



Department
of Health



A positive and proactive workforce

A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health



Ministerial foreword



Investigations into abuses at Winterbourne View Hospital and Mind's Mental Health Crisis in Care: physical restraint in crisis (2013) showed that restrictive interventions have not always been used only as a last resort in health and care. They have even been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this.

There is overwhelming support for the need to act. Over 95% of respondents were supportive in consultation. The Royal College of Nursing Congress voted by 99% in favour of new guidelines. Whilst I appreciate there may be times when restrictive interventions may be required to protect staff or other people who use services, or the individuals themselves, there is a clear and overwhelming case for change.

This is about ensuring service user and staff safety, dignity and respect. This is absolutely not about blaming staff. Whilst at Winterbourne there was clearly abuse and this must not be allowed to happen, we know that many staff have just been doing what they have been trained to do and have been struggling in difficult situations and often with very little support.

We need to equip these individuals with the skills to do things differently. The guidance makes clear that restrictive interventions may be required in life threatening situations to protect both people who use services and staff or as part of an agreed care plan.

Together Positive and Proactive Care and A Positive and Proactive workforce provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery. I want to thank the Royal College of Nursing for leading the multi-professional consortium who led on developing the Department's guidance and Skills for Care and Skills for Health in developing the complementary guidance to support the commissioning of learning and development. This was a great example of organisations working together to deliver high quality products that affect all of us.

This guidance is only one part of the story. From April 2014, DH will launch a new, wider two-year initiative Positive and Safe to deliver this transformation across all health and adult social care. We will identify levers to bring these changes about including improving reporting, training and governance. DH will also develop accompanying guidance in relation to children, young people and those in transition in healthcare settings.

I look forward to working with you to co-produce this programme. Through Positive and Safe we have the potential to make whole scale system-wide changes, ensuring we have a modern, compassionate and therapeutic health and care service fit for the 21st century.

A handwritten signature in black ink, appearing to read 'Norman Lamb', with a horizontal line underneath.

Norman Lamb
Minister for Care and Support



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A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.

Published by:

Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP www.skillsforcare.org.uk

Skills for Health, 1st Floor, Goldsmiths House, Broad Plain, Bristol BS2 0JP www.skillsforhealth.org.uk

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Bibliographic reference data for Harvard-style author/date referencing system:

Short reference: Skills for Care & Skills for Health [or SfC&SfH] 2014

Long reference: Skills for Care & Skills for Health, *A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*, (Leeds, 2014) www.skillsforcare.org.uk www.skillsforhealth.org.uk



1. Executive summary

Within the last few years, a number of reports have focused attention on the use, or abuse of restrictive interventions in health and care services. In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital* which outlined the actions to be taken to avoid any repeat of the abuse and illegal practices witnessed at Winterbourne View Hospital.

In June 2013 Mind published its report *Mental Health Crisis Care: physical restraint in crisis* which provided evidence of significant variations in the use of restraint across the country and raised concerns about the use of face down or 'prone' restraint and the numbers of restraint related injuries that were sustained.

"A positive and proactive workforce; A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health" has been co produced by Skills for Care and Skills for Health. It is one of a suite of guidance that has been written to support the introduction of 'Positive and Safe'.

Skills for Care and Skills for Health have worked extensively with focus groups and test sites representing experts in Positive Behaviour Support, people with learning disabilities, mental health problems, autism, older people, family carers, commissioners, social care employers and learning providers to inform and agree the content of the guide.

The guide will help commissioners and employers to develop a workforce that is skilled, knowledgeable, competent and well supported to work in a positive and proactive way to.

It will inform decision making when planning, purchasing or providing learning and development activities to support workers and individuals to work in a positive and proactive way.

In addition it outlines some key points for organisations to ensure that any restrictive practice or intervention is legally and ethically justifiable and underpinned by following key principles which are shared with the DH guidance:

- **Compliance** with the relevant rights in the European Convention on Human Rights at all times.
- **Understanding people's behaviour** allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- **Involvement and participation** of people with care and support needs and their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations;
- People must be treated with **compassion, dignity** and kindness.
- Social care and health services must support people to **balance** safety from harm with freedom of **choice**.
- **Positive relationships** between the people who deliver services and the people they support must be protected and preserved.



1.1. Key points

- This guide is concerned with developing workers so that they can work in a positive and pro-active way to minimise the use of all forms of **restrictive practices**. In everyday language we consider this to be: **“Making someone do something they don’t want to do or stopping someone doing something they want to do”**.
- Anyone who may carry out a restrictive practice or provide learning in this area should have completed training in the Mental Capacity Act which covers the learning outcomes of the QCF unit MCA01, ‘Awareness of the Mental Capacity Act 2005’ (level 3) and other legislation relevant to their situation (see Appendix D).
- Learning about human rights based, positive and pro-active, non-aversive approaches must precede any training on or use of restrictive interventions.
- Significantly more time should be spent learning about positive and pro-active approaches and non-restrictive alternatives. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm and are part of an ongoing learning pathway.
- Bank / agency / casual / self-employed workers should receive training and support in line with all other workers in the team.
- Learning must be offered to individuals for whom restrictive practices are planned. Their family carers or support network should be included in learning proportionate to their level of their involvement in supporting the individual.
- Information must be offered to anyone experiencing planned or unplanned restrictive practices, and to their carers¹.
- Anyone delivering learning or assessing competence in restrictive practices should be occupationally competent and hold or be working towards achieving a recognised teaching /training qualification.
- All learning should be co-produced; including the voices of the people being supported and their carers in appropriate formats in design, production, delivery and evaluation.
- Workers in all social care and health services must have an appropriate level of awareness of the specific needs of people with whom they may come into contact. This may include people with dementia, psychosis, autism, borderline personality disorder, head injury, trauma, anxiety, learning disability, etc., and the ways in which these conditions may lead to behaviour that challenges or a resistance to essential care.
- Workers should have an understanding of how to access specialist advice and support for people, which includes advice on the impact of culture and the environment.
- Executive board members (and their equivalents in non-regulated services) who authorise

¹ ‘Carer’ is used throughout to indicate family or friends who provide social care or health support, as distinct from social care or health workers.

the use of restrictive interventions in their organisations must fully understand positive behaviour support and any physical interventions they authorise.

- Services offering positive behaviour support (PBS) must meet the specifications for a well trained workforce described in Ensuring Quality Services (EQS).

1.2. Acknowledgements

We wish to acknowledge the huge contribution made to this work by people who have shared their personal lived experiences, and friends and family members of people who have been subject to restrictive practices or restrictive interventions.

We also want to thank everyone who contributed to the development of the guide by being part of the steering group, the focus groups and guide test sites. In particular we wish to acknowledge the advice and support received from the following organisations:

- 2gether NHS Trust
- Amanda Hall Associates Limited
- Affinity Trust
- Alzheimers Society
- Ashmere
- Avon and Wiltshire Mental Health Partnership Trust : Learning Disability Intensive Team
- Brighton & Hove City Council
- British Institute of Learning Disabilities
- Carers Trust
- Care Management Group
- Care Through The Millennium
- Coventry City Council
- Care Quality Commission
- Crisis Prevention Institute Europe
- D.ESCAL8
- Department of Health
- Dimensions
- East London NHS Foundation Trust
- Gloucestershire County Council
- Health and Safety Executive: Health and Social Care Services Unit
- HF Trust Ltd (Hft)
- iMap Centre Limited
- Inspiration Care Ltd
- Integrate
- London Care Partnership



- Mind
- Monarch Healthcare
- NAViGO Health and Social Care CIC including Respect Training Solutions
- National Development Team for Inclusion (NDTi)
- National Voices
- NHS England
- North Bristol NHS Trust
- Nottingham County Council
- Positive Behaviour Support Consultancy Ltd
- Positive Response Training
- Royal College of Nursing
- Royal Cornwall Hospital Trust
- Scope
- Shropshire Council
- Shropshire Partners in Care (CWDP)
- Social Care Institute for Excellence
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Southern Health NHS Foundation Trust
- St Anne's Community Services
- The Avenues Group
- The Challenging Behaviour Foundation
- University of Kent - Tizard centre



2. Introduction

2.1. The purpose of this guide

This guide is aimed at commissioners and employers responsible for developing a adult social care and health workforce who are skilled, knowledgeable and competent. Organisations will have plans to reduce restrictive practices both for individuals and for their service as a whole and this guide should help them to implement these. This guide shows how workers can be developed and supported to minimise (reduce the necessity, frequency, intensity and duration of) restrictive practices and ensure they are only ever used appropriately and not misused or abused.

This guide applies to services for people with any kind of adult social care or health need, including people with longer term needs such as some people with a learning disability, autism, acquired brain injury or dementia, those with intermittent or frequently changing needs such as people with mental health or substance misuse problems, and people in an acute health crisis such as following an accident, severe infection, recovering from an anaesthetic or under the influence of alcohol or drugs. Those with intermittent or acute needs could, of course, include people who have also a learning disability, dementia or other long term condition.

Although the guide does not specifically apply to services for children and young people, those working within these services may find it helpful. It has particular relevance to services supporting young people in transition.

Throughout this guide we refer to 'workforce'. In this context we mean everyone involved in supporting a person or persons with social

care or health needs. This could include the individual and their family and friends along with paid workers, people who shape the services by providing regulation or training, those commissioning the service and senior level managers and board members.

This guide supports and complements the Department of Health's *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014), developed by the Royal College of Nursing, which provides guidance on the use of organisational models of restrictive intervention reduction and positive behavioural support in order to provide better outcomes for people.

This guide has also been written at the same time as *"Ensuring Quality Services - Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and / or autism who display or are at risk of displaying behaviour that challenges"* which has been developed by NHS England and the Association of Directors of Adult Social Services (NHSE LGA 2014 3). This guide aims to support and complement this in relevant services.

Current legislation, policy and accepted good practice are consistent that any restrictive practice should only be carried out where it is legally and ethically justified. This means it must be essential to prevent serious harm to somebody and it must be the least restrictive option.

In these circumstances you will be working within the Human Rights Act 1998 and the European Convention on Human Rights, the Mental Health Act 1983 as amended by the Mental Health Act 2007, the Mental Capacity



Act 2005 (MCA), including the Deprivation of Liberties Safeguards (DOLS), the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 and, in some circumstances, the Children Act 2004 and Common Law.

2.2. Why you should read this guide

Good proactive workforce planning and development will produce better outcomes for people using the services in a way that is cost effective in the long term. The reasons why you should use this guide will be different dependent upon your role. These include:

People in need of care and support, and patients

- The guide offers clear expectations of how people working and contributing to the service you use, should be developed.
- You should receive a higher quality service and one you can trust.
- These standards should help when purchasing your own care and support, contributing to commissioning for others or monitoring services.

Workers

- You should feel knowledgeable, skilled, competent, and supported to do your job to the best of your abilities.
- You will know what is expected of you.

Employers and managers

- Provides clear expectations of the standards expected from workers.
- Provides clear guidance on how to purchase or plan learning for workers and teams.
- Feel confident and assured that you are developing your workforce to deliver a quality service.
- Aids good staff recruitment and retention.
- Provides a baseline for negotiating contracts with commissioners of services and with learning providers.
- Provides evidence for relevant Care Quality Commission Standards and Regulations (2010, currently under review), specifically:



Involvement and information

- Outcome 1: Respecting and involving people who use services
- Outcome 2: Consent to care and treatment

Personalised care, treatment and support

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Cooperating with other providers

Safeguarding and safety

- Outcome 7: Safeguarding people who use services from abuse

Suitability of staffing

- Outcome 12: Requirements relating to workers
- Outcome 14: Supporting workers

Quality and management

- Outcome 16: Assessing and monitoring the quality of service provision
- Outcome 21: Records

