Positive and Safe Support Policy: Reducing Restrictive Practice

Supportive Bridge Ltd | Community Support and Healthcare Staffing | Bradford, England

POLICY AT A GLANCE

- **Freedom first:** the people we support live in their own homes and have the right to make their own choices. We support them; we do not control them.
- **No restraint:** Supportive Bridge staff **never** use physical, mechanical or chemical restraint, and never lock people in, hold them down or force support on them.
- **Restrictions can be hidden:** bed rails, lap belts, door sensors, locked cupboards, covert medicines, or simply rushing someone or deciding for them can all restrict a person's freedom.
- **Only when lawful and agreed:** any restriction must be the least restrictive option, agreed through consent or a Mental Capacity Act best interests decision, recorded in the support plan and regularly reviewed.
- **Distress is communication:** we look for the cause (pain, fear, illness, the environment) and use calm, person-centred approaches instead of control.
- **If there is danger:** step back, keep yourself and others safe, call 999 if needed, and tell the office. Report any restrictive practice you are worried about.

SERVICE DETAILS (fill in before issuing)

Registered Manager	Iffrah Ishtiaq
Nominated Individual	Iffrah Ishtiaq
Reducing Restrictive Practice Lead	Iffrah Ishtiaq
Office phone	07448 266215
Out-of-hours / on-call number	
Date issued	01-10-2026
Next review date	

This summary is a quick guide only. All staff must read and follow the full policy on the following pages.

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1. PURPOSE

1.1 This policy explains how Supportive Bridge Ltd ("Supportive Bridge", "we", "us") provides support that is positive, safe and respects people's freedom, and how we recognise, avoid, reduce and review any practice that restricts a person's rights or choices.

1.2 It reflects Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which says care and support must not include acts intended to control or restrain a person unless they are necessary to prevent a risk of harm and are a proportionate response, and that people must not be deprived of their liberty without lawful authority.

1.3 It also reflects the Mental Capacity Act 2005, the Human Rights Act 1998, and national guidance on reducing restrictive practice in adult social care.

2. SCOPE

2.1 Supportive Bridge Ltd operates two arms, and this policy applies to both: our **healthcare staffing service**, supplying care and support workers to care homes, hospitals and other providers; and our **community support service**, where our own support workers visit adults and older people in their own homes, including council housing, on morning and evening shifts, to support them with daily living.

2.2 Supportive Bridge does **not** provide personal care. Personal care is a regulated activity under the Health and Social Care Act 2008 and we will provide it only if and when we are registered with the Care Quality Commission. Our support workers provide non-personal support such as companionship, meal preparation, shopping, domestic help, prompting, and support to get out and about. This policy is written to meet both local authority provider assurance requirements and the standards we will be assessed against at CQC registration.

2.3 Supportive Bridge does **not** provide support that involves planned physical restraint, and our staff are not trained or permitted to use restraint techniques. If a person's needs mean that restraint might be required, we will discuss with the person, their family and the professionals involved whether another service would be better able to meet their needs safely.

2.4 Where our staff work a shift for a client organisation, they follow that organisation's policies on restrictive practice, must never take part in restraint they are not trained and authorised to use, and must report any concern to that organisation and to our office the same day.

2.5 Failure to follow this policy may lead to action under our Disciplinary Policy, and may also be treated as a safeguarding concern.

3. WHAT IS RESTRICTIVE PRACTICE?

3.1 Restrictive practice means making someone do something they do not want to do, or stopping them from doing something they want to do. It is not only about physical restraint. In people's own homes, it can be subtle and can happen without anyone meaning to restrict the person.

Type	What it means	Examples in people's homes
Physical restraint	Using force or bodily contact to stop someone moving or acting.	Holding someone's arms; stopping someone standing up. **Never permitted.**
Mechanical restraint	Using equipment to limit movement.	Bed rails, lap belts or tilted chairs used to stop someone getting up, rather than for their safety as assessed.

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Type	What it means	Examples in people's homes
Chemical restraint	Using medicine mainly to control behaviour.	Giving "as required" sedatives to keep someone calm for the convenience of others; hiding medicine in food without lawful authority.
Environmental restriction	Limiting access to places or things.	Locking doors, cupboards or the fridge; switching off the cooker; hiding the kettle; taking away walking aids.
Surveillance and technology	Monitoring that limits privacy or freedom.	Door sensors, pressure mats, GPS trackers or cameras used without consent or proper assessment.
Psychological restriction	Using words or attitudes to control.	Telling someone they "can't" go out; threatening to tell family; ignoring requests; saying "you have to".
Restrictions on choice	Removing everyday decisions.	Deciding what someone wears or eats; controlling their money, phone or visitors without authority; set bedtimes because of the rota.

