Hesley Group Restrictive Intervention Reduction Policy and Guidance

1 Introduction

This Policy and Guidance document sits with the Positive Behaviour Support Policy and the two should be read together. It is based on the framework set out in Positive and Proactive Care, DH 2014, Reducing the need for Restraint and Restrictive Intervention, (children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings), HM Government 2019 and the Restraint Reduction Standards 2019. This policy sets out how Hesley Group is to achieve a reduction in the use of restrictive intervention. An effective reduction programme can reduce the incidence of violence and aggression and ensure that less detrimental alternatives to restrictive interventions are used.

The references to people we support includes adults, children and young people in the care of Hesley Group.

This programme will be underpinned by robust governance arrangements and a clear understanding of the legal context for applying restrictions and effective training and development for staff. The legal and ethical basis for Hesley Group to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles:

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.

- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.

- Restrictive interventions should only ever be used as a last resort.

- People we support, i.e. adults, children and young people, their carers and advocate and home involvement is essential when reviewing plans for restrictive interventions.

If Hesley Group staff impose restrictive interventions on those in our care, there **must** be a lawful basis for doing so. The law in respect of restrictive interventions, and the degree of restriction that might amount to an unlawful deprivation of liberty, continues to evolve and Hesley Group is keeping policy and guidance under review on an ongoing basis to reflect this. Restrictive interventions have the potential to cause harm including physical and psychological trauma. In some instances, they have caused harm, and even death. All restrictive interventions can pose risks.

When confronted with acute behavioural disturbance, the choice of restrictive intervention **must always represent the least restrictive option** available to meet the immediate need. It should always be informed by the person's preference (if known), any particular risks associated with their general health and an appraisal of the immediate environment. Individual risk factors which suggest a person is at increased risk of physical and/or emotional trauma must be taken into account when applying restrictive interventions. For example, this would include recognising that for a person with a history of traumatic sexual/physical abuse, any physical contact may carry an additional risk of causing added emotional trauma. Or for a person known to have muscular-skeletal problems such as a curvature of the spine, some positions may carry a risk of injury. Please see DH 2014 Positive and Proactive Care and the RRN Training Standards 2019 for more information and your TCI training pack where these matters are covered in detail.

2 What are Restrictive Interventions?

"Restrictive interventions" are defined in the DH (2014) Positive and Proactive Care guidance as:

'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and

- end or reduce significantly the danger to the person or others; and

- contain or limit the person's freedom for no longer than is necessary'.

They are also referred to elsewhere as "Restraint", for example in the Restraint Reduction Network Standards 2019 known as RRN Standards. The definitions within RRNS are:

Physical Restraint - Any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

Seclusion - involves 'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.103). NB. the Equality and Human Rights Commission (EHRC) Human Rights Framework for Restraint (2019) refers to enforced isolation: *Example: Isolation may be enforced by locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area, for example by the use or threat of force. Enforced isolation is, therefore, restraint, but it may be described as seclusion, segregation, separation, time out or solitary confinement (EHRC, 2019*).

Rapid tranquilisation refers to 'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.91).

Long term segregation (LTS) involves 'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.150).

Mechanical restraint involves 'the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (CQC, 2015b).

Clinical holding involves 'immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children (and adults), with their permission, to manage a painful procedure quickly or effectively' (RCN, 2010). See separate Clinical Holding Policy at Res 5.2A.

3 Basic Rules for the Use of Restrictive Interventions

We aim to reduce the need for restrictive intervention through implementation of this policy, PBS and HELP/TCI.

It is vital that staff **do not carry out a planned restrictive intervention** unless they have been trained and assessed as competent to do so safely. A *planned* intervention is reactive, has been assessed and agreed as suitable to use in specific circumstances for that individual, is kept under review by MDT,

monitored in the service and centrally, is necessary and proportionate and there is no less restrictive option. The safety and welfare of people is paramount.

