Minimising the use of Restrictive Practice Policy

Director Responsible	**Director of Adult Services**
Author	**Robert Krawczyk**
Issue Date	**April 2019**
Review Date	**April 2022**
Approved by	**SMT**

DOCUMENT HISTORY

Date	Author/Editor	Summary of Changes	Version No.
18.04.2019	Robert Krawczyk	1st version of policy	1

Please note that the only valid version of the policy is the most recent one. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

CONSULTATION AND RATIFICATION SCHEDULE

Name of Consultative Body	Date of Approval
Senior Management Team	

CROSS REFERENCE TO OTHER POLICIES / STRATEGIES

This policy should be read in conjunction with:	Detail
Policy 1	Adult Support & Protection Policy
Policy 10	Equality & Diversity Policy
Policy 11	Disclosures & Whistle Blowing Policy
Policy 18	Disciplinary Policy

Keywords: physical intervention, CALM, restraint, seclusion, challenging behaviour

CONTENTS

APPENDICES

1. INTRODUCTION

Primecare Health LTD supports and enables people to lead full and enriched lives and to be equal valued citizens in their communities. Our mission is to enable people living in Scotland through the whole life journey.

Our philosophy incorporates a model of wellbeing and positive behaviour support. The organisation seeks to promote a culture that encourages preventative and proactive approaches to supporting individuals whilst minimising the use of restrictive practices and seeks to promote human rights.

This policy aims to:

- Promote the human rights of the people we support
- Allow staff to work safely, whilst recognising and managing potential risk
- Promote an open and transparent framework for good practice
- Adhere to ethical and legal guidance
- Prevent prohibited practices and the misuse of restrictive practices

This policy applies to all employees within Primecare Health LTD working directly with individuals or in an advisory capacity. It is to be addressed at staff induction, during training informing of positive and proactive strategies and crisis intervention training, and when developing and reviewing any support plans or direct support that contains a restrictive practice.

The key legislation and guidance applicable in Scotland with respect to behaviour management and the use of restrictive practice, are detailed in Appendix 1, inform this policy and staff should consult them where appropriate for definitive guidance.

2. ORGANISATIONAL APPROACH TO MINIMISE THE USE OF RESTRICTIVE PRACTICE

Primecare Health LTD recognises the six key elements to realising our commitment to minimising the use of restrictive practice. These are based on *Six Core Strategies to Reduce Seclusion and Restraint Use (Huckshorn 2005)*

- Leadership
- Use of Data to inform practice
- Workforce Development
- Use of proactive and preventive strategies
- Involvement of individual, family, advocacy and multi-disciplinary professionals
- Effective de-briefing and support

3. FORMS OF RESTRICTIVE PRACTICE

There are multiple forms of restrictive practice including:

Forms	Definition
Containment	An individual is unable to physically leave a place. This may include locking doors, windows or gates. It is not considered containment if an individual has been assessed as having a lack of road safety skills and a door is locked to prevent them wandering close to a road.
Seclusion	Involves the solitary confinement of a person in a room or area at any time of day or night from which their exit is prevented by a barrier, another person or the belief they cannot leave.
Time Out	This can either be inclusion or exclusion based. Inclusionary timeout can be as simple as turning away and ignoring a behaviour that is reinforced by your attention. Exclusionary Time Out is any planned strategy to deny access to reinforcement (such as the attention of peers) by forcibly moving a person from one setting to another, for example, from a room to a corridor, where they must remain for a pre-determined period of time. When a person goes willingly to an area by themselves to calm down and they are freely able to leave at any time this is not considered to be a restricted practice or exclusionary time out.
Restricted access to environment	Includes locking doors, cupboards or refrigerators beyond developmental norms to ensure the wellbeing and safety of the person and those around them. These practices can have an impact on others in the same environment. This also includes the repeated sending home of a person from a service as a safety response to behaviour perceived as challenging or a deliberate strategy of shorter hours service than normal (as a result of behaviour perceived as challenging).
Restricted access to an object	Limiting the individual's access to an object, for example a kitchen drawer with knives. This can prevent the individual using the object to cause harm to themselves or others
Restricted access to an activity	Limiting the individual's access to an activity, for example changing or restricting time of an activity requested by individual or as part of planned timetable, as activity may be assessed as presenting with a level of risk.
Physical Escort (against a person's will)	Involves using an approved and safe technique by a trained individual to physically move a person against their will away from an area of risk to an area of safety.
Physical Intervention and Restraint	Involves a broad range of strategies including (1) Physical restraint by another person using an approved and safe technique which prevents their movement (2) Restraint by specialist or other clothing to prevent a behaviour of concern, such as a body suit, helmet, gloves or arm splint (not including devices only for therapeutic purposes) (3) Restraint by mechanical or other means such as harnessing in transport or seatbelt buckle, special chair or a tray table to prevent movement during eating.
By default	Denying an individual's aids to assist with movement E.g. Wheelchair

