The Regulation and Quality Improvement Authority

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Mental Health and Learning Disability Directorate

Awareness and Use of Restrictive Practices in Mental Health & Learning Disability Hospitals December 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

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Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services.

Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

1.1 Purpose of the Review of Restrictive Practices

The Mental Health and Learning Disability (MHLD) team in RQIA undertook a small themed review in December 2014 in relation to the awareness and use of restrictive practices in mental health and learning disability inpatient settings across all five Health and Social Care (HSC) Trusts in Northern Ireland. The purpose of this review was to establish a baseline of staff training, understanding and practice in relation to the use of restrictive practices in inpatient care settings. This review was open to staff from all disciplines working with patients across the full spectrum of mental health and learning disability inpatient settings, from children's services to older people's services.

This report is in no way intended to be critical of how staff working in learning disability and mental health inpatient settings view, understand or use restrictive interventions. The findings of this report should instead be viewed as a baseline representation of the current position to highlight areas that may require improvement and help influence and shape how improvements can be achieved.

We hope that this piece of work will be used to help improve services for all patients and will be of benefit to staff working to support those patients.

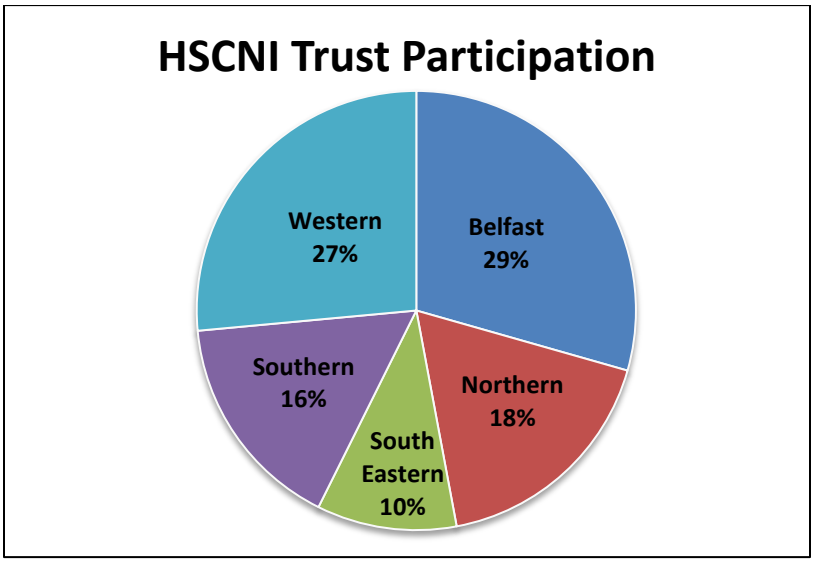
1.2 Methodology

The review was undertaken by an inspector and a project administrator from the MHLD Directorate in December 2014. Staff working with patients in inpatient settings were invited to attend one of seven focus groups. Participants were given a brief outline of the purpose and context of the review. The inspector shared some of her experiences of the use of restrictive practices both as a clinician and as an inspector within RQIA. Participants were invited to answer a series of questions relating to the use of restrictive practices in the clinical setting. Individual and group discussions were also held at each focus group and notes were taken of these. Questionnaires were developed based on the findings of MHLD Directorate inspection activity over the preceding two year period. Questions were also influenced by the noted variance in: staff awareness; practice;

access to training; and guidance documentation, in respect of restrictive practice in mental health and learning disability inpatient settings across the region.

68 staff participated in the review from a variety of professional backgrounds including:

- Nursing staff working in learning disabilities and psychiatry;
- Psychiatrists;
- Medical staff;
- Specialist nurse therapist;
- Student nurses;
- Occupational therapists;
- Social workers;
- Health care assistants;
- Safeguarding officers; and,
- Managers with responsibility for, or who work in conjunction with, patients in inpatient settings at a range of levels up to assistant director level.



Responses were received from clinicians and managers working a wide range of specialties including acute learning disability; continuing care learning disability; medium secure; older people's mental health; continuing care mental health and acute mental health. Unfortunately none of the participants who participated in this review were working in child and adolescent mental health services (CAMHS) or child and adolescent mental health services for individuals with a learning disability (CAMHS-ID).

Each HSC Trust was invited to submit policies and procedures, guidance documentation and training available to staff in relation to restrictive practices. These are detailed at Appendix 1.

Summary

The purpose of this review was to establish a baseline of staff training, understanding and practice in relation to the use of restrictive practices in inpatient care settings.

The findings from this review demonstrate that there is a lack of robust and up to date guidance for staff, a lack of understanding of restrictive practices, a lack of consistency in the use of restrictive practices, and little understanding of the governance arrangements in each Trust to monitor the use of restrictive practices.

There was no agreed definition of the term “restrictive practice.” Restrictive interventions’ are defined in the guidance document “Positive and Proactive Care: reducing the need for restrictive interventions (2014)” as: ‘deliberate acts on the part of other person(s) that restrict an individual’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 person or others; and
- contain or limit the person’s freedom for no longer than is necessary’.

Staff are not clear about what restrictive practices are or what makes a practice restrictive. For example, practice in one setting which is restrictive due to the context in which it takes place, may not be restrictive in a different context. If staff using restrictive practices are unclear about what restrictive practices are, or are unable to identify practice as being restrictive, it is very unlikely that they will be in a position to develop and implement less restrictive interventions/strategies. The absence of a clear regional definition or strategy is likely to be a major contributing factor to this. Many participants indicated that work based discussion, awareness, training and processes in relation to restrictive practices, had only happened as a result of RQIA inspection activity, and practices highlighted at the March 2014 MHLD directorate roadshow.

There is a clear lack of specialised training in relation to restrictive practices provided for staff working with patients in inpatient learning disability and mental health hospitals. 29 of the 68 participants had undertaken training specific to restrictive practice. When asked if this was useful, 19 of these 29 responses stated that they were able to apply it in their clinical setting. 45% had no training in this area at all. Some courses partially covered the use of restrictive practices, such as, physical restraint and deprivation of liberty training. However such courses only focus on a particular type of practice that is restrictive as opposed to what constitutes restrictive practice as a whole.

When this is compared to the number of participants who use restrictive practice in a clinical setting or carry management responsibility for clinical settings in which restrictive practices are used (96%), it is clear that the majority of those using restrictive practices have not had any relevant and specific training.

One participant who is a final year student nurse confirmed that the use of restrictive practice had not been covered as part of their nursing education. A doctor who was undertaking their training in relation to psychiatry, who participated in this piece of work, indicated that they were not aware of DHSSPS Deprivation of Liberty Interim Guidance

(October 2010). This is concerning given that both of these practitioners were working in settings where restrictive interventions are used. It is clear that there is a deficit in relation to training provided regarding restrictive practices to those in both employment and education.

