

Positive and Safe Champions Network

Restraint Reduction 6th &
7th October 2016

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Positive and Proactive Care

Aims

- Cultural change
- Development of therapeutic environments
- Focus on quality of life
- Governance models
- Reducing reliance on restrictive interventions
- Learning, sharing and promoting practice innovation
- To ensure that restrictive interventions are used in a transparent, legal and ethical manner

NHS Benchmarking Network-

Use of Restraint in Mental Health, CAMHS and LD Phase 4 Data Collection

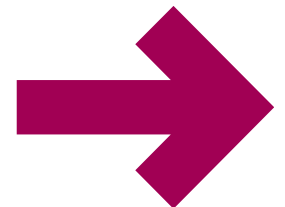
Interest in exploring the use of restraint & context of use

Phase 1, August 2014

Phase 2, January 2015

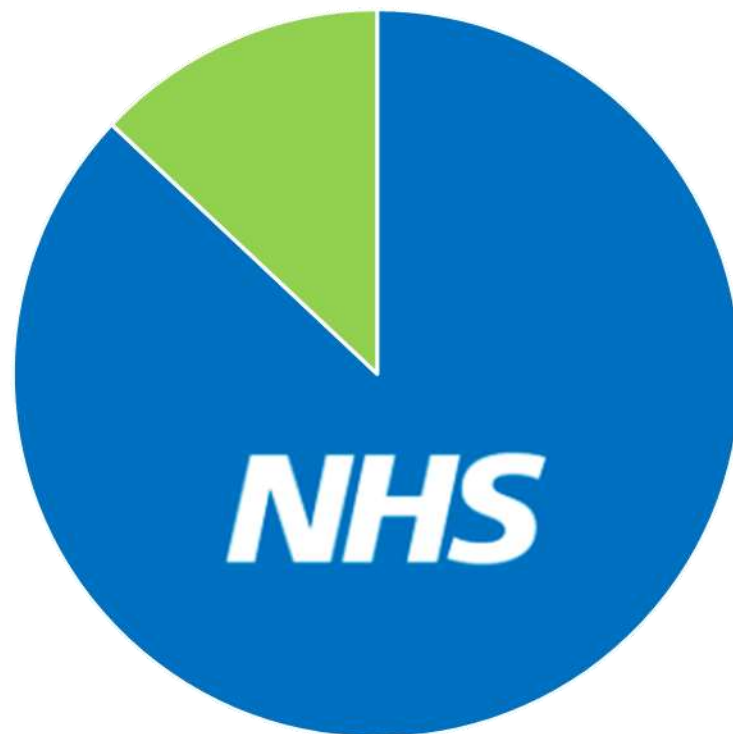
Phase 3, August 2015

Phase 4, Nov/Dec/Jan 2015-16



Scope: Participation

- 48 NHS Trusts
= 87% of beds included in the audit
- 7 Independent Sector providers
= 13% of beds included in the audit



