RESTRICTIVE PRACTICE POLICY

Policy Control/Monitoring

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Approved by: (Name/Position in Organisation) **Date:**	Director for Health and Wellbeing
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Associated National Guidance:	Mental Health Act, 1983 (as amended 2007); Mental Health Act Code of Practice Safeguarding Vulnerable Groups Act, 2006; Public Interest Disclosure Act, 1998; Protection from Harassment Act 1997 Family Law Act 1996 Part IV National Health Service Act 2006 The Care Standards Act 2000 Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 Mental Capacity Act 2005 General Data Protection Regulation and Data Protection Act 2018 The Care Act 2014 National Referral Mechanism The Anti-Slavery Day Act 2010 The Modern Slavery Bill (amendment 2021) HM Government Information Sharing Advice (2018) The Public Interest Disclosure Act 1998 Minimum Standards for Organisational Restraint Reduction Plans

	Reducing the Need for Restraint and Restrictive Intervention RRN Training standards Use of reasonable force Advice for headteachers, staff and governing bodies Call for evidence Use of reasonable force and restrictive practices in schools
Document status	This document is controlled electronically and shall be deemed an uncontrolled documented if printed. The document can only be classed as 'Live' on the date of print. The current 'LIVE' policy can be found within 'Foundation Policies' following the below link: https://percyhedleyfoundation.sharepoint.com/sites/PHFConnect

Equality Impact Assessment

This document forms part of Percy Hedley's commitment to create a positive culture of respect for all staff and service users. The intention is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment, pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.
As part of its development this document and its impact on equality has been analysed and no detriment identified.

Version Control Tracker

Version Number	Date
V 1.0	Draft
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Version Number	Date

Contents page

1. Introduction

2. Purpose

3. Scope

4. Definitions

5. Principles

6. Monitoring and Compliance

7. Associated Policies & References

1. Introduction

This policy aims to provide guidance and information in relation to the safe and therapeutic use of restrictive practice within the Percy Hedley Foundation.

1.1. At the Percy Hedley Foundation we will continuously strive to deliver care and treatment that is safe and effective which means that the people we support are supported in an environment that is free from harm.

1.2. We are committed to delivering the highest standards of health, safety and welfare to our visitors and employees.

1.3. We are committed to regularly reviewing and reducing the use of restrictive and coercive practices. We aim to reduce incidents of behaviour of concern that can occur by proactively supporting the people in services. These are highlighted within this policy and the Positive Behaviour Support policy.

1.4. The Percy Hedley Foundation acknowledges the following:

1.4.1. There will be occasions where a person we support may necessitate the use of restraint and/or restriction but that we need to understand that in doing so it can cause distress, be retraumatising, undermine dignity, and cause short or long term physical and psychological harm.

1.4.2. That there remains an over-reliance on restraint and restrictions within the health and social care and education sector. Therefore, restraint and/or other restrictive practices will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary ‘time out’, or gaining consent to taking medication, have not been successful, or are judged likely to fail in the circumstances.

1.4.3. The Foundation acknowledges that all members of staff have an ethical, professional and legal obligation to prevent harm to themselves and others, and that this may lead to restrictive interventions to prevent greater harm from occurring.

1.4.4. We will achieve this by continuing to adhere to evidence-based preventative strategies. This includes a systemic approach to change by embedding a positive, rights-respecting culture. Alongside a whole-organisational approach which incorporates the six core strategies on leadership, data collection, training, prevention, involving people with lived experience and post incident support and debriefing are key to creating culture change that supports restraint reduction.

1.4.5. There will need to be two forms of risk assessments carried out. The first one is a training needs analysis risk assessment which will be held on the NAPPI portal, this must be completed to ensure that the service identify any areas to focus to ensure the greatest impact and outcomes. The components of risk are dynamic and may change depending on context and circumstance so it is important that these are reviewed formally on NAPPI annually but in service must be reviewed more frequently. Which means that the risk assessment will be ongoing and care plans are accurate with up-to-date information. The second is generic risk assessments for the health and welfare of employees and visitors so that we reduce the risk of injury.

1.4.6. We will work collaboratively with the people that we support, their carers and families and any other relevant stakeholders.

1.4.7. We will learn from incidents and further develop a culture of recovery through open discussions and building therapeutic relationships. This will be achieved through post-incident reports and de-brief processes.

