Restrictive practices

Key points:

- In all services, we expect care to be person-centred where staff listen to and try to understand people, including how they communicate their needs, emotions or distress.
- Over the last year, we have seen positive examples of people being involved in their care and supported as individuals. This has helped to keep them safe and reduce unnecessary restraint.
- While we recognise that the use of restraint may be appropriate in limited, legally justified, and ethically sound circumstances, it must be remembered that it can have a significant impact on a person's mental health, physical health, and their emotional wellbeing, and could even amount to a breach of their human rights.
- Services must work to understand the events that led up to any incidents where restrictive practice was used, report on them, learn from them, and actively work to reduce them in future.
- In August 2023, we published our cross-sector policy position on reducing restrictive practice, which clarifies our expectation of providers. We are committed to helping services promote positive cultures that support recovery, engender trust between patients and staff, and protect the rights, safety and wellbeing of all patients and people using services.

Most people know that restraint, seclusion, and segregation are the more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice that easily become day-to-day normal responses to perceived risk or lack of time.

This includes, for example, not being able to make hot drinks after a specified time, or denying people access to visitors, friends, or food due to a lack of staff or time.

In all services, we expect care to be person-centred where staff listen to and try to understand people, including how people communicate their needs, emotions or distress. Providers must use this understanding to support adjustments that remove the need to consider the use of any restrictive practice.

We recognise that the use of restrictive practices may be appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights. This means that any restriction must be:

- lawful
- for a legitimate aim
- the least restrictive way of meeting that aim.

However, our expectations are clear: everyone in health and care has a role to play in reducing the use of restrictive practices. In its place, we expect to see regularly reviewed, trauma informed care plans that are tailored to people's specific needs.

In our last report, we highlighted the progress made by some services in reducing the use of restrictive practices and creating therapeutic environments for patients. While we have seen improvements in some areas, overall there is significant work still to be done. For example, we remain concerned about the disproportionate use of force against some groups of people, including:

- people from Black and minority ethnic groups
- autistic people and people with a learning disability.

Our cross-sector policy position on reducing restrictive practice, published in August 2023, clarifies our expectation of providers. Building on our work to encourage providers to reduce their use of restrictive practices and considering best practice in person-centred care, the policy is clear that we expect providers of all registered services, including mental health services to:

- promote positive cultures that support recovery
- engender trust between patients and staff
- protect the rights, safety and wellbeing of all patients and people using services.

We also ask providers in all sectors to record and analyse incidents at board level or equivalent and work to reduce them.

We are embedding our policy position on restrictive practice in our assessment framework for inspecting services. Working with British Institute of Learning Disabilities (BILD) and the Restraint Reduction Network, we have also developed training for CQC staff to improve our reporting where we identify restrictive practices during inspections.

Person-centred care

Over the last year, we have seen examples of services struggling to provide personalised care.

In one example, the family of a patient told us through our complaints service that their relative was restricted from seeing their emotional assistance dog, which was causing them unnecessary distress. We found that staff had not recorded in the patient's treatment plan the therapeutic rationale for withholding visits from the emotional assistance dog. In addition, we found no reference to nationally recognised guidance or best practice to support the decision.

At another service, we saw how the lack of care planning could lead to patients being kept in seclusion for longer than needed:

> "There was no seclusion care plan for the patient and no clear steps recorded in order to bring seclusion to an end. The record of seclusion did not include the information required as set out in the Code of Practice. This included information about the person responsible for authorising the seclusion, who undertook 2-hourly nursing reviews and details of the patient's presentation at the time, the date and time seclusion ended nor the details of the person who determined this. In the records we reviewed, the recording of seclusion reviews was inconsistent."

Psychiatric intensive care unit for men, September 2022

However, we are pleased to have also seen positive examples of people being supported as individuals, which has helped to keep them safe and reduce unnecessary restraint. For example, at one service, we observed how staff providing person-centred care to patients in long-term segregation helped them to progress:

> "The patients in long-term segregation had complex needs and the staff showed commitment to individualised person-centred care. While patients remained restricted, most had progressed on this ward compared to their previous places of detention. Progress for long-term segregation patients could take time and we heard about a positive example of one patient who we observed in the quiet area listening to music. He had previously been in holds throughout his time out of long-term segregation and

> then in a zoned area of one room. He was making progress that appeared to be small steps but, for him, were huge achievements aided by staff."

Increased support and treatment ward for men, January 2023

At another service, the care plans we read showed evidence of patients' involvement and that people were aware of their rights under the MHA. The hospital's booklet explained environmental blanket restrictions, contraband items, and the ward's locked door. Staff told us that restrictions were discussed regularly. All patients could use their mobile phones on the ward. Patients who did not have a mobile phone could use the ward's tablet to speak with their families.

> "Individualised restrictions were discussed with the patients during ward rounds. Blanket restrictions were reviewed by both patients and staff during weekly patients' forum meetings."