Participants identified a wide range of restrictive practices and demonstrated some understanding of what they consider restrictive practice to be. The majority of people (58.5%) had positive feelings towards the use of restrictive practices, on the basis that they felt it was in the best interest of patients. It is important to note that those who felt positive, focused on the reasons in terms of patient safety and wellbeing for using restrictive practice.

40.5% of participants expressed negative feelings towards the use of restrictive practices. These individuals felt vulnerable and sometimes isolated when implementing restrictive interventions. They also expressed concern over the legal implications for staff who use restrictive practices. Participants who felt negative about restrictive practice focused on the consequences and implications for them as practitioners and professionals.

These responses suggest that clinicians and practitioners are comfortable with the reasons why restrictive practices should be used, but not necessarily how to identify, implement and document their use effectively. It cannot be concluded that patients' human rights are always upheld and safeguarded when deciding that the use of any restrictive practice is in the patients' best interest.

There is a lack of available documentation or an awareness of any available documentation to guide staff when using restrictive practices. The three most common documents staff referred to were: Human Rights Act (1998) (43.5%); Mental Health (Northern Ireland) Order 1986 (19.5%); and, DHSSPS Deprivation of Liberty Interim Guidance (October 2010) (36%). There were seven further published standards and guidance documents identified by participants, but these were noted by only a small percentage of participants. For example, Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services DHSSPSNI May 2010, was mentioned by one person in the focus group. In addition, 25.5% stated that they do not use/consult any standards/published guidance or legislation to inform and govern the use of restrictive practices.

There is a lack of governance arrangements / awareness of governance arrangements within HSC trusts. 48% of people indicated that there are no governance arrangements in their Trust regarding the use of restrictive practice; they were unsure what governance arrangements their Trust had regarding the use of restrictive practice, or they did not provide an answer. In addition, none of the 68 participants mentioned how Trust governance arrangements influenced their daily practice when using restrictive practices.

While there is a range of methods used to document the use of restrictive practice, there is no consistent approach. Care plans were the most common method mentioned, with 28 of the 68 participants using care plans to document the use of

restrictive practice. The second biggest response to this question was 18 of the 68 participants noting that they do not document the use of restrictive practice anywhere.

The outcome of this small themed review demonstrates that there are significant variances within and across Trusts in relation to the need for, and use of, restrictive practices, highlighting the need for a regional approach.

RQIA would like to take this opportunity to thank all participants and stakeholders for making themselves available and for their very honest feedback and answers.

Questionnaire Responses

The response to the questionnaires and the ensuing discussions were analysed and are summarised below.

2.1 What is your understanding of the term restrictive practice?

Of the 68 participants, two participants indicated that they did not know what a restrictive practice is.

A further five participants provided examples of what they understand restrictive practices to be, but they did not provide an explanation or definition of the term restrictive practice.

Of the 66 participants who did provide an answer, staff indicated that they are aware of what practices may be restrictive. However there was no clear agreed definition of what constitutes a restrictive practice.

2.2 What training (if any) have you received regarding restrictive practices?

There were varying responses to this question, indicating that training regarding restrictive practices may not have been prioritised when training programmes are developed. Responses are summarised as follows:

- 29 of the 68 participants (43.5%) indicated that they had undertaken training specifically in relation to restrictive practices;
- 30 of the 68 participants (45%) reported that they had received no training specifically regarding restrictive practices;

- Three participants (4.5%) indicated that they had undertaken independent research and learning in relation to restrictive practices;
- Six of the participants (9%) stated that restrictive practices were discussed as part of staff/team meetings;
- Twenty of the participants (30%) reported that they have discussed restrictive practices as part of training in relation to physical restraint;
- Nine participants (13.5%) indicated that they had undertaken training in relation to deprivation of liberty which included restrictive practice;
- Three participants (4.5%) highlighted that they had undertaken training in relation to restrictive practices as part of approved social work training;
- Two participants (3%) indicated that they had familiarised themselves with Trust policy in relation to restrictive practice.

Other training courses that participants indicated included reference to the use of restrictive practice were:

- Promoting Quality Care Training (PQC) (2 participants);
- Mental Health (Northern Ireland) Order 1986 (2 participants);
- Safeguarding Vulnerable Adults training (3 participants);
- Safeguarding Children training (2 participants);
- Capacity and Consent training (3 participants).

Of concern, is a response from a pre-registration student nurse undertaking the final year of training to become a learning disability nurse registrant, who indicated that the area of restrictive practices is not taught as part of the course.

2.3 How often do you attend training in relation to restrictive practice and what does it involve?

Of the 29 participants who indicated that they had received training in relation to restrictive practice, 10 indicated that the training was once only, 14 stated they attended training on an annual basis, 3 respondents noted that training was available in relation to restrictive practice every 18 months, 1 respondent attended training every 2 years and the 1 remaining respondent failed to indicate the frequency of training.

2.4 If you have attended training on restrictive practice were you able to apply this to your day to day job?

29 of the 68 participants (43.5%) stated that they had undertaken training in the use of restrictive practices. 19 of these 29 (28.5%) respondents found this training useful, and could apply the learning to their role within the clinical setting they were working in.

3 of these 29 participants, who indicated that they had undertaken training in relation to restrictive practice, stated that they were not in a position to apply the learning from this training to their role.

The remaining 7, who completed training in the use of restrictive practices, stated that although some areas were useful, it was not always fully applicable to their area of care

and/or didn't provide them with the clarification and confidence they had hoped. For example, one participant stated that some elements of the training they received were relevant, however following training -

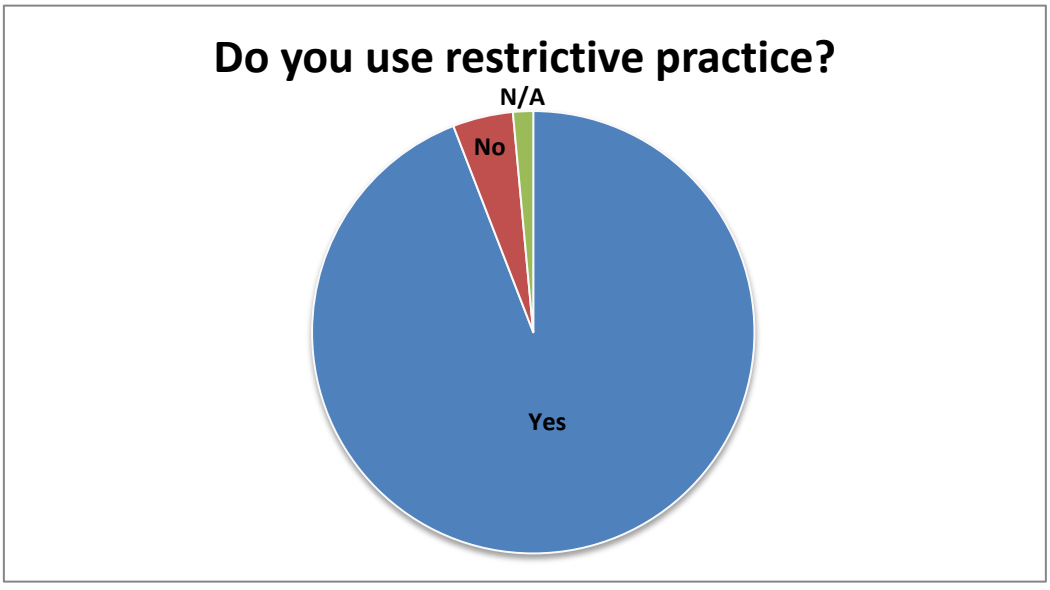
> "Most staff in the group left with more questions than answers and some degree of confusion. Discussion highlighted that some participants were not convinced about the accuracy of some of the information contained in the training session."

