Reducing Restrictive Practice Procedure

Procedure Reference:		CS06a	
Related Policy:		CS06	
Effective date:	October 2020	**Review date:**	February 2023
Approved by SLT:		September 2020	
Owner:	Colin Phillips	**Job Title:**	Assistant Director – Care & Support
To be issued to:		Board of Management ARK Management Care & Support Staff	
Method of Delivery:		Email Policy LearnPro	

Version Control

Date	Owner	Version	Reason for Change
June 2020	**Nikki Fildes**	**3.0**	**Cyclical review** **New procedure template**

Reducing Restrictive Practice Procedure

Contents

1.0 Introduction

A positive and proactive approach to supporting people requires consideration of the practices, methods and models used by Care & Support teams to ensure that their actions and behaviours do not infringe on an individual's ability to move freely and make choices.

Appendix 1 contains a list of examples of restrictive practices.

1.1 Restrictive practice and human rights

Any practice that places a limit on an individual's rights to liberty and autonomy is, by its nature, restrictive. All Care & Support teams must be aware of their obligation to uphold the rights of the supported person, while keeping them safe from harm and abuse.

Supported people may make choices that seem unwise to others. This does not mean that they are not free to make that choice.

Any restriction of a person's liberty or choice must only be in place because it would put them at an unacceptable level of risk otherwise. Restrictive practices are never used as a form of punishment.

Further guidance: **Appendix 2 - Human Rights Framework for Restraint** (Equality & Human Rights Commission, 2019)

1.2 Legal authority and consent

It is against the law to interfere with the actions of an adult without legal authority to do so.

An adult who lacks the capacity to keep themselves safe may require the intervention of others to do so. The authority to undertake an intervention must be legally obtained through, for example; welfare guardianship that includes relevant decision-making powers, or an intervention order granted by a sheriff. See: **G36 Keeping People Safe** and **G57a Adult Support & Protection**

Any intervention must be of the least restrictive method required to remove the risk or reduce it to an acceptable level. Alternative methods that avoid restricting an individual must be explored and used wherever possible.

Any restrictive practice that is undertaken without authority to do so, or is not in the best interests of the individual may be considered assault and/or a breach of the individual's

human rights. This may result in disciplinary proceedings and the involvement of the police and social work, and referral to the Scottish Social Services Council.

Consent to undertake any restrictive practice or restraint should be obtained from the supported person.

It is a reasonable adjustment (**Equality Act, 2010**) to discuss the use of restrictive practices and seek consent from the individual through alternative and augmentative communication methods including the use of gesture, visual supports, body language and any other method of communication the individual uses.

If an individual is unable to consent because they lack capacity, their legal proxy must consent on their behalf; this may be a welfare guardian, or an appropriate medical practitioner using an 's.47 certificate' (**Adults with Incapacity (Scotland) Act 2000**).

2.0 Assessing, planning and recording

The introduction of any restrictive practice as part of an individual's support must be agreed by a multi-disciplinary team. This should include any legal guardian, relevant family, the individual and any relevant health or social care professional.

2.1 Risk & Vulnerability

It is essential that the risks of restrictive practices and restraint are assessed.

Serious injury and death can occur from poorly-planned or inappropriate use of restraint.

Restrictive practices that are not physical in nature also carry risk. An incorrect restriction on a person's autonomy may result in a loss of skills or abilities, and/or have an impact on their sense of self-efficacy or self-esteem. This may also affect the individual's behaviour and have a counter-productive effect.

Where it has been assessed and agreed by the multi-disciplinary team that restrictive practices are required, a Risk & Vulnerability Assessment (RVA) must be completed. See: **CS04 Risk & Vulnerability.** The RVA must consider potential impacts of the proposed restrictive practice on the behaviour of the individual, their dignity, and how it may affect their relationships with others.

2.2 Good Life Planning

All supported people must have a Good Life plan that details their personal outcomes, needs and wishes, see: **CS02 Good Life Planning**.

All planned restrictive practices must be detailed in the individual's Good Life documentation. It is the responsibility of all Care & Support staff to read, understand and follow what is stated in the person's Good Life plan and to contribute to it as required.

