Belfast Health and Social Care Trust
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Title:	**Restrictive Practices Policy for Adults and Children**		
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	Assurance Framework – Sub-Committee Structure 2018 BHSCT Core child protection regional policy and procedures (2017) SG 38/17

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**** POLICY DISCLAIMER**

Throughout the policy those known to the Trust as; clients, individuals, patients, residents etc. will be referred to as service user (s)

1.0 INTRODUCTION

The Belfast Health and Social Care Trust acknowledge that restrictive practices take place and is committed to reducing restrictive practices and applying least restrictive principles to all aspects of the Trusts service delivery. The use of restrictive practices is based on the philosophy of Eliminate, Minimise, and Make Safe. The ideal is to deliver services and supports which are free from restrictive practices. However, if restrictive practices are necessary to maintain the safety of the service user, staff or members of the public, each service area should ensure that there are robust legal grounds for the restriction, it is reviewed regularly and a person centred approach is adopted when considering the treatment of each individual. When restrictive practices are used they are as a last resort when all other less restrictive measures have been exhausted and applied in a manner that ensures privacy and dignity.

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

This can also be viewed as depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do, without physically intervening. It includes the use of threats and coercion. (Restraint Reduction Network, 2019)

- Restrictive interventions are a specific subset of restrictive practices. They are deliberate acts on the part of other person (s) that restrict a person's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken and end or reduce significantly the danger to the service user or others. (DOH, 2014)

2.0 SCOPE OF THE POLICY

The Belfast Health and Social Care Trust is committed to delivering the highest standards of care in conjunction with the Trust Values: Excellence, Openness & Honesty, Compassion and Working Together.

The Trust as a statutory responsibility to safeguard the welfare of children, young people and adults in need of protection, including members of staff.

This policy includes definitions, the Trusts objectives and duties/responsibilities of key staff.

This policy sets out the overarching framework for the use of restrictive practices within the Trusts services.

This policy includes details of legislative framework and guiding principles within which all staff should work.

This policy is supported by subordinate policies and protocols that provides further detail and guidance on safe, lawful and legitimate use of specific forms of restrictive interventions.

The Trust considers that the management of behaviours that challenge is a process requiring openness & honesty, compassion, dignity & respect for the rights of the service user, acting in their best interests and balanced against the risk of harm to themselves, staff and members of the public.

The Trust considers that restrictive interventions should be reasonable and proportionate to the risk presented, least restrictive for the least amount of time and used as a last resort.

The Trust recognises that a service user's behaviour can escalate to the point where restrictive interventions may be needed to protect the service user, staff or other users of the Trust from significant injury or harm, even if all best practice to prevent such escalation is deployed.

2.1 Types of Restrictive Interventions and/or Practices

Environmental Intervention:

The use of obstacles, barriers or locks to prevent a person from moving around freely.

Psychological intervention:

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion:

The practice of persuading someone to do something by using force or threats.

Observation:

A minimally restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Physical Restraint:

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body of another person.

Clinical Holding:

The use of physical holds to assist or support a person who lacks capacity to consent to receive clinical or personal care or treatment.

Chemical restraint:

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Mechanical restraint:

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Seclusion:

The confinement of a person in a room or area from which free exit is prevented.

Refer to Appendices 1 for 'Procedural and further guidance on Restrictive Interventions'

2.2 Three Steps to Positive Practice Framework

All areas of the organisation that are required to use restrictive interventions must embed the Three Steps to Positive Practice Framework when considering and reviewing the use of restrictive interventions.

The *Three Steps to Positive Practice* are designed to encourage careful consideration and reflection on the use of any potentially restrictive practice, before it is implemented, and throughout the entire timeline when the restrictive practice may be used. It is applicable at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time or are associated with a particular environment.

The three steps are intended to assist staff to ensure that the decision they make and the actions they take are consistent with legal, ethical and professional accountability frameworks, every time a decision is made or an action is taken. (RCN, 2017)

Refer to Appendices 3 for link to 'The RCN Three Steps to Positive Practice Framework'

2.3 Proactive and Preventative Strategies

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings highlights the need that all local organisational policies must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that a support a better quality of life.

The use of positive and proactive interventions will support the development of a therapeutic relationship between staff and those that they care for. The benefit of an established therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

2.3.1 Communication

Effective and person centred communication is key in supporting a person and their family to be part of their care and treatment.