As Required Medication	Psychotropic medication prescribed to be given only as needed as a reaction to behaviour perceived as challenging, rather than on a daily basis. This does not involve medication given for health reasons e.g. medication used to respond to a seizure.
Over-correction *	Is a punishment procedure that involves restoring the environment to a better state than it was before a behaviour that was displayed; for example, a person who has purposely knocked over a glass is then required to clean the whole area.
Response Cost *	Is a form of punishment that requires a person to lose pre-determined items or activities of a positive value, for example removing access to the TV for a short period, and is enforced as a consequence of behaviour perceived as challenging.

****The practices of over-correction and response cost (sometimes called 'social restraint') are not unlawful or illegal but do not adhere to Primecare Health LTD's ethos and values therefore should not be used.***

Restrictive practice includes a wide range of practices that stop individuals from doing things that they want to do or encouraging them to do things that they don't want to do, or could also be construed to potentially limit individual's right to privacy, self-determination, freedom or freedom of movement.

It should be understood as part of a continuum, from limiting choice, to reactive response to an incident or an emergency, or if a person is going to seriously harm themselves or others.

4. WHEN RESTRICTIVE PRACTICE CAN BE USED

Where a restrictive practice is deemed necessary this should only be after other methods of positive intervention have been unsuccessful or are not practicable. Any restrictive intervention should only ever be used as a last resort. (See Holding Safely for a discussion around last resort.) Where a risk assessment has identified a foreseeable risk whose management may require the use of a restrictive practice, as part of their support plan this must be planned in writing. That plan should incorporate a risk assessment with clear documentation stating why the restrictive practice is needed in the first instance. However, in a crisis situation, staff have a responsibility to ensure duty of care and act in the best interests of the individual.

Civil Law recognises "Duty of Care" obligations. "Duty of care exists when duties and responsibilities are imposed upon professionals or paid carers to take reasonable care to avoid acts or omissions which are likely to cause harm to another person".

Restrictive Practice must only be considered where it is deemed <u>in the best interest</u> of the individual and <u>to prevent a greater harm</u>. The wishes and preferences of the individual must also be considered. When all other options have been exhausted and there is no other alternative procedure, physical intervention can be used as a very <u>last resort</u>.

Service staff should consider restrictive practice without the permission of the individual only when that individual's capacity to understand why restrictive practice is necessary is reduced or absent.

Restrictive practice may be unlawful unless there is a legal justification. The most common justification is the prevention of harm in order to reduce the risk to an individual who is:

- Harming themselves
- Harming others
- And the harm cannot be prevented without intervention.
- There are other legal justifications where restrictive practice may be permissible. (Primecare Health LTD would only consider this where the consequences of actions would amount to a threat or actual harm to self or others, severe emotional distress, or place the individual at risk of further restriction or legal prosecution.)

The risk must be assessed severe enough to justify the restrictive practice and any restriction in proportion to the risk presented.

