Use of Restrictive Practice in NAS Schools Procedure

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Contents

1. Scope

This procedure applies to all National Autistic Society services that provide support for children, young people where the National Autistic Society has a duty of care.

2. Purpose

The purpose of this procedure document is:

1. To give guidance to staff to enable them to be clear as to what forms of restrictive practices are permissible and when they should be considered.
2. To give clear guidance to staff about which forms of restrictive practices are never acceptable and the reasons for this.
3. To ensure that the use of restrictive practices is minimized, and clear reduction plan(s) and strategies exist for those where restrictive practice is necessary.

The rights and dignity of the children and young people who use National Autistic Society Schools, even when behaving in a physically challenging way, must always be borne in mind. Any restrictive practice must be used with a view to keep them and others safe, with the aim of allowing the children and young people not only to recover from dysregulation and distress, but also to acquire alternative adaptive behaviours and functional skills that, over time, decrease the level of intervention needed.

This procedure document must be read in conjunction with the Use of Restrictive Practice in Schools Policy SO-0040 and Supporting Behaviour in Schools Policy SO-0030.

The NAS has pledged to the Restraint Reduction Network (RRN) to ensure that there is a focus in Schools on the reduction of restrictive practices.

This pledge includes adhering to the Six Core Strategies outlined by the RRN below:

The RRN promotes the Six Core Strategies as a systemic approach to culture change and reducing restrictive practices. The Six Core Strategies provide a framework to enable cultural change in support of restraint reduction that includes:

Leadership – at both organisational and practice levels.
Data collection and analysis – using evidence-based decision-making, and monitoring progress.
Workforce development – training in *preventative* methods, rather than reactive.
Using prevention tools and strategies – with trauma-informed schools or Positive Behaviour Support.

Involving children / people with lived experience – informing reduction strategies at all levels.

Post incident support and debriefing – providing emotional support, and opportunities to reflect and learn.

NOTE - Procedure for admission to a school where children and young people are dependent on seclusion or restraint to manage their behaviour must be read in conjunction with this Policy (Related Document - SO-0039-005-0723).

3. Introduction

There are a variety of approaches and strategies that can be used to prevent situations from developing into incidents likely to cause harm such as: learning environments that fit the children and young people, de-escalation, distractions, individualised communication plans, individualised sensory profiles, low arousal approaches and other examples of Positive Behaviour Support – refer to the Supporting Behaviour in Schools policy SO-0030.

However, on some occasions it may be necessary to use, as a last resort, a strategy that includes a restrictive practice. Any form of restrictive practice will only be used in order to maintain the welfare and safety of the children and young people we support and others. Staff will be trained in approved techniques and any unplanned interventions outside of an individual's Individual Behaviour Support Plan will be investigated to ensure that action taken was proportionate and applicable at the time to prevent harm to the children, young people or others and support strategies developed to prevent it happening again.

If you can find no alternative to using a restrictive practice, then it must be lawful, justified, proportionate, and least restrictive. For any action to be considered proportionate and least restrictive, all preventative options must first be exhausted. (Examples of Non-Restrictive Practice see Related Document - SO-0039-002-0623)

A useful concept to bear in mind when carrying out any trained Restrictive Intervention is that of **Social Validity**. During any restrictive practice we should be conscious both of how our intervention may look to others not involved in the interaction and how we would like ourselves, family members or friends to be interacted with in similar circumstances.

4. Restrictive Physical Interventions

All those supported by the National Autistic Society who require any form of supporting behavioural intervention will have an Individual Behaviour Support Plan that provides detailed information relating to all aspects of the children and young people and how to support them.

The plan is person centred in its approach setting out details about the children and young people's behaviours including hypotheses about the functions of a particular behaviour, known as contributory environmental and personal factors, antecedents, triggers, as well as how known behaviours should be recorded when they occur. Whenever possible the plan

should be produced in collaboration with the autistic individual. The plan describes the proactive, secondary preventative and reactive strategies that are to be followed by those supporting the children and young people to improve the person's quality of life and reduce the risk of harm to themselves or others (RRN Key Strategy 3 & 4).