These five key themes must be evident in practice:

- Transparency
- Trust and Relationship building
- Compassion, dignity and respect
- Supporting and managing expectations
- Consistency in communication

A partnership approach to care and wellbeing is essential. Underpinning a rights based approach and developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected.

Where required, staff should have access to appropriate communication support tools and must be appropriately trained to empower and support the people that they work with to communicate effectively.

Refer to Appendix 2 'Methods of Reducing Restrictive Interventions'

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board

The Trust board is responsible for ensuring that a policy is in place that governs the safe use of restrictive interventions via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

3.2 The Chief Executive

Has overall responsibility and accountability for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust and is responsible for the following:

- Fostering a framework within which the Trust can develop a culture and ways of working that focuses on restraint reduction and will reduce the need for restrictive interventions. When restrictive interventions are used it will be in the least restrictive way for the minimum amount of time and as a last resort.

- Appointing a senior manager at director level to take the lead responsibility for restrictive intervention reduction programmes.

3.3 Director of Human Resources and Organisational Development

Has overall delegated responsibility for service user and staff safety with an emphasis on compassionate person centred care and treatment, and is responsible for the following:

- Ensuring that appropriate arrangements are in place to demonstrate the Trusts commitment to reducing the use of restrictive practices as detailed in the policy purpose. Leadership, Performance measurement, Learning and Development, Providing personalised support, Communication and Person-Centred Focus and Continuous improvement.

- Ensuring communication of The Restrictive Practices Policy and review where appropriate.

- Ensuring adequate arrangements are in place to meet training needs identified through the regional strategy.

3.4 Co-Director of Human Resources and Organisational Development

Supports the Human Resources and Organisational Development Director and has responsibility for the following:

- Assisting the Human Resources and Organisational Development Director in the communication and ongoing review of the Trust Restraint Reduction Framework, Policy on Restrictive Practices and associated structures.

- Managing the process of reporting and monitoring incidents involving the use of restrictive practices and ensuring that managers and relevant agencies are kept informed of any significant implications highlighted and shared learning.

- Alerting other senior managers to significant risk issues in relation to the use of restrictive practices.

3.5 Directors and Co-Directors

Are responsible for the following:

- Ensuring compliance with The Restrictive Practices Policy and associated strategies.

- Ensuring that the development or review of local procedures in relation to the use of restrictive practices within their directorate reflects the ethos of this policy.

- Ensuring that where the use of restrictive practices is reasonably foreseeable in their service area that their staff teams are equipped with the knowledge and skills to understand and prevent crisis behaviour, make evidence based decisions regarding the use of restrictive practices to facilitate clinical procedures, and provide staff training in the key competencies that supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Ensuring the use of restrictive practices within their service groups is appropriately recorded.

- Ensure that all incidents involving the use of restrictive practice are appropriately reported, investigated and monitored in line with the Trust's incident reporting procedure and that learning outcomes are implemented and shared across the Trust.

- Responsible for high level monitoring of incident patterns, to identify high-risk areas, and the subsequent development of relevant management strategies.

- Authorising and approving commissioned training in relation to restrictive practices and restrictive interventions which is provided by external / licenced providers.

3.6 Managers

- Managers of services (at all levels) will ensure that services are resourced appropriately and that their staff teams are able to access training, supervision and support to enable them to practice in a manner that complies with the relevant legislation and guidance.

- Managers will design staff structures to minimise restrictive practice by maintaining a consistent workforce with the right values, attitudes and skills and in the right numbers.

- Managers will ensure that all areas have regular forums and opportunities for service users, their families and advocates to contribute to the design, delivery and evaluation of services with specific reference to reducing the need for restrictive practices.

- Managers will ensure that post-incident reviews and debriefs take place so that lessons are learned from incidents occurring wherein restrictive practices have had to be used. This includes gathering the views of the service user and the experience of restraint or restriction placed on them, why this occurred and their understanding of the situation.

- Managers will ensure that all their employees are complying with this policy and that measures are in place to release staff for the appropriate training.

- Managers will ensure that data is collected for audit purposes.

- Managers will ensure that there are systems in place for appropriate reporting, recording and monitoring of safeguarding incidents involving adults, children or young people.

- Managers will ensure that their staff are offered the appropriate training for their area of work and assessments and training needs are completed for their type of work and working environments.

3.7 All Staff

- Have individual responsibility to ensure they work within the legal and ethical framework that pertains to their practice and interventions that would be defined as restrictive with a pro-active response to poor practice.

