|---|
| Aripiprazole<br>Amisulpride<br>Clozapine<br>Flupentixol<br>Fluphenazine<br>Olanzapine<br>Risperidone<br>Sulpiride | Chlorpromazine<br>Quetiapine | Haloperidol<br>Pimozide<br>Sertindole |

The SPC for haloperidol recommends a baseline ECG before commencing treatment with haloperidol and the NICE guideline for Schizophrenia (CG82) recommends an ECG before starting an antipsychotic if a patient is admitted as an inpatient.

A number of medications are associated with prolonged QTc including erythromycin, quinine, amiodarone, ciclosporin, diphendyramine and tamoxifen. Diuretics can cause electrolyte disturbance which is also a risk factor. Consult the BNF for further examples of drugs that prolong QTc.

## 1.3 Drug Selection

See Appendix E for a summary of recommended drugs, their onset of action and doses for different age groups.

A benzodiazepine may be the safest and best tolerated drug with which to effect 'rapid tranquillisation' of the patient. Once the patient has been calmed, either by de-escalation techniques or by a benzodiazepine, an antipsychotic drug may be best for maintenance of the situation. Remember that repeated use of a benzodiazepine may result in tolerance to the effect and this will probably become evident by 7 to 10 days.

There is limited clinical experience of aripiprazole IM within the Trust. It is included in this policy as a 3rd line option to provide an alternative whenever haloperidol or olanzapine are contraindicated or have failed to produce and adequate response. Aripiprazole is not recommend as an option in Adolescents aged between 13 and 18 years

### 1.4 For Adults Over 18 years

*The flow chart in Appendix B outlines a stepped approach to rapid tranquillisation for Adults over 18 years of age.*

If you are unsure about initial pharmacological management then always call a more senior doctor. If you are a junior doctor and your initial drug treatment does not work then you should consider discussion with someone more senior. If you are a Consultant and have tried two or three approaches without success then it may be wise to seek a second opinion from a colleague. If the incident is outside a mental health unit, clinicians may wish to consult a psychiatrist for further advice.

### 1.5 For Adolescents aged between 13 and less than 18 years

*The flow chart in Appendix C outlines a stepped approach to rapid tranquillisation for Adolescents between 13 and less than 18 years of age.*

If you are unsure about initial pharmacological management then always call a more senior doctor. If you are a junior doctor and your initial drug treatment does not work then you should consider discussion with someone more senior. If you are a Consultant and have tried two or three approaches without success then it may be wise to seek a second opinion from a colleague. If the incident is outside an adolescent mental health setting, clinicians may wish to consult a child and adolescent psychiatrist for further advice.

### 1.6 For Older People (65+) (see appendix E)

This guideline applies to the management of acutely disturbed behaviour and not to the management of delirium.

There is evidence that antipsychotics are associated with increased mortality (probably by increasing the risk of cerebrovascular adverse events) even in people without dementia. A cautious approach is recommended.

- Oral medication should always be offered whenever possible.
- Lorazepam, starting at a low dose, is the preferred first line treatment.
- If there is confirmed history of previous antipsychotic use then oral haloperidol or olanzapine may be considered.
- If a patient requires IM medication, lorazepam should be used first line.
- IM haloperidol or IM olanzapine may be used if there is confirmed history of previous antipsychotic use.
- If previous use of antipsychotics can't be confirmed and lorazepam fails to control the situation, low dose olanzapine may be considered. In such cases it may be appropriate to consult a doctor experienced in the management of older people.

### 1.7 For people with dementia. (see appendix E)

Non-pharmacological options should be considered as first line management. If this is ineffective, then lorazepam may be considered. Risperidone is licensed for short-term use for persistent aggression in people with moderate to severe Alzheimer's dementia. The starting dose is 0.25mg twice daily increased to 0.5mg twice daily. If ongoing use of risperidone is considered necessary then the advice of a doctor experienced in the management of dementia should be sought.

In very exceptional circumstances, when oral treatment is impossible, low dose haloperidol IM may be used. In these cases, consider consulting a doctor with experience in managing disturbed behaviour in people with dementia.

### 1.8 Monitoring after Use of Intramuscular medication

Appendix D outlines the monitoring required after the use of intramuscular medication.
If patients refuse monitoring of vital signs or of they remain too behaviourally disturbed to be approached, this must be documented in the patients notes at each time monitoring would have been due. The patient should be observed for sign/symptoms of pyrexia, hypotension, over sedation and general physical well-being and documented accordingly

### 1.9 Drugs NOT recommended for rapid tranquillisation

The following drugs are NOT recommended for rapid tranquillisation:

- Oral and IM chlorpromazine – IM chlorpromazine is painful and can cause severe hypotension. Chlorpromazine must never be given intravenously.
- IM diazepam – absorption is erratic.
- IM depot antipsychotics.
- Olanzapine in dementia related disturbance.
- Zuclopenthixol acetate is not recommend for routine use in rapid tranquillisation due to its slow onset of action. It may however be recommended by a senior doctor or consultant when:
  - The patient is disturbed/violent over an extended time period
  - Past history of good/timely response
  - Past history of repeated parenteral administration required
  - Cited in an advance decision

### 1.10 Actions after Rapid Tranquillisation

A doctor should be available to quickly attend an alert by staff members when Rapid Tranquillisation has been implemented, for an appropriate period of time to ensure the treatment has been effective and that undue adverse effects are no longer likely to occur.

A report of use of Rapid Tranquillisation should be made on a Trust Incident Form. A post-incident review may be held within 72 hours.

Appendix B

# Pharmacological management of violent and aggressive behaviour (FOR ADULTS OVER 18 YEARS)

See Appendix D for management of older people and people with dementia

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques.**

If de-escalation techniques are unsuccessful or inappropriate, consider pharmacological management.

## LEVEL 1

**Disturbed but accepting oral medication**

- Ongoing verbal de-escalation.
- Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.

Appropriate oral medicines and doses are listed below. Consider combination of lorazepam with an antipsychotic if indicated by clinical circumstances.

**DO NOT USE OLANZAPINE IN DEMENTIA.**

Lorazepam 1 – 2mg
**(Max 4mg/24hrs)**

Haloperidol 5 – 10mg
(Max 30mg /24hrs)

**Olanzapine 10mg**
(Max 20mg/24hrs)

Review the situation after 45 minutes. If response is inadequate consider repeating oral therapy or moving to LEVEL 2.

**NOTES**

- **Consider oral risperidone in people with** Alzheimer's dementia – see Appendix E
- Oral lorazepam alone may be preferable where there is uncertainty about previous history:
  - Including history of cardio-vascular disease
  - Uncertainty regarding current medication
  - Possibility of current illicit drug/alcohol intoxication
- Oral antipsychotics may be preferable in patient with
  - Current regular benzodiazepine use
  - A history of respiratory depression

If unsuccessful or inappropriate

## LEVEL 2

**Disturbed but refusing oral medication or risk of harm to self or others**

- Review all medication administered within the last 24hrs – be aware of BNF maximum doses.
- Ensure resuscitation equipment and emergency drugs are available within 3 minutes.

**Consider:**

**IM treatment with lorazepam, haloperidol or olanzapine as single agents. Consider aripiprazole if haloperidol or olanzapine are contraindicated or have failed to produce an adequate response**

**OR**

**Lorazepam in combination with an antipsychotic**

**Lorazepam 1-2mg IM**
(Max 4mg/24hrs)

**Olanzapine 5-10mg**
(Max 20mg/24hrs)

**Haloperidol 5-10mg IM**
(Max 18mg/24hrs)

**Aripiprazole 5.25-9.75mg** IM
(Max 30mg/24hrs)

Review the situation after 45 minutes. If there is continued concern seek advice from a more senior doctor before proceeding further

***Don't use IM lorazepam within one hour of IM olanzapine. Use oral lorazepam with caution***

**NOTES**

- For aripiprazole and olanzapine, leave at least 2hrs between injections. Max of three injections in 24hrs
- Dilute lorazepam 1:1 with saline or water for injection prior to administration.
- Flumazenil must be available if IM lorazepam is used.
- If IM haloperidol is used, monitor for emergence of EPSEs, especially dystonia and give procyclidine 5mg orally or IM according to severity of symptoms.

If unsuccessful or inappropriate

## LEVEL 3

**Situation rapidly deteriorating or failure to respond to LEVEL 2 Interventions**

- Review current treatment to date.
- Seek advice from a more senior doctor, or a Consultant before proceeding.

Options to consider at this stage include:

- Repeat IM injections as per LEVEL 2.
- Zuclopenthixol acetate (See Guideline notes)
- Promethazine 50mg IM, useful in benzodiazepine intolerant patients. Onset of action is slow. Allow 1-2 hours to assess response before repeating to maximum of 100mg in 24 hrs.

# Appendix C

# Pharmacological management of violent and aggressive behaviour (FOR ADOLESCENTS from 13 to 17 years inclusive)

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques.**
If de-escalation techniques are unsuccessful or inappropriate, consider pharmacological management.

## LEVEL 1
## Disturbed but accepting oral medication

- Ongoing verbal de-escalation.
- Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.

**Appropriate oral medicines and doses are listed below. Consider combination of lorazepam with an antipsychotic if indicated by clinical circumstances. DO NOT USE OLANZAPINE IN DEMENTIA.**

**Lorazepam 0.5 - 2mg**
(Max 4mg/24hrs)

**Haloperidol 1 – 5mg**
(Max 15mg /24hrs)

**Olanzapine 10mg**
(Max 20mg/24hrs)

Review the situation after 45 minutes. If response is inadequate consider repeating oral therapy or moving to LEVEL 2.

NOTES
- Consider oral risperidone in people with Alzheimer's dementia – see Appendix D
- Oral lorazepam alone may be preferable where there is uncertainty about previous history:
  - Including history of cardio-vascular disease
  - Uncertainty regarding current medication
  - Possibility of current illicit drug/alcohol intoxication
- Oral antipsychotics may be preferable in patient with
  - Current regular benzodiazepine use
  - A history of respiratory depression

If unsuccessful or inappropriate

## LEVEL 2
## Disturbed but refusing oral medication or risk of harm to self or others

- Consult a CAMHS doctor before proceeding.
- Review all medication administered within the last 24hrs – be aware of BNF maximum doses.
- Ensure resuscitation equipment and emergency drugs are available within 3 minutes

**Consider:**
**IM treatment with lorazepam, olanzapine or haloperidol as single agents**
**OR**
**Lorazepam in combination with an antipsychotic**

**Lorazepam 0.5-2mg IM**
(Max 4mg/24hrs

**Haloperidol 2-5mg IM**
(Max 15mg/24hrs)

**Olanzapine 5-10mg**
(Max 20mg/24hrs)

Review the situation after 45 minutes. If there is continued concern about the patient, seek advice from a more senior colleague before proceeding further.

***Don't use IM lorazepam within one hour of IM olanzapine. Use oral lorazepam with caution***

**NOTES**
- The dose of haloperidol will be guided by the patient's weight.
- For olanzapine, leave at least 2hrs between injections. Max of three injections in 24hrs
- Dilute lorazepam 1:1 with saline or water for injection prior to administration.
- Flumazenil must be available if IM lorazepam is used.
- If IM haloperidol is used, monitor for emergence of EPSEs, especially dystonia and give procyclidine 5mg orally or IM according to severity of symptoms.

If unsuccessful or inappropriate

## LEVEL 3
## Situation rapidly deteriorating or failure to respond to LEVEL 2 Interventions

- Review current treatment to date.
- Consider appropriatness of current placement.
- Seek advice from a more senior doctor, or a Consultant with experience in Child and Adolescent Psychiatry before proceeding.

Options to consider at this stage include
- Repeat IM injections as per LEVEL 2 to maximum daily doses.

Rap
adol

**Appendix D**

# Post Rapid Tranquillisation Monitoring Guidelines

## Rapid tranquillisation - Monitoring

After any parenteral drug administration for RT, or where clinically necessary with oral medication, patients require to be monitored as below. (Where the patient's mental state or behaviour makes this impossible this must be documented. Observe for, and record, any signs of over sedation, pyrexia, hypotension or general malaise.)

**Use the Trust Standard Observation Chart (SOC) to monitor**:

- **Level of consciousness**
- **Temperature**
- **Pulse**
- **Blood pressure**
- **Respiratory Rate**

- **Monitoring should be every 10 minutes for one hour, then half-hourly until the patient is ambulatory.**
- **The Early Warning Score should be calculated from the SOC each time and further action taken if indicated by this.**
- **If necessary, a doctor should be called and transfer to an acute medical facility may sometimes be required.**
- **Remember that <u>protection of the airway is paramount</u> and it is important to <u>maintain good hydration</u>.**
- **If the patient is asleep or unconscious, the use of pulse oximetry to continuously measure oxygen saturation is recommended.**

- Pay particular attention to level of consciousness and blood pressure when IM antipsychotics and IM benzodiazepines are used in combination.
- An ECG is recommended when parenteral antipsychotics are given, especially when higher doses are used. Staff should be sufficiently well trained to interpret ECG traces (including calculation of QT/QTc interval). If an ECG shows any cause for concern then a physician must be asked for advice on patient management.
- **NOTE: An ECG is essential if IM antipsychotics are used in adolescents.**

## Management of problems occurring during Rapid Tranquillisation

| Problem | Remedial Measures |
|---|---|
| **Acute Dystonia** (including oculogyric crises) | Give **procyclidine 5 - 10mg Orally or IM** |
| **Reduced respiratory rate**<br><10/minute or<br>oxygen saturation <92% | Give oxygen; ensure patient is not lying face down.<br>Give **flumazenil** if benzodiazepine induced.<br>Give flumazenil 200microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1mg (1000microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level.<br>N.B. Effect of flumazenil may wear-off & respiratory depression return – monitoring must continue beyond initial recovery of respiration.<br>If induced by any other agent the patient will require mechanical ventilation. |
| **Irregular or slow pulse**<br><50 beats/min | **Refer to specialist medical care immediately.** |
| **Fall in blood pressure**<br>> 30mmHg drop in systolic BP on standing or diastolic BP <50mmHg | Lie patient flat, raise legs if possible. Monitor closely and seek further medical advice if necessary. |
| Increased temperature | **Withhold antipsychotics –**risk of NMS or perhaps arrhythmias.<br>Monitor closely, cool the patient, and check muscle creatinine kinase**.**<br>**Refer to specialist medical care** if continued or other signs of NMS present e.g. sweating, hypertension or fluctuating BP, tachycardia, incontinence (retention or obstruction), muscular rigidity (may be confined to head and neck), confusion, agitation or loss of consciousness. |

# Appendix E
# Dose Information for medicines used in Rapid Tranquillisation

| Medication | Time to Peak Plasma concentration | Adolescents (13 – 17) | Adults (18 – 65) | Older People (65+) | People with Dementia |
|---|---|---|---|---|---|
| Lorazepam tablets and IM injection | 50 – 90 minutes<br>(Sedation within 30-45 minutes) | By Mouth OR by IM injection<br>0.5mg - 2mg<br>Maximum 4mg/24hrs | By Mouth Or by IM injection<br>1mg - 2mg<br>Maximum 4mg/24 hours | By Mouth Or by IM injection<br>0.5mg - 1mg<br>Maximum 4mg/24 hours | By Mouth Or by IM injection<br>0.5mg - 1mg<br>Maximum 4mg/24 hours |
| Aripiprazole IM injection | 1 –3 hours | Not Applicable | By IM injection<br>9.75mg (1.3ml) – Consider lower dose (5.25mg) on basis of clinical status<br>Effective range 5.25 –15mg<br>Max dose 30mg/24hrs by any route | Effectiveness in over 65's not established. Consider lower doses on basis of clinical status | **Not Recommended** |
| Risperidone tablets oral solution | | Not applicable | Not applicable | Not applicable | By mouth in Alzheimer's dementia<br>0.25 – 0.5mg twice daily. |
| Olanzapine tablets and Orodispersible tablets | 5 – 8 hours | By mouth in psychosis<br>5mg – 10mg<br>Maximum 10mg/2hrs | By mouth<br>10mg<br>Maximum 20mg/24 hours | As a second line option<br>By mouth<br>5-10mg<br>Maximum 20mg/4hrs | **DO NOT USE OLANZAPINE IN PEOPLE WITH DEMENTIA** |
| Olanzapine IM injection | 15 – 45 minutes (peak levels up to 5 times that of oral dose) | By IM injection<br>2.5mg – 10mg/2hrs<br>Maximum of 3 injections in 24 hours with at least 2 hours between injections.<br>When used for Rapid tranquillisation, Maximum of 20mg/24 hours by ALL routes must NOT be exceeded | By IM injection<br>5-10mg<br>Maximum of 3 injections in 24 hours with at least 2 hours between injections<br>When used for Rapid tranquillisation, Maximum of 20mg/24 hours by ALL routes must NOT be exceeded | By IM injection<br>>60 yrs 2.5mg – 5mg<br>Maximum of 3 injections in 24 hours with at least 2 hours between injections<br>When used for Rapid tranquillisation, Maximum of 20mg/24 hours by ALL routes must NOT be exceeded | **DO NOT USE OLANZAPINE IN PEOPLE WITH DEMENTIA** |
| Haloperidol injection | 15 – 60 minutes<br>(Sedation in 30 – 45 minutes) | By IM injection<br>1mg – 5mg<br>Maximum 10mg/24hrs | By IM injection<br>5mg – 10mg<br>Maximum 18mg/24 hours | Only use first line if there is confirmed history of previous exposure to typical antipsychotics. Start with lower doses than the 18-65 age group | Use only in very exceptional circumstances. Consider consulting a doctor with experience in dementia.<br>**Do not use in dementia with Lewy Bodies** |
| Haloperidol Oral solution and tablets | 2 – 6 hours<br>(Sedation usually within 30-45 minutes) | By Mouth in psychosis<br>2mg - 5mg<br>Maximum 15mg/24hrs | By Mouth<br>5mg - 10mg<br>Maximum 30mg/24 hours | Only use first line if there is confirmed Hx of previous exposure to typical antipsychotics. Start with lower doses than the 18-65 age group | **Consider oral risperidone as an alternative** |

**NOTES:**

- Remember, 0.5mg lorazepam is equivalent to 5mg diazepam.
- Haloperidol 5mg IM is equivalent to approx 8mg – 10mg orally.
- Orodispersible tablets offer no advantage in speed of onset but are harder to spit out or conceal.
- Olanzapine injection is not licensed for use beyond 3 days.
- Olanzapine IM and lorazepam IM should not be used within one hour of each other and then only after careful consideration with strict post-injection monitoring.
- There is probably an increased risk of cerbro-vascular events in older patients with all antipsychotics.

## Appendix F

## Rapid Tranquillisation Training Needs Analysis

Set out below is the training needs analysis for all staff groups indentifying which groups of staff require training and the level and frequency required.

The aim of training is to ensure that all staff are aware of their duties, role and responsibilities to enable them to implement the Rapid Tranquillisation guideline.

| Staff Group | RT training including flow chart and monitoring | Medication used in RT | Basic Life Support | Intermediate Life Support | Automated external defibrillator | Pulse oximetry |
|---|---|---|---|---|---|---|
| Frequency | Annual | Annual | Annual | Annual | Annual | Annual |
| **Medical Staff** | | | | | | |
| Consultant | √ | √ | | √ | √ | √ |
| Specialist Trainees | √ | √ | | √ | √ | √ |
| Core Trainees | √ | √ | | √ | √ | √ |
| Staff Grade | √ | √ | | √ | √ | √ |
| F1/F2 Trainee | √ | √ | | √ | √ | √ |
| **Staff Based in Acute inpatient units** | | | | | | |
| Registered nurses | √ | √ | √ | √ (in high risk areas) | √ | √ |
| Healthcare assistants | √ (overview) | √ (overview) | √ | | | |

Belfast Health and Social Care Trust

**Reference No:** SG 35/13

| | | | |
|---|---|---|---|
| **Title:** | Observations within Mental Health Services | | |
| **Author(s)** | Mairead Mitchell, Senior Manager, Service Improvement and Governance<br>Cahal McKervey, Operations Manager<br>Patricia Minnis, Quality Co-ordinator | | |
| **Ownership:** | Catherine McNicholl, Director, Adult Social and Primary Care | | |
| **Approval by:** | Standards and Guidelines<br>Policy Committee<br>Executive Team Meeting | **Approval date:** | 3/7/13<br>19/8/13<br>21/8/13 |
| **Operational Date:** | November 2013 | **Next Review:** | November 2016 |
| **Version No.** | 1 | **Supercedes** | |
| **Key words** | general, continuous, observations, arm's, eyesight, risk | | |
| **Links to other policies** | • Regional Guideline on the use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland<br>• Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;<br>• The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;<br>• Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;<br>• The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;<br>• The Belfast Health and Social Care Trust Named Nurse Policy;<br>• UNOCINI Guidance;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;<br>• The Belfast Health and Social Care Trust AWOL Policy. | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 09/08 | 0.1 | T. McNeany | Circulated to all Adult Mental Health Inpatient Wards |
| 20/12/12 | 0.2 | P. Minnis | Reviewed |
| 10/01/13 | 0.2 | As above | Sent out for Consultation |
| 10/01/13 | 0.3 | As above | Comments received - updated |
| 09/04/13 | 0.3 | As above | Approved by Mental Health Governance Committee |
| 09/05/13 | 0.3 | As above | Circulated to all Adult Mental Health Inpatient Wards |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

Belfast Health and Social Care Trust Mental Health Services seeks to promote and maintain a caring and safe environmental for patients admitted into any of its mental health inpatient facilities. Every patient receiving care within a mental health inpatient facility will be observed as a necessary part of their care. This is principally a task which falls to nursing staff following a joint nursing and medical assessment.

### 1.2 Purpose

This policy has been developed to supersede any previous observation policies and to ensure a standardised approach across all its mental health facilities as outlined in the Regional Guideline on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011.

This policy provides staff with guidance regarding the levels of observations and the decision making process to implement or adjust same.

### 1.3 Objectives

This policy aims to provide staff working within a psychiatric inpatient facility with a structured and standardised framework for delivering care to patients across the spectrum of inpatient facilities within the Trust.

This policy ensures the Trust’s compliance with mandatory requirements arising from the following: -

- The Report of the inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006;
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007;
- The Report of the Inquiry Panel (O’Neill) to the Eastern Health and Social Services Board 2008;
- Mental Health (NI) Order 1986

This policy should be read in conjunction with the following: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;
- The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;

- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;
- The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;
- The Belfast Health and Social Care Trust Named Nurse Policy;
- UNOCINI Guidance;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;
- The Belfast Health and Social Care Trust AWOL Policy.

## 2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all patients, voluntary and detained, admitted to and discharged from an adult psychiatric inpatient facility. This operational policy provides staff working within a psychiatric inpatient unit with a structured and standardised framework for delivering care to service users and their carers across the spectrum of inpatient facilities within the Trust.

## 3.0 ROLES/RESPONSIBILITIES

All staff working within the mental health inpatient facility have a responsible role to play in achieving the policy objectives.

There are specific roles and responsibilities outlined in the Policy for: -

### 3.1 Nurse in Charge:

The Nurse in Charge will: -

- Ensure the safety and wellbeing of all patients and staff within the inpatient facility;
- Agree the level of observation for patients in conjunction with the Consultant Psychiatrist;
- Satisfy his/herself that they are aware of the location of all the patients both on or off ward and be aware of their mental and physical state;
- Allocate an observing nurse to each patient on continuous observations ensuring they are competent, have the appropriate experience and training i.e. communication/engagement skills, brief intervention training and management of aggression and have an understanding of the patient’s care plan;
- Allocate one member of staff to make visual checks of every patient on the ward on no less than an hourly basis throughout the shift;
- Remain accountable for delegation of observation duties;
- Ensure that a nurse is allocated to each patient for each shift regardless of their observation status to monitor their mental state and implement the patient’s care plan;

- Ensure that nursing staff meet with their allocated patients during the shift;
- Address any concerns raised by a staff member or family regarding the levels of observation a patient is on;
- Ensure as far as possible that no member of staff remains on continuous observation duties for more than two hours consecutively;
- Initiate the Record of Continuous Observation form (App 3) for any patient being placed on continuous observation;
- In the event of a patient going AWOL, implement the AWOL Policy;
- In the case a patient is being taken off continuous observation complete the Record of Continuous Observation form and the Continuous Observation Prescription Form (App 1) in conjunction with the Consultant Psychiatrist or their nominated deputy.

### 3.2 Consultant Psychiatrist or nominated deputy (this role will be undertaken by the Duty Doctor during the evening, weekends and bank holidays)

The Consultant Psychiatrist or their nominated deputy will: -

- In conjunction with the Nurse in Charge agree the level of observation required for patients;
- Ensure that patients placed on continuous observation are reviewed daily by his/herself or their named deputy;
- In the event of a patient being taken off continuous observation complete the Continuous Observation Prescription Form in conjunction with the Nurse in Charge.

