Document Title:	Reducing Restrictive Interventions	
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Summary	The aims of the policy are: • To promote positive and proactive care, thereby reducing the use of restrictive interventions (frequency and duration) and preventing inappropriate use of restrictive practice • To ensure and safety and wellbeing of people using services, ensuring that service users at risk of restrictive interventions have sound proactive and preventative strategies in place • To ensure the service user receives the care and support rendered necessary before, during and after any restrictive practice (especially restraint) has taken place • To ensure proper monitoring of restrictive practices and to provide a complete record to monitor compliance and audit • To ensure that local policy is aligned with current national guidance and legislation	
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Amendment Dates:	Section	Brief Description
June 2022	1	Change to policy statement- new director
June 2022	8	Amendments to Deprivation of Liberty Safeguard wording

CONTENTS

POLICIES AND PROCEDURES
Adult Social Care

1. Policy Statement

Supporting the fundamental principles of human rights and wellbeing, the framework provided by this policy is designed to promote best practice across a range of health and social care settings. This will support the adults most at risk in our communities to receive high quality health and social care, free from harm, abuse and neglect.

Reports such as Winterbourne View and guidance from the Department of Health, promote the use of individual support plans, positive behavioural support (PBS), de-escalation techniques and the minimisation of physical interventions, (physical intervention only being used as a last resort.)
This Reducing Restrictive Interventions Policy is designed to help minimise risk behaviours in a person centred way and promote safety for all, using techniques that meet the requirements of current national guidance and recommendation.
Shropshire Council remains committed to supporting people with compassionate care, dignity, and respect.

Tanya Miles
Executive Director of People
Shropshire Council

2. Main Sources

Positive and Proactive Care: reducing the need for restrictive interventions (Department of health 2014)

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NICE 2015)

Transforming Care: a national response to Winterbourne View Hospital (Department of Health 2012)

BILD Code of Practice for minimising the use of restrictive physical interventions: planning developing and delivering training (BILD 2014)

Health and Social Care Act (Department of Health 2012)

Mental Health Act 1983 (revised 2007)

Violence and aggression: short term management in mental health, health and community settings (NICE 2015)

Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards – to be known in the future as Liberty Protection Safeguards

Health and Safety at Work Act 1974 (and subsequent amendments)

Learning Disabilities: Challenging Behaviour – Quality standard 101 (NICE 2015)

3. Introduction

3.1 Since this policy was first written, there have been many changes in legislation and practice; some, sadly, arising from poor practice and tragedies in the health and social care sector in relation to the use of restrictive interventions. The revision of this policy draws on the framework provided through recent legislation and guidance and, as such, now contains a broader and more proactive focus on reducing restrictive intervention.

3.2 This policy is applicable to ***all adults*** (aged 18 upwards), including those with physical disabilities, mental health problems, learning disabilities, and older people.

3.3 This is an overarching policy for staff working within Shropshire Council, Shropshire Clinical Commissioning Group, and independent sector organisations providing health and social care services to adults in the Shropshire and Telford and Wrekin area.

3.4 It is recognised that, because of the number and range or organisations involved, there may be certain aspects where individual services need to develop their own procedures in line with national guidance which they can use in conjunction with the policy to clarify how they intend to enact their responsibilities.

3.5 It is hoped that this policy, and the associated easy-read version (Appendix 1), will help people using services and their families/carers to understand what they should be able to expect from services.

3.6 This policy is up to date at time of writing, and will be reviewed annually. It is the responsibility of all services to keep themselves up to date with changes in guidance and legislation. Training will include information on current guidance.

The contents of this policy have been shared with Telford and Wrekin Council and the Joint Training Partnership Group Shropshire including: Shropshire Clinical Commissioning Group, South Staffordshire and Shropshire NHS Foundation Trust, Shropshire Council Adult Social Care and Shropshire Council Public Health who have confirmed they are happy with the content.

