Restraint Reduction Network

Towards Safer Services

National Minimum Standards

Organisational Restraint Reduction Plans

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Content

Contextual editorial

The impetus for these National Minimum Standards goes as far back as 2004 when the National Institute for Mental Health in England (NIMHE) and the National Patient Safety Agency (NPSA) launched a joint project entitled, Prevention and Management of Aggression and Violence in Mental Health Services. The project was established in the wake of a number of national reports and inquiries which raised concerns on the level of violence and aggression and the management of safety in mental health units, and the tragic death of David 'Rocky' Bennett.

The project was led by Colin Dale and Gary O'Hare, and overseen by Malcolm Rae. It had 17 main objectives, many of which were successfully delivered within the life of the project. In 2004 NIMHE published the *Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings* (Department of Health, 2004a), setting out a range of positive practice standards to promote transparency and improvements in safety and managing violence. The project concluded with a published report in June 2006, outlining progress and successes of each of the 17 objectives.

Two main proposals were not advanced further until recently. The first was to 'develop proposals for accreditation and regulation of PI trainers and programmes of education and training'. (PI in this context meant Physical Intervention.) This has now been developed and published by the UK Restraint Reduction Network (RRN) as the *National Training Standards 2019*. The second was to 'publish definitive standards (for services) for the safe and therapeutic management of aggression and violence'. The agenda for reducing restrictive practices is widely established. It has been supported through various publications, regulation, an NHSE Expert Reference Group and more recently has been augmented by the Reducing Restrictive Practice (RRP) Collaborative established by NHS Improvement (NHSI) in partnership with the Care Quality Commission (CQC) in response to a request made by the Secretary of State.

We aim to prescribe the steps necessary to attempt to reduce restraint. The legal duty upon providers to do so is created by the Mental Health Units Use of Force Act 2018, informally referred to as 'Seni's law'.

Dr Ben Thomas and Guy Cross organised a national focus group to bring together a 'coalition of willing experts' to review current literature and agree what form new organisational standards in reducing restrictive interventions should take.

This document has been informed by the original NIMHE/NPSA project, and the advances in practice and understanding in the reducing restrictive practices agenda expressed in a growing evidence base and the focus group deliberations.

Executive summary

This document outlines the National Minimum Standards for the content of Restrictive Interventions Reduction Plans* in Mental Health and Learning Disability Settings and offers a framework to support care providers in the reduction of the use of restrictive practices. The content is in line with the legislative requirements outlined in the Mental Health Act Code of Practice (Department of Health, 2015), other relevant legislation such as the Human Rights Act 1998 (HRA), and is informed by evidence based best practice. The state of the art in violence prevention is, and has been for some time, that general principles are well established but implementation is a challenge.

The National Minimum Standards, in accordance with the Mental Health Act Code of Practice (Chapter 26, Safe and Therapeutic Responses to Disturbed Behaviour), acknowledge that interventions to prevent a greater harm occurring are sometimes necessary to protect people's human rights, including from risk of serious harm, and where the legal framework is followed.

Restrictive practices are often a response to those overlapping behaviours conceptualised by care providers and wider society as 'behaviours of concern', 'challenging behaviour', or 'behaviours which challenge'. Such behaviours can occasionally include willful acts that cause or have the potential to cause harm in another person or the individual but are more often than not symptoms of distress or frustration and a response to the environment or situation that a person finds themselves in.

The National Minimum Standards have been informed by contemporary best practice and bring together the recommendations outlined in key publications to protect human rights and maximise the safety and welfare of people who receive services, staff and others.

The publications that have informed this document are listed in the selected bibliography. The standards have been developed in consultation with expert practitioners and experts by experience, and have been endorsed by leading national bodies.

The compliance statements contained in this document also provide a structure for organisational assurance that will be monitored by the Care Quality Commission (CQC). Due to their systematic nature, the statements vary in their scope and so we have given a thematic summary at the start of sections, similar to the style of the foundational 2004 NIMHE document.

The CQC uses a human rights approach (see http://www.cqc.org.uk/guidance-providers/all-services/our-human-rights-approach). The Standards are applicable to all providers of mental health and learning disability services including independent health and social care providers. They will by extension be of interest to any health, care or education service or sector where there are risks associated with the relevant behaviour and restriction.

The Restraint Reduction Network provides a template restraint reduction plan for members based on six core strategies. See Appendix 2

Foreword

Health, social care and education providers should not accept as inevitable the occurrence of violence, behaviours of concern, nor restrictive interventions used to manage such incidents in mental health and learning disability services. Organisations must aspire to eradicate the causes of these behaviours, the behaviours themselves, and the restrictive interventions used to manage them. To do so they must monitor, understand, prevent and mitigate them. This requires a proactive organisational approach that enhances the understanding of the cause and provides interventions necessary to promote a service that is safe and rights-respecting for people who receive services, staff and the wider community. Providers will work in collaboration with people who receive services, their family and carers, and other stakeholders, including the criminal justice services, to achieve this goal.

> *Understanding the context of violence is vital in designing interventions. All societies experience violence, but its context – the circumstances in which it occurs, its nature and society's attitude towards it – varies greatly from one setting to another. Wherever prevention programmes are planned, the context of violence must be understood in order to tailor the intervention to the targeted population.* (World Health Organisation, 2002)

The National Minimum Standards, in accordance with the Mental Health Act Code of Practice (Chapter 26, Safe and Therapeutic Responses to Disturbed Behaviour), acknowledge that interventions to prevent a greater harm occurring are sometimes necessary. Service providers and their staff have a legal, professional and ethical obligation to minimise harm to everyone. Interventions to manage high risk situations must, however, take place in a culture that focuses on delivering safe and effective care, promoting recovery and respecting human rights.

The Mental Health Act Code of Practice Ch26.15 (Department of Health, 2015), a mainstay of these guidelines, mandates the concept of primary, secondary and tertiary interventions. These have their roots in public health concepts, and successive reports by the World Health Organisation. They originally referred to first, second and third steps in a trajectory or time-line of violence, but have come to mean universal, selected and indicated steps:

- Primary preventative strategies aim to enhance a person's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern

- Secondary preventative strategies focus on recognition of early signs of impending behaviours of concern and how to respond to this in order to encourage the person to be calm

- Tertiary strategies guide the responses of staff and carers when there is an actual behaviour of concern. Tertiary intervention can include restrictive interventions such as enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion and segregation. There are also tertiary strategies that are nonrestrictive and are effective even at crisis stage and these should be the first resort

Restrictive interventions are defined as deliberate acts by providers that restrict a person'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, so that the danger to the persons or others may be ended or reduced significantly.