### 3.3 Observing staff

- The Nurse in Charge will allocate one member of staff to make visual checks on every patient in the ward on no less than an hourly basis and record same. This member of staff will report any changes in patients' mental state or their lack of presence in the ward to the Nurse in Charge;
- All staff observing a patient on a continuous basis have a responsibility to ensure they have the appropriate knowledge, skills and experience to safely perform this task including management of aggression training and communication/engagement skills, brief intervention training and management of aggression
- They must ensure they are aware of the rationale behind the level of observation and have an understanding of patient's care plan;
- The observing staff member will record the nature and purpose of the continuous observation on the Continuous Observation Record form (APP 2);
- The role of the observing staff member for patients on continuous observation does **<u>not</u>** replace the role of the named nurse who is responsible for observing the patient's health, well being and behaviour;
- Where a patient is on continuous observation the observing nurse will support the named nurse in assessing the patient's risk and mental state and in engaging the patient;
- Positive engagement with the patient is an essential aspect of constant observation.

- Whilst taking account of the patient's wishes staff should try to interact with the patient as much as possible, be this through assisting them with activities of daily living, social interaction or other activities on or off the ward dependent on the level of risk. In doing so staff should ask the patient about past beneficial interventions or things they feel might prove beneficial (please see a list of possible activities – this list is not exhaustive).

### 3.4 On-ward activities:

- **Activities of daily living** – assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate write letters, make telephone calls.
- **Social interaction** – respect a patient's right for silence. If a patient wishes to talk don't only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the patient may be due to a staff member's personal difficulty with silence.
- **Clinical interaction** – a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the patient to have some guidance in working through it.
- Respect a patient's wishes within safety boundaries, and the level of observation. Open the door if the patient's mental state is deteriorating as a consequence of close proximity and observation.
- **On-ward occupational therapy** to assist patients in engaging in activities during the time of an acute onset.

### 3.5 Off-ward activities:

- Engage in occupational therapy/other therapeutic opportunities
- Walks around grounds (assuming risk allows)

### 3.6 Named Nurse (in their absence a nurse will be allocated to the patient)

- The role of the observing staff member does **not** replace the role of the named nurse.
- A patient will be allocated a nurse during each shift. This nurse will be responsible for observing the patient's health, well being and behaviour. A record of this assessment will be made in the patient's notes and where necessary the patient's care plan will be modified;
- Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give patients a chance to discuss concerns and frustrations.
- All nurses should be aware of the general whereabouts of each patient in their charge, whether on or off the ward.

### 3.7 Multidisciplinary Team

If any member of the multidisciplinary team has any concerns about the levels of observation a patient is receiving these must be reported immediately to the Nurse in Charge of the inpatient facility. These discussions should then be discussed with the multidisciplinary team or if deemed urgent the Consultant Psychiatrist or their deputy.

If there is disagreement between individuals regarding the patient's level of observation this must be brought to the attention of the individuals' line managers. Staff should always choose the safest option for the patients and staff.

## 4.0 KEY POLICY PRINCIPLES

### 4.1 Levels of Observation

Observation should be used as an opportunity to assess and engage the patient, developing a therapeutic relationship. The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland recognises two levels of observation (these can apply to both voluntary and detained patients): -

a. General Observation – this is the minimum level of observation for all patients. This level of observation is suitable for patients assessed as presenting a low to medium risk of deliberately harming themselves or others. A member of staff will check the exact location of each patient on general observation at least every hour and record same in their notes. All nurses should be aware of the exact location of all patients under their charge;

b. Continuous Observation – continuous observation should be constant where a patient is assessed as presenting a high risk of deliberately harming themselves or others. Any patient nursed on continuous observation should be provided with a written information sheet, detailing the nature and purpose of continuous observation (App 4). Their level of observation should be recorded on a Continuous Observation Prescription form and in their notes. A record of their care and any issues relevant to risks should be recorded on the Continuous Observation Record sheet on an hourly basis by the observing member of staff. There are two categories of continuous observation: -
   - Within eyesight (Level 2): the patient should be kept within eyesight and accompanied at all times day and night;
   - Within arm's length (Level 1): the patient should be constantly supervised in close proximity. Additional staff member(s) may be required especially in instances where the patient presents with a history of violence. Consideration may be given to changing within arm's length to within eyesight during patient visits, at night or whenever the patient is in the bathroom however this must be recorded on the continuous observation prescription sheet.

Due to the restrictive nature of continuous observation the patient should remain on same for the shortest time possible.
Any change to the levels of continuous observation must be stated in the Continuous Observation Prescription sheet (this will include the reasons for doing so) and signed by the staff members making that decision. The decision will also be recorded in the patient's notes.

## 4.2 Implementing Observation Levels

All patients will receive a joint medical and nursing mental state and risk assessment (on a Risk Screening Tool or Comprehensive Risk Assessment as per Trust protocol) on their admission to hospital. The results of which will determine the level of observation to be implemented. Any decisions taken regarding the level of observation should where possible involve the patient and if appropriate their carer/next of kin. It must be recognised that all relevant information may not be available at the point of admission. Levels of observation should therefore be continuously reviewed in light of any new information and/or occurrences and changes made where appropriate.

## 4.3 Reviewing Observation Level

All observation levels should be continuously reviewed to ensure that the patient receives the least restrictive care needed to maintain their and others' safety. Decisions to increase the level of observation should be taken by the Consultant Psychiatrist or named deputy and the Nurse in Charge – ideally this should be done in conjunction with the patient and if appropriate their next of kin/carer. However in cases of emergency a higher level of observation can be implemented by any member of the multidisciplinary team if an increased risk is suspected.

Where a patient is on continuous observation, the levels of observation should be reviewed by both the Consultant Psychiatrist or named deputy and the Nurse in Charge at least every day and if appropriate decreased. The patient and if appropriate their carer/next of kin should be included in this decision making.

Observation levels must be reviewed at each multidisciplinary team review and any decisions taken to include the patient and if appropriate their carer/next of kin where possible.

Any changes to a patient's level of observation should include the reason for the change in observation and describe the change in risk to warrant the change. Staff should document this in the patient's notes and if applicable in the Continuous Observation Prescription Form.

Staff should always choose the safest option for both the patient and others

## 4.4 Emergencies

In the event of an emergency i.e. fire, assault the observing nurse must remain with the patient.
Alarms should be activated immediately and the Nurse in Charge advised of the emergency so staff can be organised as appropriate. In cases where the

emergency involves the observing nurse being assaulted by the patient, the nurse in question should be reallocated duties and another member of staff allocated to continue the observation.

In the event of a fire, the observing nurse should evacuate the patient from the area of the fire as outlined in the Trust Fire Safety Policy and remain with them at all times;.

### 4.5 Delegation to Non-Registered Staff

Whilst continuous observations are generally undertaken by a registered nurse this may on occasion be delegated to an unregistered member of staff. The Nurse in Charge will remain accountable for the delegation of observing staff ensuring they are sufficiently competent to undertake the role. Unregistered staff can complete the continuous observation recording sheet however this must be countersigned by a registered member of staff.

At **NO TIME** will a student nurse carryout observation without the direct supervision of a registered nurse or without the agreement of the patient.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This policy will be disseminated to all staff working within a mental health inpatient facility.

### 5.2 Resources

Nil

### 5.3 Exceptions

This policy applies to mental health inpatient facilities

## 6.0 MONITORING

An audit of the policy implementation will be carried out on an annual basis.

## 7.0 EVIDENCE BASE / REFERENCES

- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.
- The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008.
- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006
- The Mental Health (Northern Ireland) Order 1986.
- The Code of Practice Mental Health (Northern Ireland) Order 1986.
- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010
- The Human Rights Act 1998.
- The Northern Ireland Act 1998 (Section 75 Equality Considerations)
- In-patient psychiatric care for young people with severe mental illness (Recommendations for commissioners, child and adolescent psychiatrists and

general psychiatrists) Council Report CR106 June 2003 Royal College of Psychiatrists.

- Children (NI) Order 1995-The Regional Child Protection Policy and Procedures (ACPC 2005)
- The Data Protection Act 1998
- National Institute for Clinical Excellence. Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report June 2011, DHSSPSNI, 2011.
- Central Nursing Advisory Committee (CNAC) Operational Framework for Delegation Decision Making, September 2009
- The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities within Northern Ireland, HSCB and PHA, November 2011.
- Scottish Executive – Engaging people: Observation of people with acute mental health problems, 2002

## 8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: -

- Belfast Trust Mental Health Inpatient Services
- Belfast Trust Users, Advocacy and Carers Forums
- Belfast Trust Mental Health Services Policy Committee

## 9.0 APPENDICES / ATTACHMENTS

App 1: Continuous Observation Prescription Form
App 2: Continuous Observation Record Sheet
App 3: Record of Continuous Observation
App 4: Patient Information Leaflet

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Mmitchell.

_________________________________ **Date: ________Nov 2013____________**

**Author**

_________________________________ **Date: ________Nov 2013___________**

**Director**

**App 1**

# Continuous Observation Prescription Form

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name: | | DOB: | | | Consultant: | | |
| Please respond to all statements below | | Yes | No | Sign/Date | Update Sign/Date | Update Sign/Date | Update Sign/Date |
| Patient to be within eyesight | | | | | | | |
| Patient to be at arm's length | | | | | | | |
| Observation when using bathroom | Eyesight | | | | | | |
| | Arm's length | | | | | | |

| | |
|---|---|
| Date plan commenced: | Time: |

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

Patient: ______________________ Signature:
Print Name

Summary of risk factors relating to observation plan:

Rational for observation level:

Known triggers/changes in behaviour which would increase risk:

What would be the rational for reducing observation levels (e.g. visitors, asleep)?

Cessation of Continuous Observation

Rational for decision

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

**App 2**

# Continuous Observation Recording Sheet

| | | |
|---|---|---|
| **Patient Name** | **DOB** | **Hospital No** |
| **Ward:** | **Named Nurse:** | **Consultant:** |
| **Date:** | | |

| Time | Sign & Date | Print Name | Comments |
|---|---|---|---|
| **0800 - 0900** | | | |
| **0900 - 1000** | | | |
| **1000 - 1100** | | | |
| **1100 - 1200** | | | |
| **1200 - 1300** | | | |
| **1300 - 1400** | | | |
| **1400 - 1500** | | | |
| **1500 - 1600** | | | |
| **1600 - 1700** | | | |
| **1700 - 1800** | | | |
| **1800 - 1900** | | | |

| | | | |
|---|---|---|---|
| **1900 - 2000** | | | |
| **2000 - 2100** | | | |
| **2100 - 2200** | | | |
| **2200 - 2300** | | | |
| **2300 - 0000** | | | |
| **0000 - 0100** | | | |
| **0100 - 0200** | | | |
| **0200 - 0300** | | | |
| **0300 - 0400** | | | |
| **0400 - 0500** | | | |
| **0500 - 0600** | | | |
| **0600 - 0700** | | | |
| **0700 - 0800** | | | |

# Record of Continuous Observation

- The Nurse in Charge must complete this record for every patient commenced on continuous observation
- This form must be completed even if no additional staff were required
- When continuous observation ceases, this form must be signed and forwarded to the nursing services manager, who will arrange for the details to be recorded

| **Patient Details** | | | |
|---|---|---|---|
| Patient's Name: | | Ward: | |
| DOB: | | Consultant: | |

**Staffing**

Number of staff currently on ward: ________

Number of patients on continuous observation: ________

Number of additional staff required on ward: ________

| | |
|---|---|
| Date Commenced: | Time Commenced: |
| Date Finished: | Time Finished: |

Duration of continuous observation (Number of Days)

Signed: ________________________ Designation of Nurse_______________

Print Name: _________________________

**App 4**

# Information for Patient/Carer

# Continuous Observation

## INFORMATION FACT SHEET FOR PATIENTS

Your nurse and doctor will have discussed the reasons why they feel you need continuous observation at this particular time and hope you will be in agreement with this decision.

The ward staff are concerned about you at the moment and we want to make sure you are safe.

We will treat you with dignity and respect at all times and involve you in all decisions regarding your care.

During continuous observation a member of the nursing team will observe you and will be there to work with you and involve you in activities that you feel able to participate in at present.

All patients are treated individually and your nurse will discuss your care plan with you.

The nursing team will work with you to help you with any concerns and to keep the time on continuous observation to an absolute minimum.

We would ask you to remain in the unit at present to assist with assessment of your needs and plan how you can make progress.

Your progress will be discussed with you every day, offering you the opportunity to have a say in your own care and to determine the length of time spent on special observation.

We appreciate that this is a very difficult time for you and your family/carer, but hope this time will assist and offer the opportunity to discuss and find solutions to some of your concerns.

Belfast Health and
Social Care Trust

**Reference No:** SG 33/13

| | | | |
|---|---|---|---|
| **Title:** | Levels of Supervision/Observations within Learning Disability Inpatient Services | | |
| **Author(s)** | Mairead Mitchell, Senior Manager, Service Improvement and Governance<br>Brendan Ingram, Business and Performance manager<br>Jenni Armstrong, Resource Nurse<br>Dr Patrick Ling, Staff Grade | | |
| **Ownership:** | Catherine McNicholl, Director, Adult Social and Primary Care | | |
| **Approval by:** | Standards and Guidelines<br>Policy Committee<br>Executive Team Meeting | **Approval date:** | 3/7/13<br>19/8/13<br>21/8/13 |
| **Operational Date:** | November 2013 | **Next Review:** | November 2016 |
| **Version No.** | V1.0 | **Supercedes** | |
| **Key words** | Inpatient, observation, supervision, Learning disability, Multidisciplinary, assessment | | |
| Links to other policies | • Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;<br>• The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;<br>• Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;<br>• The Belfast Health and Social Care Trust Safeguarding Adults Policy;<br>• The Belfast Health and Social Care Trust Named Nurse Policy;<br>• UNOCINI Guidance;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;<br>• The Belfast Health and Social Care Trust AWOL Policy | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| Feb 2013 | 0.1 | Mairead Mitchell, Brendan Ingram, Patrick Ling and Jenni Armstrong | Initial Draft |
| 28/02/13 | 0.2 | Mairead Mitchell, Brendan Ingram, Patrick Ling and Jenni Armstrong | Circulated for comment |
| 07/03/13 | 0.2 | LD Governance Group | Approved subject to suggested changes |
| 12/03/13 | 0.3 | Mairead Mitchell, Brendan Ingram, Patrick Ling and Jenni Armstrong | Changes made, circulated for comment |
| 28/03/13 | 0.4 | Mairead Mitchell, Brendan Ingram, Patrick Ling and Jenni Armstrong | Sent to Carer's Advocate Cause<br>And Service User and Carer Consultant for comment |
| 09/03/13 | 0.4 | | No Comments received |

?dates

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

This policy has been developed to supersede any previous observation policies and to ensure a standardised approach across all its Learning Disability facilities as outlined in the Regional Guideline on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011.

### 1.2 Purpose

Belfast Health and Social Care Trust Learning Disability Services seek to promote and maintain a caring and safe environmental for patients admitted into any of its Learning Disability inpatient facilities.
Every patient receiving care within a learning disability inpatient facility will be observed as a necessary part of their care. This is principally a task which falls to nursing staff following a joint nursing and medical assessment.
This policy provides staff with guidance regarding the levels of observations and the decision making process to implement or adjust same.

### 1.3 Objectives

This policy aims to provide staff working within a Learning Disability inpatient facility with a structured and standardised framework for delivering care to patients across the spectrum of inpatient facilities within the Trust.

This policy ensures the Trust's compliance with mandatory requirements arising from the following: -

- The Report of the inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006;
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007;
- The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008;
- Mental Health (NI) Order 1986

This policy should be read in conjunction with the following: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;
- The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;
- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;

- The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;
- The Belfast Health and Social Care Trust Named Nurse Policy;
- UNOCINI Guidance;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;
- The Belfast Health and Social Care Trust AWOL Policy.

## 2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all patients, voluntary and detained, admitted to and discharged from a learning disability inpatient facility. This operational policy provides staff working within a learning disability inpatient unit with a structured and standardised framework for delivering care to service users and their carers across the spectrum of inpatient facilities within the Trust.

This will ensure a consistent approach in defining appropriate levels of observation and supervision of patients to: -

(a) Reduce The Risk Of: -

- Accidental or deliberate self harm
- Harm to others
- Absconding from hospital
- Vulnerability from other patients

(b) Allow for the development of a positive therapeutic relationship between the member of staff and the patient by sensitive monitoring of the patient's behaviour or mental state and allow for a rapid response to any change.

## 3.0 ROLES/RESPONSIBILITIES

All staff working within learning disability inpatient facility have a responsible role to play in achieving the policy objectives.

There are specific roles and responsibilities outlined in the Policy for: -

**3.1** The Multidisciplinary Team (MDT) will: -

- Ensure the safety and wellbeing of all patients and staff within the inpatient facility;
- Agree the level of observation required for patients

**3.2** The Nurse in Charge will: -

- Satisfy his/herself that they are aware of the location of all the patients both on or off ward and be aware of their mental and physical state;

- Allocate an observing nurse to each patient on continuous observations ensuring they are competent, have the appropriate experience and training i.e. management of aggression, if necessary, have an understanding of the patient's care plan and have received induction training on the policy on level of observation

- When allocating staff to patients who have been prescribed an enhanced level of observation (levels 2 – 4), it is important that the Nurse in Charge ensures that the designated staff are fully conversant with the requirements of the policy and be familiar with the patient, their history and current needs, in particular, the reason for their enhanced level of observation.

- Remain accountable for delegation of observation duties.

- Aims and the level of observation should be communicated, with the patient's approval, to the nearest relative, friend or carer and address any concerns raised by a staff member or family regarding the levels of observation a patient is on.

**3.3** The patient is entitled to information why they are under observation, how long it will be maintained and what may happen. Information should be provided in a form accessible to the patient. This will be documented in the patients care plan as and when communication takes place and following each review.

## 4.0 KEY POLICY PRINCIPLES

### 4.1 LEVELS OF OBSERVATION

### A Level 1 – General Observation

- Staff must always be aware of the general whereabouts of all patients in their care.

- Particular attention must be paid to patients with known behavioural problems or in specific situations. These should be documented in the Nursing Care Plan and reviewed appropriately.

- Some patients will require a daily assessment of their mental state by nursing staff as agreed by the multi disciplinary team. This should be recorded in the Care Plan. The patient should be referred to the Medical Officer if a deterioration of their mood or mental state is suspected.

- Staff are responsible for ensuring that unescorted patients in their care arrive at their destination and should initiate early action when a patient does not arrive where he/she should be.

### B Level 2 – Intermittent Observation

- Reasons for the use of this level of observation should be well defined in the clinical notes and care plan.
- The patient must be directly observed at specific intervals (e.g. 30 minutes) by a designated member of staff who may have other duties. The time interval will be determined by the Multi Disciplinary team and documented in their clinical notes and care plan.
- The designated staff member will make a written record of each observation. Reasons for the use of this level of observation should be well defined in the clinical notes and care plan.

### C Level 3 – Within Eyesight 1:1

- The distance the supervising member of staff is from the patient will be individually assessed and vary depending upon individual circumstances.
- This should be documented in clinical notes and care plan. Practical steps should be taken to ensure the patient and others are kept safe.
- The patient should be kept within sight by a designated member of staff at all times.
- The staff member will not have any other duties.

### D Level 4 – Within Arms Length

- A designated member of staff shall keep the patient under constant supervision and within arms length at all times.
- On occasions more than one member of staff may be necessary.
- The staff member will not have any other duties.

The Multi Disciplinary team should consider issues of privacy, dignity, environmental dangers and the gender of staff to be allocated. These issues must be incorporated into the nursing care plan.

### E Emergencies

- In the event of an emergency i.e. fire, assault the observing nurse must remain with the patient, when it is safe to do so.
- Alarms should be activated immediately and the Nurse in Charge advised of the emergency so staff can be organised as appropriate. In cases where the emergency involves the observing nurse being assaulted by the patient, the nurse in question should be reallocated duties and another member of staff allocated to continue the observation.

- In the event of a fire, the observing nurse should evacuate the patient from the area of the fire as outlined in the Trust Fire Safety Policy and remain with them at all times, when it is safe to do so.

## 4.2 Guidelines

- In order to maintain a therapeutic approach, patients on all levels of observation including 3 and 4 should have the opportunity to participate in structured therapeutic activities and training programmes including Day Care.
- The MDT is responsible for deciding the appropriate level of observation. The overall responsibility for levels of supervision lies with the Consultant.
- The Nurse-in-Charge may, if he/she feels it appropriate, increase the level of supervision on a daily basis in consultation with the Medical Officer and inform the Nurse Duty Officer of this decision as soon as possible.
- The Medical Officer should attend and assess the patient as soon as possible thereafter.
- The Nurse-in-Charge will ensure that the staff members engaged in supported observations of patients on levels 3 and 4 are given a break at appropriate times.
- These times may vary depending upon the circumstances but no individual staff should be engaged in this level of observation for more than 4 hours except in exceptional and agreed circumstances. On occasions staff may require a break more frequently depending upon individual circumstances. This should be discussed with the Nurse in charge

## 4.3 Reviewing Observation Levels

Generally patients will require to be placed on a level of observation for a number of reasons

- Acutely unwell, i.e. this may occur during initial admission
- As a result of a decline in mental health or due to behaviours that challenge
- As an action in a protection plan put in place following vulnerable adult process

Within learning disability inpatient facilities, agreement has been reached by the MDT that each of these categories of observation should be reviewed as detailed

- Acutely unwell – daily review by the MDT and recorded in the patients care plan. Prior to weekends and bank holidays, the MDT will review the level of observation for each patient. This level of observation will remain in situ, for that period of time. However, if the patient's condition deteriorates and the level of observation needs a further review, the nurse in charge will discuss this with the 1st on-call psychiatry cover. Medic
- Deterioration in mental health/challenging behaviour – where it is considered that a level of observation is required and forms part of the patients treatment plan, this will be agreed by the MDT and reviewed on a weekly basis and recorded in the patients care plan
- Part of a protection plan – This will be agreed by the team investigating the vulnerable adult incident and will be reviewed by the vulnerable adult team at each subsequent vulnerable adult meeting and recorded in the patients care plan

## 5.0 IMPLEMENTATION OF POLICY

**5.1 Dissemination**
This policy will be disseminated to all staff working within a learning disability inpatient facility.

**5.2 Exceptions**
There are no exceptions

## 6.0 MONITORING

This policy will be reviewed every three years.
The Implementation of this Policy will be reviewed on a yearly basis.

## 7.0 EVIDENCE BASE / REFERENCES

- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.
- The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008.
- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006
- The Mental Health (Northern Ireland) Order 1986.
- The Code of Practice Mental Health (Northern Ireland) Order 1986.
- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010
- The Human Rights Act 1998.
- The Northern Ireland Act 1998 (Section 75 Equality Considerations)
- In-patient psychiatric care for young people with severe mental illness (Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists) Council Report CR106 June 2003 Royal College of Psychiatrists.

- Children (NI) Order 1995-The Regional Child Protection Policy and Procedures (ACPC 2005)
- The Data Protection Act 1998
- National Institute for Clinical Excellence. Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report June 2011, DHSSPSNI, 2011.
- Central Nursing Advisory Committee (CNAC) Operational Framework for Delegation Decision Making, September 2009
- The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities within Northern Ireland, HSCB and PHA, November 2011.

## 8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: - LD Governance, Hospital Service Manager, Ward Manager, Senior Nurse Managers, Medical Staff,

## 9.0 APPENDICES / ATTACHMENTS

Nil

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Nmitchell

______________________________ Date: _______Nov 2013____________

**Author**

______________________________ Date: ________Nov 2013_____________

**Director**

Belfast Health and Social Care Trust

**Reference No:** SG 27/13

| | | | |
|---|---|---|---|
| **Title:** | Policy to be followed when obtaining consent for examination, treatment or care in adults and children. | | |
| **Author(s)** | Dr. Gary Heyburn<br>Consultant Orthophysician<br>[redacted] | | |
| **Ownership:** | Prof. Ian Young, Chairman Ethics Committee, BHSCT. | | |
| **Approval by:** | Standards and Guidelines<br>Policy Committee<br>Executive Team Meeting | **Approval date:** | 29/04/2015+23/9/15<br>03/06/2015<br>05/06/2015 |
| **Operational Date:** | September 2015 | **Next Review:** | September 2018 |
| **Version No.** | V1 | **Supercedes** | Legacy policies |
| **Key words:** | Consent | | |
| **Links to other policies** | Photography, digital and video imaging of Service Users: Consent and Confidentiality, Copyright and Storage.<br>Consent for Hospital Post-Mortem Examination - Regional Policy.<br>Policy and guidance for obtaining consent in Occupational Health Practice.<br>Policy For The Use Of Site Specific Consent Forms For Radiotherapy Treatment.<br>Gaining Consent For Endoscopy Procedures. | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 03/09/2009 | V 0.1 | G Heyburn | Initial Draft |
| 15/10/2009 | V 0.2 | JR Johnston | Formatting; amendments |
| 29/07/2013 | V 0.3 | JRJ | New Template, Review |
| 07/08/2013 | V 0.4 | JRJ, CM, Heather Russell | After consultation |
| 28/08/2013 | V 0.5 | JRJ | Interpretation appendix. |
| 25/10/2013 | V 0.6 | JRJ | For Ethics Comm. |
| 01/05/2015 | V 0.7 | JRJ | Hyperlinks fixed, changes appendix 3 for flu vaccine, |
| 01/05/2015 | V 0.8 | JRJ | 4.2.2 & 4.2.3 following Montgomery ruling. |
| 07/09/2015 | V 0.9 | JRJ | Changes to 4.4.2, vaccination form |

## 1.0 Policy for obtaining consent for examination, treatment or care in adults and children.

### 1.1 Background

Patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is therefore absolutely central in all forms of health care, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between healthcare professionals and their patients.