4. Definitions

The definitions are listed in order reflective of the content of the policy.

4.1 **PBS**, or Positive Behaviour Support, is a recognised model of behavioural intervention, endorsed and promoted throughout current guidance and legislation as the recommended model of best practice.

4.2 The term "**capacity**" is referred to in this document, in accordance with the Mental Capacity Act 2005, to mean a person's ability to make a specific decision at a time it needs to be made.

> *"A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of or a disturbance in the functioning of the mind or brain." (MCA 2005) Section 2 4.3*

4.3 **Challenging behaviour** can be defined as 'Behaviour of such intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.' *(Ref Banks et al 2007, Challenging Behaviour:*

A unified approach. Royal College of Psychiatrists). All behaviour has a function or purpose, and does not occur in isolation.

4.4 **Primary/proactive interventions** – Proactive approaches to addressing the person's support needs (including health, communication, meaningful activity, social networks and leaning opportunities), aiming to improve quality of life.

4.5 **Secondary interventions** – Interventions which attempt to defuse, downplay, interrupt, or redirect potential triggers to prevent escalation.

4.6 **Restrictive interventions** can be defined as: "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."

(Positive and Proactive Care 2014)
The term **Physical Intervention** is used in this policy to indicate the use of bodily contact or force to restrict movement.

4.7 **CPI Safety Intervention ™** is a risk management strategy, and is a trademarked model of training, commissioned from CPI (Crisis Prevention Institute) and accredited by BILD (British Institute of Leaning Disabilities) and is Restraint Reduction Network certified training, that includes physical interventions.

5. Values

There is a range of available guidance on cause relating to the provision of public services. The examples below are specific to legislation and guidance around the reduction of restrictive interventions.

5.1 Positive and Proactive Care focuses on six key principles:

1. Compliance with the relevant rights in the European Convention on Human Rights at all times
2. Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
3. 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.
4. People must be treated with compassion, dignity and kindness.
5. Health and social care services must support people to balance safety from harm and freedom of choice.
6. Positive relationships between the people who deliver the services and the people they support must be protected and preserved (DoH 2014)

5.2 PBS is a values-based approach. Core values of PBS are as follows:

- Prevention and reduction of challenging behaviour occurs within the context of **increased quality of life**, inclusion, participation, and the defence and support of valued social roles.
- **Constructional approaches** to intervention design, building stakeholder skills and opportunities and avoid using aversive and restrictive practices.
- Stakeholder **participation** informs, implements and validates assessment and intervention practices (Gore et al, 2013)

5.3 The value framework of CPI Europe (CPI Safety Intervention™) is:

- **Care:** Demonstrating respect, dignity, and empathy; providing support in a non-judgemental and person-centred way.
- **Welfare:** Providing emotional and physical support; acting in the person's best interests in order to promote independence, choice, and well-being.
- **Safety:** Protecting rights, safeguarding vulnerable people, reducing or managing risk to minimise injury or harm.
- **Security:** Maintaining safe, effective, harmonious, and therapeutic relationships which rely on collaboration. (CPI 2022)

Further guidance on values can also be found in:

- Human Rights Act 1998
- Health and Social Care Act 2012
- Care Act 2014
- Health Care Professionals Council; Standards of conduct, performance and ethics *(HSPC 2008 amended 2012)* as well as other relevant guidance and codes of practice.

6. Assessment

6.1 Where it has been identified that someone presents behaviour which challenges services, particularly if that person is at risk of restrictive interventions, assessment should be undertaken. Initial assessment must include:

- Description of behaviour (including frequency, intensity and duration)
- Explanation of how the behaviour is developed and maintained (including personal and environmental factors, and the role of the service, staff and carers).

6.2 If needs are more complex, full functional assessment, involving specialist support and the multi-disciplinary team, will be required.