Acute admission ward for women, November 2022

We expect services to have strong safety and learning cultures, focusing on improving expertise, listening and acting on people's experiences to deliver person-centred care, and taking clear and proactive action when safety doesn't improve.

Use of restrictive practices

As noted at the start of this chapter, in limited, legally justified, and ethically sound circumstances, for example where there is no other option but to restrain a person to avoid harm to themselves or others, the use of restraint may be appropriate./p>

But restraint must:

- never be used to cause pain, suffering, humiliation or as a punishment

- only be used to prevent serious harm
- be the least restrictive option, applied for the shortest possible time
- only be carried out with the correct authorisations beforehand.

We have heard of examples of restraint being used appropriately in this way. For example, during our interviews with people with lived experience, Kevin told us about seeing his daughter restrained:

> "Before they restrained her, they told me that it may be distressing to watch, and they offered for me to move away but I decided to stay nearby and watch it. I wanted to witness it so I could see for myself what happened. It was distressing to see it, especially as my daughter is only small and (the staff) were big. But I was really impressed with how they did it. The staff were extremely professional during the restraint. I couldn't have asked for them to handle it any better than they did..."

Interview with person with lived experience

In our interview with Andrew, he shared his experience of being restrained while detained:

> "I was physically restrained a few times and held down until I calmed down, but they never hurt me. I've never really looked into what they are allowed to do, but it felt appropriate at the time and if I was in their shoes, it's exactly what I would do."

Interview with person with lived experience

While these are positive examples, it must be remembered that the use of restrictive practices can have a significant impact on a person's mental health, physical health, and their emotional wellbeing. Use of restrictive practices could even amount to a breach of their human rights. Services must work to understand the events that led up to any incidents where restrictive practice was used, report on them, learn from them, and actively work to reduce them in future.

We expect services to take a proactive and preventative approach to stop situations reaching crisis point. If aggression occurs despite this, de-escalation techniques can help staff to respond in line with the least restrictive principle. Every patient's situation is different, and the detail of the de-escalation will depend on their needs, the environment and what has to be done to keep everyone involved safe. Person-centred planning and support can promote quicker de-escalation and reduce unnecessary restraint. Providers must have effective processes to call on and use staff with specialist skills in a timely way if a person reaches crisis.

Research published by the National Institute for Health and Care Research highlights the importance of therapeutic relationships in successful de-escalation. It states, "the fears and anxieties of both patients and staff are a key barrier to successful use of de-escalation… stronger therapeutic relationships between patients and staff could make a difference."

The Mental Health Units Use of Force Act 2018 aims to reduce the use of force and ensure accountability and transparency about the use of force in mental health services. Services are required to have a policy, co-produced with patients, that commits to reducing the use of force. Guidance for the Act also includes requirements over training, recording and reporting the use of force, and requires services to identify a Responsible person, who is accountable for implementing the Act.

At one service, our reviewer raised concerns that some people hadn't received any information about the Act, but other wards in the same trust have readily available information. It is essential that information for patients about the use of force is available across all wards.

Policies and governance

It is vital that staff understand policies relating to restrictive practice. Through our monitoring visits we have seen variation in how well staff knew and understood policies around restrictive practice.

Approved leave and access to fresh air are important for people's recovery, and decisions around people's ability to take leave should be based on risk. However, at one service we saw evidence of leave being used as a reward or punishment which, the MHA Code of Practice states as being completely unacceptable:

> "The way the care plan and contract were presented indicated that section 17 leave was being used as a reward or punishment."

Ward providing treatment and rehabilitation to male patients who have complex needs relating to mental illness, acquired brain injury or progressive neurological conditions, January 2023.

Another ward had applied strict blanket policies around patients' access to fresh air and we saw evidence of staff failing to be flexible in how they applied the policy. Blanket policies are applied to everyone regardless of their individual needs and are contrary to person-centred trauma informed care. The MHA Code of Practice is clear that blanket restrictions should be avoided and should never be for the convenience of the provider. Any blanket restrictions should be:

- agreed by hospital managers
- documented with the reasons for such restrictions clearly described
- subject to the organisation's governance procedures.

> "Staff applied a blanket approach to all patients who wished to access fresh air ...

> There was a list of prescriptive times displayed in the office. We observed a patient requesting time off the ward for fresh air. Ward staff informed the patient they had missed the prescribed time for fresh air and would have to wait approximately 2 hours. The patient was becoming visibly agitated. The qualified nurse granted immediate time off the ward. We are concerned ward staff did not exercise flexibility without the nursing staff intervening."

Acute admissions ward for male patients, February 2023

Limiting fresh air time is unacceptable, and we instructed the service to ensure it was included as part of people's individual care plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

We are concerned that poor understanding of the Mental Capacity Act (MCA) and issues with the management of Deprivation of Liberty Safeguards (DoLS) are contributing to the over-use of restrictive practices.

