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# Table of Contents

## Section 1 - Introduction


**1.** Introduction and Policy Statement ..... **3**

**2.** Values Informing Practice ..... **3-4**

**3.** Protecting People's Rights and the Role of the Rights Review Committee ..... **4**

**4.** From Challenging Behaviour to Behaviours of Concern ..... **5**


## Section 2 – Listening and Responding


**5.** Positive Behaviour Support ..... **6**

**6.** Listening to the Person with Behaviours of Concern ..... **6-7**

**7.** Step by Step Guide in responding to Behaviours of Concern ..... **7-8**

**8.** Responses are Informed by a Low Arousal Approach ..... **9**

**9.** Development of a Personal Risk Management Plan (PRMP) ..... **10-11**

**10.** Developing a Behaviour Support Plan/Stress Management Plan ..... **11-14**

**11.** Supporting the Supporters ..... **14-15**


## Section 3 – Restrictive Practices


**12.** What are Restrictive Practices ..... **15-16**

**13.** Use of Restraint in Western Care Association ..... **16-17**

**14.** Types of Restraint (Physical, Mechanical, Chemical, Environmental) ..... **18-22**

**15.** Bibliography and References ..... **23**


### APPENDICES


**APPENDIX A** Framework for Developing Multi-Element Behaviour Support Plans ..... **24**

**APPENDIX B** Responding to a new referral – Information Gathering Process ..... **25-27**

**APPENDIX C** Physical Restraint Protocol ..... **28-30**

**APPENDIX D** Developing a PRN Protocol ..... **31-35**

**APPENDIX E** Example of a Low Arousal Approach applied to an Individual……..**36-38**


***Policy and Procedure Feedback Form***

*A Policy and Procedure Feedback Form is available on the Western Care Association Intranet (under Procedures) which will provide an opportunity to comment on any policy/procedure.*

*Your comments will be forwarded to the person who has the lead for the on-going development of the policy/procedure.*

*All comments will be collated by the person responsible and will inform the three-yearly review cycle for updating procedures.*

# 1. Introduction / Policy Statement

**Purpose: This policy describes Western Care's approach to listening and responding to people who engage in behaviours of concern and whom the service finds a challenge. It promotes the importance of supporting people in a positive, respectful, empathetic and non-judgemental way.**
**It also defines practices that are viewed as prohibitive and which must never be used and practices that are considered restrictive which may be used in supporting a person from time to time.**

Western Care Association is committed to ensuring that adults and children who engage in behaviours of concern are entitled to the same rights and safeguards as any other adult or child in society and that they are supported in environments that are positive, empathetic, respectful, safe and inclusive.

The purpose of a Policy around how we support people who challenge us is to make sure that the practices, strategies, plans and interventions that we use to work with people are of the highest standards.

a) All people within the organization are not the subject of dehumanizing practices.
b) Procedures that limit or restrict personal freedoms are only carried out in accordance with the national and international laws governing such actions.
c) To ensure a collaborative and consistent approach to supporting people who may engage in behaviours of concern.

Promoting positive behaviour and preventing and managing behaviours of concern in a safe non-aversive way is vital for the safety of those we support and for their supporters.

# 2. Values Informing Practice

**Respect the Rights of the Person Served**
The human rights, safety, and well-being of the individual are paramount. Each individual is treated with the same degree of respect and dignity that would be accorded to any citizen. In particular, the dignity, feelings, values, personal and lifestyle choices of the individual must be respected and safeguarded. The person's culture, ethnic background, heritage, religious and spiritual beliefs, must also be respected.

**Positive Focus on the Interests and Quality of Life of the Person Served**
Service users and staff are people first; all people are valuable and have strength and abilities Support must focus on benefits for the individual through increased quality of life and independence. It should support the growth and learning of the individual as a whole person, within a positive environment. It must be appropriate to the age, maturity and understanding of the individual involved.

**Limit Use of Restrictive Practices**
Restrictive practices may only be used within an individual's Personal Risk Management Plan (PRMP) or in an emergency. Restrictive practices are only included in the PRMP when circumstances are serious enough to justify them, and there must be a clear plan in place to address them. The principle of "there is no alternative" should apply to any intervention that places limits or restrictions on an individual.