6.3 All assessments must take risk factors for challenging behaviour into account including the person's physical and mental health, secondary disabilities, expressive and receptive communication, life experiences (including trauma), sensory needs, and physical and social environment *(NICE 2015).*

> Behavioural assessment should lead to the development of a behaviour support plan (and must do so for anyone at risk of experiencing restrictive interventions). Such plans must include primary/proactive strategies which enhance quality of life and help people to develop positive, pro-social ways of getting their needs met, as well as secondary prevention and reactive strategies. The assessment and resulting plan enable staff to have a full understanding of the needs of the people they support.

6.5 People identified with behaviour which challenges must have a designated person who is responsible for co-ordinating and behavioural support plan and ensuring that it is reviewed.

7. Primary/proactive approaches

7.1 Proactive approaches are known to reduce the use of, and need for, restrictive interventions. Proactive approaches are most effective when they include:

- Close working between service users, families, and staff. This can assist in information sharing and planning, and may include the use of advance decisions that someone may make regarding their needs and wishes at times when they may not have capacity.
- Increasing staff understanding of people's behaviour. This can have the effect of creating a shared understanding, thereby increasing the confidence and optimism of staff leading to an agreed and structured way forward.
- Developing support, activity, and intervention plans. These should be based upon formal and comprehensive assessment, and should include a range of proactive engagement strategies geared to the needs, preferences and best interests of the individual. Interventions should aim to promote positive and socially acceptable behaviours and enhance quality of life, thus reducing the likelihood and impact of negative challenging behaviours.
- Developing risk assessments. Good practice must always be concerned with assessing and minimising risk to service users, staff and others.

7.2 Primary Prevention (proactive strategies) includes:

- Ensuring that the number of staff deployed and their level of competence corresponds to the needs of the people they support and the Care Standards Act 2000, and that staff work to the relevant code of conduct. Staff should not be left in vulnerable positions.
- Ensuring there is a good match between the person's needs and their environment.
- Ensuring there is a good understanding of the person's communication – both how to understand their communication, and how to communicate effectively with them.
- Creating opportunities for people to engage in meaningful activities – which include opportunities for choice, learning skills and a sense of achievement – with the right level of support.
- Ensuring that the person's health needs are recognised and addressed.
- Helping people to avoid known triggers, and situations which are known to provoke anxiety and risk.
- Ensuring that person-centred care plans, which are responsive t individual needs, are up to date, and include current information on risk assessment.
- Developing staff expertise in working with people who present behaviours which can challenge, and ensuring that there is a good match between staff skills and the needs of the people they support.
- Talking to people who use services, their families and advocates about the way in which they prefer to be supported at all times, including times when things are difficult or stressful and there may be risks to themselves or others.

7.3 Secondary prevention

- Secondary prevention describes actions taken when someone may have begun to move away from being calm and rational; these interventions are intended to de-escalate a situation, to minimise risk and reduce the likelihood of restrictive interventions.
- Secondary prevention includes recognising the early stages of a behavioural sequence that is likely to develop into a challenge or risk, and employing non-physical diffusion or de-escalation techniques or other agreed strategies to avert any further escalation. Secondary prevention sections of a behaviour support plan should include information on early warning signs to enable staff to recognise that someone is becoming more unsettled, as well as individualised strategies to support that person to recover.
- All strategies must be carefully selected and reviewed to ensure that they do not limit opportunities or have an adverse effect on the welfare of the quality of life of people involved.
- Anti-psychotic medication, at any stage in the process, should only be used as one component within a wider psycho-social intervention, and should be reviewed after 12 weeks and then every 6 months.

8. Legal Considerations

8.1 All health and care staff are required to work within the law. There is no single law on restrictive interventions. While the law allows for the use of reasonable force in certain circumstances, force is **NOT** justifiable to secure compliance, force control, or in pursuit of retaliation or punishment.
8.2 The Human Rights Act 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions. Knowledge and implementation of this guidance will help to ensure that practice within services is consistent with this Act.