An unplanned intervention is one that is used in emergency situations in order to prevent a person being harmed or prevent serious property damage. Any unplanned intervention used will be subject to review and learning lessons as appropriate. The use of unplanned interventions will be monitored in the service and centrally. Debrief and review should occur after an unplanned intervention.

If a restrictive intervention is carried out for **any other purpose** than those listed above concerns should be escalated through Hesley Group's Safeguarding Adults at Risk Policy and Guidance, ReS 2.1, Fullerton House School Safeguarding and Child Protection Policy, ReS 2.1A, Wilsic Hall School Safeguarding and Child Protection Policy, ReS 2.1B, Wheatley House Safeguarding and Child Protection Policy, ReS 2.1C or Ivy Lane School Safeguarding and Protection of Children Policy, ReS 2.1D.

- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

- If restrictive intervention is used it must not include the deliberate application of pain.

- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

- Whilst it may be at times necessary in a crisis situation to temporarily restrict a person's movement between environments, for example by holding a door closed to protect a person's privacy, dignity or safety, the use of seclusion is not appropriate in Hesley Group settings and is likely in most cases to be considered illegal. People we support must not be routinely subject to such a measure.

- Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

- Use of any physical means of restraint for reasons of risk and safety such as travelling harnesses and wheelchairs must be subject to appropriate assessment and support and kept under review. In the case of travelling harnesses guidance is situated in the Safe Driving Policy - Car & Minibus Specialist Equipment to Travel (Wheelchairs and Harnesses) – Practice Guidance, H&S 1.9.12.

- People we support, families and carers and the person's home authority should be involved in planning, reviewing and evaluating all aspects of care and support.

4 Consent

The Mental Capacity Act presumes that all persons aged 16 and over have the ability to make their own decisions and protects their right to **make and act on** their own free will. It also provides important safeguards where people **lack** capacity to make their own decision. The five principles are as follows:

- A person must be assumed to have capacity unless it is proved otherwise.
- A person must not be treated as unable to make a decision unless all practicable steps to help have been taken without success.
- A person is not to be treated as unable to make a decision merely because an unwise decision is made.
- An act done, or decision made under the Act for, or on behalf of a person who lacks capacity, must be done in their best interests.
- Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved **in a less restrictive way.**

So for example, having established that a person lacks capacity to consent to intervention in a situation identified as having the potential to require this, staff must consider whether it is possible to reach the desired outcome (e.g. calming and restoration to baseline) in more than one way. Is it possible to help someone to calm themselves by changes to the environment or relaxation for instance rather than taking medication or using a physical intervention? Whatever intervention is agreed it should be the least restrictive available and appropriate to the situation. These decisions should be made having considered all relevant parties' views and the preferences of the person concerned. Please see Hesley Group Capacity and Consent (MCA 2005) Policy and Guidance, ReS 6.4A. The use of Restrictive Interventions may amount to assault or battery (if the person has mental capacity to refuse what is proposed), wilful neglect or ill treatment of people lacking mental capacity (an offence under section 44 of the MCA 2005 amended in 2014) or unlawful deprivations of liberty.

It is considered that a reduction in restrictive interventions and finding alternative means of support will generally be in people's interests. Hesley Group's intervention reduction programme is based on the principles of:

1. Providing effective leadership
2. Involving and empowering of people who use services, their families and advocates
3. Developing programmes of activities and care pathways for people using services
4. Using clear crisis management strategies and restrictive intervention reduction tools
5. Effective models of post-incident review including learning from critical incidents
6. Data-driven quality assurance.

The programme will set out guidance using each of the above numbered points as headings.

5 Providing effective leadership

5.1 Leadership at corporate level will be the responsibility of the Operations Directors/Assistant Directors and Director of Quality and Workforce Development in the Executive Team.

They have responsibilities to (a) ensure there are appropriately skilled, qualified and experienced therapists and clinicians to deliver the programme; (b) for the quality assurance and governance of their performance and (c) supporting achieving successful outcomes for individuals.