9 of the 68 (13.5%) participants indicated that they had not attended specific training for restrictive practices; however they had attended training in areas such as physical restraint, deprivation of liberty, consent and capacity, which they believed was valuable and the learning could be applied to restrictive practices.

One of the above applicants indicated that following training in relation to deprivation of liberty, they had developed a process and procedure at ward level to identify and review all restrictive practices being utilised on the ward to ensure they were proportionate, necessary and appropriate and subject to regular review.

30 of the 68 participants (45%) indicated that the question was not applicable as they had not received training in relation to restrictive practice.

2.5 Do you use any restrictive practices in your clinical setting?



If so, can your list the restrictive practices that you use or have used in the past?

64 of the 68 participants (96%) indicated that they use restrictive practices in their clinical setting or that they carry management responsibility for clinical settings in which restrictive practices are used.

Three participants (4.5%), indicated that they do not use restrictive practices in their clinical setting, although they work as part of the multidisciplinary team for patients who were subject to restrictive practices and interventions

One respondent indicated that they do not work directly with a patient population in a clinical setting.

Examples of restrictive practices used in clinical settings shared by participants included:

- Use of bed (cot) sides;
- Use of lap belts on wheelchair / commodes/other harness/restrictive equipment;
- Locking doors (including the use of baffle locks) e.g. ward doors, bedroom doors, kitchen door, which restrict free movement within the ward;
- Removing or restricting access to a patients possessions, e.g. money, medication, shoes, cigarettes/lighters;
- Use of 'when required/prn' medication;
- Use of restrictive clothing;
- Use of sanctions (behavioural) techniques;
- Use of restraint;
- Use of technology e.g. monitoring devices /door alarms to detect patient movements;
- Restricting access to food/drink;
- Use of observation, 'peep' holes/uncovered windows;
- Use of furniture to restrict access/movement;
- Restricted visiting times;
- Designated smoking areas;
- Restricting patients from using/accessing their phone;
- Seclusion;
- Restricting patients from leaving ward environment;
- Use of Mental Health (Northern Ireland) Order 1986;
- Removing possible ligature risks from patients clothing e.g. laces, belts, cords;
- Preventing the use of alcohol/drugs;
- Restricted access to children;
- Rapid tranquilisation.

2.6 How do you feel about using restrictive practices?

Over the past two years, while conducting inspections in mental health and learning disability inpatient settings, inspectors had found a significant variance in staff's attitude and confidence in relation to implementing restrictive practices. Participants provided a range of responses to this question.

Two of the 68 participants (3%), indicated that this this question was not applicable to them.

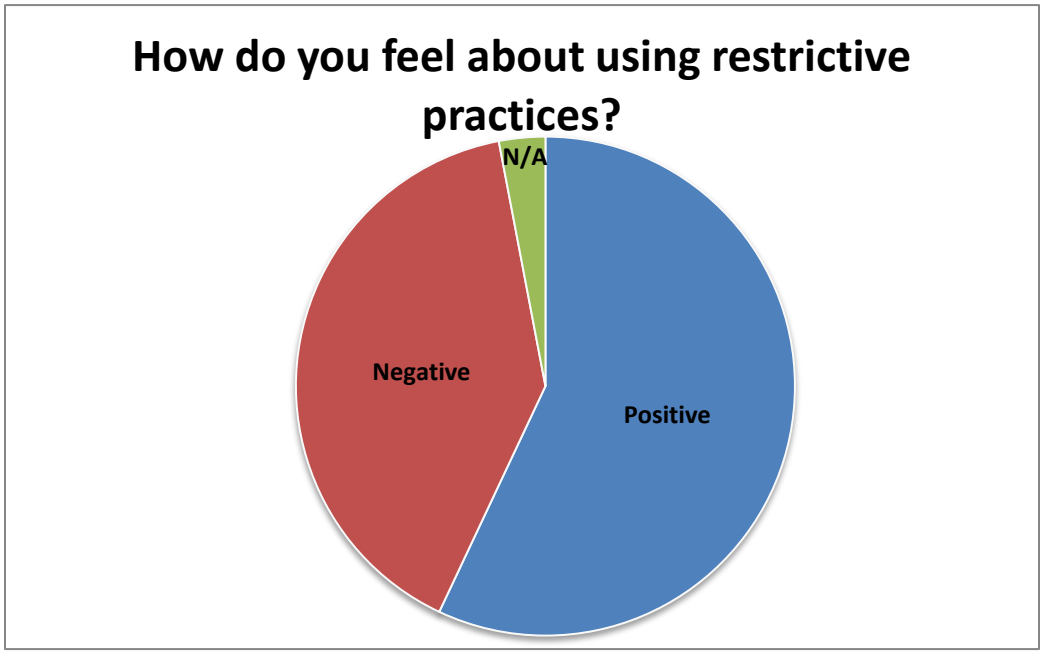
39 of the 68 participants (58.5%), indicated that they had positive feelings regarding the use of restrictive practices. Participants reported that the use of restrictive practices was not ideal but that they felt confident in using the interventions. Respondents indicated that they regret having to use restrictive practices but felt confident that it is in the patients best interests, that it was their duty to keep patients safe, and that restrictive practices are beneficial, necessary, important to keep patients safe and used in the best interests of patients and patient safety.

One respondent stated that

> "having worked as a nurse for many years I have seen vast improvements in practice and consideration of the person's human rights"

Another stated that they were

> "confident as it is always proportionate to the level of risk posed and for the shortest time possible."



27 of the 68 participants (40.5%) indicated that they had negative feelings regarding the use of restrictive practices.