3.2 Some of these may, in rare cases, be lawful and in the person's interests, for example bed rails that the person has chosen, or a sensor mat agreed through a best interests decision to reduce the risk of a serious fall. What matters is that every restriction is recognised, justified, agreed, recorded and reviewed (see section 6).

4. OUR APPROACH: POSITIVE AND PERSON-CENTRED SUPPORT

4.1 We work to prevent situations where restrictions might seem necessary. We do this by:

- getting to know each person well, including their history, routines, likes, dislikes, fears and what helps them feel calm and safe;
- planning support with the person, and involving people who know them well, so that it fits their life rather than our rota;
- keeping to consistent workers wherever possible, so people are supported by familiar faces;
- allowing enough time on shifts so people are not rushed;
- supporting positive risk-taking, where the benefits of an activity for the person's independence and wellbeing are weighed against the risks, and sensible steps are taken to reduce the risks rather than simply stopping the activity;
- working with GPs, district nurses, occupational therapists, mental health teams and behaviour support professionals where people have more complex needs.

5. RESPONDING TO DISTRESS AND REFUSAL OF SUPPORT

Understanding distressed behaviour

5.1 When a person becomes upset, agitated or aggressive, this is usually their way of communicating that something is wrong. Staff should think about possible causes, such as pain, infection, hunger or thirst, needing the toilet, tiredness, feeling cold, fear, not understanding what is happening, noise, or a change in routine or worker. A sudden change in behaviour can be a sign of illness, such as delirium, and must be reported the same day.

Calm, supportive responses

- stay calm, speak slowly and gently, and use the person's preferred name;

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- give the person space and time, and do not stand over them or block their way;
- explain what you are doing in simple words, offer choices, and do not argue;
- try distraction or something the person enjoys, as described in their support plan;
- if the person does not want support right now, stop, reassure them and try again a little later, or ask whether they would prefer a different worker;
- record what happened, what helped and what did not, and tell the office.

When someone refuses support

5.2 A person who has capacity has the right to refuse support, even if this may put their health at risk. Staff must never force support on anyone. They should explain the possible consequences in a way the person understands, respect their decision, record it, and tell the office so that the Registered Manager can decide what to do next (for example, contacting family or the GP).

5.3 If a person may lack capacity to decide about a particular part of their support, and refusing it would cause them harm, the Registered Manager arranges a mental capacity assessment and, if needed, a best interests meeting with the person, their family and professionals. Any agreed approach must be gentle, the least restrictive possible, written in the support plan, and reviewed regularly. It must never involve force.

6. WHEN A RESTRICTION MAY BE CONSIDERED

6.1 A restriction may only be used if all of the following apply:

- **Lawful authority:** the person has capacity and freely agrees to it, **or** they lack capacity to decide and it has been agreed as being in their best interests under the Mental Capacity Act 2005, **or** there is other legal authority (for example a Court of Protection order);
- **Necessary:** it is needed to prevent a real risk of harm to the person or others, and less restrictive options have been tried or carefully considered;
- **Proportionate:** it is the least restrictive option that will work, and is in proportion to the likelihood and seriousness of the harm;
- **Planned and recorded:** it is written in the support plan and risk assessment, with the reasons, who agreed it, how it will be used, and when it will be reviewed, using the Individual Restriction Record (Appendix B);
- **Reviewed:** it is reviewed at least every three months and whenever the person's needs change, and stopped as soon as it is no longer needed.

6.2 Restrictions must never be used to punish, to make support easier or quicker for staff, because of a lack of staff or time, or as a blanket rule applied to everyone.

THINK BEFORE YOU RESTRICT: SIX QUESTIONS

1. What exactly is the risk, and how likely and serious is it?
2. Why is it happening? Have we looked for causes such as pain, illness, fear or the environment?
3. What less restrictive options have we tried or considered?
4. Does the person have capacity to decide? If so, what do they want? If not, what is in their best interests?
5. Who else needs to be involved (family, advocate, GP, OT, social worker)?
6. How and when will we review this and remove it if we can?

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7. SPECIFIC SITUATIONS IN PEOPLE'S HOMES

Bed rails, belts and equipment

7.1 Bed rails, lap belts, specialist chairs and similar equipment must only be used where a health professional (such as an occupational therapist or district nurse) has assessed the person and a risk assessment is in place, following Medicines and Healthcare products Regulatory Agency (MHRA) guidance on bed rail safety. The person's consent, or a best interests decision, must be recorded. Staff check equipment is fitted correctly and report any concerns about entrapment or misuse.

Sensors, alarms and technology

7.2 Telecare, door sensors, pressure mats, GPS devices and cameras can help people stay safe and independent at home, but can also restrict privacy and freedom. They should only be used with the person's consent or a best interests decision, and be recorded in the support plan. If a family has installed cameras in the home, staff should be told, and the Registered Manager will discuss with the family how this affects the person's and staff members' privacy.

Medicines given covertly

7.3 Medicines must never be hidden in food or drink unless the person lacks capacity to decide about their medicine, a best interests decision has been made involving the prescriber, and a pharmacist has advised how to give it safely. This must be documented and reviewed, in line with our Medication Policy. Medicines must never be used to control behaviour for the convenience of others.

Locks, keys and access to the home

7.4 Staff must never lock a person in their home or a room. Where there are concerns that a person may leave home and come to harm, for example a person living with dementia, this is discussed with the person, their family and social worker, and least restrictive options are explored. Key safes are used only to let staff in, and codes are kept confidential.

Money, phones, visitors and everyday choices

7.5 Staff must not control a person's money, phone, visitors, food, drink, alcohol, cigarettes or daily routine unless this is part of an agreed and lawful plan. If a worker notices that someone else, such as a family member, appears to be unreasonably restricting the person, they must report it to the office as a possible safeguarding concern.

8. DEPRIVATION OF LIBERTY

8.1 A person may be deprived of their liberty if they lack capacity to consent to their care arrangements, are under continuous supervision and control, and are not free to leave. This can happen in a person's own home as well as in a care home or hospital.

8.2 For people living in their own homes, a deprivation of liberty can only be lawful if it is authorised by the Court of Protection. The application is normally made by the organisation that arranges or funds the care, usually the local authority.

8.3 If the Registered Manager believes a person's support arrangements may amount to a deprivation of liberty, they will raise this promptly with the person's social worker at Durham County Council (or the funding body), record the concern, and follow up until it is resolved. Staff who are worried that someone is not free to leave or to make their own choices must tell the office.

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9. EMERGENCIES AND KEEPING SAFE

9.1 If a person's behaviour puts themselves, a worker or others in immediate danger, the worker should:

- stay calm, keep a safe distance and move away if possible, keeping an exit route clear;
- remove themselves from the room or home if they are at risk, while keeping the person as safe as possible;
- **call 999** if anyone is in immediate danger or seriously hurt;
- call the office or on-call manager as soon as it is safe to do so.

9.2 In law, anyone may use the minimum reasonable force needed to protect themselves or others from immediate harm, for example by releasing a grip or moving away. This is a last resort in an emergency only. It is not a planned intervention, and any such incident must be reported immediately.

9.3 Where a risk assessment shows that staff may face aggression, the Registered Manager will review whether the support can be provided safely, arrange extra support (such as two workers), and consider breakaway training from a provider certified against the Restraint Reduction Network Training Standards. See also our Lone Working Policy.

10. RECORDING, REPORTING AND LEARNING

10.1 Staff record in the daily notes any distressed behaviour, refusal of support, and any situation where a restriction was used or considered, including what happened before, what they did and what helped.

10.2 Any use of force in an emergency, any restriction used that is not in the support plan, and any concern that someone is being restricted without authority is reported to the office **the same day** and recorded under our Incident and Accident Reporting Policy.

10.3 The Registered Manager reviews each incident, offers the person and worker a chance to talk about what happened (a debrief), updates the support plan and risk assessment, and considers whether a safeguarding referral to Durham County Council's Social Care Direct (03000 267 979) is required.

10.4 The Reducing Restrictive Practice Lead keeps a register of every planned restriction in use across the service, and makes sure each one is reviewed on time.

11. CONCERNS, COMPLAINTS AND SAFEGUARDING

11.1 Any use of restraint or restriction that is unlawful, unnecessary, or intended to punish or humiliate may be abuse. Staff who see or suspect this must report it immediately under our Safeguarding Adults Policy. Staff can also use our Whistleblowing (Speaking Up) Policy and will be protected from any unfair treatment for raising concerns.

11.2 People we support and their representatives are told how to raise concerns about any restriction through our Complaints, Concerns and Compliments Policy, and are supported to access independent advocacy if needed.

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12. ROLES AND RESPONSIBILITIES

Role	Responsibilities
Nominated Individual	Makes sure the service has a positive, least restrictive culture, and reviews the restrictions register, incidents and audits at least quarterly.
Registered Manager	Leads positive and safe support, arranges capacity assessments and best interests decisions, approves and reviews any restriction, raises possible deprivations of liberty with the local authority, and acts on incidents and concerns.
Reducing Restrictive Practice Lead	The named person (the Registered Manager unless someone else is named on page 1) who keeps the restrictions register, checks reviews happen on time, and promotes good practice.
Field Supervisor / Care Coordinator	Looks for hidden or unplanned restrictions during assessments, reviews and spot checks, and reports them.
Support workers	Provide support in a positive, respectful way, never use restraint or force support, follow the support plan, and record and report any restriction or concern.

13. TRAINING

13.1 All staff complete training during induction (linked to the Care Certificate) in: this policy; the Mental Capacity Act 2005; person-centred support; understanding and responding to distressed behaviour, including in dementia; de-escalation; and recognising restrictive practice. This is refreshed at least every year.

13.2 Staff supporting people with learning disabilities, autism, dementia or mental health needs receive extra training relevant to those needs. Any breakaway or safety intervention training is only delivered by a provider certified against the Restraint Reduction Network Training Standards.

14. MONITORING AND REVIEW

14.1 The Registered Manager audits support plans, daily notes and the restrictions register each month, and uses spot checks to look for restrictions that may have become "just how things are done". The Nominated Individual reviews a summary at least quarterly.

14.2 This policy is reviewed every year, or sooner if the law or guidance changes (including any future changes to the Deprivation of Liberty Safeguards), or if an incident shows it needs to change.

15. LEGISLATION AND GUIDANCE

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, especially Regulation 9, Regulation 11, Regulation 12 and Regulation 13
- Mental Capacity Act 2005 and its Code of Practice
- Human Rights Act 1998 (especially Article 3, Article 5 and Article 8)
- Care Act 2014
- Health and Safety at Work etc. Act 1974
- Department of Health: Positive and Proactive Care: reducing the need for restrictive interventions (2014)
- Skills for Care: A positive and proactive workforce (2014)

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- Restraint Reduction Network Training Standards
- NICE guideline NG11: Challenging behaviour and learning disabilities
- NICE guideline NG97: Dementia
- MHRA guidance: Bed rails: management and safe use

16. RELATED POLICIES AND FORMS

Related policies: Safeguarding Adults; Consent and Mental Capacity; Medication; Support Planning and Risk Assessment; Equality, Diversity, Dignity and Respect; Incident and Accident Reporting; Lone Working; Whistleblowing; Complaints, Concerns and Compliments; Moving and Handling.

Forms: Is This a Restriction? checklist (Appendix A); Individual Restriction Record (Appendix B); Restrictions Register; Mental Capacity Assessment and Best Interests Record; Incident Report.

17. DOCUMENT CONTROL

Version	Date	Approved by	Role	Reason
1.0			Nominated Individual	New policy for local authority assurance and CQC registration

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APPENDIX A: IS THIS A RESTRICTION? CHECKLIST

Use at assessments, reviews and spot checks. A "yes" does not always mean something is wrong, but it must be justified, agreed, recorded and reviewed.

Question	Yes / No	Notes and action
Are any doors, rooms, cupboards, the fridge or the cooker locked, switched off or out of reach?		
Are bed rails, lap belts, tilted chairs or similar equipment in use?		
Are walking aids, glasses, hearing aids or the phone ever moved out of the person's reach?		
Are sensor mats, door alarms, trackers or cameras in use?		
Are any medicines given hidden in food or drink, or used to calm the person?		
Is the person told when to get up, go to bed, eat or wash because of shift times?		
Does someone else control the person's money, phone, visitors, food, drink or cigarettes?		
Is the person ever told they "can't" do something, or discouraged from going out?		
Is support ever given when the person has said no?		
Is the person stopped from making choices others think are unwise?		

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APPENDIX B: INDIVIDUAL RESTRICTION RECORD

Complete one record for each planned restriction. Keep with the support plan and add to the Restrictions Register.

Person's name	
What is the restriction?	
What risk is it meant to reduce? How likely and serious?	
Less restrictive options tried or considered	
Capacity: does the person have capacity to decide about this?	
Consent given by the person, OR best interests decision (date and who was involved)	
How exactly it will be used (when, by whom, for how long)	
Professionals involved (e.g. GP, OT, social worker)	
Could this be a deprivation of liberty? If yes, date raised with local authority	
Agreed by (Registered Manager) and date	
Review date(s) and outcome	

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