Organisational arrangements must reflect an overt focus on primary and secondary prevention that seeks to avoid or minimise recourse to tertiary interventions, all carried out in a context of rigorous organisational learning. The overall aim must be to avoid or minimise the use of all restrictive interventions and promote collaborative working arrangements to ensure people are cared for in environments that are safe, rights-respecting and focus on evidence based therapeutic intervention. Robust systems for incident reporting, meaningful post incident support/debrief and clinical risk review must be in place to inform organisational learning. The Six Core Strategies of restraint reduction are an evidence based framework which organisations may find it useful to refer to – see https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use. Combining the six core strategies with a human rights framework provides an effective approach to facilitate the culture change necessary to reduce restrictive practices.
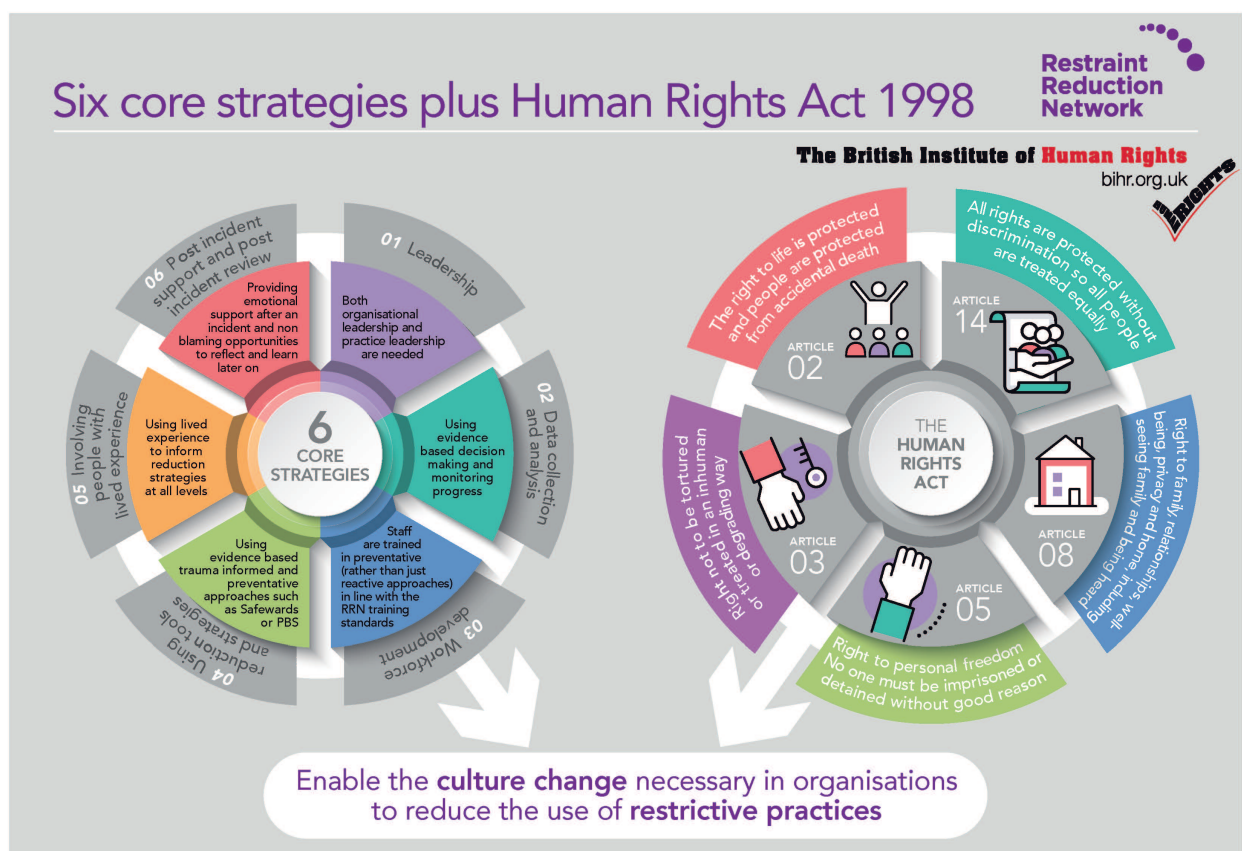
Introduction

The National Minimum Standards aim to encourage services and clinicians to review practices and philosophies of person centred care and support in order to maximise the rights of everyone, including wellbeing and safety. The cost of inaction is excessive in both human and financial terms (due to the increased care costs associated with the physical and psychological harm that can be caused by restrictive practices). Ongoing service review by provider organisations is essential. The Standards outline the leadership, assurance, accountability and monitoring arrangements necessary to ensure transparency and inform an organisational learning culture aimed at further improving care provision, namely:

- Making prevention uppermost in the minds of all parties. This will promote cultures that recognise personal factors and types of environments which may cause behaviour, which then leads to the use of restrictive interventions in practice, and progress effective interventions to reduce risk

- Implementing primary prevention strategies that mitigate certain cultural problems within services in relation to the nature of staff relationships with people receiving the service, the role of practitioners and their wider skills. The effect of systemic factors physical environments and staffing levels must also be considered

- Fostering organisational strategies that are evidence based and include procedures for regular self-appraisal, for example, against characteristics of successful restraint reduction initiatives

Named individuals at a senior level should be specifically tasked with and directly accountable for the development, implementation and robust evaluation of a proactive, evidence-based strategy as part of their leadership function.

Reducing the use of all unnecessary restrictive practice is a focus for the CQC in accordance with human rights and all clinicians and members of the leadership and board should be fully engaged in the arrangements in place within their organisation. An identified executive and non-executive lead to oversee implementation and monitoring is recommended.

Minimisation of restrictive interventions and the development and maintenance of co-produced therapeutic, outcome focused services are crucial enablers to ensure individual rights are respected within safe and recovery focused environments where the use of restrictive interventions can be avoided.

Ongoing education must be used to shift the emphasis from secondary and tertiary prevention (and the historical emphasis on crisis management) to a focus on prevention through organisational learning. Thoughtful, planned and strategic change, which is subject to rigorous local evaluation in terms of its impact on both service users and staff, is therefore the priority. The importance of individual formulation-based assessment of need to inform care planning is key, in order to respect people's autonomy (protected by Article 8 of the Human Rights Act). Such formulation avoids labelling and diagnostic overshadowing

that can lead to assumptions about potential behaviour, which in turn can perpetuate incidents and necessitate the interventions deployed to manage this.

Informed procedural documents are required to effectively communicate the restrictive intervention reduction plans in place.

A 'strategy' is a high level approach, formulated by decision making leaders such as directors, with a clear aim. It concentrates resources and informs prioritisation within an organisation. Successful strategies are simple enough to comprehend but comprehensive enough to cover all foreseeable practice. Restraint reduction strategies will promote cultural change to foster compassion, collaboration, and safe and therapeutic approaches should intervention occur. This in line with services' duties under the Human Rights Act.

Organisations must take a clear stance on the difference between practices which may, exceptionally, be legally defensible in extremis, those for which training is provided, and those which are legal but organisationally 'banned'. Simplistic approaches overly reliant on target setting, and blanket restrictions or bans, are less systemically effective and may have unintended and adverse human rights and safety implications.

Effective strategies take time to embed and require more than an aspirational or visionary statement to 'reduce violence and the use of restrictive intervention'. Organisational strategies led at a senior level are key to progressing thoughtful, planned and sustainable culture change.

> *Using a human rights approach has improved the culture in our organisation. I think I started off skeptical about what difference it would make, but there has been a big turn around and the service is better as a result.* (Practitioner on BIHR's Delivering Compassionate Care project, https://www.bihr.org.uk/evaluation-report)

'Policies' outline standards for practice that will help to embed the strategic goal. Policies need to be compatible with the Human Rights Act and informed by best evidence and pertain to particular clinical issues in order to provide a framework to inform for clinical decisions and operational management. The Equalities and Human Rights Commission has produced a framework which should be used to develop policies (EHRC 2019, see https://www.equalityhumanrights.com/en/publication-download/human-rights-frame-work-restraint)

Guidance for providers is included in the Mental Health Act Code of Practice 26.7 (Department of Health, 2015). Supporting documents should be reviewed in response to developments in practice, organisational learning and legislation change. Policy documents may be supported by 'practice guidance notes', or 'local standard operational procedures' (SOPs) which provide instructions for the practising clinician, promoting points of good practice. The sharing of good practice in restraint reduction should override competition between providers.

Primary prevention

For primary prevention to be effective, it is essential to understand root causes rather than addressing superficial presenting symptoms and behaviours. Good formulation generally informs person centred preventative strategies. This requires individual assessment of needs to guide proactive intervention from the outset.

Many incidents of behaviours of concern arise from the individual feeling frightened, frustrated, vulnerable, disregarded or ignored. The need for restrictive interventions can be reduced by engaging with the individual, prior to acute disturbance, identifying their triggers and 'co-producing' intervention plans – ie intentionally and genuinely making the patient a co-author of plans where possible. Focusing on the individual and their particular needs and preferences in care helps protect their right to autonomy, protected by the right to private life in Article 8 of the Human Rights Act 1988.

By considering together the antecedent situation, the proposed intervention, the person's history and current presentation, clinical teams can start to anticipate the likelihood of violence or behaviours of concern occurring, and construct plans to reduce the risk. These plans may use traffic light models to describe progressive preventative efforts.

While behaviours of concern may appear to be initiated by an individual, the broader organisational root causes cannot be ignored. The effects of the social and physical environment have been identified in the literature as potential causes. Developing such understanding, for example, where the person has a learning disability, may involve the completion of a functional and communication assessment. Communication passports have a significant role to play in many settings especially where cognitive differences, dementia, autistic spectrum features or a learning disability may be present.