- Must ensure they comply with the Trust policy relating to restrictive practice and contribute to activities designed to support a reduction or elimination of restrictive practices.

- Must ensure they are competent within their role and within the setting in which they are employed in order to meet the needs of the service user being cared for.

- Must ensure that any gaps in knowledge, skills or practice in the area of restrictive practices and/or restrictive interventions are raised swiftly to their manager.

- Must ensure they attend the appropriate training in relation to this policy.

- Must take reasonable care of their own health and safety and that of others.

- Are responsible for risk assessing the wearing of personal protective equipment (PPE) in the use of restrictive interventions.

- Must ensure they report all incidences of restrictive practices and/or interventions.

3.8 Training associated with the use of Restrictive Interventions and/or Practices

Training must be identified using a 'Training Needs Analysis' for each service area.

An example can be found in the BHSCT Zero Tolerance Policy. Human Resources Learning and Development and be contacted for support.

Training in the use of restrictive interventions must be accredited and provided by a certified training organisation.

The philosophy, lessons and skills trained to staff must align with the BHSCT values, with a focus on proactive, preventative and evidence-based strategies. The training provided must be guided by BHSCT policies and procedures relating to restrictive practices and restrictive interventions, relevant legal and regulatory frameworks and professional standards for best practice.

Refer to Appendices 5 for link to 'Zero Tolerance Risk Assessment and Training Needs Analysis'

4.0 CONSULTATION

During this policy review, the following groups were consulted: CAUSE, The Management of Aggression Team, The Trust Joint Health and Safety Committee, Trade Unions, Occupational Health, Consultant Psychiatry, Senior Managers in Emergency Department, Mental Health, Learning Disability Services, Pharmacy, Children's services, Security and Peer Support, Restrictive Practices Task and Finish Group.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Dissemination

This policy applies to all services and their staff involved in caring for service users receiving treatment or care within the Trust.

Any concerns regarding the implementation of this policy should be addressed with your senior manager or further clarification can be sought from the author.

Training queries should be directed to the appropriate training provider.

5.2 Resources

This policy will be made available on the policies and guidelines page on the Trust intranet.

5.3 Exceptions

There will be no exceptions, as the policy will apply to all staff.

5.4 Implementation

It is the responsibility of the multidisciplinary team to ensure that the relevant assessments have been completed in areas where staff are expected to engage in any form of restrictive practice as defined within the policy. This must be done in conjunction with relevant legislation identified within this policy.

This assessment and subsequent management plan should include service specific preventative strategies, safe systems of work, training, support and supervision for staff, which is sensitive to the needs of the service user.

These assessments will require regular audit to determine their acceptability and efficiency.

5.5 Legal and Professional Issues Related to the Use of Restrictive Practices

5.5.1 Principles

Belfast Trust is committed to delivering safe, high quality and compassionate services. Employees are expected to deliver services and behave in a manner that is compatible with this commitment. Belfast Trust expects all employees to treat others with dignity and respect whether it be service users, carers, visitors or colleagues.

Belfast Trust is committed to carrying out its functions in line with the core principles and values that underline human rights legislation namely Freedom, Respect, Equality, Dignity and Autonomy (FREDA). Staff should use FREDA principles to red flag any behaviour that is not compatible with the Trust ethos of delivering safe, quality and compassionate care or which violates our equality and human rights statutory commitments.

All employees will make every effort to ensure that human rights are protected, that respect for human rights, is part of day to day work and that human rights are an integral part of all actions and decision making. The Trust will keep human rights considerations, relevant legislation and previous judicial reviews at the core of decision-making.

5.5.2 Human Rights Act 1998

In addition to anti-discrimination legislation Belfast Health and Social Care Trust employees have a duty to deliver services in a manner that meets our statutory equality, human rights and good relations duties. These duties include:

Section 75 of the NI Act 1998

- Promotion of Equality of Opportunity in relation to the nine equality categories.

- Promotion of Good Relations between persons of different religious belief; political opinion; and racial group.

Section 49A of the Disability Discrimination Act 1995

- Promotion of positive attitudes towards disabled persons.

- Encouraging the participation by disabled persons in public life.

Duty to respect, protect and fulfil rights outlined in the Human Rights Act 1998 including:

- Article 2 - the right to life.

- Article 3 - the right not to be tortured or inhumanly or degradingly treated or punished.

- Article 5 - the right to liberty and security of the person.

- Article 8 - the right to respect for one's private and family life, correspondence and home.

- Article 14 - protection from discrimination.

- United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976], which includes the right to the highest attainable standard of health.

