National Patient Safety
Improvement Programmes

Mental
Health

Reducing restrictive practice

A benchmarking report for the East Midlands

November 2020 – January 2021

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Patient story

I felt surrounded and as they approached, I felt closed in and everything disappeared as I was engulfed in a forest of people.

The hands kept coming, clutching at my clothes, pinning my arms, twisting my wrists, grabbing at my fingers until I could no longer move. I felt helpless and on my own, I had nowhere to go, I was scared, I was confused. Why are they doing this to me? Leave me alone, please don't hurt me!

I tried to fight back to free myself from this sea of grabbing hands, but it was no use. I couldn't move, I was held tight. I wanted to stay standing, but I couldn't. I felt my legs give way.

That was my first experience of been restrained. Sadly, there would be other occasions but that is another story.
My journey to mental wellbeing has been a difficult one, with many experiences of hospitalisation, both good and bad.
I appreciate that sometimes, in exceptional circumstances, that using restraint and other forms of restrictive practice is unavoidable and necessary to keep everybody safe. But other times, the use of restraint can be avoided and isn't always necessary. In these instances, I ask you to remember my experience.

I'm in a better place now. The world makes more sense to me these days. I don't get the voices that condemned me or the ideas that people are trying to hurt me. I don't feel scared anymore. I feel connected now to things around me. I can think straight, and I can see things more clearly.

Introduction

High numbers of people continue to be restrained and are subject to restrictive practice.

Despite guidance supporting positive and proactive care, designed to avoid these practices, the 2017 *State of care* review of mental health and learning disability services reported a large variation in practice across different units for people with similar needs.

In recent months, the Care Quality Commission (CQC) has raised concerns that the reduced availability of staff to keep people safe may have increased restrictive practice during the COVID-19 pandemic. Research has indicated that there is also variation between groups in the rates of restraint experienced, and it is higher in people from black and minority ethnic backgrounds.

The National Collaborating Centre for Mental Health (NCCMH) was initially commissioned by NHS Improvement in 2018 to develop a Reducing Restrictive Practice Collaborative. Its aim was to reduce restrictive practice in participating inpatient mental health and learning disability settings by 33% by April 2020.

The collaborative has completed the first phase of the improvement work, and the NCCMH and national patient safety team are in the process of reviewing the outcomes and data to establish the quantifiable reductions in restrictive practice and the measurable interventions which have led to this. Participating teams report they have achieved exceptional improvements in specific areas of restrictive practice. There are many stories from patients, staff and senior leaders within these organisations that support the conclusion that the collaborative has made a real difference in reducing restrictive practice (RRP) within inpatient services.

We need to understand why some people receive inconsistent and unsafe practice, and design services in response to the needs of those using the service. As part of the NHS National Patient Safety Improvement Programmes (NatPatSIP), a mental health work programme has been commissioned with a particular focus to reduce the incidence of restrictive practices by 50% by 2023. This will require interventions to reduce the use of restrictive practice and address inequalities. Successful interventions will be identified and scaled up nationally.

East Midlands self-assessment

This report summarises the findings from a self-assessment (completed November 2020 - January 2021) as part of a regional benchmarking exercise in the East Midlands. The partners in the East Midlands Mental Health Alliance decided that they would complete the reducing restrictive practices checklist (sourced from the Restraint Reduction Network) so they could support peer-to-peer learning, and to create a baseline for their organisations and the East Midlands which would assist in identifying key areas of priority.

