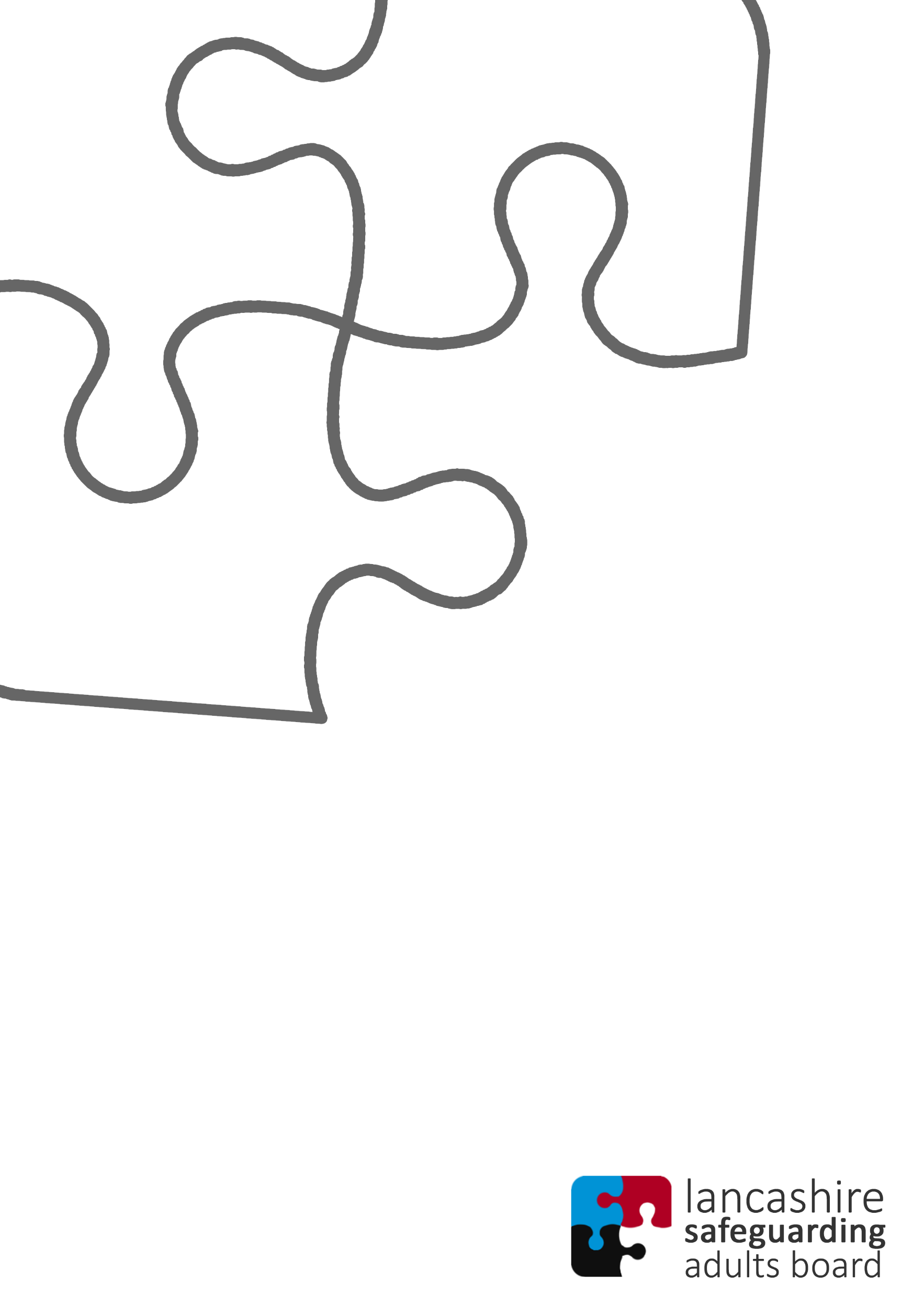
****

Audit Tool

For Provider

Services

June 2020

An Audit Tool to support **Provider Services**

with Physical Intervention, Restrictive Practice

& Positive Behavioural Support



# 4. Physical Intervention, Restrictive Practice & Positive Behavioural Support Focussed Audit Tool for Provider Services

**N.B please read and use in conjunction with the LSAB ‘Restrictive Practice’ and ‘Positive Behavioural Support Best Practice’ Guidance**

|  |  |  |  |
| --- | --- | --- | --- |
| **Location name:** |  | | |
| **Provider name:** |  | | |
| **Auditor Name:** |  | **Audit date:** |  |
| **Auditor location:** |  | **Name and position of person supporting audit:** |  |
| **Location address:** |  | **Location telephone number:** |  |
| **Type of service:** | Care home with nursing  Care home without nursing  Supported living | **Residents include:** | People with a learning disability  People with autism  People with dementia |