8.3 Positive and Proactive Care stresses the duty on all public services to follow a human rights based approach. The table below is taken from Positive and Proactive Care, and addresses ways in which these principles can be applied to people whose behaviour may challenge services.

Key Principle	What it means	What it looks like in practice
Participation	Enabling participation of all key people and stakeholders	Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights.
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach	Clearly outlining responsibilities under the Mental Health Act (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes. Including quality of life, against agreed standards.
Non-discriminatory	Avoiding discrimination, paying attention to groups who are vulnerable to rights violations	Using person-centred planning approaches that do not discriminate on the basis of religion or belief, race or culture, gender, sexual preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights.
Empowerment	Empowering staff and people who use services with the knowledge and skills to realise rights	Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions; empowering people through appropriate interventions.
Legality	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy.

(DoH 2014)

8.4 It is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock an adult in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency e.g. the use of a locked room as a one-off temporary measure while waiting or seeking assistance to safely manage the presenting risk.

8.5 Use of restrictive interventions may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the service user concerned. Pain compliance can be considered a

breach of article 3 (Freedom from torture or inhuman or degrading treatment). Pain compliance refers to the use of pain to control behaviour or enforce discipline, and is unlawful.

8.6 Under the **Health and Safety at Work Act 1974** (and subsequent amendments) employers are responsible for the health and safety of service users and visitors. This required employers to assess and manage risks to both employees, service users, and others arising from work activities, including the use of restrictive interventions. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained.

Employers should ensure that all employees, including agency staff, have access to appropriate information about service users they are working with. This information should be within the context of all information to do with the needs of the individual (relevant to the role of the staff) rather than just focussing on risk information.

8.7 **Duty of Care:** Providers of health and social care services owe a duty f care towards all service users, as well as to staff and anyone else who may be affected. The duty of care required that reasonable measures are taken to prevent harm. Employees also have responsibilities to assist their employer in fulfilling their obligations under the Act; e.g. to raise concerns appropriately and comply with any policy provision and training provided.

8.8 **Risk Assessment:** The use of restrictive interventions can be reduced by having robust risk assessments in place. Risk assessment falls under the responsibilities evoked by health and safety legislation. Risk cannot be eliminated and positive risk taking is to be encouraged, with appropriate steps taken to reduce risk to both staff and service users to an acceptable level. Staff will need to balance the risks of physically intervening against the risks of what may happen if they do not intervene. Risk assessments should be set in the context of behaviour support plans, care plans and other documents describing a broader strategy for managing risk.

8.9 **Control measures** to manage the risk should include both primary and secondary preventative strategies as well as guidance on what to do if these should be unsuccessful. One of the measures identified may mean deciding at what point a restrictive intervention may or may not be considered/used. Whenever it is foreseeable that a restrictive intervention may be used, a risk assessment should be carried out which identifies and benefits and risks associated with the application of different intervention techniques with the person concerned. Any risks associated with a physical intervention must be assessed with reference to the health profile of the service-user. The benefits of taking such an approach must outweigh the risks.

8.10 **The Mental Capacity Act 2005** The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.
Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.
MCA Code of practice 1:1

Section 6.4 of The Mental Capacity Act states that someone is using restraint if they:
• use force – or threaten to use force – to make someone do something that they are resisting,
• restrict a person's freedom of movement, whether they are resisting or not.

In order for staff to be protected from liability two conditions must be met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the time it lasts must be proportionate to the likelihood and seriousness of the harm.

'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.' 5.1 MCA COP

8.11 **Deprivation of Liberty Safeguards** (DoLS):
Although section 5 of the Mental Capacity Act permits the use of restraint where it is necessary, section 6.5 confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty as defined by Article 5 of the European Convention of Human Rights.
This applies not only to public authorities covered by the Human Rights Act 1998 but to everyone who might otherwise get protection under section 5 of the Act. It also applies to attorneys or deputies – they cannot give permission for an action that takes away a person's liberty.