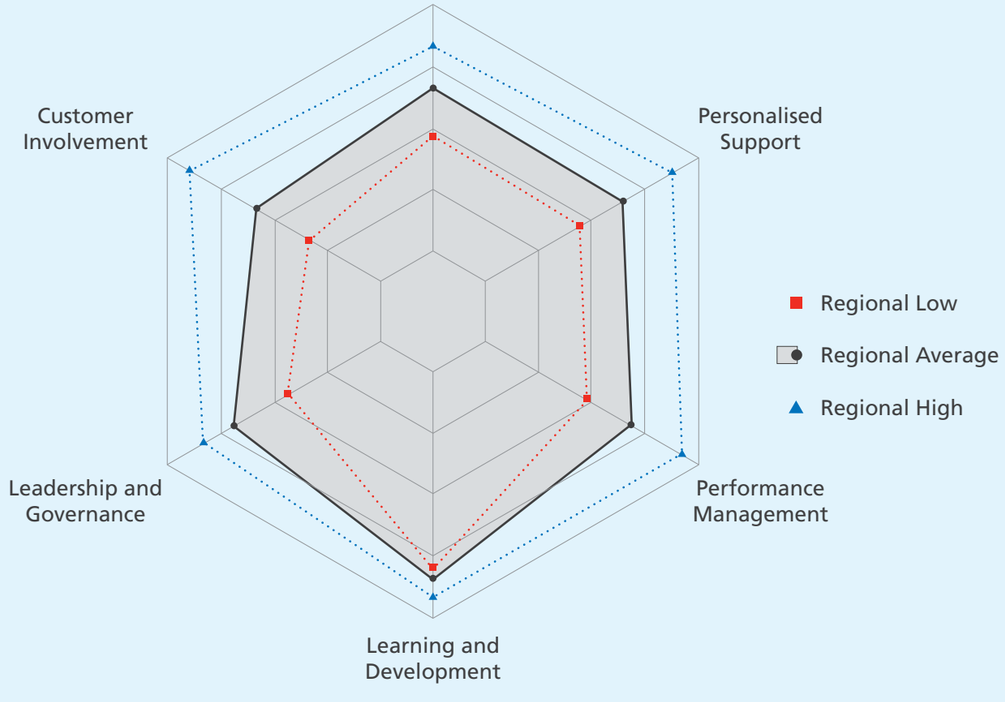
Methodology

Each organisation's restraint and restrictive practice leads completed a self-assessment to determine how well the organisation is perceived to be implementing a particular strategy based on the assessor's observations and triangulation of evidence.

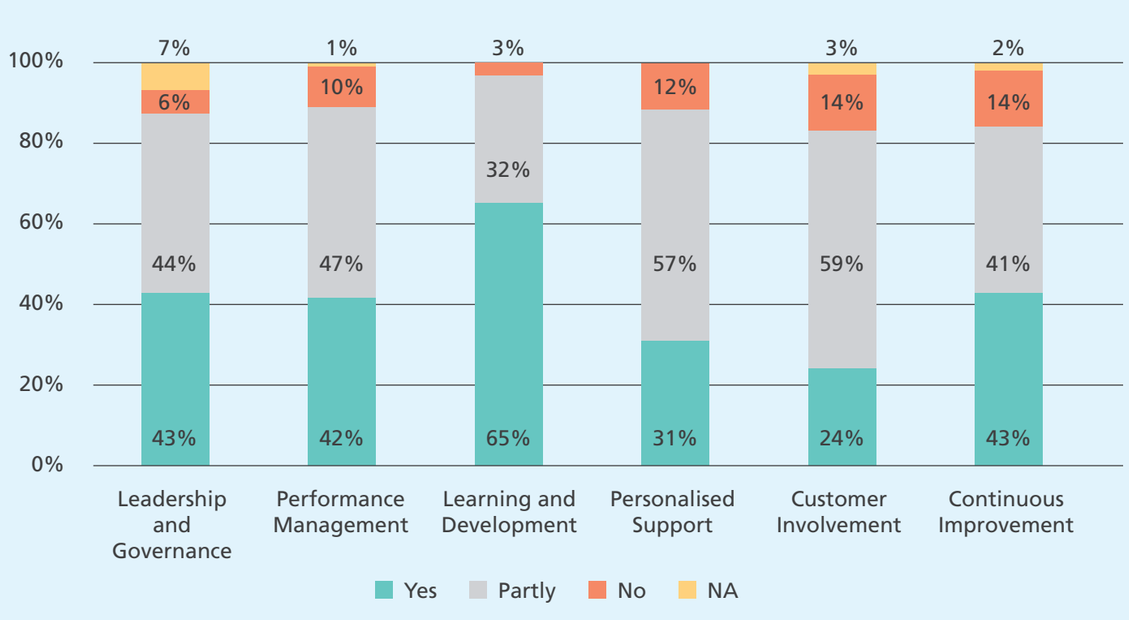
Once a judgement is made, a score is entered against the criteria and an overall score is calculated for each section. The score from each section of the assessment tool was collated at the end to give an overall picture of the organisation's current position and a regional baseline was created, taking all the scores into account.