Scope: Bed Coverage January

21,578 beds

MH = 18,352

LD =
2,056

CAMHS = 990

Adult Acute = 6251

Older Adult
= 3545

Other MH = 8736

November – 19,321 beds

December – 19,762 beds

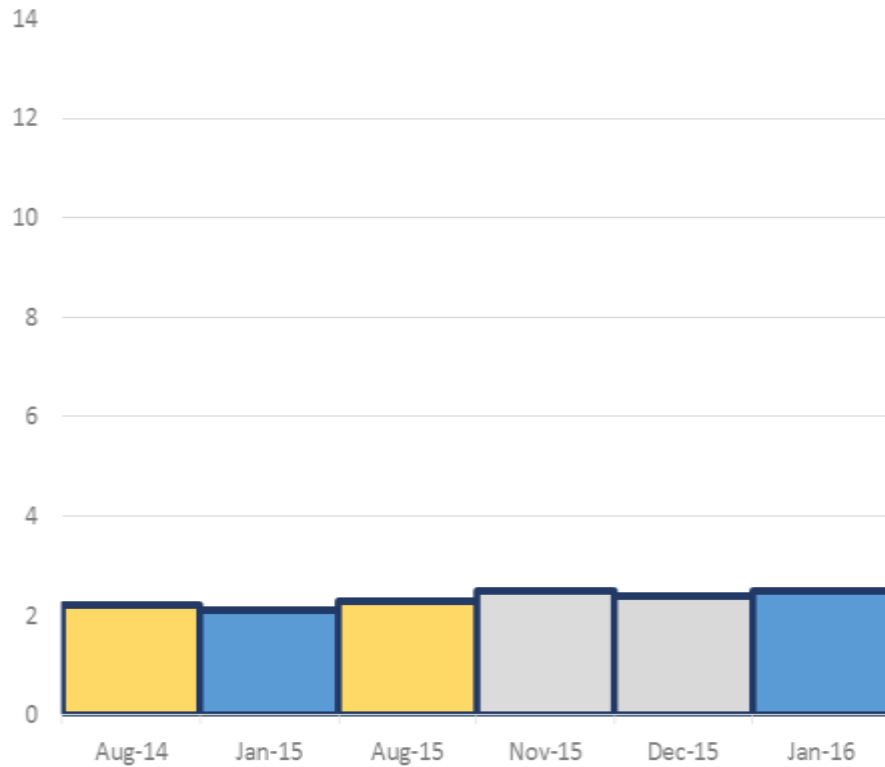
NHS

Benchmarking Network

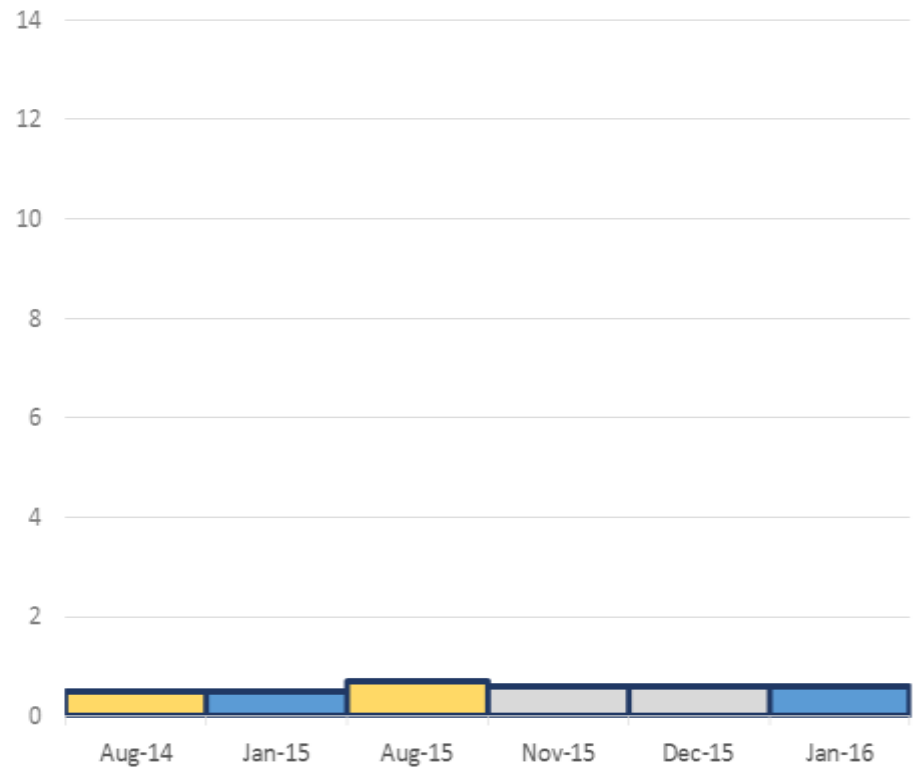


Adult Acute

Adult Acute - Restraint per 10 beds



Adult Acute - Prone per 10 beds

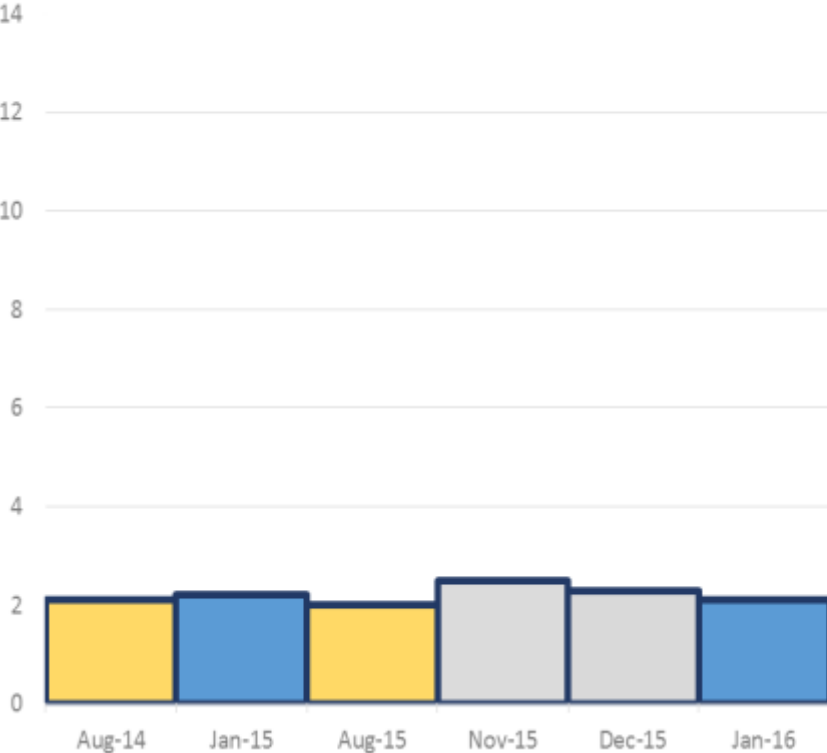


Benchmarking Network

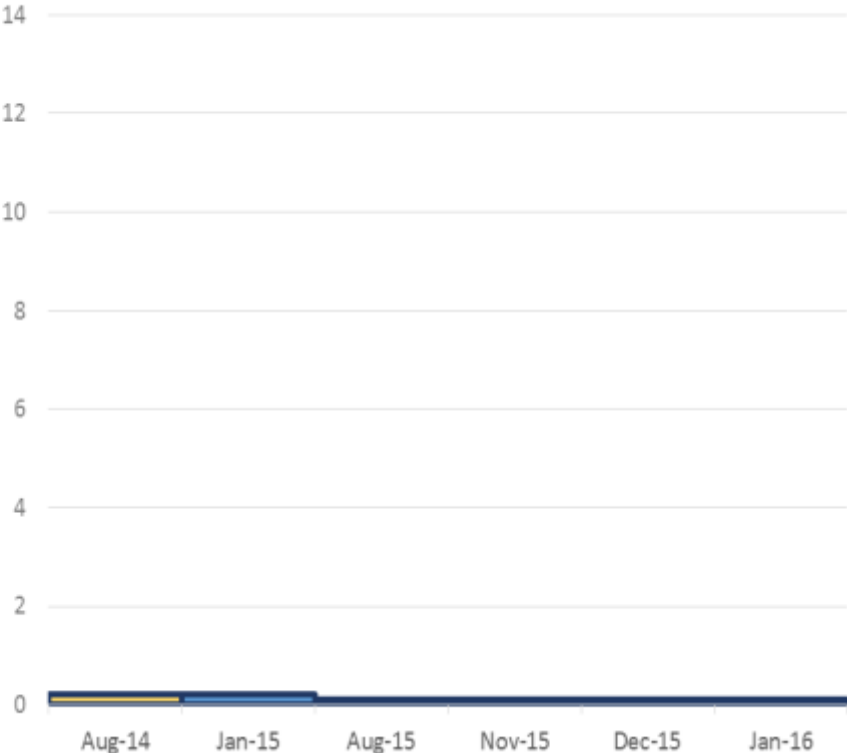


Older Adult

Older Adult - Restraint per 10 beds



Older Adult - Prone per 10 beds

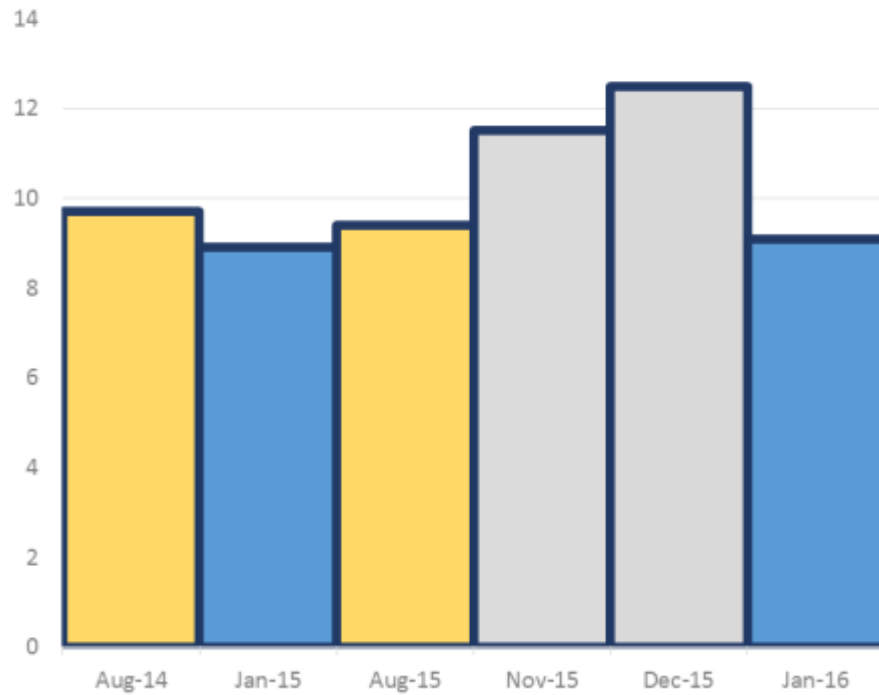