Suitability of management

- Outcome 24: Requirements relating to registered managers

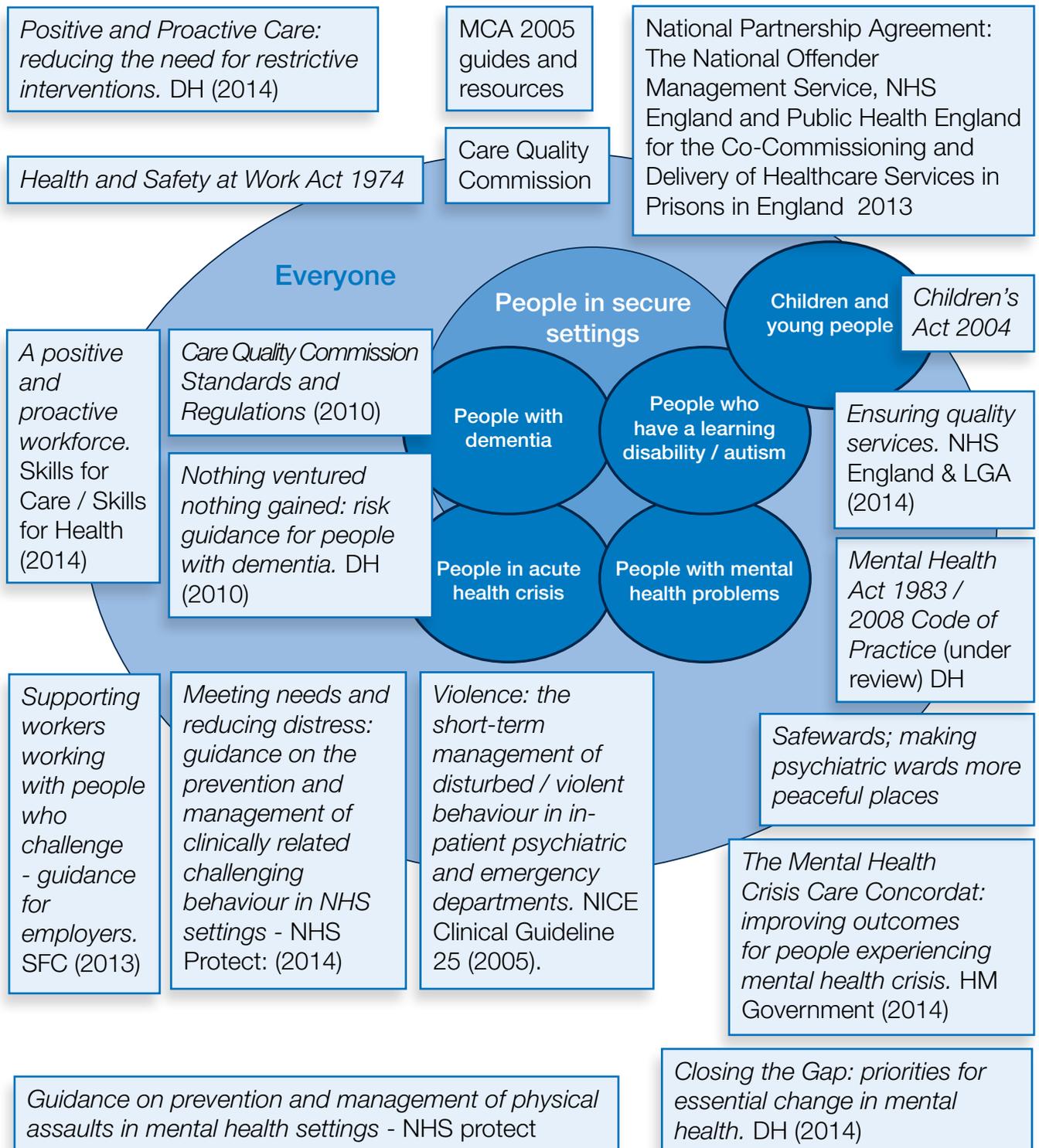
Commissioners, regulators and inspectors

- Outlines the standards required.
- Outlines good practice in workforce development to enable transparency in discussions with service providers.

Safeguarding leads

- Assists in considering situations where restrictions or interventions are used which may or may not be ethically or legally justified.

New and current resources



This guide fits with other guidance that is currently available and with work which is on-going.

Current on-going work; allied projects and future products

A number of additional projects are on going which include;

- The positive and safe programme.
- New DH guidance for children and young people on restrictive interventions.
- New NICE guidelines on violence and aggression and also on challenging behaviour and learning disability. both due 14 / 15
- A place I call home; the winterbourne view joint improvement programme

2.3. Shared key principles

This guide and *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) are based upon a number of shared key principles which apply to adult social care and health services. These key principles underpin the need to deliver positive and proactive care, which requires rigorous governance in order to reduce excessive reliance on restrictive practices and interventions and to ensure that, when they have to be used, it is only ever as a last resort and is undertaken in a proportionate, least restrictive way.

Shared key principles

- **Compliance** with the relevant rights in the European Convention on Human Rights at all times.
- **Understanding people's behaviour** allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- **Involvement and participation** of people with care and support needs and their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations;
- People must be treated with **compassion, dignity** and kindness.
- Social care and health services must support people to **balance** safety from harm with freedom of **choice**.
- **Positive relationships** between the people who deliver services and the people they support must be protected and preserved.

2.4. What do we mean by 'restrictive practices'

This guide is concerned with developing workers so that they can work in a positive and pro-active way to minimise the use of all forms of **restrictive practices**. In everyday language we consider this to be:

Making someone do something they don't want to do or stopping someone doing something they want to do.



Positive and Proactive Care: reducing the need for restrictive interventions (DH 2014) includes detailed definitions of forms of **restrictive interventions** which are used as an immediate and deliberate response to behaviours that challenge; the MCA has a broader definition of **restraint** and of **deprivations of liberty**. This guide considers restrictive interventions, **restraint** and **deprivations of liberty** as well as broader forms of restrictive practices that might be used as a routine feature of someone's care and support rather than solely in response to some form of crisis

Restrictive practices can be very obvious or very subtle; they may be planned in advance or used as a response to an emergency. We have identified four main ways in which restrictive practices can happen, as follows.

- Restrictions that arise because of habit or blanket rules, like everyone having to be up by a certain time, rules on whether people can have their phones or doors being routinely locked. These are sometimes called “de facto” restrictions.
- Safety: these could be restrictions such as locking a room to keep household cleaning products or medicine out of someone's reach or allowing someone a planned portion of jam each day. This could also mean responding to violence or aggression towards the individual themselves, or to workers or others.
- Treatment or care: restrictive practices may be used in a planned or unplanned way in order to provide essential care, support or medical treatment. This could be in an emergency. Some prescribed medication not designed to restrict, such

as sleeping tablets, can have restrictive side effects.

- Restrictions may also be used with people who are displaying or are at risk of displaying behaviour that challenges, including self-injurious behaviour. In this case, the principle of an approach called ‘positive behaviour support’ (PBS) should be used. More detail about this is in section 4.1 below. Other techniques are also useful with people with specific needs, this might also include those outlined within the ‘Safewards Project’ in mental health in-patient services or ‘dementia care mapping’ with people who have dementia. The NHS Protect guidance, *Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings* (2014) will be particularly useful in situations where you do not know the person in advance or do not have enough time to fully use PBS.

In all situations where restrictive practices may be used many of the principles and techniques of PBS will help to create a caring culture and a positive and proactive workforce. There should be evidence that restrictions are questioned and considered and only ever carried out when all other approaches have been considered and tried or are impractical.

Restrictive practices are a wide range of activities, some deliberate and some less so, which restrict people. **Restrictive interventions** lie within this and are a range of specific interventions.



For the purposes of this guide we are using the definitions of restrictive interventions as contained in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).

“‘Restrictive interventions’ are defined as:

‘Interventions that restrict an individual’s movement, liberty and/or freedom to act independently in order to:

- *take immediate control of a dangerous situation; and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the patient’s freedom for no longer than is necessary’.*”

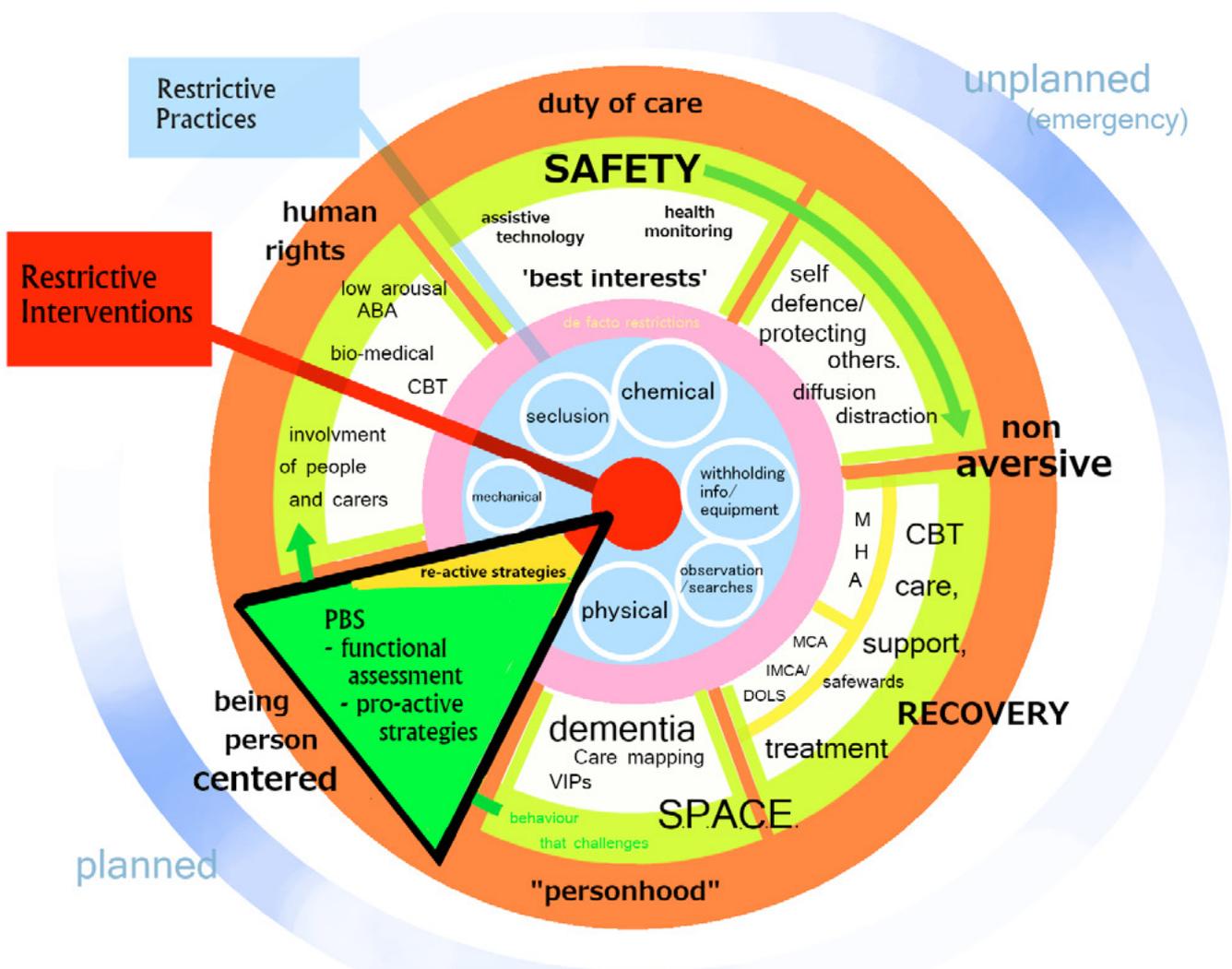
If carried out for any other purpose concerns about the misuse of restrictive interventions should always be escalated through local safeguarding procedures and protocols.

Within the context of this definition, restrictive interventions can take a number of forms, each defined more fully in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014):

- physical restraint (using physical contact)
- mechanical restraint (using devices)
- chemical restraint (using medication)
- seclusion (confining or isolating people).

Diagram illustrating how restrictive practices and restrictive interventions can be seen within a human rights-based model of positive and proactive support

Positive and proactive care



This diagram illustrates how restrictive interventions and/or restrictive practices may sit within a human rights-based positive and proactive system of care, treatment or support. It is not intended to be exhaustive, but shows that restrictive interventions and restrictive practices will always be a small part of an overall response to supporting people. Learning activities for workers should have a similar focus on positive ways of working in difficult situations.

2.5. The legal and ethical justification for restrictive practices

Workers should always strive to support and care for people in ways that are enabling and empowering. When people are distressed, ill, angry, confused or lack understanding of their situation they may need some degree of restriction to keep them or other people safe. All restrictive practices should be expressly acknowledged and must be legally and ethically justifiable. Decisions to use restrictive practices must be transparent and establish clear lines of accountability. Many of these decisions will involve assessing whether the person involved has the mental capacity to make a specific decision, for example to understand that a product or foodstuff may be unsafe, or to refuse or accept treatment. Anyone carrying out or observing any restrictive practice must be sure that it is absolutely necessary to prevent harm, that it is the least restrictive option available, that it is not done routinely for convenience, and that it is done for the shortest possible time.

It is preferable that restrictive practices should be considered and planned in advance and involve the individual (and their family where appropriate) and relevant multi-disciplinary professionals. They must ensure that monitoring, planning and reviewing takes place to find a more positive alternative on a longer term basis.

Pain

Workers must not cause deliberate pain to a person in an attempt to force compliance with

their instructions. *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) explains that pain should only ever be used in the most extreme situations where there is an immediate risk to life.

A successful physical restrictive practice should never cause pain and if it does it needs to be reviewed. "The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of workers, service users and/or others. *NICE Clinical Guideline CG 25, Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*"

2.6. How to identify when a practice is a restrictive practice or intervention

The following examples and flowchart may be a useful tool for identifying whether restrictive practices are appropriate and the legal and ethical justification for their use.

The examples illustrate the range of different restrictive practices and interventions and are based upon real life situations.