Organisational scores

Regional average score



Answer distribution per strategy



Please note: These findings are based on self-assessments completed by the participating organisations, and this report has been written with their agreement.

Summary of findings

Across the six strategies, the following themes emerged across the region as areas requiring further work and improvement.

1 Leadership and governance

- Involvement of staff and service users in the formulation of the restraint reduction strategy.
- The restraint reduction strategy is communicated across the organisation and shared with stakeholders (service users and families, staff, commissioners, regulators).
- The culture in the organisation emphasises that the use of restraint is a 'treatment failure'.
- Restraint reduction is supported by strong, visible leadership. A senior manager is named as a lead for restraint reduction, and service users and families know who to speak to if they have concerns.
- Debriefs capture learning from restraints, including staff and service users.

2 Performance management

- Review what data is available and establish if that meets the needs of the staff. There needs to be more information showing trends, percentage increase/decrease, outliers and patterns. Comparison of restraint/seclusion should be available.
- Clear set of measures that are used to determine the level of performance in relation to restraint and restraint reduction, which can then be compared to other trusts.
- Data is shared at all levels within the organisation so that everyone is aware of the organisation's performance (organisation, department, team and individual level).
- Data is provided to and used by staff to help them understand the needs of each person they support.
- Collect staff and patient experience relating to restrictive practice.
- Improved translation of data from paper to clinical practice.

3 Learning and development

- Review the quality of supervision and strengthen the infrastructure to ensure clinical supervision is effective, and enables learning to be applied to the needs of individuals they support.
- Improved access to support in practice, to deal with challenging individual cases.
- Ward-based coaching.
- Advanced positive behaviour support training to be more prominent and explicit in the delivery of the programme.

4 Personalised support

- The use of individual positive behaviour support plans in non-acute areas.
- Where risk behaviours are identified, each service user's behaviour support plan outlines how a flexible and responsive crisis response and post-crisis support will be delivered.
- Better use of external and peer review.
- Implementation of service user and carer involvement for all strategy and trust development relating to the planning, development, and implementation of reducing restrictive practice.
- Improvement of the clinical environments to establish a culture of least restrictive practice along with care, safety and collaboration.
- Consistent capture of what level of flexibility should be incorporated into plans at the secondary and tertiary levels, in particular the need to establish advance decisions in a consistent way.

5 Customer involvement

- Identify ways of sharing performance relating to restrictive practice data with service users and families, and where improvements have been made.
- Clear information is given to service users and families which outlines the circumstances when restrictive practices can be used, including how to complain when service users and families are unhappy about the use of restraint.
- Service users are involved in the co-delivery of training to staff on the use of restrictive practices.
- Debriefing is always offered/provided to service users when any restrictive practice is implemented, and is flexible to the needs of the service user.
- Outcomes of debriefings are used to enable collaborative action with service users and staff, to develop more effective personal support and behavioural management strategies.

6 Continuous improvement

- Use assessment tools which give an indication of staff attitudes towards restraint reduction, and the level of care and compassion afforded to service users subject to restrictive practices.
- Improve access to data and improve its accuracy.
- Build front-line continuous quality improvement capability to address themes relating to restrictive practice.
- Improve the lessons learned process.