The Director of Quality and Workforce Development also has responsibilities in terms of (a) the quality assurance and governance of training provided to Hesley Group staff; (b) the quality assurance and governance of the use of interventions and the success of this programme and (c) the currency of policies and guidance that support the programme.

To aid effective governance data is collected from the HELP Management System (incident reporting) to inform reports to the Incident Review meetings, Children and Adult Safeguarding Boards, Executive Team and the Board of Hesley Group. The reports will prompt action as appropriate.

Hesley Group Executive Team and Board will undertake appropriate training in the use of PBS and physical interventions to ensure they are fully aware of the techniques their staff are being trained in.

Hesley Group Board is ultimately accountable for what happens in Hesley Group services. The Board will review Hesley Group Positive Behaviour Support policy and this guidance annually through the Children and Adult Safeguarding Boards. The Hesley Group Board will approve the training packages to be delivered to staff in respect of restrictive intervention. This measure will fulfil the RRN Standards.

5.2 Leadership at service level – every manager, clinician and therapist involved in the delivery or management of services to people will model a person-centred approach to supporting people, and will provide support and appropriate challenge to members of the team. The Multi-Disciplinary Team will monitor and review the effectiveness of each person's individual plans including their behaviour support and HELP profile against outcomes and in line with the principles of positive behaviour support. Reviews should involve consultation with the person, their carers, and their family/relevant others. Please see consultation and involvement below. Effective leadership involves listening to others and taking account of and respecting their information and their views.

Transparent policies and appropriate governance structures must be established against a context of positive and proactive working and within care pathways which provide behaviour support plans. The risks vary from intervention to

intervention; it is important that those who use restrictive interventions understand the risks associated with each intervention. In many instances a rigorous practice of identifying and assessing risks can be an effective safeguard to minimise risks.

The use of physical interventions is hazardous and puts both the people we support and Hesley Group staff at risk of harm. The Health and Safety at Work Act 1974 places a duty on employers to ensure so far as is reasonable and practicable that health safety and welfare of employees and others who may be affected in Hesley Group services is safeguarded.

No staff member will be asked to undertake to perform a restrictive intervention that has not been agreed as a part of a person's plans, or for which the member of staff has not been trained.

Responsible managers or clinicians/therapists will ensure risks are assessed including any reasonably foreseen violence, and decisions made as to how these risks can be prevented or controlled. These measures must be implemented to reduce the risks. Managers will ensure anyone who has been involved in a restrictive intervention have immediate post incident checks, are given any first aid required and are removed from duty if necessary.

Managers will ensure that post incident reviews take place as set out further in this guidance. The post incident review is a critical process in determining the appropriateness and effectiveness of the intervention but chiefly to ensure that each party is properly supported.

All restrictive interventions will be recorded as set out further in this guidance and the incident reporting guidance, ReS 5.1D. Staff will receive training in the recording of incidents and restrictive interventions.

Registered Managers are responsible for ensuring the data is entered onto the relevant database within two weeks of this incident taking place – see also section 11 of this document. This process is currently under review and the policy and guidance will be updated when appropriate.

6 Involving and empowering of people, their families and advocates

Effective governance strategies must ensure that there is transparency around the use of restrictive interventions. Wherever possible people should be engaged in all aspects of planning their care including how crisis situations should be responded to. People should be involved in post-incident debriefings, and there should be rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.

Advocacy arrangements and access to therapists should give people we support the opportunity to reflect on incidents particularly where restraint has been applied. Life Space Interviews are held with individuals wherever this is possible.

Families are notified of significant incidents when this is appropriate given any matters of confidentiality & consent. Families at some Hesley Group services have a Family Forum where anything from a training session for family carers to concerns about the performance of a service can be discussed. Families are encouraged and supported to visit their relatives as and when they wish, are involved in the reviews of people's care and the multi-disciplinary team meetings when appropriate and necessary.