Some of these examples could be abusive, or alternately an appropriate way to support someone, some might be justifiable as a last resort, when absolutely necessary, in an extreme situation. The justification for using them is dependent upon proper care planning which includes assessment of the person's mental capacity, the likelihood and potential severity of harm, the cultural perspective of



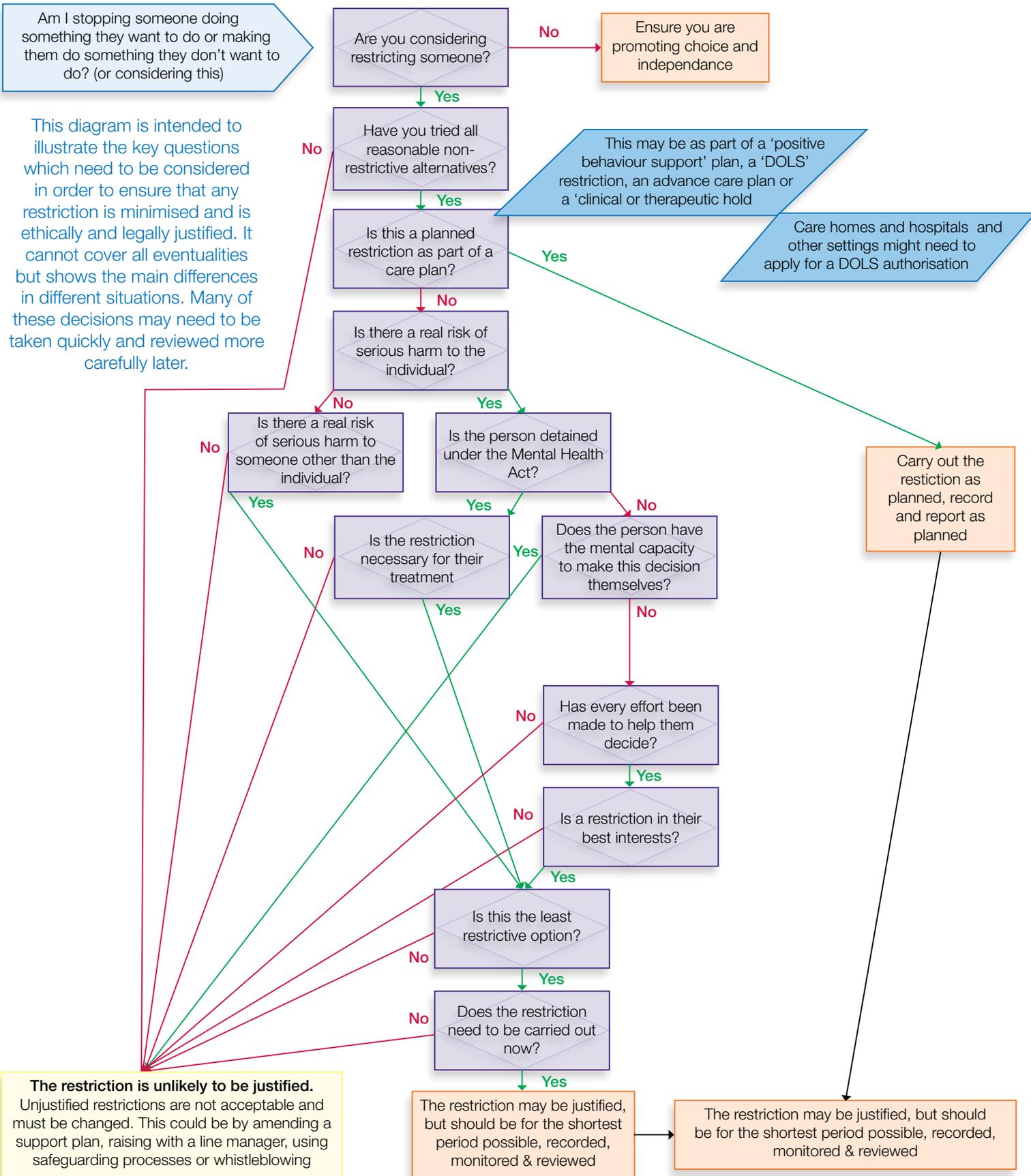
the individual involved, the potential for using alternatives, and the legal situation.

- A lady who lives in a care home is regularly encouraged to return to 'spend time in your room alone' because her singing upsets other residents.
- A man with dementia on a 'respite' stay brings a bottle of whisky with him. The workers keep it in the office and bring him up to two glasses per evening when he asks for it. If he asks for a third then they remind him he has already had two.
- A man is prescribed a sleeping tablet because his family are worried he may get up and wander or fall during the night.
- An ambulance crew attend to someone who is intoxicated with alcohol and has a head injury from a fall. They strap the person to a trolley to stop him climbing off.
- In a day centre, a guest is left for several hours with her dinner tray or wheelchair seatbelt on to prevent her 'wandering'.
- On a hospital ward a man's walking frame is moved out of his reach while workers are cleaning and they forget to put it back.
- A daughter wheels her dad in his wheelchair away from a crowded section in a supermarket because he is making sexually explicit comments about other customers. She tells him she won't bring him here again.
- A woman is told she can't go home 'on leave' from a mental health ward unless she shows that she is willing to take her medication.
- A member of the intensive care nursing team holds a woman's hands to stop her from removing a tracheotomy tube following surgery.
- A young woman who is detained under section 3 of the Mental Health Act is held down on her bed while nurses give her an injection of medication because she is refusing it.
- The personal assistants to a young man with severe epilepsy, learning disabilities and some mobility difficulties are told by his Mum to use his wheelchair when out even though he can walk short distances, as he is less likely to injure himself badly if he has a seizure while seated and strapped in and will be generally 'safer'.
- A person with Prader-Willi Syndrome needs to have food in his home provided to him in small portions at mealtimes. All other food needs to be locked away to prevent him overeating or eating raw food.
- During an admission under section to a mental health unit a person is denied access to blades although it is written in their care plan that they can use blades for safe & responsible self harm.

Restrictive practices - what you should consider

Am I stopping someone doing something they want to do or making them do something they don't want to do? (or considering this)

This diagram is intended to illustrate the key questions which need to be considered in order to ensure that any restriction is minimised and is ethically and legally justified. It cannot cover all eventualities but shows the main differences in different situations. Many of these decisions may need to be taken quickly and reviewed more carefully later.



The restriction is unlikely to be justified.
Unjustified restrictions are not acceptable and must be changed. This could be by amending a support plan, raising with a line manager, using safeguarding processes or whistleblowing

The restriction may be justified, but should be for the shortest period possible, recorded, monitored & reviewed

The restriction may be justified, but should be for the shortest period possible, recorded, monitored & reviewed

Information on assessing 'mental capacity' and 'best interests'; <https://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act>

Seclusion is never justified except when the person is detained under the mental health act.

'Least restrictive' will depend on the likelihood of harm occurring, the severity of the harm and how proportionate the restriction is to the level of likely harm. How often is this restriction carried out? How long does it last? How intense / forceful is it? What other options are there?

This may be as part of a 'positive behaviour support' plan, a 'DOLS' restriction, an advance care plan or a 'clinical or therapeutic hold

Care homes and hospitals and other settings might need to apply for a DOLS authorisation

[Click here](#) for Printable version of
Restrictive practices - what you should consider.

Edie's story

Throughout this guide we consider briefly how a team in a residential care home learned to positively support a woman whose distress and behaviour presented the team with challenges in how they could best offer care to her.

On the Skills for Care and Skills for Health website Edie's story is available as a supporting resource for the guide as a full 'case study' along with other case studies and vignettes from other people. These are in written and video format. For more information see www.skillsforcare.org.uk/cbcasestudies

All of the case studies and vignettes are anonymous and full permission for their use has been granted.

We would encourage people to submit further examples in order to share good practice.

Edie is 82, she is widowed, has dementia, and lives in a residential care home. She was placed there reluctantly by her family as she had been assessed as not having the capacity to make the decision to move by herself.

During her first year there she became increasingly distressed and anxious. This seemed to happen most in her bedroom when she needed personal care such as help with washing and dressing. She was incontinent of both urine and faeces and workers believed that it was in her best interests to wash her and change her clothing.

She would resist any help by screaming, biting and pushing workers, and so workers became scared of going into her room to support her.



3. Effective workforce development to minimise the use of restrictive practices

Much of this section draws on more detailed guidance in other Skills for Care or Skills for Health guides:

- **Practical approaches to workforce planning; A guide to support workforce planning processes and plans for adult social care support services.**
<http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Workforce-planning/Workforce-planning-guide.pdf>
- **Principles of workforce redesign.**
<http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-redesign/Principles-of-Workforce-Redesign-downloads-and-practical-resources.aspx>
- **National occupational standards (health).**
<http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards>
- **The NHS Knowledge and Skills Framework.**
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4090843
- **Supporting workers working with people who challenge – guidance for employers.**
<http://www.skillsforcare.org.uk/Skills/People-whose-behaviour-challenges/People-whose-behaviour-challenges.aspx>

Commissioners and employers may find it useful to plan and deliver good workforce development on minimising restrictive practices by considering the following questions:

- **Who** are my workforce?
- **What** do we expect them to do?
- **Where** do we expect them to do it?
- **What** skills, knowledge, attitudes, values, confidence and competences do they **(a) need** and **(b) already have**?

- **When** can I assess and improve the levels of skills needed and the level that workers have?
- **How** will I develop the skills that workers have?

See Appendix A for more detail

The answers to these questions will in many cases come from collecting and analysing reliable data well.



3.1. Organisational values into practice

How to design, recruit and retain the workforce you need

“In order to design a workforce with very well developed knowledge and skills to support people who challenge, an employer needs to ensure that their organisational processes and systems enable workers to use their skills effectively. Training workers to a high degree of skill will not, on its own, lead to high quality support. The organisation needs to have the structures and culture in place to support the application of those skills.” *Institute for Public Care, 2012*

The values of any organisation are vital to the way that services are commissioned and delivered. To ensure that workers are able to practise in a way which minimises the use of restrictive practices, organisations need to:

- recognise that the person is central to the service it delivers
- operate in a culture of openness, respect and transparency
- have organisational leadership which is fully committed to identifying and minimising the use of restrictive practices and promoting person-centred working. Management teams need to be in touch with what actually happens, and have systems in place to reduce or eliminate restrictive practices
- develop a culture of learning from incidents and mistakes, avoiding attaching blame to genuine mistakes
- promote a culture of learning from practice; sharing and promoting good practice with a pro-active response to poor practice
- ensure everyone understands the legislation, policies and requirements of their particular situation, including CQC's Essential Standards and regulations. See Appendix D.

Edie's story: a culture of fear

Workers were scared of going to support Edie and were doing so in two's and wearing coats to protect their arms. Edie was becoming defensive; protecting her bedroom and becoming more isolated by remaining alone in her room, on her bed.

Data collection and use

It is essential to collect and use data effectively in order to monitor how well people are being supported and to make improvements. Services should routinely collect and regularly analyse data from:

- feedback from people being supported by the service, their families, friends, visitors and advocates, ideally this should be systematically sought through satisfaction surveys, complaints or regular activities as well as being encouraged *ad hoc*
- incidents of behaviour that challenges and any other incidents which give rise to any restrictive interventions and any planned or significant restrictive practices
- the use of any restrictive interventions and any planned or significant restrictive practices, including form, intensity and duration, and any injuries sustained during them
- post-incident debrief and analysis
- safeguarding alerts, complaints, use of internal whistleblowing policies, relevant workers' grievances
- worker vacancies, turnover and sickness rates
- relevant data about the needs and wellbeing of the people being supported by the service (such as participation in meaningful activities, medication, waiting times or other health indicators).

Analysis will vary from service to service but should enable the information to:

- be triangulated (checking one source of data against another)
- be monitored over time to identify trends
- and/or be compared with comparative services or with targets set
- identify 'exceptions' to usual expectations; for example, particular times of day or particular activities which coincide with higher or lower than usual levels of restrictive practices
- highlight sudden changes
- identify individuals who are particularly at risk of experiencing restrictive practices.

The outcome of the analysis should:

- inform individual support plans
- shape learning and development activities
- be used to review worker performance
- inform organisational policies and actions such as restrictive practice reduction plans.

Being a person-centred organisation

This involves adopting person-centred approaches to all areas of organisational activity in a way that recognises the person and takes a positive, solution-focused attitude. This includes the following.