Currently there are different ways to ensure that a deprivation of liberty is lawful
1) Deprivation of liberty safeguards (to be replaced with Liberty Protection Safeguards) This scheme applies in hospitals and care homes
2) If this is not the case an application may be made to the **Court of Protection** who may grant an order to permit the deprivation of liberty if it is in the persons best interests. Otherwise actions which amount to a deprivation of liberty will not be lawful.
3) When there is no alternative way to provide care or treatment in a hospital for a mental disorder other than depriving the person of their liberty, consideration should be given to the use of the **Mental Health Act** if the relevant criteria is met.
4) Finally, in some cases the High Court might agree to a deprivation of liberty using its Inherent Jurisdiction

8.12 **Criminal Law Act: Reasonable force** – the use of force proportionate to the level of risk and balances against the risk of not intervening (planned or emergency) – may be legally defensible when it is required to prevent:

- Injury to other people
- Significant damage to property
- An offence being committed

The degree of any restrictive intervention must be proportionate to both the level of risk presented, and the nature of the harm that may be caused, considering the potential and intent of the person to cause harm. In emergency situations these judgements have to be made at the time, taking due account of all the circumstances, including any known history.

9. **Use of restrictive intervention**

9.1 Positive and Proactive Care sets out the following guidance around the use of restrictive interventions:

- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint o 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 evaluation 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] (DoH 2014)

9.2 The term "Restrictive Interventions" can incorporate the use of the following methods of restricting movement:
Mechanical restraint (such as the use of straps, tethers, harnesses, or devices designed to prevent self-injury)
Environmental restraint (such as locked doors, baffle handles, seclusion rooms)
Chemical/pharmacological restraint (the use of medication)
Social/psychological restraint (the use of instructions, commands, time out procedures)
Physical intervention (the use of bodily contact or force)

All of these should be considered a form of restriction, even if a person does not resist their use. Restrictive intervention must be considered as a short term risk management strategy. Methods should be selected carefully to impose the least restriction of movement required to prevent harm, while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions.

9.3 The use of any type of restrictive intervention is highly contentious and consequently required organisational approval, in-depth staff knowledge, understanding and skill in their workplace application. In particular, mechanical devices, medication and physical interventions should only be used by staff who have received specific training in their usage.

9.**4 Planned use of restrictive interventions**. Evidence shoes that it is safer to use restrictive interventions in a planned, organised and risk assessed way than as an emergency response.

9.5 Restrictive Interventions may only be used in situations where:
- Primary and secondary prevention have not been effective, and
- Other appropriate methods, which do not involve physical interventions, have been tried without success, and
- The risks associated with not using a physical intervention are greater than the risks of using a physical intervention, and there is no safer alternative, and
- The nature and level of physical intervention used is considered to be reasonable and proportionate to the presenting level of risk.

9.6 Planned restrictive intervention strategies must:
- Be agreed in advance by a multi-disciplinary meeting working in consultation with the person, his or her carers and/or advocate.
- Be described in writing and incorporated into other documentation (e.g. care plans, behaviour support plans etc) along with the rationale and context for the agreed intervention, within a broader strategy for addressing the person's needs.
- Take into account the capacity of the person, as well as the issues of informed consent and best interest.
- Be implemented by staff who have undertaken appropriate BILD , Restraint Reduction Network accredited training.
- Be recorded in writing so that the method of restrictive intervention and the circumstances in which it was employed can be monitored and, if necessary, investigated.

- Be risk assessed.
- Be only one component of a broader holistic approach to behaviour management, treatment or therapy, and should only be used when the risks of employing an intervention are judged to be lower than the risks of not doing so.
- Be aimed at reducing risk, NOT securing compliance.
- The minimum necessary force should be used.

The group agreeing interventions needs to comprise a cross section of people representing both professional opinion and the person's best interests (and may include advice from a CPI Safety Intervention™ Instructor about the most appropriate methods available).

