Policy Group: Clinical
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Approved by: Quality and Safety Group, Executive Team

Least Restrictive Practice Policy

Contents

1. **Policy Summary / Statement**

The policy articulates St Andrew's Healthcare commitment to reducing restrictive practices and applying the principles of Least Restrictive Practice in all aspects of service design, delivery and development. These principles, are summarised in the Mental Health Act Code of Practice para 1.5 *' any restrictions should be the minimum necessary to safely provide the care and treatment required having regard to whether the purpose of the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action'.*

Breaking this down, restrictions are:
Sometimes necessary to enable care and treatment that will promote recovery and independence and/or to keep people safe.
Should be the minimum necessary to achieve that purpose.
Reducing restrictions is not an end in and of itself but must be for the above purpose(s).

Reducing restrictions in a way that increases risk to patients and/or does not promote their recovery is, therefore, not least restrictive practice.

St Andrew's Healthcare is committed to reducing unnecessary restrictive practices, in line with the principles of the MHA Code of Practice, the Human Rights Act 1998, the Equality Act 2010, various NICE guidance and the CQC Brief Guide to Blanket Restrictions in Mental Health wards (Nov 2020).

2. **Links to Procedures**

This policy sits within the overarching Use of Force policy.

Related policies:
Seclusion
Enhanced Support
Long Term Segregation
Rapid Tranquillisation
Mechanical Restraint
Search
Security

Policies and procedures available via the Policy A-Z:
Policies - Policies - A-Z (sharepoint.com)

3. **Scope**

This policy applies to all clinical staff and services.

4. **Background**

Operational Definitions

'Restrictive Practices are those that limit a person's movement, day to day activity or function' (RCN 2017)

Put simply, restrictive practices means actions that stop a person from doing something they want to do, or doing it the way they want to do it.
e.g. only allowing a person to access their bedroom at certain times of the day.

A subset of Restrictive Practices are **Restrictive Interventions** which are defined by the Department of Health as:

*(1) 'Planned or reactive 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

(2) end or reduce significantly the danger to the person or others;

and

(3) contain or limit the person's freedom'

Restrictive Interventions include restraint (physical, chemical and mechanical), enhanced support, seclusion and long term segregation. See Appendix A of detailed definitions that inform the Mental Health Minimum Dataset.

Rationale for use of Restrictive Practices

Restrictive practices are NOT inherently wrong or harmful. They can help keep people safe and create opportunities for them to learn new skills and recover. Their use overlaps significantly with the concept of application of procedural security / boundaries which should also only be used to enhance safety and/or promote recovery. This is important to note, because many of the perceived restrictions result from procedural boundaries 'expected' of a certain service within national quality standards e.g. having a process to search patients within a secure setting.

This is detailed in MHA Code of Practice 8.8:

"8.8 *Within secure service settings some restrictions may form part of a broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public. The individual's need for such security measures should be justified to meet the admission criteria for any secure service. In any event, the application of security measures should be based on the needs of and identified risks for individual patients, and impose the least restriction possible. Where individual patients in secure services are assessed as not requiring certain security measures, consideration should be given to relaxing their application, where this will not compromise the overall security of the service. Where this is not possible, consideration should also be given as to whether the patient should more appropriately be managed in a service that operates under conditions of lesser security*

Guiding Principles of Use of Restrictive Practices and Interventions in St Andrew's Healthcare

The guiding principles of a least restrictive practice culture are:

1. They must only be used for an outcomes based therapeutic benefit and/or to keep the person and others safe; this should be within a culture of proactive support to enable positive and safe behaviour.

