Mental Capacity Act, Best Interest and Deprivation of Liberty Safeguards Policy

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Contents

PURPOSE OF THIS POLICY

The purpose of this policy document is to provide staff working in The Children's Trust with guidance about the Mental Capacity Act and how it is applies, to ensure best interest decision making for our young people and adults, who lack capacity.

It sets out the main provisions of the Mental Capacity Act, local procedures, roles and responsibilities of staff. This policy is not a replacement for the Code of Practice, which is a guide about how to apply principles of the Act.

1. INTRODUCTION

The Mental Capacity Act 2005 provides a legal framework to empower and protect vulnerable people over the age of 16 in England and Wales, who are unable to make certain decisions for themselves, i.e. about the care and treatment they receive; participation at school and in activities; their therapeutic and care plans and important decisions such as managing their finances and where they should live

Having mental capacity means that a person is able to make their own decisions. Capacity can vary over time and by the decision to be made. A lack of capacity could be the result of a permanent, temporary or fluctuating condition.

2. MENTAL CAPACITY PRINCIPLES

Mental Capacity Act - The Five Key Principles

Within the MCA are five statutory principles which set a legal requirement that the individual is placed at the heart of the decision making process, maximising their ability to participate, particularly in those decisions which are made on their behalf.

PRINCIPLE 1 – PRESUMPTION OF CAPACITY

The starting point when working with any individual is to always assume capacity "until there is proof that they do not" (MCA, 2005).

PRINCIPLE 2 – ALL PRACTICABLE STEPS

"All practicable steps" should be taken to help the person make the decision until it is confirmed that they lack capacity to make the decision. **Appendix A** Practical Steps to Promote Capacity provides guidance on tools that can support the formal assessment process e.g. who best to support the assessment; when it should be done, with whom; how to support communication and key questions to think about.

It is important that the individual is given all the relevant information about the decision that is required (in a way that they can understand). For example, the risk and benefits and potential alternatives.

PRINCIPLE 3 – ECCENTRIC OR UNWISE DECISION MAKING

It is important to remember that individuals have the right to make unwise or eccentric decisions. The quality of the decision is irrelevant as long as the person understands what they are deciding.

PRINCIPLE 4 – BEST INTERESTS

This principle sets a balance between autonomy and protection whereby decisions must be made in the individuals "best interests". Although the MCA does not define 'best interests' there is a clear checklist framework within the Act which guides practice **(see Section 5).**

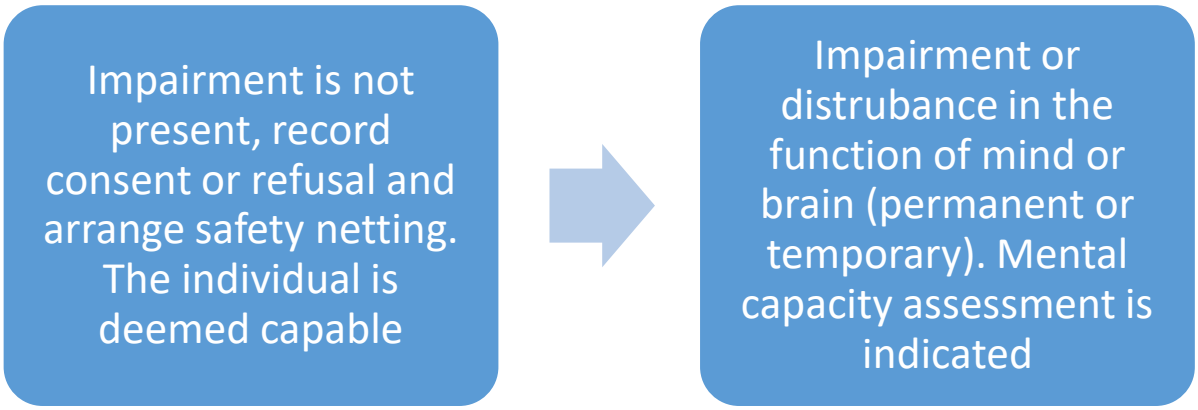
PRINCIPLE 5 – LEAST RESTRICTIVE

This principles states that the least restrictive, effective option is chosen, which interferes least with the individual's freedom of action. The code of practice states that the restriction 'must be the minimum amount of force for the shortest period of time possible".