9.7 Unplanned or **emergency use** of restrictive interventions may be necessary in unforeseen circumstances, or when preventative strategies have failed. Research evidence shows that injuries to staff and to service users are more likely to occur when restrictive interventions are used to manage unforeseen events, and for this reason great care should be taken to avoid situations where unplanned restrictive interventions might be needed.

9.8 An effective risk assessment procedure together with well-planned proactive and preventative strategies will help to keep emergency use of restrictive interventions to an absolute minimum. In an emergency, the use of restrictive intervention can be justified if it is the only way to prevent injury or to prevent an offence being committed. The use of force should be reasonable and proportionate, using the minimum force and the least restrictive option. Whenever possible, it should reflect the person's training in the appropriate use of restrictive intervention, as well as taking into account the needs and wishes of the service user.

9.9 The **staff** concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences which might have occurred without the use of a restrictive intervention.

9.10 **Chemical/pharmacological interventions**. Medication must only be used where it is included within a person's care plan and prescribed by a medical practitioner. The administration of medication must comply with regulations or national minimum standards issued under the Care Standards Act (2000), as well as the organisations medication policy. Except in an emergency, rapid tranquillisation should not be used. In services where rapid tranquillisation may be used, managers must seek legal advice and ensure that there is a policy in place informing staff as to the correct and legal procedures, and that all staff are fully trained and familiar with this policy and associated procedures.

9.11 **Mechanical restraint**. This refers to the use of any device which restricts movement, intentionally or unintentionally, and should be agreed following the same process as any other restrictive intervention.

9.12 Social/psychological restraint. This refers to the use of behaviour or commands used to staff to influence the behaviour of an individual. Restrictive interventions should never be used as a threat, and staff should be aware that the misuse of social/psychological restraint (for example, the use of threats) is abuse.

10. Post-incident work

Certain actions are required after any incident has taken place. These fall under the headings of recording and reporting, post-incident support, and post-incident analysis.

10.1 **Recording and reporting**.
If it is foreseeable than an individual will require some form of restrictive intervention, there must be a written protocol for that person. A system of recording the use of restrictive interventions using agreed

incident books/forms must be in place. A comprehensive report must also be in the person's notes/records. Any accidents or injuries should be reported as usual using standard procedures.

The use of any restrictive intervention should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the staff involved in the incident, and reported to the appropriate person in line with organisational procedures.

- The written record will indicate:
- The names of the staff and service users involved.
- The reason for using a restrictive intervention (rather than another strategy, including any other strategies attempted).
- The type of restrictive intervention employed, and staff roles.
- The date, time and duration of the restrictive intervention.
- Whether the service user or anyone else experienced injury or distress and, if they did, what action was taken?
- The views and reactions of the service user(s) involved in the incident should be sought and recorded.
- The offer of post incident support, and post incident analysis where appropriate (see below).

Recording will be used for different purposes, including:

- Compliance with statutory requirements (professional and legal).
- Monitoring of service users' welfare.
- Providing staff and service user feedback about the use of the restrictive interventions.
- Monitoring of staff performance and identifying training needs or outcomes.
- Contributing to service audit and evaluation.
- Updating medical, clinical and professional records.
- Identifying strategies for future incident management to reduce restrictive interventions.

10.2 **Post Incident Support** (Defusing, Debriefing and Counselling)
Incidents of violence or aggression can provoke a range of emotional reactions (including fear, guilt, anger and anxiety) in all of those involved. It is essential that following such incidents sources of emotional support are available to service users, staff, families/carers' and anyone else who has been involved in or affected by an incident. Initial support, or *defusing* (emotional 'first-aid' and checking out) should be available immediately and prior to staff leaving duty. This must be compulsorily offered by managers/senior person on duty (but service users and staff can decline or 'not engage' as is their choice).