The Department of Health, Social Services and Public Safety has issued GOOD PRACTICE IN CONSENT and a number of guidance documents 2003 on consent and these should be consulted for advice on the current law and good practice requirements in seeking consent. Specific guidance, incorporating both the law and good practice advice is available for health and social care professionals working with children, with people with learning disabilities and with older people.

Health and social care professionals must also be aware of any guidance on consent issued by their own regulatory bodies e.g.
General Medical Council: Consent: patients and doctors making decisions together 2008
Nursing & Midwifery Council: Consent 2013
General Dental Council: Principles of patient consent 2009
General Pharmaceutical Council: Guidance on consent 2012

This policy sets out the standards and procedures in this Trust which aim to ensure that health and social care professionals meet their responsibilities for obtaining valid consent. While this document is primarily concerned with health care, social care colleagues should also be aware, from CONSENT IN SOCIAL CARE (DHSSPS), of their need to obtain consent before providing certain forms of social care, such as those which involve touching the patient or client.

### 1.2 Purpose

The BHSCT recognises the right of every individual receiving Trust services to be given appropriate information to help them to make informed choices about their care and treatment. This policy defines best clinical guidelines practice in obtaining consent for examination, treatment or care in the BHSCT.

## 2.0 SCOPE OF THE POLICY

This consent policy applies to all members of BHSCT staff where a patient/client undergoes examination, treatment or care and is applicable to both adults and children.

## 3.0 ROLES/RESPONSIBILITIES

### Medical Director

The Medical Director is accountable for ensuring that the consent policy and guidelines are fit for purpose and their effectiveness evaluated.

He will seek assurance from Directors that the policy is implemented and practice is consistent with policy.

**Directors**
Directors with responsibility for clinical or social care services will be accountable for ensuring that:

- the policy and guidelines are implemented in all services provided;
- when the need for consent training is identified, it is resourced;
- there is a mechanism in the directorate for monitoring incidents related to consent issues.

**Co-Director, Service Managers**
They are responsible for ensuring:

- easy access to consent policy, guidelines and consent documentation
- reporting of failure to obtain consent as a clinical incident or near miss;
- identification of local operational procedures for which written consent is required.
- consent policy is part of the induction programme for new staff;
- that when appraisal and audits identify the need for training in consent, this is facilitated;
- staff are released for training when there is an assessed need;
- information leaflets on consent meet corporate standards and are procured.

**Responsibility of health or social care professionals**
It is a health or social care professional's own responsibility to:

- be fully aware of the documentation currently in use to record the process of consent;
- practice within the law, the DHSSPS consent guidelines and Trust policy;
- ensure that colleagues seeking consent on their behalf are competent to do so;
- work within their own competence and not to agree to perform tasks which exceed that competence;
- provide patients and clients with consent information and the relevant written information on the procedure/intervention they may be consenting to in an appropriate format/language.

## 4.0 KEY POLICY PRINCIPLES

**Definition**
"Consent" is a patient's agreement for a health or social care professional to provide care.

Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision;
- have received sufficient information to take it;
- not be acting under duress.

## Key Policy Statement(s)

### Policy Principles

**4.1** This policy's aim is to assist the BHSCT in promoting good practice for obtaining consent for examination, treatment or care.

4.1.1 It is based on guidance contained in,

- DHSSPSNI documentation
- GMC documentation - Consent: patients and doctors making decisions together 2008
- The ruling of *Montgomery -v- Lanarkshire* Health Board of 11th March 2015.

The DHSSPSNI document GOOD PRACTICE IN CONSENT: Consent for Examination, Treatment or Care (March 2003) is available on the DHSSPS website along with,

- Consent Guides for Healthcare Professionals:
  - Reference Guide to Consent for Examination, Treatment or Care
  - Good practice in consent: Implementation guide for health care professionals

  - Seeking Consent: Working with children
  - Seeking Consent: Working with older people
  - Seeking Consent: Working with people with learning disabilities
  - Seeking Consent: Working with prisoners and other detainees

- Consent Guides for Social Workers, Social Care Staff and Students:
  - Consent in Social Care
  - Good Practice in Consent - Social Work Students

- Consent Forms: (appendix 3)
  - Form 1 - Adults
  - Form 2 - Parental agreement for a child or young person
  - Form 3 - Procedures where consciousness not impaired
  - Form 4 - Adults who are unable to consent

- Patient Information Leaflet: Consent - it's up to you.

- Consent - What you have a right to expect - Guides for:
  - Adults
  - Parents
  - Children and young people
  - People with learning disabilities
  - Relatives and Carers

4.1.2 Many of the questions staff may wish to ask regarding consent are answered in the document 12 key points on consent: the law in Northern Ireland which is also on the DHSSPS website; also given in appendix 1.

4.1.3 Patient Information leaflet “Consent – it’s up to you”
The patient information leaflet about the consent form “Consent – it’s up to you” is available on the DHSSPS website.

### 4.2 Provision of information

4.2.1 The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen, where the procedure will take place, how long they will be in hospital, how they will feel afterwards and so on.

4.2.2 Following the landmark decision in *Montgomery v Lanarkshire Health Board*, given by the UK Supreme Court on 11 March 2015, the way doctors obtain consent from patients, particularly the way they tell patients about the risks of any treatment, has changed.

Previously, the *Bolam* test specified that a doctor’s conduct would be considered acceptable if it would be supported by a responsible body of medical opinion. This applied to the treatment chosen, the method of carrying it out and the information given out during the consent process. Following this ruling, this test will no longer apply to the issue of consent.

The law has moved away from the ‘reasonable doctor’ to the ‘reasonable patient’. A doctor now has a duty *“to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments*,” “*The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to it*.”

If information is material, doctors should generally disclose it. They should not wait for the patient to ask for it.

Notwithstanding this change in the law, this decision demands a standard of consent broadly similar to that already required by the professional guidance of the General Medical Council and enshrines in law principles that are already in the GMC guidance on consent, *Consent: Patients and Doctors Making Decisions Together* (2008). This encourages doctors to focus on the “*individual patient and the risk to them*” when getting consent and not to make assumptions about the patient’s understanding of risk. It states that doctors should discuss with patients side effects and complications that are particularly relevant to their case.This BHSCT policy is based upon the GMC guidance.

So, when obtaining consent, doctors will now have to ask themselves these questions:

- Does the patient know about the material risks of the treatment I am proposing?
  Regarding what would define a material risk – ask,
    - What sort of risks would a reasonable person in the patient's circumstances want to know?
    - What sorts of risks would this particular patient want to know?
- Does the patient know about reasonable alternatives to this treatment?
- Have I taken reasonable care to ensure that the patient actually knows all this?
- Do any of the exceptions to my duty to disclose apply here? (see below).
- Have I properly documented my consent process?

4.2.3 Exceptions to the duty to disclose

There are three exceptions to the duty to disclose.

1. The patient might tell the doctor that he or she would prefer not to know the risks.
2. The doctor might reasonably consider that telling the patient something would cause serious harm to the patient's health.
3. No consent is needed in circumstances of necessity, such as when a patient in need of urgent treatment is unconscious or lacks capacity.

Patients and those close to them vary in how much information they will understand or want; some want as much detail as possible, including details of rare risks, others may ask health or social care professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the *presumption* must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

### 4.3 Documentation

4.3.1 For significant procedures, it is essential for health or social care professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's health record if necessary), or through documenting in the patient's health record that they have given oral consent.

Following the Montgomery ruling, making a detailed record of the information provided to the patient about the risks involved in proposed treatment is likely to be all the more important.

4.3.2 When a competent adult refuses or withdraws consent to a proposed examination, treatment or care, this should also be clearly documented in the patient/client health record.

4.3.3 Written consent

Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is *evidence* that the patient has given consent, but is not *proof* of valid consent. If a patient is rushed into signing a form, the consent may not be valid despite the signature; on the basis that too little information was provided. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

4.3.4 It is rarely a legal requirement to seek written consent,[1] but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health care professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- the provision of clinical care is not the primary purpose of the procedure
- the possibility of significant consequences for the patient's employment, social or personal life
- the treatment is part of a project or research programme or is an innovative treatment designed specifically for their benefit.

4.3.5 The DHSSPS consent forms, in use in the BHSCT, can be seen on the DHSSPS website and are obtained from Regional Supplies: (Each form is available in a range of languages on the DHSSPS website).

4.3.6 The top white copy of the completed DHSSPS consent form should be offered to the patient and this action recorded. Other copies of completed forms should be kept with the patient's health record. Any changes to consent made after the form has been signed by the patient, should be recorded and dated by the health care professional and initialled by both patient and health care professional.

4.3.7 For some procedures, clinicians may decide to use a printed sticker for documenting the information provided around details of procedure / risk / benefit. When services take the decision to use a pre-printed sticker they must insure that:

- the stickers are kept up to date and old stickers removed from circulation
- where a patient chooses to take the white copy, a sticker is placed on both the top white copy and the copy been kept in the patient record.

---

[1] The Mental Health (Northern Ireland) Order 1986 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

4.3.8 When services are designing consent forms specific to their treatments or interventions they should have them approved by the Directorate Governance Team to ensure they meet DHSSPS standards.

4.3.9 If the consent giver cannot write, they may be able to make a mark on the form to indicate consent. It would be good practice for this to be witnessed by a person other than the clinician/practitioner seeking consent; and the fact that consent was confirmed in this way recorded in the health record. If the consent giver is physically unable to mark the form, this fact should be recorded in the health record or on the consent form.

4.3.10 It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if there is any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about similar care in the past), it would be helpful to do so.

### 4.4 Procedures to follow when patients lack capacity to give or withhold consent

4.4.1 For a person to have capacity, he or she must be able to comprehend and retain information relevant to the intervention. This applies to the consequences both of having and not having the intervention in question. He or she must be able to use and weigh this information in the decision–making process. Thus, people may have capacity to consent to some procedures but not to others.

4.4.2 Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented either using,

- **Form 4** (form for adults who are unable to consent to investigation or treatment), along with a record of the assessment of the patient's capacity, why the health care professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient.

or

- An alternative BHSCT form (appendix 4) to be used in place of Form 4 for vaccination. General Practitioners are asked to complete and sign the form to approve a practice list of adult patients who are unable to give or withhold consent but do require vaccination, 'in their best interests' and which are to be administered by community nurses.

The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's health record.

An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. Appropriate colleagues should be involved in making such assessments of capacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible the patient should be assisted to make and communicate their own decision e.g. by providing information in non-verbal ways where appropriate.

4.4.3 Occasionally, there will not be a consensus on whether a particular treatment is in the best interests of an adult who lacks capacity. A court declaration may be sought where the consequences of having, or not having, the treatment are potentially serious.

4.4.4 The courts have identified certain circumstances when referral should be made to them for a ruling on whether it is lawful.

These are:
- where there is doubt as to the individual's capacity or best interests.

and also
- sterilisation for contraceptive purposes.
- donation of regenerative tissue such as bone marrow.
- withdrawal of nutrition and hydration from an individual in a persistent vegetative state.

## 4.5 Treatment of young children

4.5.1 Children and young people should be involved as much as possible in discussions about their care, even if they are not able to make decisions on their own.

4.5.2 A young person's ability to make decisions depends more on their ability to understand and weigh up options, than on their age. When assessing a young person's capacity to make decisions, it should be borne in mind that:
- a young person under 16 may have capacity to make decisions, depending on their maturity and ability to understand what is involved
- at 16 a young person will probably have capacity to make most decisions about their treatment and care.

4.5.3 Decisions on behalf of all other children should be made by someone with parental responsibility (unless, in an emergency, no such can be traced).

4.5.4 Only people with 'parental responsibility' are entitled to give consent on behalf of their children. Not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility unless named on the birth certificate, although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

4.5.5 The GMC 2007 guidance in *0-18 years: guidance for all doctors*, and in particular the section *Making decisions* (paragraphs 22–41) is a useful source of information. It gives advice on involving children and young people in decisions, assessing capacity and best interests, and what to do if they refuse treatment. It also explains the different legal requirements across the UK for decision-making involving children and young people.

4.5.6 When babies or young children are being cared for in hospital, it may not be practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays, however, in law, such consent is required. Therefore, when a child is admitted, there should be a discussion with the parent(s) concerning what routine procedures will be necessary, at which they give consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, this must be respected unless the delay involved in contacting them would put the child's health at risk.

## 4.6 When should consent be sought?

When a patient formally gives their consent to a particular intervention, this is only the *endpoint* of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of 'seeking consent'. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient's condition.

### 4.6.1 Single stage process

In many cases, it will be appropriate for a health or social care professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health and social care professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health or social care professional may then proceed.

### 4.6.2 Two or more stage process

In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health and social care professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Patients receiving elective treatment, intervention or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process in advance. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team **must** check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

4.6.3 Emergencies
Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's health record to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

4.6.4 Duration of Consent
When an individual gives valid consent for an intervention, that consent remains valid for an indefinite duration unless it is withdrawn by the patient. However, the GMC guidance states that a doctor or member of the healthcare team should inform the patient and reconfirm their consent if new information becomes available regarding the proposed intervention (for example new evidence of risks or new treatment options) between the time when consent was sought and when the intervention is undertaken.

In addition it is good practice, if a significant time has elapsed, to confirm that the consent giver (assuming he or she retains capacity) still wishes the intervention to proceed even if there is nothing new to discuss.

### 4.7 Who is responsible for seeking consent?

4.7.1 The health or social care professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law for ensuring that the individual has given valid consent before treatment or care begins.

4.7.2 The GMC guidance states that where this is not practicable, the task of seeking consent may be delegated to another health care professional, as long as that professional is suitably trained and qualified. In particular, they must

- have sufficient knowledge of the proposed investigation or treatment,
- understand the risks involved,
- be able to provide any information the individual may require.
- understand, and agree to act in accordance with, the guidance in the GMC booklet Consent: patients and doctors making decisions together

Inappropriate delegation (for example where the clinician seeking consent has inadequate knowledge of the procedure) may mean that the "consent" obtained is not valid. Health and social care professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

It is considered best practice for such delegated staff to have their training renewed annually, records kept of the course content, list of attendees and consideration given to some sort of accreditation process. It must be clear that they must have the requisite knowledge of the procedure and for them to have experience of witnessing the procedure, for the consent to be valid.

4.7.3 Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health or social care professional responsible. However, team work is a crucial part of the way the HPSS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent. If the person cannot write or is physically unable to sign a form, a record that the person has given verbal or non –verbal consent should be made in their health record or on the consent form.

## 4.8 Seeking consent for anaesthesia

Where an anaesthetist is involved in a patient’s care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic.

The anaesthetist should ensure that the discussion with the patient and their consent is documented in the anaesthetic record, in the patient’s health record or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

Information for patients’ relatives and friends on anaesthesia has been produced by the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland.

4.8.1 A separate formal consent form signed by the patient is not required for anaesthetic procedures that are done to facilitate another treatment or as part of an inter-related process.

Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

### 4.9 Provision for patients whose first language is not English

The BHSCT is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

The process for accessing the written and verbal translation and interpreting service are available in Appendix 6.

### 4.10 Refusal of treatment

If the process of seeking consent is to be a meaningful one, refusal must be one of the patient's/client's options. A competent adult person is entitled to refuse any treatment.

The situation for children is more complex: see the Department of Health Social Services and Public Safety *Seeking consent: working with children* for more detail. The following paragraphs apply primarily to adults.

Mental health legislation does provide the possibility of treatment for a person's mental disorder and its complications without their consent. This legislation does not give power to treat unrelated physical disorders without consent. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their health record. If the patient has already signed a consent form, but then withdraws consentthe health or social care professional should document this on the form (and where possible the patient should initial the change ).

Where a patient has refused a particular intervention, the health or social care professional must ensure that they continue to provide any other appropriate care for which there is consent. The health or social care professional should also ensure that the patient realises they are free to reverse any previous decision and, at a later date, accept treatment if they wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

If a patient consents to a particular procedure but refuses certain aspects of the intervention, the health or social care professional must explain to the patient the possible consequences of partial consent. If it is genuinely believed that the procedure cannot be safely carried out under the patient's stipulated conditions, the health or social care professional is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another health or social care professional believes that the treatment can be safely carried out under the conditions specified by the patient, a request to transfer the patient's' care to that practitioner should be facilitated.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

Applies to all health and social care professionals and is disseminated widely throughout the BHSCT using the standard mechanisms.

### 5.2 Resources

Will require a training resource.

## 6.0 MONITORING

The trust will participate in any regional audit of consent forms.

Periodic trust wide audits are carried out and audits of consent within specific areas should be carried out as required.

## 7.0 EVIDENCE BASE / REFERENCES

1. DHSSPS website
2. GOOD PRACTICE IN CONSENT: Consent for Examination,Treatment or Care (March 2003). DHSSPSNI.
3. GMC: Consent patients and doctors making decisions together. 2008.
4. UK Supreme Court. Montgomery v Lanarkshire Health Board. 11 Mar 2015. https://www.supremecourt.uk/decidedcases/docs/UKSC_2013_0136_Judgment.pdf.
5. Dyer C. Doctors should not cherry pick what information to give patients, court rules. BMJ 2015;350:h1414.
6. Daniel K Sokol. Update on the UK law on consent. BMJ 2015;350:h1481 doi: 10.1136/bmj.h1481
7. GMC: 0-18 years: guidance for all doctors 2007.
8. Belfast Trust Interpreting Service -

## 8.0 CONSULTATION PROCESS

Standards and Guidelines Committee.
Clinical Ethics Committee internal groupings, staff side etc.
Acknowledge NHSCT policy: Consent for Examination, Treatment or Care.

## 9.0 APPENDICES / ATTACHMENTS

Appendix 1 - 12 key points on consent: the law in NI.
Appendix 2 - DHSSPS Website details
Appendix 3 - Consent forms explained.
Appendix 4 - Seeking consent: remembering the patient's perspective
Appendix 5 = Procedure for booking Interpreters

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** ☐

**SIGNATORIES**

________________________________ **Date: ____September 2015____**

**Author**

Ian Young

________________________________ **Date: _____September 2015___**

**Director**

Appendix 1

# 12 KEY POINTS ON CONSENT: THE LAW IN NORTHERN IRELAND

## When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.

2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the person is incompetent, but may indicate a need for further information or explanation.

3. Patients may be competent to make some health care decisions, even if they are not competent to make others.

4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

## Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents should ideally be involved). In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

## Who is the right person to seek consent from a patient?

6. It is always best for the person actually treating the patient to seek consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

## What information should be provided when seeking consent?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment or course of action, and appropriate alternatives. If a patient is not offered as much information as they reasonably need to reach an informed decision, and in a form they can understand, their consent may not be valid.

## Is the patient's consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health and social care professionals, family or friends.

### Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

### Refusals of treatment

10. Competent adult patients have the right to refuse treatment, even where it would clearly benefit them. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus**.**

### Mental Health Legislation

11. Mental health legislation provides the possibility of treatment for a person's mental disorder or its complications without their consent. This legislation does not give power to treat unrelated physical illness without consent.

### Adults who are not competent to give consent

12. **No-one** can give consent on behalf of an adult who is not deemed competent. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these matters. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

    If people no longer have capacity but have clearly indicated in the past that they would wish to refuse such treatment in the circumstances in which they now find themselves, (an "advance refusal"), the refusal must be accepted.

**This summary cannot cover all situations. For more detail, consult the Reference Guide to Consent for Examination or Treatment or Care, available from your HPSS Trust and at www.dhsspsni.gov.uk**

Appendix 2

# DHSSPS Website

http://www.dhsspsni.gov.uk/index/phealth/professional/professional_good_practice_guidelines/public_health_consent.htm

## Consent for Examination, Treatment or Care

**Consent Guides for Healthcare Professionals:**

- HSS (MD) 7/2003 Circular: Good Practice in Consent (PDF 172 KB)
- Reference Guide to Consent for Examination, Treatment or Care (PDF 155 KB)
- Good practice in consent: Implementation guide for health care professionals (PDF 194 KB)
- Good practice in consent: Implementation guide for health care professionals (MS Word 222 KB)
- Good practice in consent : Desk Aid 12 Key Points on Consent (PDF 55 KB)

- Seeking Consent: Working with children (PDF 111 KB)
- Seeking Consent: Working with older people (PDF 97 KB
- Seeking Consent: Working with people with learning disabilities (PDF 97 KB)
- Seeking Consent: Working with prisoners and other detainees (PDF 109 KB)

**Consent Guides for Social Workers, Social Care Staff and Students:**

- Consent in Social Care (72.6KB)
- Good Practice in Consent - Social Work Students(60.1KB)

**Consent Forms**

- Form 1 - Adults (PDF 36 KB)
- Form 1 - Adults - Cantonese Translation (PDF 157 KB)
- Form 1 - Adults - Irish Translation (PDF 86 KB)
- Form 1 - Adults - Lithuanian Translation (PDF 151 KB)
- Form 1 - Adults - Mandarin Translation (PDF 171 KB)
- Form 1 - Adults - Polish Translation (PDF 157 KB)
- Form 1 - Adults - Portuguese Translation (PDF 67 KB)
- Form 1 - Adults - Romanian Translation (PDF 203 KB)

- Form 2 - Parental agreement for a child or young person (PDF 42 KB)
- Form 2 - Cantonese Translation (PDF 141 KB)
- Form 2 - Lithuanian Translation (PDF 152 KB)
- Form 2 - Mandarin Translation (PDF 86 KB)
- Form 2 - Polish Translation (PDF 158 KB)
- Form 2 - Portuguese Translation (PDF 67 KB)
- Form 2 - Romanian Translation (PDF 235 KB)

- Form 3 - Procedures where consciousness not impaired (PDF 113 KB)
- Form 3 - Lithuanian Translation (PDF 147 KB)
- Form 3 - Polish Translation (PDF 149 KB)
- Form 3 - Portuguese Translation (PDF 64 KB)
- Form 3 - Romanian Translation (PDF 176 KB)

- Form 4 - Adults who are unable to consent (PDF 130 KB)

**Patient Information Leaflet**

- Consent - it's up to you (PDF 106 KB)
- Consent - it's up to you -Cantonese Translation (PDF 181KB)
- Consent - it's up to you - Mandarin Translation (PDF 171 KB)
- Consent - it's up to you - Irish Translation (PDF 131 KB)

**Consent - What you have a right to expect - Guides for**

- Adults (PDF 66 KB)
- Adults - Cantonese Translation (PDF 226 KB)
- Adults - Lithuanian Translation (PDF 217 KB)
- Adults - Mandarin Translation (PDF 205 KB)
- Adults - Polish Translation (PDF 250 KB)
- Adults - Portuguese Translation (PDF 68 KB)
- Adults - Romanian Translation (PDF 184 KB)

- Parents (PDF 67 KB)
- Parents - Cantonese Translation (PDF 228 KB)
- Parents - Lithuanian Translation (PDF 207 KB)
- Parents - Mandarin Translation (PDF 209 KB)
- Parents - Polish Translation (PDF 249 KB)
- Parents - Portuguese Translation (PDF 64 KB)
- Parents - Romanian Translation (PDF 211 KB)

- Children and young people (PDF 101 KB)

- People with learning disabilities (PDF 127 KB)

- Relatives and Carers (PDF 62 KB)

Appendix 3

# Consent forms explained

An electronic version of the consent forms is obtained from

http://www.dhsspsni.gov.uk/index/phealth/professional/professional_good_practice_guidelines/public_health_consent.htm

The four forms are designed to meet the needs of different groups of patients at different times:

**Form 1**
for patients able to consent for themselves.

**Form 2**
for those with parental responsibility, consenting on behalf of a child/young person.

**Form 3**
both for patients able to consent for themselves and for those with parental responsibility consenting on behalf of a child/young person, where the procedure does not involve any impairment of consciousness.

This form is shorter than the others, as the fact that the patient is expected to remain alert during the procedure makes some of the information covered in forms 1 and 2 unnecessary. The use of this form is optional.

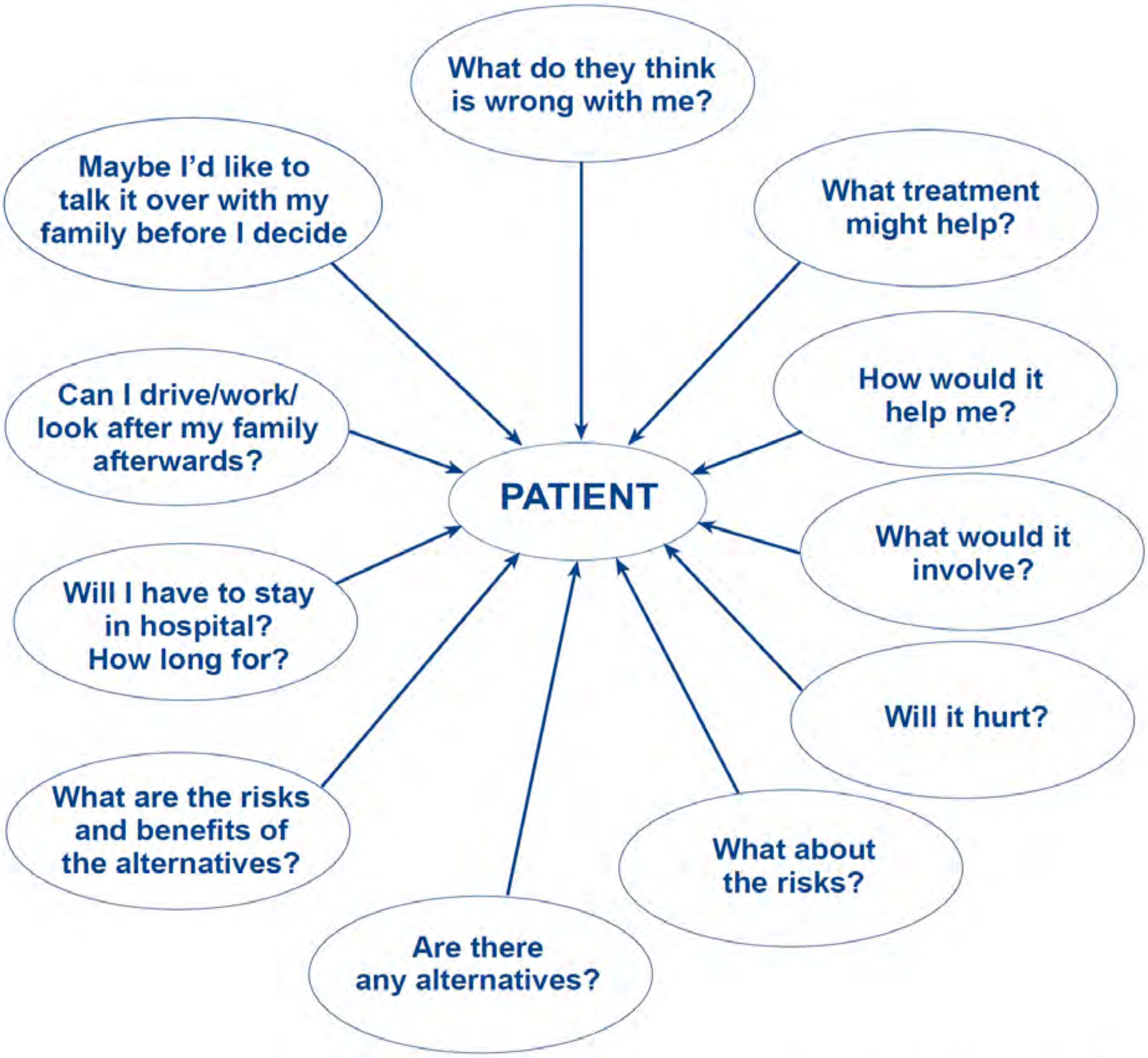
**Form 4**
for adults who lack capacity to consent to a particular treatment.

As no-one else can give consent on behalf of such a patient, they may only be treated if that treatment is believed to be in their ‘best interests’. This form requires health and social care professionals to document both how they have come to the conclusion that the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in the patient’s best interests. It also allows the involvement of those close to the patient in making this healthcare decision to be documented.

An alternative BHSCT form (appendix 4) referred to in 4.4.2 is to be used in place of Form 4 for vaccination. General Practitioners are asked to complete and sign the form to approve a practice list of adult patients who are unable to give or withhold consent but do require vaccination, ‘in their best interests’ and which are to be administered by community nurses. The form will be available on the BHSCT HUB and also via the DHSSPSNI / HSCB.

Appendix 4

## Seeking consent: remembering the patient's perspective.



**Good practice in consent:** Implementation guide for health care professionals 53

Appendix 5

# NI Health and Social Care Interpreting Service
# PROCEDURE FOR BOOKING INTERPRETERS

**Big Word Telephone Interpreting Service**

thebigword

**0800 757 3053**

- shorter than 10 minutes
- No face to face Interpreter available
- Emergency

**NI Health and Social Care Interpreting Service**

FACE TO FACE INTERPRETERS

Complex/detailed appointments

Longer than 10 minutes

**Written Translations**

See contracted Translation Services

**Sign Language Interpreters**

**Contact Action On Hearing Loss:** 028 9023 9619

FULLY COMPLETE –**NIHSCIS Interpreter Booking Form and forward via email to:**

**interpreting@belfasttrust.hscni.net**

NB – **Please try to give as much notice as possible**

**In an immediate emergency or out of hours Tel: 028 9056 3794**

NIHSCIS will aim to confirm the availability or non-availability of suitable Interpreters **via email** 1 week before the appointment

NIHSCIS will confirm receipt of Email. Once an Interpreter is booked confirmation of the booking is sent to you via email.

Please check Interpreter's ID Badge. After the appointment the Practitioner must sign the Interpreter's invoice. The Interpreter will then forward the invoice to the relevant Finance Department.

**Please note we will aim to accommodate emergency appointments where possible.**

**If an Interpreter is not available the Booking Source will be notified ASAP**

If NIHSCIS **cannot** provide you may contact the alternative source below - **only after you have contacted NIHSCIS in the first instance**:

- **STEP: 028 8775 0213**

**CANCELLATIONS**

In the event of a cancellation please contact NIHSCIS **immediately**.

Belfast Health and Social Care Trust
caring supporting improving together

**Reference No:** SG 35/13

-

| | | | | |
|---|---|---|---|---|
| **Title:** | Observations within Mental Health Services Inpatient Units | | | |
| **Author(s)** | Cahal McKervey, Operations Manager, Acute Mental Health Services<br>Paul McCabe, Senior Nurse Manager<br>Patricia Minnis, Quality & Information Manager | | | |
| **Ownership:** | Catherine McNicholl, Director, Adult Social and Primary Care | | | |
| **Approval by:** | Mental Health Governance<br>Standards and Guidelines<br>Policy Committee<br>Executive Team Meeting | | **Approval date:** | 28/04/2016<br>19/05/2016<br>01/06/2016<br>08/06/2016 |
| **Operational Date:** | June 2016 | | **Next Review:** | June 2019 |
| **Version No.** | 2 | **Supercedes** | V1 – November 2013-2016 | |
| **Key words** | general, continuous, observations, arm's, eyesight, risk | | | |
| **Links to other policies** | • Regional Guideline on the use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland<br>• Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;<br>• The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;<br>• Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;<br>• The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;<br>• The Belfast Health and Social Care Trust Named Nurse Policy;<br>• UNOCINI Guidance;<br>• The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;<br>• The Belfast Health and Social Care Trust AWOL Policy. | | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 09/08 | 0.1 | T. McNeany | Circulated to all Adult Mental Health Inpatient Wards |
| 20/12/12 | 0.2 | P. Minnis | Reviewed |
| 10/01/13 | 0.2 | As above | Sent out for Consultation |
| 10/01/13 | 0.3 | As above | Comments received - updated |
| 09/04/13 | 0.3 | As above | Approved by Mental Health Governance Committee |
| 09/05/13 | 0.3 | As above | Circulated to all Adult Mental Health Inpatient Wards |
| 2016 | 1.1 | Cahal McKervey | Review |
| 16/02/2016 | 1.1 | Cahal McKervey | Sent out for comment |
| 28/04/2016 | 1.1 | Cahal McKervey | Approved by MH Governance |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

Belfast Health and Social Care Trust Mental Health Services seeks to promote and maintain a caring and safe environmental for patients admitted into any of its mental health inpatient facilities. Every patient receiving care within a mental health inpatient facility will be observed as a necessary part of their care. This is principally a task which falls to nursing staff following a joint nursing and medical assessment.

### 1.2 Purpose

This policy has been developed to supersede any previous observation policies and to ensure a standardised approach across all its mental health facilities as outlined in the Regional Guideline on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011.

This policy provides staff with guidance regarding the levels of observations and the decision making process to implement or adjust same.

### 1.3 Objectives

This policy aims to provide staff working within a psychiatric inpatient facility with a structured and standardised framework for delivering care to patients across the spectrum of inpatient facilities within the Trust.

This policy ensures the Trust's compliance with mandatory requirements arising from the following: -

- The Report of the inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006;
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007;
- The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008;
- Mental Health (NI) Order 1986

This policy should be read in conjunction with the following: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;
- The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;
- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;
- The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;
- The Belfast Health and Social Care Trust Named Nurse Policy;
- UNOCINI Guidance;

- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;
- The Belfast Health and Social Care Trust AWOL Policy.

## 2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all patients, voluntary and detained, admitted to and discharged from an adult psychiatric inpatient facility. This operational policy provides staff working within a psychiatric inpatient unit with a structured and standardised framework for delivering care to service users and their carers across the spectrum of inpatient facilities within the Trust.

## 3.0 ROLES/RESPONSIBILITIES

All staff working within the mental health inpatient facility have a responsible role to play in achieving the policy objectives.

There are specific roles and responsibilities outlined in the Policy for: -

### 3.1 Nurse in Charge:

The Nurse in Charge will: -

- Ensure the safety and wellbeing of all patients and staff within the inpatient facility;
- Agree the level of observation for patients in conjunction with the Consultant Psychiatrist;
- Satisfy his/herself that they are aware of the location of all the patients both on or off ward and be aware of their mental and physical state;
- Allocate an observing nurse to each patient on continuous observations ensuring they are competent, have the appropriate experience and training i.e. communication/engagement skills, brief intervention training and management of aggression and have an understanding of the patient’s care plan;
- Allocate one member of staff to make visual checks of every patient on the ward on no less than an hourly basis throughout the shift;
- Remain accountable for delegation of observation duties;
- Ensure that a nurse is allocated to each patient for each shift regardless of their observation status to monitor their mental state and implement the patient’s care plan;
- Ensure that nursing staff meet with their allocated patients during the shift;
- Address any concerns raised by a staff member or family regarding the levels of observation a patient is on;
- Ensure as far as possible that no member of staff remains on continuous observation duties for more than two hours consecutively;
- Initiate the Record of Continuous Observation form (App 3) for any patient being placed on continuous observation;
- In the event of a patient going AWOL, implement the AWOL Policy;
- In the case a patient is being taken off continuous observation complete the Record of Continuous Observation form and the Continuous

Observation Prescription Form (App 1) in conjunction with the Consultant Psychiatrist or their nominated deputy.

## 3.2 Consultant Psychiatrist or nominated deputy (this role will be undertaken by the Duty Doctor during the evening, weekends and bank holidays)

The Consultant Psychiatrist or their nominated deputy will: -

- In conjunction with the Nurse in Charge agree the level of observation required for patients;
- Ensure that patients placed on continuous observation are reviewed daily by his/herself or their named deputy;
- In the event of a patient being taken off continuous observation complete the Continuous Observation Prescription Form in conjunction with the Nurse in Charge.

## 3.3 Observing staff

- The Nurse in Charge will allocate one member of staff to make visual checks on every patient in the ward on no less than an hourly basis and record same. This member of staff will report any changes in patients' mental state or their lack of presence in the ward to the Nurse in Charge;
- All staff observing a patient on a continuous basis have a responsibility to ensure they have the appropriate knowledge, skills and experience to safely perform this task including management of aggression training and communication/engagement skills, brief intervention training and management of aggression
- They must ensure they are aware of the rationale behind the level of observation and have an understanding of patient's care plan;
- The observing staff member will record the nature and purpose of the continuous observation on the Continuous Observation Record form (APP 2);
- The role of the observing staff member for patients on continuous observation does **not** replace the role of the named nurse who is responsible for observing the patient's health, well being and behaviour;
- Where a patient is on continuous observation the observing nurse will support the named nurse in assessing the patient's risk and mental state and in engaging the patient;
- Positive engagement with the patient is an essential aspect of constant observation.
- Whilst taking account of the patient's wishes staff should try to interact with the patient as much as possible, be this through assisting them with activities of daily living, social interaction or other activities on or off the ward dependent on the level of risk. In doing so staff should ask the patient about past beneficial interventions or things they feel might prove beneficial (please see a list of possible activities – this list is not exhaustive).

## 3.4 On-ward activities:

- **Activities of daily living** – assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate write letters, make telephone calls.

- **Social interaction** – respect a patient's right for silence. If a patient wishes to talk don't only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the patient may be due to a staff member's personal difficulty with silence.
- **Clinical interaction** – a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the patient to have some guidance in working through it.
- Respect a patient's wishes within safety boundaries, and the level of observation. Open the door if the patient's mental state is deteriorating as a consequence of close proximity and observation.
- **On-ward occupational therapy** to assist patients in engaging in activities during the time of an acute onset.

### 3.5 Off-ward activities:

- Engage in occupational therapy/other therapeutic opportunities
- Walks around grounds (assuming risk allows)

### 3.6 Named Nurse (in their absence a nurse will be allocated to the patient)

- The role of the observing staff member does **not** replace the role of the named nurse.
- A patient will be allocated a nurse during each shift. This nurse will be responsible for observing the patient's health, well being and behaviour. A record of this assessment will be made in the patient's notes and where necessary the patient's care plan will be modified;
- Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give patients a chance to discuss concerns and frustrations.
- All nurses should be aware of the general whereabouts of each patient in their charge, whether on or off the ward.

### 3.7 Multidisciplinary Team

If any member of the multidisciplinary team has any concerns about the levels of observation a patient is receiving these must be reported immediately to the Nurse in Charge of the inpatient facility. These discussions should then be discussed with the multidisciplinary team or if deemed urgent the Consultant Psychiatrist or their deputy.

If there is disagreement between individuals regarding the patient's level of observation this must be brought to the attention of the individuals' line managers. Staff should always choose the safest option for the patients and staff.

# 4.0 KEY POLICY PRINCIPLES

## 4.1 Levels of Observation

Observation should be used as an opportunity to assess and engage the patient, developing a therapeutic relationship. The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland recognises two levels of observation (these can apply to both voluntary and detained patients): -

a. General Observation – this is the minimum level of observation for all patients. This level of observation is suitable for patients assessed as presenting a low to medium risk of deliberately harming themselves or others. A member of staff will check the exact location of each patient on general observation at least every hour and record same in their notes. All nurses should be aware of the exact location of all patients under their charge;

b. Continuous Observation – continuous observation should be constant where a patient is assessed as presenting a high risk of deliberately harming themselves or others. Any patient nursed on continuous observation should be provided with a written information sheet, detailing the nature and purpose of continuous observation (App 4). Their level of observation should be recorded on a Continuous Observation Prescription form and in their notes. A record of their care and any issues relevant to risks should be recorded on the Continuous Observation Record sheet on an hourly basis by the observing member of staff. There are two categories of continuous observation: -

   - Within eyesight (Level 2): the patient should be kept within eyesight and accompanied at all times day and night;
   - Within arm's length (Level 1): the patient should be constantly supervised in close proximity. Additional staff member(s) may be required especially in instances where the patient presents with a history of violence. Consideration may be given to changing within arm's length to within eyesight during patient visits, at night or whenever the patient is in the bathroom however this must be recorded on the continuous observation prescription sheet.

   Due to the restrictive nature of continuous observation the patient should remain on same for the shortest time possible.

   Any change to the levels of continuous observation must be stated in the Continuous Observation Prescription sheet (this will include the reasons for doing so) and signed by the staff members making that decision. The decision will also be recorded in the patient's notes.

## 4.2 Implementing Observation Levels

All patients will receive a joint medical and nursing mental state and risk assessment (on a Risk Screening Tool or Comprehensive Risk Assessment as per Trust protocol) on their admission to hospital. The results of which will determine the level of observation to be implemented. Any decisions taken regarding the level of observation should where possible involve the patient and if appropriate their carer/next of kin. It must be recognised that all relevant information may not be available at the point of admission. Levels of observation should therefore be continuously reviewed in light of any new information and/or occurrences and changes made where appropriate.

## 4.3 Reviewing Observation Level

All observation levels should be continuously reviewed to ensure that the patient receives the least restrictive care needed to maintain their and others' safety. Decisions to increase the level of observation should be taken by the Consultant Psychiatrist or named deputy and the Nurse in Charge – ideally this should be done in conjunction with the patient and if appropriate their next of kin/carer. However in cases of emergency a higher level of observation can be implemented by any member of the multidisciplinary team if an increased risk is suspected.

Where a patient is on continuous observation, the levels of observation should be reviewed by both the Consultant Psychiatrist or named deputy and the Nurse in Charge at least every day and if appropriate decreased. The patient and if appropriate their carer/next of kin should be included in this decision making.

Observation levels must be reviewed at each multidisciplinary team review and any decisions taken to include the patient and if appropriate their carer/next of kin where possible.

Any changes to a patient's level of observation should include the reason for the change in observation and describe the change in risk to warrant the change. Staff should document this in the patient's notes and if applicable in the Continuous Observation Prescription Form.

Staff should always choose the safest option for both the patient and others

## 4.4 Emergencies

In the event of an emergency i.e. fire, assault the observing nurse must remain with the patient.
Alarms should be activated immediately and the Nurse in Charge advised of the emergency so staff can be organised as appropriate. In cases where the emergency involves the observing nurse being assaulted by the patient, the nurse in question should be reallocated duties and another member of staff allocated to continue the observation.
In the event of a fire, the observing nurse should evacuate the patient from the area of the fire as outlined in the Trust Fire Safety Policy and remain with them at all times.

## 4.5 Delegation to Non-Registered Staff

Whilst continuous observations are generally undertaken by a registered nurse this may on occasion be delegated to an unregistered member of staff. The Nurse in Charge will remain accountable for the delegation of observing staff ensuring they are sufficiently competent to undertake the role. Unregistered staff can complete the continuous observation recording sheet however this must be countersigned by a registered member of staff.
At **NO TIME** will a student nurse carryout observation without the direct supervision of a registered nurse or without the agreement of the patient.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This policy will be disseminated to all staff working within a mental health inpatient facility.

### 5.2 Resources

Nil

### 5.3 Exceptions

This policy applies to mental health inpatient facilities

## 6.0 MONITORING

An audit of the policy implementation will be carried out on an annual basis.

## 7.0 EVIDENCE BASE / REFERENCES

- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.
- The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008.
- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006
- The Mental Health (Northern Ireland) Order 1986.
- The Code of Practice Mental Health (Northern Ireland) Order 1986.
- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010
- The Human Rights Act 1998.
- The Northern Ireland Act 1998 (Section 75 Equality Considerations)
- In-patient psychiatric care for young people with severe mental illness (Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists) Council Report CR106 June 2003 Royal College of Psychiatrists.
- Children (NI) Order 1995-The Regional Child Protection Policy and Procedures (ACPC 2005)
- The Data Protection Act 1998
- National Institute for Clinical Excellence. Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report June 2011, DHSSPSNI, 2011.
- Central Nursing Advisory Committee (CNAC) Operational Framework for Delegation Decision Making, September 2009
- The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities within Northern Ireland, HSCB and PHA, November 2011.
- Scottish Executive – Engaging people: Observation of people with acute mental health problems, 2002

## 8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: -

- Belfast Trust Mental Health Inpatient Services
- Belfast Trust Users, Advocacy and Carers Forums
- Belfast Trust Mental Health Services Policy Committee

## 9.0 APPENDICES / ATTACHMENTS

App 1: Continuous Observation Prescription Form
App 2: Continuous Observation Record Sheet
App 3: Record of Continuous Observation
App 4: Patient Information Leaflet

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** x☐

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

________________________________ **Date: _____June 2016_________**
**Author**

________________________________ **Date: ________June 2016________**
**Director**

**App 1**

## Continuous Observation Prescription Form

| | | | | | | |
|---|---|---|---|---|---|---|
| Name: | DOB: | | | Consultant: | | |
| Please respond to all statements below | Yes | No | Sign/Date | Update Sign/Date | Update Sign/Date | Update Sign/Date |
| Patient to be within eyesight | | | | | | |
| Patient to be at arm's length | | | | | | |
| Observation when using bathroom – Eyesight | | | | | | |
| Observation when using bathroom – Arm's length | | | | | | |
| Date plan commenced: | | | Time: | | | |

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

Patient: ______________________ Signature:
Print Name

Summary of risk factors relating to observation plan:

Rational for observation level:

Known triggers/changes in behaviour which would increase risk:

What would be the rational for reducing observation levels (e.g. visitors, asleep)?

Cessation of Continuous Observation

Rational for decision

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

**App 2**

# Continuous Observation Recording Sheet

| | | |
|---|---|---|
| **Patient Name** | **DOB** | **Hospital No** |
| **Ward:** | **Named Nurse:** | **Consultant:** |
| **Date:** | | |

| Time | Sign & Date | Print Name | Comments |
|---|---|---|---|
| **0800 - 0900** | | | |
| **0900 - 1000** | | | |
| **1000 - 1100** | | | |
| **1100 - 1200** | | | |
| **1200 - 1300** | | | |
| **1300 - 1400** | | | |
| **1400 - 1500** | | | |
| **1500 - 1600** | | | |
| **1600 - 1700** | | | |
| **1700 - 1800** | | | |
| **1800 - 1900** | | | |

| | | | |
|---|---|---|---|
| **1900 - 2000** | | | |
| **2000 - 2100** | | | |
| **2100 - 2200** | | | |
| **2200 - 2300** | | | |
| **2300 - 0000** | | | |
| **0000 - 0100** | | | |
| **0100 - 0200** | | | |
| **0200 - 0300** | | | |
| **0300 - 0400** | | | |
| **0400 - 0500** | | | |
| **0500 - 0600** | | | |
| **0600 - 0700** | | | |
| **0700 - 0800** | | | |

**App 3**

# Record of Continuous Observation

- The Nurse in Charge must complete this record for every patient commenced on continuous observation
- This form must be completed even if no additional staff were required
- When continuous observation ceases, this form must be signed and forwarded to the nursing services manager, who will arrange for the details to be recorded

| **Patient Details** | | | |
|---|---|---|---|
| Patient's Name: | | Ward: | |
| DOB: | | Consultant: | |

**Staffing**

Number of staff currently on ward: ________

Number of patients on continuous observation: ________

Number of additional staff required on ward: ________

Date Commenced:

Time Commenced:

Date Finished:

Time Finished:

Duration of continuous observation (Number of Days)

Signed: ________________________ Designation of Nurse_______________

Print Name: ________________________

App 4

# Information for Patient/Carer

## Continuous Observation

### INFORMATION FACT SHEET FOR PATIENTS

Your nurse and doctor will have discussed the reasons why they feel you need continuous observation at this particular time and hope you will be in agreement with this decision.

The ward staff are concerned about you at the moment and we want to make sure you are safe.

We will treat you with dignity and respect at all times and involve you in all decisions regarding your care.

During continuous observation a member of the nursing team will observe you and will be there to work with you and involve you in activities that you feel able to participate in at present.

All patients are treated individually and your nurse will discuss your care plan with you.

The nursing team will work with you to help you with any concerns and to keep the time on continuous observation to an absolute minimum.

We would ask you to remain in the unit at present to assist with assessment of your needs and plan how you can make progress.

Your progress will be discussed with you every day, offering you the opportunity to have a say in your own care and to determine the length of time spent on special observation.

We appreciate that this is a very difficult time for you and your family/carer, but hope this time will assist and offer the opportunity to discuss and find solutions to some of your concerns.

Belfast Health and Social Care Trust
caring supporting improving together

**Reference No:** SG 44/12

| | | | |
|---|---|---|---|
| **Title:** | **Rapid Tranquillisation Guideline for the Pharmacological Management of Violent and Aggressive Behaviour in Adults, Children and Young People in Inpatient Units** | | |
| **Author(s)** | Stephen Guy, Lead Mental Health Pharmacist | | |
| **Ownership:** | Dr Cathy Jack, Medical Director | | |
| **Approval by:** | Drugs and Therapeutics Committee<br>Standards and Guidelines Committee<br>Trust Policy Committee<br>Executive Team Meeting | **Approval date:** | 23/01/2017<br>25/01/2017<br>01/02/2017<br>08/02/2017 |
| **Operational Date:** | February 2017 | **Next Review:** | February 2022 |
| **Version No.** | 2 | **Supercedes** | V1 - May 2012-2015 |
| **Key words:** | Violence, aggression, rapid tranquillisation, restrictive practices | | |
| **Links to other policies** | Use of Restrictive Interventions for Adult & Children's Services (SG 15/09)<br>Policy for measuring and recording physiological observations (SG 07/09) | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 15/5/2009 | 0.1 | S Guy | 1st Draft |
| 14/11/2009 | 0.2 | S Guy<br>S Cooper | Incorporation of comments on consultation. |
| 11/6/2010 | 0.3 | S Guy | Update in light of changes in Maudsley Guidelines. Aripiprazole IM added |
| 22/9/2010 | 0.4 | S Cooper | Changes to monitoring section. Incorporation of PEWS and SOC after consultation with Resuscitation Team |
| 30/10/2010 | 0.5 | S Guy | References added |
| 2/6/2011 | 0.6 | S Guy<br>Chris Kelly | Changes from D&T committee meeting 14/1/2011 |
| 20/8/2011 | 0.7 | S Guy | Change from D&T committee meeting 5th August 2011 |
| 05/04/12 | 0.8 | S Guy | Addition of training needs assessment and review date |
| 30/5/2012 | 0.9 | S O'Donnell | Formatting |
| 19/1/2016 | 1.1 | S Guy | Update of Policy to incorporate change in NICE Guidelines |
| 7/6/2016 | 1.2 | S Guy | Comments from Medical Staff consultations |
| 16/11/2016 | 1.3 | S Guy | Acceptance that policy applies within Emergency Departments |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person. The violence or aggression can be physical or verbal. Rapid tranquillisation is the use of medication by the Intramuscular route if oral medication is not possible or appropriate and urgent sedation with medication is needed.

### 1.2 Purpose

The purpose of this Guideline is to ensure a consistent approach to Rapid Tranquillisation or the acute management of violent and aggressive behaviour in order to minimise risk

This Guideline should be read alongside the Policy on the Use of Restrictive Practices in Adults and Children's Services (S&G 15/09)

## 2.0 SCOPE OF THE POLICY

2.1 This guideline describes intramuscular (IM) medication treatment options that may be used to manage violence and aggressive behaviour in adults, older adults, children and young people when oral medication is not possible or appropriate and urgent sedation is needed. This is commonly called Rapid Tranquillisation (RT)

2.2 The policy applies to adult mental health inpatient units, child and adolescent mental health inpatient units, learning disability inpatient units and to people with violence and aggression associated with mental illness in Emergency Departments

2.2 In addition this guideline outlines the use of "as required" or PRN oral medication that may be considered as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression

2.3 The Trust Policy Use of Restrictive Interventions for Adult & Children's Services (S&G 15/09) sets out the circumstances where restrictive practices may be used and the interventions in this Guideline must be used within the framework of the restrictive interventions policy

2.4 This guideline describes the physical observations and monitoring required after Rapid Tranquillisation has been administered. This guideline is not aimed at the management of violence and aggression encountered on general medical wards however, it might offer useful guidance for staff in these environments. In these situations, clinicians may wish to seek further advice on management from a psychiatrist

## 2.0 ROLES/RESPONSIBILITIES

This Guideline should be implemented on all mental health, learning disability, child and adolescent mental health inpatient wards and Emergency Departments

3.1 It is the responsibility of the Medical Director to ensure implementation of this guideline.

3.2 All staff involved in the Rapid Tranquillisation of patients presenting with aggressive or violent behaviour should be aware of this guideline and follow it when it is appropriate to do so.

3.3 Clinicians should use their own clinical judgement in each case and if they decide that a different management approach is clinically indicated then the reasons for this should be clearly documented. This is particularly important in Level 3 interventions as there is less evidence to guide practice. Some of the recommendations in Level 3 are not mentioned in the NICE Violence (NG10) Guideline. The NICE guideline does clearly state that its recommendations do not preclude the use of alternative treatments provided their use is tailored to the individual's clinical circumstances. It is the prescriber's responsibility to clearly document the rational for their treatment choice in these circumstances.

## 4.0 KEY POLICY PRINCIPLES

### Definitions

- *Rapid Tranquillisation* - The use of medication by the intramuscular route if oral medication is not possible or appropriate and urgent sedation with medication is needed.

- *Adult* - A person over the age of 18yrs

- *Child* – A person aged 12 years and under

- *Young Person* –A person aged between 13 and 17 years

- *Violence and Aggression* - a range of behaviours or actions that can result in harm, hurt or injury to another person. The violence or aggression can be physical or verbal.

### Key Policy Statement(s)

### Policy Principles

4.1.1 This guideline does not apply to the management of delirium or acute alcohol withdrawal.

4.1.2 Rapid Tranquillisation should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques and should only be considered when de-escalation, including oral PRN, have failed to produce a satisfactory response

4.1.3 Staff should be trained, to a level appropriate to their role, in how to assess and manage potential and actual violence or aggression using de-escalation techniques, restraint and pharmacological management. Staff should also be trained to use Immediate Life Support when appropriate.

4.1.4 If the patient has expressed a preference for a particular antipsychotic in an Advance Decision consider prescribing this if appropriate to the clinical circumstances.

4.1.5 Before administering an intramuscular medication, the patient must be given the opportunity to take oral medication if it is thought this would be effective and appropriate in the clinical circumstances. If oral medication is given in these cases staff should consider if initiating the post RT monitoring in Appendix E might be appropriate.

4.1.6 Only exceed the BNF maximum daily dose (including PRN. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor. Consider lower maximum doses in older adults or the physically frail.

4.1.7 An Incident Form (IR1) must be completed after each instance of RT. NOTE an IR1 is not an automatic requirement after use of oral PRN medication given as part of a de-escalation strategy unless warranted by other events.

4.1.8 If Rapid Tranquillisation is being used, a senior doctor should review all medication at least once a day.

4.1.8 All staff should be aware of the legal framework that authorises the use of these interventions. If repeated interventions are required, give consideration to use of the Mental Health Order NI (1986)

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This Guideline is relevant to the following staff groups

5.1.1 Medical staff working in adult, child and adolescent mental health wards, learning disability wards and Emergency Departments

5.1.2 Nursing staff working in adult, child and adolescent mental health wards, learning disability wards and Emergency Departments

5.1.3 Pharmacists working in adult, child and adolescent mental health wards, learning disability wards and Emergency Departments

5.1.4 This guideline should be implemented by relevant services within 3 months of approval. If this timescale can't be met then the Co-Director for Mental Health should be notified

### 5.2 Resources

A training needs analysis is included in Appendix F. It is the responsibility of the Co-Director and the Associate Medical Director for mental health to ensure training is in place.

Training on Rapid Tranquillisation forms part of the Induction Training for Medical Staff on rotational training placements.

Training on Rapid Tranquillisation is part of the MAPA 5 day training for Staff working in Mental Health Inpatient units

### 5.3 Exceptions

There are no exceptions.

## 6.0 MONITORING

Compliance with this Guideline will be monitored by reviewing either

- Case notes of patients who undergo rapid tranquillisation
- Incident forms completed after rapid tranquillisation
- Physical Intervention monitoring forms completed after episodes of restraint

This monitoring should include any section 75 implications of implementing the policy.

## 7.0 EVIDENCE BASE / REFERENCES

Maudsley Prescribing Guidelines 12th Edition, Taylor, D, Paton C, Kapur S, Wiley Blackwell, London 2015

NICE: NG10, Violence and aggression: short-term management in mental health, health and community settings: May 2015.

NICE: CG178, Psychosis and schizophrenia in adults: prevention and management: February 2014

SPc Haloperidol tablets and Injection (Mercury Pharmaceuticals), Electronic Medicines Compendium, www.medicines.org.uk accessed 6/6/2016

SPc Aripiprazole Injection 7.5mg/ml Electronic Medicines Compendium, www.medicines.org.uk accessed 6/6/2016

SPc Olanzapine tablets and Injection, Electronic Medicines Compendium, www.medicines.org.uk accessed 6/6/2016

SPc Risperidone tablets, Electronic Medicines Compendium, www.medicines.org.uk accessed 6/6/2016

SPc Lorazepam Tablets and Injection Electronic Medicines Compendium, www.medicines.org.uk accessed 6/6/2016

## 8.0 CONSULTATION PROCESS

The following were consulted and asked for comments on draft versions of this policy

- Consultant medical staff working in Adult Mental Health services
- Consultant medical staff working in child and adolescent mental health services (CAMHS) and CAMHS learning disability services
- Consultant medical staff working in Adult Learning Disability Services
- Senior Mental health nurse managers

## 9.0 APPENDICES / ATTACHMENTS

Appendix A - Medication in Acute Psychiatric Emergencies
Appendix B - Dose Information for medicines used in Rapid Tranquillisation
(Refer to flow charts for place in RT)
Appendix C - Pharmacological management of violent and aggressive behaviour (FOR ADULTS OVER 18 YEARS)
Appendix D - Pharmacological management of violent and aggressive behaviour (for Children and Young People under 18 YEARS)
Appendix E - Rapid Tranquillisation - Monitoring
Appendix F - Rapid Tranquillisation Training Needs Analysis

## 10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact.** X

**SIGNATORIES**
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Stephen Guy

________________________________ **Date: ___February 2017____**

**Author**

Cathy Jack

________________________________ **Date: ___February 2017____**

**Director**

**(Appendix A)**

## Medication in Acute Psychiatric Emergencies

### Introduction

This guideline is based around NICE NG10 Violence and aggression: short term management in mental health, health and community settings (2015). All staff should familiarise themselves with the NICE Violence and Aggression pathway which serves as a useful summary of the full NICE guideline. The Pathway also offers guidance on prevention and de-escalation strategies which are not described in this medicine related guideline.

**Level 1** describes oral "as required" (PRN) management options that may be offered as part of a strategy in order to de-escalate or prevent situations that might lead to violence and aggression. The NICE guideline clearly states that PRN medication on its own is not de-escalation.

**Level 2** describes Intramuscular (IM) management options which should only be considered when there is actual or clear risk of violence or aggression and de-escalation and other preventative strategies including PRN have failed. It is common practice for patients to be prescribed the same PRN medicine to be administered orally or if indicated intramuscularly. Administration of the PRN medication intramuscularly would not be de-escalation and must be considered Rapid Tranquillisation (RT). De-escalation attempts should continue up to the administration of IM medication, if in these circumstances the person then accepts oral medication instead of IM, consider if initiating the post RT monitoring in Appendix E might be appropriate.

**Level 3** describes interventions to consider if Level 2 interventions have failed to produce a sufficient response. Level 3 interventions should only be used by or after consultation with a senior doctor. Level 3 interventions include

- Repeating the same Level 2 intervention
- Alternative approaches in Level 2 that were not offered
- Different strategies including medicines or combinations not included in NICE NG10. These must be tailored to the individual and might be guided by previous response in similar circumstances. The rationale and outcome must be clearly recorded

### 1.0 General Prescribing Principles

When prescribing PRN medication as part of a de-escalation strategy or medication for rapid tranquillisation it is important to individualise the dose and type of medication for each service user. This will depend on several factors including previous response to medication, age, allergies, physical problems (renal, hepatic, cardiovascular or neurological disease) other prescribed medication and possible use of drugs of abuse. Consider the following points when prescribing

- Check that the patient has not had previous allergy or severe idiosyncratic reaction to the drugs to be used.

- Check there is no recent history of Neuroleptic Malignant Syndrome or hyperthermia.
- Simultaneous administration of IM antipsychotics and IM benzodiazepines (lorazepam) may be associated with excessive sedation and cardio respiratory depression. If this combination is deemed necessary, then patients must be monitored for excessive sedation and for postural hypotension. (Note this is a Level 3 intervention)
- Patients taking clozapine and olanzapine require care when giving benzodiazepines, in particular parenterally, as potentially fatal orthostatic and cardio-respiratory dysregulation have been reported. If this combination is considered necessary, it is essential to undertake frequent monitoring of the patient especially after the use of IM preparations.
- If the patient has expressed a preference for a particular antipsychotic in an Advance Decision, consider prescribing this if warranted by clinical circumstances.
- Avoid unnecessary polypharmacy. This may necessitate careful choice of drug in relation to either current treatment or expected maintenance treatment.
- Carefully consider the number of active PRN prescriptions operative at any one time in relation to the risk of inadvertent overdose. Check if the patient is prescribed the same or similar medicine as a regular and PRN.
- Prescribe oral and IM doses separately – do not use PO/IM abbreviation.
- When administering more than one IM medicine don't mix medications in the same syringe.
- When prescribing haloperidol in combination with promethazine, do not pre-emptively administer procyclidine to reduce risk of EPSE. The rationale for haloperidol combined with promethazine is improved tolerability (lower incidence of EPSE), Prescribing promethazine and procyclidine together is likely to increase anticholinergic side effects.
- Patients entering LEVEL 2 on the protocol must have details of all medicines administered, rational of use and an assessment of effectiveness recorded in the clinical notes. All current PRN prescriptions on the kardex should be discontinued and reviewed in 6-12 hours after which they may be re-prescribed if necessary.

### 1.1 Maximum Doses

Only exceed the BNF maximum daily dose (calculate total dose including PRN dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor. If BNF doses are exceeded in Rapid Tranquillisation, undertake frequent and intensive monitoring post incident. Monitor level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. (Appendix E).

### 1.2 Prescribing PRN medication

As required (PRN) medication may be prescribed as part of a de-escalation strategy to prevent situations that might lead to violence and aggression or during the rapid tranquillisation process. When prescribing PRN medication take the following points into consideration.

- Do not prescribe PRN medication routinely or automatically on admission
- Individualise PRN medication and discuss with the patient if possible
- State the rationale for prescribing PRN e.g. “for agitation” and ensure this is recorded in the care plan.
- If more than one PRN medication is prescribed for the same indication the prescription should state which is first line and which is second line for the indication.
- State the maximum dose of PRN that can be administered in a 24 hour period.
- State the minimum interval between PRN doses.
- When possible avoid variable doses of PRN e.g. lorazepam 1–2mg as this leads to higher doses being administered without review.
- Check that prescribing PRN medication does not inadvertently lead to exceeding the maximum BNF dose when combined with the patient’s regular medication.
- Only exceed the BNF maximum daily dose (calculate total dose including PRN dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor.

### 1.3 Cardiovascular Safety

Antipsychotics as a group are probably associated with an increased risk of QTc prolongation. Normal limits of QTc are less than 440 ms in men and less than 470 ms in women. Limited evidence suggests the risk of arrhythmia increases exponentially beyond normal limits, with strong evidence that QTc greater than 500ms is clearly linked to an increased risk of arrhythmia. The risk is dose related and the risks for individual drugs are probably additive when they are used in combination.

Table 1 summarises the risk for common antipsychotics

**Table 1**

| **Low Effect**<br>**No or average increase <10msec at clinical doses or severe effect only reported following overdose** | **Moderate Effect**<br>**Average increase >10msec at clinical doses or ECG officially recommended** | **High Effect**<br>**Average increase >20msec** |
|---|---|---|
| Aripiprazole<br>Asenapine<br>Clozapine<br>Flupentixol<br>Fluphenazine<br>Lurasidone<br>Olanzapine<br>Paliperidone<br>Risperidone<br>Sulpiride | Amisulpride[*]<br>Chlorpromazine<br>Haloperidol<br>Levomepromazine<br>Quetiapine | Any intravenous antipsychotic<br>Pimozide<br>Sertindole<br>Any antipsychotic or combination of antipsychotics used in doses exceeding BNF maximum dose |

[*] Torsades de pointes common in overdose with Amisulpride

Table adapted from the Maudsley Guideline 12th edition, 2015

The NICE Guideline CG 178 Psychosis and schizophrenia in adults: prevention and management recommends that before starting an antipsychotic, an ECG should be offered if the person is admitted as an inpatient. In particular, the Summary of Product Characteristics for haloperidol recommends a baseline ECG. If an ECG is not available the prescriber should consider the risks and benefits of using intramuscular haloperidol and be able to justify their prescribing decision, because it may be considered an off-label use

A number of non-psychotropic medications are associated with prolonged QTc. These are shown in Table 2

**Table 2**

| **Antibiotics** | **Antimalarials** | **Antiarrhytmics** | **Others** |
|---|---|---|---|
| Erythromycin<br>Clarithromycin<br>Ampicillin<br>Co-trimoxazole<br>Ciprofloxacin<br>Levofloxacin<br>Moxifloxacin | Chloroquine<br>Mefloquine<br>Quinine | Quinidine<br>Disopyramide<br>Procainamide<br>Sotalol<br>Amiodarone<br>Bretylium | Amantadine<br>Ciclosporin<br>Diphenhydramine<br>Hydroxyzine<br>Methadone<br>Nicardipine<br>Tamoxifen |

Table adapted from the Maudsley Guidelines 12th edition, 2015

### 1.4 Drug Selection

See Appendix B for a summary of recommended drugs and recommended doses for different age groups.

A benzodiazepine may be the safest and best tolerated drug with which to effect ‘rapid tranquillisation’ of the patient. Once the patient has been calmed, either by de-escalation techniques or by a benzodiazepine, an antipsychotic drug may be best for maintenance of the situation. Remember that repeated use of a benzodiazepine may result in tolerance to the effect and this will probably become evident by 7 to 10 days.

## 2.0 Rapid tranquillisation For Adults over 18 years

*The flow chart in Appendix C outlines a stepped approach to rapid tranquillisation for Adults over 18 years of age.*
If you are unsure about initial pharmacological management then always call a more senior doctor. If you are a junior doctor and your initial drug treatment does not work then you should consider discussion with someone more senior. If you are a Consultant and have tried two or three approaches without success, then it may be wise to seek a second opinion from a colleague. If the incident is outside a mental health unit, clinicians may wish to consult a psychiatrist for further advice.

## 3.0 For Children and Young People under 18yrs of age

The NICE Guideline on Violence and Aggression states that restrictive interventions (which includes Rapid Tranquillisation) should only be used if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.

Staff must be familiar with and use the de-escalation techniques outlined in the NICE guideline to avoid having to use a restrictive intervention

### 3.1 General Prescribing Principles in Children and Young People

The general prescribing principles for adults outlined in Section 1.0 apply when prescribing for children and young people.

### 3.2 Consent

Medication can be given against a child's will with parental consent i.e. permission from a person with Parental Responsibility under The Children's Act NI and or common law. If repeated medication is required, the Mental Health Order NI (1986) should be considered. Children and young people should be informed that a medication is going to be given and always given the opportunity to accept oral medication.

### 3.3 Rapid Tranquillisation for Children and Young People

*The flow chart in Appendix D outlines a stepped approach to rapid tranquillisation for Children and Young People aged between 6 and 18 years of age.*
If you are unsure about initial pharmacological management then always call a more senior doctor. If you are a junior doctor and your initial drug treatment does not work then you should consider discussion with someone more senior. If you are a Consultant and have tried two or three approaches without success then it may be wise to seek a second opinion from a colleague. If the incident is outside an adolescent mental health setting, clinicians may wish to consult a child and adolescent psychiatrist for further advice.

## 4.0 For Older Adults (65+) Without Dementia

This guideline applies to the management of acutely disturbed behaviour and not to the management of delirium.

Follow the flow chart for Adults over 18 after considering the information below and the specific dose information for Older Adults without Dementia in Appendix B

There is evidence that antipsychotics are associated with increased mortality (probably by increasing the risk of cerebrovascular adverse events) even in people without dementia. A cautious approach is recommended.

- Oral medication should always be offered whenever possible.
- Lorazepam, starting at a low dose, is the preferred first line treatment.
- If there is confirmed history of previous antipsychotic use then oral haloperidol or olanzapine may be considered.

- If a patient requires IM medication, lorazepam should be used first line.
- IM haloperidol or IM olanzapine may be used if there is confirmed history of previous antipsychotic use.
- When using haloperidol in older adults consideration should be given to the appropriateness of combining with promethazine due to the increased risk of additive anticholinergic side effects and increased confusion.
- If previous use of antipsychotics can't be confirmed and lorazepam fails to control the situation, low dose olanzapine or haloperidol may be considered. In such cases it may be appropriate to consult a doctor experienced in the management of older people.

## 5.0 For people with dementia

Follow the flow chart for Adults over 18 after considering the information below and the specific dose information for People with Dementia in Appendix B

Non-pharmacological options should be considered as first line management. If this is ineffective, then lorazepam may be considered. Risperidone is licensed for short-term use for persistent aggression in people with moderate to severe Alzheimer's dementia. The starting dose is 0.25mg twice daily increased to 0.5mg twice daily. If ongoing use of risperidone is considered necessary then the advice of a doctor experienced in the management of dementia should be sought.

In very exceptional circumstances, when oral treatment is impossible, low dose haloperidol IM may be used. In these cases, consider consulting a doctor with experience in managing disturbed behaviour in people with dementia.

## 6.0 Physical Health and Side Effect Monitoring after Use of Intramuscular medication

**Appendix E summarises the monitoring required after rapid tranquillisation (i.e. IM administration of medicines)**

Physical health and side effect monitoring is essential after an episode of rapid tranquillisation. Note routine monitoring is not automatically required after oral medication unless it is clinically indicated by the patient's condition.

The following observations should commence 15 minutes after each episode of rapid tranquillisation and be documented on the Trust Standard Observation form

- Respiratory rate
- Sa02 if clinically indicated or if patient is asleep
- Pulse
- Blood Pressure
- Temperature
- Level of Consciousness

In addition observe for side effects of medication and maintain good hydration. When possible, obtain an ECG after administration of an IM antipsychotic. An ECG is essential after administration of an antipsychotic to a young person. Staff should be sufficiently trained to interpret ECG traces (including calculation of QT/QTc interval). If an ECG shows any cause for concern then contact a physician for advice on patient management. Record these observations and any actions in the clinical notes.

### 6.1 Frequency of monitoring

After rapid tranquillisation carry out the required observations every 15 minutes for the first hour.

After one hour, continue observations at least every hour until there are no further concerns about physical health status.

Consider extended or more frequent monitoring in the following circumstances

- The BNF maximum dose of a prescribed medicine has been exceeded
- The patient appears to be asleep or sedated
- Concerns about possible illicit drug or substances or alcohol use
- Pre-existing physical health problem
- The patient experienced any harm as a result of a restrictive intervention

### 6.2 Documentation of side effect and physical health monitoring

Checks for side effects after rapid tranquillisation should be recorded in the clinical notes. Physiological observations must be recorded on the Standard Observation Chart and EWS scores calculated in accordance with the Trust Policy on Measuring and Recording Physiological Observations

### 6.2 Refusal to co-operate with side effect and physical health monitoring

If patients refuse physiological observation or of they remain too behaviourally disturbed to be approached, this must be documented in the patients notes at each time monitoring would have been due. The patient should be observed for sign/symptoms of pyrexia, hypotension, over sedation and general physical well-being and documented accordingly

## 7.0 Drugs NOT recommended for rapid tranquillisation

The following drugs are NOT recommended for rapid tranquillisation:

- Oral and IM chlorpromazine – IM chlorpromazine is painful and can cause severe hypotension. Chlorpromazine must never be given intravenously.
- IM diazepam – absorption is erratic.
- IM depot antipsychotics.
- Olanzapine in dementia related disturbance.
- Zuclopenthixol acetate is <u>not</u> recommended for routine use in rapid tranquillisation due to its slow onset of action. It may however be

recommended as a LEVEL 3 intervention by a senior doctor or consultant when:

- The patient is disturbed/violent over an extended time period
- Past history of good/timely response
- Past history of repeated parenteral administration required
- Cited in an advance decision

## 8.0 Actions after Rapid Tranquillisation

A doctor should be available to quickly attend an alert by staff members when Rapid Tranquillisation has been implemented, for an appropriate period of time to ensure the treatment has been effective and that undue adverse effects are no longer likely to occur.

A report of use of Rapid Tranquillisation should be made on a Trust Incident Form. A post-incident review may be held within 72 hours.