The decision rule to follow for when restrictive practices (as defined in this Guide) are used is that the least intrusive responses must be used for de-escalating the behaviour while providing safety for the individual and others. (See Section 8 for further information)

**Prohibited Practices are never to be used**
Prohibited practices are never to be used. Use of any prohibited practices constitutes abuse and staff and service providers must report it immediately, as outlined in the Association's Protection and Welfare policy.

It is prohibited to use any practice whose purpose is to demonstrate power, enforce compliance, inflict pain, harm, to punish or discipline an individual.

Examples of practices which would be considered prohibitive are:

a) Restrict food, drink, clothes, choice, and information for the sole purpose of trying to encourage 'good behaviour' i.e. obedience
b) Shout at service users, swear at them or strike them.
c) Deny or restrict the basic rights of everyday life such as food or drink
d) Talk about them as if they were not present
e) Treat someone as if their feelings do not matter.
f) Withdraw the things that people value, own or are entitled to, as a punishment for bad 'behaviour'.
g) Any instance where fear is deliberately induced in an individual.

## 3. Protecting Peoples Rights / Role of the Rights Review Committee

It is the policy of Western Care Association to ensure that the rights of people using services are upheld in accordance with the Irish Constitution, the Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities.

The organisation has a rights review committee comprised of various community members.

The functions of the committee are:

a) To provide an avenue for service users to address perceived restrictions in Western Care Association and promote fair treatment for people using services, both through direct referral and through review of any records of logged restrictions.
b) To promote and protect the rights of people using services through scrutiny advice and guidance.
c) To promote positive practices that assert the rights of people using services
d) To review data on incidents and complaints.
e) To support organisational efforts to learn and improve its practice in the area of Rights.

## 4. From Challenging Behaviour to Behaviours of Concern

The term ***behaviour that challenges the service*** began to be adopted in the field of intellectual disability in the 1980's. At that time it was considered a progressive development, as it was a move away from stigmatising individuals who may at times be compelled to display severe behaviours because in some-way their needs were not being met.

Internationally there is now a move away from the term challenging behaviour to 'behaviours of concern', this is an endeavour to ensure that an individual will not have the stigmatising and devaluing label challenging behaviour attached to them as a person.

When considering a person's behaviour of concern we always need to consider who the behaviour is a problem for? Is it a problem for the person, a problem for those supporting the person, a problem for those living with the person or for those who come into contact with the person in the community?

For the context of this document behaviour of concern is defined as: "*behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed or is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to ordinary community facilities, services and experiences".* (Emerson 1995).

Some people have developed 'behaviours' over many years and may be part of the person's coping mechanism or a means of escaping from situations that they found stressful or fearful. These behaviours serve a purpose for the person and whilst we should always 'listen deeply' and seek to understand what the person is trying to communicate via their behaviour, we must always be extremely cautious about interfering in a person's life and seeking to change their behaviour just because it does not fit with what we believe to be 'normal behaviour'. A real danger in trying to extinguish behaviour without fully understanding it from the person's perspective is that it can be replaced by more extreme and more dangerous behaviours.

People may engage for instance in behaviours on an episodic basis e.g. loud vocalisations, these may be long-standing and they require those supporting the person to be patient, tolerant, empathetic, supportive and resilient. Other people living with the person during those times also will need additional support including the opportunity to spend quality time away from the person who is experiencing difficult times.

When a person engages in behaviours of concern we support them by trying to understand the reason for these behaviours. We develop a plan that is appropriate to the particular behaviours of concern. We track how the plan is working through the use of evidence such as data gathered for that specific purpose. For directly provided centre based services we also use the Associations Incident reporting system to provide data to flag concerns and track whether our plans help to reduce the frequency or severity of incidents are working.

This Policy sets out the various approaches that are used to address behaviours of concern as they escalate. It provides some background on the approaches used and some detail regarding specific elements of these approaches. All approaches are based in the same set of Person/Family Centred values.