Participants reported that they feel nervous, vulnerable, anxious, stressed, worried, and unhappy regarding the consequences. Respondents suggested that the use of restrictive practices conflicts with their values and ethics as a professional.

Respondents indicated that on occasions it is difficult to get the patient's multi-disciplinary team to participate in decision making regarding the use of restrictive practices and that there are occasions when nurses believe that they are unsupported when they must implement restrictive interventions.

Participants reported that on occasions nurses can feel isolated as multidisciplinary teams do not always want to accept responsibility in relation to decision making to implement restrictive interventions.

Therefore nurses are the professional group who act to ensure patient safety and impose restriction.

It was suggested by respondents that staff feel vulnerable and they are concerned that imposing restrictions could result in allegations being made by patients. Staff also suggested by failing to impose restrictions, regardless of necessity or proportionality, they were afraid that should a patient come to some harm, they may be held accountable.

This is concerning given that staff working in services should be promoting positive risk taking in line with Promoting Quality Care, Good Practice Guidance on the Assessment

This is concerning given that staff working in services should be promoting positive risk taking in line with Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services DHSSPSNI May 2010.

One participant stated

that they felt anxious, that they "hope it (the implementation of restrictive practices) are for the right reasons", and that they are "guided by nursing staff"

One participant commented that

"Whilst I feel assured that we use them (restrictive practices) appropriately, it is a very subjective area. What I feel may be required may not be in line with the opinion of an RQIA inspector. I think we have become wary of restricting for fear of being criticised that we are doing something wrong. All staff are very aware of litigation."

This comment captures a theme that RQIA inspections have highlighted in some clinical settings in the previous two years –that staff who implement restrictive interventions in inpatient settings do not always appear to be confident in their own decision making and practice in relation to the implementation of restrictive practices, particularly in terms of necessity and proportionality.

2.7 What standards/published guidance or legislation (if any) do you use/consult to inform and govern the use of restrictive practices?

Participants identified two pieces of legislation that they use/consult to inform and govern the use of restrictive practices.

29 of the 68 participants (43.5%) reported that they use/consult the Human Rights Act (1998) to inform and govern the use of restrictive practices.

13 of the 68 participants (19.5%) indicated that they use/consult the Mental Health (Northern Ireland) Order 1986.

Eight published standards and guidance documents were identified by participants to inform and govern the use of restrictive practices.

- DHSSPS Deprivation of Liberty Interim Guidance (October 2010) (24 participants, 36%);
- RCN guidance (4 participants, 6%);
- NMC Code of Conduct (2 participants, 3%);
- Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services DHSSPS August 2005 (1 participant, 1.5%);
- Department of Health Best Practice Guidance, Specification for adult medium-secure services 2007 (1 participant, 1.5%);
- Accreditation for Inpatient Mental Health Services – Learning Disabilities (AIMS-LD) Standards for Adult Inpatient Learning Disability Units – Assessment and Treatment Units (1 participant, 1.5%);
- The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006 (1 participant, 1.5%);
- Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services DHSSPSNI May 2010 (1 participant, 1.5%).

17 of the 68 participants (25.5%) indicated that they also use/consult local HSC Trust guidance on the use of restrictive practice; 11 of the 68 participants (16.5%) indicated that they use/consult Trust policy on the use of physical interventions and 6 of the 68 participants (9%) indicated that they use/consult local Trust policies and guidance in relation to areas such as locked doors; use of mobile phones, and guardianship.

Of concern is the report by 17 participants (25.5%) who indicated that they use restrictive practices but do not use/consult any standards/published guidance or legislation to inform and govern the use of restrictive practices.

Types of restrictive practices identified used by these respondents included:

- Locked doors;
- Use of bed (cot) sides;
- Use of lap belts on wheelchair / commodes/other harness/restrictive equipment; removing or restricting access to a patients possessions, e.g. money, medication, shoes, cigarettes/lighters;
- Use of restraint.

The 17 participants who indicated that they do not use/consult any standards/published guidance or legislation to inform and govern the use of restrictive practices, came from a variety of disciplines to include medicine, social work and nursing and worked across all five HSC Trust areas.

Other responses regarding policies/procedures used to guide practice identified by participants included:

- Disability Discrimination Act (1995) (2 participants, 3%);
- Consent (1 participant, 1.5%);
- NICE guidelines (1 participant, 1.5%);
- Department of Health Positive and Proactive Care: reducing the need for restrictive interventions (2014) (1 participant, 1.5%);
- Positive and Proactive workforce (1 participant, 1.5%);
- Draft Mental Capacity Bill, Northern Ireland (1 participant, 1.5%).

2.8 What policies (if any) are available regarding restrictive practice?

Thirteen different types of Trust policies were recorded by participants, with some participants referring to more than one policy.

- 12 participants (18%) stated that the Trust policy on restrictive intervention was available;
- 10 participants (15%) indicated that availability of the Trust policy on physical restraint;
- 8 participants (12%) referred to the Trust policy on enhanced observations;
- 8 participants (12%) referred to the Trust policy on locked doors;
- 6 participants (9%) referred to the Trust security/search policy;
- 6 participants (9%) referred to Deprivation of Liberty Interim Guidance;
- 6 participants (9%) referred to the Trust complaints policy/procedure;
- 5 participants (7.5%) referred to Promoting Quality Care Guidance;
- 4 participants (6%) referred to the Trust seclusion policy;
- 4 participants (6%) referred to the Mental Health (Northern Ireland) Order 1986;
- 3 participants (4.5%) referred to the Trust administration of medication policy/procedure; 2 participants (3%) referred to the Trust vulnerable adults policy/procedure;
- 1 participant (1.5%) referred to the Trust Guardianship policy/procedure

10 of the 68 participants (15%) indicated that there was no policy available regarding restrictive practices or they were unsure what the policy is.

2.9 What is available to guide your practice in relation to developing and implementing restrictive practice?

19 of the 68 participants (28.5%) reported that they use/consult DHSSPS Deprivation of Liberty Interim Guidance (October 2010), as a guide to develop and implement restrictive practices. Other sources identified by participants to guide the development and implementation of restrictive practices included:

- Local Trust guidance on the use of restrictive practice (19 participants, 28.5%);
- Human Rights Act (13 participants, 19.5%);
- Multi-disciplinary team (11 participants, 16.5%);
- Trust policy on the use of physical interventions (8 participants, 12%);
- Trust care plan (8 participants, 12%);
- Risk assessment (6 participants, 9%);
- Best interest pathway (3 participants, 4.5%);
- Vulnerable adults process (1 participant, 1.5%);
- Deprivation of Liberty training (1 participant, 1.5%);
- Department of Health Positive and Proactive Care: reducing the need for restrictive interventions 2014 (1 participant, 1.5%);
- Resource nurse (1 participant, 1.5%);
- Litigation officer (1 participant, 1.5%);
- Safeguarding lead (1 participant, 1.5%);
- Directorate of Legal Services (1 participant, 1.5%);
- RCN guidance (1 participant, 1.5%).