Areas of good practice

There were several questions which scored highly across the region; the following scored the maximum for all trusts:

The organisation implements an ongoing training cycle which ensures that staff maintain their competencies and continue to develop their knowledge and skills.

High scores were noted in the following strategies. This aligns with the regional performance and areas that require improvement.

Strategy	Number of high-scoring responses
Learning and development	6
Leadership and governance	3
Performance management	3
Continuous improvement	2
Customer involvement	1
Personalised support	1

Some examples of work in the East Midlands

Body worn cameras

Trials of body cameras worn by staff on inpatient areas of mental health trusts have been positively received by service users (*The Guardian, 2019*).

"I think it prevents lots of aggression and puts patients' minds at ease knowing there is a record of what happened."

"I am fully in support of the technology being used permanently in the future. I can see nothing but positives from it with recourse to its potential in reducing/de-escalating violent incidents."

"Feel more reassured when having to utilize restraint techniques that cameras are activated and capturing the incident."

"I have seen a few occasions where the incident had de-escalated and believe this to have been helped by the camera being turned on. It would be good to see some sort of footage used in training if appropriate to do so."

Progression and Management of Violence and Aggression training (PMVA)

Training was co-designed with patients and they are involved in training staff.

"Both myself and my partner are experts by experience and have been involved in the mandatory PMVA training for the last eight years. We co-produce and deliver a session on what physical intervention can feel like from a service user's perspective.

"The aim is to develop an understanding of emotional safety, and what that feels and looks like. It also conveys the importance of professional calm and validation in de-escalating challenging situations. In terms of trauma informed care, we try to get staff to think about triggers, and developing good safety plans that include this information and are working documents.

"We have really felt part of the PMVA team and are proud of what we have developed and importantly we really feel valued. At the end of each session, we receive lots of really encouraging feedback, so we really feel that we are moving things forward in a positive way."

'Talk First' de-escalation training

One trust completed a review of its theory and skill training curriculum in relation to conflict resolution and management. The updated curriculum has changed in both its format and content, and now reflects an increased emphasis on primary prevention skills as part of the drive towards reducing restrictive practices.

Integral to this increased emphasis on primary prevention strategies is the development and inclusion of the 'Talk First' module, which provides a structured approach to using effective de-escalation skills.

"The training feels so different, there's a lot more emphasis on preventing incidents."

"I really like the memory aide slides on top tips for listening and staying safe."

"I think that 'Talk First' really gives you some structure to using de-escalation!"

"The patient experience of restraint is very powerful, it really made me think."

"The 'Communication Model' really makes you think about how much we assume when talking to patients."

Nicotine reduction approach

Through consultation and involvement, a new approach has been created in which one trust has moved away from being a no-smoking trust and adopted an approach of nicotine reduction during inpatient stays. As a result, all patients are supported at the point of admission to create a nicotine reduction plan, and designated areas for smoking are in place.

As a result, incidents of violence relating to smoking have reduced, absconding has reduced, and patient safety and satisfaction have improved. This has led to a reduction in the use of restrictive practice such as physical restraint, challenges at the point of admission and locked doors.

Listening to patient feedback

Sam was being admitted to the acute inpatient wards on a monthly basis. During these admissions, there were occasions where physical restraint was needed due to self-harming behaviours. During a period of recovery, Sam raised a concern regarding some of the restrictive practice taking place, from their experience. As a result, some actions were outlined and agreed. However, some were felt to be superficial, so Sam was asked to become part of a panel on reducing restrictive practice across the unit.

Sam was also invited to tell their story to the trust's board to identify shortfalls and improvement opportunities. This continued engagement has led to alterations in trust practice, including the implementation of new practices such as **safety pods.** These look like a large beanbag and can be used to support the patient in a position on their back.

Recommendations

Two clear threads were noted:

- Engaging service users to support the development of services, pathways and training.
- Involving staff so that their perspectives and attitudes are considered, and they are supported to understand the data and provide solutions on how to improve the care provided.