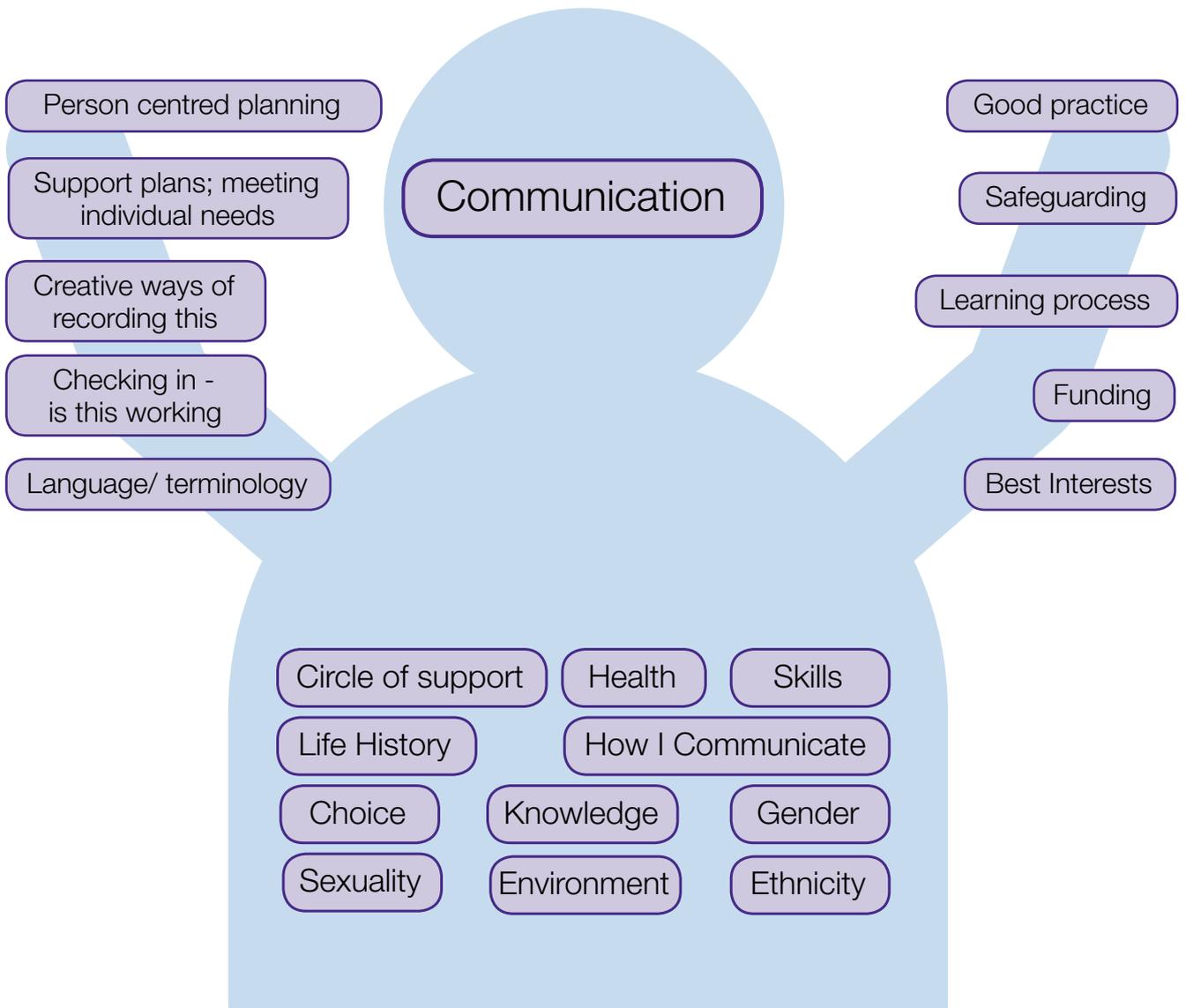
- Knowing that the rights of the individual are paramount, and respecting them.
- Valuing the individual's history, skills, aspirations and knowledge.
- Involving and nurturing the individual and their support network, e.g. friends, family, community, professionals.



- Understanding that people's behaviour serves an important function for them, and is a form of communication.
- Recognising that behaviour may be influenced by a chronic, intermittent or acute physical condition such as very high temperature / effects of anaesthesia, epilepsy, pain or the influence of drugs or alcohol.
- Recognising that behaviour may be influenced by their environment and the behaviour of others.
- Promoting choice and control for individuals in all the decisions made about their lives, and involving their friends and families where this is relevant.
- Providing a space for the individuals' voices and preferences to be heard; giving access to independent accessible information, advice and advocacy to ensure that choices are well informed and current.
- Considering people's culture and belief systems at all times.
- Valuing workers and recognising their individual and team strengths.
- Developing holistic, strengths-based plans of care that encourage positive risk-taking and enable people to live less restricted lives, while maintaining a 'duty of care'.
- Where it is not possible for the individual to make a decision at the time it needs to be made or by indicating their decision in advance, then a best interests decision should be made – again involving all relevant people.
- Understanding that restrictive practices are only to be used once all other planned proactive and reactive interventions have been tried or are not practical.
- Wherever possible, working with the individual and supporting them (and their family should they choose to involve them) to understand the restrictive practices that are affecting them, preferably prior to use.
- Adopting and promoting the principles and practices of positive behaviour support in a way that suits your service and the individuals supported by it.



Person-centred thinking



Edie's story continued:

Edie became more isolated, staying in her room and with workers tending to avoid her.

With the help of the local challenging behaviour service a holistic assessment was carried out including work to capture Edie's life story and, views from her daughter who visited her often. This revealed particular triggers for Edie, such as feeling her personal room was being "invaded" and the cultural practice in the home of getting people dressed by a certain time.

A detailed individual support plan was put in place which allowed Edie to rise and dress in her own time and allowing her to eat breakfast in her dressing gown if she chose. It also specified proactive strategies for workers to offer personal care; only entering the room individually, using and avoiding specific language (both verbal and non-verbal), and leaving if Edie indicated that she was not ready, coming back 10 minutes later.

Changes to her environment were also made; the wall behind her toilet was painted a dark colour so that she could see the toilet better and the workers played quiet background music when they offered her personal care.



3.2. Designing support and care that works

Commissioning social care and health

You may be commissioning a service for a large population in a geographic area or for a known individual or small group of people.

Anyone commissioning and purchasing social care or health services should always:

- Understand the needs of the people for whom they are commissioning services.
- Understand the importance and role of positive behaviour support plans for the individuals concerned and commission services built around their needs.
- Engage with people being supported by services, and with their families and communities – particularly if there is a risk of someone having to move away from their home area, such as in “out of area placements”.
- Understand the settings and situations and the incidents where workers may be required to use restrictive practices—and how to provide positive and pro-active alternatives.
- Understand the implications and role of restrictive practices in the services they are commissioning.
- Consider all of the local services that can:
 - work in a positive way in partnership with providers in order to provide a good range of support and services
 - establish seamless pathways for transitions and changes (for example into adulthood or as conditions progress)
 - avoid the need for ‘out of area placements’.
- Describe the appropriate staffing levels required to deliver the service including the need for specialist advisors (for example, specialist learning disabilities liaison nurses in general hospitals).
- Use local and national service specifications that lead to good workforce development, such as *Ensuring Quality Services (EQS)* when commissioning services for people who have learning disabilities and/or autism and who display or are at risk of displaying behaviour that challenges.
- Establish contracts which include the right resources for good workforce development.
- Visit the services they commission or see them in action.
- Consider data on their local population, including that about children and young people who have special educational needs or disabilities.

Commissioners should ensure that employers and services have clear systems for:

- Setting outcomes and work plans that support person-centred care (including positive behaviour support) and aim to improve quality of life, physical and mental health and reduce ‘placement breakdown’.



- Measuring and monitoring service and worker performance.
- Addressing poor practice.
- Recording and reporting when restrictive practices have been used or avoided, both internally and externally.
- Defining accountability at all levels of the organisation.
- Making sure whistleblowing policies are in place, reviewed and are working.
- Organisational, team and individual learning from what works well.
- Ensuring staff capacity to respond to fluctuating or emergency situations.
- Proactive transferable knowledge between services; for example, the use of 'hospital passports' between care homes and A&E, between departments in acute hospitals and when people are moving into adulthood.
- Promote effective sharing of knowledge between statutory, independent and voluntary services.
- Monitoring the impact of learning and development activities.

The right staff

The baseline of any good service is having the right workers to meet the needs of the individuals being supported by it. This will involve everything that happens throughout their employment, such as designing the staff team, finding people, recruiting and selecting them, inducting them to their role, training and supporting them, monitoring how they work, dealing with poor performance, celebrating

good performance, retaining them and developing a career pathway.

Throughout these processes you should:

- involve people who are supported by the service ('experts by experience')
- demonstrate a commitment to equality and diversity.

Designing staff structures to minimise restrictive practices

Employers and services must have clear systems to meet the commissioners' requirements as outlined above and must design a staff structure capable of meeting the needs of the service at all times. This will involve considering the following.

- How to balance the need for consistency of care with realistic expectations of individual workers, including the support that workers need.
- Using a matching process to ensure the team can meet people's needs and interests.
- The consistency and continuity that contracted workers can offer and only using 'bank', casual or agency workers when there is a compelling reason to do so.
- Ensuring that workers do not have to work excessively long shifts and have breaks, holidays and rest periods.
- Responsive rotas based on person-centred plans and or periods of expected high demand (times of the week, winter pressures, etc).

- The effect of workers' holidays, training and sickness.
- Ensuring workers' capacity to respond to fluctuating and emergency situations.
- Up-to-date assessment of risk, and behavioural audits.
- Staffing requirements from the service specification and as recommended by relevant national and local policies, procedures and legislation.
- Any organisation or practitioner that develops and implements behaviour support plans or restrictive practices must be able to provide evidence of their competence to do so.

Recruiting and retaining the right workers

In recruiting workers you should consider:

- Where and how to recruit workers including ways of recruiting from diverse groups of people with the right attitudes, physical abilities and availability.
- Using competence-based job profiles.
- At what stage to share information about what the job is in order to; build rapport, be clear about the organisational values and aims and allow people to self-select themselves out.
- Using appropriate selection techniques involving people being supported by the service, and their carers, such as scenario-based interviews and/or task-orientated assessments.
- How to ensure the candidate has the necessary skills, qualifications and

experience and is registered with the relevant professional body where registration is required.

- How to recruit people with the right attitude and values, which may include:
 - a **caring*** supportive attitude
 - respect
 - **commitment*** to offer dignified care and choice and to team working
 - demonstrating unconditional positive regard
 - showing **compassion***
 - having the **courage*** to learn and to appropriately challenge,
 - having an understanding of the importance of good **communication***
 - flexibility
 - willingness to learn and develop **competence***
 - relevant interests (in very personalised services, shared characteristics with the individual)
 - a **commitment*** to equality and diversity.

* indicates the "Six 'C's":

The 6Cs strategy sets out the shared purpose of nurses, midwives and health visitors in response to the Francis report into the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) into the care of patients in hospital.

<http://www.midstaffpublicinquiry.com/>

<http://www.6cs.england.nhs.uk/>



Supporting workers

It is important to support workers to find alternatives to restrictive practices. When restrictive practices are used it is essential to offer support and de-briefing to the person concerned, their families and carers, the staff team, and other people being supported, if relevant, or any witnesses.

Support and supervision should allow time for essential reflection on practice and the feelings that are brought up.

Edie's story continued: supporting workers to minimise restrictive practices

Workers who supported Edie had become very scared of working with her and their behaviour reflected this, such as showing fear or bravado or wearing outdoor clothing to protect themselves.

In response to this culture of fear the care team worked alongside the challenging behaviour specialists and Edie's daughter to develop Edie's care plan.

Workers and Edie's daughter needed support individually and as a team to implement the plan. The manager also prepared a one page profile to help workers see Edie as an individual with a history and a range of experiences and to put her behaviour into context. For example, explaining that she likes to sing along to music, but may stop if others join in.

Supervision

Management and clinical supervision for individuals and groups is an essential tool in minimising restrictive practices. It should be written into policies and procedures as the way of regularly monitoring an individual's performance, setting their targets and responsibilities and highlighting their development needs.

Supervision should be:

- regular—planned in advance but also available *ad hoc* when needed
- of a high quality—provided by someone who has been trained to undertake supervision, including specialists when required
- underpinned by and support the values of the organisation
- structured around a shared agreed agenda
- prioritised—all involved identify protected time for it to happen



- a way of celebrating success and achievement and addressing areas for improvement.

Other support

This can include support from:

- experts by experience
- peers
- coaching
- shadowing
- mentoring
- use of “champions” within the service to offer specialised support.

De-briefing

De-briefing is essential and can be a way of offering support and developing learning. It might identify a learning need for an individual worker or team, an amendment to a care plan or inform organisational actions through incident review, data collection and analysis. There is further advice in *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).

De-briefing following an incident or a ‘near miss’ should:

- be led by the needs of the worker
- be undertaken by a skilled practitioner with a ‘no blame’ attitude, emphasising any learning and considering the psychological impact on the people involved
- identify any further or on-going support and learning that is needed.

All of the above forms of support should feed back into individual and team learning and development plans and into organisational development plans. These include restrictive practice reductions plans, stress management and reduction plans and reviews of policies and procedures.

3.3. Developing your workforce’s skills and knowledge

In order to provide good support and services to people, employers need to know that workers have the right skills and knowledge and are competent to undertake their work. This involves understanding what is required within the service, setting or role, identifying the skills and knowledge held within the team and by the individual, putting in place learning and development plans to meet any gaps in knowledge and skills and to ensure that workers continue to develop.

Identifying workforce skills and knowledge

Employers can work out what knowledge and skills workers need to have, and when, from the following.

- The shared key principles and core values, vision and purpose of the organisation.
- The needs, preferences and aspirations of the people being supported by the service.
- Understanding the impact of trauma and life experience on people’s behaviour and decision making. Relevant people

may include individuals supported by the service, carers, staff, board members and the public.

- Understanding the setting, situations and incidents in which staff are required to use the range of restrictive practices, and why they may be needed. This could include:
 - preventing someone from hurting themselves
 - holding a person or part of their body so that an essential health or care task or intervention can be carried out, in a planned or emergency situation
 - carrying out planned reactive physical interventions in line with a positive behaviour support plan
 - self defence
 - escaping (breakaway) from violence and aggression
 - protecting vulnerable people from violence and aggression.
- The legal and policy frameworks that apply to the service.
- Undertaking a regular skills reviews of the team.
- Completing a comprehensive training and learning needs analysis based upon appraisals, supervision, policies, standards, learning from incidents and de-briefs, feedback from learning providers, changes to the needs of people supported by the service, inspections and contract reviews, etc.