2. Purpose

2.1. The aim of this policy is to encourage good practice and positive culture across the Foundation where the use of restrictive practices are minimised and used in a transparent, legal, and ethical manner.

2.2. This policy will provide guidance on restrictive practices to all staff. It will also look at the process for managing behaviours of concern by using primary, secondary and tertiary approaches including reporting and evaluating the use of restrictive interventions/practices.

2.3. This policy will cover:

- The 8 types of restraint
- Blanket Restrictions
- Principles of positive and proactive care
- Six Core Strategies and human rights infographic
- Positive approaches: reducing restrictive practice
- National Minimum Standards (restraint reduction plans)
- Restrictive Practices tools and process

3. Scope

- The restrictive practice policy has been established to monitor, record and reduce the overall restrictive practices that occur within our education and health and social care services

- All members of staff are responsible for ensuring they implement this policy and that they report any concerns to their line manager and they record any incidents on the Foundations incident reporting system Vatix (or equivalent)
- To ensure that the Foundation complies with national policy
- To record and monitor restrictive practices implemented alongside a skill building plan to reduce the restriction
- Ensure standards in quality of practice
- Reduce risks to individuals
- Encourage staff teams to consider and reflect on their practice
- Highlight the need to justify restrictions
- Reduce the risk of 'low-level' restrictions developing into greater restrictive practices
- Raise the issue of restraint during personal care
- Establish restriction reduction plans

4. Definitions

- ***Restrictive Practice***- Interventions that may infringe a person's human rights and freedom of movement, including locking doors, preventing a person from entering certain areas of the living space, seclusion, manual and mechanical restraint, rapid tranquillisation and long-term sedation. (NICE guidelines)

- ***Restraint-*** Any method of responding to challenging behaviour which involves some degree of force to limit or restrict movement of mobility. (Harris et al., 2000). It is important to note that restraints are not treatments, but a safety measure of last resort.

- ***Seclusion-*** The Code of Practise for Mental Health Act 2008 in England defines seclusion as the supervised containment of a person in a room which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. (Department of Health., 2008).

- ***Tranquilisation/as required medication***- rapid tranquilisation is defined as the use of medication to calm, lightly sedate the service user and reduce the risk to self and all others. Its aim. Is to achieve an optimal. Reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place whilst allowing comprehension and response to spoken messages throughout. (NICE., 2005).

- ***Practice***- using standards, practices, methods and procedures conforming to the PBS framework.

- ***Intervention***- actions that are in line with the PBS framework to improve quality of life.

5. Policy

5.1 Key principles underpinning the guidance:

• Compliance with the relevant rights in the European Convention on Human Rights13 at all times

• Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced

• Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations

• People must be treated with compassion, dignity and kindness

• Health and social care services must support people to balance safety from harm and freedom of choice

• Positive relationships between the Foundation and the people they support must be protected and preserved

5.2. 5 types of restraint described:

- ***Physical restraint*** involves one or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.
- ***Mechanical restraint*** involves the use of equipment. Examples include everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop a person we support from getting out of bed. It also involves measures that controls the freedom of movement such as keys, baffle locks and keypads.
- ***Technological surveillance*** – this involves any form of surveillance on a person we support such as tagging, pressure pads, closed circuit television, or door alarms. This is often used to alert staff that the person is trying to leave or to monitor their movement. Whilst not a direct restraint in themselves, they could be used to trigger restraint, for example through physically restraining a person who is trying to leave when the door alarm sounds. These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.
- ***Chemical restraint*** involves using medication to restrain. This could be regularly prescribed medication or medication that can be used as required. It includes over-the-counter medication and/or illegal drugs.

- ***Cultural restraint*** is using cultural norms to make a person do something they don't want to do or stopping them from doing something they do want to do. I.e stopping a person from expressing their cultural views or preferred ways of being.

- ***Environmental restraint*** is using the physical environment to make someone do something they don't want to or stop them from doing something they do want to do. Numerous terms refer to environmental restraint – segregation, isolation, time-out, solitary confinement.

- ***Psychological restraint*** can include constantly telling the person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

- ***Blanket restraints*** are rules or policies that restrict a person's liberty and other rights.

