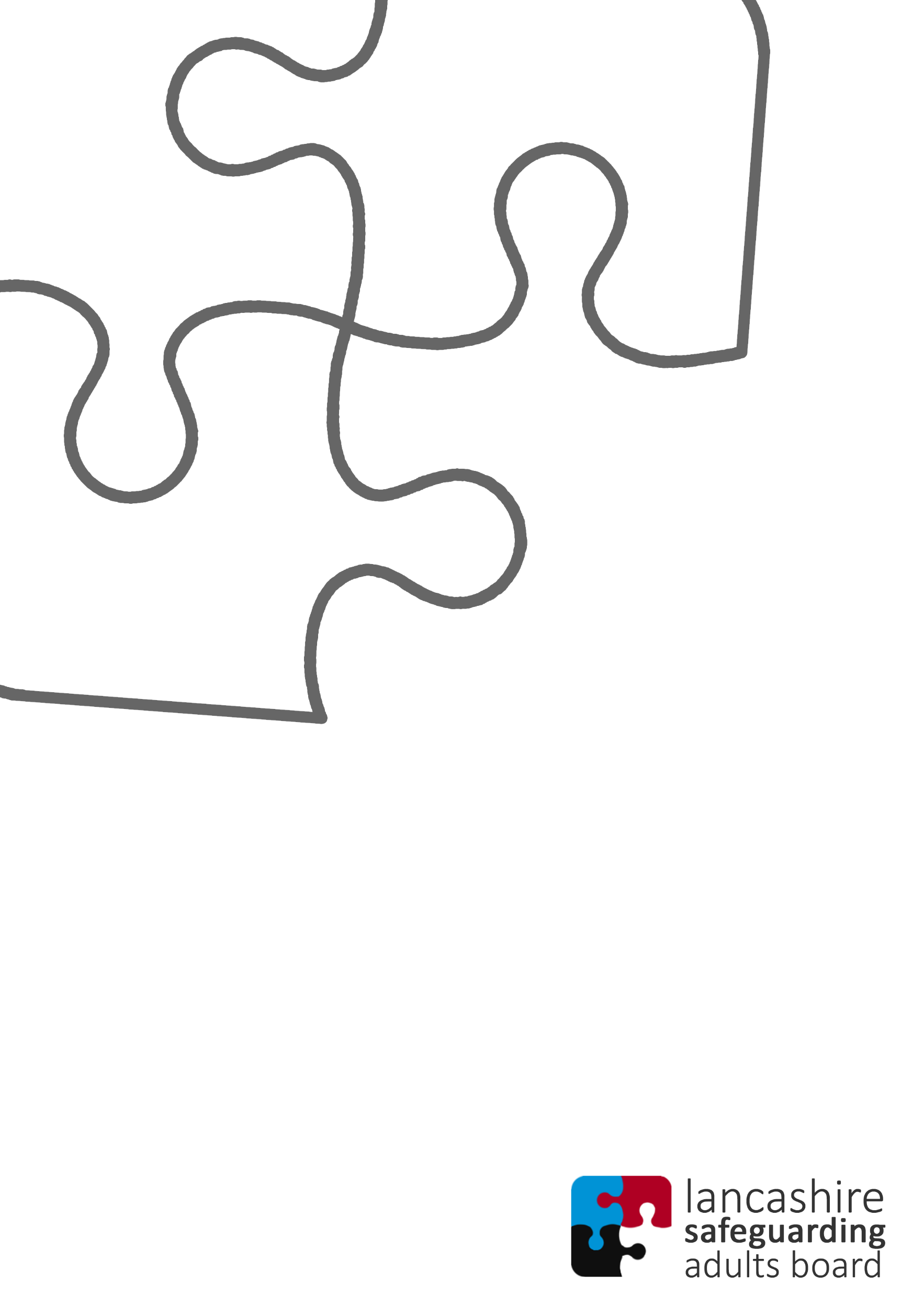
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Audit

Tool for

Commissioners

June 2020

An Audit Tool for Commissioners to support

Physical Intervention, Restrictive Practice

& Positive Behavioural Support



# 5. Physical Intervention, Restrictive Practice & Positive Behavioural Support Focussed Audit Tool for Commissioners

Questionnaire to be completed by Commissioner/Contracts Officer with registered manager/provider or most senior person available

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |

|  |  |  |
| --- | --- | --- |
| **1** | **Section 1: Restraint - Physical Intervention** | |
| 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 Restrictive Practice Guidelines for further clarity) | *Please tick all that apply*  Guiding walk / simple arm hold  One / two person arm holds (standing)  One / two person holds (Seated)  Although no longer recommended, are there instances where the following are used;  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  Safeguarding triggers: |
| 1.4 | **If other physical intervention** is used please describe. |  |
| 1.5 | 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 approved 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 an 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? * Any safeguarding concerns? | Yes  No |
| 4.4 | How is physical intervention, mechanical & pharmaceutical restraints recorded? | *Please tick all that apply*  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 | How is physical intervention, mechanical & pharmaceutical restraints monitored? | *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** | **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 | Does the service have a designated seclusion facility? | Yes  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?  No |
| 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  **Safeguarding indicators**:  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 |
| 5.5 | How often is this intervention used in this service? | More than once a 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 | How does the provider record the use of this intervention? | *Please tick all that apply*  Care planning for residents requiring behavioural management strategies must 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, Court of Protection DoL or Welfare Order 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 person's 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? | *Please tick all that apply*  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 | How do you monitor the appropriateness of this way of providing care? | *Please tick all that apply*  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, Court of Protection DoL or Welfare Order 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 of the use of restraint, seclusion or segregation shows 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 does the provider have in place? | 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 assessment.  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 | Is the service actively seeking feedback? This could be from the individual, internal staff, visiting professionals and relatives. | Yes  No |
| 9.2 | How do you ensure that feedback is captured from all parties? | 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  Staff 1:1  Visiting professionals  Patients/service users  others |
| 9.3 | Is feedback regularly reviewed? | Audits of suggestions box  Complaints response folder  Supervision audit |
| **10** | **Section 10: Question for the Contract Monitoring Officer** | |
| 10.1 | At the end of this focussed audit, did you have any concerns about the use of restrictive interventions at this location? | Yes  No |
| 10.2 | If yes what action will you take? | Safeguarding alert for one person  Safeguarding alert for more than one person  Contacted local authority to raise concern about provider/location  Management review to discuss enforcement action - type of enforcement not yet decided  MDT referral  Share information with out of area commissioners  Report to the police  Contract default notice  Suspension notice  Share intelligence to RADAR |