Part of this reactive plan may include restrictive practices where necessary and deemed in the children and young people best interest and the least restrictive option.

Mental capacity must be assessed when plans are required to be implemented. Where someone has capacity to consent, then they need to agree and sign their plan. Where someone does not have capacity, the plan must be agreed as in their best interest and least restrictive option by the relevant people involved in their care (RRN Key Strategy 5). All documentation must be reviewed on an annual basis and be kept in the individuals support folder.

Restrictive practices can take several forms and may not always involve direct physical force

Physical Restraint

Physical restraint is when a person or persons use direct physical contact to make someone do something they don't want to or stopping them from doing something they do want to do. Support staff working for the NAS will be trained, where appropriate to use Studio 3 techniques to keep the children and young people they are supporting, themselves and members of the public safe. The NAS does not use any supine or prone restraints as part of their prescription to either behaviour management framework.

Chemical Restraint

Chemical restraint includes the use of prescribed medications to alter a person's behaviour. Pro re nata (PRN) medication (in the form of sedation), rapid tranquilization is when drugs are used to make someone do something they don't want to or stop them from doing something they do want to do

The use of any PRN will be guided by a specific and individual protocol from the prescribing medical professional and a multiagency team. (See Related Document - SO-0039-002-0623 for further details).

Environmental Restraint - Seclusion or Enforced Isolation and Long-term Segregation

Environmental restraint is using the physical environment to make someone do something they don't want to or stop them from doing something they do want to do such as the holding of doors or blocking access by use of a person. Numerous terms refer to environmental restraint – segregation, isolation, time-out, solitary confinement.

Mechanical Restraint

Mechanical restraint is using materials or equipment used to restrict or prevent movement (e.g., arm splints); to make someone do something they don't want to or stop them from doing something they do want to do.

Surveillance

Surveillance is when staff watch and/or listen to people, places, and property. This might include human surveillance where staff physically observe a person. It might also include cameras, microphones, or other technology such as GPS trackers.

Cultural Restraint

Cultural restraint is using cultural norms to make a person do something they don't want to do or stopping them from doing something they do want to do.

This might include:

• Stopping a person from expressing their cultural views or preferred ways of being

• Stopping someone doing something that is important to them, their values, ethnicity and/or culture

• Making someone feel ashamed, inferior and/or humiliated because they are different to someone else

Psychological Restraint – Coercion

Psychological restraint is any kind of communication strategy that puts psychological pressure on people to do something they don't want to do or stop them from doing something they do.

Blanket Rules

Blanket restrictions are rules or policies that restrict a person's liberty and other rights, without individual risk assessments to justify their application. Blanket restrictions include lack of access to certain places, belongings or activities.

Restrictive practices can be categorised as planned or unplanned practices:

4.1 **Planned Restrictive Practice –** pre-arranged interventions based on Risk Management, Training Needs Analysis (TNA) and Restraint Reduction plans, and risk assessments and are clearly recorded in care and positive behaviour support plans. These interventions should be Studio 3 sanctioned techniques and staff will be fully trained to carry out these interventions based on the individual needs of the children and young people. They will be agreed as in an individual's best interest and as the least restrictive intervention and used for the least amount of time possible (when the present and immediate danger has passed). The time frame for reporting the use of a Planned Restrictive Practice is within 24 hours of the practice/Intervention taking place.

4.2 **Unplanned Restrictive practices –** There may be occasions whereby the use of an intervention occurs in response to unforeseen circumstances to prevent the immediate risk of harm to the child or young person or others such as a person supported is about to run out in front of a car. This may be referred to as an emergency or unplanned response. The time frame for reporting the use of an Unplanned Restrictive Practice is within 24 hours of the practice/Intervention taking place.