People's social workers/case workers/nurses must be involved with the review process and information shared with them as necessary to form an understanding of the care and support being delivered, including the use of restrictive intervention.

7 Developing programmes of activities and care pathways for people using services

Each person's programme of education and/or activity should reflect the person's individuality and identity and their hopes, aspirations and plans for the future. The way such a plan's agreed outcomes and actions are developed should be discussed with the individual concerned, putting them at the centre of any planning. It should include a person's needs in relation to culture and diversity and how we aim to ensure these are met.

The Head and Registered Manager for each service are ultimately responsible for ensuring there is a broad and well-balanced choice of activities available to everyone that engages their interest, meets expressed wishes, social, emotional and developmental needs and that people are supported to have good experiences and form positive relationships.

8 Clear strategies and restrictive intervention reduction tools

The TCI System **–** Hesley Group is committed to the use of TCI as an integral part of Hesley Enhancing Lives Programme (HELP for short). TCI is an acknowledged and accredited means of reducing high risk interventions.

"The level of effectiveness in preventing and reducing the need for high risk interventions depends on and begins with the leadership's commitment to using alternatives to high risk interventions. When leadership is fully informed about the TCI crisis prevention and management system and understands its foundation leaders can support the necessary components that are integral to its implementation and maintenance" (TCI Post Crisis Response Reference Guide, Cornell University 2010).

TCI is a system that aims to reduce and prevent physical intervention and that sits well in the context of Positive and Proactive Care (DH 2014). To this end all support workers, managers involved with service delivery, therapists and clinicians are trained in and provided with tools for the use of TCI. The initial training lasts for one week. All staff will receive training in the TCI model of support. This is included in the "HELP" model (Hesley Enhancing Lives Programme) that is being delivered to all new starters and as refreshers. Refreshers are provided annually as a minimum. Our model is certificated by

British Institute of Learning Disability Association of Certified Trainers (BILD-ACT). Training is provided in line with the Restraint Reduction Standards (RRN) 2019.

The HELP model is the positive behaviour support system that incorporates five crucial elements for effective implementation. They are:

- leadership and programme support
- clinical participation
- supervision and post crisis response
- training and competency standards
- incident monitoring and feedback.

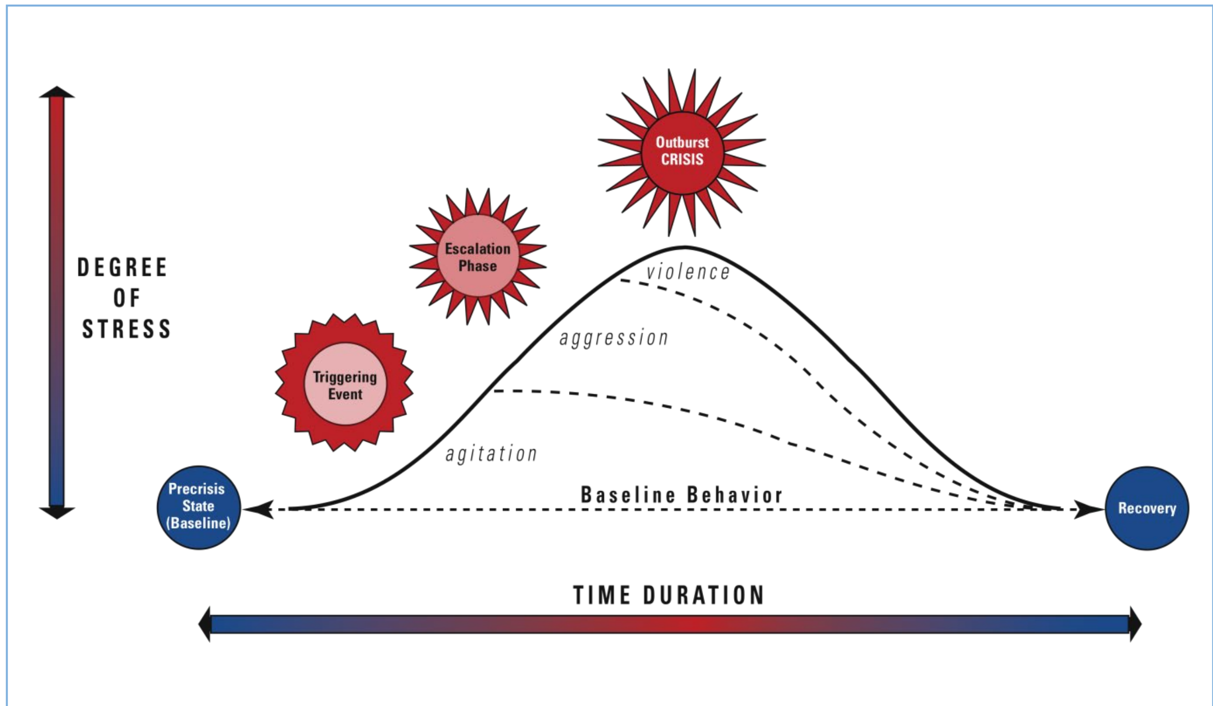
All five elements need to be actively implemented in order to ensure restraint prevention.