- The Trust is committed to upholding the principles of the UN Convention on the Rights of Persons with Disability (UNCRPD), which seeks to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all service user's with disabilities and to promote respect for their inherent dignity.

- Use of restrictive interventions must be undertaken in a manner that complies with the Law, Health and Safety Legislation, Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

(For further information, please visit website The Human Rights Act | Equality and Human Rights Commission (equalityhumanrights.com)

5.6 The Safe and Ethical use of all forms of Restrictive Interventions

Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

There must be a real possibility of harm to the service user or to staff, the public or others if no action is undertaken.

The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.

Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.

Restrictive interventions should only ever be used as a last resort.

People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions (DOH, 2014).

5.6.1 Duty of Care

Duty of care is a legal obligation to:

- Always act in the best interest of individuals and others.
- Not act or fail to act in a way that results in harm.
- Act within your competence and not take on anything you do not believe you can safely do.

5.6.2 Mental Capacity Act (NI), 2016 – Deprivation of Liberty Safeguards Code of Practice (2019)

The statutory principles are:

- Principle 1: a person is not to be treated as lacking capacity unless it is established that the person lacks capacity in relation to the matter in question.
- Principle 2: the question if a person is able to make a decision for himself or herself can only be determined by considering the requirements of the Act and no assumptions can be made merely on the basis of any condition that the person has or any other characteristics of the person.

- Principle 3: a person is not to be treated as unable to make a decision for himself or herself unless all practicable help and support to enable the person to make the decision has been given without success.

- Principle 4: a person is not to be treated as unable to make a decision merely because the person makes an unwise decision.

- Principle 5: any act done, or decision made, must be made in the person's best interests.

(For further information, please visit website Mental Capacity Act | Department of Health (health-ni.gov.uk)

5.6.3 The Children (Northern Ireland) Order, 1995

A range of legislation provides legal basis for how social services and other agencies deal with issues relating to children. This legislation has been introduced so that all individuals looking after children, in the workplace are aware of how children should be looked after and legally protected.

Whilst different legislation may give greater or lesser focus on the use of restrictive practices, there is a universal expectation that the use of any force should be a last resort, reasonable and proportionate to the circumstances.

The overall aim is to protect the child or young person from harm. This range of legislation aims to make sure the care children and young people receive is well supported, of high quality and tailored to their needs whilst also improving their educational experience and achievements.

(For further information, please visit website The Children (Northern Ireland) Order 1995 (legislation.gov.uk)

5.6.4 The Mental Health Order (NI), 1986

Mental health legislation covers the reception, care and treatment of mentally disordered persons. The Mental Health Order aims to provide stronger protection for service users and clarify roles, rights and responsibilities. This includes:

- Involving the service user and, where appropriate, their families and carers in discussions about the service users care at every stage.

- Providing personalised care.

- Minimising the use of inappropriate blanket restrictions and restrictive interventions including medication, physical restraint and seclusion.

(For further information, please visit website The Mental Health (Northern Ireland) Order 1986 (legislation.gov.uk)

6.0 MONITORING AND REVIEW

This policy will provide a framework whereby the Trust will develop Key Performance Indicators in relation to restrictive practices.

All services must have a robust monitoring process in place and ensure that their governance arrangements enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive practices.

The monitoring process will include audit on the use of restrictive practices. An example of an audit tool that could be used is the RRN Reducing Restrictive Practices Checklist.

Refer to Appendix 4 for link to 'The Restraint Reduction Network's Reducing Restrictive Practices Checklist'

The use of restrictive practices and interventions must be reported in line with divisional assurance frameworks. Feedback from patients, families, carers and advocates will be used to review and monitor use of the policy.

The service must discuss the use of restrictive practices and interventions through regular reports and reviews with attention to statistical data.

The policy will be reviewed on a five yearly basis as a minimum or sooner should there be changes in legislation or best practice.

6.1 Support Mechanisms

Following the use of restrictive practices and/or restrictive interventions it is essential to address any immediate needs of the service user, bystanders, family members, or staff who have been involved.

A post incident review or debrief must take place as soon as reasonably possible, providing an opportunity for learning and support for staff and the service user involved. This process must include the service user's view and thoughts about the incident as well as the staff members involved.

This process must include:

- Basic facts - What happened? When? Why? Where? Who else has been affected?

- Patterns in behaviours, triggers or precipitating factors and patterns in staff responses.

- Alternatives to the behaviours - what can be done differently next time? How to strengthen staff responses.