Environmental factors may include:

- failures by services to identify and meet people's needs

- failure by services to recognise and meet people's sensory needs

- failure by services to provide appropriate physical environments

- failures by services to meet the complex needs of people with mental illness and/or learning disability and autistic people

- the nature of relationships between staff and the people receiving services and the development of unhelpful cultures

- failures by services to meet the needs of staff including compassion fatigue/ secondary traumatic stress

- the impact of previous traumatic experiences on people and the staff that support them

- the emotional and cognitive impact of previous violence on staff

- the admission of people to services that do not have the correct therapeutic, communication or security capabilities

The realisation of primary prevention in practice requires action across the whole organisation, including:

- the person

- the individual worker (providing direct support)

- the multiagency staff team, family members and carers (as appropriate) and advo-cates

- the broader organisation management team

Overlapping or complementary implementation models, such as Six Core Strategies, Positive Behaviour Support, Safewards, Trauma Informed Care, Restrain Yourself, Aqua, No Force First and many others, have an important and increasingly evidence based role to play in organisational approaches to provide safer management of behaviours of concern. Though we introduce them here with primary interventions, most also include secondary intervention. Many are informed by an explicit consideration of the impact of trauma, and all are deployed to reduce conflict and containment. The challenge is less of finding the best model and method of implementation. Legal responsibility for the choice and implementa-tion sits with the board.

Family members and carers can help inform the individual assessment of need and care and support planning. The Triangle of Care approach could be utilised to ensure appropriate inclusion throughout the treatment and recovery process.

The recognition of environmental triggers (for example, unfamiliar environment, lack of privacy, restrictions on free movement) should not be under-estimated when planning care, and the least restrictive option must be provided.

Secondary prevention

Secondary prevention as defined above relies on effective observation and active engagement by staff so they are aware of warning signs and can intervene empathically and constructively. It relies upon the skilled practice of conflict resolution and de-escalation skills by staff and teams who can sustain reflective practice under what may be significant stress.

In any setting, in-depth knowledge of the service user, their background and history helps in both averting and managing crisis.

Conflict may occur due to a number of factors (eg internal triggers, external triggers, and a mixture of both) and staff should be sensitive to the potential of these in order to minimise the risk of situations escalating. Internal triggers can include symptoms, eg paranoid ideas that may impact on the person's interpretation of events, or affective or behavioural insta-bility. Care and support plans should reflect the impact of relevant symptoms.

Emotional states, eg fear, frustration or shame, can lead to poor communication and confrontation. Multidisciplinary team members must make every effort to positively engage with service users and be attuned to when people's emotional states have altered. External triggers can include, for example, loss of liberty, autonomy, choice, excessive noise, perceived staff attitudes, being ignored and actual or perceived injustice. Staff must seek to behave respectfully and in a contained way even when exposed to violence or behaviours that challenge. Identifying the needs indicated by the behaviour and finding ways to acknowledge or meet them may be key. Training for staff in approaches such as mindfulness can help them to sustain reflective practice under stress.

De-escalation is always the preferred intervention when confronted with potential risk. This should only be superseded when delaying the use of other interventions would result in an increased risk of physical harm.

Tertiary prevention

In some areas it may be necessary to intervene promptly in line with duty of care principles to avoid a situation escalating and harm occurring. There is a positive obligation on practitioners under the Human Rights Act to act to protect people from an immediate risk to life or of serious harm (under the Right to Life and the Right to be Free from Inhuman/degrading Treatment, Articles 2 and 3, HRA).

Knowledge of the person's history and associated risk factors will help inform clinical judgments and decisions regarding necessary and proportionate responses. Subjective preferences and aversion to tertiary interventions are highly individualistic, may be markedly culturally bound and should be discussed with individuals.

Any form of involuntary restriction on the liberty and free movement of people whether physical, mechanical, environmental or pharmacological must be necessary and justified, in order to respect service user's Right to Liberty (Article 5, HRA).

The overarching principle of least restrictive intervention must always guide decision making. It is acknowledged that in certain circumstances the presenting risk may merit the need for restrictive intervention to be utilised in order to prevent a greater harm from occurring. It is vital, therefore, that where any restrictive procedures are used, staff are fully aware of the rights and risks involved. These must be addressed in training syllabuses which place them within the relevant legal, ethical and professional context. Training standards for reducing restraint need to be seen in the context of learning about both human rights and duty of care.

All forms of restrictive intervention are potentially dangerous; staff deploying restrictive physical interventions are also at risk of relative physical injury and potential psychological harm.

Anyone exposed to violence, behaviours of concern (and restrictive interventions to manage such incidents) by others, could experience a traumatic response. This can be kindled by repeated exposure. Certain staff can be particularly selected to be involved in tertiary

responses due to skill mix, gender and other human resource factors such as perceived skill or resilience, and there should be system in place to supervise and mitigate risks.

If the use of restraint is unavoidable, it may sometimes be justifiable to combine physical restraint with pharmaceutical restraint, which may then facilitate safer transfer to a low stimulus, de-escalation or safer area.

The use of one or more restrictive interventions requires consideration of the interacting risks and must again be held to the test of necessity, proportionality and least restrictive care to be considered legally, professionally and ethically justifiable.

Restrictive practices must be human rights compliant. This means ensuring they are justified and only used when they are in the best interest of the person (taking into account their human rights), and only if they will reduce the duration of the application of restraint or prevent serious harm to the health of the person or others. Restraint should never be inhuman and degrading, as human rights law sets out an absolute ban on such treatment (see Article 3, HRA).

Review, support and debrief

Tertiary prevention includes not just the interventions but the post-incident support, debrief and review procedures that must accompany their use. This is necessary in order to ensure lessons are learned from incidents arising, and that action is taken to prevent the risk of re-occurrence and to minimise associated harm.

Post-incident review requirements for staff, service users, carers and others involved in incidents where restrictive physical interventions are used are outlined in NICE guidance - Quality Standard 154 to NICE Guideline 10 (2017).

Debrief is a term that is widely applied to various post-incident processes in practice, so the intention of each episode should be clear to all those involved and should be carried out in a non-blaming way.

Best practice and review of the limited evidence base suggest there are two main components of post-incident review, each with a distinct purpose:

1. Post-incident support – attention to physical and emotional wellbeing of the individuals involved
2. Post-incident reflection and learning review

With reference to a review of current available evidence, these standards support a clear separation of these two components (Baker, 2017).

Reasons why either of these components are not undertaken should be recorded, for example, refusal or where there are grounded concerns that attempting support or reflection may trigger further crisis.

Referring to how people's human rights were considered and balanced can provide an important element of defensible, informed decision-making.

Any staff whose role may involve the use of restrictive practices must have access to regular structured clinical supervision as well as their line management supervision. The agenda for supervision should include the opportunity to discuss and reflect on any incidents. Exposure to behaviours of concern will sometimes generate negative feelings. Unless negative feelings are acknowledged and actively managed, this could influence wellbeing, or their behaviour towards the people that they support and ultimately impact on the service culture.

The intended use of these compliance statements

The following compliance statements define standards for the adoption and implementation of a total organisational approach to the safe and therapeutic reduction of restrictive interventions in mental health and learning disability settings. The compliance statements aim to provide a regulatory framework but do not provide a system of accreditation.

Clinical governance arrangements within provider organisations should be used to assess compliance with the Standards. Providers should take responsibility for this governance and arrangements for peer review of compliance to the minimum standards could be used by provider organisations to gain additional assurance.

In instances where the Standards are not applicable, for example, small provider organisations such as group homes, a documented rationale should be provided, and perhaps conceptually similar smaller scale safe practice arrangements described.

The compliance statements contained in this document provide a structure for organisational assurance that will be monitored by the Care Quality Commission. The Standards are applicable to NHS providers and independent health and social care providers.

The Standards

Section 1: Board Level Organisational Compliance Standard

Section 1 of the Standards provides positive practice indicators for accountable officers and delegated clinical and operational managers. The following organisational arrangements should be in place to demonstrate a well-led organisation.

1.1 Strategy and policy

I.   Board approves an evidence-based strategy informed by organisational risk assessment that describes actions to minimise the risk of behaviour that is challenging and the use of restrictive interventions.

II. The strategy has an implementation procedure that is regularly reviewed.

III. The strategy emphasises the need for rights-based individual person-centred interventions.

IV. Responsible executive lead for reducing restrictive practice is identified in the strategy/policy.

V.   Responsible non-executive lead is identified in the strategy/policy.

VI. Board approved policies and procedures support the Restrictive Interventions Reduction Strategy.

1.2 Involvement of people who receive services and their carers in strategy development and implementation

I.   Board approved policies and procedures emphasise the need for clear and effective communication with people who receive the service and their carers. (This should include arrangements for accessing communication aids, for example, signing, visual aids, and access to interpreters.)