5. WHO SHOULD BE CONSULTED BEFORE, DURING & AFTER RESTRICTIVE PRACTICE?

- The individual
- Support Staff
- Managers

Where required:

- Relatives, advocates, welfare attorneys or guardians, or other representatives
- General Practitioner or Clinical Psychology Dept

6. PRACTICE GUIDELINES

Individual support plans should identify through assessment, each individual's Profile and assessed need. Presentation of the individual and the possible function of behaviour should identify positive behaviour support approaches that are known to be effective for the individual. The aim should be to minimise any use of restrictive practice and all other options must be considered. Where restrictive practice is deemed necessary, it should be the least restrictive. Physical Intervention must be used only as a very last resort. Where used as a planned response, a behavioural risk assessment must always be carried out, with clear documentation of why the restrictive practice is needed. This requires to be regularly reviewed and measures must be considered to reduce the reliance of restrictive practice with plans to implement alternative approaches.

No single service staff member can decide upon the use of restrictive practice alone out with an unforeseen emergency. Consultation with Managers must be carried out and authorisation to carry out the appropriate restrictive practice when necessary.

Where restrictive practice is used as an unplanned response or emergency intervention, a full review of the incident is required and where appropriate, a full behaviour risk assessment and support plan developed.

When restrictive physical intervention is used, the organisation’s policy for Accident and Incident Reporting must be adhered to. Debriefings should take place following incidents for all those involved.

Service Staff should be familiar with their Duty of Care in relation to restrictive practice.

Service staff, and especially those in positions of responsibility, should be fully aware of the content of this policy and of their duties and responsibilities under it.

7. CHALLENGING BEHAVIOUR LANGUAGE & DEFINITIONS

The language we use in relation to our practice and the people we support is important. It reflects our organisational culture and values. Primecare Health LTD fully acknowledges that staff members will encounter behaviour that challenges the service. Our model of service delivery focuses on establishing the underlying causes and contexts for such behaviours and seeks to provide support that enables and promotes well being whilst reducing stress. The following definitions are helpful in understanding the range of challenges that might be encountered however our focus is on who people are and not on defining people by how they behave.

Behaviour perceived as Challenging is any persistent behaviour that causes difficulties and limits a person's ability to have a good life. The behaviour presented is understood as part of an interaction between (1) an individual, their current & past experiences and what they have been taught (or learned) (2) the other people in their lives & (3) the environments, communities and cultures they live in. Behaviour is called "challenging" because it challenges everyone who supports the person to understand why it is happening and to work together to find a solution. The term can be used interchangeably with "behaviours of concern" or "behaviours that challenge."

"Behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to and use of community facilities."

"Challenging behaviour emphasises that such behaviours represent challenges to services rather than problems which individuals with learning disabilities in some way carry around with them."

8. ASSESSING RISK AND BEHAVIOUR

All care plans should incorporate appropriate risk taking and risk assessment as per organisation policy. When an individual's behaviour leads to restrictive practice being considered, the following guidance for assessments should always be considered:

- Examine the possible reasons (root cause) for the individual presenting in this way, or the function of the behaviour, for example:
  What has changed for the individual?
  Is the behaviour new or is there previous history?
  What is the individual trying to communicate through their behaviour?
  Is the behaviour a reaction to something else E.g. Environment, Health, Others communication?
  Sensory overload?
  Consult with Psychological Services?
  Use behaviour checklist?

- Examine whether the restrictive practice is absolutely necessary for example*:*

What are the individual's intrinsic wishes and preferences?
Is this in the best interest of the individual?
Does this individual have a previous history involving abuse or trauma related to the use of restrictive practices?
Will the restrictive practice itself further increase risk?
Will it distress the individual?
Will it distress anyone else?
What are the health and safety implications for the individual?
Can physical intervention be an opportunity for a therapeutic intervention by staff?

- Examine what the risks could be if restrictive practice is not used for example*:*
  What is the degree of risk involved for the individual or for others if restrictive practice is not used?
  Are the risks of the behaviour(s) if we do not intervene greater than the risks associated with the restriction of liberty of the individual?