All restrictive practices recorded in the individual's Good Life documentation must include at a minimum:

- The members of the multi-disciplinary team
- The exact practice that is required and why
- Who has consented to its use
- The circumstances in which it may used
- How the effectiveness of the practice will be monitored
- When it will be reviewed, and by whom

Historical restrictive practices that are no longer in use should never form part of the individual's Good Life plan. This may create an unrealistic impression of the supported person and change others' perceptions of them.

2.3 Reviewing

A **Restraint Reduction Log (Appendix 3)** must be in place for every supported person whose care needs mean there are restrictive practices in use, and every episode of restraint recorded. These must be reviewed every 6 months by the Care & Support Manager (CSM)/Registered Operations Manager (ROM).

The review, as part of the Good Life planning process, must evidence how restrictive practices are being reduced as an individual's skills and abilities increase.

Questions for consideration:

- Was each instance of restrictive practice required?
- What were the consequences of each instance?
- Are there any negative effects from this practice?
- Are these negative effects justified or do they outweigh the benefit?
- Does this practice still meet the individual's needs?
- How could the restriction be lessened while still keeping the person safe?
- Are there any new, less restrictive methods that could meet the person's needs?
- What does the supported person think?
- Are any necessary legal powers still in effect?

Where an individual has been assessed as requiring physical intervention (for example, a particular hold), the frequency of use is particularly important in deciding whether it is still required.

If a particular intervention has not been used for **12 months**, there should be a multi-disciplinary meeting to decide whether the intervention is still needed. If not, it must be removed from documentation.

It is **not** acceptable for a restrictive practice that has been unused for more than 12 months to remain open to use for that individual 'just in case' it is needed again in the future.

3.0 Physical intervention and restraint

ARK Care & Support services will only use CALM-accredited physical intervention/restraint techniques.

Any episode of physical intervention/restraint must be recorded as an incident; see **HS04 Incident Reporting**. It must also be recorded on the **CALM monitoring form (Appendix 4)**.

'Physical intervention' includes techniques like guiding or positioning.

'Restraint' means any technique that stops an individual from moving their body or part of their body. 'Restraint' also includes the use of seclusion. Seclusion means any practice or action that stops an individual from leaving a room, or keeps them separate from others, see **Appendix 2 - Human Rights Framework for Restraint** (Equality & Human Rights Commission, 2019)

Restraint must only be used as a 'last resort' (Mental Welfare Commission, 2013). A proactive approach to supporting people must mean that de-escalation techniques and other less-restrictive methods are used before restraint is considered.

An individual who is subject to physical intervention or restraint must have a Positive Behaviour Support plan in place; see **CS17a Behaviour of Concern**

Required information:

- Who was involved in the multi-disciplinary assessment?
- Who has given consent?
- Details of the exact restraint technique, and in what circumstances it may be used
- How long the restraint may last
- Recording process for each instance of restraint
- How the effectiveness of the technique will be monitored
- Review dates and who will be part of the review

Every instance of physical intervention or restraint must be explained to the supported person using their preferred format.

The individual's welfare guardian or relevant family may wish to be informed of any instance of physical intervention or restraint. This must be documented in the individual's Good Life plan.

ARK's in-house CALM instructor **must** be part of the multi-disciplinary team for individuals who are subject to physical intervention or restraint in order to discuss appropriate CALM techniques.

4.0 Emergency restraint

ARK Care & Support workers have a duty of care. If an individual's disability, condition or other care need puts them at risk, staff must do what is reasonable and proportionate to keep them safe. If, for example, an individual went to step out onto a busy road, it would be reasonable for the worker to verbally alert them to the danger. If this didn't work, it could be reasonable to physically stop them.

In exercising the duty of care, there may be emergency situations where a Care & Support worker who has not completed CALM training may be involved in a physical intervention / restraint.

The intervention must still be reasonable, proportionate and required to protect the individual from harm.

Emergency restraint may be an Adult Support and Protection issue, see **G57a Adult Support & Protection** and **G36 Keeping People Safe**.

After any emergency restraint, a review of the circumstances and consequences of the incident must take place by the CSM/ROM. A multi-disciplinary meeting should be convened if the individual's needs must be reassessed as a result.