## 5. Positive Behaviour Support

Positive behaviour support (PBS) comes from the perspective that there is not a simple answer to the complex reasons why people show behaviours of concern. PBS has emerged from three main sources; the movement towards inclusion, applied behaviour analysis and person centred approaches which has as a primary goal the enhancement of the quality of life of the person with a disability.

Carr describes PBS in the following manner:
*"Positive Behaviour Support is less a process of selecting an intervention, and more the construction of a comprehensive set of procedures that include change of the environment to make the problem behaviour irrelevant, inefficient and ineffective, and helping the person to achieve his or her goals in a socially acceptable manner"*. Carr et al (2002).

The PBS approach includes the systematic gathering of relevant information, conducting a functional assessment, designing support plans, implementation and on-going evaluation. Immediate response strategies are put in place via a *Personal Risk Management Plan* to manage serious episodes of behaviour. There is a strong belief that the best behaviour support happens when the behaviour is not happening, hence the strong emphasis on proactive strategies.

This approach places an emphasis on the need for responsiveness to a person's feelings and needs and has the following defining features:

- Valuing the person, deliberately building a sense of self-worth, acknowledging all attempts at positive interaction
- Creating situations that enable the person regardless of the behaviours of concern that they show to be seen in a positive light
- Acknowledging and trying to interpret what the person is communicating via their behaviour
- Analysing the function(s) (meaning) of the behaviours
- Teaching the person other ways to meet their need or communicate their feelings
- Gently supporting and leading the person to a calmer state
- Providing encouragement and praise to the person about any person successes they may achieved and any difficult situations they may have handled well.

## 6. Listening to the Person with Behaviours of Concern

People who engage in behaviours of concern always do so for a reason and the challenge for those supporting them is to listen deeply and continue to seek to understand why the person is engaging in the behaviour.

The way we behave around other people and the relationships we establish are a critical factor in determining and achieving our goals, hopes and dreams. People with behaviours that others find difficult to understand often find that their relationships are difficult to maintain and their goals, hopes and dreams can be difficult to ascertain or achieve.

It is important to consider the environmental factors that can exist in any given situation around a person. This can include the physical environment that the person experiences, the range of activities available to the person, the predictability of the person's day and the person's communication system. It can also include the rules, routines and restrictions present in the environment. Also the relationship that exists between the person and other people that may share the environment needs to be considered.

An important consideration is the quality of the relationship between the person and their supports both paid and freely given. Is there consistency in the people providing supports or is there a lot of turnover which provides staff coverage but does not foster continuity, security or strong relationships. Good practice would always place a high priority to achieving a 'good match' between the person and his or her supporters and on sustaining this relationship.

Supporters who want to 'walk a mile' in the person's shoes and try to understand the chaos the person is experiencing, and who are prepared to give the person ' a break' in terms of their behaviour, are the ideal people to be around the individual. Empathy, positivity, optimism and resilience are vital characteristics in those supporting a person who is in crisis.

## 7. A Step by Step Guide in responding to Behaviours of Concern

a) Role of Direct Support Staff: When someone's behaviour changes, we need to pay attention to what might be causing them to act like this. We also need to acknowledge that we support people in the Association who engage in particular behaviours either on an on-going basis or periodically. These behaviours may be long-standing and in may take a long time to change. Those supporting the person will need to be tolerant, empathetic, supportive and resilient. Special consideration must be given to those who share the same environment with the person and they may need to spend quality time away from that location to reduce their stress and any distress that they may be experiencing as this may be their home and they may not have had a choice in who they live with.

b) Look at any changes that may have taken place in their lives recently. What is different in their life now and how are we going to manage this?

c) Consider their health and what might be causing them to feel differently - see Enabling People to Enjoy Best Possible Health, Indicators of a Possible Underlying Health Problem, page 7-10 which includes useful guidance from the work of Dr Ruth Ryan.

d) Review their IP and use the principles set out by O'Brien and Lyle O'Brien below when considering their overall life circumstances. Develop an Action Plan to comprehensively address what is happening for person.

e) If the situation persists and the behaviour continues or escalates, all those who are closest to the person (Circle of Support) should come together and review how life is for the person using the IP process and try to develop solutions.

f) The strength of this approach is it assumes capacity in the local team and Support Network to address situations based on their knowledge of and relationship with the person, their experience and training and their ability to respond rapidly as a staff team who see the person on a daily basis. Ownership and implementation of solutions closest to the source of occurrence is an empowering model for the person's supporters. It also represents a more targeted use of resources so that referrals to more specialised functions occur only when local efforts require additional support.

g) If the situation is not resolving and the behaviour continues and/or escalates staff will need to consider onward referral to another source. At this point a referral form, (Appendix B), will be completed and forwarded to the Regional Services Manager who will make a decision as to who might best respond to the referral at this time.

