Avon and Wiltshire Positive Behaviour Support Network

For people who support individuals with a learning disability who have challenging behaviour

Reducing Restrictive Practices

Updated Guidance

January 2019

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Contents

1. Introduction

What do we mean by Restrictive Intervention?

The Mental Health Act Code of Practice, January 2015 says:

> "Restrictive intervention' means a deliberate act to restrict a person's movement, liberty and/or freedom to act independently."

2. Who is it for?

This guide is for people working with those who need support.

This may include adults of all ages, or children, who have:

- A Learning Disability and/or Autism
- Autism Spectrum Disorder
- Mental Health conditions
- Sensory processing difficulties
- Communication difficulties
- Behaviours that challenge services
- Involvement with the Criminal Justice System

3. How does it work?

The list in number 5 identifies things that are restrictive practices.

The flowcharts show you the process you need to follow to make sure your actions are lawful and in the best interest of the individual.

The processes that need to be followed, to make sure that we are acting within the law in the way we support people, are explained in an easy to follow way.

4. Acknowledgements

With thanks to Community Therapeutic Services (CTS) for sharing the documentation in the appendices. Please feel free to use, but please acknowledge CTS.

5. Restrictive practices

Restrictive practices include:

- **Physical intervention**

  "the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm."

  The Mental Capacity Act 2005

BBC News – 27th July 2011

Physical interventions, such as removal or restraint, are **NOT** treatments, and can only be used to make a situation safe.

They must be approved techniques that are part of a package of care.

Panorama

Use of physical restraints that are not approved and part of a package of care, is not acceptable, and the police could be involved.

- **Seclusion**

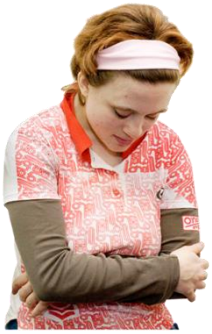
"The supervised confinement of a patient in a room, which maybe locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others."

Royal College of Psychiatrists

NCR - A Film by John Kastner

Homes don't usually have a seclusion room.

These are more likely to be found in Mental Health wards.



Withdrawing support, or leaving someone alone, for long periods, can make the person feel isolated.

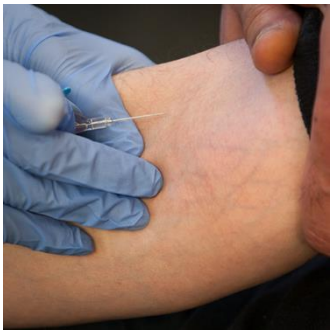
Support should always remain available to the person and re-established as soon as possible.

- **Chemical restraint**

"Chemical restraint is defined as the use of any type of drug to restrict an individual's movement or freedom. Chemical restraint may be used solely for the purpose of sedating an individual. In most cases, chemical restraint typically refers to psychopharmacological drugs, such as sedatives and anti-anxiety medications."

Nursing Home Abuse Guide

"When medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need."
nice.org.uk

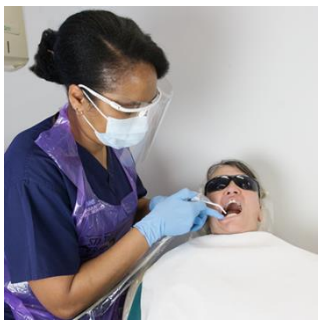


Rapid tranquilisation involves the use of physical restraint to hold a person while they are given an injection.

- **Pro-Re-Nata (PRN) medication**

"PRN, the abbreviation of Pro Re Nata in Latin, means *as the circumstance arises* or *in the circumstance*. It is commonly used in medicine to signify a medication that should be taken only when needed, as opposed to medications that should be taken strictly at a given time with a given dosage."

New health guide.org



Giving PRN medication when the person is already distressed is unhelpful.

Planned use of PRN to reduce anxiety before a difficult appointment or situation can be helpful.

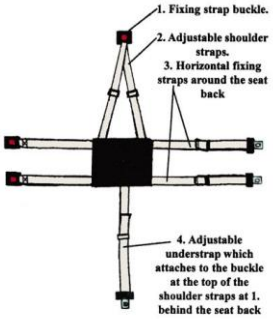
- **Mechanical restraint**

shutterstock

"Any restrictive device (e.g., seatbelt, straitjacket (camisole), vest, or physical confinement) used to restrict a person's free movement, most commonly in emergency situations."

medicaldictionary.thefreedictionary.com

What-when-how.com



Activerehab.net

Many everyday items, used for the best reasons, could be classed as mechanical restraint if their use is not clearly stated and managed in a support plan.

- **Environmental restraint and Electronic Surveillance**

  "change or modify a person's surroundings to restrict or control movement."

  alzheimer.ca

Pharmeden

ivacbe.info

Frequency Precision

elitehealthcare.ie

- **Forced care**

  (i.e. personal hygiene)
  "Restrictive practices may be used in a planned or unplanned way in order to provide essential care, support or medical treatment."

Everyone has their own preferences and standards around personal care.

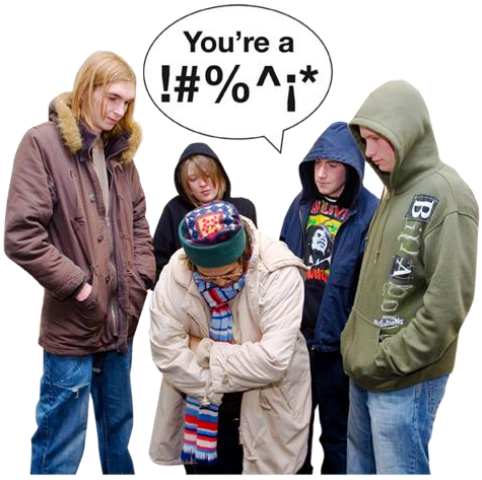
We can't impose our standards on others.

As carers, we may feel judged if the person we support attracts attention from others.