Targeted work on staff attitudes will support all the strategies and ensure that changes are embedded and sustained. The Mental Health Patient Safety Network will be the 'engine room' for patient safety improvement at a sub-regional level and will directly support several systems to take local ownership for delivery of the National Mental Health Safety Improvement Programme.

The Mental Health Patient Safety Network will employ a co-design approach, representative of the diversity of the population served, and will follow key stages as part of their improvement approach:

1 Define:

Map their care pathways and define the nature of any gaps or problems that will be addressed, as outlined in the programme driver diagram (appendix 1). The network will need to determine the number of local systems within its geographical footprint.

2 Diagnose:

Understand the scale of the gap or problem across the network, baseline position, interdependencies, anticipated outcomes of the work, and identify any effective interventions not already highlighted in published literature. During the diagnostic stage, there are several activities that Patient Safety Networks can undertake:

- Reviewing data
- Understanding variation and flow
- Setting aims and scope
- Identifying interdependencies
- Agreeing communication processes

3 Plan:

Based on the outcomes of the diagnostic stage, plan an annual network programme of improvement work, with engagement from all organisations and local systems. The work is likely to be phased over several years in order to address all the clinical themes and enablers.

→

4 Test:

Using the Model for Improvement, test and measure how to implement evidence-based interventions and tools reliably and sustainably across the care pathways, or where there isn't enough evidence, seek to develop new, innovative pathways and solutions.

5 Scale-up:

Embed interventions that have been tested in multiple environments across the network in redesigned care pathways.

Potential projects for quality improvement (QI)

The national team are developing a tool for improvement for restrictive practice (theory of change) which will inform future practice. But reviewing the Royal College of Psychiatry website, there are several QI projects related to restrictive practice that the East Midlands could undertake, which align to the themes noted in the self-assessments:

- Collaborative care plans (written by patients in their own words)
- Ward round preparation sheets
- Knowing patients' preferences (e.g. knock on the door and wait before entering)
- Getting to know each other (staff boards)
- Visual displays of QI / restrictive practice boards used to share information/data
- Patient safety climate survey
- Safety huddles
- Simulated de-escalation and observation training for staff
- Going-home checklists (used for staff at the end of their shifts)

Next steps

- This regional report will be shared with partners in the East Midlands.
- Discussion of the report at the Mental Health Patient Safety Network.
- Agree actions in response to the report at the Mental Health Patient Safety Network.
- Webinar for staff on the principles and top tips on co-design.

Conclusion

The self-assessment tool was intended to help partners ensure that the use of restrictive practice is minimised and that the misuse and abuse of restraint is prevented.

The results for the East Midlands indicate that partners have many processes in place and are committed to learning and improving what they are doing. The strategy which stands out is 'learning and development', as the questions in this strategy scored highly across the region.

The strategies which will further reduce the use of restraints relate to customer involvement and personalised support. The Mental Health Patient Safety Network will be the 'engine room' for patient safety improvement. Ensuring service users are part of this will mean that co-design is a foundation for all the work that happens in the East Midlands.

"Restrictive practices and restraint can cause trauma, harm, and affect the dignity and emotional safety of service users and staff alike. It should always be a last resort, using the minimum of force required to ensure patient safety and, as a former service user once described to me, always applied with a sense of professional calm.

"I am pleased to see there is openness and transparency emerging in this work and it is great to see examples of good practice being shared, as opportunities are explored to see where further improvements can be made.