3. ASSESSING CAPACITY

The MCA sets a two stage test for assessing whether a person lacks capacity to make a particular decision at a particular time. It is a "decision-specific" test. No one can be labelled 'incapable' or 'without mental capacity' as a result of a particular medical condition or diagnosis. The MCA makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead to unjustified assumptions about their capacity.

Functional test



- With all possible help given is the person able to understand the information relevant to this decision?
- Are they able to retain the information long enough to make the decision?
- Are they able to weigh the information as part of the decision making process?
- Are they able to communicate the decision?

An answer of 'yes' in all of these areas means that the person has capacity.

An answer of 'no' to **any one** of these 4 areas will constitute a lack of capacity for the particular decision to be made.

Refer to the MCA Assessment Guidance **(Appendix B)** for further guidance.

4. AUDIT OF MENTAL CAPACITY ASSESSMENTS

Quality audits will be introduced to ensure that mental capacity is being considered in day to day interactions with our adults and young people, that there is consistency in how this is managed, to ensure that care plans and single sets of noes reflect that when we support our young people and adults, these factors are taken into account and that their care, therapy, health and leisure opportunities are delivered in a person-centred way and in their best interests.

Care Plans for our young people aged 16 and over include a section on mental capacity and the young person or adult's ability to consent to care, treatment etc. This will be reviewed at

monthly key worker meetings, as capacity, particularly with regard to young people with acquired brain injury can change.

5. **BEST INTERESTS DECISION MAKING FRAMEWORK – DETERMINING THE BEST INTEREST OF ADULTS WHO LACK CAPACITY**

A best interest decision is only needed when the person aged 18 has been assessed as lacking capacity for the particular decision at the time it needs to be made. A person can be easily overlooked in the process and yet should be central to it; "there should be no decision about me, without me".

If a young person aged 16 and 17 year has the capacity to make particular decisions but parents are in disagreement The Children's Trust will advocate on behalf of, or with the young person, by having conversations with their parents.

A Best Interest Template is available in the Clinical Toolkit, which should be completed when making a formal best interest decision as part of the MCA process (**see Appendix C).** Whilst many minor day-to-day decisions relating to a person's care may be recorded in case notes, significant decisions relating to assessment of capacity and best interests should be recorded.

When completing the template, there should be a clear connection with the *statutory checklist* for best interest decision making under the MCA. Attempts need to be made to capture the person's wishes, feelings, beliefs and values and, if possible, to demonstrate the outcomes the person would like. The information captured from the Mental Capacity Assessment can inform the best interest decision, regarding the person's views and wishes. The checklist is not exhaustive; issues of culture, the person's physical, emotional, social and psychological wellbeing should be addressed.

By recording people's views and the weighing up process, you can demonstrate that, on the balance of probabilities, you have acted in the persons best interests.

Less restrictive options must always be considered and given greater priority in the weighing up process. Where there are no alternative, available options to consider, the decision to be made would be weighed against the known risks by not taking any action/providing treatment.

There may not always be agreement about what is in the best interests of an individual. Case records must clearly demonstrate that decisions have been based on all available evidence and have taken into account all the conflicting views.

If there is a dispute, the following courses of action can help in determining what is in a person's best interests: Involve an independent advocate, obtain second opinion, hold a formal or informal (multi-agency) case conference, go to mediation, as a last resort, apply to the Court of Protection for a ruling.

6. **PROTECTION FOR THOSE MAKING DECISIONS**

Emergency Treatment

When a person requires emergency medical treatment to save their life or prevent serious harm the 'reasonable' steps to determine capacity and best interests, including consultation with others, will differ from non-urgent situations. In emergencies it will almost always be in the person's best interests to give urgent treatment without delay. One exception would be when staff are satisfied an 'advance decision' to refuse treatment exists.