II. Accessible organisational information are available for people who receive services, in respect of their human rights including personal safety and security. This is compliant with the Accessible Information Standard.

III. Decision making teams at differing operational levels, such as boards, steering groups, project teams and leadership teams, especially in large organisations, include individuals with explicit lived experience of services such as representatives of people receiving services peer support workers, or governors with lived experience.

IV. There is evidence of the involvement of people with lived experience of using mental health learning disability services or services for autistic people in the

authorship, consultation, and implementation of strategies, policies and practice guidance notes.

V. Peer support workers, advocacy and other defined processes aid care planning for individual people, within constraints of ethics and clinical expertise, supported by clinicians in the team.

VI. Staff members not employed on the basis of lived experience but with experience of mental health services, learning disability and autism services are supported by a culture, etiquette and supervision, or practice guidance concerning guidelines for disclosure of lived experience, including support for decisions not to disclose, as they might for any other protected characteristic.

1.3 Training and education

I. Board approved education and training programme promotes recognition, prevention and de-escalation as the first line approach when responding to behaviours that challenge. (Details are in Section 3.)

II. Training includes the Human Rights Act, which underpins other law and policy on   reducing restrictive interventions. This allows understanding of how the Act underpins other aspects of law and policy, on restrictive interventions, their duties under the Act, how to make defensible decisions, and how to balance rights and not just focus on risk.

1.4 Incident reporting, monitoring and assurance

I. Transparency, openness and candour are promoted within the organisation through regular communications, training and policy in order to demonstrate safe, effective, caring, responsive and well-led services.

II. An incident reporting process is in place in order to review incidents, which reports where applicable to the National Reporting and Learning System and other central agencies as required. This must address actual occurrences that have led to harm or potential harm and near miss incidents.

III. Organisations must work with national bodies to foster fair and timely reporting of incidents, which allow comparisons of activities between providers while taking into account their differing circumstances and patient needs.

IV. Procedures allow direct treating teams to benefit from the knowledge gained from incident reporting analysis and trends, as close to real time as possible.

V. Incident reviews inform the organisational service improvement agenda and training to ensure that learning from events is translated into safer care delivery arrangements. This is also informed by learning from national inquiries, for example Ministerial Board on Deaths in Custody, and from local events and themes emerging from potential near miss incidents.

VI. Risk registers account clearly and at the right level for known organisational risks pertaining to the positive and safe care and support of people. For example, issues of the effects on the therapeutic environment arising from delays in building works may be held by directors and the board, whereas limitations in staffing may be held at ward or service level. The organisational levels must communicate effectively.

1.4.1 Responsibilities of directors and the executive and non-executive lead

Directors and the executive and non-executive lead ensure the following:

I. A robust incident reporting process is in place.

II. Systems are in place to ensure learning from incidents, complaints and inquiries is shared across services.

III. Governance structures are in place to monitor incident reports and establish themes and trends.

IV. Structures are in place to act on any emerging themes or trends.

V. Systems are in place to ensure actions agreed in response to learning from incidents complaints and inquiries are implemented, and the impact is monitored.

VI. There are periodical reports to the board and to the senior executive team in the organisation.

VII. It is possible for external assurance to show evidence of changes to the restrictive intervention reduction strategies, policies, and/or practice guidance notes in the light of learning from incident reporting.

1.5 Incident reporting procedures

These should address the following:

I. All incidents where physical interventions, or rapid tranquillisation, or restriction of liberty, or seclusion where permitted are used must be formally reported.

II. Procedures should allow the analysis of trends such as frequency and seriousness of different types of restraint over time and in different areas of the provider services.

III. Procedures should allow for the routine gathering of important demographic information relating to the individual, such as ethnicity, age and gender, etc.

IV. Procedures allow for the routine gathering of important clinical information, in line with current positive practice and legislative standards. This will mean such detail as anonymised reporting of the people involved, location and time of incident, duration of incident, different phases and postures of the incident, possible causes, and injuries to service users.

V. Procedures support routine information gathering, or where practicable cross referencing to other databases containing proportionate employee information,

such as injuries to staff, grade/role and or experience of staff involved in incidents, training level of staff involved in incidents etc.

VI. Directors show an ability to consider and synthesise the data presented in the light of service transitions, emerging themes and their other strategies, lessons to be learned and how practice improvement will be implemented.

1.6 Sharing lessons learned

I. Documented reflective practice sessions occur to inform staff of lessons learned in order to implement practice change.

II. Supervision procedures are in place and audited.

III. Post-incident support and debrief arrangements are well defined and in place for everyone.

IV. Reporting incidents and learning lessons systems include effective, supportive ways to learn from people's experience (but make clear that feedback is an offer, not compulsory for the person that has been restrained).

1.7 Safer staffing

I. Organisations have a responsibility to ensure that staffing levels are appropriate in relation to capacity and skill mix in order to ensure the delivery of caring, safe and effective services. Arrangements in place must be compliant with the NHS England safe staffing recommendation or other organisational recommendations and the organisation's duties under the Human Rights Act.

1.8 Induction

I. All staff, permanent or temporary, are provided with a thorough values-based induction programme which allows them to understand and safely use the principles and practice of primary, secondary and tertiary intervention in accordance with their occupational role, the specific expectation of the worker in the post and their legal duties under the Human Rights Act.

II. Accessible organisational information is available for staff in respect of their rights including personal safety and security and the arrangements for these.

III. The workforce arrangements concerning such inductions are provided for employed or volunteering service users or peer support workers.

1.9 Temporary staffing

I. Arrangements are in place with agency staff providers to ensure that the training provided to agency staff is compatible with the employing organisation's standards, ensuring the same high standards.

II.   Demonstrable organisational arrangements ensure bank and agency staff members are adequately trained for the environment they are expected to work in for their own safety and the safety of others.

1.10 Health and wellbeing

I.   An appropriately resourced and effective occupational health service, with access to counselling services, is available.

II.   Proactive systems are in place for the promotion of health and management of sickness and annual leave in order to reduce the reliance on temporary staff.

1.11 Joint working arrangements

I.   In order to demonstrate safe and responsive arrangements organisations should have in place established multiagency partnership boards which should include the police, Crown Prosecution Service (CPS), people who receive services, carers, advocates, health and local authority managers, ambulance service personnel, and other key stakeholders in order to meet the required joint working standards as outlined in the *Memorandum of Understanding* (College of Policing, 2017).

1.11.1 Roles and responsibilities

A shared understanding between agencies is particularly important because of the different organisational goals and cultural assumptions of different stakeholders. To reduce the possibility of a lack of understanding of the professional and operational boundaries within each contributor agency, the following should be established:

I.   Clear roles, responsibilities and purpose are articulated when joint working is required in any way which may be restrictive.

II.   Joint working arrangements are in place with social services regarding the use of restrictive practice.

III.   Joint working arrangements are in place with other relevant stakeholders regarding the use of restrictive practice.

IV.   Joint protocol is in place with police regarding how people's safety and rights will be maintained when police deploy police restraint in the care setting, meeting requirements of the Use of Force Act 2018.

V.   Joint working procedures and policies are in place outlining situations when police will and will not respond.

1.11.2 Communication

I.   Effective and mutually beneficial communication and information sharing systems are informed by common sense, confidentiality and Caldicott 2 (Department of Health, 2013).

II.   Joint approaches to education, training, policy and practice.

III.   Shared lessons learned and positive practice initiatives regarding restrictive practice.

IV.   Tabletop multiagency incident planning.

V.   Reciprocal training and awareness sessions.

VI.   Allocation of resource to maintaining relationships, such as local police liaison meetings.

1.11.3 Criminal justice procedures

I.   Local security management specialist (or designated responsible person) in place.

II.   Agreed processes for the bringing of criminal proceedings and where appropriate, liaison with external bodies.

III.   Systems for the tracking of cases/proceedings through to conclusion, with providers able to keep track of case outcomes through effective liaison with courts and police.

1.12 Environmental safety

I.   Organisations ensure that environments comply with statutory health and safety legislation. Providers must carry out and regularly review environmental risk assessments in order to manage identified environmental risks.