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| **CHANGE IN BEHAVIOUR NOTICED; BEHAVIOUR OF CONCERN APPEARS** | Those closest to the person should consider why and pay close attention to:<br>• Changes in their life<br>• Health | Develop Action Plan to address what is happening. |
| **IF THE BEHAVIOUR OF CONCERN CONTINUES** | Overall review of I.P. and what is happening in the person's life | Develop plans to address priorities. |
| **IF THE BEHAVIOUR OF CONCERN CONTINUES AND ESCALATES** | Onward referral to R.S.M. to consider actions to be taken | |

Using the framework above as a reference guide, select the appropriate level of review, planning or intervention based on the nature of the concerns. For behaviours of concern, the response hierarchy might look as follows, beginning with the most straightforward response and moving to more complex ones if the behaviour of concern continues or escalates:

- Review the person's overall life circumstances through the IP; Staff Team/Support Network
- Apply a Low Arousal Approach as appropriate to the circumstances; Staff Team/Support Network
- Develop a Personal Risk Management Plan to ensure people's safety if this is a concern; Staff Team/Support Network
- Staff Team/Support Network seek support of BSS in developing a PRMP
- Develop a more comprehensive Behaviour Support Plan/Stress Management Plan; BSS / Psychology
- Seek additional or bespoke training; BSS / Psychology / SLT / ETD
- Complete a formal Functional Assessment and intervention plan; BSS / Psychology
- Develop an alternative support arrangement; Management.

If the behaviour of concern continues or escalates or is of such intensity from the outset, the point of action may be elevated directly to one of the more comprehensive responses. In Children's Services, particularly services provided to families, the issues may present differently given the different dynamics and the approach needs to be adapted accordingly.

# 8. Responses are Informed by a Low Arousal Approach

**What is a Low Arousal Approach?**
Low Arousal is a style of interacting with a person who is highly stressed.

a) Low Arousal is a non-confrontational way of managing challenging situations
b) A philosophy of care which is based on valuing people
c) An approach that specifically attempts to avoid aversive interventions
d) An approach that requires staff/carers to focus on their own responses and behaviour and not just locate the problem in the person with the label
e) A collection of strategies that are designed to rapidly reduce aggression.

A Low Arousal Approach identifies a number of specific practices that support a calming and low key way of interacting with a person who may be in a heightened state of arousal or stress. These include attention to your own body language, eye contact, physical proximity/distance, tone of voice, communication, distraction, etc. An example is provided in Appendix E.

However, there has been some confusion and mixed messages around what is meant by Low Arousal. It is important that these are considered. *Do not misinterpret Low Arousal to mean No Arousal.*

**Low arousal is not:**
A low arousal approach does not mean *NO* rules/guidance, *NO* structure/demands or *NO* boundaries.

It is clear that rules and demands that arise from service related routines are often the source of conflict. For many people who are going through a difficult and stressful time it is really important we should be aware that they need to have fewer demands on them. However, some people, particularly those on the autism spectrum need structure and boundaries in their life. Implement the degree of routine and structure that is required based on your knowledge of what helps the person.

For example – John (autism) appears stressed in the morning and horse riding is on the schedule. Staff believes he shouldn't go / doesn't want to go or can't go because of how he is, and yet completing the routine of the day is necessary for John because predictability of routine is as necessary for the person with autism as 'air is for breathing'.

Supporting John in an autism-informed manner tells us that:

a) We shouldn't assume he doesn't want to go horse riding
b) If he doesn't go horse riding he needs to do another meaningful predictable activity
c) Doing a Physical activity will help John when he is in a stressed state and is necessary to help him work off the levels of cortisol that are in his system.