- Job descriptions and person specifications associated with the role.
- Supervision, appraisal and personal development planning.

Skills and knowledge development

There are a wide range of learning options available and as commissioners and employers you need to be certain that the learning solutions that you are using are right for your teams and the people that they are supporting. All workers should learn to meet the requirements of the service they provide and their role. Learning and development will vary according to role but all workers should learn to deliver a service which is person-centred and seeks to minimise the use of restrictive practices. When an individual's family are providing support to them they should be offered opportunities for learning alongside workers and the individual or other learning opportunities suitable for their situation.

Currently there are no nationally recognised or approved training standards for the minimisation of restrictive practices.



Edie's story continued: lessons learned

The best way to develop Edie's care and support plan was by holding a staff development day with the challenging behaviour team and developing the plan during the day.

Many of the aspects of the plan appeared to not only help Edie be calm but also made it much easier and more pleasant for workers, allowing them to 'let go' of the negative emotions when an incident had occurred.

"It's been like everyone has breathed a sigh of relief," said the manager.

All training and learning activities about restrictive practices should be:

- Part of a coherent learning pathway, based on evidence of good practice in that situation and emphasising positive communication, support for fulfilling lives and dignified care, and understanding of the functions of behaviour.
- Delivered by someone who is qualified to deliver and is occupationally and clinically competent. This means people who have relevant experience and knowledge.
- Inclusive in design and delivery of the perspectives of people being supported by the service.

"I feel that the service user input / forum was excellent, thought provoking and powerful / beneficial."

Participant on 'RESPECT' training



- Realistically costed and have resources (funding, physical space and time) allocated in the context of the costs of failing to proactively develop the workforce.
- Regularly and systematically monitored and updated to meet changes to policy, practice and legislation. (At least once a year but more often as necessary.)
- Based on a commitment to minimising the use of restrictive practices throughout the organisation for people working at all levels, and applied to each job and service as appropriate.
- A priority for strategic and senior management teams (for example by CEOs and boards of trustees) who are responsible for authorising and approving the content.
- Fully understood by executive board members in regulated services, and their equivalents in non-regulated services, to ensure they are fully aware of the techniques workers are learning and that all learning reflects the therapeutic nature and purpose of social care and health settings.
- Be tailored to meet the needs of particular service users (e.g. for individuals with a learning disability, autism or dementia).
- Essential for 'bank', casual and agency workers as well as regular employees.

It should also include:

- the assessment of the impact of learning and training (McGill *et al*, 2006 & 2013).

- the teaching of *only* those physical intervention skills which have been assessed as physically and bio-mechanically suitable for the individuals concerned, as well as legally and ethically justified.

There are social care and health units, and BTEC qualifications, relevant to positive behaviour support and to restrictive practices. Units can be taken as part of a qualification and/or as part of continuing professional development. The learning outcomes from the units can help you structure bespoke training programmes. A list of relevant units and other qualifications can be found at Appendix B.

Although this guide is unable to provide a set of standards for commissioners and employers, some suggestions for content can be found at Appendix E.

Choosing the right learning provider

You may choose to develop internal learning providers to deliver 'in-house' learning or to commission external learning provision. In some areas partnerships exist to enable smaller providers to commission with others. Larger providers who develop in-house learning may also be able to offer this externally to other providers. This choice might well depend on the size of your organisation, the capacity and capabilities of your workers and the results of your training needs analysis. The following apply to both in-house and external learning provision.

Planning and purchasing learning and development

The person commissioning or planning learning should:

- Understand the process of commissioning including specifying learning outcomes and the required impact on practice.
- Specify outcomes which are measurable and show how the learning will support workers to improve life outcomes for people supported by the service.
- Have direct experience of the service.
- Ensure that learning is co-produced, including the voices of people being supported, and carers, in appropriate formats in the design, production, delivery and evaluation.
- Have an understanding of approaches to minimising restrictive practices with the ability to focus strategically.
- Ensure adequate funds and resources are available.
- Ensure the content meets the needs of the service, this will include:
 - consideration of organisational policies and procedures
 - training needs analysis
 - consideration of specific roles and situations, including chief executive, management and trustee levels and possibly in-house learning providers' development
 - learning from incidents, including:
 - recording / reporting / analysis
 - discussing / debriefing
 - feedback from people being supported, and carers
- considering how the content of bespoke learning provision can map to units, awards, certificates or diplomas (see Appendices B and E).
- Be clear about what physical restraint techniques should be taught and in which circumstances they may be used.
- Ensure that significantly more time is spent learning about positive and pro-active approaches, and non-restrictive alternatives, than on restrictions. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm, and are part of an ongoing learning pathway.
- Take a long-term view of the learning and development which the workers will need, including:
 - refresher and update learning when needed, and at least once a year, which takes account of the current needs of people being supported and of feedback and reflection on practice and workforce development over the previous year
 - induction training for new workers
 - changes to learning and development as needs change
 - career development
 - offering learning opportunities to

- people being supported, their carers and support networks.
- Ensure that anyone delivering learning or assessing competence in restrictive practices should be occupationally competent and hold or be working towards achieving a recognised teaching or training qualification (see Appendix C for more detail).
 - Have systems in place for learning providers to feed back when learners are seen as not competent to practise.
 - Plan and carry out evaluation and quality assurance to ensure that learning is embedded into practice and fed back into restraint reduction plans.

If you decide to commission external learning providers you may find the Skills for Care guide to choosing a learning provider, *Choosing workplace learning*, useful. This tool is also available as an app with an interactive checklist for both iOS and Android.

<http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Finding-learning-providers/Finding-learning-providers.aspx>

Other resources which are relevant to the issue of restrictive practices include Skills for Care's *Workforce development outcome measurement tool*

<http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-commissioning/Workforce-outcome-measurement-model.aspx> and Skills for Health's:

- national occupational standards
<http://www.skillsforhealth.org.uk/about-us/competences%10national-occupational-standards/>
 - Quality mark; a new benchmark for outstanding healthcare training.
<http://www.skillsforhealth.org.uk/getting-the-right-qualifications/quality-mark/>

At present there is no current mandatory accreditation system for learning providers. Further information on voluntary accreditation systems can be found in Appendix F.

The learning provider's role

The learning provider must work in partnership with the person commissioning the learning and with people being supported to ensure that the learning delivered meets the requirements listed above.

Additionally the learning provider should:

- Ensure all individual learning providers and assessors are occupationally competent and have or are working towards a recognised teaching or training qualification.
 - Ensure that individual learning providers and assessors are experts by practice and have knowledge relevant to the types of service to which they provide learning, including understanding:



- the needs of the people being supported, including awareness of the needs of that group (e.g. dementia, autism, etc.), and the specific needs of individuals being supported
- relevant legal frameworks
- the remit and aims of the services to which they are delivering.
- Carry out or contribute to a training needs analysis.
- Ensure that assessment of learning is robust and carried out by suitably occupationally competent people.
- Feed back to employers on learners who are not competent to practise, so that this is reflected in the individual's personal development plan.
- Ensure that individual learners have the opportunity to put what has been learnt into practice.
- Develop the skills and experience of individual learning providers and the learning provision available to meet the very specific needs of services (for example a service for people with early onset dementia) and network with other learning providers to ensure that appropriate provision is available to the full range of social care and health services.
- Be willing, skilled and able to challenge existing practices when required.

Edie's story continued: Getting the culture right

"It's about giving people choice and control, making sure we take the time to understand people. Previously it had been our fault as we had not taken the time to understand what Edie was going through or fully understand her needs. Now that we do, Edie is a lovely person and much happier."

Care worker

"I want these changes to continue; the atmosphere is much better now, and I see parts of Mam returning. I don't think she'll ever come back, which is hard, but she is improving and happier. I still find it hard, but it's been a big change, not just for Mam but for everyone."

Edie's daughter



4. Implementation: information for specific situations

This guide aims to show how workers can be developed and supported to minimise (reduce the necessity, frequency, intensity and duration) restrictive practices and ensure they are only ever used appropriately and not misused or abused.

It outlines key recommendations for good practice in workforce development for commissioners and employers whose role it is to ensure that restrictive practices including physical intervention are only ever used as a last resort.

Central to this is ensuring that the recommendations of this guide and of *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014) are implemented, monitored and reviewed within organisations and services.

Workers in every service will need to have information about the very specific conditions, disorders and diagnoses of any of the people they are supporting.

National organisations such as Mind, Age UK and the National Autistic Society provide robust information through their websites. It is also important to find local sources of information and support.

Below are short summaries and illustrative vignettes about people who have displayed behaviour that is challenging with lists of helpful contacts that may be useful in specific situations. All of the vignettes have been anonymised and full consent to their use agreed.

Other vignettes in written and video format are available on the Skills for Care and Skills for Health websites to accompany this guide - see www.skillsforcare.org.uk/cbcasestudies

4.1. 'Positive behaviour support' (PBS)

"PBS is a framework for developing understanding of an individual's challenging behaviour and for using this understanding to develop effective support" (NHSE LGA 2013). This is described in detail in *The International Journal of Positive Behavioural Support* (IJPBS), Volume 3, Number 2, Autumn 2013.

There is a strong evidence base for the use of PBS for people with intellectual impairment or learning disabilities and we would also advocate the use of this model for people with other needs, such as people who have dementia and people with mental health needs.



IJPBS proposes that PBS is a multi-component framework which, while flexible and adaptable for individuals, must contain the following components.

Values	1. Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation and the defence and support of valued social roles.
	2. Constructional approaches to intervention design build stakeholder skills and opportunities and eschew aversive and restrictive practices.
	3. stakeholder participation informs, implements and validates assessment and intervention practices.
Theory and evidence base	4. An understanding that challenging behaviour develops to serve important functions for people.
	5. The primary use of applied behaviour analysis to assess and support behaviour change.
	6. The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system.
Process	7. A data-driven approach to decision making at every stage.
	8. Functional assessment to inform function-based intervention.
	9. Multicomponent interventions to change behaviour (proactively) and manage behaviour (reactively).
	10. Implementation support, monitoring and evaluation of interventions over the long term.

Services offering positive behaviour support should meet the specifications described in EQS, including these for a well trained workforce, as follows.

1. All support workers receive training in positive behaviour support, which is refreshed at least annually.

2. All support workers with a leadership role (e.g. shift leaders, direct employers, frontline managers) should have completed or are undergoing more extensive training in PBS which includes practice-based assignments and independent assessment of performance.

3. All workers with a role (which may be peripatetic or consultant) in respect of assessing or advising on the use of PBS with

individuals have completed, or are undergoing, externally-validated training in PBS which includes both practice and theory-based assignments with independent assessment of performance at National Qualifications Framework level 5 or above.

4. All workers involved in the development or implementation of PBS strategies receive supervision from an individual with more extensive PBS training and experience. Workers in consultant roles are supervised by an individual (within or outside the organisation) with a relevant postgraduate qualification, e.g. applied behaviour analysis, positive behaviour support, clinical psychology.

In addition, a core competences framework for PBS is currently being developed.



Simon's story

Using a PBS approach for both the person in need of care and support and the team and others around him or her: Simon's very good day at the zoo

Simon (not his real name) is young person with identified behaviour management issues around his need to feel in control of other people including his support workers. Procedures had been put in place to support workers in how to manage the demands placed on them by Simon when necessary. Simon also has an identified need to be supported to learn social rules so that he is more able to socialise with other young people without him wanting to be in control of the interaction.

Simon was having a lovely day out at the zoo. Around 40 minutes before the time to leave Simon noticed a stream in the play area. The water was around an inch deep in some places. Simon removed his shoes and paddled in the stream, then asked if his supporting workers would like to join in. They told Simon that the water was too cold for them and that they would prefer to watch instead. Simon persisted attempting to make the workers get in the water. Simon then threatened to run away if they did not join in. The workers knew Simon very well and realised that he was showing signs of irritation but felt that he wasn't showing signs of anxiety or becoming distressed.

The workers made the decision to not respond to the threats and used distractions to which they thought Simon might respond well, such as

mentioning the gorillas in the pen nearby. Simon began to move away from the stream towards a quiet lane. The zoo was reasonably empty and there were no other people nearby. The workers realised that Simon would move further away if approached. Therefore the workers decided to follow slowly behind him, understanding that if they moved too fast this might make him run. Simon led himself away from the stream and into a grass clearing where he could no longer see the stream or any water. The workers realised that this meant the trigger had been removed. They then decided to sit on a bench where they could see Simon safely. After five minutes Simon approached them and continued to be unsettled. Simon re-engaged with the Workers, when they offered him a choice between two options.

As there was only fifteen minutes left at the zoo before they had to leave and return home. They explained that he could either leave and play on his iPad in the van and show them what he had been making that morning or he could choose an animal he wanted to see before they left. Simon decided to leave but wanted to pass the maze on the way back. There were no more challenging incidents.

