

Use of Restrictive Practice in NAS Schools and Services (Policy and Procedure)

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1. Scope

This policy applies to all National Autistic Society services that provide for children, young people and adults where the National Autistic Society has a duty of care.

2. Purpose

The purpose of this policy document is:

1. To state the National Autistic Society's philosophy towards restrictive practice (s) within the relevant legal and regulatory framework.
2. To give guidance to staff in order to enable them to be clear as to what forms of restrictive practices are permissible and when they should be considered.
3. To give clear guidance to staff about which forms of restrictive practices are never acceptable and the reasons for this.
4. To ensure that the use of restrictive practices are minimized and clear reduction plan (s) and strategies exist for those where restrictive practice is necessary.

The rights and dignity of people who use National Autistic Society services, even when behaving in a physically challenging way, must always be borne in mind. Any restrictive practice must be used with a view to keeping them and others safe, with the aim of allowing the individual not only to recover self-control, but also to acquire alternative adaptive behaviours that, over time, decrease the level of intervention needed.

NOTE - Procedure for admission to a school or service where an individual is dependent on seclusion or restraint to manage his or her behaviour must be read in conjunction with this Policy (Related Document - SO-0039-005-0617).

3. Introduction

Autistic individuals sometimes behave in ways that others can find challenging and which, on some occasions, may be dangerous; potentially resulting in harm to the person displaying the behaviour, peers, staff or the public. Such behaviours may initially appear to be unpredictable and can be frightening for all concerned including the person displaying the behaviour.

Across the United Kingdom, the primary duty of the National Autistic Society as a care and education provider is to ensure the people we support are safe from harm. The fundamental but complex need to balance the right to freedom, dignity and respect, with ensuring safety from harm is at the heart of this policy and guidance.

There are a variety of approaches and strategies that can be used to prevent situations from developing into incidents likely to cause harm such as: de-escalation, low arousal techniques and other examples of Positive Behaviour Support – refer to Behaviour Support in Schools & Adult Services policy (SO-0029). However, on some occasions it may be necessary to use, as a last resort, a strategy that includes a restrictive practice. Any form of restrictive practice will only be used in order to maintain the welfare and safety of the people we support and others.

Staff will be trained in approved techniques and any unplanned interventions outside of an individual's positive behaviour support plan will be investigated to ensure that action taken was proportionate and applicable at the time to prevent harm to the individual or others.

4. Legal context

British Institute of Learning Disabilities define a restrictive practice as:

'The implementation of any practice or practices that restrict an individual's movement, liberty and freedom to act independently without coercion or consequence. Restrictive practices are highly coercive actions that are deliberately enacted to prevent a person from pursuing a particular course of action' - BILD Code of practice 4th edition.

Regarding physical intervention, the crux of common law (both criminal and civil) is that;

- Any threat of non-consensual touching is an **assault**,
- Any actual touching is **battery**
- Any wrongful hindrance to mobility is **false imprisonment**.

The law recognises that there are situations where some restrictive practice is necessary as an act of care. For example, if someone has a learning disability, mental illness or related disorder, that puts someone at risk, carers may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the carer must do what is reasonable to protect the person from reasonably foreseeable harm. If someone's actions could put other people at risk, staff have a duty of care to respond positively, which might include as a last resort restraining the person to prevent harm.

For the National Autistic Societies Services in Scotland Only - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 or implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers. See also the Safeguarding Board Act (Northern Ireland) 2011 and Mental Capacity Act (Northern Ireland) 2016.

Restraint exercised without legal authority may be a criminal offence. In the circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Any physical act which causes injury, affront or harm to a victim could constitute an assault if there is no lawful justification for its use. Common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm. No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law. No client should be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or other clients.

A restrictive practice is only justified in law if there is the presence of a clear and **immediate danger**. The term 'immediate' in this context refers to seconds as opposed to minutes. It does not justify action taken to prevent a possible danger unless incident data clearly shows that a given behaviour or cue quickly results in escalation to a dangerous level, in which case a planned intervention may be justified in the short term, whilst further more positive and proactive strategies are developed (See British Institute of Learning Disabilities Code of Practice).