2. They must never be used for punishment or other non- therapeutic purpose.
3. They must be proportionate to the perceived risk of harm or the lack of therapeutic benefit that would occur if the restriction was not in place.
4. They must be necessary and a last resort i.e. there is no other way of achieving the same purpose.
5. They must be used for the shortest possible time and with the minimum force to achieve its purpose.
6. They must be done in a way that maximises privacy and dignity.
7. They must be subject to regular review, by both staff and patients.
8. They must be individualised and appropriately care planned: their use will be based on an assessment of the individual's needs, taking account of their history, physical and psychosocial needs and preferences in order to minimise distress, trauma or risk of unintended harm.
9. Staff should work to reduce the amount of 'blanket' bans in operation that result in restrictive practices. **Blanket restrictions are "rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application."**
   Ward based restrictive practices will be documented in a log and subject to review at ward level (with patients) and at the levels of the governance system. **The process and expected templates are in Appendix D - Restrictive Practice Log template and governance flowchart**.
10. Individuals who may be subject to restrictive practices will be given clear information about the range of restrictive approaches authorised and used within the service, the circumstances that govern their use and whom to complain to if there is a concern about how these measures are implemented.
11. When restrictive interventions have been applied, there should be learning from patient and staff experience, so as to help reduce the likelihood of future use of such interventions.

Patient Involvement Principles

1. Patients should be encouraged to be involved (where possible) in all aspects of care planning relevant to restrictive practices. These include positive behaviour support plans, seclusion, LTS and enhanced support care plans.
2. Where appropriate, patients can make and have recorded advance statements with respect to use of restrictive practices. For example, patients with cognitive impairment such as dementia, or with fluctuating mental disorders, can be encouraged to express advance views during more stable periods.
3. Patients should be able to access a copy of this policy on request.
4. The Safeguarding Lead should be informed whenever a complaint is raised about use of a restrictive intervention.

Post Restrictive Intervention Review / Debrief (See Flowchart as Appendix B)

In line with CoP 26.167, after an episode of any acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review or debrief should be undertaken, so that all parties, including patients, have the appropriate support and there is organisational learning.

NICE guidance 10 states that this should occur after any restraint, use of rapid tranquilisation or after behaviour that has led to use of seclusion.

The Restraint Reduction Network guidance on Post Incident Support for Children and Young People (2022) distinguishes post-incident support (with the aim of containment) from post incident learning (thinking about how the event could be prevented in the future) acknowledging that the latter may occur later due to the need to be emotionally calm after an event.

This policy will separate the concepts of staff debrief from patient debrief. In some cases, it may be appropriate for this to occur together, but it may also be appropriate for them to occur separately.

Staff debrief should be held as soon as possible, involve the MDT as far as is possible, and be with the aim of understanding what happened, why and making relevant changes to care planning and treatment. **In line with the RRN guidance, as soon as possible means after the incident has been contained and staff are emotionally calm and able to have a learning based discussion. This timescale will vary by incident but key milestones can be by end of shift, or within the first 48-72 hours**. The NIC should identify the person to lead the debrief. Although this could be held as a separate meeting, it is also possible for debriefs about incidents within a relevant previous time period to be incorporated into structured meetings such as morning MDT meetings, **reflective practice, clinical supervision** or nursing handovers as appropriate to the individual ward. It would be expected that any such debrief occurs by the end of the same shift where possible

Recording that the debrief has occurred for patients and staff should be noted on DATIX- this will link the debrief to the related incident.

It is good practice, where possible, to conduct the staff and patient debrief together. However, It is recognised that patient debriefs may occur later, in order to allow the patient to appropriately stabilise to take part in the review. As a general principle, this should occur no later than 72 hours post incident and specific findings recorded in the progress notes (including their refusal to engage if that is the case).

It is important that patients are appropriately supported to help them understand what has happened and why.

If a patient is able and willing to participate in a review, then their understanding and experience of the incident should be explored (CoP 26.169). What aspects of the intervention helped or did not help, their feelings, anxieties and concerns about the intervention should be explored and documented in the progress notes.

If appropriate, positive behaviour support plans and related care plans and risk assessment and management plans should be updated.

Recording of the occurrence and content of a patient debrief can be recorded in RiO progress notes using the Nursing- Debrief progress note option.

If a patient is unable or unwilling to participate in a review, the team should explore methods for assessing the effect of the intervention on the patient's behaviour, emotions and clinical presentation and adapting the positive behaviour support plan accordingly.

