Restrictive Practices Strategy for Positive Active Care: reducing the use of restrictive practices and interventions.

Strategy start date: October 2020

Strategy review date: October 2023

This Strategy has been compiled by the clinical governance and management teams at Oldercare (Haslemere) Ltd known as Oldercare.

Strategy awareness	
The service/s this strategy applies to	All Oldercare hospital and nursing services
People who need to know this policy in detail	Medical Director, Registered Managers, All medical and nursing staff, Business Director, Management teams, Heads of Department
People who need to have an understanding of this strategy	All care and non-care staff
People who need to know that this policy exists	Regulatory Organisations and Commissioners

Oldercare has discouraged the printing of policies and strategies since April 2015 and can only guarantee a policy or strategy is the most up to date version in the electronic policy folders on the U Drive

1. Strategic aim

We commit to working with our patients their carers and our staff to ensure that we reduce the use of restrictive practices and restrictive interventions and to ensure that any misuse of restraint is prevented.

2. Background

There is a relationship between mental disorders and the risk of violence1. Many people who are admitted to psychiatric hospital are deemed to pose a risk to themselves or others. Many of those people will then be subjected to restrictive practices and interventions. While such practices are often instituted to manage the risk of violence, they can sometimes have the opposite effect. Furthermore, there are examples when restrictive practices and interventions have been abused by professionals and have led to harm to patients.

3. Introduction

This strategy aims to promote a positive and caring culture at St Magnus to support and care safely for patients who do pose a risk to themselves and others while simultaneously reducing the need for restrictive practices and interventions.

The strategy will help to make our hospitals safer for our patients, their visitors and the people who work here.

Nationally it is a key Department of Health target to achieve a reduction in restrictive interventions by improving the quality of care, clinical and managerial leadership, transparency and data access and management and oversight2.

The key principles that informed the development of this strategy are based on our respect for patients and their carers, a desire for all our care interventions to be individualised for every patient and to ensure that all our approaches are focused on recovery.

4. Method:

Our strategy divides the interventions into six key areas:

I. Leadership
II. Use of data
III. Workforce development
IV. Restraint reduction tools
V. Patient views and input
VI. Debriefing strategies

[1] Elbogen EB, Johnson SC. The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry. 2009;66(2):152–161. doi:10.1001/archgenpsychiatry.2008.537

[2] Positive and Proactive Care: reducing the need for restrictive interventions. Social Care, Local Government and Care Partnership Directorate, Department of Health. April 2014.

The interventions were identified by consulting our patients and staff and by reviewing relevant literature and examples of best practice in the field**.**

5. Outcomes to measure

The success of this strategy will be measured against specified outcomes that include:

- Counts of key specific restrictive practices and interventions that will include but are not necessarily restricted to restraint, rapid tranquilisation, seclusion and blanket bans
- Assessment of patient experience captured from the regular ward meetings and the annual patient survey
- Assessment of carer experience captured from the annual carers' survey
- Assessment of staff experience captured from the annual staff survey

6. Leadership

An Executive Management Team (EMT) level lead has been identified to increase the use of recovery based approaches including Positive Behaviour Support (PBS) plans and reduce restrictive interventions.

- The EMT will be accountable for the overall programme to reduce restrictive practices and interventions.
- The EMT will ensure that our relevant policies support efforts to reduce restrictive practices and interventions.
- The EMT will ensure that positive behavioural support is taught to staff as a priority.
- The Ward Managers and Deputy Managers will be empowered to develop and implement quality improvement initiatives working collaboratively with their patients and carers.

7. Use of data

We will collect and monitor data showing the number of incidents reported in the following highlighted areas

- restraint
- restraint for personal care
- rapid tranquilization
- seclusion

This information will be broken down by service and ward.

We will complete quality audits of the PBSs and in the use of key restrictive practices.

We will set appropriate realistic and achievable targets tailored to specific services and wards.

8. Workforce development

- We will begin with a value-based recruitment strategy to ensure that people who bring the right attitudes are in our workforce.
- We will ensure that all members of staff have access to regular management and clinical supervision. We will ensure that the completion of that supervision is recorded.
- We will ensure that staff education and training programs are delivered in collaboration with patients and carers.
- We will train our staff to recognise and understand how their actions and inactions influence patients' experience and behaviour.
- We believe and will encourage our staff to be positive role models when dealing with safety issues, starting with themselves.
- We will ensure that clinicians are able to recognise challenging and violent behaviour as it develops, can contribute to functional assessment and can develop positive behaviour support plans (PBSs) with the patients.
- We will ensure that staff who work in clinical environments are trained in NAPPI and suitable de-escalation strategies. We will ensure that this is delivered and maintained and recorded through mandatory training processes.
- We will ensure that staff are suitably trained to understand the legal framework that supports the use of restrictive practices and interventions.
- We will ensure staff use inappropriate means of restraint for example that does not impact on a patient's breathing and circulation, nor deliberately inflict pain.
- We will ensure that staff are trained to understand the principles that guide the deployment of restrictive interventions, for example use of the least restrictive option and that the force used must be proportionate.
- We will include qualified and unqualified staff in decision-making processes. We will include support workers in mental capacity assessments, best interest meetings and ward round discussion for specific patients.