Performpodiatry.com

- **Threatening or verbal intimidation**

  "Psychological abuse: including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming controlling, intimidation coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive network."



- **Cultural restraint**

  "Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group."

  Royal Cornwall Hospitals NHS Trust

This may include failure t support the person to attend religious or spiritual events of their choosing; not providing for dietary needs; not providing access to showers or handwashing facilities.

- **1:1 (+) staff support**

  Having staff with the person all the time.

Most of us value having some time to ourselves.

- **Decision Making**

  Making a decision on the person's behalf, or not accepting or acting on a decision the person has made.

Royal Cornwall Hospitals NHS Trust

Withholding information

Not giving the person information that they are entitled to. This may include reading/censoring their mail before giving it to them.

Dietary restrictions

Putting someone on a diet, giving them 'low-fat' foods, diet drinks, decaffeinated tea/coffee.

Financial restrictions

Telling someone what they can or can't spend their money on, 'looking after' their money.

Alcohol restrictions

Telling someone they are not allowed to drink alcohol.

Tobacco restrictions

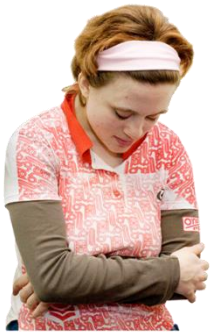
'Looking after' someone's cigarettes. Telling them when they can smoke.

Therapy

Telling someone they must attend appointments and therapy sessions.

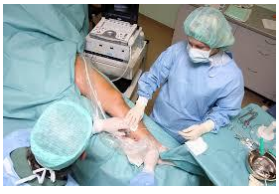
Community access

Restricting when a person can go out, or where they can go.



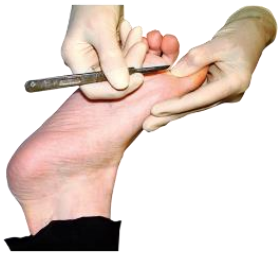
Health Appointments

Including blood tests, treatment, operations, etc..

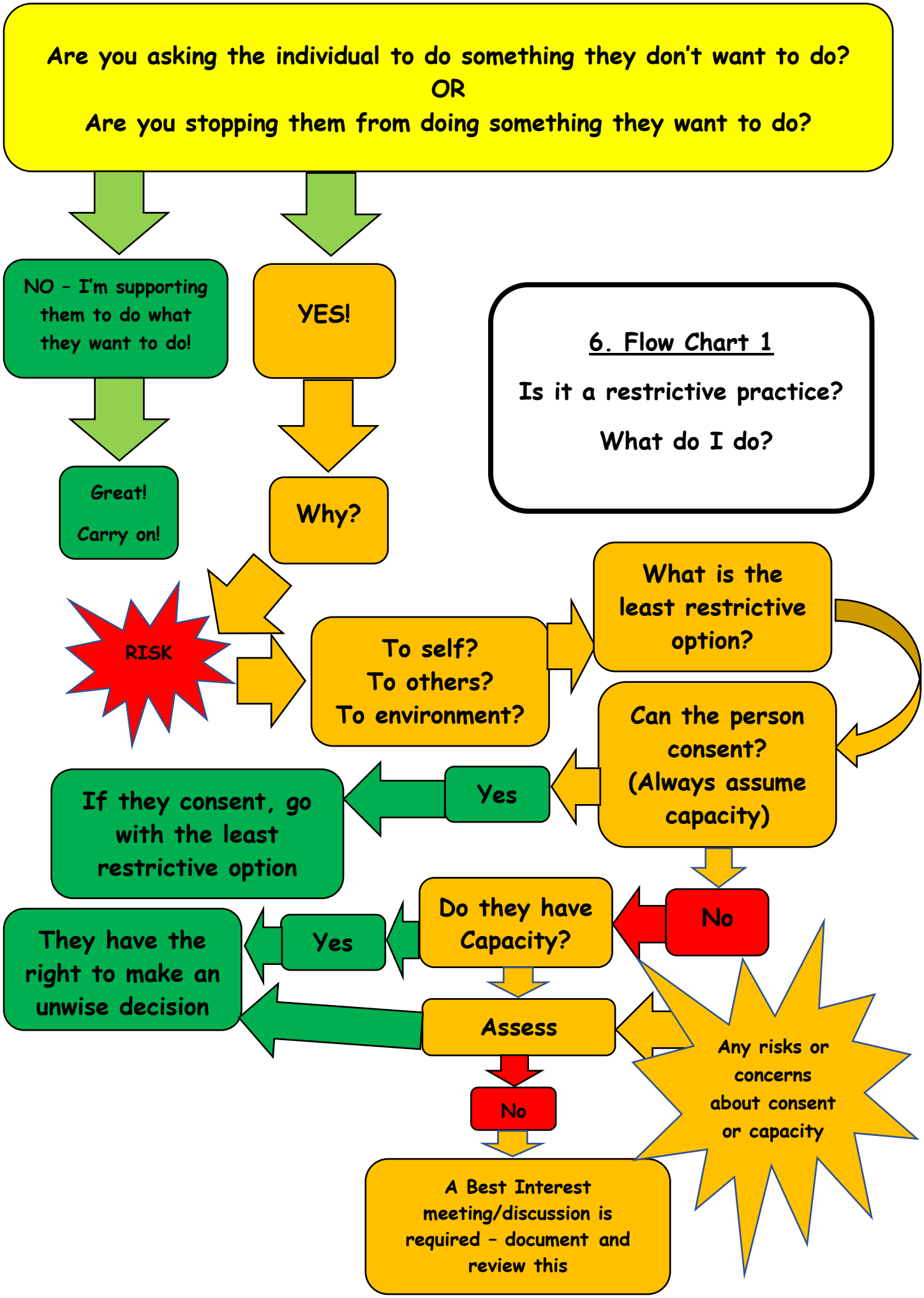


Commons.wikimedia.org

Pixabay.com



This is not an exhaustive list. Anything that stops a person from doing what they want to do, or makes them do something they don't want to do, is a restrictive practice.