Not engaging Simon when he made demands, but presenting alternative options that his workers knew Simon enjoyed, was easier once the main trigger had been removed, i.e. the water from the stream. Simon found it harder once the trigger had been removed to carry on with the incident with the same conviction, although it is thought that his main need was to be able to feel in control.

4.2. People with mental health needs

Grace's story

We have included Grace's story here to illustrate the use of physical restraint within a mental health setting and how workers can positively undertake restrictive practices and physical interventions. Grace is not her real name. Grace is 18 and lives in North London. She has some positive experiences of restraint in healthcare settings, which she is able to compare with negative experiences of restraint by the police around the same time.

Grace spent 14 months in a mental health hospital in London and was discharged in July. The hospital has a very strict 'no touch' policy, where staff don't physically touch patients unless absolutely necessary and patients can't touch other patients under any circumstances. Restraint is very much a last resort and even then is done in a way that is very gentle and respectful.

From time to time Grace would have psychotic episodes that would see her self-harm. It was in these situations that workers might feel it necessary to restrain Grace to prevent her from harming herself. They would speak to her calmly to explain what was about to happen and then gently move her arm to prevent her from hurting herself.

At the time, she says, she may have felt angry and resentful that someone was stopping her doing what she needed to do. Coming out of a psychotic episode is scary and she would be confused about why someone was touching her, especially since she traditionally struggles with physical contact. But she can see that it was the right thing for the workers to do. She adds that because it was done in such a positive way, it actually helped to solidify the relationship between her and the workers, helping to improve trust.



Grace has witnessed others being restrained in a more forceful way—a friend of hers was restrained and injected with medication, which she says was frightening to witness. She feels strongly that restraint shouldn't be done in front of other people as it is humiliating for the person being restrained and distressing for those watching.

Grace has also been restrained by police, when on one occasion she ran away from the hospital. This was a different experience altogether and Grace was given a direct order to 'stand still' before being "grabbed and shoved in the back of the police car". She felt she was treated like a criminal."

When considering the minimisation of restrictive practices within mental health settings you could make reference to the following mental health specific resources.

- Recovery-based care. Recovery-based approaches are central to mental health care. Personal recovery means different things to different people and should be defined by the person experiencing mental illness. It has become more accepted that people can and do recover from severe mental illness. However, for many people it means a way of living a satisfying and meaningful life within the limits of their mental health condition. <http://www.rethink.org/living-with-mental-illness/recovery/what-is-recovery>
- The Mind campaign on restraint: <http://www.mind.org.uk/news-campaigns/campaigns/crisis-care/>
- The 'Safewards' Project from research, model formulation, through trial to management action: Safewards project: Force Free Futures
- 'Talk well' guide for communicating with people on in-patient wards, including people who have psychosis <http://starwards.org.uk/publications/187-talkwell-2nd-edition-is-ready-to-download>
- ImROC (Implementing Recovery through Organisational Change). This supports mental health service providers to become more recovery oriented and its themes are very relevant to restrictive practices work, e.g. culture change, changing the approach to risk assessment and management, increasing personalisation and choice, transforming the workforce and supporting workers. A joint initiative of the Centre for Mental Health and the NHS Confederation's



- Mental Health Network.
<http://www.imroc.org/>
- National Survivor User Network (NSUN): National Involvement Standards - 4PI
<http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf>
 - Wellness Recovery Action Plans (WRAP)
<http://www.mentalhealth.org.uk/help-information/mental-health-a-z/R/recovery/>
 - Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives.
 - No health without mental health: implementation framework:
<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>
 - The Mental Health Crisis Care Concordat
<https://www.gov.uk/government/publications/mental-health-crisis-care-agreement>
 - Closing the Gap: Priorities for essential change in mental health:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
 - The Ten Essential Shared Capabilities A Framework for the Whole of the Mental Health Workforce:
<http://www.iapt.nhs.uk/silo/files/10-essential-shared-capabilities.pdf>
 - Service User Involvement in Mental Health Training, Education and Research in West Yorkshire
<http://eprints.hud.ac.uk/12434/1/6210.pdf>
 - Peer support (from other people with experience of mental health problems):
<http://www.imroc.org/peer-support-workers-in-mental-health-recovery-benefits-and-costs/>) and ‘advance statements’ to encourage more empowering ways of working and anticipate issues that could arise.



People who self-harm, or who are at risk of doing so, may need extra reassurance about a service being non-judgemental and confidential, so that their own uncertainty or feelings of shame do not become, in effect, restrictive practices. RAISE mental health have produced a video by two women who self harm explaining that for them it is a way of staying alive. The video can be viewed on the skills for care website. Below is part of a series of posters offering guidance to accident and emergency staff to help them support people who come for treatments following self harming behaviour.

Self harmed?

Want to speak to someone in private?
Let reception know its personal and it will
be arranged. We have a separate room
where you can sit and be helped.

We are here to help.
We will treat you with respect.
You are not alone.
You have NO reason to feel
ashamed.

*Source: Sam O'Brien, Service User Consultant
for Mental Health, Respect Training Solutions*

4.3. People with dementia

We have included Ron's story here to illustrate the importance of understanding a person's life history and the function that a behaviour is serving for an individual when providing care and support. Ron is not his real name.

Ron's story

Ron had fronto-temporal dementia diagnosed at the age of 60. He was physically fit, energetic and had always had a 'feisty' personality! As his illness progressed, he was placed in a nursing home close to his family. On hearing shouting and banging from Ron's room, the nurse entered to find him throwing things around and trying his best to push clothing out of the small gap in the open window, water had been left running in the bathroom and was slowly seeping over the carpet. Ron immediately began to shout at the nurse, his verbal skills were limited but there was no question about his mood or intention as the nurse became the focus for the flying missiles of socks and pants.

The nurse immediately called for assistance, the first to arrive in the room was the ancillary worker who had been in the next room; she had always got on well with Ron and found him helpful and polite. On seeing the situation she grabbed a refuse sack from her trolley and calmly walked up to Ron holding the bag open, saying "Here you go Ron, lets collect them all up for you so we can sort them out". The effect was instant; Ron began to stuff the clothing into the sack, muttering as he did so.

Ron was a very private person who had lived alone for many years with a few close friends; he prided himself on being self sufficient. He had dirty underwear that he couldn't work out how to wash. Having tried to do so in the sink he became more and more frustrated, which damaged



his social skills and inhibitions, Ron's temper flared so he did what he could to get rid of the dirty clothes out of the window. The nurse coming into the room in uniform made Ron feel humiliated at not being able to do things for himself so he lashed out in temper.

The ancillary worker had got to know Ron and recognised his frustration, guessing it was something to do with the clothing. Staying calm and offering the refuse sack made Ron feel his actions were understood. Seeing the immediate response, the nurse backed out of the room but observed what was happening; once Ron was calmer she was then able to re-enter and support Ron to collect the clothing. A team meeting was called, including the ancillary worker, to update Ron's personal profile, and his family were consulted to build a better understanding of Ron's habits, values and principles. The care plan was updated to reflect the new information with the amount of clothing left in Ron's room reduced to a minimum by doing twice daily checks for dirty laundry.

Good practice in patient care must involve all workers sharing information and knowledge of the individual needs. Identifying triggers for the behaviour allows for practical strategies to avoid conflict. Most importantly, manage the situation that is causing the behaviour, not just the behaviour.



Additional resources to support people with dementia

When considering the minimisation of restrictive practices when supporting a person with dementia you could make reference to the following specific resources.

- Common Core Principles for Supporting People with Dementia: guide to training the social care and health workforce.
<http://www.skillsforcare.org.uk/Skills/Dementia/Dementia.aspx>
- Dementia care mapping: Approaches based on the work of Professor Tom Kitwood.
<http://www.nursingtimes.net/dementia-care-mapping/201154.article>
- Department of Health (2009). Living Well with Dementia: A National Dementia Strategy.
<https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy>
- Department of Health (2010). Quality Outcomes for people with dementia: Building on the work of the National Dementia Strategy.
<https://www.gov.uk/government/publications/quality-outcomes-for-people-with-dementia-building-on-the-work-of-the-national-dementia-strategy>
- Department of Health (2010) Nothing ventured nothing gained: risk guidance for people with dementia.
<https://www.gov.uk/government/publications/nothing-ventured-nothing-gained-risk-guidance-for-people-with-dementia>
- Factsheet on dementia and aggressive behaviour.
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=96
- Royal College of Nursing S.P.A.C.E.
http://www.rcn.org.uk/development/practice/dementia/commitment_to_the_care_of_people_with_dementia_in_general_hospitals/make_space_for_good_dementia_care
- National Institute of Health and Clinical Excellence (NICE) (2010) Dementia Quality Standards.
<http://publications.nice.org.uk/dementia-quality-standard-qs1>
- National Institute of Health and Clinical Excellence Public Health Intervention Guidance
<http://www.nice.org.uk/guidance/phg/>
- Occupational therapy intervention and physical intervention to promote the mental health and well being of older people in primary care and residential care
<http://www.nice.org.uk/Guidance/PH16>
- Life Story work
<http://www.dementiauk.org/information-support/life-story-work/>
- VIPS tools and resources University of Worcester
<http://www.carefitforvips.co.uk/>



4.4. People who have a learning disability

Positive behaviour support is widely accepted as good evidence-based practice when supporting people with learning disabilities and/or autism who display or are at risk of displaying behaviour that is challenging. We have included Jane's story here to illustrate the importance of PBS when supporting a person with a learning disability. Jane is not her real name.

Jane's story

Jane is a woman with learning disabilities. She lives in a residential care home with three other people. Jane requires support with her personal care and wears incontinence pads. Sometimes, Jane is reluctant to go to the bathroom to have her pad changed, including when she has been doubly incontinent. This places her at risk of infection and also places her dignity at risk. The manager of Jane's home raised concerns about the level of intervention that her team were feeling was necessary in order to support Jane with this aspect of her personal hygiene, particularly as workers were lifting Jane and carrying her to the bathroom where she could have her pad changed in privacy. Jane appeared not to like this intervention and would often struggle when being carried. This was distressing and potentially dangerous for all involved. It was also a restrictive practice. Under the Mental Capacity Act (2005) Jane was deemed not to have the mental capacity to decide whether and where to have her incontinence pad changed.

The multi-disciplinary team worked with the home manager and her team to try to understand the reasons why Jane was reluctant to have her pad changed, in an approach consistent with positive behaviour support. This included a health screening (from a community nurse), a sensory assessment (from an occupational therapist) and a



communication assessment (from a speech and language therapist). The physiotherapist in the team also advised that Jane should only be lifted in 'emergency' situations.

This information led to a new care plan, agreed by all involved to be in Jane's best interests (Mental Capacity Act, 2005), which took much greater account of the reasons why Jane may have been reluctant to have her pad changed. This led to prevention strategies that meant that Jane was generally happy to accompany workers to the bathroom to have her pad changed. These included improved communication strategies so that Jane could understand what workers were asking and what would be involved. There was also a change in the décor of the bathroom, so that it was much more calming to Jane from a sensory perspective. Through constructing the plan, the team agreed much more clarity about the circumstances in which they would have to step in and change Jane's incontinence pad, even if she was refusing to go to the bathroom (based on a clear risk assessment). In this (now considerably less likely event), workers would find a way to screen Jane from others' view in whatever room she was in and change her pad there. Jane's Mum was much happier with the plan than with the previous set of circumstances and agreed that it was in Jane's best interests.

The key to success in this situation was close multi-disciplinary work including the care home workers alongside the other multi-disciplinary workers. This was facilitated by having a clear process and system through which restrictive practices could be reviewed, encouraging open and honest dialogue. All involved were agreed that being changed behind a screen is not an ideal situation, but it avoids the need for potentially damaging physical interactions while better solutions are developed.

Additional resources to support people with a learning disability

When considering the minimisation of restrictive practices when supporting a person with a learning disability you could make reference to the following specific resources.

- “Ensuring Quality Services - Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges”
<http://www.local.gov.uk/documents/10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f>
- Driving up quality code.
<https://www.drivingupquality.org.uk/home>
- The Challenging Behaviour Foundation (CBF) is a charity specialising in severe learning disabilities and behaviour described as challenging. Established by a family carer, they work with families and professionals supporting children and adults across the UK. The Challenging Behaviour Foundation offers a wide range of resources about challenging behaviour and related topics.
<http://www.challengingbehaviour.org.uk>
- Functional communication training
- Health action planning
- Use of communication tools such as objects and easy to understand language
- Total communication systems / PECS (Picture exchange communication systems)
- Think Local Act Personal – Making it real (making it real for everyone)
www.thinklocalactpersonal.org.uk/Browse/mir/
- Five good communication standards: Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings
http://www.rcslt.org/news/good_comm_standards
- Greenhill B., Whitehead R., Grannell M., Carney G., Williams J., Cookson A., Chapman F., Ward E. & Lee A. (2008) Human Rights Joint Risk Assessment & Management Plan. (HR-JRAMP), 2nd edn. Equality & Human Rights Commission. Available at:
http://www.equalityhumanrights.com/uploaded_files/humanrights/HRO/mersey_care_hr-jramp.pdf
- Lee A., Kaur K., Cookson A. & Greenhill B. (2008) The Keeping Me Safe and Well Screen (KMSAW), 2nd edn. Equality & Human Rights Commission. Available at: http://www.equalityhumanrights.com/uploaded_files/humanrights/HRO/mersey_care_keeping_me_safe_and_well.pdf
- Active support
<http://www.kent.ac.uk/tizard/active/>
- Prader-Willi Syndrome Association UK guidance on legal and ethical issues around restricting food.
<http://www.pwsa.co.uk/index.php/what-is-pws/136-ethical-and-legal-issues>
- The Confidential Inquiry into the premature deaths of people with a learning disability <http://www.bris.ac.uk/cipold/>

4.4. Acute health services

We have included this vignette here to illustrate the importance of reviewing the use restraint reduction plans in a timely manner and ensuring that individual, team and organisational learning takes place and is implemented following the use of a restrictive practice or a physical intervention. The person's name is fictional.