5.3. Blanket Restrictions

Blanket restrictions is explained by the Mental Health Act Code of Practice as rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket Restrictions might include restricting a person's access to the outside world or certain rooms within a care setting; limiting or banning access to the internet and/or mobile phones, electronic games, DVDs and charging units; restricting connection with the outside world by 'checking' incoming or outgoing mail, implementing rigid visiting hours, reducing access to money, food and drinks and the ability to make purchases and/or take part in preferred activities. These are only a few examples.

The Code states that rules which are routinely applied to everybody should not be used unless they:

- Can be justified as necessary to manage an individual's risk
- Are proportionate to the individual's risk
- Continue to be needed and are regularly under review

There are certain policies and procedures in place within the Foundation that are in place to match the needs of the people we support, to ensure progress whilst minimising risks. Where an area in the Foundation needs to operate a blanket restriction which is not indicated within the operational policy or that the policy indicates

a blanket approach that needs to more person centred, this should be done for the shortest reasonable time and be monitored and reviewed through local governance frameworks with a clear measurable outcome for the restriction ceasing. If the blanket restriction needs to be in operation for an indefinite period, this should be reflected within the service's operational policy (i.e school, college, care home).

Staff should display the restrictive practice policy within their service.

Blanket Restrictions Poster.pdf

The following guidance has been published by the Restraint Reduction Network. It has been aimed at practice leaders and refers to the 4 R's model:

- Rules – Let's identify them and name them as such
- Reason – Let's find out the reason they are being used
- Rights – Do they impact on rights and wellbeing without good reason?
- Review – What are we going to do about them?

There is a checklist which managers are expected to complete to record where they think their service is at and identify what action needed. The audit must be revisited on a quarterly basis with the identified team.

RRNBR Practice leader tool.pdf

5.4. Principles of positive and proactive care

The Percy Hedley Foundation follows the principles of positive and proactive care which will allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles. These are:

- 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 severity 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 who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.

If there is a situation relating to the use of restrictive practice/restraint within the Percy Hedley Foundation, we will ensure that it is explicit and clearly documented in the relevant notes . We will also have a written care plan which reflects the above principles and should also include:

- Assessing/documenting if the adult we support has mental capacity- this can be completed using an MCA 1 and MCA 2. Presumption of capacity- it is assumed that everyone has capacity until proved otherwise
- The Mental Capacity Act 2005, does not relate to children under the age of 16.
- A mental capacity assessment must be complete for all students 16+ to determine if they have or lack the capacity to decide and consent to the proposed restrictions. This must follow the Mental Capacity Act and should complete in collaboration with social care. Only when a student has been identified as lacking capacity for this specific decision can we progress to the next step as the best interest decision can only be made when it has been determined that a student lacks capacity.
- An aligned risk assessment
- Rationale for the use of restraint/restrictive practice and evidence of multi-disciplinary discussion and approach
- The frequency of re-assessment of the need for restraint/restrictive practice. Review times should be specified in advance. There should be emphasis on ongoing review of the need to use restrictive practice /restraint
- There should always be a restraint reduction plan alongside a restriction. This is to ensure the restriction is not in place for longer than is necessary
- All discussions that have taken place to allow the person we support to give valid consent and to assess best interests if they lack capacity
- Details about the use of any restraint/restrictive practice itself

5.5. Six Core Strategies and human rights:

- **Leadership-** Both organisational leadership and practice leadership is needed. For example, leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects restraint reduction, within The Percy Hedley Foundation, this will form part of the Positive Behaviour Support strategy. Within this strategy we will also ensure that a plan is in place to monitor and improve our workforce development.

- **Data Collection and Analysis-** for successfully reducing the use of restrictive practice it requires the collection and use of data by facilities at both local level and organisational level. We will carry monthly reporting which will include information on the restrictive practices used at services, shifts, day, time, individual staff members involved in events, involved person we support demographic characteristics, the concurrent use of stat involuntary medications;

the tracking of injuries related to restrictive practice events in both people we support, staff and other variables.

- **Workforce Development-** that staff are trained in preventative strategies and not just reactive strategies. At The Percy Hedley Foundation we will achieve this through intensive and regular staff training and education. We will also provide consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to restrictive practice reduction through training about the prevalence of violence in the population of people that are served in learning disability settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. We will also ensure that our recruitment teams are aware of restrictive practices so that when we recruit new applicants we can reflect it in our interview questions, job descriptions, performance evaluations, new employee orientation, and other similar activities.