II.   Environments take into account the factors that influence recovery, for example, sleep, and privacy.

III.   Secure estates departments incorporate best practice design into developments to ensure any future care personal space, access to fresh air, lines of sight, and sensory needs of certain populations.

1.13 Needs-led provision

I.   Services have admissions or bed management systems in place that reduce the risk of people being admitted to or treated in services that do not meet their needs in terms of recovery, safety and security. These issues may impact on people's rights to be free from abuse/neglect (Article 3, HRA) and right to liberty (Article 5, HRA) and the right to private and family life (Article 8, HRA).

II.   People receiving services can access worship space, faith leaders and spiritual/religious/faith groups.

III.   Staff are informed of and sensitive to religiously/culturally significant dates and practices, to support the right to be free from discrimination (Article 14, HRA) and the right to freedom of thought, conscience and religion (Article 9, HRA).

IV.   All settings provide daily opportunities (not including mealtimes) for people to have effective communication and therapeutic engagement. Apart from being good clinical practice this protects the right to wellbeing, protected by the right to private life (Article 8, HRA).

1.14 Environmental security

I. Any policy on the use of cameras (including CCTV and body cams) is compliant with the required legal standards, including the Mental Health Units Use of Force Act 2018, and the right to respect for private life (Article 8, HRA). As part of this, service users and carers are given information explaining the organisational policy on the use of cameras.

II. Any policy on the use of locked doors is compliant with the required legal standards including the right to liberty (Article 5, HRA), and service users and carers are given information explaining the organisational policy.

1.15 Audit

I. Local audit and quality assurance arrangements differentiate the arrangements in place for the regulation of training providers and training programmes and the regulation of the care organisation. Training providers cannot assume responsibility for the wider aspects of organisational assurance. Service providers have regard for the *Restraint Reduction Network (RRN) Training Standards* and work in partnership with training providers.

II. In instances where any aspects of the standards are not applicable, for example, small provider organisations such as group homes, a documented rationale must be provided and the bespoke safe practice arrangements in place described.

III. Peer review of compliance to the positive practice statements can be used as part of organisational assurance.

1.15.1 Responsibilities of organisations

Organisations should ensure the following:

I. Clinical governance arrangements are in place to ensure that audit and monitoring is carried out to progress full compliance in line with the minimum standards outlined in this document.

II. Peer review learning processes are considered best practice and a joint working approach to assess compliance should be progressed when feasible.

Section 2: Effective Care Planning and Multidisciplinary Team Compliance Standard

Organisational procedures are only effective if applied consistently in practice. Section 2 of the Standards provides positive practice indicators for clinical teams. Clinical teams have a crucial role in the promotion of safe and therapeutic care. It is their care and support to people at the front line that must be rights-respecting, which includes care that is safe, caring, effective and responsive, often in difficult circumstances.

Individual staff members must comply with their duties under the Human Rights Act and demonstrate the values outlined by the organisation and their professional body. This includes compliance with the conduct and capability framework in accordance with their occupational role, for example, physical health, fitness to practice and adherence to any reasonable adjustments and attendance at training and development sessions.

Clear and effective communication is an integral part of prevention and de-escalation of aggression and violence. It is of absolute and central importance in primary and secondary interventions for people who have hearing or visual impairment, cognitive impairment or whose first language is not the same as staff. Communication and engagement help ensure effective collaboration between staff, service users and their carers/advocates when assessing, planning, delivering and evaluating care. This will help to minimise the risk of misinterpretation of actions and behaviours on 'both sides'. Specific competencies in communication with people with relevant difficulties, eg intellectual difficulties, developmental spectrum conditions, or dementia, are crucial in both averting incidents and in their actual tertiary management.

In services a variety of terminology may be used to describe individual care planning, including: crisis plan, personal safety plan, reactive management plan, reactive strategies plan, restraint safety and reduction plan, positive behaviour management plan or traffic light plan. For simplicity we use 'care plan' to cover all of these. The purpose of a care plan is to ensure a personalised, reasonably predictable and informed approach to the use of safe and therapeutic intervention. It allows challenge and defensibility. It allows new staff to care and support more safely. It allows services to respect the rights of people who receive their services. The care plan intervention must therefore be understood by and accessible to the care staff and be regularly reviewed and consistently applied.

2.1 Training

I. Multidisciplinary team staff must attend relevant training programmes and refresher training as informed by the standards of their continuous professional development.

II. Multidisciplinary team members should attend formulation, clinical risk assessment, and training in care planning and interventions in accordance with their occupational role.

III. Where there are needs for further training created by the possibility of being involved in restrictive practice, the delivery and frequency of that training should be based on training needs analysis.

IV. Training should cover their duties under the Human Rights Act, and how these legal standards underpin other laws and policies relevant to restrictive interventions.

2.2 Initial risk assessment and safety planning

I. On admission and after significant events or new information a clinical risk assessment should be carried out, based on as wide a set of sources of information as possible and using structured professional judgement, and a safety care plan should be put in place to inform the safe and therapeutic management of identified risks. Separate elements of the plan may be necessary to deal with separate risks, such as to self or others, or different types of risk to others.

II. This should be conducted in collaboration with the person and, if appropriate their carer wherever possible and any advance decisions clearly recorded and communicated.

III. The risk assessment findings should be communicated to all relevant staff, typically at least the whole multidisciplinary team, and other agencies such as MAPPA as appropriate in line with information sharing procedures.

IV. If tertiary intervention strategies are foreseeable due to historical risk factors or current risk profile, any known vulnerabilities or those that become apparent after appropriate physical health assessments or otherwise should be clearly detailed in the care plan.

V. Risk assessments and risk management care plans should be recovery focused and reviewed in line with organisational policy and in response to any incidents occurring.

2.3 Care planning

I. Care plans are coproduced with the person whose plan it is and, where appropriate, their family/carer from the outset.

II. Clinical teams work in collaboration with the individual and, where appropriate, their family/carer to develop individualized advanced decisions. This helps interventions meet their specific needs and advance wishes, and respects people's right to autonomy (Article 8, HRA).

III. Care plans record known triggers and early warning signs to distressed behaviours or behaviours that challenge.

IV. Care plans clearly define the agreed, preferred or less preferred interventions.

V.   Discussions in relation to the use of tertiary interventions are conducted with the person themselves and family/carer (when appropriate) and identify preferred options/choices to be adhered to unless the presenting risk does not allow this.

VI.   Care plans should consider the influence of environmental factors, for example, boredom, client mix, and any limitations to access to fresh air and exercise, all of which can lead to frustration and increase the risk of challenging or aggressive behaviour.

VII.   Care plans address any spiritual, religious, and cultural needs, beliefs and behaviours of the service user, protecting the right to be free from discrimination (Article 14, HRA) and the right to freedom of thought, conscience and religion (Article 9, HRA).

VIII. Care plans address any individual needs associated with physical disability, including communication with service users who have a sensory impairment (Article 14, HRA).

IX.   Care plans address any specific needs in relation to gender, for example, dysphoria, previous domestic violence and associated trauma.

X.   Care plans address any specific issues in relation to older people's needs, for example, cognitive impairment, or physical health risks, in keeping with the right to wellbeing (Article 8, HRA).

XI.   Care plans address any specific issues in relation to children or younger people's needs, for example, impact of isolation from family, or changes to their developmental experiences which admission to hospital may create, to respect their right to family life (Article 8, HRA).

XII.   Care plans should address any specific known triggers that may impact on behaviour, for example, anniversary of a traumatic event.

XIII. People receiving services benefit from personalised strategies as part of their care plan; this includes use of positive behaviour support planning or equivalent appropriate strategies, such as offence specific work.

XIV.   Care plans address any physical healthcare needs and psychological issues and clearly highlight factors that will increase risk of harm during restraint. Staff know that mechanisms of death in restraint include crush injury, chest wall mechanical restriction, cardiac exhaustion and occlusion of the airway. Medical factors which worsen these must be assessed and treated where possible. Restraint techniques with a risk of serious harm or death in a specific patient's case are avoided.

XV.   Care plans address any dignity issues associated with the use of physical intervention, to protect the right to be free from inhuman or degrading treatment (Article 3, HRA).

XVI.   Medication prescriptions both regular and 'as needed' should be subject to regular review in a structured way, for example as part of weekly multidisciplinary meetings, in order to respect autonomy (Article 8, HRA). The use of medication to manage

behaviours that challenge is reviewed as part of a care planning process in particular for individuals with learning disability (The Challenging Behaviour Foundation, 2016).