Mr Palmer's story

Mr Palmer was admitted to neuro-surgical ward following an operation and was assessed as being at risk of falls. He has already fallen out of bed once and banged his head and the team were concerned that he may break a limb. The ward doctor had written in the medical notes that he needed to be restrained and wrist restraints were put on him to help prevent falls.

The night nurse thought this was not the way forward but did not question it as the doctor had written it in the notes.

Mr Palmer was very distressed by the wrist restraints and kept pulling against them as they dug into him and made him very agitated. He was very strong man and was being nursed on a one-to-one ratio.

His key nurse on the next shift escalated her concerns to the bleep holder and the use of wrist restraints was reviewed and they were removed. Mr Palmer continued to receive one-to-one care but his agitation decreased without the restraints.

The situation was fed back to the medical and nursing teams. The safeguarding team became involved and they organised learning for the junior doctors on safeguards, the use of restraint and falls prevention. It was noted, too, that nurses need to feel empowered to question medical practice that they feel might not be correct at the time.



Additional resources to support people and workers using acute health care services

When considering the minimisation of restrictive practices when supporting a person using acute health care services you could make reference to the following specific resources:

- NHS Protect, Meeting needs and reducing distress: the prevention and management of clinically related behaviour in NHS settings
www.nhsprotect.nhs.uk/reducingdistress
- How to use the knowledge and skills of families and specialist professionals to provide a holistic service.

4.6. Working in partnership with people in need of care and support, patients and carers

We have included Bert's (fictional name) story here to illustrate the importance of working in partnership with people in need of care and support, patients and carers to understand the individual's life story and factors that might trigger behaviour which challenges, to help minimise any need for restrictive interventions.

Bert's story

Bert had fallen and broken his hip. Following surgery to repair it he was recovering on an orthopaedic ward. He had a catheter and an intravenous drip in place and an oxygen mask. Bert was semi-conscious and he was trying to remove these.

The ward workers tried to explain to Bert that he needed this treatment; in moments of lucidity Bert agreed that he needed and wanted the treatment but as he became drowsier he began pulling at the oxygen mask. When it was replaced Bert instantly removed it and was becoming exhausted and more agitated in the process, trying to climb out of bed.

There was a real risk that Bert would injure himself by falling out of bed or by damaging his skin, bladder or urethra. There were risks to other



patients as well as workers were distracted from their needs by taking care of Bert.

Ward workers lowered Bert's bed to the floor and placed foam mattresses either side of the bed so that if he did 'get out of bed' the chances of him being injured were greatly reduced.

Bert's son Martin arrived to visit and the nurses asked him to try and help Bert tolerate the equipment. This was very stressful for Martin as he wasn't sure how forceful to be; he wanted the best for his father and did not like to see him distressed.

Martin remembered that his father had been used to wearing breathing apparatus during his long career as a fire-fighter. He explained to Bert that the oxygen mask was just like his 'breathing apparatus' using that term and also saying "B.A." which was the acronym Bert was familiar with. This greatly alleviated Bert's distress as the concept of wearing a face mask was firmly lodged in his memory as an unpleasant but necessary thing. He did still try to remove the mask but less often and when reminded verbally he left it in place without needing it to be physically replaced. As Bert's distress lessened he was more tolerant of the catheter and the drip, and actually needed the oxygen for a shorter period of time.

In Bert's case it was fortunate that he had that experience of wearing BA in his working life; this will not be the case for everyone. However, workers and carers can always work together quickly to think about experiences and terminology that people might know (or conversely which might be particularly worrying for them) from their earlier lives to help them understand and accept treatment and interventions that they need.

Additional resources to support partnership working with people who have care and support needs, patients and carers

When considering the way to work in partnership working with people who have care and support needs, patients and carers to minimise the use of restrictive practices, you could make reference to the following specific resources.

- National involvement partnership
Involvement standards
<http://www.nsun.org.uk/about-us/national-involvement-partnership/>
- NHS England; Transforming Participation in Health and Care, Guidance for Commissioners
<http://www.england.nhs.uk/2013/09/25/trans-part/>
- SCIE; The participation of adult service users, including older people, in developing social care
<http://www.scie.org.uk/publications/guides/guide17/participation/>
- Skills for Health & Skills for Care, Carers Matter – Everybody’s Business (2011)
<http://www.skillsforcare.org.uk/Skills/Carers/Carers.aspx>

4.7. Individual employers

People who have care and support needs may employ or commission their own support workers using direct payments or their own savings or resources.

- <http://www.skillsforcare.org.uk/Document-library/Employing->

[your-own-care-and-support/Working-for-personalised-care---A-framework-for-supporting-personal-assistants-working-in-adult-social-care.pdf](#)

- <http://www.thinklocalactpersonal.org.uk/Browse/mir/aboutMIR/>

4.8. People with autism

When considering the minimisation of restrictive practices when supporting a person with autism you could make reference to the following specific resources:

- Sensory differences
<http://www.autism.org.uk/sensory>
- National Autistic society
<http://www.autism.org.uk/living-with-autism/understanding-behaviour.aspx>
- High functioning autism and aspergers
<http://www.autism.org.uk/about-autism/autism-and-asperger-syndrome-an-introduction/high-functioning-autism-and-asperger-syndrome-whats-the-difference.aspx>
- The Autism strategy, rewarding and fulfilling lives
<http://www.autism.org.uk/autismstrategy>
- Skills for Care and Skills for Health’s ‘Autism skills and knowledge list’
<http://www.skillsforcare.org.uk/Skills/Autism/Autism.aspx>



5. Appendices

Appendix A – More details on workforce

Who is my workforce?: Consider how many people are in these roles, including part time, relief, casual, bank and agency workers	
The individual and their family or representatives	Individuals, family carers, friends, partners, neighbours advocates, peer advocates, nearest relatives, next of kin, 'relevant person's representative' (DOLS), shared lives carers, foster carers.
Paid workers	Support & care workers; registered workers including nurses, allied health professionals and social workers; managers; medical workers and doctors both community and inpatient; receptionists, administrators, housekeeping, bank and agency workers.
Managers; paid and unpaid	Chief executives, board members, senior managers, trustees and shareholders.
Volunteers	People working voluntarily within people's homes, community and hospital settings.
Trainers or Individual learning providers	All training / learning and development workers including assessors and specialist practitioners.
Advisors / shapers	Safeguarding leads, service commissioners, CQC, health and safety advisers, solicitors and legal advisers including MCA & DOLS leads.
Students	Any student on placement.

What we expect people to be able to do is dependent upon the person's individual situation and the service setting/provision. It may include:	
Planned	<ul style="list-style-type: none"> ■ Upholding a person's rights and dignity at all times ■ In partnership with individuals and their families/carers develop person centred care plans which include positive behaviour support plans and functional analysis ■ Developing and reviewing restrictive plans / reduction plans and programmes ■ Undertake risk assessments to include choice and positive risk taking in partnership with individuals and their families/carers ■ Carry out physical restraint as part of a person's plan of care and support ■ Provide hands on care and support tasks for example: bathing, dressing, help with eating and drinking and giving medication.



What we expect people to be able to do is dependent upon the person's individual situation and the service setting/provision. It may include:

<p>Planned cont.</p>	<ul style="list-style-type: none"> ■ Provide hands on medical and nursing care tasks for example: changing dressings, undertaking physical health checks ■ Ensure that people's physical health needs are identified and met through regular and timely health checks ■ Undertake controlled restraint as part of a restraint team. ■ Deliver staff training and other learning and development activities including assessment for qualifications. ■ Manage and supervise people delivering direct care ■ Embedding new learning into culture and practice ■ Work intensively in one to one situations supporting people and teams ■ Write, scrutinise and interpret policy for practice ■ Commission services and /or learning ■ Record and report incidents of restraint as per organisational policy and procedure ■ Approve strategic plans such as learning plans or policies and procedures ■ Work alone
<p>Unplanned</p>	<ul style="list-style-type: none"> ■ Upholding a person's rights and dignity at all times ■ Respond to unexpected situations which pose a risk of harm to the individual and/or others ■ Provide emergency lifesaving interventions ■ Fill in for others when absent

Where

<p>Where do we expect them to do it?</p>	<p>In relation to restrictive practices; good practice and the law may be applied differently dependent upon different situations, these might include:</p> <ul style="list-style-type: none"> ■ residential care homes ■ a person's own home / family home ■ community / public places, e.g. accident and emergency units, in the street, cinema, etc. ■ near environmental hazards, e.g. traffic, water, steep cliffs, etc. ■ stimulating or calming environments, e.g. noise, heat, crowds, aromas, etc. ■ where children or vulnerable adults may be present ■ in a secure settings such as a secure mental health unit.
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What	
<p>What skills, and knowledge, attitudes, values, confidence and competences do they (a) need, and (b) already have?</p>	<p>This might be assessed by considering:</p> <ul style="list-style-type: none"> ■ The expectations above. ■ The needs of people being supported which should be expressed in care plans: positive behaviour support plans / Wellness Recovery Action Plans (WRAP) / life story / advance care plans. ■ The appropriate level of awareness of the specific needs of people with conditions such as dementia, borderline personality disorder, autism. Either because the service is for people with these conditions or because people with these conditions may access the service as part of the general public. ■ The organisation's values, purpose, policies and procedures. ■ Service specifications / contracts / feedback and instructions from people being supported or their carers. ■ Codes of conduct / (minimum) training standards induction standards / sector skills council guidance / registration requirements. ■ Supervisions, appraisal, personal development plans. ■ Job descriptions / person specifications.

When	
<p>When can I assess and improve the levels of skills needed and the level that workers have?</p>	<p>Opportunities might exist when carrying out:</p> <ul style="list-style-type: none"> ■ Recruitment and selection. ■ Designing or redesigning a service or team; changes to individuals' circumstances and roles. ■ Annual reviews (contract compliance / inspection / budget planning). ■ Debrief / learn from incident / near misses / improvements. ■ Induction / probation / supervision / appraisal / personal development planning. ■ Delivering learning/ assessing competence / refresher periods ■ Degree / 'pre-registration' training. ■ When data analysis suggests that skill levels need to be considered.



How	
How will I develop the skills that workers have?	<p>By involving the voice of people being supported. The following opportunities might exist:</p> <ul style="list-style-type: none">■ Shadowing, mentoring, coaching, peer support.■ In house or external learning; How will I ensure that learning providers are up to date, teaching evidence-based approaches that are in tune with my service?■ Theory and competence; developing the relevant physical / practical skills.■ As part of induction / qualification / continuing professional development.■ Co-training with other partners / competitors / agencies.■ How will I evaluate the learning and its impact on practice.



Appendix B - List of recommended units and qualifications to support the minimisation of restrictive practices

Units applicable to family carers and workers. To find detail of units visit the Ofqual site <http://register.ofqual.gov.uk/> and click on 'search units'

Unit number	Name	Level
H/504/2891	Behaviour Change for health and wellbeing	2
H/601/9282	Approaches to enable rights and choices for individuals with dementia whilst minimising risks	2
M/501/6004	Communication, relationships and promoting mental wellbeing with older people	2
A/601/9546	Contribute to support of positive risk-taking for individuals	2
A/502/0590	Defusing Difficult Situations in the Workplace	2
K/501/5210	Effective communication in mental health work	2
A/601/8140	Implement person centred approaches in health and social care	2
Y/601/7352	Provide active support	2
HSC 2012	Support Individuals who are Distressed L/601/8143	2
F/601/4056	Support use of medication in health and social care settings	3
MCA01	Awareness of the Mental Capacity Act 2005	3
K/601/2415	Applied Psychological Perspectives for Health and Social Care	3
M/501/0591	Contribute to the prevention and management of abusive and aggressive behaviour of individuals who misuse substances	3
L/601/9034	Enable individuals with behavioural difficulties to develop strategies to change their behaviour	3
A/601/9191	Enable rights and choices of individuals with dementia whilst minimising risks	3
H/601/8049	Facilitate person centred assessment, planning, implementation and review	3
K/505/7778	Promote positive behaviour	3
Y/602/3099	Provide support for individuals with communication and interaction difficulties	3
M/602/4825	Support individuals during emergency situations	3
R/503/9985	Enable individuals with mental health problems to develop alternative coping strategies	4
HSC 3065	Implement the positive behavioural support model	4

L/504/7079	Managing risk behaviour when supporting individuals with cognitive related challenge	4
J/504/6240	Managing the risk of aggressive and challenging behaviour in the workplace	4
R/504/6239	Managing the risks associated with crisis behaviour in the workplace	4
A/504/2217	Lead practice in assessing and planning for the needs of families and carers	5
H/504/2213	Lead practice which supports individuals to take positive risks	5
K/602/2572	Lead positive behavioural support	7
Units applicable to social care and health workers		
Y/505/8005	Delivering instruction in the implementation of physical interventions in the management of high risk behaviours in the workplace.	4
D/505/8006	Delivering instruction in the use of physical interventions in the management of acute behavioural disturbance and extreme risk behaviour in the workplace.	4

Other qualifications include:

BTEC Professional Diploma in Positive Behaviour Management

BTEC PBS Advanced certificate.