Debriefing (the opportunity for people to offload and talk through their feelings and experiences) tends to be most effective between 24 and 72 hours after the event. Staff and service users should be given separate opportunities to talk about what happened in a calm and safe blame free environment. Debriefing must be offered, but it is not compulsory for staff or service-users to take up on this offer.

Service managers have the responsibility to follow up incidents which service users or staff find distressing (regardless of whether or not restrictive interventions are employed).

In particular managers should pay attention to the physical and emotional well-being of all involved and, if they are traumatised, should provide any assistance necessary to access external counselling (through, for example, Psychology or Occupational Health Departments). This follow up should be arranged as soon as possible after the event.

If anyone has **concerns** regarding the use of any restrictive interventions, then the **Adult Protection Policy** should be initiated.

Any framework that is utilised should not be focussed on victim blaming or engendering feelings of guilt and insecurity in people. Any debriefing model should be concerned with positive support for all involved, coupled with active strategic planning if necessary. All discussions should take place in a helpful and supportive environment and within the normal limits of confidentiality.

10.3 **Post Incident Analysis**
Managers should encourage staff to reflect in incidents. This will encourage good practice to be shared, and outcome to be measured. Following resolution of incidents where restrictive interventions have been used, particularly if unplanned, analysis and planning must be undertaken to ensure proactive strategies are put in place for the future.

Post incident analysis should involve a discussion of why the incident happened, what worked well, and what didn't work so well, enabling more positive proactive risk management strategies to be identified for any future event (for example, records of incidents sometimes show that there are set patterns relating to people, context, environment or other factors which, if unchecked, could lead to heightened risk.

Analysis of such events can lead to the implementation of proactive strategies. Involving the service user in this process is desirable and advisable, and can lead to the development of better mutual understanding as well as improved strategies for future use.

Incident records should be reviewed regularly (at least on a bi-monthly basis) and appropriate action taken at all levels. There should be a documented review every time physical interventions are used.

11. Roles and Responsibilities

This policy aims to help in providing clarity, ensuring that all involved are clear as to their roles and responsibilities. How these responsibilities are implemented will depend on the individual organisation.

Board level responsibilities include:

- Providing leadership in developing the right values and culture.
- Providing a lead for the focus on recovery and PBS approaches, and for reducing the use of restrictive intervention.
- Having good governance systems in place.
- Overseeing and approving PBS and restrictive intervention training programmes.
- Ensuring restrictive intervention policies are transparent, clear, and accessible to people using services and their families.
- Suing audits of behaviour support plans to develop action plans.
- Ensuring appropriate recruitment systems to select suitable staff.
- Understanding the quality of care and support in the services they oversee.

Service Managers (Line managers and above) have a number of major responsibilities in relation to supporting both staff and service users in their services. Specific guidance can be found in the BILD Code of Practice for the use of restrictive interventions (fourth edition) and in Positive and Proactive Care. In essence these are to:

- Provide good management and supervision.
- Ensure that all at risk of restrictive interventions have an individualised behaviour support plan in place.
- Ensure that people being supported, their families and carers are involved in planning and reviewing all aspects of care and support (Multi-disciplinary input is also required).
- Ensure that the staff have the necessary training and support to be able to implement agreed plans.

- Review the quality, design and application of behaviour support plans (annual audit).
- Ensure that there are post-incident reviews in order to learn lessons.
- Ensure that internal data is accurate and complete (including details of training and of restraint reduction programmes).
- Report the use of restrictive interventions to commissioners.
- Ensure staff work within the law, and in ways which are consistent with the organisations values and principles.
- Ensure the needs of people using services are met.
- Meet their responsibilities for safety in the workplace (Health and Safety at Work Act 1974 and subsequent amendments).
- Ensure that all complaints and investigations are undertaken within the policies of the employing organisation and Protection of Vulnerable Adults Policy.
- Ensure that staff have access to and are familiar with plans, this policy, and other relevant documents.
- Establish and maintain systems for recording and monitoring all incidents that involve the use of restrictive interventions.
- Ensure that appropriate First Aid procedures are followed in any event of injury arising as a result of a restrictive intervention being used. (When it is predictable that restrictive interventions will be utilised, it is *strongly* advised that there are staff on duty who have CPR/ emergency aid training – BILD Code of Practice).
- Ensure that all staff have access to and are up to date with appropriate training as identified by training needs analysis and risk assessment (including updates and refreshers), and that managers are aware of the content and context of such training. In particular, **managers must ensure that any staff using restrictive interventions hold a valid and up-to-date certificate in the use of agreed interventions.**