18 of the 68 participants (27%) indicated that they believed that there was nothing available to guide their practice in relation to the development and implementation of restrictive practices. All 18 participants indicated that they use restrictive practices. These participants came from a variety of disciplines to include medicine, social work and nursing and worked across all five HSC Trust areas.

The reference to a ligation officer and to legal advice from the Directorate of Legal Services, confirms the information provided by some staff that they are not confident in the use of a restrictive practice, particularly for those staff who believe there is no guidance available to direct and support them.

Two of the 68 participants (3%) indicated that they had undertaken self-directed learning to guide their practice in developing and implementing restrictive practices and as a result they had developed a local ward specific tool to guide the implementation of restrictive practices in their clinical setting.

2.10 Is an assessment used to decide if a restrictive practice is required?

5 of the 68 participants (7.5%) indicated that assessments are used in their clinical setting to decide if a restrictive practice is required but they did not specify what this assessment is.

23 of the 68 participants (34.5%) indicated that no assessment is used in their clinical setting to decide if a restrictive practice is required.

Other participants answered this question by indicating assessments used in their clinical setting to decide if a restrictive practice is required. Responses to this question included:

- Promoting Quality Care Risk Assessment (19 participants, 28.5%);
- Nursing assessment (18 participants, 27%);
- Multi-disciplinary assessment (9 participants, 13.5%);
- Mental health assessment (4 participants, 6%);
- Vulnerable adults process (2 participants, 3%);
- NHSCT occupational therapy assessment (1 participant, 1.5%);
- Capacity assessment (1 participant, 1.5%).

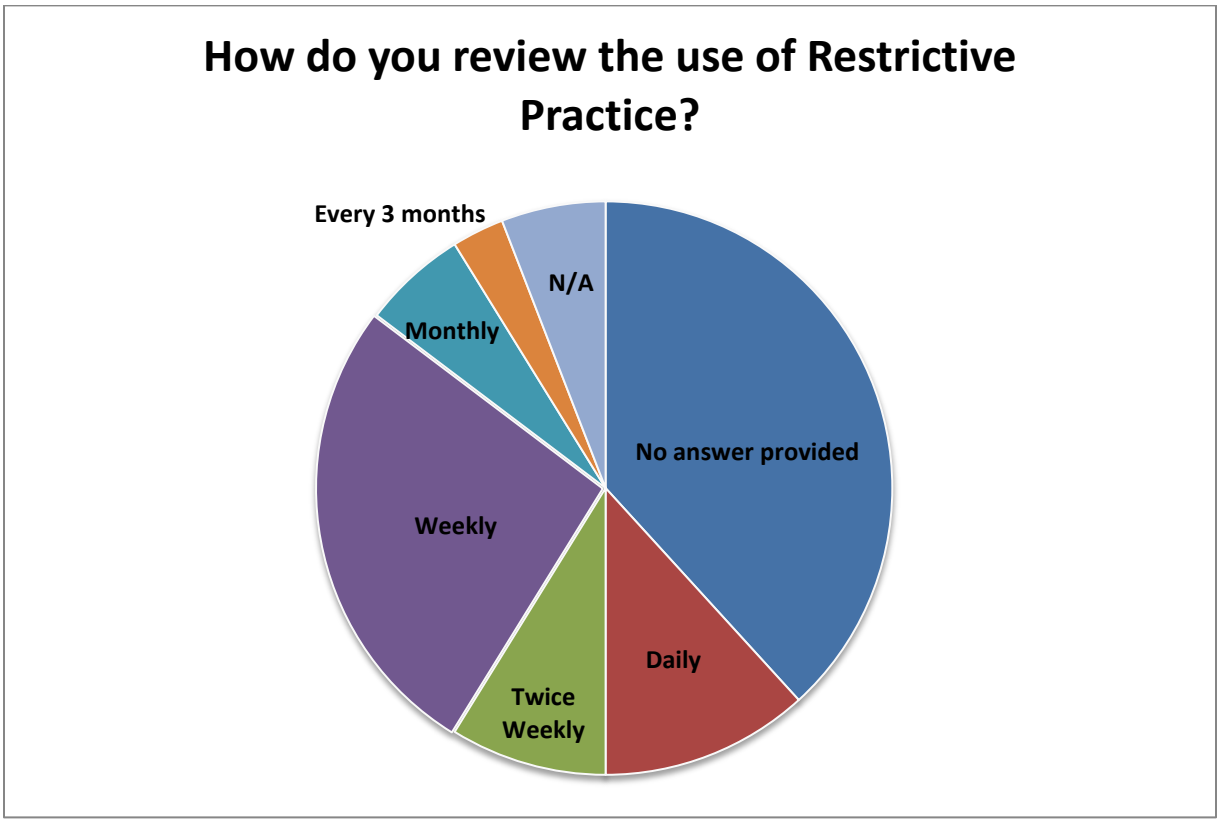
2.11 How do you communicate with patients/representatives regarding the use of restrictive practices?

26 of the 68 participants (39%) indicated that they communicate with patients/representatives regarding the use of restrictive practices via care planning. 20 participants (30%) indicated that they communicate with patients/representatives regarding the use of restrictive practices during multidisciplinary discussions or ward rounds.

Other ways in which participants indicated that they communicate the use of restrictive practices to patients or their representatives included:

- Admission (8 participants, 12%);
- In the patient information booklet (4 participants, 6%);
- At patient meetings/forums on the ward (4 participants, 6%);
- As part of PQC risk management plan (3 participants, 4.5%);
- As part of safeguarding vulnerable adults strategy meetings (2 participants, 3%).

2.12 How do you review the use of a restrictive intervention with patients/representatives?



26 of the 68 participants did not provide a description of how they review the use of restrictive practices with patients and/or their representatives.

Participants indicated that where restrictive interventions were reviewed in conjunction with patients and/or their representatives, this review took place as part of the Multi-Disciplinary Team (MDT) discussion or ward round. 8 of the 68 participants (12%) reported that this review took place on a daily basis; 6 participants (9%) indicated that it took place twice weekly; 18 (27%) participants reported it as occurring weekly; 4 (6%) reported monthly review; 2 participants (3%) reported reviews take place at three monthly intervals and 4 of the 68 participants (6%) indicated that the use of restrictive interventions does not occur in conjunction with patients and/or their representatives in the clinical setting they work in.