Trauma Support Debrief

This policy also recognises that incidents can also have an emotional impact on staff and patients and certain incidents may require more a trauma informed and comprehensive debrief and review.

- The NIC will need to consider whether or not to refer the incident for a trauma support debrief.
- If a trauma support debrief is indicated, then the Trauma Response Lead needs to be informed via email.

The aim of the trauma support debrief is to develop a comprehensive understanding of a single or multiple incidents, and to place the incident within the wider context of the person's care (physical environment, their treatment, staffing, their care plan etc) and to bring about actions that will reduce the likelihood of further incidents. The debrief should take place as soon as possible following the incident and no later than one week following the incident.

Factors indicating a trauma support debrief may be required:

- An incident occurs that is outside the normal range of events that happen at work
- Someone was hurt/seriously threatened
- Hostage incidents
- There has been a pattern of incidents involving the same person
- The restraint was prolonged
- Incident occurred in a public place
- Police attended

Appendix C of this policy gives good practice guidance templates that can be used to facilitate a comprehensive debrief process.

5. Roles and Responsibilities

Accountabilities and Responsibilities:

Board of Directors	Is responsible for overseeing the reduction of restrictive practice within its services, and legal and ethical use of restrictive practices when they are required; should ensure that patients are safeguarded and their equality and human rights are not compromised.
Chief Nurse	Accountable to the Board for the development, consultation, implementation and monitoring of compliance with this Policy.
Director of Operations, Operational Leads and Clinical Directors	Have operational responsibility for divisional compliance with this Policy and will ensure mechanisms in place within each division for: - Identifying and developing resources within the division to safely deliver this Policy. - Ensuring all clinical staff receive orientation to the content of this Policy. - Monitoring the division's compliance and consistent application of the Policy.

Responsible Clinician	The Responsible Clinician has a legal and professional responsibility for the care and treatment of their patients. They are responsible for ensuring: - That the rationale for use of Restrictive Practices is appropriately documented and justified.
Nurse Manager/ Ward Manager	Nurse Managers/ Ward managers are responsible for ensuring that the guiding principles of this policy are manifest in day to day operational running of the ward.
All clinical staff	To be aware of the principles of this policy To promote these principles and challenge (and if necessary escalate) practice that may be breaching these principles
Training and Development	St Andrew's Healthcare training and development department will offer that all clinical staff training in the appropriate knowledge, skills and behaviours that enable consistent application of the guiding principles of this policy. This will include a focus on non-restrictive approaches, therapeutic interactions and de-escalation skills. The Mental Health Law Steering Group can provide subject matter expertise in mental health law across the Charity and use this to influence best practice and support/monitor effective governance over the use of the MHA. In addition, to support and educate staff to understand and meet the standards set out in the MHA Code of Practice for patients in their care.
Quality Improvement	As an organization, St Andrew's Healthcare is committed to Restrictive Practice Reduction using a continuous improvement methodology. Our Restrictive Practice Reduction Programme (REDUCE) incorporates a Violence Reduction Programme and includes the key elements required of such a programme as set out in the MHA Code of Practice 26.6: • Organizational commitment at the most senior level to reduce Restrictive Practices • Use of data to inform service development • Workforce professional development • How models of care known to reduce restrictive practices are being integrated into care delivery • How patients are being engaged in service planning and evaluation • How lessons are learned following restrictive interventions • A system for continuous quality improvement and governance

6. Monitoring and Oversight

The ward to board structure of Governance that oversees the quality control, assurance and improvement of use of restrictive practices are:

Ward Clinical Governance meeting reports into Divisional governance that reports into: Divisional Quality and Performance reviews that then go to the Charity Executive
Divisions attend the Quality and Safety Group, that receives input from the divisions and the Restrictive Practices Monitoring Group (RPMG) that then reports into the Board Quality and Safety Committee

Any formal CQI projects related to restrictive practice reduction will be noted at QSG and then incorporated into business as usual governance if proven to be effective.