Staff also have clean responsibilities. Specific guidance can be found in relevant codes of practice and Health and Safety legislation. Areas of responsibility for all staff include:

- Reporting any risks.
- Contributing to the development of risk assessments, proactive strategies and interventions.
- Familiarising themselves with, and working in accordance with, policies, procedures and plans.
- Familiarising themselves with and working to current skid management strategies.
- Attending training as identified (including updates/refreshers).
- Staff must only use methods of restrictive intervention for which they have received training (unless in an unforeseeable emergency, or when alternatives have been specifically agreed and written up by a multi-disciplinary team in relation to the needs of the individual). Specific techniques should be closely matched to the characteristics of individual service users and there should be a record of which staff are permitted to use the techniques that they have been taught.

12. Training

All staff working in adult health and social care services should have access to training as identified by training needs analysis and risk assessment. Training needs analysis should identify the broader training needs to ensure that staff have the necessary knowledge, skills, and competence to work with people positively, meet the needs of the people they support and fulfil the requirements of their role.

All staff require induction before working with people in health and care settings. Staff working with people whose behaviour may challenge will need additional, more specialised training. Any training in the use of restrictive interventions should take place within the context of training on positive behaviour support. Staff will receive training in the appropriate use of restrictive interventions relevant to the level of risk identified

in their workplace using this policy as guidance. Trainers of restrictive interventions, and commissioners of this training, will work to the BILD Code of Practice.

CPI Safety Intervention™ is the preferred model of training in restrictive interventions within this county, and the organisations signed up to this policy will work to ensure that it is appropriate and accessible to staff, providing a risk assessment and training needs analysis has been undertaken to identify and appropriate level of training (and associated annual refreshers). If any independent organisations choose not to use CPI Safety Intervention ™ they should be able to demonstrate that they are using a model which carries BILD Restraint Reduction Network accreditation.

Reducing restrictive interventions policy
Easy-read version

- This policy is about making sure that people have as much freedom as possible
- Sometimes people can become angry or upset and can need staff to help keep then and others safe.
- All behaviour happens for a reason.
- If this happens, services must assess the person's needs to understand the behaviour and see how best to support them. They will then design and plan.
- The plan will have ideas to improve the person's quality of life and help the person find positive ways to get what they need.
- The plan will also include how to support the person if they do get upset or distressed. The person, and their families/carers should be involved in writing the plan.
- In an emergency, staff may have to touch or hold the person to keep them safe. People must still be treated with respect. Staff will not hold anyone unless they really have to. Staff will always do what is best for you and do what the law says.
- Staff will write down what happens on an incident form. People must be able to talk to someone after an incident.
- Staff will have special training so they can support people on a safe way.
- If you need to know more about this, you can ask your keyworker, a social worker or service manager to help you find out.

You can also look on www.shropshire.gov.uk

Original policy Developed by Taking Part, Anna Gillions, Bethphage, Lauren Short, MAPA® Learning and Development Officer, Joint Training, Shropshire Council 2015/16

Policy amendments made in June 2022 by Lauren Titley Restraint Reduction Lead lauren.titley@shropshire.gov.uk, and Joint Training Learning and Development Officers. Amendments made in relation to CPI change of course title, now CPI Safety Intervention™/ Verbal Intervention™ formerly, MAPA® (Management of Actual or Potential Aggression)