The HELP model emphasises that the only acceptable definition of behaviour that challenges is "behaviour of concern" or 'any behaviour that challenges the service that is being offered'. For this reason, the company's behaviour support system relies on an understanding of the meaning behind a person's behaviour and a positive and supportive response to the challenges presented. Planning and implementing a programme for long term change to improve the quality of a client's life is, therefore, crucial.

The model is one that provides for effective support and management of behaviour of concern and its possible causes; ways of working that enable staff to understand there is a function and purpose to people's behaviour and why the outburst may have occurred.

9 The TCI Stress Model of Crisis

This model is the one on which Hesley Group bases behaviour support plans, their monitoring, recording and review. The model is based on four events/phases: Pre-crisis state (or Baseline) Triggering Event, Escalation Phase; Outburst/Crisis Phase and Recovery.



The model describes and gives an overview of behaviour of concern. The term "Challenging Behaviour" is one that we would prefer not to use. The basis for using it is that **we** are challenged generally because we do not understand or respond appropriately to individuals who often have very complex needs. Hesley Group prefers the term "Behaviour of Concern".

Hesley Group behaviour support plans are based on this model. Behavioural incidents are reported upon using this framework to achieve congruence in terms of language, reporting and understanding.

10 Effective models of post-incident review including learning from critical incidents

Effective Post Crisis Response is fundamental to the functioning of any behaviour support and restrictive intervention policy. Leaders in Hesley Group services are provided with training and support to carry out post crisis response that is effective and preventative but also along with therapeutic inputs helps us to set goals for our staff and for people we support.

The aim of post crisis response is to learn from incidents and improve outcomes. Barriers to effective post crisis response can be associated with the following:

- Blaming the person supporting rather than openly and honestly examining other potential factors including developing a good understanding of the likely function of a person's behaviour.

- Inappropriate job expectations of staff – i.e. if staff work with people with complex needs, they must expect negative outcomes, including the need to use restrictive intervention and its consequences.

- Training will fix everything – training is essential but is only one part of an effective crisis management system.

11 Data-driven quality assurance

Behaviour incident forms are currently completed either electronically or on paper formats dependent on the location and accessibility of IT equipment. The information on the forms must be sufficiently detailed to give a true picture of the incident and outcomes. Please see this Guidance and Incident Reporting, ReS 5.1D, for the detailed Incident Report and Reporting Guidelines.

The information from the incident reports is entered onto the HELP Management System, which is a database. This has capacity to record a significant amount of information, including who, where, when and how the incident occurred, any restrictive interventions used and what could have been done differently.