XVII. The individualised plan of care reflects emotional needs and person specific post-incident monitoring in relation to previous trauma.

XVIII. Changes in levels of risk are recorded, communicated and risk management care plans updated accordingly.

XIX. Debrief processes are defined and generally used.

XX. All people who have been subject to restraint have post-incident physical review, and individual needs for these stages of care are considered in the care plan.

XXI. Review dates should be stated in the individual's care plan.

2.4 Communication needs in care planning

Safe interventions cannot occur without effective communication of need. Limitations in the ability of teams to communicate with people can foster behaviours that challenge, violence and restrictive practice. People with developmental, learning, cognitive or organic problems, or combinations of these, are more likely to require specialist communication skills.

I. Primary and secondary intervention plans in these areas reflect the importance of individualised communication strategies. This may include communication passports and should allow as a minimum a new staff member to communicate effectively with all people who are receiving a service. Specific needs in relation to learning disability, for example, communication needs, physical health risks, are informed where appropriate by speech and language therapist assessments, or communication aids such as visual tools.

II. Interpreters can be accessed for those people whose first language is not English.

III. There is access to staff with specific communication skills, eg signing, visual aids.

IV. Literature is available in languages other than English in order to avoid discrimination (Article 14, HRA).

V. Providers adhere to the Accessible Information Standard (NHSE 2016/17).

VI. Providers adhere to 'the five good communication standards' of the Royal College of Speech and Language Therapists.

VII. Where, due to reasonable adjustments for communication, paper based bespoke non-electronic care plans, co-produced wellness plans, or risk formulations are used (such as picture boards), there is a robust framework for reviewing these that mitigates the loss of governance that that can occur with non-electronic records.

2.5 Monitoring physical healthcare during and after restraint

It is well established that people's lives can be at risk during or post restraint episodes due to direct airways obstruction, crush, respiratory restriction, cardiovascular collapse after physical exertion, or combinations of these. Certain conditions may alter the balance of risks

in relation to the application of tertiary interventions and are important to identify, formulate and plan for in advance of restraint occurring. These include conditions which impact on cardio-pulmonary function including prolonged QTc interval, or muscle and joint impairment, eg asthma, acute stimulant intoxication, large muscle bulk leading to increased oxygen demand, heart disease, obesity, medication, arthritis, high blood pressure, diabetes or propensity for using illicit drugs and/or alcohol, and pregnancy. The risk of fracture may be increased in schizophrenia.

Medical review (by which we mean a medical doctor reviewing the person and at least triaging them for whether they need a more detailed history and examination) should occur at the earliest opportunity after the commencement of any physical restraint. There are variances in existing published guidance and any such standard is to some extent arbitrary. In this guidance we recognise that while best practice is that review occurs 'as soon as possible' we are suggesting a governance standard that all medical entries are timed, dated and occur within one hour or include a documented rationale for delay. Onward reviews must occur and be proactively planned in line with a person's individual presentation and any identified risk factors. Such plans require careful and clear articulation, for example with specific stipulation of review periods, the actual physical observations to be taken, and what the care team must do if the individual's condition changes. This meets the positive duty to protect service users' right to life and to be free from inhuman/degrading treatment (Articles 2 and 3, HRA).

Physical monitoring is especially important:

- following a prolonged or violent or high intensity struggle

- if the person has been subject to enforced medication or rapid tranquillisation

- if the person is suspected to be under the influence of alcohol or illicit substances – consideration should also be given to risk and novel psychoactive substances

- if the person has a known physical condition which may inhibit cardio-pulmonary function, eg asthma, obesity

- if the person is held in a position that can compromise respiration

2.5.1 Physical health preparedness standards for all people receiving services

I.   On admission, within 24 hours, individuals have a basic physical examination and their physical needs are assessed.

II.   Prescribing staff consider possible drug interactions when prescribing antipsychotic medication, particularly high dose.

III. People receiving services are asked about consent to any prescribed medication, and whether they have been taking it prior to admission, to meet with good clinical care, the Mental Health Act and to respect their autonomy (Article 8, HRA)

IV.   Medication is reviewed as part of a care planning process for individuals with learning disability in keeping with advice from The Challenging Behaviour Foundation (Stomped) (2016).

V.   There is a recorded capacity assessment especially in relation to 'as needed' medication.

VI.   Any physical condition which may increase the risk to the person of collapse or injury during restraint is clearly documented in the person's records and communicated to all multidisciplinary team members.

VII.   Where there is a foreseeable risk a care plan clearly identifies the physical condition and the strategies to minimise the risk to the person.

VIII.   The care plan is communicated to all multidisciplinary team members and regularly reviewed and evaluated with the person themselves and, where appropriate, their carer/advocate.

2.5.2 Staff who may be involved in the restraint process

Staff who may be involved in the restraint process are trained in the following:

I.   Basic life support skills and attend annual updates.

II.   Qualified staff are trained in Immediate Life Support (ILS).

III.   The physical risks associated with restraint.

IV.   Recognizing conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and the effects of illicit substance misuse and how to take appropriate action.

V.   Use of emergency equipment.

VI.   How to summon appropriate assistance.

VII.   The Human Rights Act, and how this applies to everyday decision-making and practice, in particular the right to life, the right to be free from inhuman/degrading treatment, the right to liberty, the right to wellbeing and the right to autonomy (Articles 2, 3, 5 and 8, HRA).

VIII.   In all wards/units where the use of restraint is foreseeable there is immediate access to life support equipment, which is checked weekly, as a minimum, and maintained in working condition.

IX.   The physical health of any person subject to restraint is continuously considered and evaluated and there is vigilant observation with the best information available for signs of deterioration, such as where possible counts of respiration rate, use of pulse oximetry, talking to the person. Warning signs of deterioration should be in the care plan and a contingency plan for their emergence should be in place.

X. In all wards/units where the use of restraint is foreseeable and where urgent medical assistance may be required, there are systems in place to access medical/para-medical assistance via on-call duty doctor, cardio-pulmonary resuscitation teams, or para-medical services.

XI. Any person subject to physical restraint is medically assessed within one hour of the commencement of the restraint, or the reason for the delay recorded. The Code of Practice implies that this examination should be by a registered medical doctor where it says that organisations must have clear arrangements for this.

XII. The Code of Practice mandates at Ch26.82 medical review at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Local policies should determine 'which of their registered medical practitioners should undertake medical reviews'. Reviews should be undertaken more frequently if requested by nursing staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the person's physical and mental health condition.

XIII. Any injuries are clearly documented and reported to the service management, summarised for the directors and board and reported into the National Reporting and Learning System and the Mental Health Services Dataset.
Frequency of subsequent medical reviews will be planned at this point in accordance with individual needs and risk factors.

XIV. If consent and co-operation for post-restraint physical observations is not given, or if other problems arise, eg failure of technology, then it should be clearly documented in the service user's records why certain checks could not be performed and what alternative actions have been taken.

XV. Person specific post-incident monitoring needs are defined in the care plan. For lengthy, invasive or more restrictive practices, independent review should be considered.

XVI. Individualised care plans reflect any relevant sensory or prosthetic needs.

XVII. Individualised care plans stipulate the frequency and length of monitoring of physical status. These checks should include:

- care in the recovery position where appropriate
- pulse
- blood pressure
- respiration
- temperature
- fluid and food intake and output

Section 3 : Training and Trainer Content Compliance Standard

Effective training that is informed by contemporary evidence and subject to regular review promotes a culture of human rights, safety and recovery. Organisations must have arrangements in place for education and training programmes for the positive and proactive prevention and therapeutic management of aggression and violence. These should be delivered as part of staff induction, for staff in post and include updates covering both theory and physical skills. Organisations should ensure training is certified as complying with the *Restraint Reduction Network (RRN) Training Standards* (whether commissioned from an external training provider or delivered in house) – see https://restraintreductionnet-work.org/know-the-standard/

The *Restraint Reduction Network (RRN) Training Standards* are mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks and the Use of Force Act statutory guidance from April 2020. This includes services in the independent, private and voluntary sectors. Training with a restrictive intervention component must be certified against the *Restraint Reduction Network (RRN) Training Standards* by a body accredited by the United Kingdom Accreditation Service (UKAS).

