Guidelines for the Prevention of/Use of Restrictive Interventions

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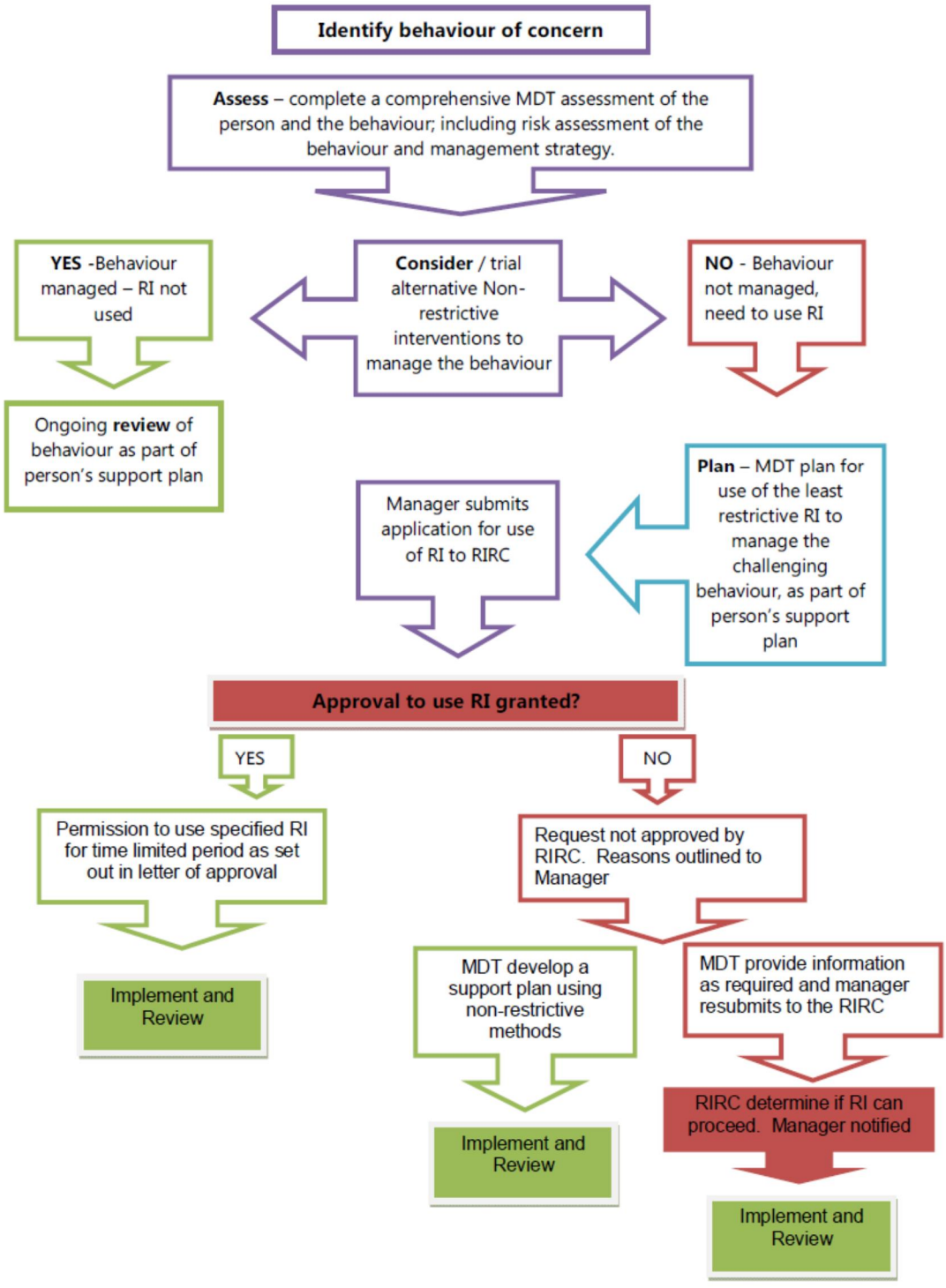
Flow chart when considering Restrictive Interventions (RI)



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Statement

COPE Foundation promotes a restrictive-free environment; however, it is acknowledged that on occasion, the use of restrictive interventions may be required as a measure of last resort, and for the purpose of protecting a personôs well-being or the well-being of others. These guidelines are integral to COPE Foundationôs policy on the prevention and use of restrictive interventions.

1.0 Purpose

The purpose of these guidelines is to outline the roles and responsibilities of staff, and to provide guidance in relation to the use, management and review of restrictive interventions in line with best international practice.