To facilitate the provision of worthwhile data, the Registered Manager for each service must ensure that every incident form is scanned and uploaded into the service's folder and the data entered onto the HELP Management database **WITHIN TWO WEEKS** of the incident taking place (process under review).

Reports may be produced in relation to individuals, varying timescales, areas, services, the whole of Hesley Group, so may be presented for governance purposes in a range of settings. Reporting can identify trends and patterns by individuals and staff and help inform people's behaviour support plans, reviews, multi-disciplinary team meetings, and improving staff practice. All general managers, deputies, care managers, deputy care managers, therapists and clinicians are able to access and use the reporting tool. **If the data has not been entered by the service it is not possible to provide an accurate report.**

11.1 Ulysses System

Hesley Group is rolling out a new recording system that is effective in real time (Ulysses). The process allows incidents to be monitored locally and centrally. Training has commenced at the time of writing and work is underway to transfer entirely to the new system in Autumn 2021. This policy guidance will be reviewed and updated to reflect the new system.

12 Procedures

12.1 Assessment and Planning

People will have a sufficiently detailed assessment of their needs and risk assessments prior to being supported by Hesley Group services. This should include an assessment in relation to their known behaviour support needs at the time based on evidence seen and collected during assessment (see Hesley

Group PBS Policy Guidance, ReS 5.1A.1, and ReS 5.1B.1, also Hesley Group Practice Guidance on Referrals, Assessments, Contracts and Admissions for Children's and Adult Services, ReS 1.1.1).

Planned and effective behaviour support delivered in accordance with the principles of person-centred care and positive behaviour support will be an integral part of people's individual plans, underpinning **all aspects** of the person's daily living experience.

Behaviour support plans will be individualised, and based on a comprehensive multi-disciplinary assessment of the abilities and needs of the person concerned.

Behaviour support will be positive. This means it should be focused on teaching and encouraging the person to develop and use more adaptive ways of responding in difficult situations.

Behaviour Support will be evidence-based. This means it will be consistent with available research evidence on successful management of specific problems and situations from external bodies as well as what we know about the person and their needs and wishes.

Behaviour support plans will seek to use the least restrictive strategies as possible. Any reactive strategies should only be used to bring about effective control over situations by utilising approved and agreed techniques as set out later in this document.

12.2 Monitoring/Reviewing the plans

Behaviour support plans will be reviewed and revised on the basis of regular, structured and objective monitoring of the person's progress in replacing unwanted behaviours, replacing these with more positive alternatives, and improving quality of life.

Behaviour support will be implemented by all staff, and where appropriate by the person using our services, according to the agreed and published behaviour support plan. The staff implementing this plan will be trained for this role and their immediate managers/supervisors given appropriate training for them to enable them to effectively support the member of staff concerned.

An effective behaviour support plan is important so that people understand how best to support each individual. A person's staff team will be advised how best to deliver the plan.

If staff are having difficulty delivering the plans, they must ask their manager for guidance. The support being delivered should match the plans. People who have agreed the plans need to know if they are ineffective. Staff must not "do their own thing".

The behaviour support plans and Individual Crisis Management Plans reflect the "Stress model of crisis" that people learn about when undertaking TCI

(Therapeutic Crisis Intervention) training or the HELP (Hesley Enhancing Lives Programme). The plan will be reviewed on an ongoing basis through the MDT process, as a part of any other ongoing case review and annual processes (see Review Policy and Guidance - Adult Services, ReS 1.2A, and Children's Services, ReS 1.2B and by using the Planning to Reduce Individual Restrictive Practices document, ReS 5.2.4.

All behaviour support plans/HELP profiles must be delivered in conjunction with each person's other individual plans and each person's Individual Risk Assessment and Management Plan (see Individual Risk Assessment Policy, ReS 6.11).