Questionnaire to be completed by most senior person or delegated auditor within the service (6 monthly as a minimum or more frequently as required). Whilst Care Plans are covered in section 4.1 of the audit, this tool is intended as a service review which may lead to an individual’s review of support.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **1** | **Section 1: Restraint - Physical Intervention** | | **Actions Arising / Timescale** |
| 1.1 | Do you sometimes physically intervene a person to restrict their movement? | Yes  No – If no please move to section 2 |  |
| 1.2 | **If yes,** how many people using this service have been subject to physical intervention on one or more occasions? | *Add number of people in last six month period* |  |
| 1.3 | **What types of physical intervention are used**?  Please note ‘breakaway’ is a ‘keeping safe’ technique and not a form of restrictive practice so should not be included here.  (please refer to the LSAB Restritive Practice Guidelines for further clarity) | *Please tick all that apply*  Guiding a person by linking arms  Arm Supports  Seated holds  One person guide  Two person guide  Holding a person on the bed or floor (supine – on their back)  Holding a person on the bed or floor (prone – face down)  Other physical restraint |  |
| 4 | **If other physical intervention** is used please describe. |  |  |
| 5 | Is there always enough staff on duty that are appropriately trained to carry out a physical intervention safely?  Check:   * Staff induction. * Rotas. * Training for rota's staff * BILD accredited training (as appropriate). * Training needs analysis for each resident requiring physical intervention. * Competency assessment assurance of staff using physical intervention. | Yes  No |  |
| **2** | **Section 2: Restraint - Mechanical Restraint**  the use of a device (e.g. bed rails, safe suit, arm splints, harness, helmet or strap) | | |
| 2.1 | Do you sometimes use mechanical restraints to prevent, restrict or subdue movement of person's body, or part of their body, for the purpose of maintaining the safety of the person or others? | Yes  No – if no please move to section 3 |  |
| 2.2 | **If yes,** how many people using this service have you used mechanical restraint with? |  |  |
| 2.3 | How often do you use mechanical restraint? | Daily  More than three times a week  Weekly  More than three times a month  Monthly  Every 2-3 months  Every 6 months  About once a year  Less often  Never |  |
| 2.4 | What types of mechanical restraint are used? | *Please tick all that apply*  Wheelchair belt (for reason of unsafe behaviour, not just to prevent the person falling from the wheelchair)  Harness in the car (if different from normal seatbelt)  Arm splints  Safe suit  Safe chair (that the person cannot get out of unaided)  Bed Rails  Recliner chairs  Lap straps  Other |  |
| 2.5 | **If other,** please describe? |  |  |
| **3** | **Section 3: Pharmaceutical restraint** | | |
| 3.1 | Do you sometimes use pharmaceutical restraint, including the use of PRN (as and when needed) medicines to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce extreme agitation and anxiety? | Yes  No – If no please move to section 4 |  |
| 3.2 | If yes – how many people? |  |  |
| 3.3 | If yes – how often | Daily  More than three times a week  Weekly  More than three times a month  Monthly  Every 2-3 months  Every 6 months  About once a year  Less often  Never |  |
| **4** | **Section 4: Recording of physical intervention, mechanical & pharmaceutical restraints** | | |
| 4.1 | Is use of physical intervention, mechanical & pharmaceutical restraints in **every** person’s care plan for whom it is sometimes used?  Check:   * Volume of individuals have a PI plan * Each intervention is detailed in the care plan. * Is adequate de-escalation and PBS recorded for each person? * Person centred? * Evidence of traffic light systems? * Are PRN protocols in place for pharmaceutical restraint? (and how instructive are these?). * Health Action Plan in place? (where people with learning disability are being supported?). * Communication plans and passports? * Proactive strategies? (routines, timetables, activities, environmental strategies, staff matching person centred approaches, consistency). | Yes  No |  |
| 4.2 | Is there a risk assessment for use of physical intervention, mechanical & pharmaceutical restraints for **every** person it is used with?  Check:   * Has a MDT approach has been applied? * Does it follow the Restraint Reduction Standards? | Yes  No |  |
| 4.3 | Is there (for every person who may be subject to restrictive practice) a mental capacity assessment and where a person lacks mental capacity to consent to the use of physical intervention, mechanical & pharmaceutical restraints arrangements for their care or treatment, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005?  \* **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.**  Check:   * Has an MDT approach been applied? * Where the person lacks capacity, has a Best Interests Decision been evidenced? (with MDT?). * Is there consideration of less restrictive options? * Has there been appropriate review by appropriate professionals? (e.g. GP where pharmaceutical interventions are being used) * DoLs application/consideration? | Yes  No |  |