Best practice complements formal training and refresher courses with frequent local skills/group supervision sessions informed by learning from routine reporting procedures, clinical audits and incident reviews.

Annual updates are recommended as best practice in *Positive and Proactive Care* (Department of Health, 2014b) guidance and a requirement within the *Restraint Reduction Network (RRN) Training Standards*. Updating practice should reflect what is needed in order to maintain competence. This may require more regular but shorter practice sessions.

3.1 Theoretical content

Detailed guidance on staff development and training has been published jointly by Skills for Care and Skills for Health, in *A Positive and Proactive Workforce* (Skills for Care and Skills for Health, 2014). Aspects of training in non-physical intervention require interaction and engagement and the full package cannot be delivered via e-learning. Any aspects addressed via e-learning or via pre-course reading should be outlined in the training assessment and a clear rationale given for that teaching approach. Section 2 of the *Restraint Reduction Network (RRN) Training Standards* covers content that must also be included if people are being taught to use restrictive interventions.

Training strategies need to be explicit regarding learning outcomes relating to:

    I.   the experience of people who use services

    II.   trauma informed care

    III.   core skills in building therapeutic relationships

    IV.   the principles of positive behaviour support (or equivalent interventions aimed at understanding and safely and therapeutically supporting behaviour)

    V.   legal and ethical issues, including services' duties under the Human Rights Act

    VI.   risks associated with restrictive interventions

    VII. staff thoughts and feelings on being exposed to disturbed behaviour

    VIII. the use of safety planning tools and advance decisions

    IX.   alternatives to restrictive interventions

    X.   effective use of de-escalation techniques

    XI.   conflict resolution styles

    XII. the risks associated with restrictive interventions and how these risks can be minimised

    XIII. the use of breakaway techniques by which to disengage from grabs and holds

    XIV. safe implementation of restrictive physical interventions

    XV. post-incident review and support for both staff and people who use services

3.2 Training safety

Care providers that do not have access to in-house occupational health provision should work with organisations to ensure pre-course health and safety arrangements are addressed as part of the training needs assessment.

The training environment should be risk assessed and fit for purpose, any emerging environmental risks should be clearly outlined to participants and safety protocols de-scribed. The ratio of trainer to participant must be risk assessed in accordance with the activity
occurring and the rationale for the agreed ratio outlined in the course risk assessment and Training Needs Analysis.

3.3 Physical intervention – avoidance of pain compliance

The European Committee for the Prevention of Torture advise that pain should never be used to gain compliance. Any physical intervention technique can potentially result in pain as the perception of pain will be defined by individual circumstances. This guidance takes the position that deliberately eliciting pain should be strenuously avoided.

Professional Codes of Practice clearly define that the deliberate application of pain is not an acceptable practice and therefore should not be taught. It may, in exceptional circumstances, represent the 'least bad' intervention capable of providing safe care: rare examples include extreme emergencies or rescue type situations. Individual practitioners are professionally and personally accountable for their role in the application of restrictive interventions and are obliged to report any actions that cause concern.

Certain actions or practices which may exceptionally be legally defensible in extremis, for absolute life and limb emergencies, will be inappropriate to provide training in. If exceptional measures are trained for they can become normalised. If banned practices continue but are not reported they cannot be legally challenged or monitored. This balancing act of expectations is the legal responsibility of the board. The implementation is ultimately the responsibility of the clinician.

3.4 Training standard checklist

I.   Non-physical intervention training in the positive and proactive prevention and therapeutic management of aggression and violence is informed by a risk assessment and needs based approach to ensure and evidence that training is 'fit for purpose'.

II. The Training Needs Analysis (TNA) should be agreed between the service provider and training provider and should be signed off by the executive lead for reducing restrictive practice in the provider organisation.

III. The training approach arising from the TNA should be signed off by the executive lead responsible in the provider.

IV. Responsibilities arising from sub contractual arrangements for training, for example for injuries to staff occurring during training with an external training provider, should be addressed clearly in the service level agreement.

3.4.1

Service providers must work with training providers to ensure that any training delivered is appropriate to the needs of the people being supported and the staff and that it is proportional and takes into account any elevated risks. It should be based on a TNA and the analysis should be reviewed regularly. Blanket training should not be delivered and any restrictive intervention component of training should be reviewed to see if it is still a necessary part of the training content.

3.4.2

The TNA should outline the following:

I.   The specification of which staff need training.

II. The level of training required.

III. The frequency of training.

IV. The non-physical and physical content of the training specific to the service area.

V. Learning outcomes for physical and non-physical training.

VI. Arrangements for testing knowledge, competency and attitudes against identified learning outcomes.

VII. The rationale for inclusion of the physical interventions.

VIII. Training for any sub-specialty issues such as gender, diversity, dementia, the Children's Act, PBS etc, as indicated by service need.

IX. The duration of the course based on the agreed content.

X. Physical intervention training is not delivered in the absence of an evidence based theoretical training package.

XI. Training updates include changes to legislation, national guidance, supporting organisational policy and procedure, lessons learned and reinforce non-physical intervention elements.

XII. Staff attending training are provided with pre-course information which outlines expected conduct, dress code and course content.

XIII. Organisational arrangements are made to manage staff who are unable to participate on a temporary or permanent basis, including occupational health support, where necessary.

XIV. Staff attending training complete an occupational health checklist prior to commencing physical aspects of training. This should:

    a. address any pre-existing conditions that may impact on participation

    b. inform staff of the range of movement and activity required to participate safely

XV. Trainers are informed of any adjustments that can be made to support the individual.

XVI. Links between training and occupational health are established in order that occupational health practitioners understand what is being taught in training and utilised in clinical practice so that when a member of staff is referred, they can be effectively assessed and treated.

XVII. All theoretical training courses are outlined in a training manual, held by the training provider that is evidence based, fit for purpose, covering the training content including the relevant legal frameworks and organisational policy.

XVIII. The training manual is subject to review in line with policy and practice developments and, for example, relevant legislative changes.

XIX. Physical intervention techniques are taught in accordance with the rights protected in the Human Rights Act, explaining which rights can be restricted (where lawful, necessary and proportionate) and which rights cannot be restricted.

XX.   Physical intervention training includes interventions to facilitate assault avoidance, escape or disengagement from a risk situation and restraint interventions in accordance with the assessed service needs.

XXI.   Physical interventions follow an intervention hierarchy that is mapped to the presenting risk.

XXII.   Training includes services' duties under the right to life (Article 2, HRA) and reinforces that the service user's breathing and airway must not be obstructed, and monitoring of the service user's wellbeing throughout the restraint procedure is designated to an identified staff member.

XXIII. Training reinforces that physical interventions should be used if a failure to intervene will result in harm that is judged likely to be greater than that caused by the use of intervention; this includes intervention to provide essential care and treatment.

XXIV.   Physical interventions taught within the syllabus and approved for use within services are clearly outlined and recorded in a written training manual.

XXV.   Physical interventions noted in the training manual have been risk assessed and the balance of these risks has been signed off by the executive lead.

XXVI.   The risk assessment outlines the risks in training and in practice and is conducted by an appropriately qualified professional. This may include medical or legal staff for relevant assessments

XXVII. The use of simulated resistance during training may pose significant risks. Only trainers should role play resistant service users.

XXVIII. Role plays must be directly managed by a separate trainer who should immediately stop the scenario if there is evidence of risk.

XXIX.   Physical interventions are regularly reviewed to ensure they remain fit for purpose.

XXX.   The physical intervention risk assessment highlights risks in clinical practice and outlines mitigating factors to reduce risk.

XXXI.   The risks associated with physical intervention use are clearly articulated in the training manual; this must include both physical and psychological risks.

XXXII. In services with environmental restraint such as de-escalation, seclusion or low stimulus rooms, training includes reference to organisational policy and procedure.

XXXIII. The use of mechanical restraint equipment. In services using mechanical restraint, equipment training includes procedures to safely manage procurement, maintenance, specification (eg weight limits) and the use of the equipment in line with organisational policy and procedure.

XXXIV. The use of pharmacological restraint. In services using pharmacological restraint, training includes reference to the relevant organisational policy and procedure for medication management and rapid tranquillisation and references Stomped (The Challenging Behaviour Foundation, 2016) appropriately.