4.3 Wherever possible, an unplanned response should still be a studio 3 sanctioned and trained technique. However, in an emergency situation if this was not practicable, but an intervention is still urgently needed to prevent harm to self-and/or others, staff must

follow the legal principles laid out at the start of this corresponding policy and the Managing Signs of Distress training, by providing a reasonable and proportionate response to the situation they are presented with, only when all other options have been explored where and when possible.

4.4 Where unplanned or unintentional incidents of restrictive practices occur, they should always be recorded, opportunity given to debrief, followed by a reflective session / incident analysis to ensure learning and continuous safety improvements (RRN Key Strategy 6).

4.5 If monitoring shows that an unplanned restrictive practice is required on more than one occasion in a 4-week period the Individual Behaviour Support Plan and risk assessments should be amended to include any planned restrictive practices, along with proactive measures to reduce the need for such interventions over time (RRN Key Strategy 6).

4.6 **Unacceptable and dangerous intervention -** There are a number of interventions that are either unacceptable, dangerous and often both:

- Prone restraint - Chest on floor / other surface
- Supine restraint - Back on floor / other surface
- Any restraint using the locking of joints
- Any restraint using pain to achieve compliance
- Any restraint that involves forcing the head forward onto the chest area.

The above interventions should be avoided even in emergency situations. Particular care should be taken with any Physical Practice involving the children and young people due to vulnerable joints and or with underlying health problems such as swallowing, obesity or heart problems.

When assessing the needs of any the children and young people that require the use of a restrictive practice as part of their support plan, it is essential that advice is sought from the relevant medical professionals around the use of such practices for the individual when underlying medical conditions are diagnosed and/or apparent.

When considering the use of new restrictive practices Reasons could be;

- Following unplanned response
- Change in health/need
- Change in environment
- Change in circumstance
- Change in presentation

The following processes should be applied and followed;

- Underlying medical issues identified at the assessment stage
- Advice sought as part of any proposed offer of service around the use of Restrictive Practice and the how this may influence any potential regression, relapses or risks to the children and young people
- A risk management plan developed including input and guidance from the relevant professionals around the diagnosis and safe uses of agreed restrictive practices.

- Risk Management plans of this nature should not be carried out without external support from medical services (Consultants etc.).
- Comprehensive post incident checklist and guidance around ensuring any potential effects from the use of such practices have been monitored, recorded and reported to the relevant professionals.
- Where a child or young person is currently accessing our schools with underlying medical issues does not have a plan in place, this must be organised internally, and the relevant professionals contacted in order to implement the strategies and documentation to support policy expectation.
- Awareness of the significant harm that may be caused to the child or young person due to their physical under development

Medical attention should be sought if a Restrictive Practice has been used to support someone with underlying health issues (RRN Key Strategy 5).

5. Seclusion

Seclusion is supervised containment or isolation away from others in a room the child or young person is prevented from leaving

The definitions below seek to explain the practice and give examples that might apply in social care or educational situations.

- Seclusion normally takes place as a direct response to manage an incident or episode.
- Segregation is usually an active decision to care for somebody separately.

Seclusion can be described indirectly in the following terms, but the principles of its use apply:

- Time out
- Exclusion
- Segregation
- Seclusion
- Safe-space
- Chill out room
- De-escalation room
- Quiet room
- Calming room
- Garden time
- Solitary
- Staff Withdrawal (from Individuals place of residence, behind locked doors)

Seclusion of a person in a room, which may be locked or being held closed, to protect others from significant harm. Its sole aim is to contain behaviour which is likely to cause harm to others. During any period of seclusion, support staff must remain in sight of the children and young people at all times.

Staff must be able to observe the children and young people at all times to ensure the health and well-being and that their needs are met. This includes access to the toilet, food and drink and activities.