9. ALTERNATIVE METHODS OF INTERVENTION

Before using any method of restrictive practice, alternative measures should be considered and implemented. Support plans should:

- Identify the primary preventative plan designed to avert the need for restrictive practices based on needs assessment of the individual and profiling
- Detail the indicators of early distress and preferred de-escalation strategies that comprise the secondary prevention plan
- Identify how someone can be supported in crisis, the tertiary intervention plan
- Identify how the service user will be supported post crisis in order to promote recovery and reconnection

Examples of alternative approaches are:

- Stress Reduction Plans
- Low arousal approaches
- Positive Behaviour Support approaches
- Positive Intervention Techniques
- Diversion techniques – can the individual be diverted away from their behaviour or situation
- Increased activity – would this help to lessen the behaviour
- Increased staff presence – would this reduce the risk or offer therapeutic alternatives
- Can the behaviour be reduced or removed in any other way

10. USING RESTRICTIVE PRACTICE

No restricted practice may be used in isolation out with an unforeseen emergency situation. It must form part of a support plan, and be accompanied by positive proactive approaches and educational strategies.

Where practicable the least restrictive option should always be considered and tried first and used for the shortest time possible. Any restriction must be proportionate to the harm it is aimed to prevent and justified in order to protect the rights or safety of the person or others.

Attempts must be made to ‘reduce’ the use of a restricted practice, to try and use a less restrictive option or to give the person an opportunity to show it can be removed.

The use of each restricted practice is time limited.

Where a practice has a risk of harm to a person or a staff member clear practice instructions should be provided for staff involved in the implementation of programmes.

11. USING PHYSICAL INTERVENTION

If physical intervention is absolutely necessary as a last resort the following should apply in all instances:

- Service Staff must be trained and verified in the physical intervention techniques (currently CALM.)
- The level of physical intervention must be agreed
- Use the minimum physical intervention required for as little time as is absolutely necessary
- Inform the individual that you are going to use physical intervention and when this will stop
- The individual must be given back self control as soon as is reasonable
- Any signs of health related symptoms apparent during physical intervention, staff must release immediately and seek medial advice as soon as possible
- Physical intervention must never be used as a threat
- Staff member/s must remain with the individual during and following the application of physical intervention to an individual.

In all instances of repeated physical intervention managers must monitor and be kept fully informed of the use, the type used and obtain an accurate recording of its use. Managers should consult with Social Work Services and/or Psychology Services.

The need to repeatedly apply physical intervention to an individual may cause the detention of that person. In this instance, managers may want to consider some of the following legislation:

The Adults with Incapacity (Scotland) Act 2000 or detention under The Mental Health Care & Treatment Act 2003 for Emergency Compulsory Admission via Social Work Departments, The Adult Support & Protection Act 2007.

12. WHAT PHYSICAL INTERVENTION CAN BE USED?

The Organisation does not endorse any other use of physical intervention other than CALM. CALM Training is accredited under the British Institute for Learning Disability (BILD) Physical Intervention accreditation scheme developed on behalf of The Department of Education and Skills and the Department of Health and adheres to the BILD Code of Practice.

13. WHO SHOULD USE PHYSICAL INTERVENTION?

Physical intervention should be used only by staff that are fully trained in CALM and have received verification and hold a current certificate.

Prior to undertaking training in CALM staff must complete theoretical training that provides knowledge of Primecare Health LTD's approaches to supporting individuals who may present with challenges, while establishing a whole organisational approach covering Legislation, Best Practice guidelines and internal systems for supporting individuals with autism and promoting positive behaviour.

14. DOCUMENTATION

The individual's care & education plans must detail and describe the type and use of restrictive practice, why it is required and who decided/consulted upon it. Where others should have been consulted but were not, the reason for this should be included.

What alternatives were taken before it was implemented, the duration of the restrictive practice and the outcome? What arrangements have been put in place to monitor and evaluate the restrictive practice? And what plans are there to reduce the use of restrictive practice and apply Positive Behaviour Support approaches.

Any use of restrictive practice must be recorded within the incident report and a clear concise description of what happened before, during and after the restrictive practice included.

All documentation must be kept securely stored, strictly private and confidential and made available on a need to know basis with authorised consent in line with the Data Protection Act (1998).