Excluded Decisions:

There are some decisions which we are not entitled to take on behalf of someone else, known as excluded decisions (S.27 of the Act). You cannot decide in someone's best interest any of the following decisions: to have a sexual relationship, life sustaining treatment, to enter into a marriage or civil partnership, to a decree of divorce, to dissolve a civil partnership, to a child being place for adoption, to the discharge of the parental responsibilities on matters that do not relate to the child's property; to give consent under the Human Fertilisation and Embryology Act. These decisions relate to family and personal relationships and the best interest framework does not apply. The decision falls under other legislation or directed to the *Court of Protection*.

Research

The MCA sets out parameters for research which may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees it is safe, relates to the person's condition and produces a benefit to the person or people with a similar condition outweighs risk / burden. Parents or nominated third parties must be consulted and agree. If the person shows any signs of resistance or indicates in any way they do not want to take part, they must be withdrawn from the research.

7. APPLYING MENTAL CAPACITY ASSESSMENTS AT THE CHILDREN'S TRUST

For the majority of decisions that are required for our young people and adults, formal assessment will not be required. For example these day to day decisions will include social and leisure activities, whether the person is well enough to go to school, if they choose to participate in an activity or a session, whether they need to see a doctor, what clothes they want to wear, how their room is decorated, routines.

These are all types of decision that young people and adults with capacity would be able to make for themselves. If an individual is unable to do this we must make decisions on their behalf and in their best interest and we must evidence this within our records.

For example:

Jenny went to bed when she showed/communicated that she was tired.

Amir chose to wear his red top and jeans.

Susan appeared unwell, doctor informed and she stayed home. She spent her morning…..

May attended her session but did not want to engage in activity so the session ceased/alternative offered.

Additionally there will be reference to a young person or adult's mental capacity within:

This Is Me (neuro rehabilitation), Hi MY NAME IS (residential) and the Care Passport

In rare circumstances a formal mental capacity assessment will be required, e.g. if there is a plan for a person to move from The Children's Trust, or from one house to another onsite. The majority of the more significant decisions will not be for staff at The Children's Trust to make, ie if it is planned by the funder to move an adult to another residence, the funder will be the decision maker. However if a formal assessment is required by staff at The Children's Trust there is an MCA assessment template in the Clinical Toolkit and **Appendix D**

7. DEPRIVATION OF LIBERTY SAFEGUARDS / RESTRAINT AND RESTRICTION

The Deprivation of Liberty Safeguards (DoLS) procedure is designed to protect a person's rights if they are aged over 18, 'deprived of their liberty' in a hospital or care home in England or Wales and lack mental capacity to consent to being there or to consent to their treatment and care. It is a way to ensure that individuals are looked after in a way that does not inappropriately restrict their freedom.

Is it a deprivation or a restriction of liberty?

The Law Society practical guidance can help decide whether a DoLS application is required. It can be hard to decide whether a restriction on liberty is actually a deprivation of liberty requiring authorisation, within the wide range of circumstances that may occur. Examples of types of restrictions on liberty in care homes include: keypad entry system , observation and monitoring , expecting all residents to spend most of their days in the same way and in the same place , saying someone can only go into the community with an escort, restricted opportunities for access to fresh air and activities (including as a result of staff shortages) , set times for access to refreshment or activities , limited choice of meals and where to eat them (including restrictions on residents' ability to go out for meals) , use of restraint in the event of objections or resistance to personal care , mechanical restraints such as lap-straps on wheelchairs.

For further guidance please see Guide to the Children's Homes Regulations including the quality standards April 2015 **(Appendix E)**

How is deprivation of liberty authorised

The Social Worker responsible for each house will support House Managers to complete urgent and standard applications for authorisation of Deprivation of Liberty Safeguards. On receipt of an approved application from the relevant Local Authority Social Workers to inform registered manager for notification to CQC.

The Deprivation of Liberty Safeguard Team in the Local Authority that provides funding for the individual will have a template authorisation form and will organise for a DOLs assessor and psychiatrist to visit the adult at The Children's Trust.

It is the responsibility of The Children's Trust to keep parents informed of the process and ensure that authorisations have not expired. The administrator for each house updates the information on a spreadsheet.