XXXV.   Lone working devices. In services using lone worker devices, training includes procedures to safely manage the use of the equipment in line with organisational policy and procedure.

XXXVI.   High Secure Services. Training in High Secure Services **must** be delivered in accordance with the approved High Secure training manual, *Positive and Safe: Violence Reduction and Management Programme* (West London NHS Trust, 2016).

XXXVII.   Trainers ensure that any injuries or incidents and near misses which occur during education and training programmes are accurately recorded and reported through established reporting systems.

XXXVIII. Trainers complete course reports outlining the course content and any issues arising so information can be sourced or reviewed as part of quality assurance process.

XXXIX.   Training programmes include a system of competency assessment for participants and a reporting structure that informs line managers of the individual's outcomes from training. A written plan for any staff that have not achieved competence should be in place that details actions needed to achieve the required level of competence to undertake their duties and an interim management plan.

XL.   Evaluation procedures are in place to establish the efficacy of training.

XLI.   Injuries or incidents are audited and reviewed on a regular basis.

3.5 Trainer competencies compliance standard

Good trainers who are committed to protecting people's human rights and reducing restrictive practices have the potential to improve practice and support an organisation-wide approach to reducing restrictive practices. Trainers must be able to evidence skills to teach, experience of supporting people with learning disabilities or mental health conditions and experience in education, health or social care settings.

The executive lead and non-executive lead should maintain accountability for ensuring suitability of trainers (either in-house or commissioned from a commercial training provider) and ensure that 'train the trainer' courses are suitable and sufficient to the needs of their service. Non-service based training providers should work with the provider's executive and non-executive lead to confirm responsibilities in relation to completion of training needs analysis, issue of pre-course information, liability for injuries, learning points about provider culture etc, prior to commencement.

Where the service provider commissions an external commercial training provider to train their own in-service staff to deliver the commercial training provider's programmes the executive lead must ensure sufficient quality assurance from the external training provider and that the training provider is certified and that the training provider has registered their service provider organisation as an affiliate organisation.

Organisations should be able to demonstrate a clear and accountable process for the selection and continuous monitoring of their trainers or training providers in line with the following standards:

I. Internal (service based) trainers' portfolios are reviewed annually by their employing organisation, and evidence of this should be presented in summary form to the executive and non-executive leads in the service provider organisation which is buying the teaching service.

II. Organisations have in place a trainer's Code of Conduct that clearly outlines organisational and individual professional and value based expectations.

III. Trainers are clinically credible and can demonstrate an understanding of services through clinical experience and/or relevant professional qualifications.

IV. Trainers can demonstrate teaching skills through formal qualifications and/or relevant organisational educational programmes.

V. Trainers attend annual updates tailored to meet the needs of the organisation.

VI. Trainers receive the essential exposure to the current and emerging best practice literature and guidance. This is supported by individual reflection and learning portfolios.

VII. Trainers understand the value and practice of involving people who receive services and are able to work effectively with people with lived experiences.

VIII. Trainers demonstrate the organisational and professional values and recognise the responsibility and accountability for what they teach and their influence on practice and culture.

IX. Trainers reinforce a culture of prevention through positive engagement and communication.

X. External training providers have evidence of the experience, qualifications, and clinical credibility of trainers.

XI. External training providers can evidence that issues of indemnity insurance are clarified.

XII. 'Train the trainer' programmes demonstrate compliance to the training content standards outlined in this document and the *Restraint Reduction Network (RRN) Training Standards* and the commercial training provider organisation has in place a competency assessment framework for trainers.

XIII. All trainers as quality assured and subject to annual competency monitoring arrangements.

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Legislation

Statutes

(All available at legislation.gov.uk)

Human Rights Act 1998 c. 42

Mental Health Unit (Use of Force) Act 2018 c.27 (Also known as Seni's Law, named for the late Olaseni Lewis. We have respectfully asked permission from Mr Lewis's family to clearly state the pronunciation of Seni's name to be ʃān-i , "sh", "a" as in "bay", "i" as in "we".)

Criminal Law Act 1967 Chapter 58

Health and Safety at Work Act 1974 Chapter 37

Human Rights Act 1998 Chapter 42

Mental Capacity Act 2005

Statutory instruments

Management of Health and Safety at Work Regulations. SI 1999/3242.

Accessible Information Standard – Making Health and Social Care Information Accessible NHSE 2016/17

Appendix 1

Exemplar titles for supporting policies

Policies should be signed off and governed by providers' boards under a coherent strategy and could include the areas below:

· Access to independent advocates

· Anti-discrimination and anti-bullying

· Approaches for the management of aggression and violence

· Basic/Immediate life support (in line with organisational/role expectations)

· Board approved values statement

· Care Programme Approach (CPA) and Care Co-ordination

· Clinical risk assessment, positive and safe risk management

· Clinical risk assessment, recognition, prevention and de-escalation strategies

· Complaints procedures

· Debriefing

· Disability Discrimination Act

· Duty of candour

· Engagement and observation

· Equality Act/gender equality duty

· Health and safety policies in accordance with the Health and Safety Legislation

· Human Rights Act (1998)

· Information governance and information sharing procedures

· Joint working arrangements with criminal justice system

· Joint working arrangements with other relevant providers

· Legislation in relation to the use of restrictive intervention and best interests

· Lone working safety procedures

· Mental Capacity Act 2005

· Mental Health Act – The Code of Practice (2015)

· Physical care and observation during and post restraint

· Positive behaviour support

· Post-incident support, review and reconciliation

· Procedures for disciplinary, grievance and attendance management

- Professional accountability and responsibility
- Race Relations Amendment Act (2000)
- Raising concerns procedures
- Recording, reporting, monitoring and audit
- Root cause analysis and sharing lessons learned
- Safe sharing of information including Caldicott 2 and common sense confidentiality
- Safeguarding procedures
- Staff management procedures for clinical and managerial supervision
- Staff wellbeing
- Supervision
- Supporting legislation including Mental Health Act 1983
- Terms of reference for inclusion of people with lived experience
  In organisational decision making
- The use of mechanical restraint equipment.
- The use of medication and tranquillisation
- The use of segregation and/or seclusion
- Use of extra care areas or low stimulus environments
- Use of long-term segregation

Restraint Reduction Network Pledge Action Plan

The Restraint Reduction Network Pledge Action Plan provides you with an opportunity to review what you have done so far in each of the SIX STRATEGY domains below, and identify your three top priority actions that you would aim to complete within the next 12 months.

On submission you will receive a Restraint Reduction Network member logo™ and your top three priorities (only) will be published on the Restraint Reduction Network website (we will not share contact info).

Here is the link to the full RPI self-assessment checklist that we would recommend you work through in the next 12 months https://bit.ly/2KqJRRi

Organisation name	
Sector (eg academy trust, NHS trust)	
Restraint reduction lead	
Contact email	
Date	

Our top priorities for the next 12 months	Our measure of success
1.	
2.	
3.	

Strategy 1: LEADERSHIP AND GOVERNANCE > The organisation develops an organisation wide plan designed to increase the quality of life for service recipients as well as reduce and minimise the use of restrictive interventions and restrictive practices. Such a systems approach should have review and planning mechanisms

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area:

Strategy 2: USING DATA TO INFORM PRACTICE > The organisation uses data to identify, plan and review the overall organisation wide plan to reduce restrictive practice/interventions, improve service delivery and/or increase quality of life

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area:

Strategy 3: STAFF TRAINING AND DEVELOPMENT > The organisation ensures that all members of its workforce have the knowledge and skills they require to implement improvement measures and prevent and respond sensitively to any behaviours of concern

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area:

Strategy 4: PREVENTATIVE MEASURES AND PERSONALISED SUPPORT > The organisation ensures that staff have access to the tools they require to manage risks, to improve or enhance service delivery as well as personalise the support provided to people using the services

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area:

Strategy 5: INVOLVING THOSE WHO RECEIVE YOUR SERVICES > The organisation fully involves the people who use services in order to establish a clear understanding of their needs and to determine whether or not the service that is delivered meets their needs and expectations

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area:

Strategy 6: CONTINUOUS IMPROVEMENT > The organisation adopts a culture of reflection and positive learning in order to ensure the necessary change can be embedded and implemented at service level, through the workforce scheme of working as well finding its way into everyday interactions between staff and people using the services

What is the main priority in this area:

What we have done so far:

What we plan to do next in this area: