New Direction Support

Restraint Reduction Strategy

Contents

1. Introduction

Physical restraint has been used in care settings for many years and it is often argued that this is for the safety of people being supported and staff members alike, however, restraint in any of its forms clearly has a profound negative **physiological** and **psychological** impact, leaving people feeling angry, anxious and traumatised which subsequently damages **therapeutic relationships** between staff and the people they support (Wilson et al., 2015).

A high **prevalence** of restraint affects staff retention due to the upset and trauma experienced from physical restraint which leaves those staff members with the burden of guilt (Fish & Culshaw., 2005) and

also causes a range of negative emotions for both staff and the people being supported such as fear, anxiety, anger and frustration (Duffy., 2017).

High staff turnover is another by product of increased levels of restraint (LeBel & Goldstein., 2005) and hinders the ability to develop meaningful relationships (Knowles, Hearne & Smith., 2015); leading to people's needs not being met and so quality of life (QoL) is then reduced significantly and creates a cycle of behaviour which further increases frequency of restraint while also having financial implications for the organisation from increased recruitment, training and induction costs and in some instances the more expensive option of agency staff members being used when the organisation struggle to cover shifts internally.

New Direction Support is committed to the reduction of **restrictive practices**, including physical restraint and as such we have created this organisational restraint reduction strategy to support restraint reduction across the service and the aim of the strategy is to promote a tangible change in culture rather than simply having a document in place that simply 'ticks a box' to meet legislative requirements.

2. A brief overview of quality of life (QoL), quality of sleep (QoS) and positive behaviour support (PBS)

QoL is a term which is increasingly being used in the field of health and social care, usually as a generalised concept of people experiencing happiness and fulfilment in their lives and if a person's needs are met then it logically follows that this reduces the need for demonstrating **behaviours of concern** such as physical aggression towards others, self harm and destructive behaviour.

It is likely that many care providers do not have the understanding of how to measure QoL effectively because there is a lack of consensus on the definition of QoL due to this being quite **subjective**, which means, what one person views as important to QoL, another might not (Carr, Gibson & Robinson., 2001).

For those who read scholarly articles, (Schalock., 2004) provided eight domains from which to measure people's quality of life and this appears to have been the most dominant QoL theory across health and social care but New Direction Support have been using a relatively new concept developed by (Seligman., 2018) known as the PERMA (Positive Emotions, Engagement, Relationships, Meaning, Achievement), using an adapted version to include 'Health' (PERMAH) and using **profilers** to measure people's QoL, supporting them to develop on the different parts of the **model** in the hope that we can demonstrate a tangible difference in people's QoL and in turn reduce behaviours of concern and the need for physical restraint and other restrictive practices.

As far as we're aware New Direction Support are one of a small number of providers using the PERMAH model in the local area at the time of writing although there appears to be growing interest.

We have also started to develop our own assessment process which will provide the information feeding into positive behaviour support strategies. SMILES℠ is a multi-disciplinary process which is intended to include the person being supported in outlining the predictable challenges they might face that could lead to behaviours of concern and how best to meet individual needs to reduce the risk of anxiety / distress escalating. This can almost be considered a functional diagnostic tool and although primarily utilised for people with a diagnosis of autism, it is also a useful tool for any individual with complex needs.

- **S**ocial Communication, Interaction & Imagination – This is in relation to the triad of impairments (autism) and how best to support people in an individualised way that meets their needs
- **M**edical – The person's diagnosis, medication side effects and health conditions that could potentially create challenging situations (internal factors)
- **I**ncrease Attention / Access to Items – The situations where a person might predictably look for an increase in support or access to items and without this would likely experience anxiety / distress leading to behaviours of concern
- **L**ife Experiences – Both positive and negative life experiences help us to understand more about the person and the function of the behaviours of concern they might demonstrate
- **E**scape – Where a person might predictably demonstrate behaviours of concern to escape / avoid a situation
- **S**ensory – Hypersensitive (avoid) or Hyposensitive (seek) factors which predictably create a situation where the person demonstrates behaviours of concern as a result of under or over sensory stimulation

QoL and quality of sleep (QoS) are entwined with each other. Without QoS there is a 60% amplification in emotional reactivity and also damaging long term **physiological** and **psychological** effects (Walker., 2017).

QoS is often not prioritised and sometimes not even considered when supporting people who demonstrate behaviours of concern (Malloch., 2020) because the focus is usually on strategies to support the person while they are awake, but without improving QoS any other strategies put in place will not be as effective and creates a cycle of anxiety whereby QoS impacts on QoL and vice versa.

New Direction Support are currently leading the way (locally and nationally) to try and motivate other providers and professionals in the field to have a better understanding of sleep and make this a focus when supporting people whether they are known to demonstrate behaviour of concern or not.

Positive behaviour support (PBS) is a **framework** of strategies used to reduce the need for people to demonstrate behaviours of concern through use of person centred values and behavioural science (CQC.,

2017) and therefore should be the foundation that all care providers work from in terms of supporting people who demonstrate behaviours of concern.

Each person supported by New Direction Support has an individualised positive behaviour support plan in place which incorporates QoL and QoS and this plan is constructed through a **multi-disciplinary approach** inclusive of professionals, the support staff, people's relatives and most importantly, the person being supported.

3. The Restraint Reduction Network (RRN)

The restraint reduction network (RRN) is an independent charity, bringing together committed organisations to reduce reliance on restrictive practices across the NHS and Adult Social Care in the UK.

The RRN (in collaboration with Health Education England) created the 'Restraint Reduction Network Training Standards' (Ridley & Leitch., 2019) to ensure that training is directly related and proportionate to the needs of populations and individual people and that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

To enable the **culture change** necessary in organisations to reduce the use of restrictive practices such as physical restraint, there are Six Core Strategies© (Huckshorn., 2014) proven to be effective in a variety of settings (Azeem et al., 2011; LeBel et al., 2014; Putkonen et al., 2013; Riahi et al., 2016) and has been adapted in the UK as part of the REsTrain Yourself programme which encompasses the six strategies:

1) Leadership (towards organisational change)
2) Data Collection & Analysis
3) Workforce Development
4) Using Preventative Tools & Strategies
5) Involving People with Lived Experience
6) Post Incident Support and Post Incident Review

This also incorporates the (Human Rights Act 1998), in particular:

- Article 2 – The right to life is protected and people are protected from accidental death
- Article 3 – Right not be tortured or treated in a inhuman or degrading way
- Article 5 – Right to personal freedom, no one must be detained or imprisoned without good reason

- Article 8 – Right to family, relationships, well-being, privacy and home, including seeing family and being heard
- Article 14 – All rights are protected without discrimination and so all people are treated equally

4. CPI Safety Intervention Training

As one of the Crisis Prevention Institute's (CPI) affiliated organisations, we recognise the importance of ensuring that CPI's Safety Intervention™ programme is delivered in accordance with (Ridley & Leitch., 2019) RRN training standards, maintaining the integrity of the programme.

We conducted a comprehensive self assessment provided by CPI and the British Institute of Learning Disabilities (Bild) throughout the period of 8th March 2021 to 17th March 2021 and this was broken down into four main sections. In addition, all of the RRN standards and sub standards are also covered in sections 5 – 10 of this document.

Section 1 – Standards supporting pre-delivery processes
Section 2 – Standards supporting curriculum content
Section 3 – Standards supporting post delivery processes
Section 4 – Trainer standards

5. Involving People with Lived Experience

During the assessment process, we realised that our scoring was far lower in the 'involving people with lived experience' section.

There were four actions that were derived from this and we began by working on two of these actions, linked to communicating to relatives and friends the circumstances where restraint might be used, and to include relatives and friends views (referred to as key people below).

A letter was sent out to these key people in June 2021, and this provided:

- A link to this restraint reduction strategy
- An overview of the history of restraint in health and social care settings
- The negative aspects of using restraint to manage behaviours of concern
- Our affiliation with the restraint reduction network
- The different types of restraint
- An overview of the formal processes for restraint being agreed for use
- The circumstances where restraint might be used

- The principles that staff are trained to follow i.e. last resort, reasonable & proportionate, least restrictive
- An overview of the debrief process

We then asked the key people to answer some questions regarding their views on restraint in social care settings such as 'what worries you most about the use of restraint in social care settings?' and 'in which situations do you think restraint would be acceptable?' The responses to all of the questions can be found below.

1) What are your views on the use of restraints in social care settings?

- Only acceptable in the service user was in physical danger of hurting themselves
- Must be appropriate and should be used as an absolute last resort
- It is an issue that needs monitoring and could be abused if not regulated
- Rarely makes the behaviour better, more than likely makes it worse

2) What worries you most about the use of restraint in social care settings

- That staff would lose their temper and go beyond the restraining process
- That service users could be provoked by staff leading to restraint
- That it is used out of anger and over-used
- That there is a lack of staff training, funding, professional help and research to promote training
- That there is a lack of support for workers trained in using safe restraints

3) In which situations do you think restraint would be acceptable?

- Under extreme circumstances and only as a last resort
- If there was a danger to themselves or others and / or a threat to safety
- When physically violent or throwing items
- Depends on the context

4) In which situations do you think the use of restraint would be unacceptable?

- When other options have not been explored
- When the person is behaving in a non threatening way
- If it was due to not doing what had been asked of them
- If they were damaging property but not at harm or risk to others
- When it is used as a normal response and not a last resort

5) What alternatives do you think there are to avoid situations where restraint is used?

- There should be long term risk assessments and policies in place
- Avoiding the concept of blame
- Use of distraction and allowing the service user space
- Listening to the service user and avoiding their triggers
- Bringing in third parties to defuse the situation

6) What would you expect of the training being provided to staff members who might have no alternative but to restrain someone?

- To have completed appropriate training
- To learn the correct and safe way to restrain
- Knowledge of when it is appropriate to use
- Practiced to avoid injuries
- Learn how to use it as little as possible
- To know how to diffuse and calm someone down
- Training to be carried out by highly qualified professionals in small groups
- Confidence in the provider with face to face training and frequent refresher training

7) What key message would you pass to those staff members who might be in a position where there is no alternative but to restrain someone?

- Did you do your best?
- Can you explain what happened?
- What have you learnt?
- What needs to be changed to prevent this happening again?
- Can you understand how the service user is feeling?
- Never restrain in anger and empathise with the person
- Talk to or reassure the person after restraint has been used
- Was it appropriate?
- Was it for a minimal time?

8) What do you think the risks are of physically restraining someone?

- The situation might get out of control or it may escalate
- Something serious might happen to the service user
- May cause injury to the service user and / or person
- May have a long term psychological impact
- Could lead to mental health deterioration or increase in mental health problems
- Risk of fear and anger
- May cause physical problems
- Breakdown of relationship between service users and staff

9) **What else can we do as an organisation to reassure you the restraint is not overused / misused / abused?**

- Choose staff who are confident to report problems to you
- The incident should be reported to family and monitored
- The view point of families taken into consideration
- Ensure us that you have the policies and procedures in place to support safe practice
- That managers would provide hand on support
- Regular training and refreshers
- Full report in writing immediately and for it to be signed off by a manager
- Policies signed by each carer
- Understanding that restraint was the only way to deal with the situation

A letter following up on these questionnaires was sent out to all Family and Cares of our service users in August 2021 and the responses will be discussed in the restraint reduction section of the fortnightly manager meetings.

6. Assessment - Leadership (towards organisational change)

Leadership towards organisational change means that the organisation develops a mission, vision and set of guiding values which promote **non-coercion** and the avoidance of restrictive practices.

It makes sense that the first natural step we need to take is to assess our current position. We have chosen to use the restrictive practices checklist (developed by the RRN) to assess our progress in this area (capturing all restrictive practices, including physical restraint), scoring is calculated as follows.

Criteria	Ranking	Score
This score is given to illustrate that the assessors believe that a particular approach is fully embedded into everyday working practice, values and culture. It would be an exception to find this approach not being implemented.	Yes	5
This score is given to illustrate that the assessors believe that some or all of a particular approach does happen, but it is not fully embedded into working practice, values and culture.	Partly	3
This score is given to illustrate that the assessors believe that a particular approach has been newly implemented and is not embedded in working practice, values and culture.	No	1
This score is given to illustrate that the assessors believe that a particular approach does not happen; or is not relevant to this team, department, organisation or service user group.	N/A	0
Overall Raw Scoring ranges from 0 (not embedded at all) to 70 (full embedded)		

Assessment Criteria

Leadership (towards organisational change)				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
The organisation has a current restraint reduction strategy which outlines a range of multi-strategic approaches to reduce coercive approaches and to prevent the misuse and abuse of restraint.	√			
The restraint reduction strategy supports the organisation's mission, vision and values and emphasises the importance of person-centred care, compassion and dignity.	√			
The restraint reduction strategy directly evidences approaches which meet national, service-specific and regulatory guidelines and standards.	√			
The restraint reduction strategy is based around the RRN's Six Core Strategies and addresses restraint reduction across the entire organisation (service, department, team, individual service user).	√			
Service user and family views are considered and integrated into the reduction plan.		√		
The restraint reduction strategy is communicated across the organisation and shared with stakeholders (service users and families, staff, commissioners, regulators).	√			
Restraint reduction is supported by strong, visible leadership. A senior manager is named as a lead for restraint reduction, and service users and families know who to speak to if they have concerns.	√			
The organisation's Senior Management Team and Board receives regular reports on the organisation's performance in relation to restraint reduction.	√			
There is an effective governance framework and policy in relation to the use of restrictive practices to ensure restraint is not misused or abused.	√			
There is a clear and transparent complaints procedure specific to the use of restrictive practices which enables service users, families and staff to raise concerns regarding the use of restraint.	√			
The organisation's policy on the use of restrictive practices provides clear and unambiguous criteria outlining when restrictive practice may be considered an appropriate and reasonable intervention.	√			
Leaders and managers promote a culture of care and compassion and inspire staff to build open and positive relationships with service users and families.	√			
The prevailing culture in the organisation emphasises that the use of restraint is a 'treatment failure'. Whenever restrictive practices are implemented, there is a clear approach which shows how staff will attempt to ensure further restraint is avoided in the future.	√			

The misuse and abuse of restrictive practices is consistently addressed by leaders and managers.	√			
Total Score *Add all scores for raw score and divide by 14 for mean*	Raw 68		Mean (Raw / 14) 4.85	

Areas for Improvement

Leadership (towards organisational change)
1. To provide quarterly updates to friends and families on the use of restraints within the organisation
2.
3.

7. Assessment - Data Collection & Analysis

Data informs our practice and in regards to restraint reduction can be used to:

- Determine those people we support who require interventions
- Analyse **function of behaviour** and inform interventions required
- Measure change in behaviour and effectiveness of interventions
- Reduce restrictive practice (including restraint)

As an organisation, we recognise that without appropriate monitoring systems in place, there is an increased risk of restraint and other restrictive practices being used inappropriately.

Although not a main focus of this plan, a note needs to be made about general data protection regulation (GDPR) and ethical use of data. Further details about GDPR and how this affects our use of people's personal information can be found here, and in addition to this, each person we support has been provided with an easy read GDPR consent form.

Assessment Criteria

Data Collection & Analysis				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
The organisation clearly sets out measures that are used to determine the level of performance in relation to restraint and restraint reduction	√			
The measures used are valid and the data captured takes account of the varying numbers of users accessing the service (e.g. incident rates are expressed as a rate per number of service users; rates per number of care hours / days delivered	√			

The measures used capture the use of all restrictive practices to ensure a reduction in one method of restrictive intervention is not substituted for an increase in another	√			
The organisation has an approach to incident reporting and recording which accurately captures measures of performance	√			
Data is captured and used to inform the organisation about performance in relation to the specified measures	√			
Data is shared at all levels within the organisation so that everyone is aware of the organisations performance (organisational, department, team and individual level	√			
Data is used non punitively to understand organisational performance and to highlight achievements and successes so that good practice is shared	√			
Data is used non punitively to understand organisational performance and to identify potential areas for improvement	√			
Data is used non punitively to identify potential areas of conflict that lead to restrictive practices being used so that preventative measures can be maintained or implemented to avoid or minimise such conflict	√			
Data is provided to and used by staff to help them understand the needs of each person they support	√			
Total Score *Add all scores for raw score and divide by 10 for mean*	Raw 50		Mean (Raw / 10) 5	

Areas for Improvement

Data Collection & Analysis
1.
2.
3.

8. Assessment – Workforce Development

The reduction of restraint relies on a number of factors relating to workforce development, not just training courses or qualifications. It includes the recruitment process, training, supervision and appraisal as well as the inclusion / input of staff with reduction initiatives (O'Hagan, Divis & Long., 2008).

Assessment Criteria

Workforce Development				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
The organisation has a workforce development plan which sets out training required to develop and maintain the knowledge and skills staff need to support service users effectively	√			
As part of the workforce development plan, staff receive an appropriate level of training in person centred values, recovery and restraint reduction	√			
As part of the workforce development plan, staff receive an appropriate level of training in Positive Behaviour Support (PBS)	√			
As part of the workforce development plan, staff receive training in a range of preventative measures which focus on conflict avoidance and resolution, including: • Understanding the nature and cause of conflict, aggression and violence • Effective interpersonal skills • Effective listening skills • Verbal de-escalation • Trauma informed care • Delivering person centred support • Collaborative problem solving • Risk assessment and positive risk taking • Debriefing	√			
As part of the workforce development plan, staff receive training in crisis prevention and management, including the use of physical interventions where required	√			
Staff training is accredited and / or linked to national or sector specific guidance	√			
Staff training provides evidence of competence which enables the organisation to deliver outcomes which meet national, regulatory or sector specific guidance	√			
Staff receive effective ongoing supervision, support and workplace coaching to ensure learning is transferred into practice	√			

The organisation implements an ongoing training cycle which ensures that staff maintain their competencies and continue to develop on knowledge and skills	√			
Staff receive workplace support which enables them to apply their learning to the specific needs of the individuals they support	√			
Total Score *Add all scores for raw score and divide by 10 for mean*	Raw 50		Mean (Raw / 10) 5	

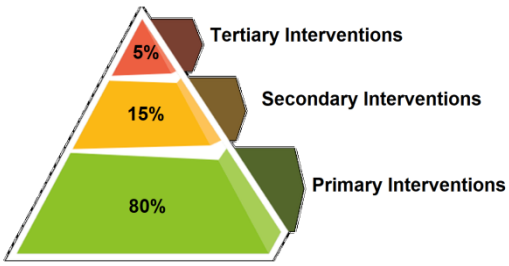
Areas for Improvement

Workforce Development
1.
2.
3.

9. Assessment – Using Preventative Tools & Strategies

There is an important model within positive behaviour support (PBS) which can be used to assess different levels of preventative strategies for each person we support and this will help to define primary, secondary and **tertiary** interventions.

- **Primary Prevention (All)** – The universal interventions / strategies which can be used to support any person to reduce the risk of behaviours of concern occurring at all
- **Secondary Prevention (Some)** – The targeted early individualised interventions which can be used when there has been a **trigger** for anxiety / distress
- **Tertiary Prevention (Few)** – The intensive interventions to ensure safe and ethical response to behaviours of concern



The strategies in places need to be personalised and need to be informed by data (as discussed in previous section)

Assessment Criteria

Using Preventative Strategies & Tools				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
Service users are fully involved in planning their individualised care and support	√			
Each service user has an individual behaviour support plan which outlines how flexible and responsive support is provided at primary and secondary preventative level so that potential conflict or crisis situations are avoided	√			
The primary and secondary interventions in each service users support plan focus on the approaches which help the person to address factors that impact on behaviour (e.g. physical and mental wellbeing; personal, social and environmental factors; coping strategies; occupation)	√			
A formal risk assessment is used to determine those individuals who are likely to present crisis behaviour which is a risk to self or others	√			
Where risk behaviours are identified, each service users behaviour support plan outlines how flexible and responsive crisis intervention and post-crisis support will be delivered	√			
Where restrictive practices are used to manage crisis behaviour, individual service user risk assessments are completed to ensure welfare, safety and dignity of service user is maintained	√			
Staff are routinely briefed on each service user's behaviour support plan and know how to implement service users preferred strategies to avoid or minimise conflict and how to safely implement restrictive practices if required	√			
Behaviour support plans are trauma sensitive and trauma informed so the specific needs of each service user are identified	√			
All restrictive practices are considered and planned around the needs of the individual in order to maintain their welfare, safety and dignity. Universal or blanket restrictions are not applied unless supported by a risk assessment and appropriate guidance which considers the welfare, safety and dignity of all users e.g. restricting materials which pose a fire hazard (matches, cigarettes, lighters)	√			
The environment promotes a culture of care, safety and collaboration. There is a calm and positive culture which promotes interpersonal connections between service users and staff	√			
Service users have access to quiet areas or sensory rooms where they can go as an alternative to seclusion	√			
All incidents of restrictive practice are reviewed by the team in partnership with the service user so that everyone gains a better	√			

understanding of what happened and what can be addressed in the future so that conflict can be avoided and future restrictions minimised				
There is a non punitive external* review of all incidents which helps everyone to gain a better understanding of performance in order to improve personalised support so that the use of restrictive practices can be avoided in the future *The term external review is used to indicate that the review involves someone not directly involved in the incident. This can be another team member, line manager or advocate; or it may include individuals or teams from external departments or agencies	√			
Total Score *Add all scores for raw score and divide by 13 for mean*	Raw 65		Mean (Raw / 13) 5	

Areas for Improvement

Using Preventative Strategies and Tools
1.
2.
3.

10.Involving People with Lived Experience

A crucial part of the restraint reduction strategy is the involvement of those with lived experience of the service we provide, including the people we support and their relatives and external advocates, however, it can also be one of the most challenging in regards to mental capacity and people's willingness to engage.

This does not mean it's impossible to include people with lived experience but simply that it requires creative thinking to actively involve people rather than fostering a culture where people are passive recipients of care with little to no involvement or choice over the way they are supported.

Assessment Criteria

Involving People with Lived Experience				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
Organisations clearly communicate the range of restrictive practices authorised and approved for use in the service. Clear information is given to service users and families which outlines the circumstances when restrictive practice can be used	√			
Organisations involve service users and families in developing their restraint reduction strategy	√			
Organisations ensure that best practice in restraint reduction focuses on the specific needs of the individual and ensures that the potential for	√			

discriminatory bias (e.g. as a result of age, gender, race, religion) in the use of restrictive practice is avoided				
Service users are recruited as advocates, experts by experience and workplace champions to promote the restraint reduction strategy in the service			√	
Organisations implement strategies which engage and empower service users to determine the care and support they need so that conflict and the use of restrictive practices are avoided	√			
Service user are involved in the co-delivery of training to staff on the use of restrictive practices		√		
Service users are involved in establishing communal rules which enable people living in shared environments to avoid or minimise conflict	√			
Debriefing is always offered / provided to service users when any restrictive practice is implemented	√			
Where it is difficult for the service user to engage in debriefing, debriefing is augmented to the needs of the individual	√			
Outcomes of the debriefing are used to enable collaborative action with service users and staff to develop more effective personal support and behavioural management strategies	√			
Organisations share their performance with service users and families so that everyone knows the successes achieved and any key areas for improvement	√			
Total Score *Add all scores for raw score and divide by 11 for mean*	Raw 49		Mean (Raw / 11) 4.45	

Areas for Improvement

Involving People with Lived Experience

11.Post Incident Support & Post Incident Review

"Those who cannot learn from history are doomed to repeat it" – George Santayana

The goals of effective debrief with both staff and the people we support, following behaviours of concern or restraint / restrictive practice, are:

- Minimising the negative effects of restraint
- Prevent future use of restraint
- Address organisational issues and make necessary changes

Assessment Criteria

Post Incident Support & Post Incident Review				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
The organisation has systematic process and management method for improving, building and sustaining performance in relation to conflict avoidance and restraint reduction	√			
Continuous improvement in relation to conflict avoidance and restraint reduction occurs at an organisational, team and individual service user level	√			
The organisation's governance arrangements ensure the use of all restrictive practices is scrutinised so that efforts to prevent or minimise restrictive practices are continually implemented and evaluated	√			
The organisation uses assessment tools which give an indication of staff attitudes towards restraint reduction and the level of care and compassion afforded to service users subject to restrictive practices	√			
Project teams are established to help the organisation find successful improvement strategies to reduce conflict and the use of restrictive practices			√	
The organisation provides staff with simple tools and techniques to understand workplace performance and how to make improvements to the quality of service delivered	√			
There is a culture of candour, the organisation admits when things go wrong and shows a commitment to improve	√			
Total Score *Add all scores for raw score and divide by 7 for mean*	Raw 33		Mean (Raw / 7) 4.71	

Areas for Improvement

Post Incident Support & Post Incident Review
1. To identify a way of having a project team to help the organisation find successful improvement strategies to reduce conflict and the use of restrictive practices
2.
3.

12. Assessment Scoring (May 2023)

13. Assessment Feedback

When we first carried out our assessment, it was clear from the scoring that involvement / inclusion of service user's and their family members with this restraint reduction strategy would be the focus going forward and so the PBS Practitioner (at the time) was tasked with working towards the actions set out in this strategy, working alongside the management team where required.

This continues to be discussed in fortnightly manager meetings and space given to identify how we can work on the actions to improve the overall score and ensure that everyone's views are taken into account in relation to restraint reduction.

The self assessment has been a very positive experience, allowing the organisation to fully reflect on current practices and we're very pleased with the outcome and also looking forward to the challenge of improving practice further and continuing our success with reducing the use of restraint across the service.

14. Training Needs Analysis (TNA) – Individual Services

Miss A – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 6 members of the core staff team have received CPI Safety Intervention™ training – this is disengagements only (not holds).
What are the roles of these staff?	4 of the identified staff members are community support workers directly supporting Miss A. 1 of the identified staff members is a Practice Leader. 1 of the identified staff members is a Care Coordinator.
Level of training required	All staff identified are trained to foundation level only (disengagements)
Service setting specific information Population specific considerations	This is a single placement (Miss A lives alone in privately rented accommodation) and she receives 2:1 support 12 hours a day. Miss A's property is based in an estate populated by general members of the public.
Person specific characteristics (such as cultural heritage, age, gender and health issues that need to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	CPI Safety Intervention™ training has a specific section which provides information regarding cultural heritage, age, gender and health considerations to make when supporting someone who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.
Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Miss A's team • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ • Equality & Diversity • Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene

	• Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Makaton Sign Language • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation given that all staff have received emergency first aid and manual handling training (data available on training database)
Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity • First Aid • Health & Safety • Ill Treatment or Wilful Neglect • Meeting Needs • Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers • Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans

	• Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We have also developed our own functional assessment process which feeds into PBS plans called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Miss A has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person-centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.
Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Miss A does not experience physical, mechanical & chemical restraint, seclusion or segregation in particular. Miss A is prescribed medication for behaviours of concern (i.e. PRN medication such as diazepam or lorazepam) but the use of this is extremely rare. The Behaviour Support Plan outlines the disengagements that could be used if there is a significant risk of harm and are expressly last resort, some examples of where these might be used are: • Miss A is in immediate danger in the community • There is a risk of retaliation from others due to Miss A's behaviour

	• Miss A is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Miss A is assessed as being at risk if staff *don't* intervene In addition, staff <u>do not</u> use physical intervention for: • Damage to property where Miss A isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions were used across a 3-month period (November 2024 – January 2025): Block & Move – 0 Low Wrist Hold Disengagement – 0 Medium Wrist Hold Disengagement - 0 High Wrist Hold Disengagement - 0 Low Clothing Hold Disengagement – 0 Medium Clothing Hold Disengagement – 0 High Clothing Hold Disengagement – 0 Low Body Hold Disengagement – 0 Medium Body Hold Disengagement – 0 High Body Hold Disengagement – 0 Low Hair Hold Disengagement – 0 Medium Hair Hold Disengagement – 1 High Hair Hold Disengagement – 0 Low Neck Hold Disengagement – 0 Medium Neck Hold Disengagement – 0 High Neck Hold Disengagement – 0 Low Bites Disengagement – 0 Medium Bites Disengagement – 0
Accurate information about the current range, frequency and severity of behaviours of concern that are presented to the staff who are attending training	Behaviour analysis is conducted on a monthly basis for Miss A and the findings for this analysis are presented to ensure that staff attending understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there were 36 recorded incidents of behaviours of concern from November 2024 – January 2025 and one disengagement used.

Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named persons responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).

Mr Y – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 7 members of core staff team have received CPI Safety Intervention™ training – disengagements and holds
What are the roles of these staff?	6 of the identified staff members are community support workers directly supporting Mr Y. 1 of the identified staff members is a Practice Leader. 1 of the identified staff members is a Care Coordinator.
Level of training required	The staff who have been trained are trained at foundation level only (disengagements)
Service setting specific information Population specific considerations	This is a single placement (Mr Y lives alone in privately rented accommodation) and he receives 24 hour support (2:1 staffing ratio). The property is based in an estate populated by general members of the public.
Person specific characteristics (such as cultural heritage, age, gender and health issues that need to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	CPI Safety Intervention™ training has a specific section which provides information regarding cultural heritage, age, gender and health considerations to make when supporting someone who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.
Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Mr Y's team: • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ • Equality & Diversity

	• Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene • Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS (BILD or Careskills) • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation is given that all staff have received emergency first aid and manual handling training (data available on training database)
Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity • First Aid • Health & Safety • Ill Treatment or Wilful Neglect • Meeting Needs • Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers

	• Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans • Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We are also developing our own assessment process feeding into PBS plan creation called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Mr Y has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person-centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.
Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Mr Y does not experience mechanical, seclusion or segregation in particular. Mr Y is prescribed depot medication, administered by a district nurse. The Behaviour Support Plan outlines physical restraint (disengagements) that could be used if there is a significant risk of harm and are expressly last resort, some examples of where physical restraint might be used are: • Mr Y is in immediate danger in the community

	• There is a risk of retaliation from others due to Mr Y's behaviour • Mr Y is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Mr Y is assessed as being at risk if staff *don't* intervene In addition, staff <u>do not</u> use physical intervention for: • Damage to property where Mr Y isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions were used across a 3-month period (November 2024 – January 2025): Block & Move – 0 Low Wrist Hold Disengagement – 0 Medium Wrist Hold Disengagement - 0 High Wrist Hold Disengagement - 0 Low Clothing Hold Disengagement – 0 Medium Clothing Hold Disengagement – 0 High Clothing Hold Disengagement – 0 Low Body Hold Disengagement – 0 Medium Body Hold Disengagement – 0 High Body Hold Disengagement – 0 Low Hair Hold Disengagement – 0 Medium Hair Hold Disengagement – 0 High Hair Hold Disengagement – 0 Low Neck Hold Disengagement – 0 Medium Neck Hold Disengagement – 0 High Neck Hold Disengagement – 0 Low Bites Disengagement – 0 Medium Bites Disengagement – 0
Accurate information about the current range, frequency and severity of behaviours of concern that are presented to the staff who are attending training	Behaviour analysis is conducted on a monthly basis for Mr Y and the findings for this analysis are presented to ensure that staff attending understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there were 28 recorded behaviours of concern

	from November 2024 – January 2025 and no disengagements or holds used as all incidents managed through non-restrictive practice.
Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named persons responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).

Mr S – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 5 members of core staff team have received CPI Safety Intervention™ training – this is disengagements only (not holds).
What are the roles of these staff?	2 of the identified staff members is a support worker 1 of the identified staff members is a Practice Champion 1 of the identified staff members is a Practice Leader 1 of the identified staff members is the Care Coordinator (manager for the team).
Level of training required	The staff who have been trained are trained at foundation level only.
Service setting specific information Population specific considerations	This is a single placement (Mr S lives alone in privately rented accommodation) and he currently receives 24 hour support (1:1 staffing ratio) and 2:1 support for community hours between 9am and 5pm. The property is based in an estate populated by general members of the public.
Person specific characteristics (such as cultural heritage, age, gender and health issues that need to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	CPI Safety Intervention™ training has a specific section which provides information regarding cultural heritage, age, gender and health considerations to make when supporting someone who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.

Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Mr S's team • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ (currently 6 members of the team) • Equality & Diversity • Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene • Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS (BILD) • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation is given that all staff have received emergency first aid and manual handling training (data available on training database)
Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity • First Aid • Health & Safety • Ill Treatment or Wilful Neglect • Meeting Needs

	• Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers • Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans • Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We are also developing our own assessment process feeding into PBS plan creation called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Mr S has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person-centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.
Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Mr S does not experience mechanical, seclusion or segregation in particular. Mr S is prescribed medication for underlying reasons for anxiety distress by the clinical

	psychiatrist / GP. These are monitored and reviewed at regular intervals. The Behaviour Support Plan outlines physical restraint (disengagements) which could be used if there is a significant risk of harm and are expressly last resort, some examples of where disengagements might be used are: • Mr S is in immediate danger in the community • There is a risk of retaliation from others due to Mr S's behaviour • Mr S is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Mr S is assessed as being at risk if staff *don't* intervene In addition, staff <u>do not</u> use physical intervention for: • Damage to property where Mr S isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions were used across a 3-month period November 2024 – January 2025): Block & Move – 0 Wrist Hold Disengagement – 0 Clothing Hold Disengagement – 0 Body Hold Disengagement – 0 Hair Hold Disengagement – 0 Neck Hold Disengagement – 0 Bites Disengagement – 0 Low Risk Seated Hold – 0 Medium Risk Seated Hold – 0 High Risk Seated Hold – 0 Low Risk Standing Hold – 0 Medium Risk Standing Hold – 0 High Risk Standing Hold – 0
Accurate information about the current range, frequency and severity of behaviours of concern	Behaviour analysis is conducted on a monthly basis for Mr S and the findings for this analysis are presented to ensure that staff attending

that are presented to the staff who are attending training	understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there was 6 recorded behaviours of concern from November 2024 – January 2025 and no disengagements or holds used as incidents were managed through non-restrictive practice.
Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named persons responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).

Mr D – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 6 members of core staff team have received CPI Safety Intervention™ training; this is disengagements only (not holds).
What are the roles of these staff?	4 of the identified staff members are community support workers for Mr D. 1 of the identified staff members is a Practice Leader. 1 of the identified staff members is a Care Coordinator.
Level of training required	The staff who have been trained are trained at foundation level only (disengagements).
Service setting specific information Population specific considerations	This is a single placement (Mr D lives alone in privately rented accommodation) and he receives 24 hour support (2:1 staffing ratio during day and 1:1 staffing ratio at night). The property is based in an estate populated by general members of the public.
Person specific characteristics (such as cultural heritage, age, gender and health issues that need to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	CPI Safety Intervention™ training has a specific section which provides information regarding cultural heritage, age, gender and health considerations to make when supporting someone

	who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.
Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Mr D's team: • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ • Equality & Diversity • Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene • Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS (BILD or Careskills) • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation is given that all staff have received emergency first aid and manual handling training (data available on training database)
Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity • First Aid • Health & Safety

	• Ill Treatment or Wilful Neglect • Meeting Needs • Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers • Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans • Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We are also developing our own assessment process feeding into PBS plan creation called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Mr D has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person-centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.
Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Mr D does not experience mechanical, seclusion or segregation in particular.

	Mr D is prescribed medication for underlying reasons for anxiety and distress but does not have any PRN medication. The Behaviour Support Plan outlines physical restraint (disengagements) which could be used if there is a significant risk of harm and are expressly last resort, some examples of where physical restraint might be used are: • Mr D is in immediate danger in the community • There is a risk of retaliation from others due to Mr D's behaviour • Mr D is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Mr D is assessed as being at risk if staff *don't* intervene In addition, staff <u>do not</u> use physical intervention for: • Damage to property where Mr D isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions were used across a 3 month period (November 2024 – January 2025): Block & Move – 0 Low Wrist Hold Disengagement – 0 Medium Wrist Hold Disengagement - 0 High Wrist Hold Disengagement - 0 Low Clothing Hold Disengagement – 0 Medium Clothing Hold Disengagement – 0 High Clothing Hold Disengagement – 0 Low Body Hold Disengagement – 0 Medium Body Hold Disengagement – 0 High Body Hold Disengagement – 0 Low Hair Hold Disengagement – 0 Medium Hair Hold Disengagement – 0 High Hair Hold Disengagement – 0 Low Neck Hold Disengagement – 0 Medium Neck Hold Disengagement – 0 High Neck Hold Disengagement – 0

	Low Bites Disengagement – 0 Medium Bites Disengagement – 0
Accurate information about the current range, frequency and severity of behaviours of concern that are presented to the staff who are attending training	Behaviour analysis is conducted on a monthly basis for Mr D and the findings for this analysis are presented to ensure that staff attending understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there were 7 recorded incidents of behaviour of concern from November 2024 – January 2025. All incidents were managed through non-restrictive strategies.
Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named persons responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).

Mr K – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 10 members of core staff team have received CPI Safety Intervention™ – this is disengagements and holds
What are the roles of these staff?	8 of the identified staff members are community support workers for Mr K. 1 of the identified staff members is a Practice Leader. 1 of the identified staff members is a Care Coordinator.
Level of training required	The staff who have been trained are trained at foundation level only (disengagements & holds).
Service setting specific information Population specific considerations	This is a single placement (Mr K lives alone in privately rented accommodation) and he receives 24 hour support (2:1 staffing ratio). The property is an apartment within a respite complex
Person specific characteristics (such as cultural heritage, age, gender and health issues that need	CPI Safety Intervention™ training has a specific section which provides information regarding

to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	cultural heritage, age, gender and health considerations to make when supporting someone who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.
Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Mr K's team: • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ • Equality & Diversity • Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene • Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS (BILD or Careskills) • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation is given that all staff have received emergency first aid and manual handling training (data available on training database)
Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity

	• First Aid • Health & Safety • Ill Treatment or Wilful Neglect • Meeting Needs • Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers • Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans • Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We are also developing our own assessment process feeding into PBS plan creation called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Mr K has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.

Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Mr K does not experience mechanical, seclusion or segregation in particular. Mr K is prescribed PRN medication for anxiety (for which there is a PRN protocol). The Behaviour Support Plan outlines physical restraint (disengagements and holds) which could be used if there is a significant risk of harm and are expressly last resort, some examples of where physical restraint might be used are: • Mr K is in immediate danger in the community • There is a risk of retaliation from others due to Mr K's behaviour • Mr K is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Mr K is assessed as being at risk if staff *don't* intervene In addition, staff <u>do not</u> use physical intervention for: • Damage to property where Mr K isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions were used across a 3 month period (November 2024 – January 2025): Block & Move – 0 Low Wrist Hold Disengagement – 0 Medium Wrist Hold Disengagement - 1 High Wrist Hold Disengagement - 0 Low Clothing Hold Disengagement – 0 Medium Clothing Hold Disengagement – 0 High Clothing Hold Disengagement – 0 Low Body Hold Disengagement – 0 Medium Body Hold Disengagement – 0 High Body Hold Disengagement – 0 Low Hair Hold Disengagement – 0 Medium Hair Hold Disengagement – 0 High Hair Hold Disengagement – 0

	Low Neck Hold Disengagement – 0 Medium Neck Hold Disengagement – 0 High Neck Hold Disengagement – 0 Low Bites Disengagement – 0 Medium Bites Disengagement – 0 Low Level Hold – 0 Medium Level Hold – 3 High Level Hold - 2
Accurate information about the current range, frequency and severity of behaviours of concern that are presented to the staff who are attending training	Behaviour analysis is conducted on a monthly basis for Mr K and the findings for this analysis are presented to ensure that staff attending understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there were 56 recorded incidents of behaviour of concern from November 2024 – January 2025 and on 3 occasions a medium standing level hold was required and 2 occasions of a high seated hold. All other incidents were managed through non-restrictive strategies.
Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named person responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).

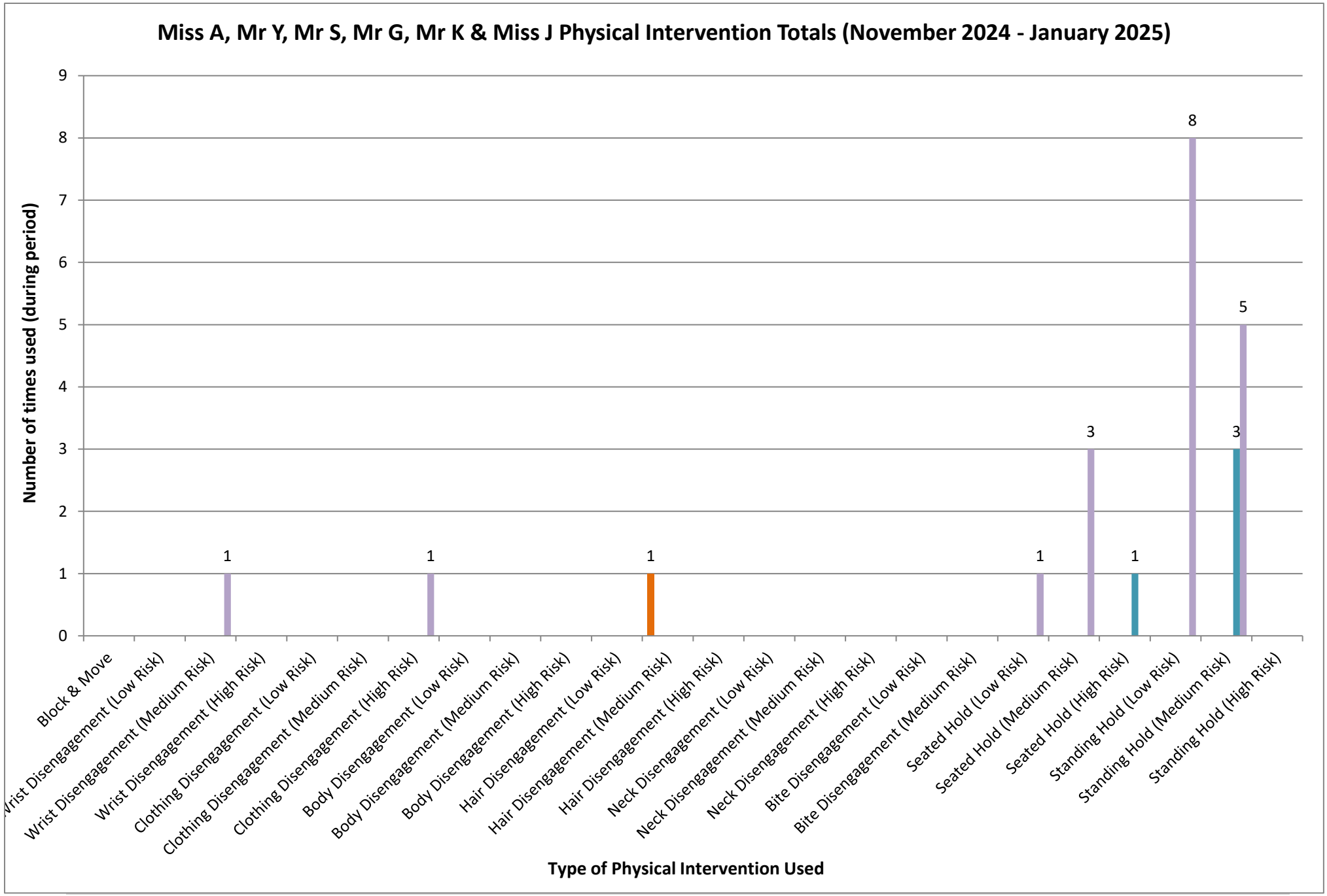
Miss J – *pseudonym used to maintain anonymity and confidentiality*	
How many staff require training?	Currently 5 members of core staff team have received CPI Safety Intervention™ – this is disengagements and holds.
What are the roles of these staff?	3 of the identified staff members are community support workers for Miss J. 1 of the identified staff members is a Practice Leader. 1 of the identified staff members is a Care Coordinator.

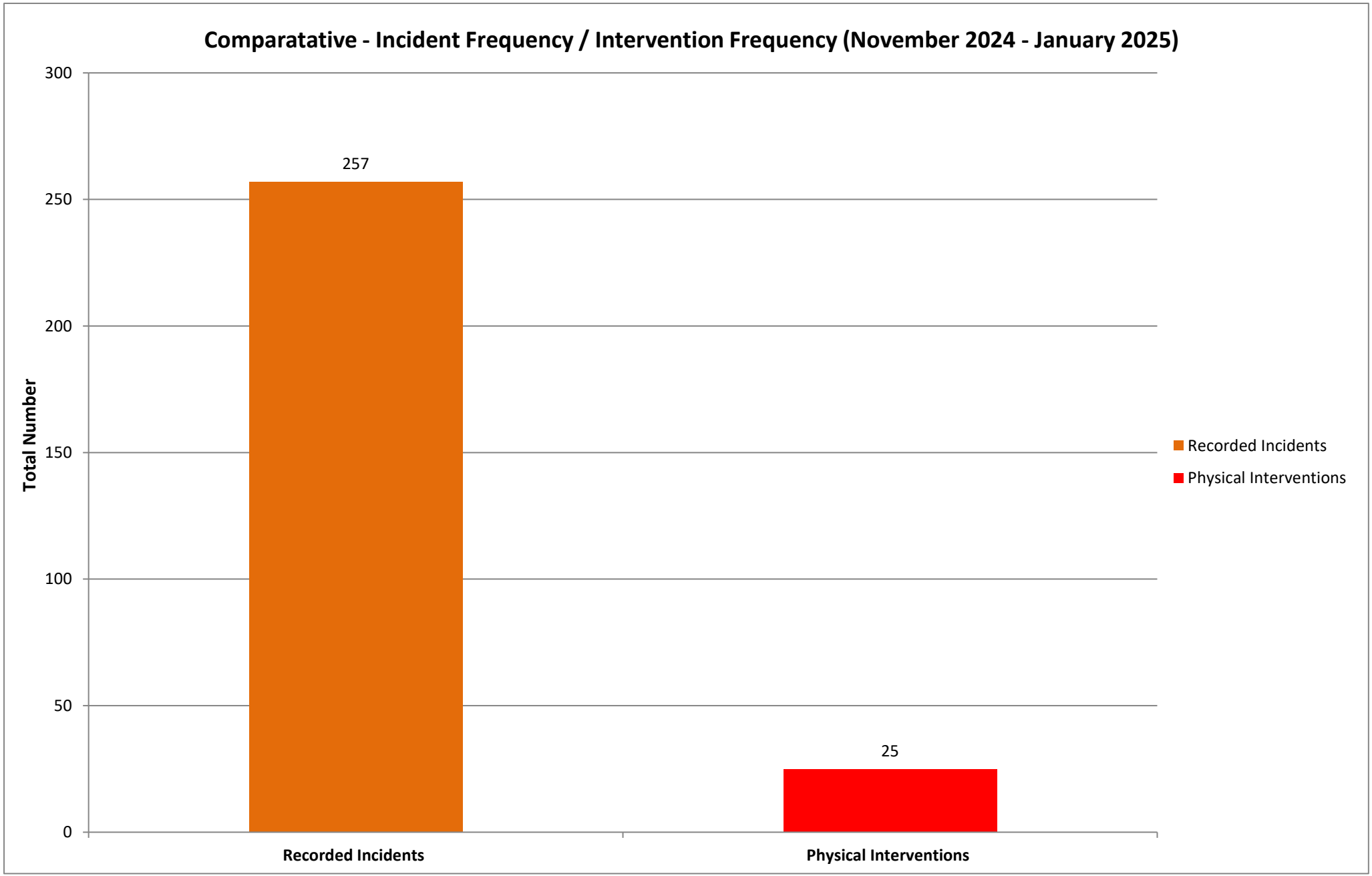
Level of training required	The staff who have been trained are trained at foundation level only (disengagements & holds).
Service setting specific information Population specific considerations	This is a single placement (Miss J lives alone in privately rented accommodation) and she receives 24 hour support (1:1 staffing ratio) with some community hours (2:1 staffing ratio). The property is flat within a residential area.
Person specific characteristics (such as cultural heritage, age, gender and health issues that need to be taken into account when developing a curriculum for both the staff who will be attending and the people they support	CPI Safety Intervention™ training has a specific section which provides information regarding cultural heritage, age, gender and health considerations to make when supporting someone who might demonstrate behaviours of concern, as well as psychosocial factors and historical trauma.
Mandatory training that all staff have undergone to date based on service specific regulatory standards	The following training courses have been completed by Miss J's team: • Autism (Oliver McGowan) • Care Certificate • Challenging Behaviour • Communicating Effectively • CPI Safety Intervention™ • Equality & Diversity • Face Masks • Fire Safety • First Aid / Basic Life Support • Food Hygiene • Hand Hygiene • Health & Safety • Infection Control • Infection Control (Covid-19) • Learning Disabilities • Medication • Mental Capacity Act & DOL's • Moving & Handling • Nutrition & Hydration • PBS (BILD or Careskills) • Recording Information • Risk Assessment • Safeguarding Adults (online) • Safeguarding Adults (Plymouth City Council)
Confirmation that all staff undertaking the training have already received training in emergency first aid and manual handling	Confirmation is given that all staff have received emergency first aid and manual handling training (data available on training database)

Relevant organisational policies	• Accidents, Incidents & Emergencies Reporting • Adult Safeguarding • Basic Life Support • Challenging Behaviour, Violence & Aggression • Complaints • GDPR • Deprivation of Liberty Safeguards • Disclosure & Barring Service • Duty of Candour • Equality & Diversity • First Aid • Health & Safety • Ill Treatment or Wilful Neglect • Meeting Needs • Mental Capacity Act • Moving & Handling • Person Centred Planning • Position of Trust • Positive Behaviour Support • Quality Assurance • Record Keeping • Recruitment & Selection • Relatives, Friends & Carers • Restraint • Risk Assessment • Safeguarding Children & Young People • Service User Plans • Social Inclusion • Staff Retention, Wellbeing & Mental Health • Supervision • Training Development & Qualifications • Whistle-blowing
Organisational mission statement	"Supporting people with learning disabilities, complex needs and autistic people to improve quality of life and quality of sleep within individualised supported living settings"
Organisational restraint reduction action plan	This strategy document is the organisations restraint reduction action plan
Any evidence based models of care employed by the organisation for example, positive behaviour support framework / recovery models etc	The organisation has adopted PERMAH as a concept / framework to support people improve quality of life (QoL) and quality of sleep (QoS), this is embedded within PBS Plans, job descriptions, employment contracts, staff probation, supervision, team meeting document templates etc. We are also developing our own assessment

	process feeding into PBS plan creation called SMILES℠.
Any other service specific information or policies which are relevant to training in the use of preventing and managing behaviours of concern	Miss J has a PBS plan and Behaviour Support Plan, both of which clearly outline the need to minimise the risk of behaviours of concern and manage it effectively and in a person-centred way. The behaviour support plan is structured in-line with CPI Safety Intervention™ training units.
Service and organisational data as appropriate which documents current restrictive intervention usage (physical, chemical, mechanical, seclusion, segregation) in the organisation	The organisation does not promote the use of restraint in any form and Miss J does not experience mechanical, seclusion or segregation in particular. Miss J is prescribed medication for anxiety / distress. The Behaviour Support Plan outlines physical restraint (disengagements) which could be used if there is a significant risk of harm and are expressly last resort, some examples of where physical restraint might be used are: • Miss J is in immediate danger in the community • There is a risk of retaliation from others due to Miss J's behaviour • Miss J is at serious risk through self-injurious behaviours and other methods have not been effective • Others are at risk of harm • There are risks in the environment such as broken glass or exposed wires which staff can't make safe • Miss J is assessed as being at risk if staff *don't* intervene In addition, staff do not use physical intervention for: • Damage to property where Miss J isn't at risk • In enclosed spaces such as bathrooms The following data provides the number of times interventions from November 2024 – January 2025 Block & Move – 0 Low Wrist Hold Disengagement – 0 Medium Wrist Hold Disengagement - 1

	High Wrist Hold Disengagement - 0 Low Clothing Hold Disengagement – 0 Medium Clothing Hold Disengagement – 1 High Clothing Hold Disengagement – 0 Low Body Hold Disengagement – 0 Medium Body Hold Disengagement – 0 High Body Hold Disengagement – 0 Low Hair Hold Disengagement – 0 Medium Hair Hold Disengagement – 0 High Hair Hold Disengagement – 0 Low Neck Hold Disengagement – 0 Medium Neck Hold Disengagement – 0 High Neck Hold Disengagement – 0 Low Bites Disengagement – 0 Medium Bites Disengagement – 0 Low Level Hold – 9 Medium Level Hold – 8 High Level Hold - 0
Accurate information about the current range, frequency and severity of behaviours of concern that are presented to the staff who are attending training	Behaviour analysis is conducted on a monthly basis for Miss J and the findings for this analysis are presented to ensure that staff attending understand the range of behaviours of concern demonstrated, the frequency and the severity. This data is not provided here due to containing identifiable information, however, as an overview there were 128 recorded incidents of behaviour of concern from November 2024 – January 2025. Low level holds were used on 9 occasions, and medium level holds were used on 8 occasions, and there were two medium level disengagements. All other incidents were managed through non-restrictive strategies.
Identification of a named person in the organisation who is responsible for restraint reduction whom the training organisation will be working in partnership with to agree the training curriculum and monitor it's delivery, and who will be able to review its application in practice. This person should be actively involved in the ongoing process of evaluation and review with the training provider	Martin Malloch (Senior Service Manager) is the named person responsible for restraint reduction across the organisation. Martin works in conjunction with CPI to ensure that the delivery of the curriculum is monitored and reviewed. Each attendee provides training evaluation and all essential information is submitted to CPI after each training course has concluded (registering of participants).


Miss A, Mr Y, Mr S, Mr G, Mr K & Miss J Physical Intervention Totals (November 2024 - January 2025)
Number of times used (during period)
0
1
2
3
4
5
6
7
8
9
1
1
1
1
3
1
8
3
5
Block & Move
Wrist Disengagement (Low Risk)
Wrist Disengagement (Medium Risk)
Wrist Disengagement (High Risk)
Clothing Disengagement (Low Risk)
Clothing Disengagement (Medium Risk)
Clothing Disengagement (High Risk)
Body Disengagement (Low Risk)
Body Disengagement (Medium Risk)
Body Disengagement (High Risk)
Hair Disengagement (Low Risk)
Hair Disengagement (Medium Risk)
Hair Disengagement (High Risk)
Neck Disengagement (Low Risk)
Neck Disengagement (Medium Risk)
Neck Disengagement (High Risk)
Bite Disengagement (Low Risk)
Bite Disengagement (Medium Risk)
Seated Hold (Low Risk)
Seated Hold (Medium Risk)
Seated Hold (High Risk)
Standing Hold (Low Risk)
Standing Hold (Medium Risk)
Standing Hold (High Risk)
Type of Physical Intervention Used


Comparatative - Incident Frequency / Intervention Frequency (November 2024 - January 2025)
300
250
200
150
100
50
0
Total Number
257
25
Recorded Incidents
Physical Interventions
Recorded Incidents
Physical Interventions

15. Rationale for Restrictive Intervention(s)

Description & Rationale of Restrictive Interventions

	**Block & Move**	'Block and Move' can be used to minimise the risk of a person punching, kicking or throwing objects Block and move allows support staff to block incoming strikes and then simultaneously move themselves to a place of safety, reducing risk of harm
	**Hold & Stabilise Disengagement (Low Risk)**	'Hold & Stabilise' is used when a person is holding (without consent) a staff member's wrist, clothing, body, hair, neck or they are biting staff Hold and stabilise allows staff time to weigh up severity and likelihood of risk while also offering the person the opportunity to release their hold
	**Push & Pull Disengagement (Medium Risk)**	'Push and Pull' is used when a person is holding (without consent) a staff member's wrist, clothing, body, hair, neck or they are biting staff and they are not letting go or the risk has increased i.e. the person begins hitting with their free hand. The push and pull principle allows staff to release the hold quickly and safely, which in turns allow them to withdraw to a place of safety
	**Lever Disengagement (High Risk)**	'Lever' is used when a person is holding (without consent) a staff member's wrist, clothing, body, hair, neck or they are biting staff and they are not letting go and the risk has increased significantly i.e. the person is hitting the staff member's head or using a weapon

		The lever principle allows staff to release the hold quickly and safely which in turn allows them to withdraw to a place of safety
 	**Seated Hold (Low Risk)**	The **low** risk seated hold involves two members of staff sat either side of the person, elbows connecting (to protect inside of body) and hand resting over person's wrist area but not holding (to protect the staff member on the other side) This will only be used if the person has become anxious (change in behaviour) *and* there is a risk of harm in the immediate environment to the person, staff or other people The low risk seated hold allows staff to be prepared for escalation while also providing reassurance and supporting the person in a therapeutic way This low risk seated hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt Out' sequence to assess level of risk, reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)
 	**Seated Hold (Medium Risk)**	The **medium** risk seated hold involves two members of staff sat either side of the person, and from the low risk position, staff move in closer to the person and use one hand to cup the elbow area (replacing their elbow) and their other hand feeds in behind the person's arm to restrict liberty of movement This will only be used if the person has become distressed and there is an imminent risk of harm in the immediate environment to the person, staff or other people This medium risk seated hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt Out' sequence to assess level of risk,

		reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)
 	**Seated Hold (High Risk)**	The **high** risk seated hold involves two members of staff sat either side of the person, and from the low / medium risk position, staff move in closer to the person, the hand that previously fed in behind the person's arm now takes hold of the person's wrist and draws backwards and then once fully back, the other hand can cup over the person's hands This will only be used if the person has become distressed and there is an imminent and significant risk of harm in the immediate environment to the person, staff or other people This high risk seated hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt Out' sequence to assess level of risk, reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)
 	**Standing Hold (Low Risk)**	The **low** risk standing hold involves one members of staff cupping their hand on the person's elbow, then moving their body behind / to the side of the person and placing their other hand on the person's other elbow (almost as if the staff member is gently guiding the person away) This will only be used if the person has become anxious (change in behaviour) *and* there is a risk of harm in the immediate environment to the person, staff or other people The low risk standing hold allows staff to be prepared for escalation while also providing reassurance and supporting the person in a therapeutic way This low risk standing hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt

		Out' sequence to assess level of risk, reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)
 	**Standing Hold (Medium Risk)**	The **medium** risk standing hold involves two members of staff stood either side of the person, and from the low risk position, staff move in closer to the person and use one hand to cup the elbow area (replacing their elbow) and their other hand feeds in behind the person's arm to restrict liberty of movement This will only be used if the person has become distressed and there is an imminent risk of harm in the immediate environment to the person, staff or other people This medium risk standing hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt Out' sequence to assess level of risk, reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)
 	**Standing Hold (High Risk)**	The **high** risk standing hold involves two members of staff stood either side of the person, and from the low / medium risk position, staff move in closer to the person, the hand that previously fed in behind the person's arm now takes hold of the person's wrist and draws backwards and then once fully back, the other hand can cup over the person's hands This will only be used if the person has become distressed and there is an imminent and significant risk of harm in the immediate environment to the person, staff or other people This high risk seated hold is not intended for use in the person's own home unless there is significant risk of harm and whether at home or in the community staff will use the 'Opt Out' sequence to assess level of risk, reduce risks and disengage as soon as safe to do so (maximum of 10 minutes)

How are the interventions taught to staff and how is their competence tested?
The training instructor (Martin Malloch) has received training and regular refresher training allowing assessment of their competence to train the theoretical and practical elements of CPI Safety Intervention™ (all of the physical interventions are detailed in the previous table). There are currently a maximum of 12 participants to 1 instructor. An important part of this training is combining the theory with the practical, ensuring that legal and professionals considerations are understood by participants, always with a focus on least restrictive, least amount of time and last resort. Participants understand that they need to feel confident using the physical interventions but do everything they can to avoid restraint of any form through use of PBS approaches and the verbal and non-verbal interventions outlined in the training. Participants are also taught how to assess risk, controlling fear and anxiety by weighing up severity and likelihood logically and also to consider 'the risk of doing something and the risk of doing nothing'. The training provided to staff is held over the course of either one or two days, one day training is for disengagements only and two days includes disengagements and holds. During the course of this the participants practice the physical elements repeatedly and each person is carefully assessed to ensure that they are competent in the use of each intervention. There is an assessment record for each participant demonstrating that they have been assessed as competent and are able to ensure the care, welfare, safety and security of the person / people they support. In addition, each participant carries out a theory test at the end of the training to ensure that they understand the principles of the training. Anyone who cannot be assessed as competent (with either theory or practical elements) will not be able to be signed off as competent and will need to retake training when it is next available. All of the information is provided to CPI via an online portal who then review the outcome of the training and once they verify that all criteria has been satisfied will provide participants with a training certificate and blue card (which holds a unique serial number).

General & person specific safety issues for staff during teaching and practice
In accordance with CPI procedure, the instructor ensures that each invitation letter contains safe participation guidelines for participants to read at their leisure prior to attending. The safe participation guidelines are then reviewed during the introduction of the course, setting out the following rules: • Respect that their colleagues have valuable knowledge, skills and experiences and therefore have something positive to contribute to the programme • Be professional at all times, work to their respective professional codes of conduct and be prepared to raise safeguarding concerns with the course instructors • Undertake all activities with due regard for the Care, Welfare, Safety & Security of themselves, other learners and the course instructors and not engage in any activity that is likely to cause distress, harm or injury to self or others • Not engage in activities that will disrupt others learning • Take account of the diverse range of course learners and not behave in ways that others may view as disrespectful, discriminatory or offensive • Work to the specific guidance and instruction of the course instructor and only undertake physical activities when asked to do so

- Notify the course instructor of injuries or limitations prior to the course commencing and report all near misses, accidents or complaints so a formal record can be made

It's recognised that some people can become over-zealous when attending training and so the focus at the start of any training is to ensure the rules are clear and that they are followed. Martin is an experienced instructor and ensures that the safe participation guidelines are followed by all attending.

There is also a training risk assessment in place which sets out control measures very clearly for all potential risks i.e. fire, infection control, accidents / injuries etc and this is sent to participants with their invite letter and also reviewed at the beginning of the training with all participants to ensure they are clear with instructions. A copy of this risk assessment is available on request.

In addition (relating to Covid-19), the training itself has also been adapted to remove non essential exercises where participants will be within 2 metres of each other and the introduction of wearing PPE, cleaning hands regularly and maintaining distance where this is possible.

Description of fragility issues that may compromise the fidelity, safety and effectiveness of the techniques between the taught version in the classroom and the application in practice

General and person specific safety issues considered when interventions are used

It's recognised that being taught in a classroom environment can be very different to applying in practice, mainly because in the classroom the people are not resisting and are consenting to being held where this is unlikely to happen in practice.

This is often a point made repeatedly through the course of the training and for each intervention taught the participants are asked the following questions (SEAT):

Is it **s**afe?
Is it **e**ffective?
Is it **a**cceptable?
Is it **t**ransferable?

As of the time of writing, although there is clearly a difference between classroom and practical application, there haven't been any reported issues (through incident records or debriefs) of fidelity / safety / effectiveness of the interventions taught when they have been used.

For each person that has an agreed restriction in place (physical restraint) there is a risk assessment which considers risk to health. Miss A, Mr Y, Mr S, Mr D, Mr K & Miss J do not have pre-existing health conditions that would increase risk of harm through disengagements.

One area of risk focused on by the instructor is the risk when transferring to high risk seated or standing hold as it's important to hold at the wrist and not the hand (to avoid damage to person's wrist when drawing arm back). Staff are not assessed as competent until they are consistently able to demonstrate that they can do this safely. It's also the case that so far, the high risk seated / standing hold has not been used with any person we support.

Another area or risk is that the person might suddenly drop to the ground or lift their legs in the air when in a standing hold which risks placing a strain on staff member's backs and the person is also at

risk when they do this. The training provides the safest possible way to support someone during an intervention when they do this (which is also assessed).

There is a section of the training which discusses the risks of physical interventions, outlining the more likely injuries i.e. soft tissue damage, bony or articular damage and the less likely i.e. respiratory or cardiovascular. All participants are offered case examples where restraint has resulted in death and this is then tied in with the 'Opt Out' sequence mentioned earlier. In addition, this is then discussed when carrying out physical interventions with participants i.e. checking in regularly with the person and making sure they're okay.

Overall, the interventions taught are safe and effective, minimising the risk of injury to both staff and the person being supported and to demonstrate this, there are no accident records in our database for any injuries following an intervention being used.

General and specific support needed afterwards for the person (to include medical checks and emotional support)
The tension reduction phase can be a difficult one and CPI Safety Intervention™ training discusses therapeutic rapport throughout to develop participants knowledge and skills so that they are able to effectively support someone when they may be feeling negative emotions such as guilt, frustration or even fear and anxiety. It's already been mentioned that support staff will need to ensure they are 'checking in' with the person at regular intervals if restraint is being used and this doesn't end after a restraint. Support staff are required to monitor the person after an incident, and to record and report injuries if there are any. Tension reduction can be a very individual process in terms of re-establishing relationships and while some people may want to talk about what happened, others prefer to continue with their day / night as if nothing had happened or continuing with activities alongside support staff to rebuild or repair what potentially feels damaged by the incident. All of this information is provided in each individual's PBS plan and Behaviour Support Plan (there is a tension reduction section) and these clearly describe the steps that support staff need to take to ensure that the person's physical and emotional needs are met after an incident has occurred (whether there was restraint or not).

16. Training Programme (Easy Read)

CRISIS PREVENTION INSTITUTE

Keep Me Safe, Treat Me With Respect

An easy read guide on the use of restrictive interventions

Introduction

- If a restrictive intervention is used when you are distressed, you need to have the facts about the help and support that you receive.
- This guide provides facts that you, your family, or others may need to know.
- If you are distressed, staff need to keep you safe. They can use restrictive interventions as long as they do not breach your human rights.
- Use this guide to talk about how the use of restrictive interventions may affect you.

What happens if you become distressed?

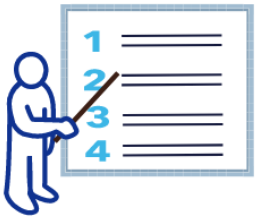
- Behaviour is what we say and do. It's how we communicate.
- When people are scared, anxious, upset, alone, or angry, these feelings can lead to a loss of control. We call this distress behaviour.
- We know that sometimes, distress is unavoidable.
- When people become very distressed and lose control, they can hurt themselves or others. Staff then have a duty of care and may use restrictive interventions to keep everyone safe.

What are restrictive interventions?

These are the actions staff are allowed to use to limit or restrict your liberty when you are distressed.

The four types are:

- **Physical:** when physical contact is made to limit or prevent your movement.



- **Chemical:** when you are given prescribed medication to reduce your distress.
- **Environmental:** when you are confined to a designated room or area to keep you away from others or to stop you leaving.
- **Mechanical:** when a device (e.g., a belt or cuff) is used to limit or prevent your movement.

Staff will do everything to make sure the help and support you receive does not include restrictive interventions. If they do happen, it will be by exception.

What training do staff receive?

- Staff are highly skilled and experienced. They are trained to understand the causes of distress behaviour and to use a range of strategies so your distress doesn't increase.

- Staff are trained to help you manage the things that cause your distress. They can agree the help and support that you need. Then restrictive interventions can be avoided.

- If your distress behaviour causes harm, staff are trained to use restrictive interventions.

- Staff are trained to use the right approach for you. Staff will agree if any restrictive interventions are necessary to keep you safe.

When can staff use restrictive interventions?

- Staff are permitted to use restrictive interventions to keep you safe as long as they do not breach your human rights.

- Restrictive interventions should be:
  - A last resort
  - Least restrictive
  - Used for the shortest time possible
  - Used to maximise safety and minimise harm

- Restrictive interventions should feel safe. They shouldn't cause pain or injury. They should never be used as a punishment or to enforce rules.

- If staff use restrictive interventions, they will always treat you with respect, dignity, and kindness.

What should happen after a restrictive intervention has been used?

- Afterwards, someone should stay with you to make sure you are OK.

- Staff will record what happened.

- Talking helps everyone to think about improving your help and support. Then restrictive interventions can be avoided in the future.

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Glossary

Behaviour(s) of concern - any behaviour which causes stress, worry, risk of or actual harm to the person, their carers, staff, family members or those around them.

Culture Change – A positive shift in the values and ethos of a community of people (i.e. an organisation such as ourselves)

Framework – The foundation or structure of a system / concept such as PBS

Function of Behaviour – The purpose the behaviour serves i.e. to escape a situation, to increase support, to access items or sensory sensitivity

Model – Representations of scientific concepts to make ideas more understandable for learners

Multi-Disciplinary Approach – An approach which creates a team or group of people with a range of different experiences and expertise to tackle complex situations

Non-coercion - not using threats or force to achieve compliance

Physiological – Relating to how body parts function i.e. slow down your body's physiological response to anger by taking deep breaths

Psychological – Relating to the mind (a mental or emotional cause rather than physical)

Profilers - A tool used to measure QoL, where people can rate satisfaction in different aspects of their lives.

Physical Restraint - any direct physical contact where the intention of the person / people intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Prevalence – The fact of something existing or happening often.

Restrictive Practices - Any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.

Subjective – Based on or influenced by individual feelings or opinions.

Tertiary – Third in order or level

Therapeutic Relationship - the relationship between a healthcare professional and a person being supported. It is the means by which a health care professional and a person being supported hope to engage with each other, and effect beneficial change in the person being supported.

Trigger – An event that occurs and has the potential to create anxiety / distress for people and may lead to behaviours of concern i.e. pain / lack of sleep (internal) or the behaviour of others (external). There can be 'slow' triggers which take time to build up and 'fast' triggers which immediately cause anxiety / distress

Created / Reviewed	Date	Page(s) Edited
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Review Date (2)	4th August 2021	5 – 6, 14 – 15, 17
Review Date (3)	6th September 2021	19, 22, 23, 26 & 27, 30 - 33
Review Date (4)	30th December 2021	9 – 12, 14, 15, 17 - 33, 38
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