| 4.4 | Describe how physical intervention, mechanical & pharmaceutical restraints are recorded?  Consider:  Daily care records  Debrief/Incident reports  Serious Incident/STEIS reports  Behavioural recording charts  Reflective Practice records  Supervision discussion  Team meetings  Review and Analysis  Near Misses  Not recorded  Other |  |  |
| 4.5 | Describe how physical intervention, mechanical & pharmaceutical restraints are monitored?  Consider:  Reviewing relevant written records of use of restraint.  Monitoring CCTV footage.  Functional Analysis of all incident reports, monitoring review analysis.  Not formally monitored  Other |  |  |
| **5** | **Section 5: Seclusion**  Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Mental Health Act Code of Practice, DoH, defined at paragraph 26.103).  **Where seclusion has been necessary and immediate but has not been included in the persons Multi Agency care plan, check safeguarding referrals have been made and consideration of the Mental Health Act for assessment as appropriate.** | | |
| 5.1 | Are there any people that you sometimes ask to go to their bedrooms or a specific area in the house or garden due to their behaviour? | Yes  No – if no please move to section 6 |  |
| 5.2 | Please state:  Is there a designated seclusion facility in place?  Yes  No  Is there a non-designated area used for the purpose of seclusion?  Consider:  Person’s bedroom, lounge areas etc.  Yes  No | If yes: does the facility meet the requirements of the MHA Code of Practice 2015, and follow the following key requirements:  Can staff clearly observe and communicate with the Individual?  Can staff clearly observe and communicate with the individual and/or ‘time out’?  Is the environment well insulated and ventilated, with temperature controls outside the room?  Have access to toilet and washing facilities?  Has furniture, windows and doors that can withstand damage?  Anti ligature points? |  |
| 5.3 | **If yes,** does the service have a robust seclusion policy that complies with the following standards (NICE): | Appropriate documentation / recording of seclusion?  Regular reviews (2 hourly)  Appropriate staff observation (within eyesight)?  Appropriately trained staff?  Appropriate debrief / post incident review? |  |
| 5.4 | What are the circumstances in which seclusion occurs i.e. reason why? | Safety of staff.  Safety of other people using the service.  Safety of the individual.  The person wanted to be away from other people.  Unsuitable physical environment e.g. lack of space.  Unsafe fixtures and fittings which could cause harm to the person.  Staffing levels (not enough staff to provide level of support needed).  Staff lack expertise to support the person.  You think this is not a suitable place for this person’s needs to be met.  Other (please specify). |  |
| 5.5 | How often is this intervention used in this service? | More than once day.  Daily.  One or more times a week.  More than once a month.  Occasionally – less than once every three months.  Rarely – less than once a year.  Never. |  |
| 5.6 | Evidence how you record the use of this intervention? | *Please tick all that apply*  Does the care planning for residents requiring behavioural management strategies include:  Service user history and relevant diagnosis.  Advanced care planning – where residents can describe how they wish to be cared for in certain situations (i.e. favouring holds, seclusion/LSE or medication).  Preventative and proactive interventions used.  Triggers to behaviour, examples of past incidences/situations that have led to escalation in behaviour.  Antecedents to triggers and measures to best prevent – including environmental, staff approaches, communication, distraction methods.  Step by step approach to best manage behaviours at various points in the escalation phase.  Detail around how to manage worst case scenarios, including staff intervention, documentation and medical review as required.  Detail relating to how best support the service user post incident (recovery stage) and how to prevent further escalation.  Care plans must include debrief for both service user and those involved (staff)  Detail of care review – MDT / Medical review |  |
| 5.7 | How do you monitor use of this intervention? | *Please tick all that apply*  Reviewing relevant written records of use of restraint.  Monitoring CCTV footage.  Functional analysis of all incident reports, monitoring review analysis.  Not formally monitored.  Other. |  |
| 5.8 | Do the people that you use this intervention for have a DoLs in place? (If applied for please answer yes) | Yes, for all people that it applies.  No.  In some cases. |  |
| 5.9 | Has there been a mental capacity assessment completed for this intervention? (asking somebody to go and spend time alone) and where a person lacks mental capacity to consent, a record in their file of a best interest process in accordance with the Mental Capacity Act 2005  \* **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.** | Yes  No |  |
| **6** | **Segregation** (Caring for people separately to other people using the service) **& Long Term Segregation** | | |
| 6.1 | Do you have anyone that you care for that is isolated from others? This could be in their bedroom or self-contained flat. It should still be considered as segregation even if the person is allowed periods of interaction with staff and peers? It is always considered segregation when it isn’t the persons choice. | Yes  No – if no please move to section 6 |  |
| 6.2 | How many people are living in isolation from others? (If multiple, review 6.3 – 6.11 for a cross sector of people). |  |  |
| 6.3 | Where does the segregation occur? | It is in a self-contained flat in supported living setting  It is within the care home |  |
| 6.4 | How would you describe the segregation arrangement? | It is a long-term living arrangement  It is just used temporarily (i.e. the person has to stay in a room/place where they don’t normally)  It is a response to an infection prevention concern.  It is the person’s choice. |  |
| 6.5 | What is the main reason for people being supported separately to others using this service? | The service is designed to be supported living with self-contained flats.  The person does not want to live with others and this is documented in their care plan.  The person is unable to live with others for their own safety.  The person is not able to live with others for the safety of others.  Decision made by commissioners.  Other adaptations in place based on persons diagnosis and medical history (please state). |  |
| ***If you answered ‘it is just temporary’ to question 6.4, please answer 6.6 - 6.9, otherwise please skip to 6.10*** | | | |
| 6.6 | If the segregation is temporary how do you record its use?  *Consider:*  Daily care records  Debrief/Incident reports  Serious Incident/STEIS reports  Behavioural recording charts  Reflective Practice records  Supervision discussion  Team meetings  Review and Analysis  Near Misses  Not recorded  Other |  |  |
| 6.7 | **If other method of recording used**, please describe |  |  |
| 6.8 | Evidence how you monitor the appropriateness of providing this care?  *Consider:*  Care plan reviews.  Internal review of relevant records.  Statutory review.  Reports to, and reviews by the commissioning authority.  Audits in place to review segregation arrangements.  Other. |  |  |
| 6.9 | **If other method of monitoring used**, please describe. |  |  |
| 6.10 | Do the people that you use this arrangement for have a DoLs in place? | Yes  No |  |
| 6.11 | Has there been a mental capacity assessment completed for this and where a person lacks mental capacity to consent to being cared for separately to others using the service is there a record in their file of a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards?  \* **Please note where care is being delivered to the individual within the provisions of the Mental Health Act 1983, the need for less restrictive practice and best interests should still be considered.** | Yes  No |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **7** | **Section 7 - Oversight Questions** | | |
| 7.1 | Where you are monitoring the use of restraint, seclusion or segregation and the frequency or type has increased, have you referred this back to the specialists and local authority for advice? | Yes  No  We would but this hasn’t happened yet |  |
| 7.2 | Do you monitor the staff involved in restraints to see if there is any pattern, e.g. if some staff restrain more than others?   * What audits do you have in place? * What trends are identified? | Yes  No |  |
| **8** | **Section 8: Minimising Restrictive Practice** | | |
| 8.1 | Is there a written plan to work actively to reduce/minimise the use of restrictive practice for every person where physical intervention, mechanical or pharmaceutical restraint is currently used? | Yes  No |  |
| 8.2 | Where staff use a form of restraint with a person, how do you ensure the person is safeguarded from abuse?  Training – All training must comply with the Restraint Reduction Network Training Standards 2019. Services must provide evidence of all trained staff including:   * Audit of need (training needs analysis). * Copy of completion certificates. * Training matrix detailing annual refreshers. * Physical intervention evaluation sheets. * Completed theory assessments. * Reflective practice document (incident analysis.) * Competency in relevant training (safeguarding, whistleblowing etc.). * Evidence of whistle blowing policy and staff notices up on site. * Clear statement of purpose or similar detailing providers stance on abuse. * Evidence of post incident debriefs. * Transparency with regard to incident reporting and that it is shared with MDT’s. * Daily logs / body maps being reflective of incidents. * Any uses of unprescribed restraint are reported and investigated thoroughly to ensure it was reasonable, proportionate and necessary. * Regular review of care plans and risk assessments to show evidence of lessons learnt. * Competence assessment for staff by the manager. * Episodes of restraint reported to CQC, commissioning authority and safeguarding (as appropriate), person’s family/advocate. |  |  |
| **9** | **Section 9: Actively seeking feedback** | | |
| 9.1 | Do you actively seek feedback? This could be from the individual, internal staff, visiting professionals and relatives. | Yes  No |  |
| 9.2 | Evidence how you ensure that feedback is captured from all parties?  Consider:  Whistleblowing policy is on display.  Safeguarding poster is on display.  Complaints policy is on display.  Regular relative meeting.  Regular staff meetings.  Anonymous suggestions box.  Relatives 1-1 review sessions.  Regular staff supervision in line with company policy. |  |  |