9. Restraint reduction strategy

We believe strategies to reduce restraint should be based on developing positive therapeutic relationships with our patients and carers.

Staff say that the most important strategy to reduce the risk of confrontation is to have a better understanding of the patient and place a lot of importance of getting to know them as a person. Staff feel that they can then gain a clear understanding of the patient's triggers and destabilisers. We will ensure that staff are given adequate time to get to know their patients.

We believe that many of the strategies to reduce restraint are based on sound clinical assessment and effective clinical management.

At the heart of this is effective multidisciplinary clinical assessment that starts before admission. It will help to inform an understanding of the patient as a person and an understanding of their mental disorder, their behaviour and associated risks. Then from there we will develop an initial risk assessment and the first positive behaviour support plan. This should not be over medicalised and should focus on understanding the person in their personal and social context not just as a patient with a mental disorder.

We will ensure that the appropriate legal framework is in place in terms of the Mental Health Act (1983) and the Mental Capacity Act (2005). We will develop new tools to support the recording of capacity and best interest decisions around for example care planning for restraint in the provision of personal care.

We will promote the principles of positive behavioural support focusing on prevention and de-escalation. We believe that the PBS plans should be person centred and value-based. They should understand the patient as an individual, know their vulnerabilities and triggers, problematic behaviour and risks. They should take an active approach to recognising changes in advance of risk escalating and have constructive interventions that help to prevent problems from escalating.

The PBS plans will focus on de-escalation and other preventative strategies. The PBS plans will be integrated and delivered within wider care planning for every patient.

We believe that certain tools and guidelines can help for example the HCR-20, the DUNDRUM and START risk assessments. These will be applied on an individualised needs basis, where commissioning arrangements allow.

We will involve staff and support them to use their clinical experience and expertise to work collaboratively with patients and carers to reduce restrictive interventions. We believe that a collaborative approach between staff, patients and carers will help us achieve these goals.

At ward level patients will participate in community meetings to help identify safety issues in advance. This will help to identify potential triggers and stressors in advance encouraging patients and staff to solutions.

Community meetings will act as an opportunity to review a ward’s rules and practices. The meeting can be an opportunity to review if these remain appropriate and to decide efficiently if they should remain, be changed or be removed. These suggestions can be escalated to the relevant Clinical and Executive Management Teams (CMT & EMT) for ratification.

We will ensure that restrictive interventions always represent the least restrictive option.

10. Debriefing & post incident reviews

We will hold debriefings and reviews after emergency restraint incidents, not for routine personal care.

We believe that debriefing and review helps clinical teams to develop a better understanding of each individual's needs and triggers and also helps to identify learning points to ensure lessons are learnt in every instance.

We believe that the starting point of any post incident debrief will be the patient. This is to learn about the patient's views of the stressors and their experience and to explore suggestions to avoid repetition.

We believe that effective debriefing will help to develop new channels of communication.

We believe that effective debriefing will improve safety on the ward.

These early first discussions should only take place once those involved had been able to recover their composure. We will acknowledge the emotional responses to the events but also promote relaxation and feelings of safety and facilitate a return to normal patterns of activity.

We will ensure that all the relevant parties have been informed and the necessary documentation has been completed.

We believe a second debrief should be conducted a few days later with a more in-depth review. For more serious incidents this may be a facilitated MDT discussion to review warning signs and what de-escalation strategies were employed, which were effective in what could be done differently in the future.

11. Strategy to reduce the use of wider restrictive practices

Restrictive practices of any intervention that forces a patient to do something they do not want to do or an intervention that prevents someone from doing something they want to do.

We will systematically review all blanket restrictions that are not inherent to service and ward security.

Where blanket restrictions are not an inherent part of service or ward security, we will permit staff to consider relaxing restrictions when it is appropriate to the care of an individual patient and will not compromise the security of the service.

We will take a systematic approach to identify and challenge our own practices that may amount to blanket restrictions.

The initial focus will be on the use of:

Seclusion and long-term segregation

12. Overall monitoring

Initial monitoring will focus on:

I. Counts of key specific restrictive practices and interventions that will include but are not necessarily restricted to restraint, rapid tranquilisation, seclusion and blanket bans

II. Assessment of patient experience captured from the regular ward meetings and the annual patient survey

III. Assessment of carer experience captured from the annual carers' survey

IV. Assessment of staff experience captured from the annual staff survey

13. These will be captured through

- The weekly incident summary and formal quarterly incident reports that are reviewed at the quarterly Clinical Governance meeting
- The annual survey report that are reviewed at the quarterly Clinical Governance meeting.