If this is an agreed Restrictive Practice, follow the guidance around **Agreed Restrictive Physical Practices.**

If seclusion is used as an unplanned response to a dangerous situation and as a last resort, follow the **Unplanned Restrictive Physical Practice** guidance and section 4.2 - 4.6 of this document.

Seclusion should only be used:

- As an absolute last resort
- For the shortest possible time

Seclusion should **never be** used:

- As a punishment or threat
- As part of a behaviour support programme, unless the aim is to introduce a graded restrictive reduction plan where these strategies have been used previously
- Because of a shortage of staff
- Where there is a risk of suicide or self-harm
- For staff convenience and comfort

If a person is confined for a short time, they are still likely to be harmed by the experience and may have psychological impact and immediate aversive reactions for example: Isolation Panic. Isolation panic includes experiences of rage, loss of control, breakdowns in wellbeing, psychological regression and increases in self-harm. Self-harm is more likely to occur in confinement and in the immediate period after confinement

5.1 Planned Seclusion

Prior to use, planned seclusion must be discussed with the Director of Education & Children's Services and the Safeguarding Lead as well as ratified with an appropriate legal framework.

Any period of seclusion must be agreed and signed by the Senior Member of shift on duty or the on-call Manager.

Agreed protocols for recording and monitoring planned seclusion must be in place before any period of seclusion.

5.2 Seclusion as an Unplanned Restrictive Practice

If seclusion is used as an unplanned response to an extreme situation, monitoring throughout the period (until the present/immediate danger has passed) must be undertaken in line with the guidance above and as soon as is practicable.

Within 24 hours, the Director of Education & Children's Services and the Nominated Individual must be notified of the incident.

5.3 Segregation

Caring for the children and young people in isolation. The isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.

The reasons for the use of segregation are as follows:

- Children and young people may be displaying high levels of behaviours of concern/Signs of Distress (Frequency, Severity, Duration), that is having an impact on others physical or emotional well-being within a shared environment
- Children and young people personal hygiene or health is having an impact on others physical or emotional well-being
- To safeguard an individual from potential abuse, bullying from peers, sensory impact, impact to physical or emotional well being

The segregation must be evidence-based and in the children and young people best interests and should always be agreed on thorough best interest protocols and procedures. Should staff require further information on this, they can contact the National Lead for Behaviour Management & Low Arousal and/or Clinical Leads.

5.4 Planned Withdrawal

Where there is 'Staff Withdrawal' as part of the children and young people Behaviour Support guidelines and/or Restrictive Practice Plan, it needs to be agreed as part of a transdisciplinary process and form part of the person's Risk Management and Restraint Reduction plan.

5.5 Staff Withdrawal (Seclusion)

If the planned withdrawal includes leaving children and young people in a room, or in the area where children and young people reside, with a locked door separating the children and young people from peers or staff members, this is deemed as seclusion and should be:

- Agreed on a multi or trans-disciplinary level
- Be based on actual risk and present/current risks
- Identified as part of the children and young people behaviour support and restrictive practice plan
- Have robust monitoring documentation in place
- Be part of Risk Management and Restraint Reduction Plan
- Staff should be fully trained in the use of this intervention, including when, how and logging and reporting systems

5.6 Staff Withdrawal (Non-Seclusion)

When staff withdraw to allow children and young people to regulate, allow privacy or have been asked to do so by the child or and young person. This would be without the use of a locked door acting as a barrier, and the children and young people should have freedom to leave or request staff engagement whenever the person chooses.

- Must be part of the persons' proactive support and therapeutic guidelines, led by the children and young people wherever appropriate
- Must have robust monitoring protocols in place to ensure the correct use of the strategy
- Doors must remain unlocked to support the guidance within the strategy and adherence to procedure
- Staff should be fully trained in the use of this intervention, including when, how and logging and reporting systems

6. Principles for the use of restrictive practices

1. When managing behaviour that is potentially dangerous to self and others, staff must act in a measured way, bearing in mind their duty to try to keep the children and young people we support, staff members and themselves safe.
2. Staff should be trained in all techniques relevant to the children and young people's care based on Training Needs Assessment and Risk Management Plan (RRN Key Strategy 3).
3. Additionally, staff have a responsibility to take all reasonable steps –through the inclusion in Individual Behaviour Support Plans, Risk Management and Restraint Reduction plans, and of up-to-date risk assessments related to children and young people we support – to safeguard the wider public and property from any potential physical danger from the children and young people we support when in the wider community (RRN Key Strategy 3).
4. Where restrictive practices are used, they must be proportionate to the risk of harm, the context in which this is taking place, any omissions to act and the seriousness of that harm. Any force used must be 'reasonable and proportionate', reasonable in that it is the minimum force required to prevent injury.
5. the children and young people should, where possible, be involved in any discussion about the use of restrictive practice. Almost all the children and young people will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed their views in the past. Wherever possible and reasonable, the children and young people informed, free and full consent to any restraining action should be obtained. The individual's relatives, advocates, welfare attorneys or guardians, circle of support should be involved in discussions about the use of restrictive practice and should be agreed as in the child or young person's best interest. In all cases explanation should be given, at a level the person can understand (RRN Key Strategy 5).
6. Under no circumstances should the use of restrictive practices result in pain or pressure on joints.
7. Wherever possible, staff should consult and collaborate with colleagues. The person who is most familiar with the children and young people and has the best

understanding of how to respond to the situation and the response behaviour observed should take the lead role. This may cut across line management and seniority.

8. Staff should always explore other possible alternatives. For example, restrictive practices should not be used when a change of staff could have meant it was not necessary.
9. Except in an emergency or where the behaviour support guideline indicates to the contrary, the only restrictive practices involving bodily contact used should be those approved by Studio 3 and only used by staff with appropriate training. It is understood that this may not always be possible during an emergency or where the bespoke behaviour support plan / guideline indicates to the contrary (RRN Key Strategy 3).
10. Where bespoke restrictive practices are required, this must be agreed by a multi-disciplinary/transdisciplinary team and all staff who are expected to support children and young people must be trained appropriately. Bespoke interventions can only be implemented when signed off through appropriate professionals, local trainers cannot implement bespoke methods. This should fall in line with the Restraint Reduction guidance around Training Needs Analysis. Where there is an expectation that an agency or temporary member of staff have achieved the 3-day Managing signs of Distress competency level and be trained and assessed as competent in the bespoke techniques in order to provide the appropriate support needed. (RRN Key Strategy 3)
11. Studio 3 consultancy service may approve and train staff in the use of bespoke restrictive practices. In such cases these should be documented within the behaviour support plans/guidelines and only used for the children and young people concerned. Restrictive practices that have not been approved by Studio 3 should not be included as part of a planned intervention.
12. All restrictive practices should be carried out for the least time necessary. Where appropriate the environment should be made safe or the children, young people or others (depending on which is the least restrictive) supported to move to a safer environment to reduce the intervention time.
13. Staff should refer to the behaviour support guidelines which detail all the strategies and interventions used, including restrictive practices, to help the child, or young person manage their behaviour. Supporting Behaviour in Schools SO-0030 (RRN Key Strategy 4).
14. Particular care needs to be taken over the use of restrictive practices when a child and/or young person we support is engaging in self-injurious behaviour (SIB) or deliberate self-harming. A full risk assessment needs to inform the strategy to support children and young people who engage in self-injurious behaviour (SIB) or self-harm. Only agreed, trained restrictive practices can be used, only as a last resort and only when it has been decided that more harm will result from not using them.
15. After any restrictive practice has been used an independent person who has not been involved should check the child or young person for any injuries or any signs of potential injuries.

7. Debriefing (RRN Key Strategy 6)

For reference, debriefing in the context of this document, is giving the opportunity to the children and young people after an incident has occurred to discuss the emotional impact the incident has had on them. It allows the child or young person to speak freely

and openly about how the incident has made them feel and be supported to move on from the incident.
Post-incident debriefing is an approved practice (Department of Health, 2014) that helps people to recover and learn from a crisis, reducing restrictive practices. Good quality post-incident debriefs help to repair, build, and maintain relationships, enabling people to feel safe and secure. Helping people to understand themselves better, gives them more control and helps them to communicate their needs more effectively. This leads to better outcomes for children and young people, families and staff.

- The debriefing session should always remain confidential unless safeguarding concerns issues are raised and not be used to influence changes to behaviour support guidelines or used as an opportunity to analyse or reflect on the individual's practice.
    - Reflective Supervision or Incident Analysis are two other forms of post incident processes, which offer the opportunity to reflect, analyse and where possible, improve on practice, and should only take place after the debrief has been offered/completed.

- The Debrief is optional but highly recommended for the individual member of staff and the children and young people we support. Staff and children and young people have the right to refuse the opportunity to be debriefed after an incident.

- Narrative around the content of the debriefing session should **not** be taken, however, the 'offer of' and 'acceptance/refusal' of the session should be logged.

- In Schools when a 'Debrief session has taken place, it is logged as part of the incident recording on CPOMS.

- Debriefing must be offered to the child, young person or adult who has been restrained in line with the guidance in their individual behaviour support guidelines.

- Debrief should be offered or sought out as soon after the incident as is possible

- Reasonable adjustments must be made for example, a child or young person we are supporting may experience difficulties processing verbal information. In this case, a 'reasonable adjustment' might be to offer visually supported information. Good communication is the foundation of good care. Making reasonable adjustments for people who communicate differently is an essential step in providing good care, preventing distress and reducing restrictive practice

- Debrief guidance NAS Debrief Guidance - 2023 V2.0

- https://restraintreductionnetwork.org/wp-content/uploads/2022/06/Post-Incident-Debriefing-Guidance-for-staff-working-with-autistic-people-or-people-with-learning-disabilities.pdf

8. Training (RRN Key Strategy 1-5)

For Tiered Framework see the policy part of this document

All training which includes the use of Physical Interventions and Restrictive Practices should be assessed by the School and Individual needs.

This guidance must be followed:

- All Physical Skills Training should be based on the school and individual need.

- Where there is a need for staff to be trained in any form of Physical Intervention, or the use of Restrictive Practice, a Risk Management, Training Needs Analysis and Restraint Reduction Plan, if required, should be completed. A Training Request form should then be sent out by the principal or Behaviour support/TDT/Clinical Teams. If there is a need for Restrictive Practice

All staff must receive preventative training before they receive any training in restrictive interventions (RRN Key Standard 1.2.1).

All staff must attend Additional 6 hours training in supporting children and young people positively, proactively and understanding individual's needs (Positive Behaviour Support, SPELL and Autism Awareness which includes a classroom/teams 1-day introduction to Autism and Spell and Online Ask Autism Modules) as part of their induction into our organisation, this a minimum requirement (RRN Key Strategy 1).

- All Staff are expected to attend annual refreshers, all curriculum content must be studied/revised over a three-year period

- All Staff members are to be well versed in the use of Studio 3 Low Arousal approach, and understand the importance of being aware of yourself, your environment and the potential risks of supporting the children and young people that access schools.

- **All staff working in Tier 1** schools are to be trained in Managing Signs of Distress Day 1 Theory, as a minimum requirement. Staff will be expected to demonstrate the retention and understanding of the theory element of the training by completing a 20 question Multiple choice questionnaire post training.

- **All staff working in Tier 2** schools will need to attend a minimum of Managing Signs of Distress Day 1 Theory and Day 2 Physical Skills Person/School based Training. Annual Refreshers will need to be attended by all Tier 2 staff in the Theory Element and any needs assessed physical skills. If there is a need for Restrictive Practice - training on the 3rd day will need to take place based on the Training Needs Analysis.