- What changes can be made to avoid future occurrences.

- Negotiate future approaches and expectations.

- What has been learned? Changes to risk assessments and care plans / individual approaches.

7.0 EVIDENCE BASE/REFERENCES

BILD Code of Practice (2014) for the use and reduction of restrictive physical interventions. Fourth Edition. Birmingham: BILD

Care Quality Commission (2015a) Brief guide: Seclusion rooms

Children's (Northern Ireland) Order 1995

Cornell University, Available at: https://rccp.cornell.edu/tci/tci-1_txt.html

Crisis Prevention Institute (2016) My Safety and Support Plan

Department of Health (2014) Positive and Proactive Care – Reducing the need for restrictive interventions. London: DH

Equality and Human Rights Commission (2019) Human rights framework for restraint: Principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions

Human Rights Act (1998)

Mental Health (NI) Order (1986) HMSO

Mental Capacity Act (Northern Ireland) (2016)

NICE: (2015a) Violence and aggression: Short-term management in mental health, health and community setting (NG 10)

Restraint Reduction Network (RRN) Training standards 2019

Royal College of Nursing 'Three Steps to Positive Practice' 2017

Royal College of Psychiatrist' Faculty of Psychiatry of Intellectual Disability (2013) People with learning disability and mental health, behavioural or forensic problems

Royal College of Psychiatrist's (2018) Prescribing Observatory for Mental Health

Royal College of Nursing (2010) Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016) Trauma-informed mental healthcare in the UK: What is it an how can we further its development? Mental Health Review Journal, 21 (3), 174-192. Doi: 10.1108/MHRJ-01-2015-006

8.0 APPENDICES

Appendix 1: Procedural and further Guidance on Restrictive Interventions
Appendix 2: Methods of Reducing Restrictive Interventions
Appendix 3: RCN Three Steps to Positive Practice – Link
Appendix 4: Reducing Restrictive Practice Checklist (RNN, 2019) - Link
Appendix 5: Zero Tolerance Risk Assessment and Training Needs Analysis - Link

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Restrictive Practices for Adults and Children Policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and Indirect Supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening

exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality and Planning Team via the generic email address [redacted]@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact	☐
Minor impact	☒
No impact	☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018, the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address [redacted]@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved	☒
A full data protection impact assessment is required	☐
A full data protection impact assessment is not required	☐

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality and Planning Team via the generic email address [redacted]@belfasttrust.hscni.net

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.
The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

[redacted]

01/02/2022
_____ **Date:** _____
Policy Author

[redacted]

01/02/2022
_____ **Date:** _____
Director

APPENDIX 1

PROCEDURAL AND FURTHER GUIDANCE ON RESTRICTIVE INTERVENTIONS

1. NICE guideline (NG10) 2015: Violence and aggression: short-term management in mental health, health and community settings

Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE

2. The Restraint Reduction Network Training Standards 2019

The Restraint Reduction Network Training Standards - Restraint Reduction Network

3. Department of Health: Positive and Proactive Care: reducing the need for restrictive interventions

Helping health and care services manage difficult patient behaviour - GOV.UK (www.gov.uk)

APPENDIX 2

METHODS OF REDUCING RESTRICTIVE PRACTICES

Recovery-based Approaches

Recovery means working in partnership with service users to improve their clinical and social outcomes. Recovery models are consistent with contemporary service philosophies across wider health and social care setting and include the promotion of human right based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion.

Recovery is possible for everyone. Each person can achieve satisfying and fulfilling life, in keeping with their own preferences, goals and aims, through empowerment, self-determination and unconditional engagement with wider communities and society more generally (DOH, 2014).

Positive Behaviour Support (PBS)

PBS provides a framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a service user's quality of life. Evidence has shown that PBS based approaches can enhance quality of life and also reduce behaviours that challenge, which in turn can lead to a reduction in the use of restrictive interventions.

PBS provides a conceptual framework, which recognises that service users may engage in behaviours that challenge because they have challenging or complex needs that are not being met. These can be associated with unusual needs and personal preferences, sensory impairments, or mental or physical health conditions (DOH, 2014).