The RPMG oversees the design and implementation of the Charity Reducing Restrictive Practices Programme, currently called REDUCE (Reducing Violence and Restrictive Practices) and has a patient led advisory committee called the LRP Advisory Group that reports into it. The REDUCE programme sets out annual objectives, progress against which are reported into QSG.
Data on the leading and lagging indicators related to RP are captured in the PSF and IPQR and reviewed from ward to board

7. Diversity and Inclusion

St Andrew's Healthcare is committed to *Inclusive Healthcare*. This means providing patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity, and not tolerating discrimination for any reason.

Our goal is to ensure that *Inclusive Healthcare* is reinforced by our values, and is embedded in our day-to-day working practices. All of our policies and procedures are analysed in line with these principles to ensure fairness and consistency for all those who use them. If you have any questions on inclusion and diversity please email the inclusion team at DiversityAndInclusion@standrew.co.uk.

8. Training

The principles of Least Restrictive Practice from this policy will be fully incorporated into induction, refresher and specific training provided to clinical staff. This training will use a range of delivery methods including e-learning and classroom based training.

St Andrew's Healthcare training and development department will offer all clinical staff training in the appropriate knowledge, skills and behaviours that enable consistent application of the guiding principles of this policy.

This will include a focus on non-restrictive approaches, therapeutic interactions and de-escalation skills.

Our Safety Intervention Training meets RRN standards.

There are related PI's related to training compliance with RP related e-learning (seclusion, LTS, ES) and classroom training (Safety Intervention Training)

The Mental Health Law Steering Group can provide subject matter expertise in mental health law across the Charity and use this to influence best practice and support/monitor effective governance over the use of the MHA. In addition, to support and educate staff to understand and meet the standards set out in the MHA Code of Practice for patients in their care.

9. References to Legislation and Best Practice

1. Department of Health (2015). *The Mental Health Act 1983: Code of Practice*. The Stationery Office (TSO).
2. Department of Health (2014). *Positive and Proactive Care: reducing the need for restrictive interventions.* London: DH.
3. Royal College of Nursing (2017). *Three Steps to Positive Practice: a rights based approach when considering and reviewing the use of restrictive interventions*. RCN: London.
4. Restraint Reduction Network (2022). *Post Incident Debriefing Guidance: working with children and young people.*
5. NICE (2015) Violence and Aggression: Short-term management in mental health, health and community settings. Updated edition (NICE Guideline 10). London: NICE.
6. Trauma Informed Care (2017) Scotland https://nes.scot.nhs.uk/media/3983113/NationalTraumaTrainingFramework-execsummary-web.pdf
7. Debrief guidance NHSE (2016) https://www.england.nhs.uk/wp-content/uploads/2016/03/prt4-act-resrc-a-debrief-temp.pdf
8. CQC (2020). *Brief Guide to Blanket Restrictions in Mental Health Wards.* London.
9. NICE (2017) Violent and aggressive behaviours in people with mental health problems. Quality Standard (QS154)

10. How to request a Change or exception to this policy

Please refer to either the Policy and Procedure Update Application Link
Or the exception process Policy and Procedure Exception Application Link

11. Key changes

Version Number	Date	Revisions from previous issue
1.0	October 2019	Revised policy onto new template – full review and update Published as a new umbrella policy linking to Positive and Safe, Seclusion, LTS, Enhanced Support, Rapid Tranquilisation.
1.1	Sep 22	IPU's to divisions Additional reference to the Restraint Reduction Network and REDUCE programme Additional Appendix D- new LRP log template Additional reference to Use of Force and CQC guides Updating the responsibilities of the training and development team to reflect what is currently in place, versus what is required in the future Additional Clinical Staff roles and responsibilities

Appendices

APPENDIX A	Definitions in MHDS
APPENDIX B	Incident Debrief Process
APPENDIX C	Post Incident Debrief of Service Users Version 2.0
APPENDIX D	LRP log template