8. FURTHER ADVICE

Staff can contact the social work team regarding queries about The Mental Capacity Act and issues such as deprivation of liberty.

9. TRAINING

Mental Capacity Act Training is included in Induction for all staff and as mandatory training, both as workshops and online webinar.

APPENDIX A

Practical Steps to Promote Capacity

Factors to consider when completing MCA assessment with young people:
Does the young person's capacity/communication/engagement fluctuate depending on factors such as fatigue/mood/memory/attention difficulties/comfort? Consider what factors affect this to select the optimum timing, environment and assessor to carry out the MCA. This may include:

1. Time of day: is the person more awake/alert on certain days or at certain times of the day?
2. Activities carried out prior to assessment which may have increased fatigue
3. Assessor: Is there a member of staff who the young person communicates most effectively with?
4. Environment: does the young person communicate more effectively or feel more comfortable in certain environments? Select a quiet distraction free environment.
5. Optimise posture and comfort to increase engagement
6. Speak to the young person and their carers about instances that may be impacting their mood/stress levels and be prepared to change the timing of assessment
7. Would the young person like other people present at assessment (e.g. a family member)
8. Length of assessment: how long is the young person able to concentrate for? What strategies help, e.g. giving breaks
9. Does the young person require glasses/hearing aids? Ensure they are using these as appropriate.
10. Implementation of strategies to support communication, memory and engagement (see communication guidelines and talk to the young person's therapy team)

Tools:

1. Individualised communication guidelines
2. Use of individualised AAC systems if the young person s accessing these (these may include communication books, devices, choosing cards – see communication guidelines or talk to the young person's therapy team for more information)
3. Use of appropriate visuals such as photos to aid communication and memory
4. Talking mats may be considered for specific decisions

APPENDIX B

Mental Capacity Assessment Guide

The Mental Capacity Act 2005 is the legal framework to empower and protect vulnerable people, aged over 16, who lack capacity to make certain decisions for themselves.

Five key principles emphasise the fundamental concepts and core values of the MCA:

1) Presumption of capacity: everyone aged 16 and over has a right to make their own decisions.

2) Individuals should be supported with practical/ appropriate help to make their own decisions.

3) Individuals can make what might be seen as eccentric or unwise decisions

4) Best Interest (BI) Principle - anything done for people who lack capacity must be in their 'best interests'. Once established that someone lacks capacity, a Best Interest decision must follow.

5) Anything done for people lacking capacity must be 'least restrictive' of basic rights.

The Code of Practice – online guidance for staff working with people who lack capacity to make certain decisions

The Process of Assessing Capacity

If there is a Deputy for Health and Welfare (over 18's only) a Mental Capacity Assessment will not be required. If unsure, seek advice from social worker at TCT.

Mental Capacity Assessment & Best Interest decision templates are saved on Clinical Toolkit

Support with the process is available from managers and the social work team

Formal assessment of mental capacity is indicated when the decision required carries an element of risk or if there is a conflict of views. It is completed by the decision maker ie the staff member recommending the course of action

Stage 1 – describe why a mental capacity assessment is indicated eg the individual has an acquired brain injury, learning disability, medical diagnosis.

Stage 2 - The member of staff completing the Mental Capacity Assessment will decide whether the person should be directly involved in the assessment, based on their knowledge of the person and the communication guidelines in the care plan. If a person cannot communicate their decision in any way, they are deemed unable to make that decision, eg if the person has a disorder of consciousness or a severe cognitive impairment, evidence for not including the person can be copied from their communication guidelines in their care plan and be explicitly recorded on the assessment. Advice can also be sought from SALT and OT professionals.

In most cases the assessment will require consultation with the person and MDT. Staff should consider using methods/tools to promote understanding and decision making. The mental capacity assessment template guides staff through the assessment process.

An individual cannot make a particular decision if unable to do one or more of the following:

Understand the information given to them • Retain that information long enough to be able to make the decision • Weigh up information available to make the decision• Communicate their decision.

Following formal assessment the staff member completing the assessment should inform the young person, parent and relevant community professional of the assessment outcome. In the case of individuals who are residing here, the funding authority should be informed. Completed assessments are filed on single set of notes, and on the young person's folder on the M-drive, under CONSENTS. Copies to be sent to parents, and local authority/funder at their request.

Recording day to day decisions:
Consent to daily activities do not require formal assessments of capacity but should be part of our daily interaction with young people/adults, in order to provide personalised and appropriate care. Staff will explain and offer choice about their daily activities and care, and make informed judgements about the person's capacity to consent. When recording, staff should refer to issues such as 'capacity', 'consent' and 'best interests', for these day-to-day decisions, as well as for formal assessments.

If an individual's presentation/capacity to make decisions is changing, existing Mental Capacity Assessments must be reviewed.

The Process of Best Interest Decisions

Any act or decision made on behalf of a person who lacks capacity must be made in that person's 'best interests' whether minor or major issues. In caring for a young person/adult we should ensure we are using the least restrictive options. If we are restraining or using restrictive measures we may be depriving someone of their liberty, and should seek advice from the Local Authority/funder.

A best interest decision is only needed when the person is aged 18+ and has been assessed as lacking capacity for the particular decision at the time it needs to be made. For young people aged 16-17 who lack capacity, we will defer decision making to the adult with parental responsibility. For looked after children who are subject to a care order (Section 31) the Local Authority social worker will be the decision maker.

Best Interest decisions - when to hold a meeting: Only certain Best Interest decisions will require a meeting, e.g. when a course of action could have a harmful side effect, if there are multiple decisions to be made, or if there is conflict in the views of parents/ staff. Most Best Interest decisions can be made in discussion (face to face or telephone) with the young person, parents, staff.

Remember that a parent of an adult aged 18+ should be consulted but cannot make decisions for their 'child'. Unresolved Best Interest decisions may need referral to the Court of Protection. Seek advice from the social workers at TCT.

APPENDIX C

The Children's Trust
For children with brain injury

RECORD OF BEST INTEREST DECISION

Name:	**DOB:**
NHS No:	**TCT No:**
House:	**Date:**

What is the issue that the Best Interests Decision needs to address (delete as appropriate) Note that a Capacity Assessment must be completed before a best interest decision is made.

Best Interest Decision Making: **Step 1: who are you going to consult?**

Who is the Decision Maker (Best interest decision maker is the person delivering/providing the intervention):

Name……

Is there a Person (i.e family member / close friend) who can inform decision making? **Yes** ~~No~~

Name ……..

NB. Consider whether an IMCA should inform the decision making process if no. Speak to the social work team for guidance.

Determination of Best Interest Decision: **Step 2: views of young person, parents/family members, professionals and interested others**

The Decision Maker must consult with the person so far as is reasonably practicable and encourage their active participation in the decision making process as fully as possible. Did they express a preference; what views and wishes were they able to express?

In relation to this decision, what are the person's past and present wishes and feelings? Can you deduce anything from their beliefs and values such as their cultural background, religious beliefs or past behaviours, likes and dislikes?

i.e during the course of the assessment of capacity it was apparent that they…….

What are their beliefs and values that are likely to influence decision making if the person had capacity?
i.e …… had never expressed any views in relation to the care they receive. It is known that they hold strong beliefs about leading a healthy lifestyle and would have a certain preference

If the person had capacity, what other factors would they likely consider if they were able to do so?
i.e the person

The Decision Maker must take into account the views of family members and anyone engaged in caring for the person or interested in their welfare.

Family members, carers and other interested parties have a statutory right to be consulted; they have the legal right to state what they think should happen.

FAMILY MEMBERS : What do they know of the persons preferences and beliefs, wishes, feelings and values (in relation to the decision); What do they think should happen?

What are the views of significant others, friends, social worker, IMCA, carers, deputy for finance etc, identify those consulted and their relationship.

If someone is not consulted explain the reason (was it not practical or appropriate?)

What are the views of the professionals?

Are there any conflicts or disagreements?
If so what steps can be taken to resolve this disagreement

Best Interest Decision Summary: Step 3: Final decision

The decision maker is not bound to follow what others have said but they must give their views due consideration. Consider using a balance sheet approach to consider different options (see attached example / template)

In consideration of the above and all relevant factors what is the final decision?