Primary Preventative Strategies:

- Deliver services that focus on person-centred, trauma-sensitive care and support
- Providing positive and rewarding social environments
- Give structure to the day and provide meaningful occupation and activities
- Addressing health inequalities
- Improving levels of independence
- Enhancing quality of life
- Improving communication skills
- Helping service users manage their own conditions by enhancing coping skills or adapting their environment
- Helping service users to exercise or sleep

Primary interventions is part of a specific approach including PBS and the Six Core Strategies. This may also include individualised approaches such as cognitive behavioural therapy, dialectic behaviour therapy and other psychological

interventions. Fundamentally, primary intervention is based on person-centred approaches, which aim to provide the 'right fit' between the services available and the needs of the service user (Restraint Reduction Network, 2019).

Secondary Preventative Strategies:

Secondary prevention focuses on early intervention and aims to minimise escalation in behaviour, which may lead to the use of restrictive practices, this includes:

- An assessment of the presenting behaviour so that a targeted approach can be used which may include the removal of immediate triggers
- Making changes to the environment
- Self-regulation techniques such as relaxation, breathing exercises, mindfulness, and meditation techniques
- Effective verbal and non-verbal approaches such as limit setting and distraction techniques
- Reinforcement of alternative positive behaviours
- The use of appropriate medication either to address underlying psychiatric symptoms or to alleviate anxiety (Restraint Reduction Network, 2019).

Tertiary Strategies:

These are reactive strategies aimed at addressing the needs of service user's where primary and secondary preventions has failed in order to help the service user to regain control. Tertiary strategies can be non-restrictive or restrictive. They aim to bring about immediate behavioural change in the service user by enabling staff to manage the situation and eradicate or minimise the risks. It is important to recognise that crisis approaches or risk management approaches and not designed or intended to achieve any long-term or lasting behavioural change (Restraint Reduction Network, 2019).

Person Centred, Trauma-Informed Care

Trauma is the experience of violence and victimisation including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disaster.

The earlier in life trauma happens, the more profound the impact on brain development. People who have experienced trauma in early childhood often struggle to self-regulate and seem to always be in a state of high alert to protect themselves from remembered harmful experiences. This is their automatic, learned response and not signs of pathology, rather they are survival strategies that have helped them cope with terrible pain and challenges.

Trauma-informed care involves universal precautions based on an assumption that the people who use services have a history of trauma, which can present behavioural in many ways including anxiety/depression, substance abuse, self-injury, eating problems, poor judgment, flashbacks, nightmares, terror, auditory hallucinations, difficulty problem solving and aggression (this list above not exhaustive).

Trauma-informed care focuses on 'what happened to the person' instead of 'what's wrong with the person' and helps understand how the person's behaviour developed, how this impacts on the person now, and how to help the person develop new coping strategies.

When taking a trauma-informed approach, it is important for staff to reflect on their own behaviours and responses to individuals, being aware of how their approach may adversely impact on the person (Sweeney, 2016)

The Six Key Restraint Reduction Strategies

The use of coercive and restrictive interventions can be minimised, and the misuse and abuse of restraint can be prevented. The first steps in doing so are to set expectations across the BHSCT.

- Strategy 1: Leadership
  The organisation develops a mission, philosophy and guiding values, which promote non-coercion and the avoidance of restraint. Executive leaders commit to developing a restraint reduction plan, which is implemented and measured for continuous improvement.

- Strategy 2: Performance Measurement
  The organisation takes a 'system' approach and identifies performance measures, which determine the effectiveness of its restraint reduction plan and which measure key outcomes for service users.

- Strategy 3: Learning and Development
  The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

- Strategy 4: Providing Personalised Support
  The organisation uses restraint reduction tools, which inform staff, and shape personalised care and support to service users.

- Strategy 5: Communication and Service User Focus
  The organisation fully involves service users in a variety of roles within the service, identifies the needs of service users and uses these to inform service provision and development.

- Strategy 6: Continuous Improvement
  The principle of post-incident support and learning is embedded into organisational culture (Restraint Reduction Network, 2019).

APPENDIX 3

THE RCN THREE STEPS TO POSITIVE PRACTICE

Three steps to positive practice | Royal College of Nursing (rcn.org.uk)

APPENDIX 4

RESTRAINT REDUCTION NETWORK'S REDUCING RESTRICTIVE PRACTICES CHECKLIST (RNN, 2019)

https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

(For further information, please visit website: Restraint Reduction Network)

APPENDIX 5

ZERO TOLERANCE RISK ASSESSMENT & TRAINING NEED ANALYSIS

Please go policy below: pages 20-25 for Zero Tolerance Risk Assessment & Training Need Analysis:

BHSCT A zero tolerance approach to the prevention and management of aggression and violence towards staff in the workplace (2019) TP 02/08