## Dose Information for medicines used in Rapid Tranquillisation (Refer to flow charts for place in RT) (Appendix B)

| **Medication** | **Child (6- 12 years)** | **Adolescents (13 – 17)** | **Adults (18 – 65)** | **Older People (65+)** | **People with Dementia** |
|---|---|---|---|---|---|
| Lorazepam tablets and IM injection | By Mouth or by IM injection<br>0.5 – 1mg<br>Maximum 4mg/24hrs | By Mouth OR by IM injection<br>0.5mg - 2mg<br>Maximum 4mg/24hrs | By Mouth Or by IM injection<br>1mg - 2mg<br>Maximum 4mg/24 hours | By Mouth Or by IM injection<br>0.5mg - 1mg<br>Maximum 4mg/24 hours | By Mouth Or by IM injection<br>0.5mg - 1mg<br>Maximum 4mg/24 hours |
| Aripiprazole IM injection | NOT APPLICABLE | NOT APPLICABLE | By IM injection<br>9.75mg (1.3ml) – Consider lower dose (5.25mg) on basis of clinical status<br>Effective range 5.25 –15mg<br>Max dose 30mg/24hrs by any route | Effectiveness in over 65's not established. Consider lower doses on basis of clinical status | **Not Recommended** |
| Risperidone tablets and oral solution | <50kg 0.5mg once daily<br>>50kg 1mg once daily | <50kg 0.5mg once daily<br>>50kg 1mg once daily | NOT APPLICABLE | NOT APPLICABLE | By mouth in Alzheimer's dementia<br>0.25 – 0.5mg twice daily. |
| Olanzapine tablets and Orodispersible tablets | NOT APPLICABLE | NOT APPLICABLE | By mouth<br>10mg<br>Maximum 20mg/24 hours | As a second line option<br>By mouth 5 - 10mg<br>Maximum 20mg/24hrs | **DO NOT USE OLANZAPINE IN PEOPLE WITH DEMENTIA** |
| Olanzapine IM injection | NOT APPLICABLE | By IM injection 2.5mg – 10mg<br>Maximum of 3 injections in 24 hours with at least 2 hours between injections.<br>When used for RT, Maximum of 20mg/24 hrs by all routes. | By IM injection 5 – 10mg<br>Maximum of 3 injections in 24 hours with at least 2 hours between injection.<br>When used for RT, Maximum of 20mg/24 hrs by all routes. | By IM injection<br>>60 yrs 2.5mg – 5mg<br>Maximum of 3 injections in 24 hours with at least 2 hours between injections<br>When used for RT, Maximum of 20mg/24 hrs by all routes. | **DO NOT USE OLANZAPINE IN PEOPLE WITH DEMENTIA** |
| Haloperidol injection | NOT APPLICABLE | **If no recent ECG, consider risk/benefits as use may be unlicensed.**<br>By IM injection<br>1mg – 5mg<br>Maximum 10mg/24hrs | **If no recent ECG, consider risk/benefits as use may be unlicensed.**<br>By IM injection<br>5mg<br>Maximum 18mg/24 hours | **If no recent ECG, consider risk/benefits as use may be unlicensed.**<br>Only use first line only with a confirmed history of previous tolerability to typical antipsychotics. Start with lower doses than the 18-65 age group | Use only in very exceptional circumstances. Consider consulting a doctor with experience in dementia.<br>**Do not use in dementia with Lewy Bodies** |
| Haloperidol Oral solution and tablets | NOT APPLICABLE | By Mouth in psychosis<br>1mg - 5mg<br>Maximum 10mg/24hrs | By Mouth<br>5mg - 10mg<br>Maximum 20mg/24 hours | Only use first line only with a confirmed history of previous tolerability to typical antipsychotics. Start with lower doses than the 18-65 age group | **Consider oral risperidone as an alternative** |
| Promethazine | NOT APPLICABLE | NOT APPLICABLE | By IM injection<br>25 – 50mg<br>Maximum 100mg/24hrs | Consider appropriateness if confusion is a concern. Consider lower doses than 18-65yrs group | **Not Recommended** |

**NOTES:**

- Remember, 0.5mg lorazepam is equivalent to 5mg diazepam.
- Haloperidol 5mg IM is equivalent to approx. 8mg – 10mg orally.
- Orodispersible tablets offer no advantage in speed of onset but are harder to spit out or conceal.
- Olanzapine IM and lorazepam IM should not be used within one hour of each other and then only after careful consideration with strict post-injection monitoring.
- There is probably an increased risk of cerbro-vascular events in older patients with all antipsychotics.
- Lorazepam is unlicensed for control of aggression in under 12's. Risperidone is only licensed <12yrs for aggression associated with Conduct Disorder

# Pharmacological management of violent and aggressive behaviour (FOR ADULTS OVER 18 YEARS) (Appendix C)

See Appendix B for additional information on the management of older people and people with dementia

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques**

## LEVEL 1

**Accepting oral meds and as part of de-escalation strategy**

- Continue de-escalation strategy
- Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances
- Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response

**Suggested oral medication**

| | |
|---|---|
| **Lorazepam 1 - 2mg**<br>(Max 4mg/24hrs)<br>OR<br>**Haloperidol 3 - 5mg**<br>(max 20mg/24hrs)<br>OR<br>**Olanzapine 10mg**<br>**Do not use in Dementia**<br>(Max 20mg/24hrs) | Continue de-escalation strategy.<br>If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 |

**When deciding which medication to use, consider**

- Oral risperidone in people with Alzheimer's dementia (Appendix B)
- Oral lorazepam is preferred with
  - an uncertain history
  - presence of cardiovascular disease
  - Current illicit drug/alcohol intoxication
- Oral antipsychotics preferred with
  - Current regular benzodiazepine use
  - History of respiratory depression

## LEVEL 2

**Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate**

- Review all medication administered in the last 24 hours – be aware of BNF max doses
- Ensure resuscitation equipment and emergency bag is available within 3 minutes

**Suggested IM medication**

| | |
|---|---|
| **Lorazepam IM 1 - 2mg**<br>(Max 4mg/24hrs)<br>**(IV flumazenil must be available)**<br>**OR**<br>**Haloperidol IM 5mg**<br>(Max 18mg/24hrs)<br>**Combined with**<br>**Promethazine IM 25 - 50mg**<br>(Max 100mg/24hrs) | If there is continued concern seek advice from a more senior doctor before proceeding further |

**When deciding which medication to use, consider**

- Lorazepam as first line if history is unclear or antipsychotic naive
- Pre-existing physical health problems or pregnancy
- Avoiding haloperidol in cardiovascular disease or if there has been no recent ECG
- Previous response, including adverse effects
- Potential for interactions with other medicine
- Possible intoxication
- Promethazine is contraindicated in CNS depression
- Promethazine may be unsuitable in older adults with confusion due to its anticholinergic effects.

## LEVEL 3

**Situation rapidly deteriorating or failure to respond to LEVEL 2 interventions**

If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours.

If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following

- The appropriateness of current placement
- Age and physical presentation
- Check sufficient time has been allowed for response
- If there has been a partial response to a LEVEL 2 intervention, consider repeating that intervention
- If a LEVEL 2 intervention has had insufficient effect consider offering the alternative LEVEL 2 intervention

If LEVEL 2 interventions have had insufficient effect

- Carry out a full review of treatment to date and seek a second opinion if needed.

Options to consider as part of an individualised care plan include

- Further repeats of LEVEL 2 interventions
- Haloperidol IM combined with Lorazepam IM
- Olanzapine IM 10mg (Max 20mg by all routes). Do not combine with IM lorazepam and use with caution if IM lorazepam has been given within 1 hour.
- Aripiprazole IM 9.5mg (Max 30mg)
- Clopixol Accuphase (see guideline notes)

# Pharmacological management of violent and aggressive behaviour (for Children and Young People under 18 YEARS)

**Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques**

**(Appendix D)**

## LEVEL 1

**Accepting oral meds and as part of de-escalation strategy**

- Continue de-escalation strategy
- Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances
- Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response

### Children 6-12 yrs Suggested Oral Medication

| | |
|---|---|
| **Lorazepam 0.5 – 1mg**<br>(Max 4mg/24hrs) | Continue de-escalation strategy.<br>If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 |

### Young People 13-18yrs Suggested Oral Medication

| | |
|---|---|
| **Lorazepam 0.5 - 2mg**<br>(Max 4mg/24hrs)<br>**OR**<br>**Haloperidol 1 – 5 mg**<br>(max 10mg/24hrs)<br>**OR**<br>**Risperidone**<br>**<50kg 0.5mg, >50kg 1mg**<br>(Max 3mg/24hrs) | Continue de-escalation strategy.<br>If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2 |

See Adult flow chart for things to consider when choosing which medication to use

## LEVEL 2

**Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate**

- Consult a CAMHS doctor before using IM medication in a child under 12yrs of age
- Consult a CAMHS doctor before using IM medication in a young person (13-18yrs) unless IM medication is already included in the young person's care plan.
- Check if an individual care plan recommends an approach not covered in this guideline
- Review all medication administered in the last 24 hours – be aware of BNF max doses
- Ensure resuscitation equipment and emergency bag is available within 3 minutes

### Children 6-12yrs Suggested IM Medication

| | |
|---|---|
| **Lorazepam IM 0.5 - 1mg**<br>(Max 4mg/24hrs) | If there is continued concern seek advice from a more senior doctor before proceeding further |

### Young People 13 -18 yrs Suggested IM Medication

| | |
|---|---|
| **Lorazepam IM 0.5 -2mg**<br>(Max 4mg/24hrs) | If there is continued concern seek advice from a more senior doctor before proceeding further |

See Adult flow chart for things to consider when choosing which medication to use

## LEVEL 3

**Situation rapidly deteriorating or failure to respond to Level 2 interventions**

If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours.
If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following options

- The appropriateness of current placement
- Check sufficient time has been allowed for response
- If there has been a partial response to lorazepam consider repeating the dose

If there has been insufficient response to lorazepam

- Carry out a full review and seek a second opinion if needed.

Options to consider at this stage include

- Further repeats of IM lorazepam
- ≥13yrs, Haloperidol IM 1 - 5mg (Max 10mg)
- ≥13yrs, Haloperidol IM combined with Lorazepam IM
- ≥13yrs, Olanzapine 2.5 - 10mg (Max 20mg by all routes). Do not combine with IM lorazepam and use with caution if IM lorazepam has been given within 1 hour.

**(Appendix E)**

## Rapid tranquillisation - Monitoring

Following any IM drug administered for RT, or where considered clinically necessary after oral medication, monitor and record as shown below. Document and record on the Trust Standard Observation Chart (SOC) or clinical notes as appropriate.

**The Early Warning Score should be calculated from the SOC each time and further action taken if indicated**

| Observations | Monitoring Frequency | General Comments |
|---|---|---|
| • Respiratory Rate<br>• SaO2 (if appropriate)<br>• Pulse<br>• Blood Pressure<br>• Temperature<br>• Level of Consciousness<br>• Assess for Side effects<br>• Monitor level of hydration | Every 15 minutes for first hour. After one hour, continue observations at least hourly until there are no further concerns about physical health status.<br>**Action when Observations are not possible**<br>Record if the patient's mental state or behaviour prevents observations. Complete and record any observations possible, in particular signs of over sedation, pyrexia, hypotension or general malaise | • Arrange medical review of the patient after administration of IM medication<br>• Protection of the airway is paramount<br>• Ensure adequate levels of hydration are maintained<br>• Consider urgent transfer to an Emergency Department if condition warrants<br>• Pay particular attention to level of consciousness and blood pressure when IM antipsychotics and IM benzodiazepines are used in combination.<br>• An ECG is recommended when IM antipsychotics, in particular when haloperidol or higher doses are given.<br>• An ECG is essential after IM antipsychotics are administered to Young People. |

## Management of problems occurring during Rapid Tranquillisation

| Problem | Remedial Measures |
|---|---|
| **Acute Dystonia** (including oculogyric crises) | Give **procyclidine 5 - 10mg Orally or IM**<br>**NOTE** Do not pre-emptively administer procyclidine when IM haloperidol is combined with IM promethazine as the risk of extrapyramidal side effects (EPSE) is significantly reduced by the promethazine. If EPSE do occur after the IM haloperidol/promethazine combination, administer additional procyclidine with caution. Monitor for increased anticholinergic side effects. |
| **Reduced respiratory rate**<br><10/minute or<br>oxygen saturation <92% | Give oxygen; ensure patient is not lying face down.<br>If induced by any agent other than a benzodiazepine the patient will require transfer for mechanical ventilation.<br>If benzodiazepine induced, give flumazenil 200microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1mg (1000microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level.<br>N.B. Effect of flumazenil may wear-off & respiratory depression return – monitoring must continue beyond initial recovery of respiration |
| **Irregular or slow pulse**<br><50 beats/min | **Refer to specialist medical care immediately.** |
| **Fall in blood pressure**<br>> 30mmHg drop in systolic BP on standing or diastolic BP <50mmHg | Lie patient flat, raise legs if possible. Monitor closely and seek further medical advice if necessary. |
| **Increased temperature** | **Withhold antipsychotics –**risk of NMS or perhaps arrhythmias. Monitor closely, cool the patient, and check muscle creatinine kinase**.**<br>**Refer to specialist medical care** if continued or other signs of NMS present e.g. sweating, hypertension or fluctuating BP, tachycardia, incontinence (retention/obstruction), muscular rigidity (may be confined to head and neck), confusion, agitation or loss of consciousness. |

**(Appendix F)**

## Rapid Tranquillisation Training Needs Analysis

Set out below is the training needs analysis for all staff groups identifying which groups of staff require training and the level and frequency required The aim of training is to ensure that all staff are aware of their duties, role and responsibilities to enable them to implement the Rapid Tranquillisation guideline.

| Staff Group | RT training including flow charts and monitoring | Medication used in RT | Basic Life Support | Immediate Life Support | Automated external defibrillator | Pulse oximetry |
|---|---|---|---|---|---|---|
| | Annual | Annual | Annual | Annual | Annual | Annual |
| **Medical Staff** | | | | | | |
| Consultant | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Specialist Trainees | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Core Trainees | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Staff Grade | ✓ | ✓ | | ✓ | ✓ | ✓ |
| F1/F2 Trainee | ✓ | ✓ | | ✓ | ✓ | ✓ |
| **Staff Base in Acute Inpatient Units** | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Registered Nurse | ✓ | ✓ | ✓ | ✓(in high risk areas) | ✓ | ✓ |
| Healthcare Assistant | ✓(Overview) | ✓(Overview) | ✓ | | | |

Belfast Health and Social Care Trust
caring supporting improving together

**Reference No:** SG 35/13

| | | | |
|---|---|---|---|
| **Title:** | **Observations within Mental Health Services Inpatient Units** | | |
| **Author(s)** | Cahal McKervey, Operations Manager, Acute Mental Health Services<br>Tel: [redacted], [redacted]<br>Paul McCabe, Senior Nurse Manager<br>Tel: [redacted], [redacted]<br>Patricia Minnis, Quality and Information Manager<br>Tel: [redacted], [redacted] | | |
| **Ownership:** | Aidan Dawson, Director, Specialist Hospitals and Women's Services (currently includes Mental Health Services) | | |
| **Approval by:** | Mental Health Governance<br>Standards and Guidelines Commitee<br>Trust Policy Committee<br>Executive Team Meeting | **Approval date:** | 23/10/2019<br>11/12/2019<br>06/02/2020<br>12/02/2020 |
| **Operational Date:** | February 2020 | **Next Review:** | February 2025 |
| **Version No.** | 3 | **Supercedes** | V2 – June 2016 – June 2019 |
| **Key words:** | General, continuous, observations, arm's, eyesight, risk | | |
| **Links to other policies** | • Regional Guideline on the use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland<br>• Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;<br>• BHSCT Procedure for the Search of Patients, their Belongings and the Environment of Care with Adult Mental Health and Learning Disability Inpatient facilities (excluding CAMHS & Iveagh) (2016) SG 34/16<br>• The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;<br>• Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;<br>• BHSCT Adult Safeguarding policy and procedure (2019) SG 20/19<br>• BHSCT Named Nurse Policy (2015) SG 08/15<br>• UNOCINI Guidance;<br>• BHSCT Admission and Discharge Policy - Learning Disability Services SG 31/16 | | |

| | |
|---|---|
| | - BHSCT Absent Without Leave Procedure (AWOL) - Adult MHLD (2016) SG 37/13 |

| Date | Version | Author | Comments |
|---|---|---|---|
| 09/08 | 0.1 | T McNeany | Circulated to all Adult Mental Health Inpatient Wards |
| 20/12/2012 | 0.2 | P Minnis | Reviewed |
| 10/01/2013 | 0.2 | P Minnis | Sent out for Consultation |
| 10/01/2013 | 0.3 | P Minnis | Comments received - updated |
| 09/04/2013 | 0.3 | P Minnis | Approved by Mental Health Governance Committee |
| 09/05/2013 | 0.3 | P Minnis | Circulated to all Adult Mental Health Inpatient Wards |
| 2016 | 1.1 | Cahal McKervey | Review |
| 16/02/2016 | 1.1 | Cahal McKervey | Sent out for comment |
| 28/04/2016 | 1.1 | Cahal McKervey | Approved by MH Governance |
| 04/04/2019 | 2.1 | P Minnis<br>P McCabe<br>J Killough | Review of V2.0 and updated following meeting |
| 04/06/2019 | 2.1 | P Minnis | Sent out for consultation; no comments received |
| 23/10/2019 | 2.1 | MH Governance Committee | Approved |

## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

Belfast Health and Social Care Trust Mental Health Services seeks to promote and maintain a caring and safe environment for patients admitted into any of its mental health inpatient facilities. Every patient receiving care within a mental health inpatient facility will be observed as a necessary part of their care. This is principally a task which falls to nursing staff following a joint nursing and medical assessment.

### 1.2 Purpose

This policy has been developed to supersede any previous observation policies and to ensure a standardised approach across all its mental health facilities as outlined in the Regional Guideline on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011.
This policy provides staff with guidance regarding the levels of observations and the decision making process to implement or adjust same.

### 1.3 Objectives

This policy aims to provide staff working within a psychiatric inpatient facility with a structured and standardised framework for delivering care to patients across the spectrum of inpatient facilities within the Trust.

This policy ensures the Trust’s compliance with mandatory requirements arising from the following: -

- The Report of the inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006;
- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007;
- The Report of the Inquiry Panel (O’Neill) to the Eastern Health and Social Services Board 2008;
- Mental Health (NI) Order 1986

This policy should be read in conjunction with the following: -

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Search Policy;
- The Admission of a Young Person into an Acute Adult Psychiatric Admission Ward;
- Regional Guidelines on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland, Health and Social Care Board and Public Health Agency, October 2011;

- The Belfast Health and Social Care Trust Safeguarding Vulnerable Adults Policy;
- The Belfast Health and Social Care Trust Named Nurse Policy;
- UNOCINI Guidance;
- The Belfast Health and Social Care Trust Mental Health and Learning Disability Services Admission and Discharge Policy;
- Adult Mental Health and Learning Disability Services Absent Without Leave (AWOL) Procedure

## 2.0 SCOPE OF THE POLICY

This policy applies to all patients, voluntary and detained, admitted to and discharged from an adult psychiatric inpatient facility. This operational policy provides staff working within a psychiatric inpatient unit with a structured and standardised framework for delivering care to service users and their carers across the spectrum of inpatient facilities within the Trust.

## 3.0 ROLES/RESPONSIBILITIES

All staff working within the mental health inpatient facility have a responsible role to play in achieving the policy objectives.

There are specific roles and responsibilities outlined in the Policy for: -

### 3.1 Nurse in Charge:

The Nurse in Charge will: -

- Ensure the safety and wellbeing of all patients and staff within the inpatient facility;
- Agree the level of observation for patients in conjunction with the medical and nursing staff;
- Satisfy him/herself that they are aware of the location of all the patients, both on or off ward, and be aware of their mental and physical state;
- Allocate an observing nurse to each patient on continuous observations, ensuring that they are competent, have the appropriate experience and training e.g. communication/engagement skills, brief intervention training and management of aggression and have an understanding of the patient’s care plan;
- Allocate one member of staff to make visual checks of every patient on the ward on no less than an hourly basis throughout the shift;
- Remain accountable for delegation of observation duties;
- Ensure that a nurse is allocated to each patient for each shift regardless of their observation status to monitor their mental state and implement the patient’s care plan;
- Ensure that nursing staff meet with their allocated patients during the shift;

- Address any concerns raised by a staff member or family regarding the levels of observation a patient is on;
- Ensure as far as possible that no member of staff remains on continuous observation duties for more than two hours consecutively;
- Initiate the Record of Continuous Observation form (App 3) for any patient being placed on continuous observation;
- In the event of a patient going AWOL, implement the AWOL Policy;
- In the case a patient is being taken off continuous observation complete the Record of Continuous Observation form and the Continuous Observation Prescription Form (App 1) in conjunction with the Consultant Psychiatrist or their nominated deputy.

### 3.2 Consultant Psychiatrist or nominated deputy (this role will be undertaken by the Duty Doctor during the evening, weekends and bank holidays)

The Consultant Psychiatrist or their nominated deputy will: -

- In conjunction with the Nurse in Charge agree the level of observation required for patients;
- Ensure that patients placed on continuous observation are reviewed daily by his/herself or their named deputy;
- In the event of a patient being taken off continuous observation complete the Continuous Observation Prescription Form in conjunction with the Nurse in Charge.

### 3.3 Observing staff

- The Nurse in Charge will allocate one member of staff to make visual checks on every patient in the ward on no less than an hourly basis and record same. This member of staff will report any changes in patients' mental state or their lack of presence in the ward to the Nurse in Charge;
- All staff observing a patient on a continuous basis have a responsibility to ensure they have the appropriate knowledge, skills and experience to safely perform this task including management of aggression training and communication/engagement skills, brief intervention training and management of aggression
- They must ensure they are aware of the rationale behind the level of observation and have an understanding of patient's care plan;
- The observing staff member will record the nature and purpose of the continuous observation on the Continuous Observation Record form (APP 2);
- The role of the observing staff member for patients on continuous observation does **not** replace the role of the named nurse who is responsible for observing the patient's health, well being and behaviour;
- Where a patient is on continuous observation the observing nurse will support the named nurse in assessing the patient's risk and mental state and in engaging the patient;
- Positive engagement with the patient is an essential aspect of constant observation.

- Whilst taking account of the patient's wishes, staff should try to interact with the patient as much as possible, be this through assisting them with activities of daily living, social interaction or other activities on or off the ward dependent on the level of risk. In doing so staff should ask the patient about past beneficial interventions or things they feel might prove beneficial (please see a list of possible activities – this list is not exhaustive).

### 3.4 On-ward activities:

- **Activities of daily living** – assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate write letters, make telephone calls.
- **Social interaction** – respect a patient's right for silence. If a patient wishes to talk don't only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the patient may be due to a staff member's personal difficulty with silence.
- **Clinical interaction** – a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the patient to have some guidance in working through it.
- Respect a patient's wishes within safety boundaries, and the level of observation. Open the door if the patient's mental state is deteriorating as a consequence of close proximity and observation.
- **On-ward occupational therapy** to assist patients in engaging in activities during the time of an acute onset.

### 3.5 Off-ward activities:

- Engage in occupational therapy/other therapeutic opportunities
- Walks around grounds (assuming risk allows)

### 3.6 Named Nurse (in their absence a nurse will be allocated to the patient)

- The role of the observing staff member does **not** replace the role of the named nurse.
- A patient will be allocated a nurse during each shift. This nurse will be responsible for observing the patient's health, well being and behaviour. A record of this assessment will be made in the patient's notes and where necessary the patient's care plan will be modified;
- Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give patients a chance to discuss concerns and frustrations.
- All nurses should be aware of the general whereabouts of each patient in their charge, whether on or off the ward.

### 3.7 Multidisciplinary Team

If any member of the multidisciplinary team has any concerns about the levels of observation a patient is receiving these must be reported immediately to the Nurse in Charge of the inpatient facility. These discussions should then be discussed with the multidisciplinary team or if deemed urgent the Consultant Psychiatrist or their deputy.

If there is disagreement between individuals regarding the patient’s level of observation this must be brought to the attention of the individuals’ line managers. Staff should always choose the safest option for the patients and staff.

## 4.0 KEY POLICY PRINCIPLES

### 4.1 Levels of Observation

Observation should be used as an opportunity to assess and engage the patient, developing a therapeutic relationship. The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland recognises two levels of observation (these can apply to both voluntary and detained patients): -

- **General Observation** – this is the minimum level of observation for all patients. This level of observation is suitable for patients assessed as presenting a low to medium risk of deliberately harming themselves or others. A member of staff will check the exact location of each patient on general observation at least every hour and record same in their notes. All nurses should be aware of the exact location of all patients under their charge;
- **Continuous Observation** – continuous observation should be constant where a patient is assessed as presenting a high risk of deliberately harming themselves or others. Any patient nursed on continuous observation should be provided with a written information sheet, detailing the nature and purpose of continuous observation (App 4). Their level of observation should be recorded on a Continuous Observation Prescription form and in their notes. A record of their care and any issues relevant to risks should be recorded on the Continuous Observation Record sheet on an hourly basis by the observing member of staff. There are two categories of continuous observation: -
  - Within eyesight: the patient should be kept within eyesight and accompanied at all times day and night;
  - Within arm’s length: the patient should be constantly supervised in close proximity. Additional staff member(s) may be required especially in instances where the patient presents with a history of violence. Consideration may be given to changing levels of observation during patient visits, at night or whenever the patient is in the bathroom however this must be recorded on the continuous observation prescription sheet.

Due to the restrictive nature of continuous observation the patient should remain on same for the shortest time possible. Any change to the levels of continuous observation must be stated in the Continuous Observation Prescription sheet (this will include the reasons for doing so) and signed by the staff members making that decision. The decision will also be recorded in the patient's notes.

## 4.2 Implementing Observation Levels

All patients will receive a joint medical and nursing mental state and risk assessment (on a Risk Screening Tool or Comprehensive Risk Assessment as per Trust protocol) on their admission to hospital. The results of which will determine the level of observation to be implemented. Any decisions taken regarding the level of observation should where possible involve the patient and if appropriate their carer/next of kin. It must be recognised that all relevant information may not be available at the point of admission. Levels of observation should therefore be continuously reviewed in light of any new information and/or occurrences and changes made where appropriate.

## 4.3 Reviewing Observation Level

All observation levels should be continuously reviewed to ensure that the patient receives the least restrictive care needed to maintain their and others' safety. Decisions to increase the level of observation should be taken by the Consultant Psychiatrist or named deputy and the Nurse in Charge – ideally this should be done in conjunction with the patient and if appropriate their next of kin/carer. However in cases of emergency a higher level of observation can be implemented by any member of the multidisciplinary team if an increased risk is suspected.

Where a patient is on continuous observation, the levels of observation should be reviewed by both the Consultant Psychiatrist or named deputy and the Nurse in Charge at least every day and if appropriate decreased. The patient and if appropriate their carer/next of kin should be included in this decision making.

Observation levels must be reviewed at each multidisciplinary team review and any decisions taken to include the patient and if appropriate their carer/next of kin where possible.

Any changes to a patient's level of observation should include the reason for the change in observation and describe the change in risk to warrant the change. Staff should document this in the patient's notes and if applicable in the Continuous Observation Prescription Form.

Staff should always choose the safest option for both the patient and others

## 4.4 Emergencies

In the event of an emergency e.g. fire or assault, the observing nurse must remain with the patient.
Alarms should be activated immediately and the Nurse in Charge advised of the emergency so staff can be organised as appropriate. In cases where the emergency involves the observing nurse being assaulted by the patient, the nurse

in question should be debriefed and offered time off the ward. The Nurse in Charge should allocate another member of staff to continue the observation.
In the event of a fire, the observing nurse should evacuate the patient from the area of the fire as outlined in the Trust Fire Safety Policy and remain with them at all times.

### 4.5 Delegation to Non-Registered Staff

Unregistered staff can be allocated to undertake continuous observations. The Nurse in Charge will remain accountable for the delegation of observing staff ensuring they are sufficiently competent to undertake the role. Unregistered staff can complete the continuous observation recording sheet however this must be countersigned by a registered member of staff.
With the exception of Open University students, only 3rd year management nursing students undertake observations; again this should be under the supervision of a registered nurse.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 Dissemination

This policy will be disseminated to all staff working within a mental health inpatient facility.

### 5.2 Resources

Nil

### 5.3 Exceptions

This policy applies to all mental health in-patient facilities

## 6.0 MONITORING

An audit of the policy implementation will be carried out on an annual basis.

## 7.0 EVIDENCE BASE / REFERENCES

- The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007.
- The Report of the Inquiry Panel (O’Neill) to the Eastern Health and Social Services Board 2008.
- The Report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006
- The Mental Health (Northern Ireland) Order 1986.
- The Code of Practice Mental Health (Northern Ireland) Order 1986.

- Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010
- The Human Rights Act 1998.
- The Northern Ireland Act 1998 (Section 75 Equality Considerations)
- In-patient psychiatric care for young people with severe mental illness (Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists) Council Report CR106 June 2003 Royal College of Psychiatrists.
- Children (NI) Order 1995-The Regional Child Protection Policy and Procedures (ACPC 2005)
- The Data Protection Act 1998
- National Institute for Clinical Excellence. Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report June 2011, DHSSPSNI, 2011.
- Central Nursing Advisory Committee (CNAC) Operational Framework for Delegation Decision Making, September 2009
- The Regional Guideline on the Use of Observations and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities within Northern Ireland, HSCB and PHA, November 2011.
- Scottish Executive – Engaging people: Observation of people with acute mental health problems, 2002

## 8.0 CONSULTATION PROCESS

## 9.0 APPENDICES / ATTACHMENTS

Appendix 1: Continuous Observation Prescription Form
Appendix 2: Continuous Observation Record Sheet
Appendix 3: Record of Continuous Observation
Appendix 4: Patient Information Leaflet

## 10.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.

The outcome of the Equality screening for this policy is:

**Major impact** ☐

**Minor impact** ☐

**No impact** ☒

## 11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

**Not necessary – no personal data involved** ☐

**A full data protection impact assessment is required** ☐

**A full data protection impact assessment is not required** ☒

**If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.**

## 12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

## 13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

Paul McCabe

12/02/2020

________________________________ **Date:** ________________________

**Authors**

12/02/2020

________________________________ **Date:** ________________________

**Director**

**Appendix 1**

# Continuous Observation Prescription Form

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name: | | DOB: | | | Consultant: | | |
| Please respond to all statements below | | Yes | No | Sign/Date | Update Sign/Date | Update Sign/Date | Update Sign/Date |
| Patient to be within eyesight | | | | | | | |
| Patient to be at arm's length | | | | | | | |
| Observation when using bathroom | Eyesight | | | | | | |
| | Arm's Length | | | | | | |

Date plan commenced: Time:

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

Patient: ______________________ Signature:
Print Name

Summary of risk factors relating to observation plan:

Rational for observation level:

Known triggers/changes in behaviour which would increase risk:

What would be the rational for reducing observation levels (e.g. visitors, asleep)?

Cessation of Continuous Observation

Rational for decision

Medical staff ______________________ Signature:
Print Name

Nursing staff ______________________ Signature:
Print Name

**Appendix 2**

# Continuous Observation Recording Sheet

| | | |
|---|---|---|
| **Patient Name** | **DOB** | **Hospital No** |
| **Ward:** | **Named Nurse:** | **Consultant:** |
| **Date:** | | |

| Time | Sign & Date | Print Name | Comments |
|---|---|---|---|
| **0800 - 0900** | | | |
| **0900 - 1000** | | | |
| **1000 - 1100** | | | |
| **1100 - 1200** | | | |
| **1200 - 1300** | | | |
| **1300 - 1400** | | | |
| **1400 - 1500** | | | |
| **1500 - 1600** | | | |
| **1600 - 1700** | | | |
| **1700 - 1800** | | | |

| | | | |
|---|---|---|---|
| **1800 - 1900** | | | |
| **1900 - 2000** | | | |
| **2000 - 2100** | | | |
| **2100 - 2200** | | | |
| **2200 - 2300** | | | |
| **2300 - 0000** | | | |
| **0000 - 0100** | | | |
| **0100 - 0200** | | | |
| **0200 - 0300** | | | |
| **0300 - 0400** | | | |
| **0400 - 0500** | | | |
| **0500 - 0600** | | | |
| **0600 - 0700** | | | |
| **0700 - 0800** | | | |

***Please note – where observations are undertaken by an unregistered member of staff or student nurse, this record should be countersigned by a registered nurse/Nurse in Charge***

**Appendix 3**

# Record of Continuous Observation

- The Nurse in Charge must complete this record for every patient commenced on continuous observation
- This form must be completed even if no additional staff were required
- When continuous observation ceases, this form must be signed and forwarded to the nursing services manager, who will arrange for the details to be recorded

| **Patient Details** | | | |
|---|---|---|---|
| Patient's Name: | | Ward: | |
| DOB: | | Consultant: | |

**Staffing**

Number of staff currently on ward: ________

Number of patients on continuous observation: ________

Number of additional staff required on ward: ________

| | |
|---|---|
| Date Commenced: | Time Commenced: |
| Date Finished: | Time Finished: |

Duration of continuous observation (Number of Days)

Signed: ________________________ Designation of Nurse________________

Print Name: _________________________

**Appendix 4**

# Information for Patient/Carer

## Continuous Observation

### INFORMATION FACT SHEET FOR PATIENTS

Your nurse and doctor will have discussed the reasons why they feel you need continuous observation at this particular time and hope you will be in agreement with this decision.

The ward staff are concerned about you at the moment and we want to make sure you are safe.

We will treat you with dignity and respect at all times and involve you in all decisions regarding your care.

During continuous observation a member of the nursing team will observe you and will be there to work with you and involve you in activities that you feel able to participate in at present.

All patients are treated individually and your nurse will discuss your care plan with you.

The nursing team will work with you to help you with any concerns and to keep the time on continuous observation to an absolute minimum.

We would ask you to remain in the unit at present to assist with assessment of your needs and plan how you can make progress.

Your progress will be discussed with you every day, offering you the opportunity to have a say in your own care and to determine the length of time spent on special observation.

We appreciate that this is a very difficult time for you and your family/carer, but hope this time will assist and offer the opportunity to discuss and find solutions to some of your concerns.

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

# Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings

# And

# Regional Operational Procedure for the Use of Seclusion

## Consultation Document

## Introduction

1. We would welcome your views on the draft Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.

## Background

2. In August 2005, the Human Rights Working Group on Restraint and Seclusion issued *Guidance on Restraint and Seclusion in Health and Personal Social Services*. The working group was commissioned by the then Department of Health, Social Services and Public Safety (DHSSPS) and the guidance was issued by the DHSSPS.

3. In the period since this guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020, the Department committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion and a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5). The draft regional policy is the conclusion of this work.

## Purpose

4. The draft policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on minimising the use of restrictive practices and provide clear guidance to ensure best practice when used.

5. The draft policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions in the UK and across the world. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This policy will play a

key role in protecting people, by reducing the risk of misuse and the potential over-reliance on restrictive practices.

6. The use of restrictive interventions, restraint or seclusion may be necessary on occasions, for example, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as a last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others. Nevertheless, some of those who have been involved with or subject to seclusion, restraint and/or restrictive interventions, recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.

7. The draft policy document sets out the standards required for: minimising the use of restrictive interventions, restraint and seclusion; and decision making, reporting and governance arrangements for the use of any restrictive practice.

**Co-production**

8. The draft policy has been developed using co-production principles and has included involvement from service users, carers, people with lived experience, professionals, academics, providers of services and policy officials.

**Funding of the Policy**

9. It is anticipated that the draft policy can be delivered within existing funding, as the policy represents current best practice and compatibility with statutory requirements. There may be some training need – for which there are funds available.

**Implementation of the Policy**

10. Across the statutory sector, implementation of the draft policy will be led by the HSC Board and HSC Trusts. In the independent and community and voluntary sectors, it will be for each organisation to consider what, if any,

implementation work will be required. The draft policy includes governance structures which will aid implementation.

## Impact assessments

11. A number of impact assessment screenings have been completed, and the outcome of these is available in Annex A to this document. A full Equality Impact Assessment has also been carried out. The EQIA and screening documents are available as part of the suite of consultation documents.

## How to Respond

12. We are seeking views on the draft regional policy, and invite written responses by no later than 1 October 2021.

13. In addition to this, we are also inviting written responses to the EQIA by no later than 1 October 2021.

14. Responses can be provided through email or hard copy to:
Department of Health
Adult Mental Health Unit
Room D4.26
Castle Buildings
Stormont
Belfast
BT4 3SQ
mentalhealthunit@health-ni.gov.uk

15. The full set of consultation questions are provided in Annex B to this consultation document.

16. When you reply, it would be helpful if you would confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:
    - Your name;

- The name of your organisation; and
- An e-mail address.

17. If you have any queries, or wish to request a copy of the draft regional policy in an alternate format, please contact the Department using the following email address:
mentalhealthunit@health-ni.gov.uk.

**Privacy, Confidentiality and Access to Consultation Responses**

18. For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity will be published. We will remove email addresses and telephone numbers from these responses; but apart from this, we will publish them in full. For more information about what we do with personal data please see our consultation privacy notice .

19. Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR) (EU) 2016/679.

20. If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why you regard the information you have provided as confidential, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

21. For further information on how we will process data and your rights, see our Privacy Notice in Annex C of this document.

## What Happens Next

22. Following the close of the consultation, all responses and feedback will be collated for review by the Department of Health, and a consultation report will be produced. The consultation report will be published alongside the final Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.

## ANNEX A: IMPACT SCREENING OUTCOMES

Full impact assessment and screening documents are available as part of the suite of consultation documents, and can be accessed via the following link:

A summary of the outcome of each is provided in the table below:

| Impact Assessment Screening | Outcome |
|---|---|
| Equality/Human Rights | Significant positive impact – full Equality Impact Assessment Completed |
| Regulatory | No significant impact identified – full impact assessment not required |
| Rural | No significant impact identified – full impact assessment not required |
| Children's Rights | No significant impact identified – full impact assessment not required |

## ANNEX B: CONSULTATION QUESTIONS

*A word version of the consultation response questions is available on Department's website:*

| | | |
|---|---|---|
| **Personal details** | | |
| Name | | |
| Email address | | |
| Are you responding on behalf of an organisation? | | Yes/No<br>*(delete as applicable)* |
| Organisation<br>*(if applicable)* | | |
| | | |
| **Questions** | | |
| Do you agree with the Regional Policy? – yes / no | | |
| Do you have any comments: | | |
| Do you agree with the screenings and Equality Impact Assessment? – yes / no | | |
| Do you have any comments: | | |

## ANNEX C: PUBLIC CONSULTATION PRIVACY NOTICE

Data Controller Name: Department of Health (DoH)
Address: Castle Buildings, Stormont, BELFAST, BT4 3SG
Email: MentalHealthUnit@health-ni.gov.uk
Telephone: 02890523311

Data Protection Officer Name: Charlene McQuillan
Telephone: 02890522353
Email: DPO@health-ni.gov.uk

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) and the UK General Data Protection Regulation (GDPR). The Department of Health (DoH) is committed to building trust and confidence in our ability to process your personal information and protect your privacy.

### Purpose for processing

The Department of Health has developed a draft Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion which is published for public consultation. We are encouraging organisations and institutions to respond but also people with lived experience and carers. We will process personal data provided in response to consultations for the purpose of informing the policy. We will publish a summary of the consultation responses and, in some cases, the responses themselves but these will not contain any personal data. We will not publish the names or contact details of respondents, but will include the names of organisations responding.

For the purpose of this consultation the only data we will process is provided by the individual when they respond to the consultation, as follows:

- Name
- Email address
- Name of organisation (if responding on behalf of an organisation)

### Lawful basis for processing

The lawful basis we are relying on to process your personal data is Article 6(1)(e) of the GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department.

### How will your information be used and shared

We process the information internally for the above stated purpose. We don't intend to share your personal data with any third party. Any specific requests from a third party for us to share your personal data with them will be dealt with in accordance the provisions of the data protection laws.

### How long will we keep your information

We will retain consultation response information until our work on the subject matter of the consultation is complete, and in line with the Department's approved Retention and Disposal Schedule Good Management, Good Records (GMGR).

### What are your rights?

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- **You have the right to** object to the processing**,** in specific circumstances
- **You have rights in relation to** automated decision making and profiling.

### How to complain if you are not happy with how we process your personal information

If you wish to request access, object or raise a complaint about how we have handled your data, you can contact our Data Protection Officer using the details above.

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire  SK9 5AF
casework@ico.org.uk

# Definitions

*The intention is to have an overarching definition for restrictive practices that describes the range of restrictive interventions from locked cupboards through to seclusion. This will assist staff in being able to accurately identify if any intervention is potentially restrictive and therefore fall under the requirements of the regional policy.*

## Over Arching Definition - Restrictive Practices

*Restrictive practices are those that limit a person's movement, day to day activity or function*

*The following definitions will then fall under the umbrella restrictive practice definition providing further clarity*

## Restrictive Interventions

### Environmental intervention

*The use of obstacles, barriers or locks to prevent a person from moving around freely.*

### Psychological intervention

*Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do, without physically intervening. It includes the use of threats and coercion.*

### Coercion

*Any action or practice undertaken which is inconsistent with the wishes of the person in question (i.e. undertaken without the persons informed consent)*

## Restraint

### Physical Restraint

*Any direct physical contact where the interveners intention is to prevent, restrict, subdue movement of the body, or part of the body, of another person.*

### Mechanical Restraint

*The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.*

Chemical Restraint

*The use of medication which is prescribed and administered for the purpose of controlling or subduing behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.*

Rapid Tranquilisation

*Use of medication by the parental route (usually intermuscular or exceptionally, interventions) if oral medication is not possible or appropriate and urgent sedation with medication is needed.*

Clinical Holding

*The use of physical holds to assist or support a patient to receive clinical care and treatment*

**Seclusion**

*The confinement of a person, alone in a room or area from which free exit is prevented.*

# DoH Restraint and Seclusion Policy Definitions – BHSCT Feedback

| Area | Staff Member | Feedback |
|---|---|---|
| BHSCT Hotel & Support Services -Security | Mandy Magee | The definitions are acceptable from a Security perspective. We are pleased to see a separate definition for Clinical Holding from physical restraint. |
| Management of Aggression Team | Neill Walsh | The course we deliver on Clinical Holding is specific about ''essential care and treatment for those who lack capacity''<br>The definition can be expanded somewhat to include those who lack capacity if you wish to include. However the Restraint Reduction Network (2019) (RRN) cite this as 'clinical or personal care':<br>Below I have included definition from RRN 2019<br>2.8.4 restricting someone's movement for clinical or personal care purposes is a form of physical restraint and should be recorded as such. This is sometimes referred to as clinical holding (RRN, 2019)<br>Please note a missing word in rapid tranquilisation reference highlighted in red:<br>''Rapid Tranquilisation is the use of medication by the parental route (usually intramuscular or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'' |
| Management of Aggression Team | Anne Brannigan | The definition for clinical holding on the attached is, 'Clinical Holding - *The use of physical holds to assist or support a patient to receive clinical care and treatment'* . This is not complete and should include essential treatment & care for those who lack capacity |
| Learning Disability Services (Day Centres and Residential & Supported Living) | Aisling Curran | I notice there is no reference to voluntary confinement which operates in Muckamore – I also think the definitions should be perhaps clearer – e.g. in the Trust policy re seclusion it states that seclusion can only occur In a room specifically designated as a seclusion room, whereas the DOH document it is simply a "*The confinement of a person, alone in a room or area from which free exit is prevented"* – which in essence could be any room which is locked. |
| Surgery & Specialist Services | Michelle Lawson | No comment from services |
| Mental Health Services | Louise Moore | **Seclusion**<br>*The confinement of a person, alone in a room or area from which free exit is prevented.* |

| | | |
|---|---|---|
| | | Is there something missing from this definition regarding segregation from peers?, for example patient may have two supervising staff present … so they are not *"alone",* however the two staff may be preventing exit rather than a locked door .. therefore the person is " *confined"*<br>I think we need clarity on this to avoid the potential for de-escalation suites becoming de-facto seclusion without safeguards |
| Older People Services | Fiona McKinney | I have reviewed the definitions and feel they cover all aspects on restrictive practices |
| Iveagh Centre | Michael McBride | **Restraint**<br>Physical Restraint<br>*Any direct physical contact where the interveners intention is to limit the range of movement of the body, or part of the body, of another person, where that movement is presents a risk of immediate or imminent harm to the person or others*<br><br>*Seclusion*<br>*Breakout into*<br>*Long-term segregation*<br>*Voluntary confinement*<br>*Confinement*<br>*Left on their own*<br><br>Suggest lifting definitions from Royal College of Psychiatry – use published definitions. |

Belfast Health and Social Care Trust
caring supporting improving together

**Policy Code:** BHSCT/PtCtCare (06) 2021

| | | | | |
|---|---|---|---|---|
| **Title:** | **Restrictive Practices Policy for Adults and Children** | | | |
| **Policy Author(s)** | Neil Walsh, Advisor/Trainer on Management of Aggression<br>Tel: [redacted] [redacted]<br>Samuel Warren, Advisor/Trainer on Management of Aggression<br>Tel: [redacted] [redacted] | | | |
| **Responsible Director:** | Jacqui Kennedy, Human Resources and Organizational Development Director | | | |
| **Policy Type: (tick as appropriate)** | *Directorate Specific ☐ | Clinical Trust Wide ☒ | Non Clinical Trust Wide ☐ | |
| If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved** | | | | |
| | | | | |
| **Approval process:** | Standards and Guidelines Committee<br>Executive Team Meeting | **Approval date:** | 01/02/2022<br>09/02/2022 | |
| **Operational Date:** | February 2022 | **Review Date:** | February 2023 | |
| **Version No.** | 4 | **Supercedes** | V3.1 – May 2015 – October 2020 | |
| **Key Words:** | Restrictive Practices, Restrictive Intervention | | | |
| **Links to other policies** | BHSCT Being open policy – Saying sorry when things go wrong (2020) TP 80/11<br>BHSCT Your right to raise a concern (whistleblowing) policy (2018) TP 22/08<br>BHSCT A zero tolerance approach to the prevention and management of aggression and violence towards staff in the workplace (2019) TP 02/08<br>BHSCT Policy and procedure for the management of comments, concerns, complaints and compliments (2020) TP 45/08<br>BHSCT Policy to be followed when obtaining consent for examination, treatment or care in adults or children (2015) SG 27/13<br>BHSCT Rapid tranquillisation guideline for the immediate pharmacological management of violent and aggressive behaviour in adults, children and young people in inpatient units (2017) SG 44/12<br>BHSCT Procedure for reporting and managing adverse incidents (2018) TP 94/14<br>BHSCT Risk management strategy 2020 – 2021 TP 58/08<br>BHSCT Adult safeguarding policy and procedure 2020 (SG 20/19) | | | |

| | |
|---|---|
| | Assurance Framework – Sub-Committee Structure 2018<br>BHSCT Core child protection regional policy and procedures (2017)<br>SG 38/17 |

## CONTENTS

**** POLICY DISCLAIMER**
Throughout the policy those known to the Trust as; clients, individuals, patients, residents etc. will be referred to as service user (s)

## 1.0 INTRODUCTION

The Belfast Health and Social Care Trust acknowledge that restrictive practices take place and is committed to reducing restrictive practices and applying least restrictive principles to all aspects of the Trusts service delivery. The use of restrictive practices is based on the philosophy of Eliminate, Minimise, and Make Safe. The ideal is to deliver services and supports which are free from restrictive practices. However, if restrictive practices are necessary to maintain the safety of the service user, staff or members of the public, each service area should ensure that there are robust legal grounds for the restriction, it is reviewed regularly and a person centred approach is adopted when considering the treatment of each individual. When restrictive practices are used they are as a last resort when all other less restrictive measures have been exhausted and applied in a manner that ensures privacy and dignity.

- Restrictive practices are those that limit a person’s movement, day to day activity or function. (RCN, 2017)

This can also be viewed as depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do, without physically intervening. It includes the use of threats and coercion. (Restraint Reduction Network, 2019)

- Restrictive interventions are a specific subset of restrictive practices. They are deliberate acts on the part of other person (s) that restrict a person’s movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken and end or reduce significantly the danger to the service user or others. (DOH, 2014)

## 2.0 SCOPE OF THE POLICY

The Belfast Health and Social Care Trust is committed to delivering the highest standards of care in conjunction with the Trust Values: Excellence, Openness & Honesty, Compassion and Working Together.

The Trust as a statutory responsibility to safeguard the welfare of children, young people and adults in need of protection, including members of staff.

This policy includes definitions, the Trusts objectives and duties/responsibilities of key staff.

This policy sets out the overarching framework for the use of restrictive practices within the Trusts services.

This policy includes details of legislative framework and guiding principles within which all staff should work.

This policy is supported by subordinate policies and protocols that provides further detail and guidance on safe, lawful and legitimate use of specific forms of restrictive interventions.

The Trust considers that the management of behaviours that challenge is a process requiring openness & honesty, compassion, dignity & respect for the rights of the service user, acting in their best interests and balanced against the risk of harm to themselves, staff and members of the public.

The Trust considers that restrictive interventions should be reasonable and proportionate to the risk presented, least restrictive for the least amount of time and used as a last resort.

The Trust recognises that a service user's behaviour can escalate to the point where restrictive interventions may be needed to protect the service user, staff or other users of the Trust from significant injury or harm, even if all best practice to prevent such escalation is deployed.

### 2.1 Types of Restrictive Interventions and/or Practices

Environmental Intervention:

The use of obstacles, barriers or locks to prevent a person from moving around freely.

Psychological intervention:

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion:

The practice of persuading someone to do something by using force or threats.

Observation:

A minimally restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Physical Restraint:

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body of another person.

Clinical Holding:

The use of physical holds to assist or support a person who lacks capacity to consent to receive clinical or personal care or treatment.

Chemical restraint:

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Mechanical restraint:

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Seclusion:

The confinement of a person in a room or area from which free exit is prevented.

*Refer to Appendices 1 for 'Procedural and further guidance on Restrictive Interventions'*

## 2.2 Three Steps to Positive Practice Framework

All areas of the organisation that are required to use restrictive interventions must embed the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions.

The *Three Steps to Positive Practice* are designed to encourage careful consideration and reflection on the use of any potentially restrictive practice, before it is implemented, and throughout the entire timeline when the restrictive practice may be used. It is applicable at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment.

The three steps are intended to assist staff to ensure that the decision they make and the actions they take are consistent with legal, ethical and professional accountability frameworks, every time a decision is made or an action is taken. (RCN, 2017)

*Refer to Appendices 3 for link to 'The RCN Three Steps to Positive Practice Framework'*

## 2.3 Proactive and Preventative Strategies

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings highlights the need that all local organisational policies must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that a support a better quality of life.

The use of positive and proactive interventions will support the development of a therapeutic relationship between staff and those that they care for. The benefit of an established therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

### 2.3.1 Communication

Effective and person centred communication is key in supporting a person and their family to be part of their care and treatment.

These five key themes must be evident in practice:

- Transparency
- Trust and Relationship building
- Compassion, dignity and respect
- Supporting and managing expectations
- Consistency in communication

A partnership approach to care and wellbeing is essential. Underpinning a rights based approach and developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected.

Where required, staff should have access to appropriate communication support tools and must be appropriately trained to empower and support the people that they work with to communicate effectively.

*Refer to Appendix 2 ‘Methods of Reducing Restrictive Interventions’*

## 3.0 ROLES AND RESPONSIBILITIES

### 3.1 Trust Board

The Trust board is responsible for ensuring that a policy is in place that governs the safe use of restrictive interventions via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

### 3.2 The Chief Executive

Has overall responsibility and accountability for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust and is responsible for the following:

- Fostering a framework within which the Trust can develop a culture and ways of working that focuses on restraint reduction and will reduce the need for restrictive interventions. When restrictive interventions are used it will be in the least restrictive way for the minimum amount of time and as a last resort.

- Appointing a senior manager at director level to take the lead responsibility for restrictive intervention reduction programmes.