2.13 How often do you review restrictive practices?

Participants reported a range of frequency of review of restrictive practices. Six of the 68 participants (9%) indicated that patients using seclusion were subject to review every 15 minutes. 1 participant (1.5%) stated that patients in the SHSCT are subject to hourly review in situations where mechanical restrictive practice is being implemented. Other timeframes indicated for review included:

- Daily (4 participants, 6%);
- Twice weekly (2 participants, 4%);
- Weekly (18 participants, 27%);
- Fortnightly (2 participants, 3%);
- Monthly (6 participants, 9%);
- Annually (2 participants, 3%).

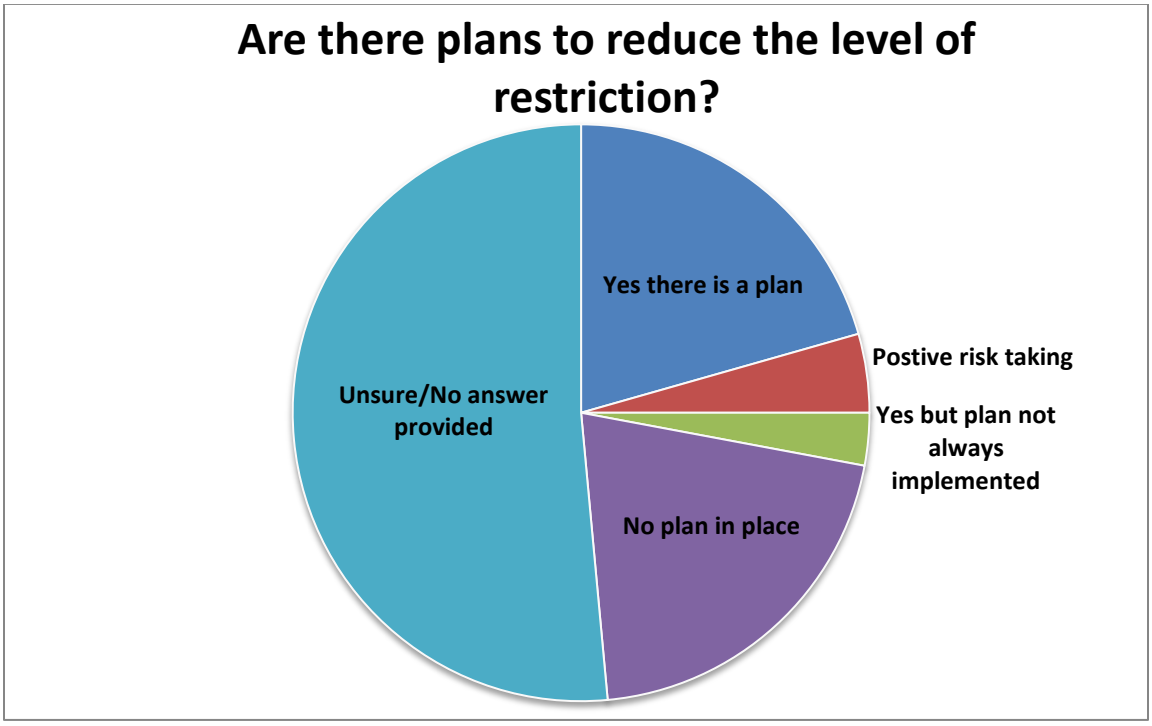
4 of the 68 participants (6%) indicated that restrictive practices were rarely reviewed and 6 participants (9%) reported that restrictive practices were not subject to review.

2.14 Where restrictive practices are in place, is there a plan currently being implemented to try and reduce the level of restriction?

14 of the 68 participants (21%) indicated that where restrictive interventions were being utilised, there was a plan in place to try and reduce the level of restrictive intervention required.

3 of the 68 participants (4.5%) reported that positive risk taking was being used to try and reduce level of restrictive interventions in place.

2 of the 68 participants (3%) reported that where restrictive interventions were being utilised, there was a plan in place to try and reduce the level of restrictive intervention required. However this was not always implemented due to constraints on staff time.



14 of the 68 participants (21%) indicated that despite restrictive interventions being utilised, there was no plan in place to try and reduce the level of restrictive intervention required.

35 of the 68 participants (52.5%) stated they were unsure or did not provide a response to this question.

2.15 What alternative interventions (if any) to restrictive interventions are available in your clinical setting?

Participants described a range of alternatives to restrictive interventions that are used in their respective clinical settings.

- 10 of the 68 participants (15%) indicated that access to meaningful therapeutic activity program was used an alternative to restrictive interventions;
- 8 of the 68 participants (12%) indicated that access to specialist staff training to deal with behaviours that challenge is used an alternative to restrictive interventions;
- 6 of the 68 participants (9%) indicated that access to 1:1 supervision (as a less restrictive alternative) is used an alternative to restrictive interventions;
- 6 of the 68 participants (9%) indicated that access to 1:1 time with named nurse was used an alternative to restrictive interventions.

Other alternatives to restrictive interventions used in clinical settings reported included:

- Environmental changes (4 participants, 6%);
- Access to assistive technology (as a less restrictive alternative) (3 participants, 4.5%);
- The use of proactive strategies/positive behaviour support (3 participants, 4.5%);
- Access to alternative therapies (2 participants, 3%);
- Patient forums (2 participants, 3%);
- Patient education (2 participants, 3%);
- Positive risk taking (2 participants, 3%);
- Access to therapeutic interventions (2 participants, 3%);
- Undertaking physical health assessments (2 participants, 3%);
- Access to Dialectical Behaviour Therapy and use of self sooth boxes (1 participant, 1.5%).

28 of the 68 participants (42%) indicated that there was no alternative to restrictive interventions available in the clinical settings they worked in.

2.16 Why do you think restrictive practices are used?

Participants provided a range of responses in relation to this question.

- 24 of the 68 participants (36%) indicated that restrictive practices were used to maintain patient's safety and wellbeing;
- 22 of the 68 participants (33%) indicated that restrictive practices were used due to the staff or organisational culture that exists –

> "That's the way it always has been."

- 20 of the 68 participants (30%) indicated that restrictive practices were used due to maintain safety of others;
- 16 of the 68 participants (24%) indicated that restrictive practices were used due to ensure patient safety due to inadequate staffing levels;
- 12 of the 68 participants (18%) indicated that restrictive practices were used due to lack of alternative interventions;
- 10 of the 68 participants (15%) indicated that restrictive practices were used due to staff being unaware of alternatives due to lack of staff training/access to staff with specialist skills;
- 10 of the 68 participants (15%) indicated that restrictive practices were used due to lack of staff awareness/staff not recognising their practice as restrictive;
- 10 of the 68 participants (15%) indicated that restrictive practices were used due to protect staff;
- 6 of the 68 participants (9%) indicated that restrictive practices were used due to staff fear of positive risk taking and patients coming to harm;
- 10 of the 68 participants (15%) indicated that restrictive practices were used due to as a last resort to optimise/ensure positive outcome for patients;
- 2 of the 68 participants (3%) indicated that restrictive practices were used due to staffs duty of care to their patients;
- 2 of the 68 participants (3%) indicated that restrictive practices were used due the absence of any alternative.