12.3 Behavioural Incident Reporting

Because the people we support are likely to have known behavioural responses to situations they have a behaviour support plan (BSP or HELP profile). Where there is an incident the BSP or HELP profile should of course be followed. If the BSP is followed and there are no adverse effects as described below and no restrictive intervention there is no need to complete an incident report.

If a member of staff discovers an unexplained injury on a person who uses our services they should complete Unexplained Injury Body Map, H&S 1.2.4. There is no need to complete an incident report. Staff will need to report the injury and inform the designated person for the service who will consider the possibility of an alert to safeguarding being required.

Recording and avoiding duplication - If a Behaviour Incident Report Form, ReS 5.1D is completed it should be cross referenced in the persons daily journal and cross referenced in the behaviour support plan update and review sheet and any others that are relevant (e.g. if the outburst was also to do with known responses to food you may need to cross reference it in the Diet and Nutrition Plan also). **There is no need to repeat the entire detail provided that people are directed to locate the report by date and time**.

If there is an outburst/crisis that does not require an incident report this should be recorded in the person's appropriate support plan using the Support Plan Update and Review Sheet, ReS 5.3.3b, and cross referenced in the individual's daily journal.

If there is any doubt about whether an incident form is required for specific individuals this should be discussed at MDT and agreed as part of the person's plan.

Where an incident form is required staff should complete this as soon as practicably possible. Please be factual and to the point. See Step by Step Guidance for Completing Behaviour Incident Reports, ReS 5.1D.3.

The form should be signed by the relevant manager and ultimately "signed off" by a designated manager so that essential information is shared and noted. The form should be saved as a part of the person's care records. The life space interview will not always be appropriate but is to be conducted, as agreed with

the person using services, bearing in mind the person's cognitive abilities and the use of their agreed communication formats.

12.4 Effective Post Crisis Response and Learning

The Incident Review, ReS 5.1A.5/ReS 5.1B.5, is a key tool for summarising the post crisis response. Hesley Group expects that staff will be supported by their managers to reflect on the incident – what went well, what did not go well, why and what we could do better or differently another time, using the TCI post crisis response model. This examines a range of factors and setting conditions that take account of the *"dynamic interaction of the person, the environment, the worker, the supervisor, clinical services, leadership, the agency and the necessity for supportive interventions for staff members who have been through these crises" (TCI Post Crisis Response Reference Guide 2010).*

The Incident Investigation Form, ReS 5.1A.7/ReS 5.1B.7, is to be used if there remain concerns about how the incident was handled, any of the outcomes or it requires referral to other agencies such as safeguarding teams/the regulator.

Managers should always be mindful that their staff are likely to be adversely affected at times – physically and emotionally – when giving people intensive support. Arrangements should be made to give staff one to one support after an incident and the opportunity to talk through how they feel. This should be recorded as an incident review, or if the content is personal and confidential the discussion and agreed outcomes recorded on an "ad hoc supervision form" (see Per 4.6.6).

Injuries and accidents associated with behavioural incidents must be linked to the incident reporting form to aid analysis.

A copy of each incident report must be scanned into the services' HELP Management System folders to await data entry. The quality of shared knowledge and reporting depends significantly not only upon the quality of the reporting and management review but upon the timeliness and accuracy of this whole process, including data entry.

Quarterly Behavioural Incident Review/HELP Meetings will be held at each service and will feed into a quarterly Corporate Incident Review Board.

13 Individual Crisis Management Plans and Physical Interventions

Where this is necessary some people will have an Individual Crisis Management Plan. This is assessed for by a member of the multi-disciplinary team and also a person who is accredited in assessment and training for physical intervention.

Where a major restrictive intervention has occurred, an Incident Report Form, Res 5.1D, must be completed as soon as possible and the intervention entered in the Major Incident Book for the service. **Please note this will include any incident where it may have been necessary to restrict a person's liberty in an emergency, e.g. by holding a door closed. Please note that**

Seclusion as an approach is not lawful except within a mental health setting or prison setting.

