



Department  
of Health

# Positive and Proactive Care: reducing the need for restrictive interventions

Prepared by the Department of Health

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# 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 21<sup>st</sup> century.



**Norman Lamb**

Minister for Care and Support



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# 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*<sup>1</sup> 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.<sup>2</sup> 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*<sup>3</sup> 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 policies 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 <sup>4</sup> *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<sup>5</sup> 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<sup>6</sup>. 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 of 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*<sup>7</sup>
- *HM Government: The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis*<sup>8</sup>
- *NHS England & LGA: A Core Principles Commissioning Tool*<sup>9</sup>
- *NICE: Clinical Guideline 25. Violence: the short-term management of disturbed / violent behaviour in in-patient psychiatric and emergency departments*<sup>10</sup>
- *DH: Mental Health Act Code of Practice*<sup>11</sup>
- *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*<sup>12</sup>
- *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<sup>14</sup> (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**<sup>13</sup> 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)<sup>15</sup> 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<sup>13</sup> (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<sup>16,17</sup>. 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
<b>Participation</b>	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.
<b>Accountability</b>	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 <sup>18</sup> and the Mental Capacity Act <sup>14</sup> (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards.
<b>Non-discriminatory</b>	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.
<b>Empowerment</b>	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.
<b>Legality</b>	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 <sup>19</sup> .



# 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<sup>20</sup> 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.<sup>21, 22</sup>

## 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<sup>23,24</sup> 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<sup>25</sup> 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<sup>26</sup> (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<sup>15</sup> 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<sup>15</sup>.

## 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<sup>22,27,28</sup>. A thorough knowledge review conducted by the Irish Mental Health Commission in 2012<sup>29</sup> 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<sup>30</sup> 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<sup>31</sup> 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 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<sup>7</sup> useful guidance on understanding and responding to behaviour that challenges, whether or not it was anticipated. The Crisis Care Concordat<sup>8</sup> 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)<sup>14</sup>, as well as to Skills for Security good practice guidance<sup>32</sup>.
- 56.** The Crisis Care Concordat also states that once a person is in a mental health setting, the MHA Code of Practice<sup>11</sup> 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*<sup>33</sup>. 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)<sup>18</sup> 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<sup>14</sup> 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<sup>34</sup>.
- 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<sup>14</sup>) 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<sup>10</sup>, 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<sup>35</sup>. 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<sup>36</sup> 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<sup>11</sup>.
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<sup>10,37,38</sup>. 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<sup>18</sup> 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<sup>11</sup> 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<sup>11</sup>. The does not apply to the segregation of prisoners within prison establishments.

### Where restrictive interventions are not enough

- 92.** NHS Protect guidance<sup>7</sup> 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<sup>14</sup> 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<sup>39</sup> provides guidance on how to assess capacity. If the person is found to lack capacity within the meaning of section 2 of the MCA<sup>14</sup>, 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<sup>39</sup> 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<sup>14</sup> (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)<sup>40</sup> in the MCA<sup>14</sup> or the MHA<sup>18</sup>. Each regime provides a procedure to authorise deprivation of liberty.
- 100.** The DoLS were incorporated in the MCA<sup>14</sup> 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<sup>40</sup>.
- 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 an independent mental capacity advocate
  - the right to challenge a deprivation of liberty
  - mechanisms for the deprivation of liberty to be reviewed.
- 103.** The MHA<sup>18</sup> 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<sup>11</sup>.
- 104.** Statutory or common law defences may apply, in the rare circumstances where, neither the MCA<sup>14</sup> nor MHA<sup>18</sup> 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*<sup>1</sup> and the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*<sup>41</sup> 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<sup>42</sup> (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<sup>43</sup>.

- 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<sup>43</sup>.
- Monitor and review the arrangements implemented to reduce the risks to ensure they are effective<sup>43</sup>.
- 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.<sup>12</sup> 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<sup>12</sup>:
- 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<sup>10</sup> 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.<sup>12</sup>
- 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<sup>35</sup>. 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)<sup>44</sup> and the Institute of Conflict Management (ICM)<sup>45</sup> 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<sup>46</sup>.
- 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.

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## 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*<sup>7</sup>

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*<sup>8</sup>

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*<sup>9</sup>

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*<sup>10</sup>

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<sup>11</sup>*

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<sup>12</sup>*

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 of 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 need 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 restrictive interventions when delivering services to children, young people and individuals in transition is being developed.

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