15. MONITORING AND EVALUATION

All use of restrictive practice must be continually reviewed on a regular basis to all concerned. It is not permissible to use restrictive practice without a clear idea of how often it will be reviewed and what action will be taken if the reasons leading to its use do not diminish. Managers are responsible for the analysis of all recorded information using Primecare Health LTD analysis tools.

16. UNPLANNED RESTRICTIVE PRACTICE

When it may be necessary on an occasion to restrain an individual in an emergency without time to explain why; “spur of the moment.”

17. PLANNED RESTRICTIVE PRACTICE

When a formal procedure and intervention takes place in response to particular behaviours being presented and is agreed by the support team through risk assessment and support plans.

18. PROHIBITED PRACTICES

These are practices which are abusive and which constitute assault or wrongful imprisonment, both of which are criminal offences and civil wrongs which could lead to legal action. These also include practices that may not be unlawful, but are unethical and should never be used. The prohibition covers both staff actions and the use by other people in the management of behaviour perceived as challenging. Refer to the organisation’s Protection of Vulnerable Adults Policy for details. These policies are informed by SSSC Codes of Practice. SSSC may investigate incidents or disciplinary where a breach has been identified.

The following practices are prohibited. The prohibition covers both staff actions and the use by other people in the management of behaviour that is perceived as challenging. They include (but are not limited to):

- Causing physical pain or serious discomfort or avoidable emotional distress;
- Degrading or demeaning of the person with a disability such as insulting or humiliating the person in front of others;
- Any practice which would not be acceptable for a person of the same age who does not have a disability;
- Any practice which may reasonably be perceived by the person as harassment or vilification;
- Any practice which is restrictive and used without the necessary procedures restricting its use - this includes lawful consent, proper authorisation and incorrect use of an approved restricted practice.
- Corporal punishment;
- Physical abuse such as hair pulling, pinching, biting, hitting or slapping or threats of physical abuse;
- “Hosing down” of a person;
- Over-correction involving coercion (often physical) or use of threats to force a person to repair damage or disruption caused by their behaviour;
- Confinement such as seclusion, time-out or containment where a person is detained or forced to remain in a room, without strict guidelines;
- The use of As Required medication to control or restrain a person when used without a behavioural management plan or without proper medical authorisation or legal consent;
- Continued use of any strategy which is usually reserved for a one-off incident;
- Any other act or failure to act that constitutes an offence under the civil or common laws;
- Verbal abuse including name calling, shouting, ridicule or continual teasing;
- Using persons with disabilities to discipline others, either physically or verbally;

- Cold showers or the use of hot and cold showers in quick succession;
- Deprivation of meals, breaks, sleep, bedding, clothing, holidays and outings, or the opportunity to maintain personal hygiene;
- Aversive therapy such as negative and often cruel treatment to promote compliant behaviour;
- Taking money or personal property.

19. COMPLAINTS

Any complaints about the use of restrictive practice should be addressed through the Organisation's complaint procedures.

20. POLICY REVIEW STATEMENT

This policy will be reviewed every three years or earlier if appropriate.

Appendix 1

Legislation and guidance in Scotland with respect to behaviour management and the use of restrictive practice

Legislation
Human Rights Act 1998
Health and Safety at Work etc Act 1974
Equality Act 2010
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland Act) 2000
The Mental Health (Care and Treatment) (Scotland) Act 2003
Protection of Freedoms Act 2012
Education (Additional Support for Learning) (Scotland) Act 2004
The Regulation of Care (Scotland) Act 2001

Good practice guidance
BILD Code of Practice for minimising the use of restrictive physical interventions: planning, developing and delivering training 2014
The Keys to Life (2013)
RIDDOR 2013
Rights, Risks and Limits to Freedom 2013
Safe to Wander 2007
Better relationships, Better Learning, Better Behaviour 2013
Holding Safely 2005 (Updated 2013)
National Care Standards 2011
SSSC Codes of Practice for Social Service Workers and Employers (Revised 2016)