As well as the presence of a clear and immediate danger staff must also be able to demonstrate that all other available less restrictive options have been tried and failed before the use of a restrictive practice. A useful acronym in this situation is 'TINA' - There Is No Alternative.

The Managing Challenging Behaviour framework and training offers guidance and a series of non-restrictive and non-aversive techniques to avoid/reduce the use of restrictive practices. There is an expectation that alternatives to a restrictive practice would increase with staff training, experience and knowledge of the individual.

If you can find no alternative to using a restrictive practice then you should use it. (Examples of Non Restrictive Practice see Related Document - SO-0039-002-0617)

- **Duty of Care** – National Autistic Society staff have a duty of care towards the people supported, which requires the organization to take reasonable care to avoid doing something or failing to do something which results in harm to another person. There are situations where some action must be taken and it is a matter of choosing the course of action that would result in the least harm.
- **Best Interest** - The principle of best interest applies. A member of staff must demonstrate that in the presence of a clear and immediate danger they have considered all available alternatives, acted in the best interest of the person in their charge, have considered that not acting could result in greater harm, and does not use unreasonable or excessive force, then the action can be defended in law.
- **Reasonable & Proportionate** - Any force used must be 'reasonable and proportionate', reasonable in that it is the minimum force required to prevent injury and proportionate in that it is not excessive given the seriousness and likely

harmful consequences of the person's behaviour. As with all issues to do with caring for, developing and teaching the children, young people and adults we support, decisions need to be made on the best available knowledge at the time.

A useful concept to bear in mind when carrying out any restrictive practice is that of **Social Validity**. During any restrictive practice we should be conscious both of how our intervention may look to others not involved in the interaction and how we would like ourselves, family members or friends to be interacted with in similar circumstances.

5.Restrictive Physical Interventions

All those supported by the National Autistic Society who require any form of behavioural intervention will have a Positive Behaviour Support Plan / Positive Individual Support Plan that provides detailed information relating to all aspects of a person's behaviour and how to support them.

The plan is person centred in its approach setting out details about the individual's behaviours including hypotheses about the functions of a particular behaviour, known as contributory environmental factors, antecedents, triggers, as well as how known behaviours should be recorded when they occur. Whenever possible the plan ought to be produced in collaboration with the autistic individual. The plan described the proactive and reactive strategies that are to be followed by those supporting the individual to improve the person's quality of life and reduce the risk of harm to themselves or others.

Part of this reactive plan may include restrictive practices where necessary and deemed in an individuals' best interest.

Where someone has capacity to consent, then they need to agree and sign their plan. Where someone does not have capacity, the plan must be agreed as in their best interest by the relevant people involved in their care.

Restrictive practices can take several forms and may not always involve direct physical force but also chemical restraint, Pro-re-nata (PRN) medication (in the form of sedation), rapid tranquilization, mechanical restraint and environmental restraint, such as the holding of doors or blocking access by use of a person. The use of any PRN will be guided by a specific and individual protocol from the prescribing medical professional. (See Related Document - SO-0039-002-0617 for further detail).

Restrictive practices can be categorised as planned or unplanned practices:

- 5.1 **Planned Restrictive Practice** - pre-arranged interventions based on risk assessments and clearly recorded in care and positive behaviour support plans. These interventions should be Studio 3 / Positive Behaviour Management sanctioned techniques and staff will be fully trained to carry out these interventions. They will be agreed as in an individual's best interest and as the least restrictive intervention and used for the least amount of time possible (when the present and immediate danger has passed). The time frame for reporting the use of a Planned Restrictive Practice is within 24 hours of the Practice/Intervention taking place.