2.0 Scope

These guidelines are applicable to all COPE Foundation employees in any setting where supports and services are provided.

3.0 Some Definitions/Terms

- **Restrictive Interventions** *(Appendix 1)* refers to the application of any physical, mechanical, environmental, psychological or pharmacological means of restraint that is used for the purpose or intent of restricting the free movement or decision making abilities of another person. (Nursing Board of Western Australia, 2009, (www.nbwa.org.au).
- **Restraint:** includes any action, word or deed that is used for the purpose or intent of restricting the free movement or decision making abilities of another person (Nursing Board of Tasmania 1999, Guidelines for the Use of Restraints as a Nursing Intervention, May, p.13) (www.nursingboardtas.org.au/publications).
- **IDT:** Interdisciplinary Team consisting of OT, RNID, CNS ANP, Psychologist, Psychiatrist, or Medical Practitioner.
- **RIRC:** Restrictive Interventions Review Committee.

Further definitions/terms used in these Guidelines can be found in Appendix 2.

4.0 Roles and Responsibilities

4.1 Managers (or Designated Manager)

It is the responsibility of the Manager:

- To ensure this Policy is made available to all staff, and that they are aware and supported in the implementation of its guidelines;
- To promote a restrictive free environment;
- To ensure staff understand the methods, circumstances, and limitations of restrictive interventions, as documented in the person's care plan;
- To ensure the person presenting with behaviour of concern is referred for a comprehensive assessment;
- To ensure any restrictive intervention is referred to and sanctioned by the RIRC. (The only exception to this is when a restrictive intervention is deemed necessary in an emergency/crisis situation);
- To ensure everybody supporting the person is aware of the restrictive interventions sanctioned by the RIRC;
- To ensure staff have the opportunity to debrief in a safe environment after an aggressive event;
- To ensure staff have opportunities to provide feedback and discuss any problems in relation to the implementation of the policy and guidelines;
- To ensure a review takes place in respect of any emergency use of restrictive interventions;
- To ensure staff attend appropriate training and education;
- To ensure that any deficiency of service, lack of professional skill, or defects in the environment, which impacts on the implementation of this policy are addressed.

4.2 Staff Members

It is the responsibility of staff:

- To understand the policy and guidelines and adhere to them;
- To promote a restrictive free environment at all times;
- To contribute to a comprehensive assessment of the person;
- To work closely in an inter-disciplinary manner;
- To familiarise themselves with, understand, and act in accordance with the personôs *Behaviour Support Plan*;
- To ensure that they do not resort to using restrictive interventions, in order to compensate for any deficiency of service, lack of professional skill, or defects in the environment;
- To report any deficiency of service, lack of professional skill, or defects in the environment to their Manager;
- To exercise a duty of care to protect people from the risk of physical or psychological harm, associated with the use of restrictive interventions;
- To make informal enquiry to any member of the RIRC, when considered necessary;
- To attend review meetings and training as required.

4.3 Director of Development & Innovation

It is the responsibility of the Director of Development & Innovation:

- To Chair the RIRC;
- To ensure the RIRC meet to discuss the *recommendations* for use of restrictive interventions, and make a decision to accept or reject the recommendation;
- To review and monitor documentation relating to the use and recording of restrictive interventions.

4.4 Restrictive Interventions Review Committee (RIRC)

The RIRC consisting of an extern, and senior staff from nursing, psychology, and occupational therapy, has the responsibility:

- To make decisions on applications for the use of restrictive interventions;
- To be up to date with international and national best practice;
- To promote a restrictive free environment;
- To ensure that interventions used are the least restrictive, only implemented as a measure of last resort, and their cessation is planned for;
- To respond to any informal enquiries made to any member;
- To assess, sanction, monitor and review the use of restrictive interventions in individual cases;
- To audit the use of restrictive interventions within the organisation as a whole;
- To review this Policy and Guidelines at least every two years, or earlier if new evidence/best practice guidelines emerge.

5.0 General Principles

- Planned restrictive interventions should only be used as part of a comprehensive support plan, when the risks of using the intervention are judged to be lower than the risks of not doing so.
- When considering the use of restrictive interventions, family and carers should be involved as advocates for a person with reduced decision making capacity (*MHC Consultation Document 2008 p.22*)
- Restrictive interventions should only be used, when:
  - There is immediate risk to the person or others within that environment;
  - A comprehensive assessment has been carried out, and the proposed restrictive intervention has been sanctioned for use (with the exception of an emergency situation);
  - Staff are trained in the use of specific individual interventions;
  - It is carried out in accordance with local and national guidelines;
  - Is subject to inter-disciplinary review. (*HIQA 2009*)
- Restrictive interventions should never be used for:
  - The convenience of staff;
  - To overcome a lack of adequate supervision;
  - To punish or negatively reinforce problem behaviours; (*MHC, 2006*)
  - To cause injury, pain, distress or psychological trauma;
  - To undermine dignity, humiliate or degrade the person.
- The restrictive intervention must be proportional to the risk identified.
- Emergency use of an un-planned restrictive intervention may be required, where there is a risk of immediate harm to the person and/or others.
- In an emergency situation, a person may need to be unexpectedly restrained, in a manner that has not previously been discussed or documented in their care plan. The use of an emergency restrictive intervention must:

  - Employ the minimum amount of force necessary to ensure the safety of all involved;
  - Undergo interdisciplinary review;
  - Be followed up with an assessment, including risk assessment, and a plan devised outlining actions to be taken in similar circumstances, if required;
  - Any subsequent planned use of restrictive interventions must be reported to, reviewed and sanctioned by the *RIRC* and documented in the person's *Behaviour Support Plan*.
- The *Behaviour Support Plan* must be reviewed regularly.

6.0 Assessment

- Prior to the implementation of a restrictive intervention, a comprehensive inter-disciplinary assessment must be carried out, to determine possible causes or contributory factors for the problem behaviour. This must be conducted with the person and/or their family/carer/advocate. *(Appendix 3)*

- A detailed risk assessment must be completed of the personôs *behaviour*, and of the proposed *restrictive intervention*; it will take account of physical, emotional, social and quality of life issues for the person and/or others. (MHC, 2008) *(Appendix 4)*

- Assessment must be on-going, and efforts should be made to move towards less restrictive practice, or preferably alternative non-restrictive practice *(appendix 5)* in line with a review schedule.

- The assessment process must determine/conclude that the use of a restrictive intervention is:

  - Absolutely necessary;
  - In the best interests of the person for whom it is used;
  - The option of last resort.

- When the use of a restrictive intervention is indicated, the Manager, in consultation with member/s of the IDT involved in the case, submits an application to the RIRC for consideration.
- Sufficient assessment information must accompany the completed application; inadequate or incomplete applications will be returned.
- The RIRC may request that additional information is submitted, and/or a staff member familiar with the person attends an RIRC meeting to ensure all relevant facts are available.

- The RIRC will respond to each application:

  - In writing;
  - Within a time frame appropriate to the urgency of each individual case;
  - Informing the applicant if additional information is required;
  - Determining whether or not the restrictive intervention has been approved;
  - The conditions for its use;
  - The date for review by the RIRC.

7.0 Behaviour Support Planning

7.1 Behaviour Support Plan

- Persons who present with behaviours that challenge must have a *Behaviour Support Plan;*
- Use of planned or unplanned/emergency restrictive interventions must be documented on the personôs *Behaviour Support Plan. (Appendix 6)*

7.2 Reasons for Planned Use of Restrictive Interventions (Appendix 7)

- Used as part of an agreed and planned behavioural support strategy;
- Used as part of a short term intervention in an emergency/crisis context;
- Used to reduce the risk of harm or injury to themselves or another person where the person appears to have no control over their behaviour.

8.0 Emergency Use of Restrictive Physical Intervention

- Should be recorded as soon as possible by the staff involved, using the *CR RIRC 2 form (Record of Use of An Unplanned/Emergency Restrictive Intervention)*, and placed in the personôs *Behaviour Support Plan;*
- A copy of the form should be forwarded to the RIRC for review;
- If an injury has been sustained as a result of an incident, it must be recorded in the internal *Accident Report Book*, or if a staff member has been injured, it must be recorded in the *Social Welfare Accident Form.*
- Following the use of an emergency restrictive intervention, a full review of the incident is undertaken, which leads to further assessment and the necessary adjustments to the *Behaviour Support Plan.*

9.0 Implementation of Restrictive Interventions

- Any planned restrictive intervention must be regularly reviewed in accordance with predetermined time lines, with the overall goal being to discontinue the use of the restrictive intervention. (HIQA, 2009)
- The planned use of a particular restrictive intervention must be prescribed by the *appropriately* qualified member of the IDT, and as part of an overall support planning process.

- All staff members are responsible for the correct and safe use of restrictive devices/ interventions with people in their care.

  The restrictive intervention should:

- Be the least restrictive to effect the desired outcome;
- Be reviewed in line with predetermined timelines with a view to discontinuation as soon as possible;
- Not jeopardize the personal safety of the person;
- Comply with national legislation, safety standards and this Policy;
- When using mechanical devices, be fit for purpose, in good working order, and applied in accordance with the manufacturer's instructions;
- Never be improvised (such as the use of trousers or skirt belts, sheets etc. to restrain individuals in chairs).

10.0 Monitoring & Review

- The relevant members of the IDT must review the decision to use restrictive interventions within predetermined time lines, to ensure that they can be reduced or removed as soon as practicable.

- The RIRC is responsible for sanctioning, monitoring and reviewing all decisions relating to the use of restrictive interventions.

11.0 Education & Training of Staff

Education and training is provided to endeavour to:

- Minimise the use of restrictive interventions;
- Ensure, when deemed necessary, the safe use of restrictive interventions;
- Ensure that all staff members adhere to this Policy and Guidelines.

Appendix 1: Examples of Restrictive Interventions

- Monitoring technologies e.g. personal movement sensors (within a specific area or GPS); surveillance (CCTV, baby monitors); boundary-crossing alarms fitted to doorways, windows or corridors; bed-leaving alarms and floor sensor pads.
- Locked cupboards/drawers.
- Delayed door opening systems.
- Furniture arrangement to impede mobility.
- Gates across entry points or stairs.
- Locked doors e.g. keypads, double handles, high handles on doors.
- Modified clothing e.g. clothing designed to be difficult to remove or to prevent access to particular body parts.
- Tied/restrictive clothing i.e. clothing designed to limit movement.
- Hand/finger restraints e.g. gloves, mitts.
- Elbow/wrist restraints e.g. splints, gaiters, wrist cuffs.
- Transfer belts or child reins.
- Removal of footwear, walking aid or wheelchair. Turning off powered wheelchair.
- Removal of aids required for communication e.g. glasses, hearing aids, communication aid. Switching off the power on a personôs alternative or augmentative communication device.
- Trays/tables in front of chairs/beds (except for the period of time that they are used for purposeful activities or meals).
- Chair/wheelchair tilted backwards.
- Cot/bed side-rails or high sides for any person over 4 years of age.
- Wheelchair specifications designed to restrict independent propulsion e.g. application of attendant-controlled brakes, small transit wheels when a person has the ability to self-propel.
- Bus/car harness
- Wheelchair/buggy/armchair/shower-chair/toilet/ straps & harnesses.

Association of Occupational Therapists of Ireland (AOTI) Practice Guidelines (2010)

Appendix 2: Definitions/Terms

Emergency is a sudden, usually urgent, un-expected occurrence or occasion requiring immediate action. (HSE 2009)

Interdisciplinary Team: An interdisciplinary team is comprised of clinicians and others directly involved in supporting the person. It is a collaborative non-hierarchical solution focused working group committed to meeting a personôs needs. The composition of the team facilitates the interfacing of many different health professionals and other people, each with separate and important knowledge, technical skills and perspectives focused on a personôs care and individual needs. (HSE 2009)

Positive Behavioural Support (PBS): Positive behaviour support is a model of support for individuals presenting with behaviours that challenge. It may be defined as ôan approach that blends values about the rights of people with disabilities, with a practical science about how learning and behaviour-change occur. The overriding goal of PBS is to enhance the quality of life for individuals and their support providersô (Horner, 1999)

Positive Behaviour Support Plan: The key characteristic of this model is the use of a comprehensive functional assessment for behaviours that challenge, in order to identify the meaning or message of the presenting behaviour. This comprehensive assessment identifies environmental factors or settings, events that may predict behaviour, biomedical factors, strengths and needs of an individual, motivational factors, as well as a detailed assessment of the individualôs lifestyle. From this assessment a multi-element positive behaviour support plan is developed, including environmental accommodations, skills teaching, direct interventions and reactive management plans, as well as lifestyle changes, in order to reduce challenging behaviour and improve an individualôs quality of life (Nessa Hughes, unpublished paper, cited in HSE 2009).

Challenging Behaviours may be defined as ôbehaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviours which are likely to seriously limit, or delay access to and use of ordinary community facilities.ô(Emerson, 1995)

Support is defined as ôthe resources and strategies that promote the interests and welfare of individuals, and that result in enhanced personal independence and productivity, greater participation in an interdependent society, increased community integration and/or an improved quality of lifeô (Thompson et al 2002)

Person Centred Approach is defined as having ôan appreciation of the person as a unique individual, requiring that all planning is based on supporting each individual lead his or her life, as and how he or she wishes. In practical terms, this means that all planning around the design, development and delivery of all services for people with disabilities, should be both based on and actively involve the individuals availing of these services, and each of those individualsôunique characteristics, capabilities, needs and wishes (that is: conducted in a person-centred way). (NDA 2004, p.11)

Risk Assessment is a process whereby a combination of the probability or frequency of occurrence of a defined behaviour, and the magnitude of the consequences of the occurrence of that behaviour, can be evaluated.

Risk Management is a process whereby decisions are made to accept a known or assessed risk, and/or the implementation of actions to reduce the consequences or probability of occurrence.

Seclusion: ôthe placement of a person in a room or other place from which voluntary exit is not possible, for a period of time not determined by that person, for the sole purpose of behaviour management or controlô This definition encompasses not only confinement resulting from doors and windows being locked from the outside, but also situations where an individual is unable to open a door from the inside (e.g. due to the position of the door handles, or the nature of the person's disability). (Community Based Support South Inc., 2006)

Mechanical Restraint: ôThe application and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints, specialized equipment designed to significantly restrict the free movement of an individual (Paley, 2008, p.6). This does not include the use of devices for therapeutic purposes, relating to postural and orthopaedic needs. (Department of Human Services, 2007, p.3)

Physical Restraint: ôthe use of physical force (by one or more persons) for the purpose of preventing the free movement of a residentôs body.ô(MHC, 2006 b) This definition excludes the steadying of a personôs arm by holding the limb as per approved technique (MAPA), or other part of the body for the purpose of venepuncture, vaccination or other procedure deemed to be medically necessary, and considered to be in the best interests of the person, subsequent to a risk assessment and as part of the personôs risk management plan.

Environmental Restraint is the intentional restriction of a personôs normal access to their environment, with the intention of stopping them from leaving, or denying their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties.(HIQA, 2013) This can include, but is not limited to bed rails, recliner chairs, locked or key padded doors or facilities, and any practices that track or limit free mobility e.g. monitoring technologies. (Nursing Board of Western Australia, 2009)

Chemical Restraint is the intentional use of medication to control or modify a personôs behaviour, or to ensure a person is compliant or not capable of resistance, when no medically identified condition is being treated, and where the intended

effect of the drug is to sedate the person for convenience or for disciplinary purposes. The appropriate use of drugs to reduce symptoms in the treatment of medical conditions, such as anxiety, depression, or psychosis, does not constitute restraint. (HIQA, 2013) Taking cognizance of this definition of chemical restraint, the use of medication prescribed by a medical practitioner, for the purpose of carrying out a medical procedure to include venepuncture, vaccinations, dental and surgical procedures, which are deemed medically necessary and considered to be in the best interests of the person, does not constitute restraint.

Emotional Restraint: ó/erbal, non-verbal or physical intimidation that is purposefully used to alter or restrict a personôs choice of behaviour, or to actively encourage or discourage particular behaviourô (Nursing Board of Western Australia, 2009)

Appendix 3: Assessment

Assessment must include but is not limited to:

- Medical assessment;
- Mental health assessment;
- Psychosocial history;
- Previous and current medications;
- A comprehensive behavioural assessment to include a functional assessment which describes situations (e.g. people, activities, locations, time periods) under which the behaviour appears more likely to occur;
- An ecological analysis of current living environment;
- Social, interpersonal and physical environment related issues;
- Communication needs assessment;
- Daily living support needs assessment.

Appendix 4: Risk Assessment

Risk assessment of the *behaviour* should consider:

- The nature of the risk to the person;
- Risk to others;
- Frequency of risk behaviour/ how often it occurs;
- Level of risk/ likelihood of undesirable outcome;
- Possible outcomes for the person, and others: short/long term and positive/negative results. (Sellars, 2005).

Risk assessment of the *restrictive intervention* should:

- Consider the benefits of using restraint, against the risks of not using restraint;
- Identify any risks associated with the use of the proposed restrictive practice, and record measures implemented to manage the identified risks;
- Must be on-going, and reviewed in light of any changes;
- Inform the person's support plan.

Appendix 5: Examples of Alternative Non-Restrictive Interventions

- Good environmental design e.g. points of interest provided in the building, natural flow through the building, avoidance of ódead endsô, use of colour/surface treatments to designate areas, use of visual symbols, open access to safe outdoor space (MWCS, 2007), clear line of vision for staff in communal areas. (MWCS, 2006)
- Padding the environment e.g. furniture, doorways, walls. (Jones et al., 2007)
- Temperature, light and noise levels monitored and controlled (DOH, 2002; MWCS, 2006)
- Overcrowding avoided. (MWCS, 2006)
- Use of calm or relaxing environments (e.g. quiet room, multi-sensory room). (MWCS, 2006)
- Subjective barriers instead of locked-of areas e.g. cloth panels/covers to camouflage doors or door knobs. (MWCS, 2007)
- Mattress on the floor or a low-to-floor bed. (MWCS, 2006)
- Purposeful activity that is meaningful for the person and provides the appropriate level of stimulation. (DOH, 2002; MWCS, 2006; MWCS, 2007)
- Opportunity for physical exercise. (MWCS, 2006; MWCS, 2007)
- Exploration of the personôs sleeping and rest patterns (e.g. amount of sleep; too little or too much, timing of sleep; day/night, level of physical activity; active/inactive). (MWCS, 2006)
- Communication strategies e.g. object of reference, PECS, visual timetables.
- Psychological strategies e.g. social stories, transitional objects.
- Sensory strategies e.g. sensory diets etc. (Mansell, 1992; Soper & Thorley, 1996)
- High densities of social reinforcement delivered non-contingently throughout the personôs day. (Jones et al., 2007)
- Avoidance of situations known to provoke behavioural issues for a person. (DOH, 2002)
- Positive behavioural support plans and care plans kept up-to-date and containing current risk assessments. (DOH, 2002)
- The person we support, their family and advocates discuss ways in which he/she prefers to be managed in instances when he/she poses a significant risk to self or others. (DOH, 2002)

- Early stages of behavioural sequences that are likely to escalate are recognized and diffusion techniques are employed. (DOH, 2002)
- Staff observation levels are adapted to take account of differing needs and levels of risk at different times of day/night. (MWCS, 2006; MWCS, 2007)
- Staff members are provided with adequate training in challenging behaviour and positive behavioural support strategies. (DOH, 2002; Jones et al., 2007)
- The number and skill level of staff corresponds to the needs of the people we support and the likelihood of behavioural issues arising (DOH, 2002).
- Padded clothing to reduce risk of injury from falls or self-injury e.g. knee pads, hip protectors, helmets. Although not restrictive practices, the social stigma that can result from the use of protective clothing or helmets should be considered and balanced against the frequency of falls/self-injury and the seriousness of the injury risk. (DOH, 2002; MWCS, 2006)

Association of Occupational Therapists of Ireland (AOTI) Practice Guidelines (2010

Appendix 6: Details on Behaviour Support Plan

- Why the restrictive intervention is necessary?
- What alternative less restrictive options were tried and the outcome? (Appendix 4)
- The type of restrictive intervention selected and rationale for it?
- Who is to implement the restrictive intervention?
- When the restrictive intervention is to be used?
- The proposed duration of the restrictive intervention period?
- The plan for cessation of the intervention?
- Details of consent/consultation around the use of the restrictive intervention?
- Details of interdisciplinary team members involved in the prescription of the proposed restrictive intervention?
- Date for review?

Appendix 7: Reasons for Planned Use of Restricted Interventions

As part of an agreed and planned behavioural support strategy

- For example the use of a strap on a chair in a school setting, to enable a child to remain seated, to allow a period of instruction/learning to occur. The overall intention shall be to reduce and ultimately eliminate the use of the restrictive intervention.

As part of a short term intervention in an emergency/crisis context

- It may be used as part of a short term management solution, applied for a given period in a reactive context, to reduce the immediate critical level of risk to the person and/or others.

To reduce the risk of harm or injury to themselves or another person, where the person appears to have no control over their behaviour

- This may occur when the person's behaviour cannot be managed in less restrictive ways; for example, the use of belts, or other positioning devices to restrict an individual in a seat, including a seat in a moving vehicle, for behavioural reasons rather than postural or orthopaedic reasons (Paley, 2008).
- Some instances of self-injurious behaviours or aggression towards others may also necessitate the implementation of a restrictive intervention, in order to prevent serious injury. The use of restrictive interventions to manage the risk of harm or injury to a person is always subject to the conditions specified in this policy. Such interventions must be proportional; a means of last resort; be evaluated on an on-going basis, and there must be evidence of attempts to cease the restrictive intervention.

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