- **Using prevention tools and strategies-** using evidence-based prevention approaches such as Positive Behaviour Support. The PBS prevention approach will allow The Percy Hedley Foundation to use universal trauma assessments, tools to identify persons with high risk factors for injury or behaviours of concern, the use of de-escalation surveys or safety plans; the use of person-centred planning and ensuring maximum quality of life.

- **Involving people with lived experience-** using lived experience to inform reduction strategies. At The Percy Hedley Foundation we will have full and formal inclusion of the people we support, children, families and external advocates in various roles and at all levels in the Foundation to assist in the reduction of restrictive practices.

- **Post incident support and review-** Providing emotional support after an incident and non-blaming opportunity to reflect and learn after an incident has occurred.

Human Rights Act 1998

The restrictive practice policy will be linked to the Human Rights Act (1998) to enable the culture change which is necessary in all organisations to reduce the use of restrictive practices. The following articles with be reflected within the work in the Foundation:

- **Article 2-** The right to life is protected and people are protected from accidental death.
- **Article 3-** The right not to be tortured or treated in an inhumane or degrading way.

- **Article 5-** The right to personal freedom, no-one must be imprisoned or detained without good reason.
- **Article 8-** Right to family, relationships, well-being, privacy and home, including seeing family, and being heard.

5.6. Positive approaches: reducing restrictive practice.

Positive and proactive (or preventative) approaches are based upon the principles of positive and proactive care (which was discussed in section 5.3) the foundation will carry out the following approaches:

- Getting to know a person.
- Respecting and valuing their histories and backgrounds, and understanding: their likes and dislikes, their skills and abilities, their preferred communication style and support structures.
- Understanding the effect their environment has upon them and using this to identify ways to support people consistently in every aspect of the care that they receive.
- Developing and monitoring plans that outline a person's needs, desired well-being outcomes and the ways they will be supported to achieve these.
- Developing good relationships is crucial, and staff should always use positive and proactive approaches. These are always essential but especially when someone is:
    - Dysregulated
    - Stressed
    - Distressed
    - Frightened
    - Anxious
    - Angry and at risk of behaving in a way that challenges their safety and/or the safety of others.
- Avoiding restrictive practices by working preventatively and meeting needs before crisis arises. However, there may be rare occasions when it is necessary to use restrictive practices to prevent harm to an individual or others.
- Positive Behavioural Support (PBS) is highlighted as on of the approaches that includes the key components required to support effective person-centred practice thus reducing restrictive practice. The Percy Hedley Foundation will continue to support the implementation of this Framework as a supportive tool to reduce restrictive practice. This is because PBS is an evidence based multi-component framework for supporting people who display behaviours that challenge, or who may be at risk of developing them. Its primary focus is to improve quality of life through an understanding of the reasons why an individual may use their behaviour to communicate and get their needs met; and then to use this understanding to build better support, to support positive outcomes, and to improve the services that individuals receive.

The Percy Hedley Foundation will balance the safety from harm with freedom of choice and positive risk taking and actively support people to balance their own safety from harm with their freedom of choice. It is important that The Percy Hedley Foundation can support people to make choices, take risks and learn from their mistakes (as well as ours). However, there may be some situations where staff need to provide a level of control and management to a person's behaviour to safeguard their welfare.

5.7. National Minimum Standards (restraint reduction plans)

This framework is called 'Towards Safer Services' and it refers to a set of standards on how to restrain people less with the any organisation. It has a 3-layer system which set out what a Director should be responsible for, what workers that care for people, like teachers, nurses, or care workers are responsible for and those who teach about restraint are responsible for.

It states that the Director should be responsible for:

- A strategy to restrain people less including a statement of intent.
- Deciding where to spend their budget.
- Knowing who is being restrained or restricted and why.
- Ensuring systems work at different levels and environments? such as a classroom, residential service or home level, department level, and everywhere.

It states that the workers are responsible for:

- Obliged to continuously reduce restraint.
- Ensuring they attend required training.
- Are aware of how to seek help when they need it.
- Be open and honest when an incident occurs.
- Contribute to the development of good quality care plans collaboratively with the person. Care plans can include 'interventions'. Interventions are the things we do to care for people and keep them safe. The first interventions are good everyday care. This might be how the person looks after themself, is treated, learns, or works. The second part of the care plan is for when the person feels dysregulated, especially if that means they might engage in unsafe behaviours. There must be a good quality plan for these difficult times. That might mean seeking more help/support, more treatment or care. This second part can help to avoid restraint. The third part of the care plan explains how the person might be restrained, or have other things, like medication they might not want at the time. These are 'tertiary' or third, interventions. Even though we don't want to do them we have to plan for them. Safety should come first.
- Workers involved in restraints need to know why they are dangerous.