The Good Life plan and RVA must be reviewed and updated as needed.

Any instance of emergency restraint must be treated as an incident, see **HS04 Incident Reporting**, and recorded in the **Restraint Reduction Log (Appendix 3)** in addition to the service incident log.

5.0 Training and support

5.1 Training and learning

All Care & Support staff supporting people who are subject to restrictive practices will be trained in their appropriate use. This may include through peer learning, service induction,

team meetings, supervision and any other method deemed suitable by the CSM/ROM, in addition to Positive Behaviour Support and CALM training.

It is the responsibility of both the individual staff member and their line manager to ensure that their CALM accreditation remains valid. The Learning & Development team hold a list of accreditations.

5.2 Support and supervision

After any episode of physical restraint, the Care & Support workers involved should meet with their CSM/ROM to discuss the incident.

6.0 Monitoring and analysis

It is the aim of all Care & Support teams to minimise the use of restrictive practices. The use of restrictive practices will be monitored at a local-level by the CSM/ROM.

At an organisational-level, all incidents are collated by ARK's Health & Safety Adviser and anonymised data reported on a quarterly basis to the whole organisation, including ARK customers. This data is also presented to the Board of Management via the Audit sub-committee.

7.0 Implementation and Review

7.1 Implementation

CSMs/ROMs are responsible for the implementation of these procedures by their Care & Support staff.

7.2 Review

ARK Area Managers' group is responsible for the review of these procedures, at least every 3 years. Any changes to the associated policy (**CS06 Reducing Restrictive Practice**) as a result must be submitted to the Board of Management for approval.

Appendix 1 – examples of restrictive practices

Type of restraint	Intervention examples	Possible circumstances	Further considerations
Physical	CALM physical intervention CALM restraint Any actual – or threatened – laying hands on a person	To prevent serious harm to the person or others around them	Staff must be CALM accredited in order to use these techniques.
Physical	Wheelchair lap-belt/ankle-straps	To prevent an individual who is unaware they are immobile from trying to walk To stop an individual falling out of their wheelchair whilst in motion	Tray tables and/or bed-sides must never be used as a restraint technique.
Environmental	Locked doors	To prevent an individual who wanders and is unable to recognise risks from leaving	Legal authority to restrict someone's liberty must be in place. In shared accommodation, those who do not need this intervention must still be able to move freely.
Environmental	Door alarms/sensors Pressure pads/passive alarms	To alert staff to an individual's movements	This may be a reasonable alternative to a locked door. In shared accommodation, consideration must be given to the rights of others to move freely.
Environmental / restraint by default	Storing walking aids out of an individual's reach Not providing support required to navigate stairs, etc.	This is not appropriate.	Individuals must have access to any aid or adaptation they require.
Environmental	Medication stored in a locked box or outside the individual's private living space.	To prevent the individual or others from accessing the medication	Medication should not be stored in communal areas. There must be justification if the individual cannot access their medication freely.

Chemical	Medication used to reduce particular behaviours, rather than treating an illness	To inhibit an individual from wandering	The individual and any legal guardian must be aware of potential side effects. Staff must monitor the effects and ensure that the prescription is reviewed regularly. A protocol for administering 'as required' medication must be in place. See **CS08 Medication**
Chemical	Covert medication – medication given without the individual's knowledge	The individual is unwilling to take medication that is essential to their health/well-being	Adults with capacity can **not** be given covert medication. Covert medication must be prescribed, agreed for use by a legal proxy and a protocol in place for its use.
Financial	Trust Accounts/Appointeeship Financial guardian/power of attorney Money/financial items locked away Staff reviewing/recording financial transactions	Individual lacks capacity to manage their money Individual needs help to budget	Can the adult manage smaller amounts of money? See **CS05 Support with Money**
Interpersonal	Verbally redirecting Guiding without touching Distraction	To control or direct the individual's actions	If this is a consistent technique used, it may be considered restraint and is therefore subject to this procedure.
Technological	Tracking device fitted to clothing 'Find my friend' or 'Find my device' apps	To identify an individual's movements	Is this level of surveillance required? What is the purpose of knowing an individual's exact location?