As highlighted in our 2022/23 State of Care report, we continue to see a variable understanding of the interface between the MCA, which DoLS are part of, and the Mental Health Act (MHA). Where both frameworks could be used, it is not always clear how staff decided that using the DoLS framework would be most appropriate for a particular patient.

We have observed some providers not delivering adequate training on DoLS, resulting in a lack of understanding among staff. This could lead to them applying restrictions without considering whether less restrictive options are available in line with the MCA. We have also seen that some people are being discharged from detention under the MHA because other options such as DoLS are considered to be more appropriate. However, this leads to some people being 'de facto detained', as delays in DoLS assessments mean they are deprived of their liberty for longer than they need to be or without the appropriate authorisation in place. We continue to encourage the government to bring forward the much anticipated Liberty Protection Safeguards reforms.

Social and physical environment

We have seen how unsuitable physical environments increase the risk of restrictive practice. For example, on one ward we visited, access to fresh air and other therapeutic facilities were all off-ward, meaning patients could not access them unless staff were available to supervise:

> "Access to the 2 ward gardens was down several flights of stairs and patients could not access the gardens without staff supervision. There was no other access to fresh air on the ward. The arts and crafts room, education room in which the computers were located, occupational therapy kitchen and multi-faith room were all off-ward and patients could not access them unsupervised. These limitations amounted to blanket restrictions."

Low secure mental health service for Deaf/deaf men, January 2023

At another service, the seclusion room did not have en-suite bathroom facilities, which we were concerned could have a negative effect on people in seclusion:

> "The seclusion room had the toilet, shower and sink within the seclusion room and not in en-suite arrangement. This meant that young people using these facilities would

> have to sleep, eat and be in the same room as a toilet, which may compromise their dignity and have a negative effect on their experience of seclusion."

Acute ward for female patients of adult age, January 2023

Bathroom facilities, including those for patients in seclusion, must protect people's human rights, especially by ensuring privacy and dignity. They must also be planned and designed with a person's individual needs in mind. It is not acceptable to have a toilet in the main area of a seclusion room. Any requirements around maintaining safety should be assessed to ensure that they have the least impact on privacy possible and should be regularly reviewed.

We require any service in a new building to have these facilities to be able to register with us and we also expect, where possible, any refurbishment of seclusion facilities to create en-suite facilities.

It is disappointing that we continue to see the use of dormitories in mental health settings. We know that patients and carers have an overwhelmingly negative opinion of shared sleeping arrangements. As we raised in our last MHA report, on wards where dormitories are still in use, some patients have raised specific concerns with us about safety and privacy. We are clear that dormitory accommodation is unacceptable, and we welcome the government's plans to invest over £400 million to eradicate dormitories. So far, over 600 beds have been replaced across 34 sites and we urge the government to continue to prioritise the eradication of all mental health dormitories.

We have seen how people's experience can improve when providers adapt service environments to meet their individual needs. For example, at one service, we found the new long-term seclusion suite had its own secure garden and bathroom arrangements that were both safe and dignified:

> "The long-term seclusion suite...[which] had been purpose built since our last visit, was a much lighter and airier environment and was much more resilient to damage. The

> suite had appropriate observation arrangements for using the bathroom whilst respecting the patient's privacy and dignity as this was done by means of an infra-red camera. The suite had separate bedroom and lounge areas. Anti-rip bedding and clothing was available where needed. The suite had its own secure garden with a bench for the patient to sit on when they wanted. We observed warm, kind and respectful interactions between staff and the patient in the long-term segregation suite."

Folkestone, Tonbridge, Poplar, Maidstone and Rochester wards (wards for autistic people and people with a learning disability), Cedar House, Coveberry Limited, December 2022

At another service, we noted a number of quiet spaces for patients to use:

> "Staff and patients had designed a quiet sensory space with self-soothing tools such as a blackboard wall. Patients had included inspirational recovery messages."

Bridford ward for women (acute ward), Glenbourne Unit, Livewell Southwest, August 2022

We found other positive examples, including an acute unit that had safely introduced an open-door policy. We support services in making policies as least restrictive as possible, assessing the level of risk on an individual basis, as the following shows:

> "Both the ward entrance door and the door of the main hospital building were kept unlocked. We were told that the open-door policy did not increase the risk of detained patients going absent without leave. At least one staff member was always present in the communal lounge area which was situated near the door. Patients were encouraged to write on a whiteboard when they were leaving the ward, including a brief note on their destination and expected time of return. Patients were supported to maintain contact with friends and relatives, and several patients had regular visitors.

> Patients could access their own internet enabled mobile phones on the unit. The patients' kitchen was open 24 hours a day."

Abbey Ward (mixed gender acute admissions ward for adults of working age), Wotton Lawn Hospital, Gloucestershire Health and Care NHS Foundation Trust, December 2022