BTEC PBS Advanced Diploma

Appendix C – List of qualifications suitable for those delivering learning and assessment activities in the use of restrictive practices

Currently there are no requirements for social care and health workers to hold teaching or training qualifications.

However where an individual learning provider or trainer does not hold or is not working towards a formal teaching or learning & development qualification (as outlined below) the employer should satisfy themselves that the learning provider meets the same standards of practice as set out in the Learning and Development National Occupational Standards and be occupationally competent in the area in which they are providing learning.

Individual learning providers

- Qualified Teacher Status
- Certificate in Education in Post Compulsory Education (PCE)
- Social Work Post Qualifying Award in Practice Teaching
- Preparing to Teach in the Lifelong Learning Sector (PTLLS)
- Certificate in Teaching in the Lifelong Learning Sector (CTLLS)
- Diploma in Teaching in the Lifelong Learning sector (DTLLS)
- Mentorship and Assessment in Health and Social Care Settings
- Mentorship in Clinical/Health Care Practice
- NOCN – Tutor/Assessor Award
- QCF Level 4 Certificate in Education and Training
- QCF Level 5 Diploma in Education and Training
- Tutor/Trainer Qualification by recognised body/association in the prevention and management of violence and aggression.
- Clinical credibility (to be evidenced by previous work related experience and working practice).

Assessors

Assessor must also be occupationally competent in the units they are assessing and hold a relevant assessor qualification, for example;

- Level 3 Award in Understanding the Principles and Practices of Assessment (QCF)
- 501/2212/5



- Level 3 Award in Assessing Competence in the Work Environment (QCF)
 - 501/2387/7
 - Level 3 Award in Assessing Vocationally Related Achievement (QCF)
 - 501/2385/3
 - Level 3 Certificate in Assessing Vocational Achievement (QCF)501/2388
- Or pre-existing equivalent.

Please see Skills for Care and Development and Skills for Health assessment principles for definitions.

http://cdn.cityandguilds.com/ProductDocuments/Health_and_Social_Care/Care/4222/Centre_documents/Assessor%20requirements_v2.pdf

Note: the new Education and Training Foundation has a priority to refresh the professional standards and launch them by summer 2014.

<http://www.et-foundation.co.uk/our-priorities/professional-standards.html>



Appendix D – Legislation and codes of practice

Legislation

- European Convention of Human Rights and The Human Rights Act 1998, in particular;
 - Article 2; right to life
 - Article 3; prohibition of torture, inhuman or degrading treatment
 - Article 5; right to liberty and security of person
 - Article 8; right to respect for private and family life
 - Article 10; freedom of expression
 - Article 14; prohibition of discrimination
- The Mental Health Act 1983 as amended by the 2007 Mental Health Act
- Mental Capacity Act 2005 (MCA)
- Deprivation of Liberty Safeguards (under MCA 2005),
- Health and Safety at Work Act 1974 (and other H&S legislation),
- Common Law. (Offences against the person act 1861)
- Statute Law
- Care Bill (currently in draft form) 2013-2014
- The Children Act 2004 where relevant
- SEND reforms where relevant – these reform the system of supporting children and young people with special educational needs or disabilities and cover the ages 0 – 25, bringing health care and education plans together.
<http://www.education.gov.uk/childrenandyoungpeople/send>
- Equality Act 2010 and the Disability Discrimination Act
<http://odi.dwp.gov.uk/disabled-people-and-legislation/equality-act-2010-and-dda-1995.php>

Guidance on relevant legislation can be found here;

<https://www.mind.org.uk/information-support/legal-rights/>

<http://www.mencap.org.uk/all-about-learning-disability/information-professionals/standards-care>

Codes of practice

- NHS Protect: Meeting needs and reducing distress
- RCN Guidance
- HCPC : Standards of conduct, performance and ethics
- NMC: (Nursing and Midwifery Council) Code of practice
- BILD code of practice / accreditation system
- National Institute for Health and Care Excellence (NICE) Guideline no. 25 Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments



- Skills for Care and Skills for Health Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England 2013
- NMC Standards for Medicines Management 2007
- Behaviour Analyst Certification Board; 1006 Guidelines For Responsible Conduct Revised, January 29, 2014 - http://uk-sba.org/?attachment_id=425

Guidance and standards

- The NHS Constitution
- Practical approaches to workforce planning; A guide to support workforce planning processes and plans for adult social care support services (SFC).
- Principles of workforce redesign (Skills for Care).
- National occupational standards.
- The Knowledge and Skills Framework.
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4090843
- Supporting Workers working with people who challenge services - Guidance for employers, Skills for Care, February 2013
- CQC Essential Standards and Quality and Safety
- A unified approach to challenging behaviour – Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, Approved by Central Executive Committee: March 2007
- Violence, The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.
<http://www.nice.org.uk/nicemedia/live/10964/29715/29715.pdf>
- HSE:
 - RR440 - Violence and aggression management training for trainers and managers
<http://www.hse.gov.uk/research/rrhtm/rr440.htm>
 - RR495 - Violence management training: The development of effective trainers in the delivery of violence management training in healthcare settings
<http://www.hse.gov.uk/research/rrhtm/rr495.htm>
- The independent restraint advisory panel
- Guidelines & policy around dealing with public & press opinion
- The Social care commitment.
- DH: Transforming care: A national response to Winterbourne View Hospital
- “Choosing workplace learning”;
<http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Finding-learning-providers/Finding-learning-providers.aspx>.
- Whistleblower’s helpline run by Royal Mencap.
www.wbhelpline.org.uk enquiries@wbhelpline.co.uk
- Francis Report

Appendix E – Content of learning; a starting point

Recommended content of learning	
Learning content should:	
<ul style="list-style-type: none"> ■ Be developed and /or delivered by those who have lived experience of services and conditions and their family members and carers. ■ Based upon policy and procedure, supported by culture and practice. ■ Be based on current evidence-based practice. ■ Be undertaken at an appropriate time so workers can work effectively from the outset. ■ Be delivered using a variety of different learning methods relevant to the situation including skills practice. 	
Content could/should include	To whom
<ul style="list-style-type: none"> ■ Value based practice. ■ Person-centred care and planning. ■ Safeguarding is all of our responsibilities. 	All workers
<ul style="list-style-type: none"> ■ Being person centred in your work/care: Core principles and values. ■ Functional assessment of behaviour including triggers and the impact of the environment and trauma. ■ Positive risk taking. ■ Understand the impact of gender, ethnicity culture, life history and experiences on behaviour. ■ Ways of communicating: behaviour and non verbal communication, communication breakdown and aided communication. ■ Physiological aspects of behaviour: pain, illness, infection, substance use, epilepsy, diabetes etc. ■ Positive behaviour support framework where person is known with planned non aversive approaches / diffusion / distraction for individual. ■ Positive person centred collaborative care planning to include: active support, life story work, health actions plans, wellness recovery action plans, advance decisions and end of life planning. ■ Legislation and application to practice: Human Rights Act, MHA, MCA, DOLs and common law. ■ Role of debriefing and organisational practice. 	Care and health workers



<ul style="list-style-type: none"> ■ Being person-centred in your work/care. Core principles and values. ■ Functional analysis of behaviour including triggers and the impact of the environment and trauma. ■ Understand the impact of gender, ethnicity culture, life history and experiences on behaviour. ■ Ways of communicating: behaviour and non verbal. communication, communication breakdown and aided communication. ■ Physiological aspects of behaviour : pain, illness, infection, substance use, epilepsy, diabetes etc. ■ De escalation techniques; non aversive approaches / diffusion / distraction for individual. ■ A gradient approach to restraint from: <ul style="list-style-type: none"> ■ De-escalation. ■ Seated. ■ The legislation and application to practice: Human rights act, MHA, MCA, DOLs and common law. ■ Role of debriefing and organisational practice. 	<p>Care and health workers</p>
<ul style="list-style-type: none"> ■ Functional Assessment. ■ The role of evidence-based psychological treatments. ■ Reflective and sustainable practice - Learning from events and promoting ongoing learning with individuals and organisations. ■ Current research. <ul style="list-style-type: none"> ■ Understanding tolerances. ■ Resilience. ■ <u>likely potential emergency</u> situations where not known. ■ Include Prevention. <ul style="list-style-type: none"> ■ Recognising distress. ■ Common causes of needs. ■ Psychological wellbeing. ■ Risk assessment. 	<p>Supervisors Managers</p>



Appendix F – Accreditation systems and models of learning

Voluntary accreditation systems

Although there is no current mandatory accreditation system for learning providers voluntary systems do exist. Further information on these systems can be found at:

- British Institute of Learning Disabilities (BILD) PIAS accreditation scheme
www.bild.org.uk/our-services/bilds-services/
- Security Industry Authority
<http://www.skillsforsecurity.org.uk/index.php/questions/1/39> or
<http://www.sia.homeoffice.gov.uk/Pages/training.aspx>

List of learning models which participants in this project have used and recommended:

- Crisis Prevention Institute: www.crisisprevention.com
- D.ESCAL8: <http://de-escalate.com>
- The General Services Association (GSA): www.thegsa.co.uk
- La-Vigna
- Mapa: (Management of actual or potential aggression)
- Maybo: www.maybo.co.uk
- NHS Protect Syllabus www.nhsprotect.nhs.uk/reducingdistress
- PROACT-SCIPr-uk ® <http://www.proact-scipr-uk.com/>
- Respect training from NAVIGO NAV. respectTraining@nhs.net
- St Anne's Community Services Positive Behaviour Support model of training
- TEACCH

Appendix G – Questions to consider when choosing a learning provider for reducing restrictive practices

- Can they can evidence bespoke learning to meet the specific needs of the service, e.g. different content will be required for a home supporting people with dementia than one that is supporting people with autism?
- What qualifications do the people delivering the learning have – for instance if the course is a PBS introduction has the person attended a university accredited course on positive behaviour support?
- Can they provide examples of services which have previously applied the learning?
- Can you provide an overview of the background requirements of the learning to be purchased?
- Does the programme conform to the 2/3 preventative proactive, 1/3 reactive physical intervention, balance?
- Does the learning provider have a system of feedback available to all, e.g. like ‘trip adviser’ or ‘check a trade’?
- Does the learning contain an element of competence testing – for instance role play testing as well as verbal competence?
- Have the individual learning providers a system in place to feed back about learners who are unsafe in their practice?
- Can the learning provider describe the biomechanical issues of any techniques that are taught?
- Do you know how to conduct a behaviour audit in order to meet the needs of the service users receiving care and ensure the workers have the appropriate knowledge and skills after the learning?
- Do they include the functions of behaviour and positive behaviour support planning within their learning provision?
- Can the learning provider offer support to your organisation following the learning provision?
- Can they help with plans or suggestions about how training and learning should be monitored to make sure it is working in practice?
- Has the learning provider been accredited by undertaking a rigorous external process (eg BILD)?



6. References

- Ensuring Quality Services (EQS: *Core principles for the commissioning of services for children, young people, adults and older adults with learning disabilities and / or autism who display or are at risk of displaying behaviour that challenges*) has been developed by NHS England and the Local Government Association (NHSE LGA 2014).
<http://www.local.gov.uk/documents/10180/12137/L14-105+Ensuring+quality+services/085fff56-ef5c-4883-b1a1-d6810caa925f>
- *Positive and Proactive Care: reducing the need for restrictive interventions* (DH 2014).
- Safewards Project.
- Dementia care mapping' with people who have dementia.
- The NHS protect guidance '*Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings*'.
- Institute for Public Care, 2012.:see NDTi Guide for reference.
- 'RESPECT' training- Navigo : Respect training from NAVIGO NAV.respectTraining@nhs.net
- "The International Journal of Positive Behavioural Support (IJPBS)", Volume 3, Number 2, Autumn 2013.
- McGill P, Bradshaw J, & Hughes A (2006), *Impact of Extended Education/Training in Positive Behaviour Support on Staff Knowledge, Causal Attributions and Emotional Responses*. Journal of Applied Research in Intellectual Disabilities, Volume 20, Issue 1, 41–51, January 2007
<http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2006.00338.x/full>
- McGill P & MacDonald A (2013), *Outcomes of Staff Training in Positive Behaviour Support: A Systematic Review*. Journal of Developmental and Physical Disabilities 2013; 25(1): 17–33.
<http://link.springer.com/article/10.1007/s10882-012-9327-8>



Notes

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