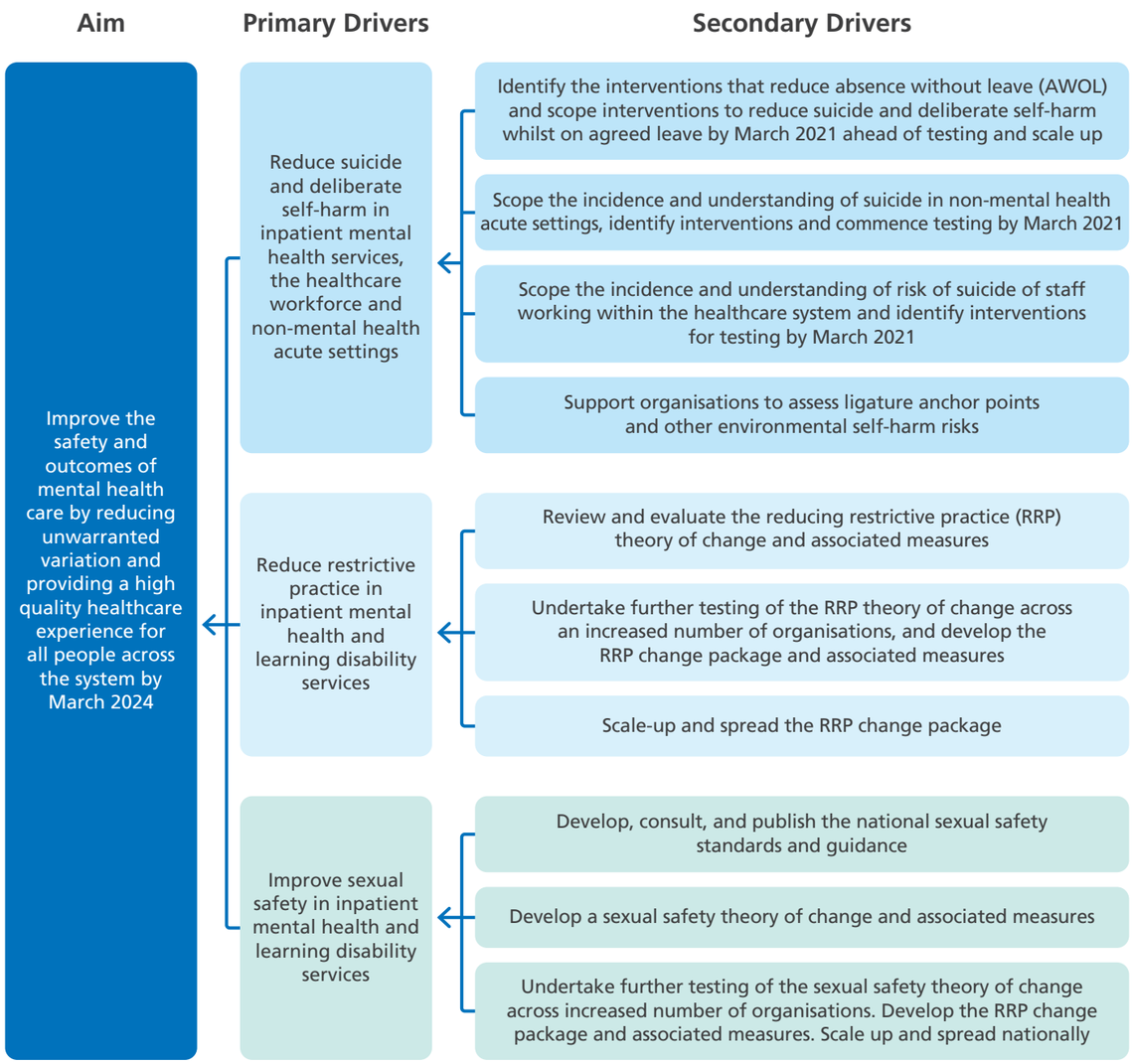
"Co-production should be at the heart of this improvement, in a process where patient, carer and clinician voices are heard together, as lessons are learned to drive progress in both restraint practices and patient safety. As patients from black and minority ethnic communities are statistically more likely to experience the use of physical restraint, issues of equality should also be an important consideration in this initiative.

"After any incident involving the use of physical restraint, the ambition should be to collaboratively rebuild trust and return to as positive a therapeutic relationship as soon as possible for all concerned; centred on recovery focused care."

Andy Willis, East Midlands Patient Public Involvement Senate member

Appendix 1

Mental Health Driver Diagram



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