## 9. Development of a Personal Risk Management Plan

Personal Risk Management Plans are based in the principles of a Low Arousal Approach. Personal Risk Management Plan (PRMP) is a tool to help people pursue their preferences and choices safely (See Risk Management Policy). *It is not limited to addressing behaviours of concern.* However, when a person engages in behaviours of concern that includes the risk of harm to themselves or others, then it is important that the nature of the risk is determined and managed in a proportionate way. The purpose of the *Personal Risk Management Plan* in this context is to respond to a situation where people are unsafe as a result of their behaviour.

The *Personal Risk Management Plan* will identify the specific harm that could occur and how likely it is that this will occur. The PRMP contains proactive strategies that reduces the probability of the harm occurring and reactive strategies that specify how in the *least restrictive way* the risk of harm can be managed if it does occur.

If physical restraint is specified as part of the reactive strategies, then the physical restraint protocol (see Appendix C) must be completed and attached to the PRMP.

The *Personal Risk Management Plan* will contain details of any Rights Restrictions imposed on the person including instances where physical restraint may have to be used to protect the person or others in a potentially dangerous situation. Details of psychotropic medications and the use of PRN where it is prescribed must also be included except where they are prescribed by psychiatry to address a mental health condition e.g. depression.

The *Personal Risk Management Plan* must be developed in close collaboration with those closest to the person and where possible with the person themselves. The person's Circle of Support should be included in the development of the *Personal Risk Management Plan* in line with their agreed way of working. Each member of the Circle should agree to and sign the plan. The Regional Services Manager should also be requested to review and sign off on the plan.

*A Personal Risk Management Plan* that contains restrictive practices must be highlighted on the rights checklist for each person and forwarded to the Rights Review Committee.

A Personal Risk Management Plan has a number of the features associated with Multi Element Behaviour Support Plans but is less comprehensive in nature. Features in common include; the use of data as evidence to inform planning and to determine effectiveness, the development of a reactive response strategy to manage behaviours of concern safely, the development of proactive strategies including environmental adaptations and some skills teaching, communication strategies or coping strategies to support self-management, etc.. However, the tool is relatively simple and does not have the level of sophistication of the more advanced Multi Element model. The assessment and focus on functional equivalence is not a strong feature of the PRMP although considerations of the cause of behaviours may arise in the process of addressing the behaviours of concern.

The strength of a PRMP is it can be used by the direct support team and it is focussed on managing situations where safety is a concern.

If behaviours of concern persist, then it may be necessary for a more comprehensive behaviour assessment to take place and a Multi-Element Plan to be developed. The components of a Multi Element Plan are described in the following section.

## 10. Developing a Behavioural Support Plan/Stress Management Plan

When a person has been referred to BSS/Psychology because of their behaviour of concern, those supporting the person will be requested to complete the 'Responding to Referral Form' (Appendix B). Completion of this form will be the first step in the information gathering process that is necessary for the development of a behaviour support plan or stress management plan where this is deemed necessary.

The most effective Plans are those that are developed in consultation with the person and the person's supporters. The responsibility for implementing the plan rests with those directly working with the person, but with support from members of the Behaviour Support Service. The member of the Behaviour Support Service (BSS) will offer practical 'on the ground' support in implementing the Support Plan, modelling and coaching will be important components of that practical support.

The plan will contain clear descriptions of the behaviours of concern and will seek to identify the 'meaning' (function (s)) of the behaviour. Strategies for enabling the person to more effectively achieve the same function without engaging in the behaviour will be developed.

Plans should be written in accessible person-centred language devoid of jargon and should be easily understood by the person and their supporters. A multi-element plan will look at a person's life in a holistic manner and will identify different areas of their lives where they require support.

The Plan will be centred around meeting the person's needs by building on the person's strengths. Plans will have pro-active strategies that are designed to lessen the possibility of behaviours of concern occurring and may also contain reactive strategies that specify the least restrictive way that person and others can be kept safe during a crisis situation. Where the person has an effective PRMP in place *this element of the Behaviour Support Plan does not need to be duplicated.* Any useful strategies already in place should be added to the Behaviour Support Plan.