Are you asking the individual to do something they don't want to do?
OR
Are you stopping them from doing something they want to do?
NO – I'm supporting them to do what they want to do!
YES!
6. Flow Chart 1
Is it a restrictive practice?
What do I do?
Great!
Carry on!
Why?
RISK
To self?
To others?
To environment?
What is the least restrictive option?
Can the person consent?
(Always assume capacity)
Yes
If they consent, go with the least restrictive option
No
Do they have Capacity?
Yes
They have the right to make an unwise decision
Assess
Any risks or concerns about consent or capacity
No
A Best Interest meeting/discussion is required – document and review this

7 Identifying and Managing Risk

What does the individual think?

Remember, if they have capacity, they have the right to make unwise decisions

Key questions to consider:

- What is the worst that could happen in this situation?
- Who is at risk?
- When does the risk occur?
- Where does the risk occur?
- Why does the risk occur?

Other considerations:

How often does the behaviour occur?

When did it last occur?

How long does it usually last

Are there any other contributing factors?

What are the options available to minimise the risk?

- List all the possible solutions
- Be creative in your approach to risk taking
    - How can you make it happen?

Which is the least restrictive option? – choose this one!

What is the next step towards reducing restrictions? – how will you work towards this?

8. <u>Managing Unforeseen Risk (or crisis)</u>

(See Flow chart 2)

We can't plan for every single possibility! Sometimes things go wrong, and we have to deal with a situation when it happens!

- **Make it safe!**

  Our priority is to make the situation safe.

- **What are the options here and now and which are the least restrictive?**

  We need to be able to think on our feet, and quickly think through the options available, and choose the one that is least restrictive. This is dynamic risk assessment.

- **How do we check everyone is OK?**

  When the immediate danger has been dealt with, it's important to make sure that ***everyone*** involved, or affected, is ok. It is helpful to have a way of documenting that this has been done, and that you know what, if any, ongoing support is needed.

- **How do we reduce the likelihood of this happening again?**

  It is essential that any 'incidents' are documented as soon as possible, and that there is an opportunity for those involved to reflect on what happened. This is often called a debrief.

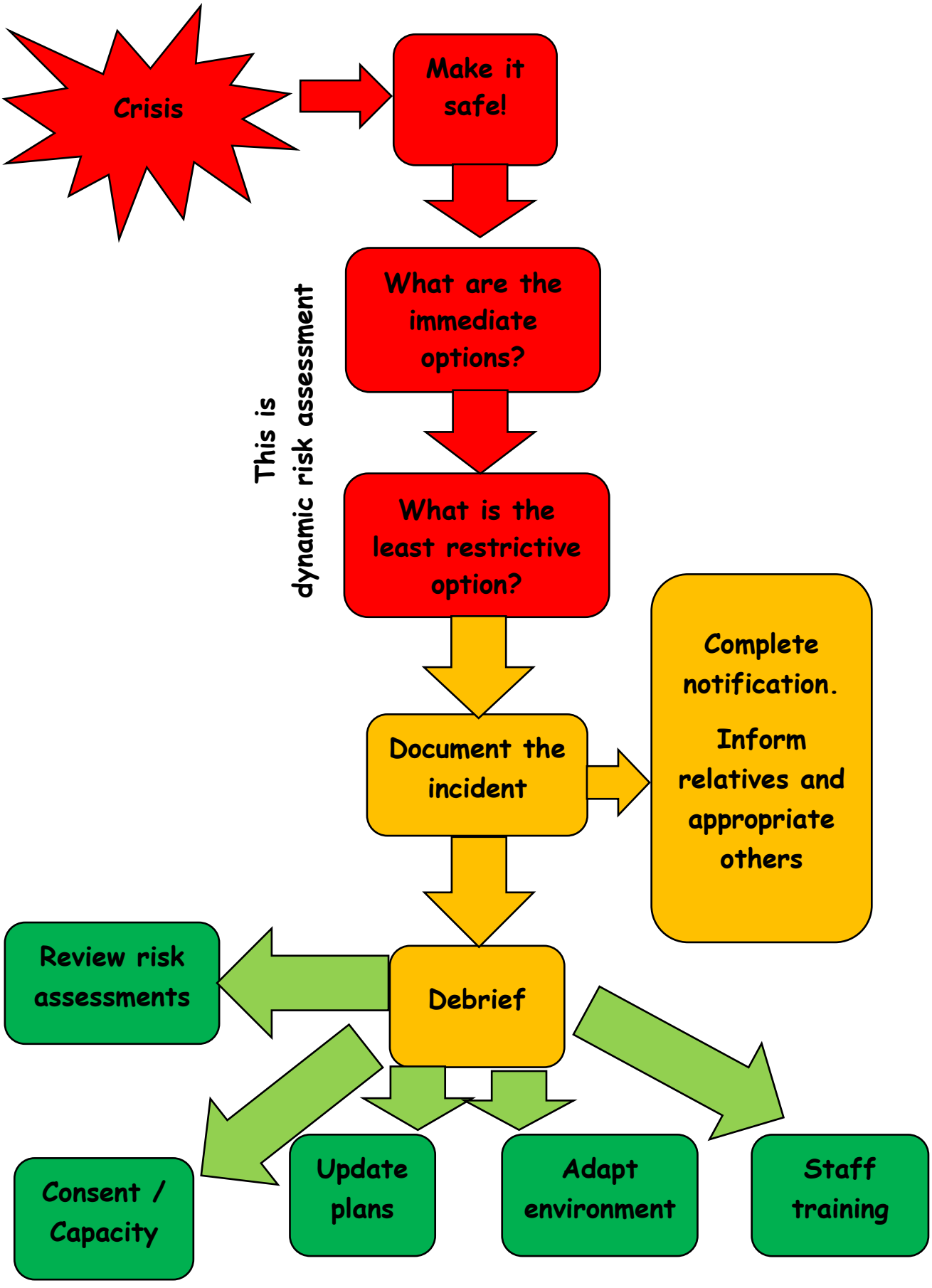
- **How do we learn from this situation?**

  The key things we want to think about are:

  - What could have been done differently
  - Were there any things that stopped things from being done differently
  - Are any changes needed? (environment, support plans)
  - Is any specific training or support needed?

  We need to know what has happened and organisations will have their own way of recording and reporting this (there is an example of blank incident form in appendix)

9. Flow Chart 2 - Managing a crisis



10 Consent

The principle of consent is an important part of the Human Rights Act.

No-one can give consent for another adult,

unless they are a Court Appointed Deputy or have Lasting Power of Attorney

Can the person consent (agree) to the least restrictive practice you suggest?

Consent must be ***voluntary*** and ***informed*** and the person consenting must have the ***capacity*** to make the decision.

- **Voluntary** - the decision to either consent, or not to consent, must be made by the person themselves and without pressure from others
- **Informed** – the person must be given all the information, including the benefits and risks, and any other choices
- **Capacity** – the person must be able to understand the information given to them, and use it to make a decision.

If an adult can give, or withhold consent, their decision must be respected.

Consent can be given:

- Verbally
- In writing (by signing a consent form)
- Non-verbally

Consent forms may need to be written, easy read or accessible.

Consider the following:

Consent to:

- Keeping information about the person
- Sharing information about the person
- Support with personal care
- Take prescribed medication
- "Looking after" the person's money

An example of an easy read and an accessible consent form is included in the appendices.

11 Mental Capacity

Always start by thinking that everyone can make their own decisions

No-one should be stopped from making a decision,
just because someone else thinks that it is wrong or bad

Give the person all the support you can, in a way that makes sense to them, to help them make decisions.

Helpful ways of giving information might include: -

- Written information/easy read or accessible
- Pictures or photographs
- Objects of reference
- Social Stories
- Visits
- Video's

The person ***has*** Mental Capacity if they can:

- Understand the information
- Remember it for long enough
- Think about the information
- Communicate their decision

A capacity assessment needs to be done for each decision,
and must be updated regularly

You will need to document when and how you have done this on a capacity assessment form (an example is attached in the appendices)

If the assessment shows they ***do not*** have capacity, you will need to move on to the Best Interest process

12 Best Interest

Where a decision needs to be made for a person who doesn't have capacity, there will need to be a best interest meeting

The person leading the meeting must:

- Listen to what the person wants
- Make sure they are involved.
- Ask people who know them
- Decide which is the least restrictive option.

The Best Interest Meeting must be documented

(There is an example of a Best Interest Decision Form in the Appendices)

13 Useful documents

- A Positive and Proactive Workforce – Department of Health, Skills for Health and Skills for Care - 2014

- Mental Health Act Code of Practice – Chapter 26 - 2015

- CQC – A Brief Guide: Restraint (Physical and Mechanical) - October 2016

- Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges – NICE - May 2015

- Violence and Aggression - NICE Clinical Guidance NG10 – 2015

- Positive Behavioural Support – A Competence Framework - Positive Behaviour Support Coalition UK - May 2015

- Training Standards - Restraint Reduction Network (RNN) – 2019

- Promoting Less Restrictive Practice – July 2016

- Restrictive Interventions in Inpatient Intellectual Disability Services: How to record, monitor and regulate – December 2018

- Reducing Restrictive Practices Checklist

- Positive Approaches: Reducing Restrictive Practices in Social Care – April 2016

14 Appendices

- Consent Forms
- Capacity Assessment Form
- Best interest Decision Form
- Reducing Restrictive Practice Plan
- BPIM (Incident Form)

Consent to Keep Information About Me

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My Name:

My Address:

My Date of Birth:

I am happy for this information to be kept on a computer or in a file:

- ☐ My name
- ☐ My address
- ☐ My phone number
- ☐ My likes and dislikes
- ☐ About my health
- ☐ Photos

Sign: _____

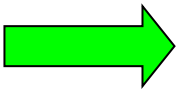
Date: _____

(You will be given a copy of this form, and one will be kept in your file)

Consent to Keep Information About Me

Community Therapeutic Services

+



Insert a photo of me here

☐ My Name:

☐ My Address:

☐ My Date of Birth:

I am happy for this information to be kept on a computer or in a file:

☐ My name

☐ My address

☐ My phone number

☐ My likes and dislikes

☐ About my health

☐ Photos

Sign: _____

Date: _____

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Capacity Assessment Pro Forma Notes

A) Why is a capacity assessment being completed?

The MCA Code of Practice gives the following advice regarding possible 'triggers' for assessing capacity.
The person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision.

- Somebody else says they are concerned about the person's capacity, or
- The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.

The local guidance recommends that a capacity assessment **must** be initiated whenever staff believe the service user lacks capacity and in the following circumstances:

The decision made by the service user will have a significant impact upon their life now or in the future.

The decision being made by the service user will place them under physical or psychological risk.

In other situations, it will be down to individual professional judgement as to the need for a capacity assessment.

B) What is the ***specific*** decision to be made?

The Mental Capacity Act states that capacity must be assessed in relation to individual decisions. This means that capacity must not be expressed in relation to the person generally but in relation to the specific decision they are making at a specific time.

Care must be taken to phrase the decision as neutrally as possible. For example, in the case of an individual refusing to take their anti-epilepsy medication, the decision in question could be 'Does A have the capacity to consent to their medication' rather than 'Does A understand the risks of not taking their medication'. This allows positives and negatives to be discussed.

C) Does the service user have a suspected or diagnosed *Mental Impairment*?

Mental Impairment in the act is defined as "a disturbance in the functioning of the brain" The MCA Code of Practice gives the following examples; 'conditions associated with some form of mental illness, dementia, significant learning disabilities, the long-term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion following a head injury, the symptoms of alcohol or drug use' (NB. This list is not exclusive)

D) What *relevant information* does the service user need to understand to make this decision?

Identifying the relevant information that the person needs to understand is an essential part of the capacity assessment. The MCA Code of Practice states that 'relevant information' needs to include the following;

- The nature of the decision
- The reason why the decision is needed
- The likely effects of deciding one way or another, or making no decision at all

E) Record how you gave this *relevant information* to the service user and steps you took to help them understand the issue.

The Capacity Assessment should not be conducted as a test or a verbal exam. The assessor must give the relevant information to the service user whilst assessing their comprehension of that information.

The Mental Capacity Act compels assessors to take all practicable steps to develop the service user's capacity to allow them to make the decision for themselves. This includes thinking about how you present the relevant information to them and how they can communicate their decision to you. Example of this may include;

- Choosing a time of day when the service user is at their most responsive / alert.
- Ensuring that the Capacity Assessment is sensitive to cultural factors.
- Ensuring that information is presented to the service user in an appropriate manner.
- Ensuring that the service user is given opportunity to communicate in an appropriate manner.

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F) Interview – Assessment

F1) Does the person *understand* the relevant information detailed above?
The service user must understand the information relevant to the decision. Initially it is about understanding why the decision needs to be made.

Relevant Information in a case where A is refusing to take diabetic medication might be judged by the Capacity Assessor as;

- Recognition of the main physical symptoms of abnormal blood sugars.
- That abnormal blood sugars can have negative implications on their health.
- How this may lead to ill health in the longer term. (problems with eyesight, vulnerability with feet, increased risk of heart attack/stroke)
- How this may affect their health immediately (loss of consciousness, death)
- That the medication helps to maintain her blood sugar at the correct level.

If A can understand these individual elements as they are discussed, then they pass this element of the assessment. Possible questions to test this component of the capacity test might include;

- Why have I come to talk to you today?
- What might happen if you decide that you don't talk to me today?
- Can you tell me how you may come to immediate harm if not taking your medication?
- Tell me some of the longer-term health problems you might experience if you choose not to take your medication?
- What symptoms might you experience that would tell you that you are becoming unwell?
- Tell me in your own words what the diabetic medication does for you.

F2. Can the person *retain* the relevant information detailed above?
A useful strategy for assessing this, is to ask the service user to summarise your discussion at the ***end of the assessment.***
The service user only needs to retain the information long enough to make the decision in question, this is usually the length of time it takes you to complete the capacity assessment.

F3. Can the person *use and weigh* the relevant information detailed above?
Ask the service user about the pros and cons of making the decision – it is helpful to evidence that the service user is able to use and weigh the information by using a degree of reasoning to make their decisions.

F4. Can the person *Communicate* their decision?

Communication is broad and different for every person, it can range from verbal, written forms to facial expression and behaviour. Only if the service user has **no** discernible communication at all will they fail this element.

Interview Assessment

COMMUNITY THERAPEUTIC SERVICES

Capacity Assessment Form			
NAME:	**Date of Birth:**	**Residential Home/ Supported living:**	**Date:**
Name/Profession of the Capacity Assessor(s)			
Mental Capacity			
Why is the capacity assessment being completed?			
What is the *specific* decision to be made? (for example, 'consenting to necessary medication', consenting to be helped with intimate personal care')			

Does the Service User have a suspected or diagnosed *mental impairment?* (such as learning disabilities, dementia, a neurological condition)
What relevant information does the Service User need to understand in order to make the decision?
Explain and record the evidence:
Record how you gave this *relevant information* to the service user and steps you took to help them understand the issue.
Record Assessors evidence:
Does the person **understand** the relevant information detailed above?

Does the person understand the purpose of the assessment and what the decision is to be made? Do they understand the individual elements of the 'relevant information' as they are discussed with them?	
Assessors observations & person's response -	
	Yes/No
Can the person ***retain*** the relevant information detailed above? *Can the person give an account of the salient details at the end of the assessment? The person only needs to retain the information for the duration of the discussion.*	
Assessors observations & person's response -	
	Yes/No
Can the person ***use and weigh*** the relevant information detailed above? *Can the person weigh up the pro's and cons of the decision OR can they give an account of professional's concerns and forward reasons why they disagree with them? Is there evidence of 'reasoning' being used to guide the person's decision?*	
Assessors observations & person's response -	
	Yes/No

Can the person ***Communicate*** their decision?
Only if the person has no verbal or non-verbal communication will they fail this element of the test (e.g. the person is unconscious or in a permanent vegetative state, minimally conscious state)

Assessors observations & person's response -

	Yes/No

Capacity Assessment Decision
Only one element must be ticked from the 3 choices below
{ } - There is no evidence, diagnosis, or suspicion of a Mental Impairment. Therefore, the person **HAS** capacity to make the decision.
{ } - The 4 elements above are *all marked YES* therefore the person **HAS** capacity to make the decision.
{ } - *One or more* of the 4 elements above are marked NO therefore the person **LACKS** capacity to make the decision.

Follow on work
Any elements that apply should be ticked from below.
{ } - The person's cognitive state is stable or deteriorating and in my view they are unlikely to regain capacity in relation to this matter in the near future.
{ } - The person's cognitive state is improving and I believe capacity should be re-assessed shortly.
{ } - I believe the person could regain capacity to make the decision with support and advice from others.
{ } - The person's cognitive state is fluctuating on an hourly / daily / weekly * basis. In my view there is a reasonable possibility they will have capacity in relation to the decision shortly.
** delete as applicable*

{ } – As the person lacks capacity I am now going to organise a Best Interests meeting discussion.
{ } – As the person lacks capacity I am going to prompt a fellow professional to organise a Best Interests meeting / discussion.
{ } – The person has capacity and is subject to restrictions upon their choices that require urgent review.
{ } – I will refer on to a relevant health professional to establish or not the existence of a mental impairment.
{ } – I will seek a 2nd opinion on this individual's capacity.

If necessary, please provide further detail on the boxes ticked above. Please also use this space to record any other thoughts or recommendations you have regarding the issue.
Signature: Print Name: Job Title: Date:

Best Interest Pro Forma Notes

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A) What is the best interest decision to be made?

This relates to section B of the capacity assessment guidance '*What is the specific decision to be made'.*

B) Has a capacity assessment been completed in relation to this decision?

The Best Interest process is only initiated once it has been established that the person LACKS capacity in relation to the specific decision identified above. If a capacity assessment has not occurred or the capacity assessment is unrelated to the decision being made, then the Best interest process should stop and arrangements made for the service user's capacity to be assessed.

C) Does the authority for making this decision lie under other provisions of the Mental Capacity Act (Lasting / Enduring Power of Attorney, Deputyship or Declarations made by the Court of Protection, Advance Decision to Refuse Treatment).

Best Interest is only one form of decision making. Others listed above also allow decisions to be made on behalf of service users who lack capacity. Detailed information on these is provided in the MCA code of practice.

D) If there is no other Authority identified in C) above who is the 'Decision Maker' in regard to this issue?

The 'decision maker' is a specific role identified in the Best interest process and is a specific role identified within the Mental Capacity Assessment. This role involves *making the decision on behalf of the person.*

E) is the Best Interest discussion taking place as a formal meeting / individual discussion / telephone conversation / written communication?

The Mental Capacity code of practice does not state what form the Best interest discussion should take, this can occur within normal working processes – for example - k/w meeting, review meetings.

Community Therapeutic Services

F) Detail who has been consulted as part of the Best interest discussion/meeting & G) If unable to ascertain an interested party's views on this matter detail the reason for this here.

There is no definitive list who must be consulted in the Best Interest discussion. This will depend upon the decision and the urgency.

The decision maker has a duty to consider the views of the following people: -

- Anyone the service user has previously named as someone they want consulted
- Anyone involved in supporting the service user
- Anyone interested in their welfare (family or advocate)
- Lasting Power of Attorney
- Deputy appointed from the Court of protection.

H) Are the conditions for appointing an IMCA met? If so please detail the IMCA consulted.

A service user must be assessed as lacking capacity to make the decision as outlined in A) The IMCA service is provided for any person aged 16 years or older, who has no one able to support and represent them, and who lacks capacity to make a decision about either: • a long-term care move; • serious medical treatment; • adult protection procedures; or • a care review.

Independent mental capacity advocate (IMCA) services support people who can't make or understand decisions by stating their views and wishes or securing their rights.

I) Consider the different options for the person considering the available resources.

This may include finances and additional support.

J) What are the person's views on this matter. What decision would they have made if they had capacity?

Try and find out the views of the person who lacks capacity, including:

- The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviours or habits.
- Any beliefs or values (religious, cultural, moral or political)
- Any factors the person themselves would be likely to consider if they were making the decision for themselves.

Community Therapeutic Services

K) Consider the pros and cons of each option. Risks and benefits must include psychological & emotional elements alongside physical factors.
Consider Risk Management approaches – Positive Risk taking.

L) Considering boxes, I, J and K above what do the group feel is ***least restrictive option*** considering ***best interest, what the person would have wanted & available resources.***

This is the space where the Best interest Decision is recorded considering the listed factors. The reason for the decisions should be recorded here.
Any differing views should also be documented here with details of the issues and why these views were not followed.

Best Interest

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Best Interest			
NAME:	**Date of Birth:**	**Residential Home/ Supported living:**	**Date:**
Date of Meeting/discussion-			
A) What is the Best Interest decision to be made?			
B) Has a capacity assessment been completed in relation to the decision? If answer is 'No' then stop best interests process & initiate capacity assessment			

C) Does the authority for making this decision lie under other provisions of the Mental Capacity Act (Lasting / Enduring Power of Attorney, Deputyship or Declarations made by the Court of Protection, Advance Decision to Refuse Treatment) If the answer is 'Yes' detail Authority below.
D) If there is no other Authority identified above who is the 'Decision Maker' in regard to this issue?
E) Is the Best Interests discussion taking place as a formal meeting / individual discussions / telephone conversation / written communication? More than one may apply

F) Detail who has been consulted as part of this Best Interests discussion / meeting
G) If unable to ascertain an interested party's views on this matter detail the reason for this here.
H) Are the conditions for appointing an IMCA met? If so, please detail the IMCA consulted. If there are no interested parties to consult and the decision involves a serious medical treatment or a change of residence, then the decision maker must appoint an IMCA. (NB IMCA's may also be appointed if there are safeguarding concerns or doubts around family / friends acting in the individual's best interests)

I) Consider the different options for the person considering the available resources.
J) What are the person's views on this matter? What decision would they have made if they had capacity? How have you ascertained this?
K) Consider the pros and cons of each option. Risks and benefits must include psychological & emotional elements alongside physical factors.

L) Considering boxes J, K, & L above what do the group feel is the ***least restrictive option*** considering, ***best interests***, ***what the person would have wanted*** & ***available resources.***

M) Follow on work - All parties **do** agree (tick all that apply)
{ } – Additional individuals need to be consulted and a repeat Best Interests decision made.
{ } – The individual's cognition is fluctuating or improving and their capacity requires re-assessing shortly.

N) Follow on work – One or more parties ***do not*** agree (tick all that apply)
{ } – I will organise a formal 'round table' Best Interests Meeting.
{ } – I will make a referral for Advocacy Services.
{ } – I will refer the matter to my line manager.
{ } – I will investigate a referral to the Court of Protection.
{ } – There is a dispute as to the individual's capacity and I will organise a re-assessment.
{ } – The individual's cognition is fluctuating or improving and their capacity requires re-assessing shortly.

O) Other Decision-Making Authority
{ } – The authority to make the decision lies under the following provisions of the Mental Capacity Act (Lasting /Enduring Power of Attorney, Deputyship / Declarations under the Court of Protection, Advance Decision to Refuse Treatment)
{ } - The decision is so serious it may only be considered by the Court of Protection.
{ } – The decision is one that is excluded from the remit of the MCA.
{ } – The decision made is likely to constitute a deprivation of liberty and a referral to the appropriate supervisory body must now be made.

P) Review
The Best Interests decision should be reviewed by the following date:
The individual's capacity should be reassessed by the following date:

Q) Please provide detail here regarding any follow up work.

Signature:	Print Name:
Job Title:	Date:

Behaviour and Positive Intervention Monitoring (BPIM) — Form 1

1. Details of Incident

Day: Date: Time:

Home: Exact Location:

2. People Involved in the Incident

For each person involved in, or affected by the incident please complete Form 2

Service User	Staff	Other Service-Users / Visitors

3. What happened?

Antecedents (Give context: circumstances before; who; when; where; what; how) Any known triggers (things that might upset that person) Cue behaviour (behaviours which warn that the specified behaviour may be imminent.) Changes in body language, mood etc. What was the person/ others doing/saying? What happened to the person immediately prior to the behaviour?	
Behaviour Objective recording of behaviour, taking into account intensity, frequency and duration. Descriptive e.g. Had clenched fists, shouting: “[set phrase]” swearing. Hit himself on the left side of the head with heavy open-handed slaps, rather than “engaged in SIB”. Kicked a chair with force over onto the floor Grabbed staff by the hair from the front in a single handed grip.	
Consequences (Describe what happened after, what maintained the behaviour, outcomes) Staff/public/service user reactions: Was attention given or withdrawn from the person. Was the person moved? Where to? Who by? Were others moved? Did any demand cease or be met after the behaviour? How long did it take for the person to calm down? Was medication given? Debriefing for people involved	

4. **PBM Techniques Used (**Tick all of those used)

a) Primary Prevention	b) Secondary Prevention	c) Reactive Strategies	d) Restrictive strategies
a) Reflective stance b) Proxemics c) Known triggers managed d) Familiar self-management strategies encouraged e) Planned, proactive use of PRN Medication f) Other (please specify)	a) Ready Stance b) Proxemics c) Assisted support – 1 person d) Assisted support – 2 people e) Space (staff/others remove themselves) f) Remove environmental triggers g) Distraction h) Directed to a compelling activity i) Change of activity j) Verbal advice k) Negotiation l) Reassurance m) Success reminder n) Change of environment o) Reduced demands p) 1:1 support/talk time q) Other (please specify)	a) Proxemics b) Space (staff/others remove themselves) c) Protective Stance d) Deflection e) Blocks f) Kicks g) Finger grab h) Pinches i) Bites j) Head-butt l) k) Wrist grab – 1 hand, 1 wrist m) Wrist grab – 2 hands, 1 wrist n) Wrist grab – 2 hands, 2 wrists o) Clothes grab p) Hair grab – front q) Hair grab – short, behind r) Hair grab – long, behind s) Blind-fold technique t) Other (please specify)	a) Proxemics b) Space (staff/others remove themselves) c) Two person assisted support d) Two-person removal e) Drop to floor f) Seated restraint on a sofa g) Use of PRN medication h) Person required to remain within a given space – state where i) Other (please specify)

5. **Reflective Account:** What can we learn? Any mistakes made? How can we prevent this in the future?

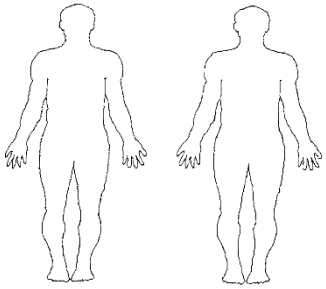
Form Completed by: (Print Name) …… **(Sign)** ……..
Job Title: …….. **Date Form Completed:** ……

SHIFT LEADER TO COMPLETE: Print Name …… Sign …… Date: ……

6. Inform On-Call Manager	Name of on-call: …….. Date/Time of call: ……	
7. Documentation: (Tick when complete)	☐ Accident Book ☐ Restrictive practice record	

MANAGER TO COMPLETE: Print Name …… Sign …… Date: ……..

8. Notifications	Required?	Date Completed
	☐ Yes ☐ No CQC	…… CQC
	☐ Yes ☐ No Safeguarding	…… Safeguarding
	☐ Yes ☐ No H&S Executive	……... H&S Executive
	☐ Yes ☐ No RIDDOR	…… RIDDOR
9. All actions from Forms 2 & 3 all completed?	Number of completed Form 2's ……	Form 3 completed ☐
10. Is an In-Depth Post Incident Debrief required?	If yes, please arrange this and go to FORM 4	

Immediate Post Incident Review Sheet For: …… Date…… Form 2		
Date of Incident:		
How has the situation been made safe?		
Please give details of how the situation has been made safe for this person.		
Is additional support needed for this person?	Yes/No (Delete as needed)	If yes – who is assigned to support? Details:
Has this person sustained any injuries or other adverse effects?	 **Details:**	
Is first aid required?	Yes / No (Delete as needed) Administered by staff / Taken to GP / Taken to Hospital / Emergency Services called If taken for treatment, name of person who took them: ……	
Give details of the initial action plan agreed with the person, to promote feelings of safety and well-being and promote a return to normal patterns of activity (If **staff** are sent/taken home, state who is taking them and what arrangements are in place to follow-up by phone within 24 hours)		

PTO for Secondary Post Incident Actions

Secondary Post Incident Actions	
Is there any ongoing physical impact from the incident? Is any further support needed?	Yes / no (delete as needed and give details) Yes / no (delete as needed and give details of appointments etc. required)
Is there any ongoing emotional or psychological impact from the incident? Is any further support needed?	Yes / no (delete as needed and give details) Yes / no (delete as needed and give details of referrals for counselling, supervision, shadowing required)
Is the person off work as a result of the incident? **OR** **Is the person not due on shift tomorrow?** (Contact to be made within 24 hours of the incident)	Date and time of follow up phone call: …… Person making the call: ……... Date and time of call: ……... Outcome of phone call/actions needed and by whom: ☐ **Manager/shift leader to check in with person at start of next shift** **OR** ☐ **Liaise with HR to arrange a welfare meeting on return**
Shift Leader/Manager completing this form: …….. Date: ……	

Service User View of Incident	Date: ……	Form 3
The service user need not attend a formal meeting, but it is essential that, where possible, their views of the incident are obtained. This may be done by a member of staff with whom they have a good relationship, a family member, or an advocate.		
Section 6 – Secondary Prevention: Post-Incident Support, in the person's Positive Behavioural Support Plan, will outline how best to support them following an incident.		
What Happened?		
What did you need / want?		
What upset you most?		
What was most helpful? -		
What was least helpful?		

What could be done differently next time?	

Is there anything else you want to tell us about what happened?

Any additional comments from person completing this form:

Name of person completing this form (Print): …… ……..

Signed: …….. Date: ……

In-Depth Post Incident Debrief	Date:……..	Form 4
To be completed at the post incident review meeting		
1. Attendees (This does not need to involve the service user, but should include a review of their experience and at least one person who was not involved in the incident.)		
2. What was the trigger?		
3. What were the warning signs?		
4. What de-escalation strategies were used?		
5. What actually happened during the incident?		

6. What feelings were evoked during the incident?	
7. What options were considered to manage the situation?	
8. What could have been done differently?	
9. Was there anything that stopped things being done differently?	

10. Are any changes needed?	• Environmental • Approach / support plans • Risk assessments • Staffing levels • Staff training
11. Is any specific training needed?	

12. How can we avoid a similar incident in the future?	
13. What have we learnt from this incident?	

Please ensure that all actions identified are assigned to a named individual, with a time scale.

Ensure that Positive Behavioural Support Plans are updated to include information learned through the debrief.

Date of Post Incident Debrief: ……

Completed by Manager: (Print Name) …… **(Sign)** ……..

MANAGER (or On-Call Manager) TO COMPLETE: Print Name …… Sign ……

	Required?	Date Completed
Have all notifications been completed and documented with any follow up actions required?	☐ Yes ☐ No CQC ☐ Yes ☐ No Safeguarding ☐ Yes ☐ No H&S Executive ☐ Yes ☐ No RIDDOR	…… CQC …… Safeguarding …….. H&S Executive …… RIDDOR
Have all actions relating to this incident been completed?	If no, give details:	

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Restrictive Intervention Reduction Plan

Non-physical Restrictive Strategies				
	Restrictive Practice	**Y/N**	**Details**	**Next stage of plan to reduce restrictive practice**
Staff support	• 1:1 or 2:1 support at home or when out and about			
Phones, computers, etc.	• Monitoring, or limited access, to mobile phones and computers, especially for using Facebook, dating sites, etc.			
Alcohol/tobacco	• Monitoring and restricting access to alcohol/tobacco			
Threatening or verbal intimidation	• Making people think they have no choice • Making people worry about the consequences of their actions			

Non-physical Restrictive Strategies - continued				
	Restrictive Practice	**Y/N**	**Details**	**Next stage of plan to reduce restrictive practice**
Environmental Restraint	• Closing or locking doors or cupboards in kitchen, bathroom, wardrobe, etc. • Coded electronic keypads • Complicated door handles • Narrow doorways • Not providing hand rails in passageways or on steps and stairs • Removal of mobility aids • Poor lighting or heating etc. • Time out or seclusion • Fobs • Alarms • Use of intercoms as the only way of communicating • Electronic Surveillance • Removal of things/furniture for safety • Choice of furniture, fixtures and fittings for safety • Placing walking aids out of reach • Staff carrying personal alarms			

Non-physical Restrictive Strategies - continued				
	Restrictive Practice	**Y/N**	**Details**	**Next stage of plan to reduce restrictive practice**
DoLS	• Deprivation of Liberty Safeguarding Referrals (DOLS)			
Liaison with, and disclosure to other Agencies	• Police • Safeguarding • MAPPA			
Cultural Restraint	• Telling the person not to do something • Telling them that what they want to do is not allowed, is illegal, or is too dangerous (internet access, community access) • Withholding information • Not having a choice about when to get up or go to bed • Not having a choice of when and what to eat or drink • Limited activities and opportunities • Limiting access to cigarettes/tobacco • Limiting access to finances •			

Physical Restrictive Strategies				
Restrictive Practice	**Restrictive Practice**	**Y/N**	**Details**	**Next stage of plan to reduce restrictive practice**
Forced Care	"Forcing" someone to receive care: • Personal care • Food • Medication • Clothing • Therapeutic intervention		.	
Seclusion	Seclusion refers to the supervised confinement and isolation of a *(patient)*, away from other *(patients)*, in an area from which the *(patient)* is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.			
Chemical restraint	• Using medication to calm people • PRN medication • Rapid tranquilisation			

Physical Restrictive Strategies in Place - continued				
Restrictive Practice	**Restrictive Practice**	**Y/N**	**Details**	**Next stage of plan to reduce restrictive practice**
Physical removal or restraint	• Blocking access or exit • Two-person assisted support • Two-person removal • Seated restraint			
Mechanical Restraint	• The use of a Houdini Harness or wheelchair lap belt to restrict movement • Pushing a chair close to the table to prevent standing •			
Medical restraint	• Using medical equipment, like catheters, to deliberately restrict movement • Positioning medical equipment so that it can't be removed			