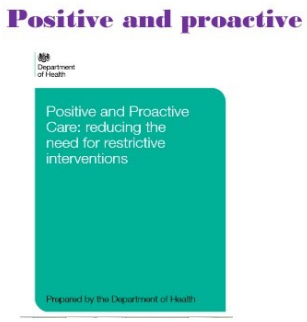
January 2016

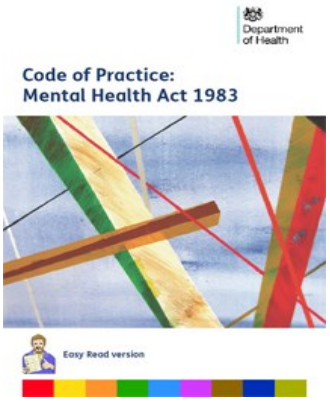
Yorkshire and Humber Involvement Network

Least Restrictive Practice Bulletin

At the first meeting of the Least Restrictive Practice project group we did lots of group work to have a think about what Restrictive practice means to everyone as it is potentially such a large topic area. Some people think solely about seclusion and restraint for example, whereas for others the majority of things we do can be deemed as being restrictive. We wanted to look at this topic in its widest sense. We looked first at the question "What does restrictive practice mean to you?" then "If restrictive practice is deemed to be unavoidable—how should it be monitored and carried out?" We then went on to look at the definition of restrictive interventions according to the Code of Practice and asked everyone to think about any times where it might be necessary to restrict someone and why? We finished off the group work by looking at what we can do to reduce restrictive practice, and finally planning for the future—what does everyone want to look at next time and in future groups. All the group work can be found throughout this bulletin.

We also looked at the new code of practice and what that says about restrictive practice, and we talked about Positive and Proactive Care: reducing the need for restrictive interventions.





Contents

Least Restrictive Practice Group Agenda

9th December 2015 14.00 - 16.00

1. Welcome and Introductions
2. **Group work** – What does Least Restrictive Practice mean to you?
3. The Code of Practice – Benefits and Challenges

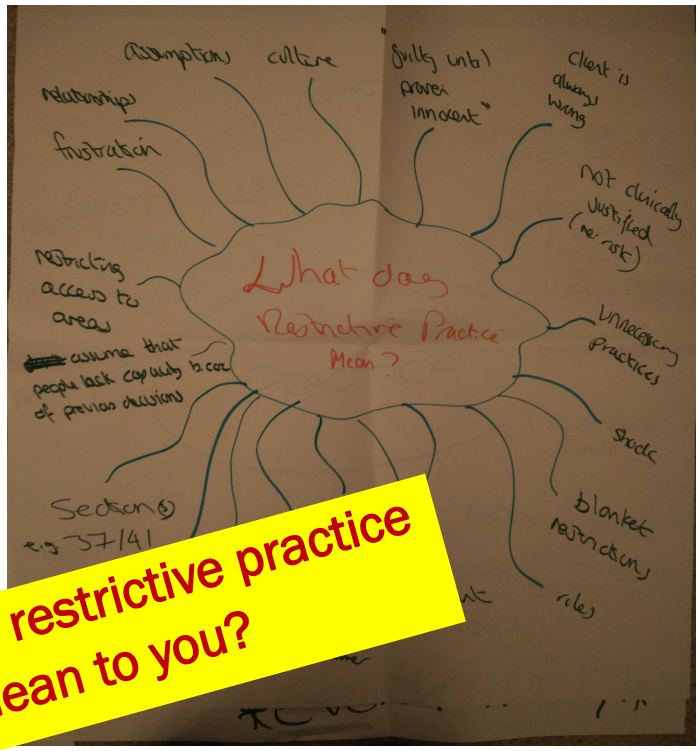
4. **Group work** – Planning the work stream for the future
5. Planning next agenda

Date of next meetings: To be confirmed on the day

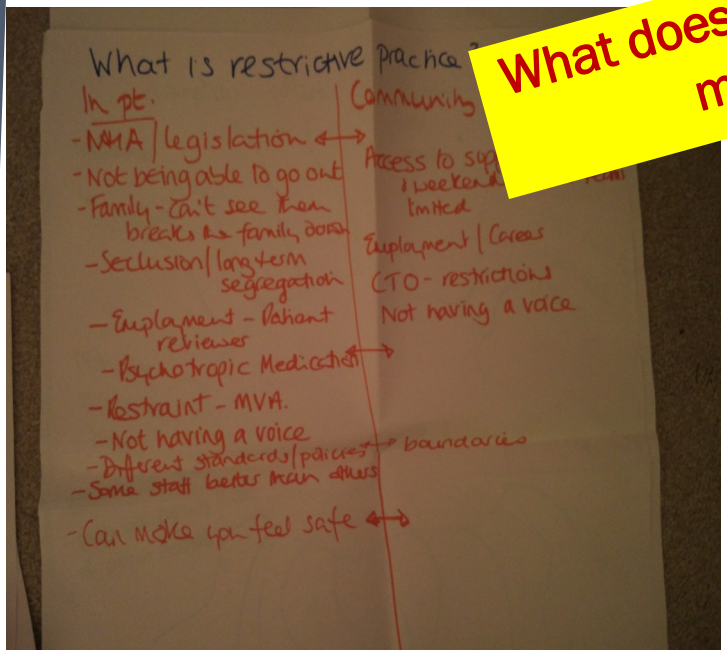
Developed by Holly Alix and Jo Harris on behalf of the Yorkshire and Humber Secure Services

Least Restrictive Practice Group work

Assumptions. Culture
Guilty until patient innocent
Client is always wrong
Not clinically justified re: risk
Unnecessary practice. Shock
Blanket restrictions. Rules
Restraint. Abuse of power
Punitive. Isolation
Old habits. Contraband rules
Sections e.g. 37/41
Assume that people lack capacity because of previous decisions
Restrictive access to areas
Frustration. Relationships

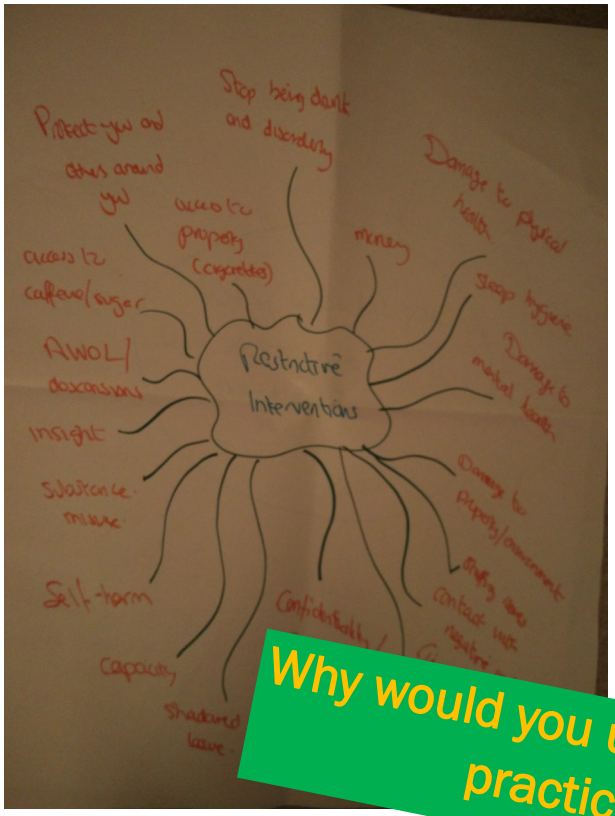


What does restrictive practice mean to you?