- 5.2 **Unplanned Restrictive practices** - an action used in response to unforeseen hazardous events such as a person supported is about to run out in front of a car and There Is No other Alternative. The time frame for reporting the use of an Unplanned Restrictive Practice is within 24 hours of the Practice/Intervention taking place.
- 5.3 Wherever possible, an unplanned response should still be a Studio 3 / Positive Behaviour Management sanctioned and trained technique. However, in an emergency situation if this was not practicable, but an intervention is still urgently needed to prevent harm to self and/or others, staff must follow the legal principles laid out at the start of this policy and the Managing Challenging Behaviour training, by providing a reasonable and proportionate response.
- 5.4 Where unplanned or unintentional incidents of restrictive practices occur they should always be recorded, opportunity given to debrief, followed by a reflective session to ensure learning and continuous safety improvements.
- 5.5 If monitoring shows that an unplanned restrictive practice is required on more than one occasion in a 4 week period the individual behaviour support plan/Individual Behaviour Support Plan and risk assessments should be amended to include a planned restrictive practices, along with proactive measures to reduce the need for such interventions over time.
- 5.6 **Unacceptable and dangerous intervention** - There are a number of interventions that are either unacceptable, dangerous and often both:
- Prone restraint - Chest on floor / other surface
 - Supine restraint - Back on floor / other surface
 - Any restraint using the locking of joints
 - Any restraint using pain to achieve compliance
 - Any restraint that involves forcing the head forward onto the chest area.

The above interventions should be avoided even in emergency situations unless the situation is life threatening. Particular care should be taken with any Physical Practice involving a person with underlying health problems such as swallowing, obesity or heart problems.

When assessing the needs of any individual that requires the use of a restrictive practice as part of their support plan, it is essential that advice is sought from the relevant medical professionals around the use of such practices for the individual when underlying medical conditions are diagnosed and/or apparent.

The following processes should be applied and followed;

- Underlying medical issues identified at assessment stage
- Advice sought as part of any proposed offer of service around the use of Restrictive Practice and the how this may influence any potential regression, relapses or risks to the person
- A risk management plan developed including input and guidance from the relevant professionals around the diagnosis and safe uses of agreed restrictive practices.

- Risk Management plans of this nature should not be carried out without external support from medical services (Consultants etc.)
- Comprehensive post incident checklist and guidance around ensuring any potential effects from the use of such practices have been monitored, recorded and reported to the relevant professionals
- Where an individual currently accessing our services with underlying medical issues does not have a plan in place, this must be organized internally and the relevant professionals contacted in order to implement the strategies and documentation to support policy expectation

Medical attention should be sought if a Restrictive Practice has been used to support someone with underlying health issues.

6. Seclusion

Seclusion and segregation are recognised terms in mental health inpatient environments and are defined in the Mental Health Act code of practice. The review seeks to identify to what extent similar practices are used in adult social care environments. The definitions below seek to explain the practice and give examples that might apply in social care situations. Seclusion normally takes place as a direct response to manage an incident or episode. Segregation is usually an active decision to care for somebody separately.

Seclusion: Seclusion refers to the supervised confinement and isolation of a person, away from other people who use services, in an area from which the person is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others.

The reason for seclusion might be because the person is highly aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

The Human Rights Act (1998) sets out important principles regarding protection from abuse by state organisations or people working for these institutions (including the National Autistic Society). It is an offence to lock an individual in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency.

The right to liberty and personal freedom is enshrined in Article 5 of the Human Rights Act (1998) and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act or Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Capacity Act (Northern Ireland) 2016 should only be considered in exceptional circumstances and should always be proportional to the risk presented by the child or person supported.

In a community setting, any form of environmental restriction imposed on individuals should be legally authorised. Therefore, if it is foreseen that it may be necessary to use a form of environmental restriction such as seclusion beyond dealing with an initial emergency in a community setting, an application should be made for a DoLS under the Mental Capacity Act 2005 or an application for welfare guardianship under the Adults with

Incapacity (Scotland) Act 2000 or Mental Capacity Act (Northern Ireland) 2016 should be considered.

Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his/her own free will, may be deemed a restriction of liberty. Under this Act, restriction of liberty of children is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation. Advice for staff working in children homes is that seclusion should not be used - if it is used as an unplanned response to prevent harm in an emergency, there should be an immediate review and risk assessment and the production of a plan that considers the use of proactive strategies and less restrictive options.

For National Autistic Society Services in Scotland Only - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers.

Restraint exercised without legal authority may be a criminal offence. In these circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm. No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law. No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

Seclusion can be described obliquely in the following terms, but the principles of its use apply:

- Time out
- Exclusion
- Segregation
- Seclusion

- Safe-space
- Chill out room
- De-escalation room
- Quiet room
- Calming room
- Garden time
- Solitary

Seclusion is the **supervised containment** of a person in a room, which may be locked or being held closed, to protect others from significant harm. Its sole aim is to contain behaviour which is likely to cause harm to others. During any period of seclusion, support staff must remain in sight of the individual.

Staff must be able to observe an individual at all times to ensure the person's health and well-being and that their needs are met. This includes access to the toilet, food and drink and activities.

If this is an agreed Restrictive Practice follow the guidance around **Agreed Restrictive Physical Practices**.

If seclusion is used as an unplanned response to a dangerous situation and as a last resort, follow the **Unplanned Restrictive Physical Practice** guidance and section 5.2-5.6 of the policy.

Seclusion should only be used:

- As a last resort
- For the shortest possible time

Seclusion should **never be** used:

- As a punishment or threat
- As part of a behaviour support programme, unless the aim is to introduce a graded restrictive reduction plan where these strategies have been used previously.
- Because of a shortage of staff
- Where there is a risk of suicide or self-harm

6.1 Planned Seclusion

Prior to use, planned seclusion must be discussed with the Director of Adult Services or Director of Education and Nominated Individual as well as ratified with an appropriate legal framework.

Any period of seclusion must be agreed and signed by the Senior Member of shift on duty or the on call Manager.

Agreed protocols for recording and monitoring planned seclusion must be in place before any period of seclusion.

6.2 Seclusion as an Unplanned Restrictive Practice

If seclusion is used as an unplanned response to an extreme situation, monitoring throughout the period (until the present/immediate danger has passed) must be undertaken in line with the guidance above and as soon as is practicable.

Within 24 hours, the Director of Adult Services or Director of Education and the Nominated Individual must be notified of the incident.

6.3 Segregation

Caring for a person in isolation. The isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.

The reasons for the use of segregation are as follows:

- An individual may be displaying high levels of behaviours of concern/Challenging behaviour (Frequency, Severity, Duration), that is having an impact on others physical or emotional well-being within a shared environment
- An individual's personal hygiene or health is having an impact on others physical or emotional well-being
- To safeguard an individual from potential abuse, bullying from peers, sensory impact, impact to physical or emotional well being

The segregation must be evidence based and in the person/s best interest, and should always be agreed on through best interest protocols and procedures.

7. Principles for the use of restrictive practices

1. When facing behaviour that is potentially dangerous to self and others, staff must act in a measured way, bearing in mind their duty to try to keep the people we support, staff members and themselves safe.
2. Additionally, staff have a responsibility to take all reasonable steps –through the inclusion in Positive Individual Behaviour Support Plans of up-to-date risk assessments related to individuals we support – to safeguard the wider public and property from any potential physical danger from people we support when in the wider community.
3. Where restrictive practices are used they must be proportionate to the risk of harm and the seriousness of that harm.
4. Individuals should, where possible, be involved in any discussion about the use of restrictive practice. Almost all individuals will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed their views in the past. Wherever possible and reasonable, the person's informed, free and full consent to any restraining action should be obtained. The individual's relatives, advocates, welfare attorneys or guardians, circle of support should be involved in discussions about the use of restrictive practice should be

- agreed as in a person's best interest. In all cases explanation should be given, at a level the person can understand.
5. Under no circumstances should the use of restrictive practices result in pain or pressure on joints.
 6. Wherever possible, staff should consult and collaborate with colleagues. The person who is most familiar with the individual and has the best understanding of how to respond to the behaviour should take the lead role. This may cut across line management and seniority.
 7. Staff should always explore other possible alternatives. For example restrictive practices should not be used when a change of staff could have meant it was not necessary.
 8. Except in an emergency or where the behavior support guideline indicates to the contrary the only restrictive practices involving bodily contact used should be those approved by Studio III / PBM and only used by staff with appropriate training. It is understood that this may not always be possible during an emergency or where the bespoke behaviour support guideline indicates to the contrary.
 9. Where bespoke restrictive practices are required this must be agreed by a multi-disciplinary/transdisciplinary team and all staff who are expected to support an individual must be trained appropriately. Where there is an expectation that an agency or temporary member of staff have achieved the 3-day MCB competency level and be trained and assessed as competent in the bespoke techniques in order to provide the appropriate support needed
 10. Studio III consultancy service / PBM may approve and train staff in the use of bespoke restrictive practices. In such cases these should be documented within the behavior support plans/guidelines and only used for the individual concerned. Restrictive practices that have not been approved by Studio III / PBM should not be included as part of a planned intervention.
 11. All restrictive practices should be carried out for the least time necessary. Where appropriate the environment should be made safe or the person or others (depending on which is the least restrictive) supported to move to a safer environment to reduce the intervention time.
 12. Staff should refer to positive individual behaviour support guidelines which detail all the strategies and interventions used, including restrictive practices, to help the child, young person or adult manage their behaviour - see Policy on Behaviour Support in Schools and Adult Services (SO-0029).
 13. Particular care needs to be taken over the use of restrictive practices when a person we support is engaging in self-injurious behaviour (SIB) or deliberate self-harming. A full risk assessment needs to inform the strategy to support individuals who engage in SIB or self-harm. Only agreed, trained restrictive practices can be used, only as a last resort and only when it has been decided that more harm will result from not using them.
 14. After any restrictive practice has been used an independent person who has not been involved should check the child, young person or adult for any injuries or any signs of potential injuries.

8. Debriefing

- For reference, debriefing in the context of this document, is giving the opportunity to an individual after an incident has occurred to discuss the emotional impact the incident has had on them. It allows the person to speak freely and openly about how the incident has made them feel and be supported to move on from the incident.
- The debriefing session should always remain confidential and not be used to influence changes to behaviour support guidelines or used as an opportunity to analyse or reflect on the individual's practice. Reflective Supervision or Debrief Analysis are two other forms of post incident processes, which offer the opportunity to reflect, analyse and where possible, improve on practice, and should only take place after the debrief proper has been offered/completed.
- The Debrief is optional and the individual member of staff, or person we support has the right to refuse the opportunity to be debriefed after an incident. This should be logged on the SERS incident form in the appropriate section.
- Debriefing must be given to the child, young person or adult who has been restrained in line with the guidance in their positive behavior support guidelines.
- Debrief should be offered or sought out as soon after the incident as is possible
- Narrative around the content of the debriefing session should not be taken, however, the offer of and acceptance/refusal of the session should be logged on the SERS form.

9. Training

- Authorised staff will receive relevant initial and refresher training in the use of restrictive practices from Studio III / PBM. All contact staff will receive the 3 day Management of Challenging Behaviour course. Refresher training must be completed every 12 – 15 months. Should the Refresher training not be completed within the allotted timescale, then staff will be required to complete the 3 day Management of Challenging Behaviour Course again.
- Non-contact staff will receive studio III / PBM training as identified by risk assessment and agreed with their line manager.
- All staff considered to be contact staff should complete the full Studio 3/PBM training course in line with MCB framework (See MCB framework for guidance).
- Where any additional staff training in the use of restrictive practices is identified through staff review (Support & Supervision) or through other means this will be provided. See MCB Framework for Guidance around continued professional development plans for contact staff.

- In some services, people may have a planned, bespoke restrictive practice and all staff supporting that individual must be trained to use the identified method of intervention prior to supporting the individual.
- Where an individual has a bespoke planned restrictive practice in their support plan any agency or temporary member of staff who is allocated to work with that person must have a full induction to the service and the individual and have been trained to use the planned physical intervention technique.

10. Recording, reporting and monitoring

- 10.1 For any incident involving the use of restrictive practice, a behavioural incident record must be completed by the end of the shift and where appropriate, formally reported to outside agencies (CQC, Ofsted, Care Inspectorate, CIW, RQIA) within 24 hours in writing in accordance with the protocol in the school or adult service. Information to be recorded is listed in Related Document 1 - SO-0039-001-0617.
- 10.2 Use of environmental change to restrict movement, use of medication/PRN to manage challenging behaviour or reduce risk of harm and use of mechanical restraint all require recording on a restrictive practice form – See appendices 3 and 4.
- 10.3 The above is to be written onto a Restrictive Physical Intervention (RPI) form that is kept by the service, and will be monitored and signed off by the senior leadership team.
- 10.4 An accident record should be completed if there is any injury.
- 10.5 The completed record, with the incident form should be signed off by the appropriate senior staff member in accordance with the school's or service's protocol.
- 10.6 Positive Behaviour Support plans must give clear strategies to reduce dependency on Restrictive Practice over time.
- 10.7 The use of all restrictive practice programmes must be reviewed by the support team following any incident that results in use of a restrictive practice. All plans must be reviewed formally at least 6 monthly.
- 10.8 After any use of Restrictive Practice, the positive behaviour support plan and risk assessments should be reviewed and updated if/as necessary.

11. Responsibilities

Trustees

- Trustees review of policy on the use of Restrictive Practices.
- Trustees will monitor the reduction in use of Restrictive Practices on a quarterly basis.

Director - Adult Services / Education

- Monitoring of implementation of this policy
- Monitor the use of Restrictive Practices on a regular basis
- Ensuring the allocation of internal and external resources (including clinical and counselling) to address the needs of individuals we support and staff with regard to the implications of serious challenging behaviour

Principals, Area Managers and National Autistic Society Service Managers

- Enforcing the implementation of this policy in their school or adult service
- Maintaining a comprehensive recording and reporting process relating to the use of restrictive practices
- Ensuring relevant staff undergo training in the use of restrictive practice, with regular refreshers; currently provided by Studio III / PBM
- Supporting care teams in developing risk assessments and behaviour support and care plans with regard to restrictive practices – with particular reference to calling for external or internal expert opinion as required.
- Ensuring plans are shared with parents/advocates, purchasers and other interested agencies, and where appropriate with the child or adult concerned, recognising the importance of consent in terms of the fundamental issues of respect and dignity.
- Regular monitoring of such plans.

All Staff

- Working always in the best interests of the child or adult.
- Taking part in training provided in the use of restrictive practices and applying the principles and strategies taught.
- Satisfying themselves that they are clear on what they may and may not do in terms of restrictive practices, seeking clarification as necessary.
- Using Support & Supervision sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary.
- Following the recording and reporting procedures.
- Contributing to the development of behaviour support or care plans, and good practice.

12. Complaints

Adults, parents, guardians, carers or children and young people have the right to offer comments and refer to the local complaints procedure (or Compliments, Comments & Complaints Policy QS-0009/ Complaints Resolution in Schools QS-0010) in the case of any disagreement in the use of restrictive practices.

Alternatively contact can be made with the appropriate external regulator: Care Quality Commission (England) / Care Inspectorate Wales / the Care Inspectorate, Scotland / Regulation and Quality Improvement Agency (Northern Ireland) / Ofsted – details can be found on the internet.

13. Whistleblowing

Employees of the National Autistic Society have a duty to voice any concerns over care practice. Please refer to the Policy on Whistleblowing (HR-0002) for further information.

14. Equal Opportunities

Those children or adults for whom restrictive practices are required to support their behaviour will continue to be valued as individuals of merit and worth.

References

KCSiE 2019

Whistleblowing Policy – HR-0002

Behaviour Support in Schools & Adult Services SO-0029

Compliments, Comments & Complaints Policy QS-0009

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Code of Practice for the use and reduction of restrictive practices. 3rd edition (2010) BILD Care Standards Act 2000

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Children's Act 1989

Children's Homes Regulations (2001) – amendment (2011)

Use of Reasonable Force - Department for Education - www.education.gov.uk

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Good practice in Physical Interventions (2006) Ed Sharon Paley and John Brook, BILD, ISBN 1-904082-742

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The Care Act 2014

Related Documents

SO-0039-001-0617	Information to be recorded for each use of a Restrictive practices
SO-0039-002-0617	Non Restrictive & Restrictive Intervention Practice
SO-0039-003-0617	Restrictive Practice Form
SO-0039-004-0617	How to complete Restrictive Practice Form
SO-0039-005-0617	Procedure for Admission to a School or Service where an individual is dependent on seclusion or restraint to manage his or her behaviour
SO-0039-006-0919	Unplanned Response Reporting
SO-0039-007-0918	Managing Challenging Behaviour Framework
SO-0038-008-0918	Debrief Analysis Form
SO-0039-009-0918	Studio 3 Verification Sheet