The guidelines for staff and managers involved with such a decision are outlined in Flow Chart, ReS 5.2.2, and Checklist, ReS 5.2.3. Managers and staff must be familiar with the content of this.

Date of this Policy	Next planned review date
29/06/2021	29/06/2022

14 Standard Forms, Letters and Documents

14.1 The Audit Process for Person Centred Physical Interventions, ReS 5.2.1

14.2 Flow Chart for Managers and Staff reference Unplanned Interventions, ReS 5.2.2

14.3 Checklist for Managers and Staff reference Unplanned Interventions, ReS 5.2.3

14.4 Planning to Reduce Individual Restrictive Practices, ReS 5.2.4

15 Other Documents to be Referred to

15.1 Positive Behaviour Support - Adult Services Policy, ReS 5.1A

15.2 Positive Behaviour Support - Children's Services Policy, ReS 5.1B

15.3 Hesley Group Clinical Holding Policy, ReS 5.2A

15.4 Incident Reporting, ReS 5.1D

15.5 Staff Learning and Development, Policy Per 3.1

15.6 Health and Safety, Policy H&S 1.1

15.7 Accidents, Policy H&S 1.2

15.8 Near Miss Recording, Policy H&S 1.3

15.9 Car & Minibus Specialist Equipment to Travel (Wheelchairs and Harnesses) – Practice Guidance, H&S 1.9.12

15.10 Care and Health Support Policy, ReS 5.3

15.11 Individual Risk Assessment and Management, Policy ReS 6.11

15.12 People's Rights and Having a Say, Policy ReS 5.8

15.13 Capacity and Consent MCA, Policy ReS 6.4A

15.14 Capacity and Consent DOLS, Policy ReS 6.4B

15.15 Safeguarding Adults at Risk Policy, ReS 2.1

15.16 Fullerton House School Safeguarding and Child Protection Policy, ReS 2.1A

15.17 Wilsic Hall School Safeguarding and Child Protection Policy, ReS 2.1B

15.18 Wheatley House Safeguarding and Child Protection Policy, ReS 2.1C

15.19 Ivy Lane School Safeguarding and Child Protection Policy, ReS 2.1D

15.20 Speaking Up, Policy Corp 5.1

15.21 Information Sharing and Confidentiality, Policy ReS 2.4

15.22 Being Open - Hesley Group Duty of Candour, Policy Corp 8.1

15.23 Ad Hoc Supervision Record, Per 4.6.6

15.24 Hesley Group Employee Code of Conduct, Policy Per 4.9

16 Other Guidance

16.1 Restraint Reduction Network (RRN) Training Standards (BILD August 2019)
https://restraintreductionnetwork.org/wp-content/uploads/2016/11/BILD_RRN_training_standards_2019.pdf

16.2 Reducing the need for Restraint and Restrictive Intervention, (Children)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf

16.3 HSCA (2008) Regulated Activities Regulations and Fundamental Standards 2014 (CQC)
https://www.cqc.org.uk/content/regulations-service-providers-and-managers

16.4 Children's Homes Regulations 2015
http://www.legislation.gov.uk/uksi/2015/541/contents/made

16.5 Positive and Proactive Care (DH 2014)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

16.6 Positive and Safe (SCIE 2014)
https://www.gov.uk/government/speeches/positive-and-safe-reducing-the-need-for-restrictive-interventions

16.7 NICE quality standards for Challenging Behaviour and Learning Disabilities (DH 2014) https://www.nice.org.uk/guidance/QS101/documents/challenging-behaviour-and-learning-disabilities-qs-topic-overview2

16.8 HELP programme including TCI Programme (Cornell University 2010) – Hard copy only – see own copy or Workforce Development Manager

16.9 TCI Post Crisis Response (Cornell University 2010) – Hard copy only – see own copy or Workforce Development Manager