Benchmarking Network

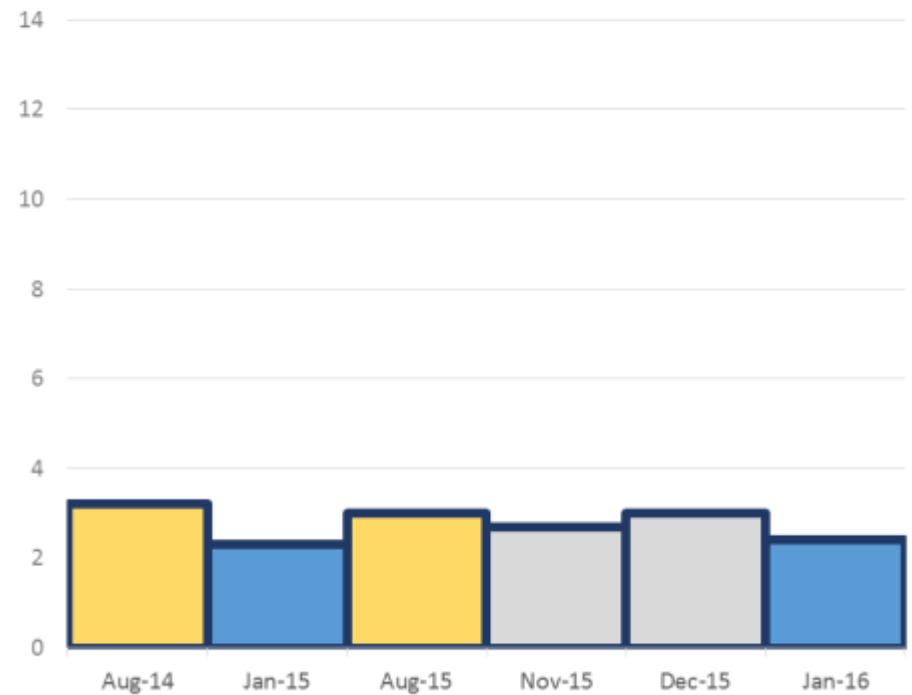


PICU

PICU - Restraint per 10 beds

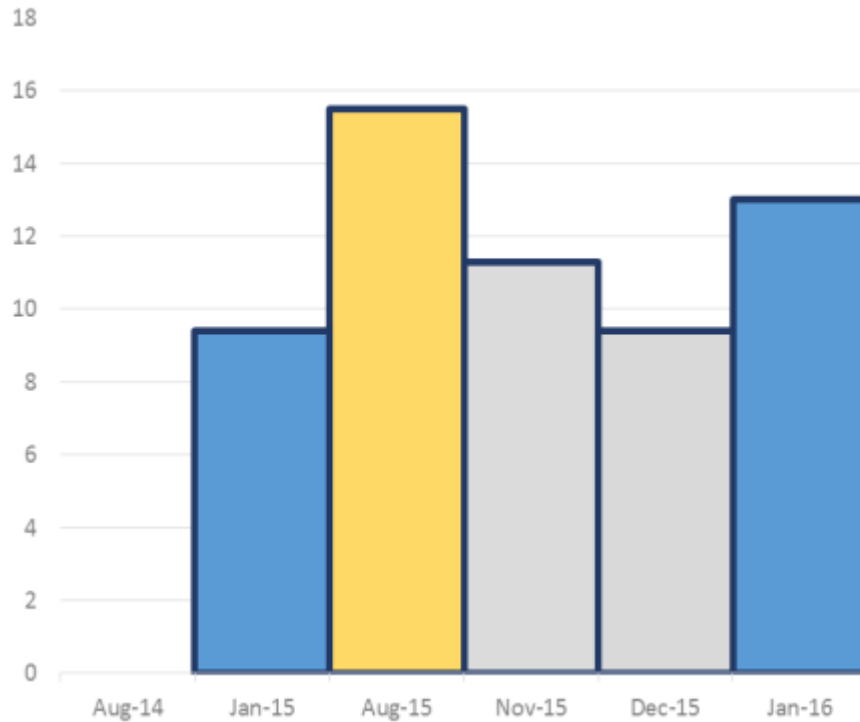


PICU - Prone per 10 beds

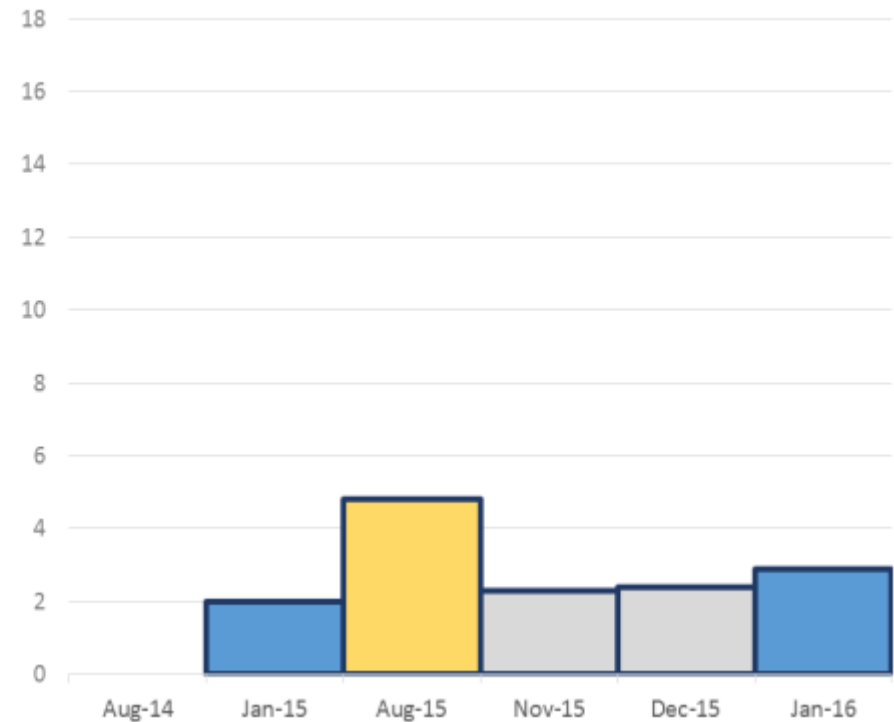


CAMHS Non-Forensic

CAMHS non-forensic - Restraint per 10 beds

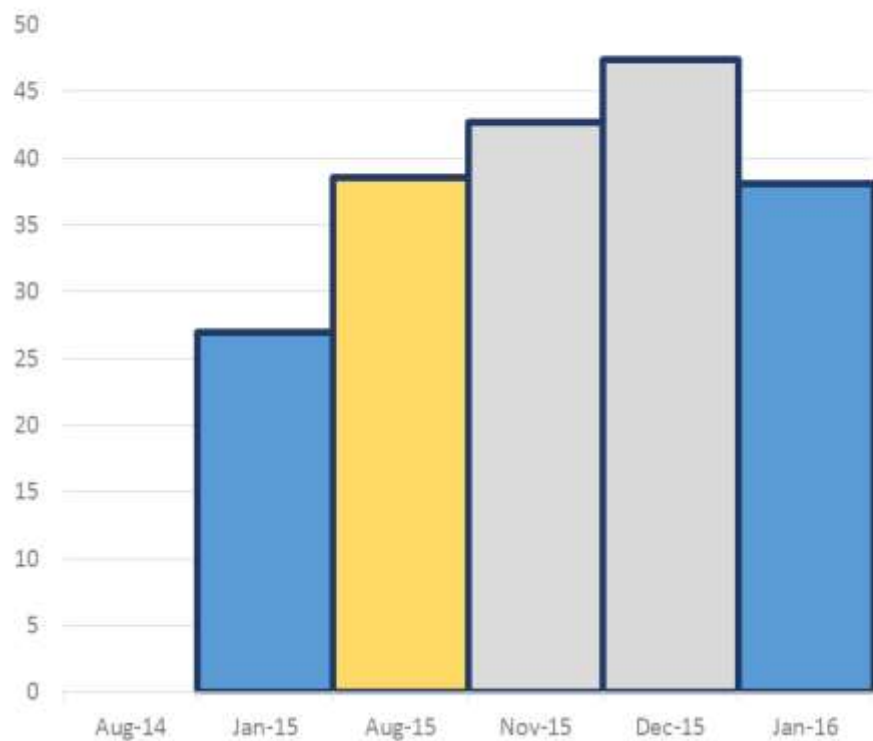


CAMHS non-forensic - Prone per 10 beds

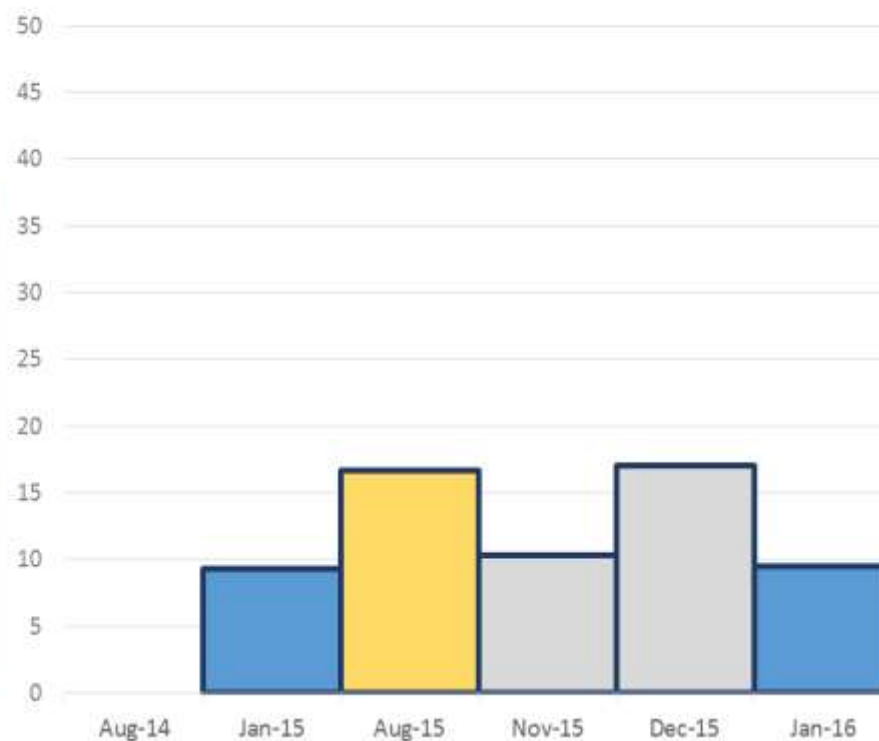


CAMHS Forensic

CAMHS forensic - Restraint per 10 beds



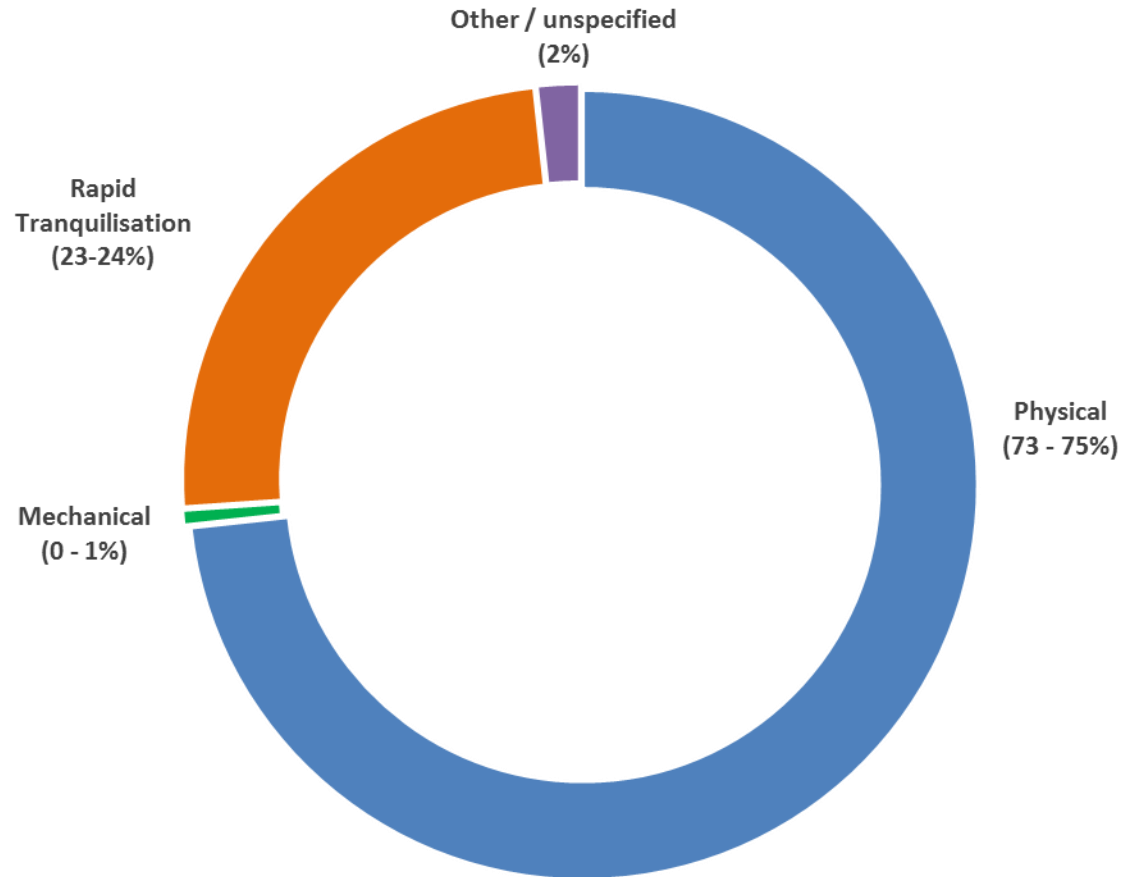
CAMHS forensic - Prone per 10 beds



Types of Restraint

13 respondents (23%) reported use of mechanical restraint over the 3 months