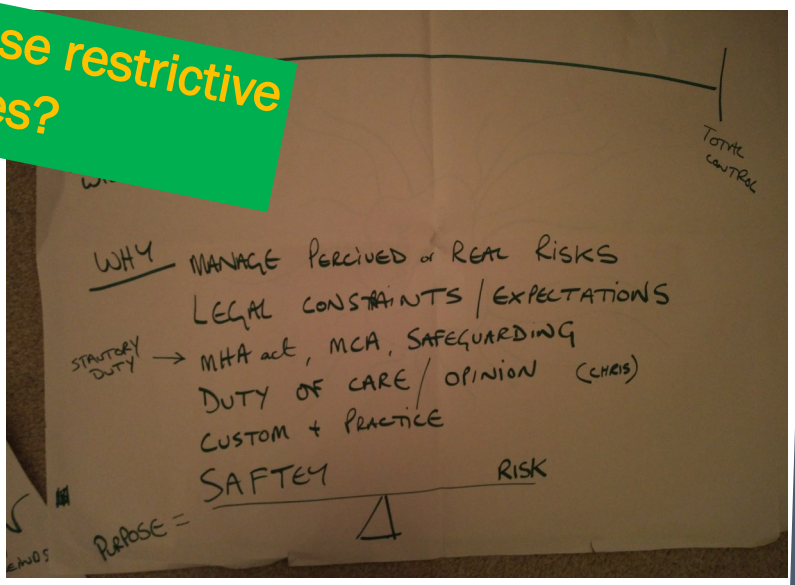


Movement. Leave
Banned items. Controlled items
Mealtimes (time, choice, amount
Routines. Smoking
Sleeping times
Association (family/friends)
Possessions. Facilities
Money. Legal
Physical and psychological
Activities
**Everything!

MHA legislation
Not being able to go out
Family—cant see them—breaks the family down
Seclusions/ long term segregation
Employment—patient reviewer
Psychotropic medication
Restraint—MVA
Not having a voice
Different standards/policies—boundaries
Some staff better than others
Can make us feel safe
Community—
CTO restrictions. Employment/careers.
Access to support overlaps—at weekends crisis team limited.



Why would you use restrictive practices?



Do what thou will - Total Control

Why?

Manage perceived or real risks

Legal constraints/ expectations

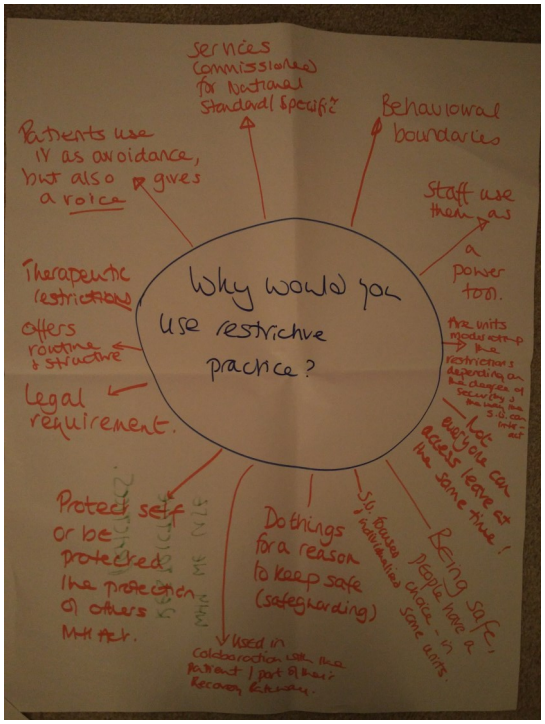
Statutory duty—MHA, MCA, safeguarding

Duty of care/ opinion

Custom and practice

Safety

Purpose = balance between safety and Risk



Patients use it as avoidance but also gives a voice

Therapeutic restrictions

Offers routine and structure

Legal requirement

Protect self or be protected—the protection of others—

MHA Services commissioned for national standards/ specific

Behavioural boundaries

Staff use them as a power tool

The units moderate the restrictions depending on the degree of security and the way the service user can interact

Being safe

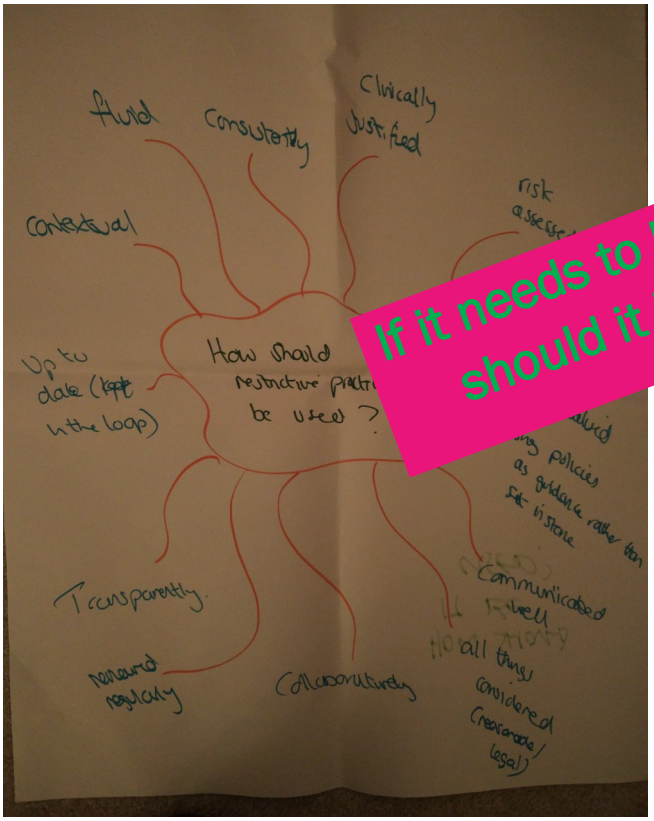
People have a choice in some units

Service user focused and individualised

Do things for a reason—to keep safe (safeguarding

Used in collaboration with the patient—part of recovery journey

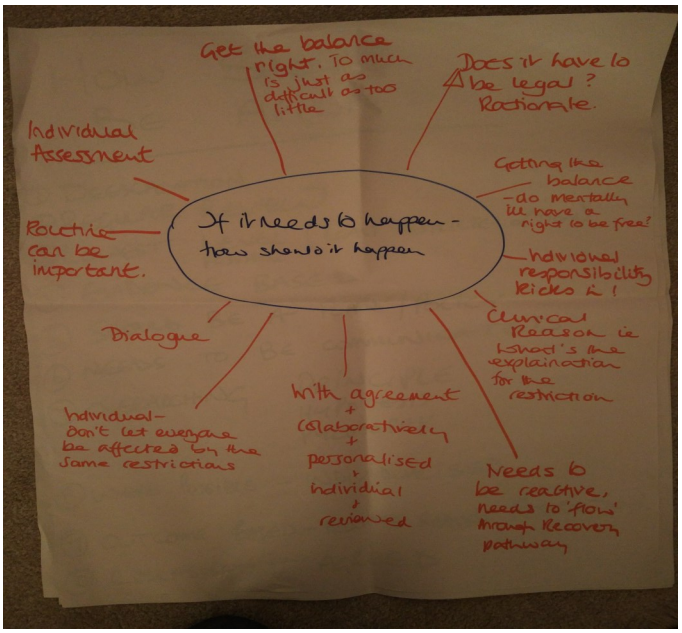
de-escalation
Regular review
Lowest level possible (least restrictive of options
Evidence based
Should be a plan/ policy in place
Needs to be communicated
Overarching principle, hypothesis and philosophy
Where possible—individualised
Outcomes based—how to reduce restrictions
Collaboratively agreed

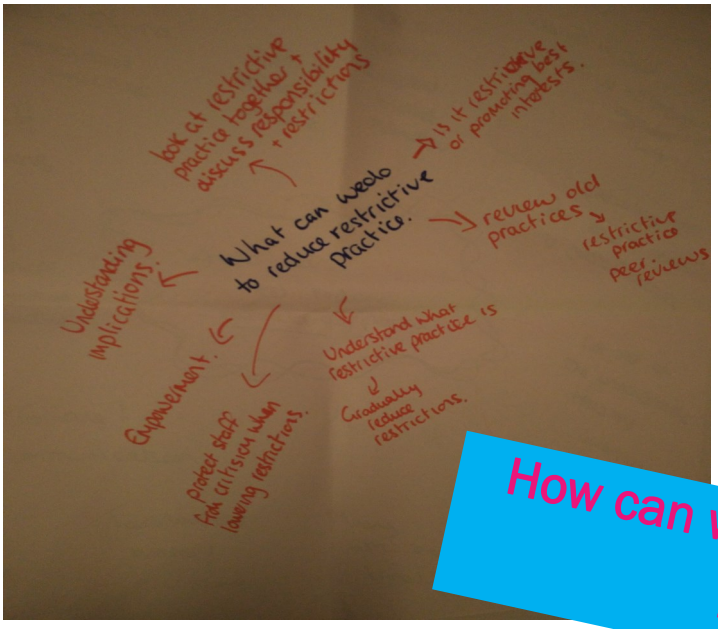


If it needs to be used—how should it be applied?

Fluid. Consistency
Clinically justified
Risk assessed
Contextual
Up to date—in the loop
Transparency
Reviewed regularly
Collaboratively
All things considered (reasonable and legal)
Communicated well
Individualised
Using policies as guidance rather than set in stone

Get the balance right—too much is just as difficult as too little
Does it have to be legal? Rationale
Getting the balance—do the mentally ill have a right to be free?
Individual responsibility kicks in!
Clinical reason i.e. what is the explanation for the restriction
Needs to =be reactive—needs to “flow” through the recovery pathway
With agreement and collaboratively and personalised and individual and reviewed
Individual—don’t let everyone be affected by the same restrictions
Dialogue. Routine can be important
Individual assessment





Look at restrictive practices together and discuss responsibility and restrictions

Is it restrictive or promoting best interests?

Review old practices—restrictive practice and peer reviews

Understand what restrictive practice is

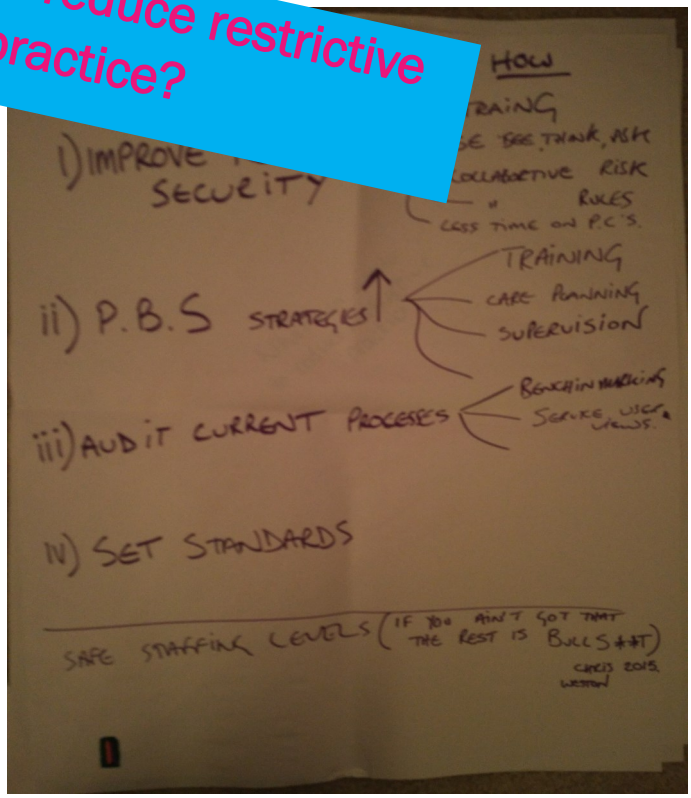
Gradually reduce restrictions

Protect staff from criticisms when lowering restrictions

Empowerment

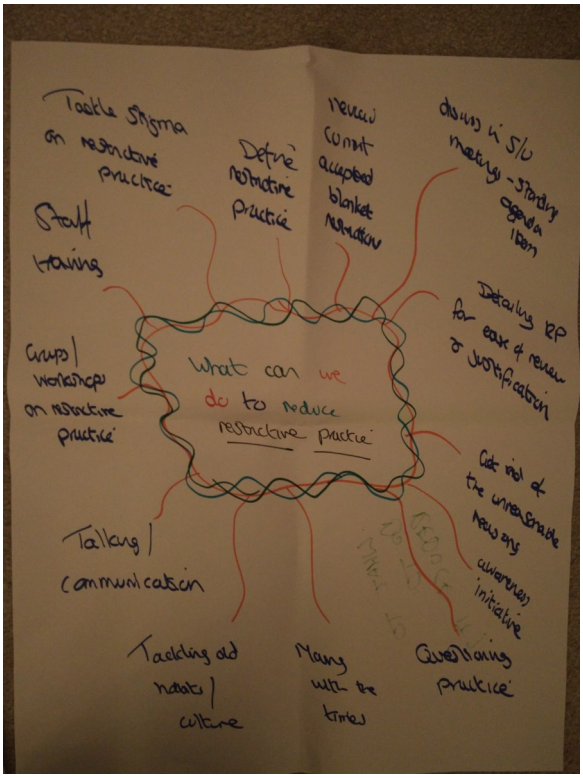
Understanding implications

How can we reduce restrictive practice?



1. Improve relational security
 - Training, - use See think act
 - Collaboratively risk assess collaborative rules
 - Less time on computers
2. Increase positive behaviour support strategies
 - Training
 - Care planning
 - Supervisions
3. Audit current processes
 - Benchmarking
 - Service user views
4. Set standards

** Safe staffing levels (if you do not have them then the rest is B*ll sh*t



Tackle stigma on restrictive practice

Staff training

Define restrictive practice

Review current accepted blanket restrictions

Discuss in service user meeting—standing agenda item

Detailing restrictive practice for ease of review and justification

Get rid of unreasonable restrictions

Questioning practice

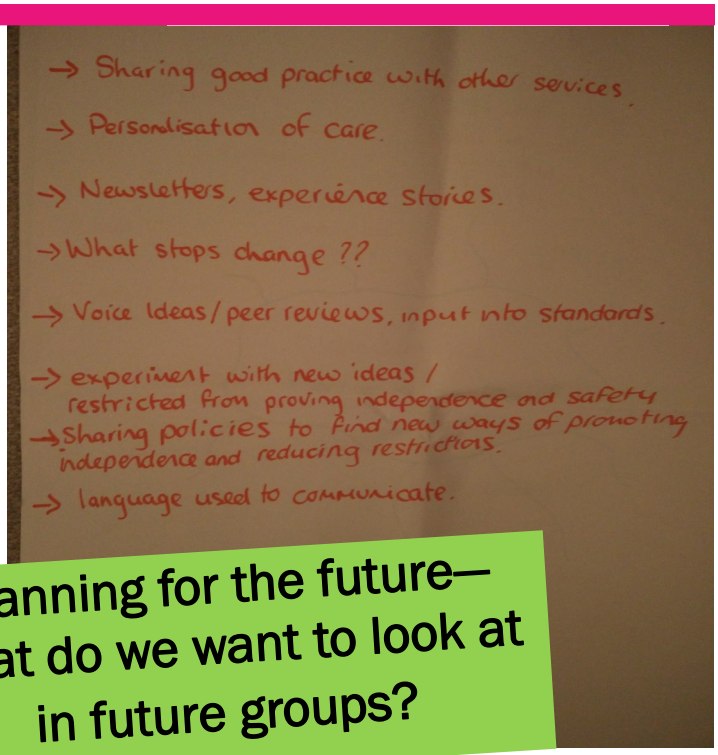
Moving with the times

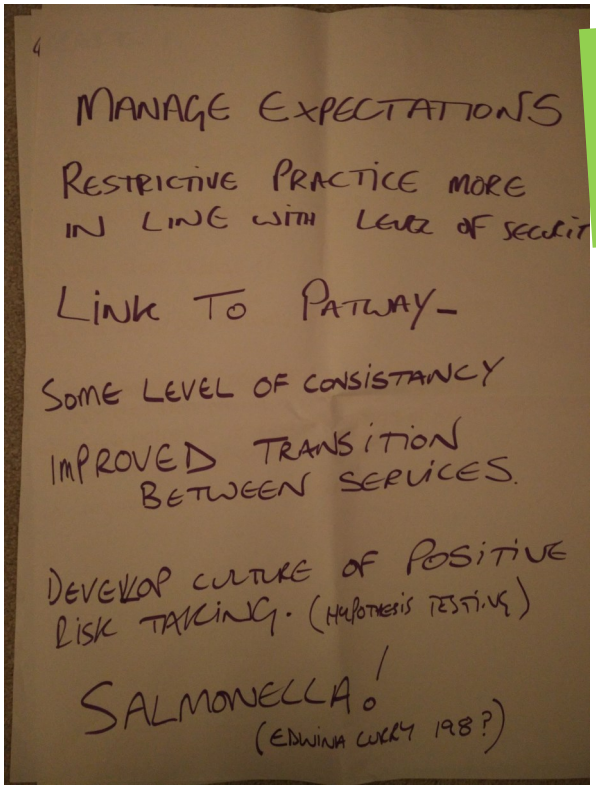
Tackling old habits/ culture

Talking and communication

Groups/ workshops on restrictive practice

Sharing good practice with other services
Personalisation of care
Newsletters, experience stories
What stops change?
Voice ideas/ peer reviews, input into standards
Experiment with new ideas/ restricted from providing independence and safety
Sharing policies to find new ways of promoting independence and reducing restrictions
Language used to communicate

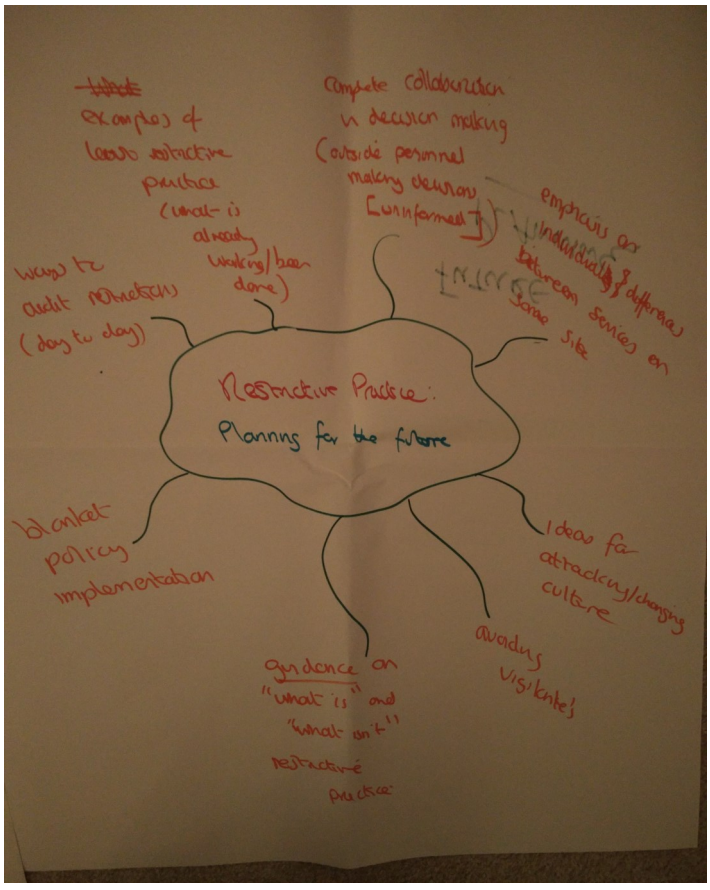




Planning for the future— what do we want to look at in future groups?

Manage expectations
Restrictive practice more in line with level of security
Link to pathway
Some level of consistency
Improved transition between services
Develop a culture of positive risk taking (hypothesis testing)
Salmonella (Edwina Curry 198?)

Examples of least restrictive practice (what is already working/ being done)
Complete collaboration in decision making (outside persons making decisions - uninformed)
Emphasis on individual differences between services on same site
Idea for attacking/ changing culture
Avoiding vigilantes
Guidance on "what is" and "what isn't" restrictive
Blanket policy implementation
Ways to audit restrictions (day to day)



Becoming a CQUIN? What will the guidance say?

Least Restrictive Practice Project Group

Friday 11th March 2016

Sandal Rugby Club Wakefield

2 – 4 pm

Refreshments Provided

Role Description for attending Yorkshire and Humber Network meetings:

Represent your service and share experiences and ideas

Celebrate achievements and share learning

Find out what is happening in other services

Give your perspective

Meet staff and service users from other services

Take back and share what you have learnt with people in your service