### 3.3 Director of Human Resources and Organisational Development

Has overall delegated responsibility for service user and staff safety with an emphasis on compassionate person centred care and treatment, and is responsible for the following:

- Ensuring that appropriate arrangements are in place to demonstrate the Trusts commitment to reducing the use of restrictive practices as detailed in the policy purpose. Leadership, Performance measurement, Learning and Development, Providing personalised support, Communication and Person-Centred Focus and Continuous improvement.
- Ensuring communication of The Restrictive Practices Policy and review where appropriate.
- Ensuring adequate arrangements are in place to meet training needs identified through the regional strategy.

### 3.4 Co-Director of Human Resources and Organisational Development

Supports the Human Resources and Organisational Development Director and has responsibility for the following:

- Assisting the Human Resources and Organisational Development Director in the communication and ongoing review of the Trust Restraint Reduction Framework, Policy on Restrictive Practices and associated structures.
- Managing the process of reporting and monitoring incidents involving the use of restrictive practices and ensuring that managers and relevant agencies are kept informed of any significant implications highlighted and shared learning.
- Alerting other senior managers to significant risk issues in relation to the use of restrictive practices.

### 3.5 Directors and Co-Directors

Are responsible for the following:

- Ensuring compliance with The Restrictive Practices Policy and associated strategies.

- Ensuring that the development or review of local procedures in relation to the use of restrictive practices within their directorate reflects the ethos of this policy.

- Ensuring that where the use of restrictive practices is reasonably foreseeable in their service area that their staff teams are equipped with the knowledge and skills to understand and prevent crisis behaviour, make evidence based decisions regarding the use of restrictive practices to facilitate clinical procedures, and provide staff training in the key competencies that supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Ensuring the use of restrictive practices within their service groups is appropriately recorded.

- Ensure that all incidents involving the use of restrictive practice are appropriately reported, investigated and monitored in line with the Trust's incident reporting procedure and that learning outcomes are implemented and shared across the Trust.

- Responsible for high level monitoring of incident patterns, to identify high-risk areas, and the subsequent development of relevant management strategies.

- Authorising and approving commissioned training in relation to restrictive practices and restrictive interventions which is provided by external / licenced providers.

### 3.6 Managers

- Managers of services (at all levels) will ensure that services are resourced appropriately and that their staff teams are able to access training, supervision and support to enable them to practice in a manner that complies with the relevant legislation and guidance.

- Managers will design staff structures to minimise restrictive practice by maintaining a consistent workforce with the right values, attitudes and skills and in the right numbers.

- Managers will ensure that all areas have regular forums and opportunities for service users, their families and advocates to contribute to the design, delivery and evaluation of services with specific reference to reducing the need for restrictive practices.

- Managers will ensure that post-incident reviews and debriefs take place so that lessons are learned from incidents occurring wherein restrictive practices have had to be used. This includes gathering the views of the service user and the experience of restraint or restriction placed on them, why this occurred and their understanding of the situation.

- Managers will ensure that all their employees are complying with this policy and that measures are in place to release staff for the appropriate training.

- Managers will ensure that data is collected for audit purposes.

- Managers will ensure that there are systems in place for appropriate reporting, recording and monitoring of safeguarding incidents involving adults, children or young people.

- Managers will ensure that their staff are offered the appropriate training for their area of work and assessments and training needs are completed for their type of work and working environments.

### 3.7 All Staff

- Have individual responsibility to ensure they work within the legal and ethical framework that pertains to their practice and interventions that would be defined as restrictive with a pro-active response to poor practice.

- Must ensure they comply with the Trust policy relating to restrictive practice and contribute to activities designed to support a reduction or elimination of restrictive practices.

- Must ensure they are competent within their role and within the setting in which they are employed in order to meet the needs of the service user being cared for.

- Must ensure that any gaps in knowledge, skills or practice in the area of restrictive practices and/or restrictive interventions are raised swiftly to their manager.

- Must ensure they attend the appropriate training in relation to this policy.

- Must take reasonable care of their own health and safety and that of others.

- Are responsible for risk assessing the wearing of personal protective equipment (PPE) in the use of restrictive interventions.

- Must ensure they report all incidences of restrictive practices and/or interventions.

### 3.8 Training associated with the use of Restrictive Interventions and/or Practices

Training must be identified using a ‘Training Needs Analysis’ for each service area.

An example can be found in the BHSCT Zero Tolerance Policy. Human Resources Learning and Development and be contacted for support.

Training in the use of restrictive interventions must be accredited and provided by a certified training organisation.

The philosophy, lessons and skills trained to staff must align with the BHSCT values, with a focus on proactive, preventative and evidence-based strategies. The training provided must be guided by BHSCT policies and procedures relating to restrictive practices and restrictive interventions, relevant legal and regulatory frameworks and professional standards for best practice.

*Refer to Appendices 5 for link to ‘Zero Tolerance Risk Assessment and Training Needs Analysis’*

## 4.0 CONSULTATION

During this policy review, the following groups were consulted: CAUSE, The Management of Aggression Team, The Trust Joint Health and Safety Committee, Trade Unions, Occupational Health, Consultant Psychiatry, Senior Managers in Emergency Department, Mental Health, Learning Disability Services, Pharmacy, Children’s services, Security and Peer Support, Restrictive Practices Task and Finish Group.

## 5.0 POLICY STATEMENT/IMPLEMENTATION

### 5.1 Dissemination

This policy applies to all services and their staff involved in caring for service users receiving treatment or care within the Trust.

Any concerns regarding the implementation of this policy should be addressed with your senior manager or further clarification can be sought from the author.

Training queries should be directed to the appropriate training provider.

### 5.2 Resources

This policy will be made available on the policies and guidelines page on the Trust intranet.

### 5.3 Exceptions

There will be no exceptions, as the policy will apply to all staff.

### 5.4 Implementation

It is the responsibility of the multidisciplinary team to ensure that the relevant assessments have been completed in areas where staff are expected to engage in any form of restrictive practice as defined within the policy. This must be done in conjunction with relevant legislation identified within this policy.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of the service user.

These assessments will require regular audit to determine their acceptability and efficiency.

### 5.5 Legal and Professional Issues Related to the Use of Restrictive Practices

#### 5.5.1 Principles

Belfast Trust is committed to delivering safe, high quality and compassionate services. Employees are expected to deliver services and behave in a manner that is compatible with this commitment. Belfast Trust expects all employees to treat others with dignity and respect whether it be service users, carers, visitors or colleagues.

Belfast Trust is committed to carrying out its functions in line with the core principles and values that underline human rights legislation namely Freedom, Respect, Equality, Dignity and Autonomy (FREDA). Staff should use FREDA principles to red flag any behaviour that is not compatible with the Trust ethos of delivering safe, quality and compassionate care or which violates our equality and human rights statutory commitments.

All employees will make every effort to ensure that human rights are protected, that respect for human rights, is part of day to day work and that human rights are an integral part of all actions and decision making. The Trust will keep human rights considerations, relevant legislation and previous judicial reviews at the core of decision-making.

#### 5.5.2 Human Rights Act 1998

In addition to anti-discrimination legislation Belfast Health and Social Care Trust employees have a duty to deliver services in a manner that meets our statutory equality, human rights and good relations duties. These duties include:

Section 75 of the NI Act 1998

- Promotion of Equality of Opportunity in relation to the nine equality categories.
- Promotion of Good Relations between persons of different religious belief; political opinion; and racial group.

Section 49A of the Disability Discrimination Act 1995

- Promotion of positive attitudes towards disabled persons.
- Encouraging the participation by disabled persons in public life.

Duty to respect, protect and fulfil rights outlined in the Human Rights Act 1998 including:

- Article 2 - the right to life.
- Article 3 - the right not to be tortured or inhumanly or degradingly treated or punished.
- Article 5 - the right to liberty and security of the person.
- Article 8 - the right to respect for one's private and family life, correspondence and home.
- Article 14 - protection from discrimination.
- United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976], which includes the right to the highest attainable standard of health.
- The Trust is committed to upholding the principles of the UN Convention on the Rights of Persons with Disability (UNCRPD), which seeks to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all service user's with disabilities and to promote respect for their inherent dignity.
- Use of restrictive interventions must be undertaken in a manner that complies with the Law, Health and Safety Legislation, Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

*(For further information, please visit website* The Human Rights Act | Equality and Human Rights Commission (equalityhumanrights.com)

### 5.6 The Safe and Ethical use of all forms of Restrictive Interventions

Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

There must be a real possibility of harm to the service user or to staff, the public or others if no action is undertaken.

The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.

Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.

Restrictive interventions should only ever be used as a last resort.

People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions (DOH, 2014).

#### 5.6.1 Duty of Care

Duty of care is a legal obligation to:

- Always act in the best interest of individuals and others.
- Not act or fail to act in a way that results in harm.
- Act within your competence and not take on anything you do not believe you can safely do.

#### 5.6.2 Mental Capacity Act (NI), 2016 – Deprivation of Liberty Safeguards Code of Practice (2019)

The statutory principles are:

- Principle 1: a person is not to be treated as lacking capacity unless it is established that the person lacks capacity in relation to the matter in question.
- Principle 2: the question if a person is able to make a decision for himself or herself can only be determined by considering the requirements of the Act and no assumptions can be made merely on the basis of any condition that the person has or any other characteristics of the person.

- Principle 3: a person is not to be treated as unable to make a decision for himself or herself unless all practicable help and support to enable the person to make the decision has been given without success.

- Principle 4: a person is not to be treated as unable to make a decision merely because the person makes an unwise decision.

- Principle 5: any act done, or decision made, must be made in the person's best interests.

*(For further information, please visit website* Mental Capacity Act | Department of Health (health-ni.gov.uk)

### 5.6.3 The Children (Northern Ireland) Order, 1995

A range of legislation provides legal basis for how social services and other agencies deal with issues relating to children. This legislation has been introduced so that all individuals looking after children, in the workplace are aware of how children should be looked after and legally protected.

Whilst different legislation may give greater or lesser focus on the use of restrictive practices, there is a universal expectation that the use of any force should be a last resort, reasonable and proportionate to the circumstances.

The overall aim is to protect the child or young person from harm. This range of legislation aims to make sure the care children and young people receive is well supported, of high quality and tailored to their needs whilst also improving their educational experience and achievements.

*(For further information, please visit website* The Children (Northern Ireland) Order 1995 (legislation.gov.uk)

### 5.6.4 The Mental Health Order (NI), 1986

Mental health legislation covers the reception, care and treatment of mentally disordered persons. The Mental Health Order aims to provide stronger protection for service users and clarify roles, rights and responsibilities. This includes:

- Involving the service user and, where appropriate, their families and carers in discussions about the service users care at every stage.

- Providing personalised care.

- Minimising the use of inappropriate blanket restrictions and restrictive interventions including medication, physical restraint and seclusion.

*(For further information, please visit website* The Mental Health (Northern Ireland) Order 1986 (legislation.gov.uk)

## 6.0 MONITORING AND REVIEW

This policy will provide a framework whereby the Trust will develop Key Performance Indicators in relation to restrictive practices.

All services must have a robust monitoring process in place and ensure that their governance arrangements enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive practices.

The monitoring process will include audit on the use of restrictive practices. An example of an audit tool that could be used is the RRN Reducing Restrictive Practices Checklist.

*Refer to Appendix 4 for link to 'The Restraint Reduction Network's Reducing Restrictive Practices Checklist'*

The use of restrictive practices and interventions must be reported in line with divisional assurance frameworks. Feedback from patients, families, carers and advocates will be used to review and monitor use of the policy.

The service must discuss the use of restrictive practices and interventions through regular reports and reviews with attention to statistical data.

The policy will be reviewed on a five yearly basis as a minimum or sooner should there be changes in legislation or best practice.

### 6.1 Support Mechanisms

Following the use of restrictive practices and/or restrictive interventions it is essential to address any immediate needs of the service user, bystanders, family members, or staff who have been involved.

A post incident review or debrief must take place as soon as reasonably possible, providing an opportunity for learning and support for staff and the service user involved. This process must include the service user's view and thoughts about the incident as well as the staff members involved.

This process must include:

- Basic facts - What happened? When? Why? Where? Who else has been affected?

- Patterns in behaviours, triggers or precipitating factors and patterns in staff responses.

- Alternatives to the behaviours - what can be done differently next time? How to strengthen staff responses.

- What changes can be made to avoid future occurrences.

- Negotiate future approaches and expectations.

- What has been learned? Changes to risk assessments and care plans / individual approaches.

## 7.0 EVIDENCE BASE/REFERENCES

BILD Code of Practice (2014) for the use and reduction of restrictive physical interventions. Fourth Edition. Birmingham: BILD

Care Quality Commission (2015a) Brief guide: Seclusion rooms

Children’s (Northern Ireland) Order 1995

Cornell University, Available at: https://rccp.cornell.edu/tci/tci-1_txt.html

Crisis Prevention Institute (2016) My Safety and Support Plan

Department of Health (2014) Positive and Proactive Care – Reducing the need for restrictive interventions. London: DH

Equality and Human Rights Commission (2019) Human rights framework for restraint: Principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions

Human Rights Act (1998)

Mental Health (NI) Order (1986) HMSO

Mental Capacity Act (Northern Ireland) (2016)

NICE: (2015a) Violence and aggression: Short-term management in mental health, health and community setting (NG 10)

Restraint Reduction Network (RRN) Training standards 2019

Royal College of Nursing ‘Three Steps to Positive Practice’ 2017

Royal College of Psychiatrist’ Faculty of Psychiatry of Intellectual Disability (2013) People with learning disability and mental health, behavioural or forensic problems

Royal College of Psychiatrist's (2018) Prescribing Observatory for Mental Health

Royal College of Nursing (2010) Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: What is it an how can we further its development? Mental Health Review Journal, 21 (3), 174-192. Doi: 10.1108/MHRJ-01-2015-006

## 8.0 APPENDICES

Appendix 1: Procedural and further Guidance on Restrictive Interventions
Appendix 2: Methods of Reducing Restrictive Interventions
Appendix 3: RCN Three Steps to Positive Practice – Link
Appendix 4: Reducing Restrictive Practice Checklist (RNN, 2019) - Link
Appendix 5: Zero Tolerance Risk Assessment and Training Needs Analysis - Link

## 9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Restrictive Practices for Adults and Children Policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and Indirect Supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

## 10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

**The outcome of the equality screening for the policy is:**

**Major impact** ☐
**Minor impact** ☒
**No impact** ☐

## 11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018, the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

**The outcome of the Data Protection Impact Assessment screening for the policy is:**

**Not necessary – no personal data involved** ☒
**A full data protection impact assessment is required** ☐
**A full data protection impact assessment is not required** ☐

## 12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

## 13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.
The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

**SIGNATORIES**
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

01/02/2022
______________________________ **Date:** ____________
**Policy Author**

Jacqui Kennedy

01/02/2022
______________________________ **Date:** ______________
**Director**

**APPENDIX 1**

# PROCEDURAL AND FURTHER GUIDANCE ON RESTRICTIVE INTERVENTIONS

1. NICE guideline (NG10) 2015: Violence and aggression: short-term management in mental health, health and community settings

Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE

2. The Restraint Reduction Network Training Standards 2019

The Restraint Reduction Network Training Standards - Restraint Reduction Network

3. Department of Health: Positive and Proactive Care: reducing the need for restrictive interventions

Helping health and care services manage difficult patient behaviour - GOV.UK (www.gov.uk)

## APPENDIX 2

## METHODS OF REDUCING RESTRICTIVE PRACTICES

### Recovery-based Approaches

Recovery means working in partnership with service users to improve their clinical and social outcomes. Recovery models are consistent with contemporary service philosophies across wider health and social care setting and include the promotion of human right based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion.

Recovery is possible for everyone. Each person can achieve satisfying and fulfilling life, in keeping with their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement with wider communities and society more generally (DOH, 2014).

### Positive Behaviour Support (PBS)

PBS provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a service user's quality of life. Evidence has shown that PBS based approaches can enhance quality of life and also reduce behaviours that challenge, which in turn can lead to a reduction in the use of restrictive interventions.

PBS provides a conceptual framework, which recognises that service users may engage in behaviours that challenge because they have challenging or complex needs that are not being met. These can be associated with unusual needs and personal preferences, sensory impairments, or mental or physical health conditions (DOH, 2014).

### Primary Preventative Strategies:

- Deliver services that focus on person-centred, trauma-sensitive care and support
- Providing positive and rewarding social environments
- Give structure to the day and provide meaningful occupation and activities
- Addressing health inequalities
- Improving levels of independence
- Enhancing quality of life
- Improving communication skills
- Helping service users manage their own conditions by enhancing coping skills or adapting their environment
- Helping service users to exercise or sleep

Primary interventions is part of a specific approach including PBS and the Six Core Strategies. This may also include individualised approaches such as cognitive behavioural therapy, dialectic behaviour therapy and other psychological interventions. Fundamentally, primary intervention is based on person-centred approaches, which aim to provide the 'right fit' between the services available and the needs of the service user (Restraint Reduction Network, 2019).

## Secondary Preventative Strategies:

Secondary prevention focuses on early intervention and aims to minimise escalation in behaviour, which may lead to the use of restrictive practices, this includes:

- An assessment of the presenting behaviour so that a targeted approach can be used which may include the removal of immediate triggers
- Making changes to the environment
- Self-regulation techniques such as relaxation, breathing exercises, mindfulness, and meditation techniques
- Effective verbal and non-verbal approaches such as limit setting and distraction techniques
- Reinforcement of alternative positive behaviours
- The use of appropriate medication either to address underlying psychiatric symptoms or to alleviate anxiety (Restraint Reduction Network, 2019).

## Tertiary Strategies:

These are reactive strategies aimed at addressing the needs of service user's where primary and secondary preventions has failed in order to help the service user to regain control. Tertiary strategies can be non-restrictive or restrictive. They aim to bring about immediate behavioural change in the service user by enabling staff to manage the situation and eradicate or minimise the risks. It is important to recognise that crisis approaches or risk management approaches and not designed or intended to achieve any long-term or lasting behavioural change (Restraint Reduction Network, 2019).

## Person Centred, Trauma-Informed Care

Trauma is the experience of violence and victimisation including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disaster.

The earlier in life trauma happens, the more profound the impact on brain development. People who have experienced trauma in early childhood often struggle to self-regulate and seem to always be in a state of high alert to protect themselves from remembered harmful experiences. This is their automatic, learned response and not signs of pathology, rather they are survival strategies that have helped them cope with terrible pain and challenges.

Trauma-informed care involves universal precautions based on an assumption that the people who use services have a history of trauma, which can present behavioural in many ways including anxiety/depression, substance abuse, self-injury, eating problems, poor judgment, flashbacks, nightmares, terror, auditory hallucinations, difficulty problem solving and aggression (this list above not exhaustive).

Trauma-informed care focuses on ‘what happened to the person’ instead of ‘what’s wrong with the person’ and helps understand how the person’s behaviour developed, how this impacts on the person now, and how to help the person develop new coping strategies.

When taking a trauma-informed approach, it is important for staff to reflect on their own behaviours and responses to individuals, being aware of how their approach may adversely impact on the person (Sweeney, 2016)

## The Six Key Restraint Reduction Strategies

The use of coercive and restrictive interventions can be minimised, and the misuse and abuse of restraint can be prevented. The first steps in doing so are to set expectations across the BHSCT.

- Strategy 1: Leadership
  The organisation develops a mission, philosophy and guiding values, which promote non-coercion and the avoidance of restraint. Executive leaders commit to developing a restraint reduction plan, which is implemented and measured for continuous improvement.

- Strategy 2: Performance Measurement
  The organisation takes a ‘system’ approach and identifies performance measures, which determine the effectiveness of its restraint reduction plan and which measure key outcomes for service users.

- Strategy 3: Learning and Development
  The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Strategy 4: Providing Personalised Support
  The organisation uses restraint reduction tools, which inform staff, and shape personalised care and support to service users.

- Strategy 5: Communication and Service User Focus
  The organisation fully involves service users in a variety of roles within the service, identifies the needs of service users and uses these to inform service provision and development.

- Strategy 6: Continuous Improvement
  The principle of post-incident support and learning is embedded into organisational culture (Restraint Reduction Network, 2019).

## APPENDIX 3

# THE RCN THREE STEPS TO POSITIVE PRACTICE

Three steps to positive practice | Royal College of Nursing (rcn.org.uk)

## APPENDIX 4

# RESTRAINT REDUCTION NETWORK'S REDUCING RESTRICTIVE PRACTICES CHECKLIST (RNN, 2019)

https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

*(For further information, please visit website:* Restraint Reduction Network)

## APPENDIX 5

## ZERO TOLERANCE RISK ASSESSMENT & TRAINING NEED ANALYSIS

*Please go policy below: pages 20-25 for Zero Tolerance Risk Assessment & Training Need Analysis:*

BHSCT A zero tolerance approach to the prevention and management of aggression and violence towards staff in the workplace (2019) TP 02/08

Belfast Health and Social Care Trust
caring supporting improving together

**Guideline Code:** BHSCT/ASPC/MH (12) 2022

| | | | | | |
|---|---|---|---|---|---|
| **Title:** | **Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation** | | | | |
| **Trust Contact** | Dr Ruth Barr, Clinical Lead for Recovery Services in ASPC<br>Tel: [redacted] [redacted]<br>Stephen Guy, Lead Mental Health Pharmacist<br>Tel: [redacted] [redacted] | | | | |
| **Policy Author(s)** | Regional Mental Health Pharmacists Group | | | | |
| **Responsible Director:** | Moira Kearney, Co-Director, Adult Social and Primary Care | | | | |
| **Policy Type:** (tick as appropriate) | *Directorate Specific<br>☐ | Clinical Trust Wide<br>☒ | | Non Clinical Trust Wide<br>☐ | |
| If policy type is confirmed as ***Directorate Specific*** please list the name and date of the local Committee/Group that policy was **approved** | | | | | |
| | | | | | |
| **Approval process:** | Drugs and Therapeutics Committee<br>Standards and Guidelines Committee<br>Executive Team Meeting | | **Approval date:** | 05/09/2021<br>05/04/2022<br>13/04/2022 | |
| **Operational Date:** | April 2022 | | **Review Date:** | April 2027 | |
| **Version No.** | 3 | **Supercedes** | V2 - February 2017 – February 2022 | | |
| **Key Words:** | Violence, aggression, rapid tranquillisation, restrictive practices | | | | |
| **Links to other policies** | BHSCT/PtCtCare (06) 2021 Restrictive Practices Policy for Adults and Children<br>BHSCT Policy for measuring and recording physiological observations (2010) SG 07/09 | | | | |

## 1.0 INTRODUCTION / SUMMARY OF POLICY

See section 1, Appendix A

## 2.0 SCOPE OF THE POLICY

See section 3, Appendix A

## 3.0 ROLES AND RESPONSIBILITIES

See section 5-5.4, Appendix A

## 4.0 CONSULTATION

**Regional Consultation**

- Pharmacy Leads in all NI Trusts with direction to forward to stakeholders in their Trust
- Service user/carer advocates (CAUSE)
- Trust Towards Zero Suicide Service improvement mangers
- Trust Directors of Nursing, Medical Directors with specific direction to include medical wards and Emergency Departments

**Belfast Trust Specific Consultation**

- All Consultant Psychiatrists in Adult Mental Health, Intellectual Disability services and Psychiatry of Old Age
- Lead Pharmacist for Emergency Department
- Consultant lead for CAMHS inpatient services

## 5.0 POLICY STATEMENT/IMPLEMENTATION

See Appendix A: sections 7 to 15

### 5.1 Dissemination

This Guideline is directed to all staff within the adult mental health, psychiatry of old age and intellectual disability inpatient settings, all acute hospital inpatient settings including emergency departments, dementia inpatient services and CAMHS inpatient settings.

Once approved by the relevant committees, this guideline will be available on the Trust intranet site.

### 5.2 Resources

See section 6 Appendix A

### 5.3 Exceptions

This guideline DOES NOT apply to

- Management of delirium or
- Acute alcohol (including psychoactive substances) withdrawal.
- Children under 6 years of age

The appropriate pathways should be followed.

## 6.0 MONITORING AND REVIEW

See section 16, Appendix A

## 7.0 EVIDENCE BASE/REFERENCES

See section 17 Appendix A

## 8.0 APPENDICES

Appendix A: Regional Guideline for the Management of Acutely Disturbed Behaviour.

## 9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

## 10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

**The outcome of the equality screening for the policy is:**

**Major impact** ☐
**Minor impact** ☐
**No impact** ☐

Wording within this section must not be removed

## 11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

**The outcome of the Data Protection Impact Assessment screening for the policy is:**

**Not necessary – no personal data involved** ☐
**A full data protection impact assessment is required** ☐

**A full data protection impact assessment is not required** ☐
Wording within this section must not be removed.

## 12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link.**

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address
equalityscreenings@belfasttrust.hscni.net
Wording within this section must not be removed.

## 13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.
Wording within this section must not be removed.

## SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Stephen Guy

**Date:** 05/04/2022

**Policy Author**

Moira Kearney.

**Date:** **05/04/2022**

**Director**

# Appendix A

## Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation