Promoting Positive Practice
Reducing Restrictive Interventions Strategy
April 2018 to March 2021

We give a clear and transparent commitment to the people that use and work in our services that all our leaders, managers and front line staff will work together to ensure that the use of coercive and restrictive practice is minimised, and the misuse and abuse of restraint is prevented.
Introduction

This document sets out our strategy for promoting positive practice and reducing restrictive interventions from 1 April 2018 to 31 March 2021. It describes the steps we will take to make our wards safer for people who visit, stay and work there, in support of our Trust’s three core goals. (NSFT, 2016).
We recognise that national evidence shows BME people, particularly young black men, often experience mental health services as culturally insensitive (Memon, 2016). This can lead to an over-estimation of risk, a reluctance to engage with services, over-use of medication, and higher use of restrictive practices.

The independent review into the death of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003), who died of positional asphyxiation in our Trust in 1998, emphasised the importance of training for staff at all levels in cultural competency. This means ensuring that staff approach people as individuals, with a sensitive understanding of the cultural factors that may influence their response. By improving the involvement of service users in safety issues, this strategy will support the Trust’s desire for continuous improvement through values based recruitment; mandatory equality and diversity training; the Faith, Spirituality and Belief Network; LGBT network; Hidden Talents network; BME Network and Equality Champions network.

This strategy will help us to provide better services to people from marginalised groups by involving them more directly in decisions about the care they receive, about the way the ward they are on is run, the staff we recruit, how we train them and how we design our services.

We will improve our understanding of how positive practice affects groups by monitoring the protected characteristics of people who experience restrictive interventions and seeking feedback from the diverse range of people our services support. This will give us a better understanding of the equality and diversity impact of any changes we make.
As a member of the Restraint Reduction Network™ we give a clear and transparent commitment to the people that use and work in our services that all our leaders, managers and front line staff will work together to ensure that the use of coercive and restrictive practice is minimised, and the misuse and abuse of restraint is prevented. We will work together to create restraint free services built on continuous learning and improvement. We support the philosophy of care and values of the Restraint Reduction Network™. (Restraint Reduction Network, 2017).

Restrictive interventions are common in managing a range of behaviours that may challenge us including self-harm, refusal of necessary care, aggression towards staff and other people in our care, violence, and absconding. We believe behaviour that challenges us is always intended to meet a need for the individual but can have harmful effects on that person’s health, self-esteem, relationships and wellbeing. We accept that our own acts, as an organisation and as individual employees, can sometimes trigger, maintain and reinforce the behaviour of the people in our care and that we need to develop better organisational and individual self-awareness to reduce the need for restrictive interventions.

By working collaboratively with service users to understand their behaviour, we will help people to recognise their triggers and improve how they respond to them, building self-control and self-esteem and empowering them to take responsibility for their own safety. We will help them identify and adopt pro-social ways to meet their needs, improve safety and enhance wellbeing.

In May 2017 we appointed a professional lead for reducing restrictive interventions who brought together a group of service users, clinicians, managers, experts, educationalists and others to form a Reducing Restrictive Interventions Strategy Group to review and modernise our strategy.

Strong, accessible, committed, high-profile leadership and oversight will drive a positive change in our safety culture. We will work together, positively and respectfully to deliver recovery oriented services that work proactively to deliver safe care and reduce stress on the wards. We have given this Board level priority by making our Director of Nursing and Quality accountable for the strategy. We will ensure culture change by learning together - service users, carers, staff, managers and directors will be brought together by a network of strong strategy champions, able to share new initiatives and collect evidence of quality improvement.

We will deliver better leadership by:

1. Organising regular executive walkrounds where senior managers will use a structured checklist to learn about safety issues, service user engagement and blanket restrictions on each ward and help to resolve organisational challenges that may halt progress
2. The head of governance will report to the Quality Governance Committee quarterly on the implementation of action plans
3. Ward managers and modern matrons will lead quality improvement initiatives on each ward, ensuring that collaboration with service users is central to decision making
4. Ward managers and modern matrons will submit an annual safety improvement plan to the Head of Governance
5. We will identify inequality issues in relation to restrictive practices and ensure locality managers work closely with equality leads in inpatient areas to demonstrate that they are promoting best practice

Aims:

1. Fewer incidents of self-harm, aggression, violence, refusal of care and absconding on our wards
2. Fewer restrictive interventions – restraint, seclusion, rapid tranquillisation and blanket restrictions
3. A better experience for the people who use and work in our services
4. Better recovery outcomes for service users, enhanced engagement of staff, higher public confidence, clear information for commissioners and inspectors
5. A positive safety culture
The use of data to inform practice

We have set an ambitious three year target to reduce the use of restrictive interventions by 25%. We will measure this against a baseline figure of 3,752 reports in the calendar year 2016. The baseline figure is calculated by adding together 2,448 restraints, 641 seclusions, 630 uses of rapid tranquillisation and 33 long term segregations. Our aim is that in the year from April 2020 to March 2021, there will be fewer than 2,814 such reports.

Trust level data helps us to identify changes in behaviour on the wards but doesn’t explain why those changes have happened. Our data systems will support quality assurance by identifying areas of concern or progress. Our analysis of data will support quality improvement at a local level and quality assurance at a Trust level.

“Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.”

(Francis, 2013)

The more fragmented data is, the more vulnerable it is to variation beyond the control of the ward and the easier it then becomes to misattribute changes to the failure or success of a quality initiative or strategy. Such variations may actually result from external factors including random variation, changes in bed occupancy or community care and so on.

Our patient safety lead and lead clinician for secure services are working on a safety dashboard for each ward to provide reliable information on numbers of incidents, use of restrictive interventions, number of occupied bed days and other contextual information. Much of the information will be presented in statistical process control (SPC) charts, which will highlight statistically significant shifts in behaviour (see Appendix 3 for an example SPC on page 20). The Patient Safety Group will monitor the charts from each ward and investigate statistically significant changes with the relevant area, providing regular reports to senior managers via the Head of Governance.

We will monitor data showing the number of incidents reported where any of the following are highlighted in the Datix report:

- Seclusion
- Physical restraint (including use of different restraint positions)
- Chemical restraint (rapid tranquillisation)
- Pain compliance
- Violence / aggression
- BME related incidents

Information will be broken down by ward, day of the week and time of day in order to identify hotspots. We will investigate ways to expand the data set to include reliable demographic information about the people subjected to restrictive interventions. We will pay particular attention to the use of restrictive practices involving people from a Black or minority ethnic background. This will allow us to ensure that no groups are subject to higher rates of restriction and will permit accurate equality impact assessment of any changes.

We will move away from setting targets for individual wards to achieve because this can be misleading – for example, a 10% reduction on each of our PICUs would have a much bigger impact on Trust performance than a 50% reduction on some of our other units. Wards will be expected to set their own targets as part of their safety planning, and to use appropriate data to measure the impact of the changes they make.

It will be important in understanding progress and in benchmarking between services that we can place our data in context, so our regular reports will also consider the impact of changes in the number of occupied bed days, service changes, reporting or policy changes, the use of agency staff, compliance with mandatory training and so on.
Workforce development

We want a skilled, confident and engaged workforce, able to promote positive behaviour change for our service users.

We will train our staff to recognise how their own actions can trigger behaviours that challenge us and how their own responses to an escalating situation can actually reinforce those behaviours. Absconding, self-harm, violence and aggression – the common causes of restrictive interventions – can be a response to our system or the behaviour of people within it, including staff and other people under our care.

We will use values based recruitment to ensure that we only hire people with the right attitudes to reflect our values. We will ensure that our staff have access to regular management and clinical supervision and annual appraisal. Staff education and training programmes will be co-produced with service users and staff and delivered in ways that encourage high levels of compliance and high levels of cultural competence.

A specific goal of workforce development will be to ensure that inpatient teams are able to identify challenging behaviour, complete a functional assessment of what drives the behaviour and write a positive behaviour support plan collaboratively with the service user. This will require honest self-assessment as we try to identify how our own practices, behaviours and rules can trigger and fuel behaviour that challenges us.

Our staff should be positive role models who demonstrate the value of calmness, problem solving, compromise and collaboration in dealing with safety issues. We will train them to recognise the triggers of behaviours likely to lead to restrictive interventions and to manage incidents in the least restrictive way and for the shortest duration possible.

The Trust will retain a team of dedicated professionals to train staff at a level appropriate to the physical risks in their work area. Our Prevention and Management of Aggression policy and training underwent a major review in April 2015 and was updated again in February 2016 to reflect best national practice.

We aim to improve training further by the following methods:

1. E-learning to supplement the PMA physical skills courses. This will be co-produced and will include training about positive behaviour support and strategies for reducing restrictive interventions.

2. The Recovery and Participation team will work closely with the PMA department and service users to pilot an experience based co-design project with the aim of making a short training film to add to the e-learning package and supplement staff training in de-escalation techniques. This will include working with BME service users identified through service lines and the BME Open Mind group to improve understanding of cultural competency in the context of restrictive interventions.

3. It is central to the promotion of a safety culture that staff complete their mandatory training. Where mandatory PMA training is below 90% ward managers will be expected to submit action plans for improving performance.

4. Wherever possible training will be co-produced with service users.

5. Ward managers and modern matrons will complete full PMA teamwork training. This will improve their ability to supervise and support their teams and ensure that all levels of staff on each ward have a common approach to risk. The quality of the PMA training will also improve because others attending the course will benefit from the experience and expertise of these senior staff.
Restraint reduction tools

We recognise that restraint reduction and violence reduction are rapidly evolving fields and that the tools wards have available to them are diverse and evolving. We will support each ward to pilot the tools that they believe will help them meet their particular challenges and will use their experience to develop our evidence base, disseminating best practice from pilot projects to help other ward teams to implement change.

There is evidence that sustainable change is more likely to result from a model that involves patients and staff in developing, designing and implementing changes than from a ‘command and control’ / top down model.

(The Health Foundation, 2013)

Examples of tools teams can use as part of a quality improvement scheme:

- Always Events
- Experience based co-design,
- Brosset Violence Checklist tool
- Safety huddles
- RAID
- REsTRAIN YOURSELF toolkit.
- Comfort rooms
- Sensory modulation
- Positive behaviour support plans
- Trauma informed care
- Behavioural coaching
- Dispute resolution – mediation
- PDSA cycles
- Floorwalkers
- Safewards
- Positive behaviour support plans
- Trauma informed care
- Behavioural coaching
- Dispute resolution – mediation
- PDSA cycles
- Floorwalkers
- Quality control board
- Safewards
- Blanket restrictions are rules that apply to all patients on a ward, regardless of the risk each individual presents. Blanket restrictions have an impact on everybody on a ward and can cause frustration, stress and resentment, reducing engagement with services and increasing the risk of incidents.

Examples might be limited visiting hours, restrictions on access to the television or kettle, doors being locked to prevent exit. We know that these restrictions are usually put in place to protect safety, but also that unless they are reviewed, they can last longer than necessary and can increase the risks they are intended to manage. With a register of blanket restrictions, we will ensure that all such restrictions are known about, justified, proportionate and regularly reviewed.

Wards will be able to access tools from an area of the PMA webpage

Each ward will consult service users, carers, advocates, staff or service user representatives to discuss safety priorities during the fourth quarter of each financial year (from January to March) and produce an annual plan based on those priorities, to implement from 1 April. We will not be able to change our culture unless we listen closely to the views of people who have experienced our services.

An exception to the bottom up approach to quality improvement will be that in all wards:

1. People who have been identified as being at risk of requiring restrictive interventions will have a clear positive behaviour support plan based on a functional assessment of what drives and triggers the behaviour. We will co-produce, publish and disseminate training on PBS to all ward areas
2. Each ward will have at least one Safewards champion whose role is to monitor the continued implementation of 10 Safewards interventions.
3. Service managers will oversee the implementation of daily unit safety huddles at each hospital site
4. Ward managers and modern matrons will work collaboratively with service users, where possible, to produce a checklist of blanket restrictions with regular review dates
5. Equality and diversity leaders will be involved in designing and evaluating quality improvement plans
On an individual level, service users whose behaviour challenges us will benefit from support to understand those behaviours. A collaborative approach from staff will help them develop and achieve their goals through adaptive or pro-social means. This will be achieved through positive behaviour support planning. Such an approach will also help us to understand how our own practices trigger some of the behaviours that lead to restrictive interventions so that we can change our culture.

Service users who have witnessed a restrictive intervention may be able to contribute useful information to reflective discussions about what could have been done differently to anticipate or head off escalating aggression.

At a ward level, service users can participate in mutual help meetings and help identify potential safety issues. These meetings can provide peer support and are an appropriate channel for raising legitimate concerns about ward practice, such as blanket restrictions.

We will pilot Always Events and experience based co-design projects on selected inpatient wards. These tools help wards to access the experience of users of their services to inform quality improvement projects.

Peer support workers’ roles are being reviewed by the Recovery and Participation team. They can play an important role in helping people reflect on the causes of incidents and in communicating issues to the nursing staff before they become flashpoints.

We want service users participating in the design of training and service delivery as we move away from a model of risk management towards shared responsibility for keeping safe. We will achieve this through the work of the Recovery and Participation team as they embed ImROC principles throughout the trust.

We are grateful for the hard work of three service user representatives and a peer support worker who have contributed greatly to this strategy and for very helpful feedback given by members of the Open Mind group in response to the initial draft. 

Debriefing

We believe that debriefing of service users, witnesses, staff and others provides our clinical teams with a deeper understanding of the needs of the individual service user and of the service delivery issues that may contribute to frustration, anger, disillusionment, deliberate self-harm, substance misuse, absconding, refusal of care, disengagement, aggression or even violence. Our policies require that debriefing is available for all people affected by traumatic incidents on the wards.

By debriefing staff, service users, witnesses and others affected by restrictive interventions we can improve support and help people using our services to develop new ways of communicating their needs that will enhance the quality of their lives. Accurate, compassionate debriefing will help us to reflect on how our own practice can change to enhance safety. The introduction of Trauma Risk Management (TRiM) will enhance staff support and staff awareness of the value and mechanism of debriefing and we are evaluating new methods of debriefing service users and other witnesses.
Summary

The Trust strategy is a broad and ambitious strategy aimed at improving the experiences of the people who use our services and those who work in them.

We aim to reduce the use of restrictive interventions on our wards by:

- Delivering a shared approach to safety
- Learning from service users and involving them in collaborative care and in developing better services
- Developing a workforce that recognises and manages triggers and consequences of behaviour
- Improving our safety planning using the latest tools
- Monitoring safety plans so that best practice is shared and poor practice addressed
- Leading change from Board to ward and back
- Facilitating change through accurate data analysis

We believe that service users, carers, staff and all other stakeholders will share our aim to reduce the levels of stress and to deliver trauma sensitive services that promote healthy recovery in calm and healthy environments.

Appendices

1. The national and international drivers of restraint reduction
2. The Process
3. Sample SPC Charts from ELFT Violence reduction dashboard
4. Feedback form
A strong desire from service users, carers, commissioners and staff to make our services positive environments where the people who come to us for help, and the people who provide that help can work collaboratively to share safety.

National drivers

Summarised in three key publications: Positive and Proactive Care (DoH, 2014), Mental Health Act Code of Practice (DoH, 2015) and NICE Clinical Guideline 10: Violence and Aggression; short-term management in mental health and community settings (NICE, 2015) which stated that:

a. Providers should have in place a regularly reviewed and updated restrictive intervention reduction programme ensuring that “where unavoidable” restrictive interventions are used in the safest manner possible”. (DoH, 2014) (DoH, 2015)
b. Restrictive practices should only be used as a last resort in emergency situations (DoH, 2014), (DoH, 2015), (NICE, 2015)
c. Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture aimed at preventing behavioural disturbances, early recognition, and de-escalation (DoH, 2014) (DoH, 2015)
d. There is an objective to reduce prone (face-down) restraint – “There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor” (DoH, 2014) (DoH, 2015) *unless there are cogent reasons for doing so” (DoH, 2015). “If the prone (face down) position is necessary, use it for as short a time as possible” (NICE, 2015)
e. Board members should be fully informed of their trust’s position on restrictive practices and the management plan to reduce their use (DoH, 2014) (DoH, 2015)
f. The Board should identify an Executive Director to lead on recovery approaches and reducing restrictive practices (DoH, 2014) (DoH, 2015)
g. Providers should publish an annual report on the use of restrictive interventions (DoH, 2014)
h. The Care Quality Commission monitors and inspects against compliance with the guidance (DoH, 2014), providing a brief guide on positive behaviour support for people with behaviours that challenge (CQC, 2015)
j. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)

International Drivers

Appendix 3
Example Statistical Process Control Charts

Appendix 4
Feedback form

Promoting positive practice: reducing restrictive interventions

Name: (can be anonymous)
Position: (staff / service user)
Age: Ethnicity: Gender:

1. Do you think the strategy will help to reduce restrictive interventions in NSFT?

2. Do you have any suggestions for ways we could improve the strategy?

3. Have you experience of working or receiving treatment in other hospitals where there was a better approach to managing violence / self-harm or other behaviour that caused stress?

4. Do you think service users’ views are listened to on your current ward?

5. Do you think staff views are listened to on your current ward?

6. Do you think your current ward has a plan for reducing the number of restrictive interventions (e.g. restraint, seclusion, rapid tranquillisation)?

7. Any other comments?

Feedback to jem.french@nsft.nhs.uk
References


DH. (2014) Positive and Proactive Care: reducing the need for restrictive interventions. London: TSO.


How and what we will do to deliver our strategy

Supporting strategies
Clinical, recovery, workforce and organisational development, service user and carers, technology, estates

Our over-arching plan and goals to achieve our mission

Five-year Trust strategy
1. Improving quality and achieving financial sustainability
2. Working as ‘one Trust’
3. Focusing on prevention, early intervention and promoting Recovery

Our values and behaviours
Positively, respectfully, together

Our vision
Working together for better mental health

Our purpose – what we want to achieve for everyone

Our mission
To be a champion for positive mental health, by providing safe, effective, trusted services together with our partners

Reviewed yearly
Reviewed every 3-5 years
Reviewed every 6-10 years
Doesn’t change

NSFT Promoting Positive Practice; Reducing Restrictive Interventions Strategy   April 2018 – March 2021

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Norfolk and Suffolk NHS Foundation Trust values and celebrates the diversity of all the communities we serve. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.

Patient Advice and Liaison Service (PALS)

NSFT PALS provides confidential advice, information and support, helping you to answer any questions you have about our services or about any health matters.

If you would like this leaflet in large print, audio, Braille, alternative format or a different language, please contact PALS and we will do our best to help.

Email: PALS@nsft.nhs.uk
or call PALS Freephone 0800 279 7257