2 of these respondents accounted for 75% of all mechanical restraint



Positive & Safe - Building a Network of Champions

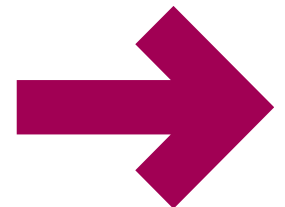
- Moving towards 300 champions
- 2 national and 8 regional champions' events
- 4 regional culture change workshops with FoNS over 300 staff attended
- Newsletters

<http://www.england.nhs.uk/6cs/groups/positive-safe-champions/resources/>

What have organisations been doing?

- Reviewing their training – more focus on non physical interventions
- Looking at where and when restraints happen
- No Force First, Safewards
- Positive Behavioural Support
- Developing Trust wide restrictive intervention reduction plans

- Focus on injections techniques other than buttock
- Post incident reviews with service user
- Define the use of force and coercion as a treatment failure
- Classed as critical incident reviews



Nottinghamshire NHS Trust: Preliminary themes

Unpleasant but accepted

Traumatic re-enactment

Control of distress

- Self-harm
- Problematic beliefs
- Hearing voices

Conflict between patients

- Racism
- Hostility
- Disinhibition
- Property

Compulsion

- Leave
- Medication
- Detention

Communication of distressing news

- Safeguarding
- Detention
- Medication
- Leave

Privacy and dignity

- Gender mix
- Safe and gentle / less brutal
- Wanted by patient – no alternative

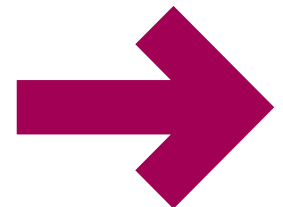
Staff enjoy it / can escalate situation

Resources

- Space
- Activities
- Staff

National minimum standards for Preventing and Managing Violence and Aggression- early draft indications

- Organisational Standards
- Team Standards
- Individual Standards
- Training Standards
- Trainer Standards



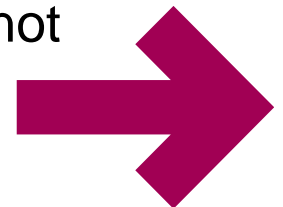
Organisational Standards

1. The organisation has demonstrated it understands how it uses restrictive practices (RP) and a named Executive board member has responsibility for ensuring RPs are used at the lowest possible levels.
2. The organisation has a clear and accessible account of how much and the type of the restrictive practice it uses.
3. The organisation has a clear view of its training needs related to restrictive practice.
4. Training programmes specifically aimed at reducing restrictive practice are in place and supported by the Board.
5. Policies have clear focus on acknowledging and reducing restrictive practices.
6. Service user and carer groups are involved in the development of work that relates to the reduction of restrictive practices.