One participant stated that restrictive practices were used due to

> "Ability of staff to organise and manage time on the ward can lead to poor communication and lack of structured activity/interaction for patients on the ward. Staff are very reluctant to change current culture and implement a new model of care for patients that may reduce levels of use of restraint."

Another participant reported that

> "I believe that we are conditioned to believe that our decisions (as a MDT) are based on risk and 'best interest'; but not enough thought is given to thinking or discussing alternatives."

2.17 What governance arrangements are in your Trust regarding the use of restrictive practice and what does this mean to you in your daily practice?

This question was poorly answered. 32 of the 68 participants (48%) indicated that there was either no governance arrangements in their Trust regarding the use of restrictive practice, they were unsure what the governance arrangements are in their Trust regarding the use of restrictive practices, or they did not provide an answer.

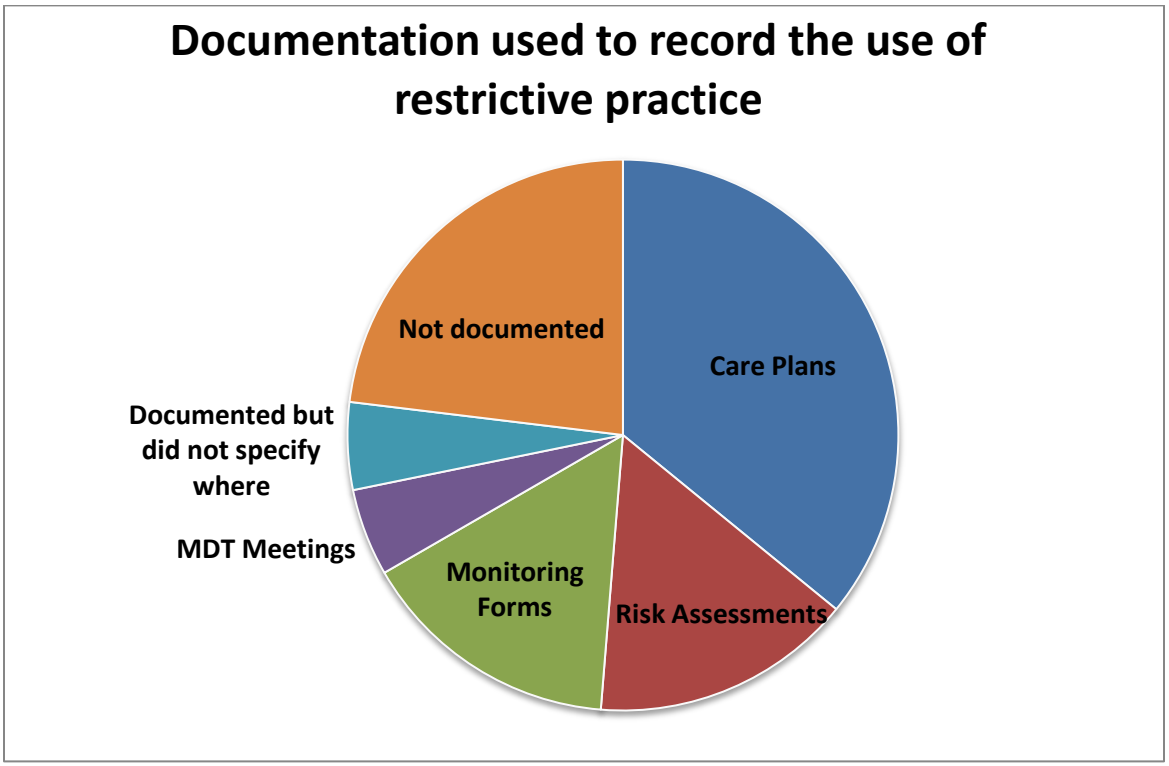
10 of the 68 participants (15%) indicated that the governance arrangements in their Trust regarding the use of restrictive practice are "RQIA inspections".

Other answers in relation to governance arrangements in Trusts regarding the use of restrictive practice included:

- Policies (6 participants; 9%);
- Supervision (4 participants; 6%);
- Incident forms (4 participants; 6%);
- Safeguarding vulnerable adults (2 participants. 3%);
- Audit (1 participant, 1.5%).

None of the 68 participants indicated how governance arrangements their Trust regarding the use of restrictive practice influenced their daily practice.

2.18 What documentation (if any) do you use to record the use of restrictive practice?



28 of the 68 participants (42%) reported that they use care plans to record the use of restrictive practice. 12 of the 68 participants (18%) reported that they use risk assessment; 12 of the 68 participants (18%) reported that they use a monitoring form as part of Trust policy on restrictive intervention; 4 of the 68 participants (6%) reported that they use the MDT team meeting review sheets.

4 of the 68 participants (6%) reported that they record the use of restrictive practice but did not specify where this is recorded.

18 of the 68 participants (27%) indicated that they do not record the use of restrictive practice.

2.19 How do you use this documentation and do you find it helpful?

Participants reported five ways in which documentation used to record restrictive practices is used.

- 6 participants (9%) indicated that it was used to ensure that the use of restrictive practice is appropriate;
- 4 participants (6%) indicated that it was used to monitor patient progress;

- 4 participants (6%) indicated that it was used to monitor use of restrictive practice;
- 2 participants (3%) indicated that it was used to ensure use of restrictive practice is safe;
- 2 participants (3%) indicated that it was used to ensure practice is recorded as restrictive.

16 of the 68 participants (24%) indicated that this documentation was useful, 20 of the 68 participants (30%) indicated that this documentation was not helpful, 12 participants (18%) indicated that this question was not applicable.

2.20 What would you find helpful to guide and inform you in relation to your practice around restrictive practices?

Participants provided a variety of response to this question.

42 participants (63%) suggested that regional guidance documents on how to identify, record, review and reduce restrictive interventions in both inpatient and community settings would be helpful.

38 participants (57%) suggested that a specific point of contact within the Trust for guidance/advice regarding restrictive practice would be useful.

35 participants (52.5%) suggested that a regional definition on what restrictive practice is would be beneficial.

34 participants (51%) suggested that specialist training in relation to restrictive practices for all staff specific to their role was necessary.

31 participants (46.5%) suggested that the opportunity to share good practice across Trusts/ region would be helpful.

27 participants (40.5%) suggested the provision of training in alternative interventions as a potential way forward.

22 participants (33%) indicated that ward specific local policy/guidance would be useful.

Other suggested ways forward included:

- Training on restrictive practice for medical staff (6 participants, 9%);
- Teams working collaboratively when children transitioning into adult services (2 participants 3%);
- The provision of clear policies around specific practices (eg covert administration of medication) (2 participants, 3 %);
- Training for registrants as part of their pre-registration training (1 participant, 1.5%);
- The identification of someone in MDT who is responsible for monitoring overall care in longer term (1 participant, 1.5%).

3.0 Good practice examples shared as part of this review

Two pieces of work that could be shared as good practice examples were identified during the review.

- Occupational therapists in Northern HSC Trust attach guidance to patients' seating to indicate how they should be used to reduce the likelihood that they are used to restrict the patient in any way.
- Two ward sisters have developed a local tool specific to their ward to help identify restrictive interventions and plan ways to reduce the level of restrictive practices in place on the ward.

Other Findings

Participants indicated that some members of the multi-disciplinary team (MDT) working in areas where restrictive practices are used, do not consider it their role to be involved in discussions or decisions regarding restrictive practices, as they are not directly involved in implementing them.

Professionals with a responsibility for oversight of patients' care and treatment in both hospital and community settings indicated that they would be guided by nursing home staff, in relation to the required frequency for review of restrictive interventions in that setting.

All of the participants shared examples of restrictive practices that are used in their clinical setting; however none of the respondents listed training in relation to positive, pro-active non aversive approaches when asked about training undertaken. This suggests that all of the staff who participated in this review are using restrictive practices in the absence of training in relation to positive, proactive non aversive approaches.

Participants highlighted that the approaches in relation to restrictive practices being used in learning disability and mental health inpatient settings do not appear to be used in other hospital setting such as acute general hospitals. For example if a patient from a dementia ward is transferred to an acute hospital setting for assessment and treatment of physical health needs, practice such as the use of cot sides that may be considered restrictive in the in learning disability and mental health inpatient setting, does not appear to be viewed in the same way in an acute hospital setting – 'the same rules do not seem to apply'.

The administration of Pro Re Nata (PRN) medication was put forward by participants as a restrictive practice. However, the question "if the administration of medication prescribed within licensed therapeutic dose to reduce acute distress, and as part of an overall therapeutic treatment plan - should this be considered a restrictive practice" was also debated amongst participants with no real consensus agreed.

Through the group and 1:1 discussions held as part of the focus groups and review of answers, it became apparent that some participants were of the understanding that RQIA do not agree with the use of restrictive practices in inpatient settings. This misunderstanding was addressed and RQIA's position in relation to the use of restrictive practices was clarified by the inspector in each case.

The Way Forward

RQIA has been commissioned by DHSSPS to undertake a formal review of the current arrangements for restraint and seclusion throughout the trusts within the next three years. The review will focus on the use of restraint and seclusion; the training provided to staff who work with patients presenting behaviours that challenge; the recording of the use of restraint and seclusion; and the role of commissioners in monitoring of the use of restraint and seclusion.

This small piece of work was not a commissioned review; therefore formal recommendations are not made. However, there are a number of steps, which if considered and implemented, could significantly improve safeguards for patients subject to a restrictive practice, and improve staff understanding and practice thereby assisting in ensuring that Human Rights are upheld. These considerations should include the following:

- a regional definition of restrictive practice could be agreed and made available. This definition should ensure that the context in which practice is occurring, should form part of the decision making to identify whether/not practice is restrictive.

- training requirements for all grades of staff, and the content of training programmes and educational programmes, could be regionally defined, particularly when staff work in specialist roles and/or facilities.

- Revised regional guidance:
  - Improve understanding and guide practice;
  - Provide consistency for the assessment of the need for the use of restrictive practices, the implementation of restrictive practices, recording of the use of restrictive practices and the review of restrictive practices;
  - Assist in the introduction of strategies to reduce the frequency of the use of restrictive practices;
  - Promote the use of positive, proactive non aversive approaches;
  - Improve the understanding of the implications for Human Rights when restrictive practices are used;
  - Improve staff confidence in decision making and practice.

- Trusts' governance arrangements for monitoring the use of restrictive practices should also be considered to ensure that:
  - The use of any restrictive practice is individually assessed, proportionate, the least restrictive measure possible and only used when there is no other option;
  - Positive, proactive non aversive approaches are used where possible, and consideration is always given to alternatives strategies
  - Staff who use restrictive practices have the appropriate knowledge, skills and experience;

- The use of any restrictive practice is recorded appropriately and reviewed regularly;
- Governance arrangements are understood by all staff, and learning disseminated to influence practice.

RQIA will share this report with the Directors of Mental Health, Learning Disability and Older People's services in each of the five HSC Trusts, the HSCB and the DHSSPS.

Appendix 1

HSC Trust	Documents Received
Belfast Health & Social Care Trust	• Physical Intervention Procedure (July 2014) • Seclusion within Learning Disability (Children and Adults) Procedure (July 2014) • Children's Positive Behaviour Support Policy (July 2014)
Northern Health & Social Care Trust	• Care Management Guidelines • Deprivation Of Liberty • Guardianship Under The Mental Health Order 1986 • Deprivation Of Liberty Powerpoint Presentation
South Eastern Heath & Social Care Trust	• Seclusion Policy (November 2013) • Observation Engagement Policy • Management Of Violence And Aggression Policy (2012) • Human Rights Module • Equality Module • Entry And Exit Policy For Acute Inpatient Units • E-Learning Portal Inc. Equality And Human Rights Awareness Training
Southern Health & Social Care Trust	• Good Practice Guidance for the use of mechanical and technological restrictive interventions within inpatient clinical settings • Management of Violence and Aggression (MOVA) Policy and Procedure • Strategies for the Management of Violence and Aggression (MOVA), MOVA strategy No. 8 : Use of Physical Intervention (RPI) • Strategies for the Management of Violence and Aggression (MOVA), MOVA strategy No. 9 : Time out from positive reinforcement • The Management of Actual or Potential Aggression (MAPA Participant workbook • The Management of Actual or Potential Aggression (MAPA) advanced worksheets 1-4 • The Management of Actual or Potential Aggression (MAPA) emergency worksheets 1-5
Western Health & Social Care Trust	• Guidance On Deprivation Of Liberty (October 2014) • Blank Positive Risk Management Plan

	• Blank Risk Management Plan • Individual Restrictive Practice Overview Form • Draft Mental Capacity Bill Powerpoint Presentation • Policy For The Use Of Restrictive Interventions With Adult Service Users • DoH Positive And Proactive Care Reducing The Need For Restrictive Interventions • Restrictive Interventions With Adult Service Users • Restrictive Practice Powerpoint Presentation WHSCT Training 2014 • Deprivation Of Liberty Safeguards: • Putting Them Into Practice Report

Siobhan Rogan
MHLD Inspector

December 2014