- **All staff working in Tier 3** schools will need to attend a minimum of Managing Signs of Distress Day 1 Theory, Day 2 Physical Skills Person/School based Training and Day

3 the use of Restrictive Practices, again, all training must be needs assessed. Training on the 3rd day will need to take place based on the Training Needs Analysis. Annual Refreshers will need to be attended by all Tier 3 staff in the Theory Element and any needs assessed physical skills.

- **Any additional Tier 4** sanctioned techniques will be monitored and trained in line with the specific needs of the children and young people, the team and the Restraint Reduction Program. Staff will need to attend a minimum of Managing Signs of Distress Day 1 Theory and Day 2 Physical Skills Person/School based Training and Day 3 the use of Restrictive Practices, again all training must be needs assessed, along with an additional workshop in the specific use of a Tier 4 strategy. Annual Refreshers will need to be attended by all Tier 4 staff in the Theory Element and any needs assessed physical skills.

- Any additional Tier 4 sanctioned techniques will be monitored and trained in line with the specific needs of the children and young people, the team and the Restraint Reduction Program.

9. Recording, reporting and monitoring (RRN Key Strategy 6)

All incident reporting should be in-line with the NAS Incident Management Policy & Process QAF2.

1. For any incident involving the use of restrictive practice, a behavioural incident CPOMS record must be completed within 24 hours and where appropriate, formally reported to outside agencies (Ofsted) within 24 hours in writing in accordance with the school's protocol. Information to be recorded is listed in Related Document SO-0039-001-0623.

2. Use of environmental change to restrict movement, use of medication/PRN to manage behaviours of concern or Signs of Distress or reduce risk of harm and use of mechanical restraint all require recording on a restrictive practice form – See Related Document SO-0039-003-0623 and SO-0039-004-0623.

3. The above is to be written onto a Restrictive Physical Intervention (RPI) form / CPOMS record that is kept by the school and will be monitored and signed off by the senior leadership team.

4. An accident record should be completed if there is any injury to any parties as a result of the restrictive practice.

5. The completed record, with the incident form should be signed off by the appropriate senior staff member in accordance with the school's protocol.

6. Individual Behaviour Support plans must give clear strategies to reduce dependency on Restrictive Practice over time.

7. The use of all restrictive practice programmes must be reviewed by the support team following any incident that results in use of a restrictive practice. All plans must be reviewed formally (as a minimum) every 12 months and regularly reviewed on a need basis alongside their respective risk assessments/RAMPs where applicable.

8. After any use of Restrictive Practice, the Individual behaviour support plan and risk assessments should be reviewed and updated if/as necessary.

10. Related Documents

SO-0039-001-0623	Information to be recorded for each use of a Restrictive practices
SO-0039-002-0623	Non-Restrictive & Restrictive Intervention Practice
SO-0039-003-0623	Restrictive Practice Form
SO-0039-004-0623	How to complete Restrictive Practice Form
SO-0039-005-0617	Procedure for Admission to a School or Service where an individual is dependent on seclusion or restraint to manage his or her behaviour
SO-0039-006-0623	Unplanned Restrictive Response Reporting
SO-0039-007-0623	Managing Signs of Distress Framework
SO-0039-008-0623	Incident Analysis Form
SO-0039-009-0623	Studio 3 Verification Sheet
SO-0039-010-0723	Protocol for Unplanned Restrictive Practices
SO-0039-011-1120	Training Request / Referral Form
SO-0039-012-0623	Restrictive Practice Management and Restraint Reduction Plan
QAF2	Incident Management Policy & Procedures
NAS Debrief Guidance - 2023 V2.0	NAS Debrief Guidance

SO-0030	Supporting Behaviour in Schools Policy SO-0030