It states that those who are responsible for teaching are responsible for:

- Everyone should work together to reduce restraint.

5.8. Restrictive Practice Tools and Auditing

The Restraint Reduction Network created a self-assessment tool which is intended for use by organisations. The tool has been designed to assist organisations to identify and consider those aspects of performance that can be celebrated and shared, and to understand which aspects of performance are weaker or not fully implemented. By undertaking this assessment, it is hoped that this information can be used to inform the organisation's improvement/development plans. The self-assessment tool has also been developed to enable organisations to share their performance so that the people we support, their families, frontline staff, commissioners, and regulators can easily observe what is happening: what is going well and what aspects are being improved.

The assessment has a criteria statement under each of the six core strategies against which observed evidence is gathered or established so that the assessor can give a rating. The rating should be seen as a confidence 'score' which illustrates the extent to which the assessor believes the Foundation implements a specific approach.

The assessment will be carried out by a senior member of staff who is qualified in Positive Behaviour Support.

It will be completed within these three steps:

- **Self-Assessment-** this involves individual teams or departments. They can be asked to undertake a self-assessment in order to give greater control and responsibility by engaging with the assessment criteria, becoming more active in their learning and taking ownership of their performance. Self-assessment and developing effective reflective skills are essential elements of restraint reduction that can help teams or departments to have a better understanding of exactly what is expected so that they can clearly identify what they do well and what they may wish to improve.
- **Peer Assessment-** this involves an assessment with a selected team or department taking responsibility for assessing the performance of another team or department. It is a powerful way to increase motivation and engagement. Peer assessment can encourage deeper understanding and learning of the assessment criteria and can allow departments to gain an understanding of how their peers implement or operationalise different approaches. Whilst peer assessors are often the harshest critics, they are also very good at identifying good practice and everyday examples of positive outcomes that their peers may overlook.
- **Service User and Family Assessment-** working together to increase understanding of the people we support and families' experiences and ensuring the differing views of the people we support and families are collected and used to improve performance is a considerable challenge but one which brings many benefits to organisations. Gaining service user and family feedback on performance can have an effect on how services are planned, organised and delivered, which in turn can have a positive effect on care outcomes by making services more responsive to people's individual needs.

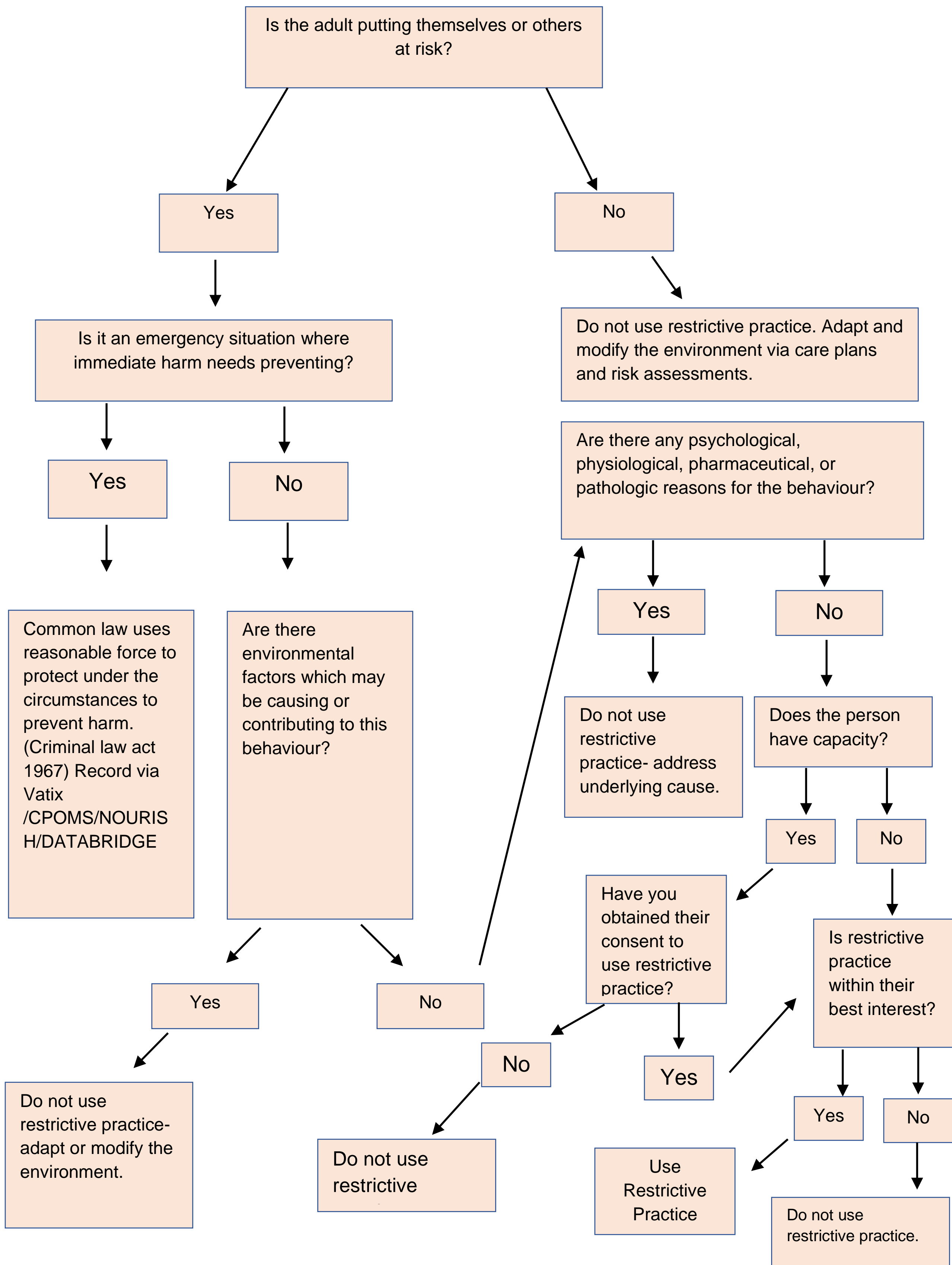
The assessment must be completed **every 6-12 months per service.**

Reducing-Restrictive-
Practices-Checklist.pd

The tool can be found on the RRN website:

https://restraintreductionnetwork.org/wp-content/uploads/2019/10/Reducing-Restrictive-Practices-Checklist_editable.pdf

Restrictive Practice flowchart (Adults)



Process for Introducing Restrictive Practice in Schools

1. **Trackplan**

Blanket restrictions - Staff member completes a Trackplan request. Maintenance Team then highlight any requests relating to potential restrictive practice to the PBS team for review and discussion.
Person Specific Restrictions – Query is raised with OT, PBS team or NAPPI Trainer or relevant Professional.

2. **Initial assessment**

Blanket Restrictions -
During the fortnightly PBS team meeting any requests will be discussed to establish the following:

- **Proportionate:** Is it felt the restriction is proportionate to the level of risk?
- **Least Restrictive:** Is it felt the restriction is the least restrictive option? Are there any other less restrictive options?
- **Best interest:** Is the restriction in the best interest of the individual?

Person specific Restrictions-
Identified Professional or PBS team will review request to establish the following:

- **Proportionate:** Is it felt the restriction is proportionate to the level of risk?
- **Least Restrictive:** Is it felt the restriction is the least restrictive option? Are there any other less restrictive options?
- **Best interest:** Is the restriction in the best interest of the individual?

(If the answer is yes to all of the above then move to number 3)

If all answers to the above questions are not yes then a conversation will need to take place to decide what changes can be made to satisfy the above, such as a less restrictive option, to look at this from a behaviour perspective, training to be provided to the team if a training need has been identified. Feedback to the team must take place so they are clear about what the next steps look like.

3. **Risk Assessment**

A risk assessment must be developed highlighting the risk to the individual and control measures required to reduce the risk to an appropriate level. The risk assessment will have identified restrictions (i.e. travel harness, walking harness…) as control measures in this scenario. *(Skip to Step 5 for those under the age of 16).*

4. **Mental Capacity Assessment**

A mental capacity assessment must be completed for all students 16+ to determine if they have or lack the capacity to decide and consent to the proposed restrictions. This must follow the Mental Capacity Act and should completed in collaboration with

social care. Only when a learner has been identified as lacking capacity for this specific decision can we progress to the next step as the best interest decision can only be made when it has been determined that a student learner capacity. When a learner is assessed to have Capacity, they should be involved in the decision making process regarding any restrictions.

5. **Best Interest Meeting**

The best interest meeting must be arranged where a conversation between professionals (typically parents, school, and the social worker) must occur. The best interest meeting aims to discuss the identified risk and the proposed control measure(s). It is also an opportunity to discuss and explore other options to ensure the agreed restriction is proportionate, in the persons best interest and the least restrictive option. Suppose the panel agrees on a restriction. In that case, the panel should decide a plan that identifies what action will be taken to support the safe removal of the restriction – this will often detail the skills/knowledge the team will support the learner to develop, so the restriction is no longer needed. The panel will agree on a review date when they will meet to review the progress made towards the plan. It must be discussed within this meeting if it is felt the restriction(s) could amount to a DoL (deprivation of liberty) – if this is the case, it will impact who can consent to the restriction.

6. **Consent**

- **Consent for Restrictions:** The school must obtain the correct consent before a restriction can be put in place. Parents must consent to restrictions for children under the age of 16 where parents have parental responsibility. The local authority must consent for children under 16 where the local authority holds parental responsibility. Consent is gathered from the panel for those 16 and over.

- **Consent for DoL:** If a learner is under 16 and looked after by their parents, the parents can consent to a DoL. Parents cannot authorise a deprivation in respect of a student learner 16-17. If the student is in the local authority's care, the LA would need to seek authorisation from the Court of Protection via a COPDOL11 form, similarly for students 16 and over.

7. **Review Meeting(s)**

Review meetings must establish if sufficient progress has been made that support the move towards either a less restrictive measure or the removal of the restriction. If any changes are agreed upon, this will be risk assessed to determine if the changes are safe before any changes are made.

6. Documents needed to record the restrictive practice

For individuals over the age of 16 who lack capacity to engage independently in the completion of an assessment for any form of restrictive practice then conversations are necessary regarding any known preferences and wishes and estimating what the person would want should be discussed between their relatives, carers and health professionals. This should be done via the best decision-making process in line with MCA 2005. The agreed information should then be documented in a clear format and supported by MCA best interest decision making documentation.

- **The MCA1** part of this form allows a capacity assessment to be documented. If the individual does not have capacity for a specific care decision.
- The **MCA2** part of the form follows the requirements of the Mental Capacity Act best interests process.
- The restriction needs to be recorded within the individuals care plan and risk assessment within the Foundation systems
- There will also need to be an individual risk assessment completed with NAPPI which will determine the appropriate level of authorised restriction. These will be reviewed annually and can be assessed by the service delivery lead and the Director of Health and Wellbeing.
- Any new restriction needs to be reported to the PBS lead and the Director of health and wellbeing so that it can be recorded with NAPPI portal and monitored through their individual risk assessment.

7. Monitoring and Compliance

Overall responsibility for the operation of the policy lies with the Director of health and wellbeing and delegated to the PBS Lead/Head of Service/Registered Manager/Deputy Principal. The effectiveness of the policy will be formally reviewed and monitored as a minimum on an annual basis to ensure that it continues to meet the requirements of The Foundation, the specific service area and that it reflects best practice and statutory legislation as appropriate.

8. Associated Policies & References

- Terms of Reference
- Safer Recruitment Policy
- Whistleblowing Policy
- Duty of Candour Policy
- Confidential Reporting of Concerns
- Equality and Diversity
- Medication Management
- Mental Capacity Act & Deprivation of Liberty Policy
- Dignity and Respect Policy
- Lone working Policy

- Social media Policy
- Positive Behaviour Support Policy
- Disclosure Barring Service (DBS) Policy
- Disciplinary Policy
- Mental Health Act, 1983 (as amended 2007);
  http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf
- Safeguarding Vulnerable Groups Act, 2006;
  https://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf
- Public Interest Disclosure Act, 1998;
  https://www.legislation.gov.uk/ukpga/1998/23/pdfs/ukpga_19980023_en.pdf
- Mental Capacity Act, 2005 (including the Deprivation of Liberty Safeguards, and MCA Codes of Practice which supplement the Act);
  http://www.legislation.gov.uk/ukpga/2005/9/data.pdf
- Family Law Act 1996 Part IV
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