Team Standards

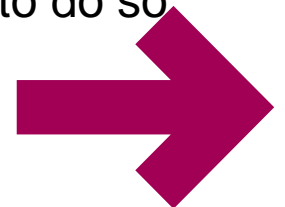
7. It can be demonstrated that the service user has had a say on how they should be treated if there is a need to restrict them including their own view on how to avoid that need.
8. Care plans include clear measures to improve the service user's situation based on their own unique characteristics. .
9. Care plans have given careful consideration to the use of "hands on" interventions.
10. Everybody that needs to know is aware of the care plans.
11. In circumstances where a "hands on approach" is needed, careful consideration has been given to ensure this will not make any existing physical problems any worse.



12. Careful consideration has been given to the previous experiences of those subject to physical intervention and how this may impact upon them.
13. The physical environment has had careful consideration towards reducing the need for restrictive practice and ensuring it is delivered as safely as possible when it cannot be avoided.
14. 7 day week meaningful activity timetable is available to service users.
15. Any spiritual, religious and cultural needs of service users have been addressed.
16. The needs of specific vulnerable groups will be considered in the implementation of tertiary interventions.
17. After it has been necessary to physically intervene with a service user it can be demonstrated that staff have been able to sit down together and reflect on the incident with a view to learning any lessons for the future

Individual Standards

18. Staff members are able to demonstrate an attitude and philosophy of only intervening with the minimum restriction necessary and only for the shortest time possible.
19. Staff report restrictive interventions as required and are clear that any action was professionally, legally and ethically justifiable. Staff have a duty to also report when, in their view, they believe action was taken that may have not have been professionally, legally or ethically justifiable.
20. Staff members can demonstrate their commitment towards prevention of the need for restrictive interventions.
21. Staff members will not apply physical interventions unless failure to do so will result in harm.



Training standards

22. Clinical staff have received training in the prevention and management of violence and aggression at the point of induction and this will be updated a minimum of two yearly.

23. Training packages for the prevention and management of violence and aggression include a theoretical component which describes the principles of primary, secondary and tertiary prevention of violence. Training will also address the following areas:

- De-escalation methods
- Reporting and escalation
- Professional accountabilities and responsibilities
- Race and cultural issues
- Risks associated with tertiary interventions
- Legal and ethical implications and framework

24. Training will be regularly updated in line with current best practice guidance and has a method of receiving feedback direct from the clinical area in which the training is being enacted.

25. A training manual will be available which provides the training syllabus.



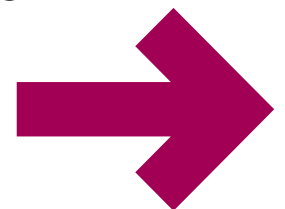
26. Physical interventions will not include the deliberate application of pain except to save life.

27. Physical interventions always start with the least possible intrusion.

28. Physical interventions have been independently medically and legally risk assessed by experts within a defined process.

29. Clinical staff applying physical interventions are trained in life support and are able to recognise physical problems should they occur.

30. A member of staff independent of applying physical interventions will be engaged in the sole purpose of monitoring a service user's physical health during and post restraint



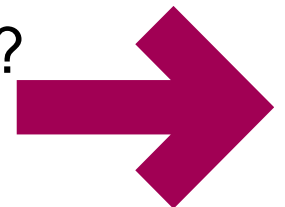
Trainer Standards

31. Training providers can produce evidence of their philosophy, attitude and values.
32. Training providers can produce evidence supporting their clinical knowledge and experience relevant to the group they are training.
33. Trainers have opportunities to regularly update their skills and knowledge of best practice.
34. Trainers can produce a portfolio of training undertaken and are able to demonstrate ongoing learning regarding the reduction of restrictive practices as part of maintaining their trainer status.
35. Trainers adhere to a code of conduct set out by the organisation.
36. Trainers can demonstrate their clinically credibility and are able to produce records of the number of hours they have spent in clinical practice over a 12 month period



Next steps

- NICE working on a quality standard to follow on from NG10
- PMVA core standards session London 17th October
- Children & Young People's guidance out for consultation by the end of the year
- Leading Change, Adding Value May 2016:
Whats the unwarranted variation in your areas?



- Is your organisation a member?
- How is the learning shared?
- Join us now
- London 14th November
- Leeds 22nd November

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Thank you