Summarise the reasoning behind the decision and why this decision would be in the person's best interests; and the least restrictive option in your judgement:

Proposed Date for Review of decision if applicable:

Name of Decision maker (print name):

Signature:

Date:

Job Title

In cases where there is conflict/ serious decision-making required:

RECORD PEOPLE CONSULTED AND THEIR VIEWS

Name Relationship Date Consulted	What do they consider to be in the person's best interests with regards to this matter?	Are they aware of any information about the person's wishes, feelings, values or beliefs, or other relevant factors that the person may have taken into account if they were able to do so?

BEST INTERESTS CHECKLIST

The Mental Capacity Act requires that certain steps need to be followed when determining what would be in a person's best interests. However;

- **The checklist must be confide to major points so that it can adapt to changing views and attitudes**
- **The checklist should not unduly burden any decision maker**
- **It must not be applied too rigidly and should leave room for all relevant considerations**

(The Law Commission, 1995, para 3.28)

Any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests, whether the decision is a minor issue, such as what to wear or a major issue, like whether to provide particular healthcare.

The 'decision maker' should • encourage the person to take part • identify relevant circumstances • find out the person's views and factors that the person may consider if making the decision themselves • avoid discrimination by making assumptions about what is in someone's best interests on the basis of age, appearance, condition or behavior • assess whether the person may regain capacity and if so, can the decision be delayed? • not make assumptions about the person's quality of life • consult others, particularly those in a caring role, close relatives, friends, Court of Protection appointed deputy • for decisions about major medical treatment/ where the person should live • if no-one fits above categories, an Independent Mental Capacity Advocate must be consulted • remember, the person has a right to privacy - do not share everything with everyone • consider if other options may be less restrictive of the person's rights • weigh up all of these factors in order to work out what is in the person's best interests • what is in a person's best interests may well change over time, so best interests should be regularly reviewed.

Staff should keep a record of the process of working out the best interests of that person for each relevant decision, describing • how the decision about the person's best interests was reached • the reasons for reaching the decision • who was consulted to help work out best interests • what particular factors were taken into account.

BEST INTERESTS DECISION – DIFFERENT OPTIONS CONSIDERED: BALANCE SHEET OF PROS AND CONS

Options:	Pros (Positive Benefits, advantages) – what are the medical, emotional and welfare considerations? (i.e the procedure of inserting a PEG would reduce risk of aspiration, reduce consequent distress and would not be an intolerable burden).	Cons (Potential Risks/disadvantages) – what are the medical, emotional, and welfare considerations? (i.e the actual procedure of inserting a PEG could be risky to their health, with a significant ris of causing distress and no longer able t engage in the enjoyment of eating)
1.Status Quo i.e leave things as they are	(Must consider this option and describe the current situation)	

APPENDIX D

The Children's Trust
For children with brain injury

MENTAL CAPACITY ASSESSMENT

Name:	**DOB:**
NHS No:	**TCT No:**
House:	**Date and time of assessment:**

If there is a Deputy for Health and Welfare (over 18's only) Mental Capacity Assessment will not be required.

The Mental Capacity Act's first principle is that a person must be assumed to have capacity to make a decision or act for themselves, unless it is established that they lack capacity in relation to a particular decision. Please refer to the Mental Capacity Act (2005) Code of Practice chapter 4, and TCT MCA policy/guidance for more information.

Decision Requiring Assessment of Mental Capacity (delete as appropriate)

Formal capacity assessments are only required for significant decisione. Young people and adults should also be involved in day to day decision making, i.e. simple decisions which relate to the here and now.

Two Stage Test of Mental Capacity (see MCA code of practice, chapter 4 for further guidance)

STAGE 1. **Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain? I.e acquired brain injury, learning disability.** ***Describe below how this will impact on their communication and cognitive abilities.***

STAGE 2. Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? ***Please evidence how you have used reasonable means to promote understanding and involved the young person in your assessment i.e note books, talking mats, pictures, objects of reference.***
If a decision is made not to involve a young person in their assessment, provide evidence of your reasoning (i.e. A Disorder of Consciousness, PMLD). Please note Stage 2 of the MCA still needs to be completed.
A) Is the person able to understand relevant information about the decision to be made? Yes / No Describe how you presented the information to promote their understanding / how did you involve them in the assessment? If you did not involve them in your assessment, please provide them with your reason
B) Is the person able to hold the information in their mind long enough to use it to make an effective decision? Yes / No Please provide evidence.
C) Is the person able to use or weigh up this information as part of the decision making process? Yes / No Provide evidence of how the young person was able to understand the pros/cons or risk and benefits of making a decision one way or another/or no decision at all. What were their personal views and wishes?
D) Is the person able to communicate their decision? Yes / No Provide evidence as to how they communicated their decision (i.e verbally, using sign language or any other means).

If a person cannot do <u>one or more</u> of these four things, they are unable to make the decision

<u>Outcome of Assessment</u>

Based on the above information my judgement is that ……*(insert name of person*) **does / does not have** the mental capacity to make a decision regarding (*insert the decision)*……

Name of Assessor (print name):

Signature:

Job Title

Date:

Where the young person is deemed to lack capacity to make the identified decisions and is aged 16 to 17, parental consent needs to be sought.

RECORD OF PARENTAL CONSENT

I …… (*name of parent*) do / do not *(delete as appropriate)* give consent to the identified decision.

Signature: Date:

APPENDIX E

Guide to the Children's Homes Regulations including the quality standards April 2015

Restraint

9.41 Restraint is defined in regulation 2(1). Restraint includes physical restraint techniques that involve using force.

9.42 Restraint also includes restricting a child's liberty of movement. This includes, for example, changes to the physical environment of the home (such as using high door handles) and removal of physical aids (such as turning off a child's electric wheelchair). Restrictions such as these, and all other restrictions of liberty of movement, should be recorded as restraint[17]. Some children, perhaps due to impairment or disability, may not offer any resistance, but such measures should still constitute a restraint.

Restraint: special cases

9.43 In some cases, such as in residential special schools that are also registered children's homes or children's homes caring for children with complex care needs, restraint may be necessary as a consequence of a child's impairment or disability. A child's EHC plan or statement of special educational needs may contain detail about planned and agreed approaches to restraint or restraint techniques to be applied in the day-to-day routine of the child. This could include, for example the use of a device, such as outlined in paragraph 9.46.

9.44 Homes that care for children where, as a result of their impairment or disability, restraint is a necessary component of their care should include information relating to this in the behaviour management policy and Statement of Purpose.

9.45 In some extreme cases where children have very complex care needs, a child may need to be restrained by mechanical or chemical means. Any use of such restraint should follow a rigorous assessment process and, as with any restraint, be necessary and proportionate. Wherever such restraint is planned, it should be identified within a broad ranging, robust behaviour support plan which aims to bring about the circumstances where continued use of such restraint will no longer be required.

9.46 For example, mechanical restraint may be needed to limit self-injurious behaviour of extremely high frequency and intensity, such as for the small numbers of children who have severe cognitive impairments, where measures such as arm splints or cushioned helmets may be required to safeguard children from the hazardous consequences of their behaviour. Such devices should be put in place by persons with relevant qualifications, skills and experience (regulation 32(3)(b)).

[17] see paragraph 9.61 for information about exemptions to recording restraint

Use of Restraint

9.48 Regulation 20 sets out the only purposes for which restraint can be used:

- preventing injury to any person (including the child who is being restrained);
- preventing serious damage to the property of any person (including the child who is being restrained); or
- preventing a child who is accommodated in a secure children's home from absconding from the home.

9.49 Injury could include physical injury or harm or psychological injury or harm.

9.50 When restraint involves the use of force, the force used must not be more than is necessary and should be applied in a way that is proportionate i.e. the minimum amount of force necessary to avert injury or serious damage to property for the shortest possible time.

9.51 Restraint that deliberately inflicts pain cannot be proportionate and should never be used on children in children's homes.

9.52 There may be circumstances where a child can be prevented from leaving a home – for example a child who is putting themselves at risk of injury by leaving the home to carry out gang related activities, use drugs or to meet someone who is sexually exploiting them or intends to do so. Any such measure of restraint must be proportionate and in place for no longer than is necessary to manage the immediate risk.

9.53 In a restraint situation, staff should use their professional judgement, supported by their knowledge of each child's risk assessment, an understanding of the needs of the child (as set out in their relevant plans) and an understanding of the risks the child faces. Professional judgements may need to be taken quickly, and staff training and supervision of practice should support this.

9.54 Approaches to restraint should recognise that children are continuing to develop, both physically and emotionally. Any use of restraint should be suitable for the needs of the individual child. The context in which restraint is used should also recognise that, as a result of past experiences, children will have a unique understanding of their circumstances which will affect their response to restraint by adults responsible for their care.

Practice issues

9.55 Any use of restraint carries risks. These include causing physical injury, psychological trauma or emotional disturbance. When considering whether restraint is warranted, staff in children's homes need to take into account:

- the age and understanding of the child;
- the size of the child;
- the relevance of any disability, health problem or medication to the behaviour in question and the action that might be taken as a result;
- the relative risks of not intervening;
- the child's previously sought views on strategies that they considered might de-escalate or calm a situation, if appropriate;
- the method of restraint which would be appropriate in the specific circumstances; and

- the impact of the restraint on the carer's future relationship with the child.

9.56 Staff need to demonstrate that they fully understand the risks associated with any restraint technique used in the home. Techniques used for restraint that may interfere with breathing and holds by the neck that may result in injury to the spine are not permissible in any circumstances.

9.57 The registered person is responsible for ensuring that all their staff have been adequately trained in the principles of restraint and any restraint techniques appropriate to the needs of the children the home is set up to care for as defined in the home's Statement of Purpose.

9.58 Those commissioning training in restraint for children's homes staff should be satisfied that the training fits with their approach to restraint or existing restraint system, and is appropriate to the needs of the children the home is set up to care for. They should see evidence that any restraint techniques the training advocates for have been medically assessed to demonstrate their safety for use in a context of caring for children who are still developing, physically and emotionally. The registered person should routinely review the effectiveness of any restraint system commissioned. In particular, they should check the medical assessment of the system remains up to date.

Records

9.59 Records of restraint must be kept and should enable the registered person and staff to review the use of control, discipline and restraint to identify effective practice and respond promptly where any issues or trends of concern emerge. The review should provide the opportunity for amending practice to ensure it meets the needs of each child.

9.60 Any child who has been restrained should be given the opportunity express their feelings about their experience of the restraint as soon as is practicable, ideally within 24 hours of the restraint incident, taking the age of the child and the circumstances of the restraint into account. In some cases children may need longer to work through their feelings, so a record that the child has talked about their feelings should be made no longer than 5 days after the incident of restraint (regulation 35(3)(c)). Children should be encouraged to add their views and comments to the record of restraint. Children should be offered the opportunity to access an advocacy support to help them with this (regulation 7(2)(b)(iii)).

9.61 Where a child has an EHC plan or statement of special educational needs in which a specific type of restraint is provided for use as part of the child's day to day routine, the home is exempted from the recording requirement in regulation 35(4). Where these plans provide for a specific type of restraint that is not for day-to-day use, on the occasions when such restraint is used it must still be recorded in accordance with regulation 35(3). Any other restraint used must always be recorded as a restraint. In any case where restraint is used, it must comply with the requirements of regulation

20. As the EHC plan is designed to be a long term plan, any specified restraints should be kept under review to ensure relevancy.

Deprivation of liberty

9.63 A deprivation of liberty may occur where a child is both under continuous supervision and control and is not free to leave the home. A children's home cannot routinely deprive a child of their liberty without a court order, such as a section 25 order to place a child in a licensed secure children's home, or, in the case of young people aged over 16 who lack mental

capacity, a deprivation of liberty may be authorised by the Court of Protection following an application under the Mental Capacity Act 2005.

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