*Note: Permission should always be sought from parents in the case of a child and where possible, the person themselves or their advocate when it's an adult before any assessment work is undertaken. The primary aim of assessment is to identify what the behaviour means for the person. Behaviour may be the person's sole way of communicating physical, mental or emotional illness and/or stress.*

**Functional Assessment**

*"It is not a matter of what causes self-injury or what causes aggression or what causes stereotyped or repetitive movements but for each of these forms of difficult behaviour, what does it do for the individual, what purpose does it serve for them in life?"* Brown and Brown (1994).

Behaviours of concern always occur for a reason nor can behaviour be explained by a single factor or cause. The same behaviour of concern may serve one function or many functions for a person. A functional assessment seeks to clearly determine what function the behaviour of concern is serving for the person. The aim is then to design support strategies that enable the person to more effectively achieve the same function in a more socially acceptable manner. In addition to analysing the more immediate circumstances in which the behaviour occurs, there are a number of important areas for exploration which provide a broader interpretive context:

- The importance of syndrome specific detailed characteristics eg. Fragile X syndrome, Rett's syndrome, Angelman syndrome, Autism, etc.
- Physical health including; (dental, ears, nose and throat, constipation and gastric issues and the endocrine system)
- Mental Health conditions
- Medications including side-effects
- Communication
- Knowing the person preferences and abilities
- Relationships
- Sexuality issues
- Sensory issues
- What are the current stressors in the person's life?
- Impact of trauma, e.g. people feeling excluded and different, people that have experienced abuse or the loss of a close family member, etc.
- Impact of attachment, e.g. adults who experienced serious medical conditions in early life and were kept in hospital often show high levels of anxiety. People who have lost one parent may be extremely anxious about the health of the remaining parent.

The Functional Assessment is used to develop a reasonable proposition (hypothesis) based on evidence of the function or purpose the behaviour is serving for the person. Some common functions that behaviours of concern can serve for people are:

- Escape from undesired or feared situations
- Sensory feedback (light, noise, smell, touch, taste)
- Tangible (food, drink, preferred items)
- Social interactions
- Expressed emotions
- Seeking control in their lives
- Reduction of arousal and anxiety.

When a hypothesis as to the function of the behaviour has been determined, then a plan will be developed that will clearly state the function and strategies to support the person to achieve the function without the need to engage in behaviours of concern. The implementation of the intervention strategy is tracked to determine if the target behaviour is reducing and support the plan is working effectively.

**The Components of a Multi Element Positive Behaviour Support Plan**

Behaviours of concern that are complex and severe may need to be addressed in a comprehensive and systematic manner. When responding to such behaviours of concern, Western Care Association embraces a non-aversive multi-element Positive Behaviour

Support (PBS) approach *to understanding the function of behaviour in the context of a person's life*. The multi-element approach considers the life of a person under the following important areas:

Environmental Strategies

- Personal factors e.g. health, medication and side effects, hunger, sensory issues and communication difficulties, etc.
- Predictable environments and consistent routines
- Opportunities to sample new activities
- Improved interactions and realistic expectations
- Increase opportunities to exercise choice
- Know the person's likes and dislikes.

Teach Skills

- General life skills
- Communication skills
- Coping and tolerance skills including managing stressful situations
- Functionally equivalent skills.

Short-term Change Strategies

- Avoiding situations that can trigger behaviours of concern
- Dos and don'ts when supporting an individual
- Reinforce specific behaviours.

Reactive Strategies

- Endeavour to de-escalate the situation
- Practice low arousal with the person
- Redirection / Distraction
- Respond to early indications of the behaviour
- Work out what the person is communicating.

These elements of a comprehensive Multi Element Behavioural Assessment may be used to match the particular circumstances. Each component does not require to be used for each person. The framework provides a set of options that should inform enquiry for solutions.

If the behaviour of concern escalates, more restrictive measures may be warranted including:

- Administration of PRN-Psychotropic if prescribed. The PRN protocol (Appendix D) should be followed that will clearly specify when the administration will take place
- Use of physical restraint but only if the person or others are in immediate danger and there is no alternative. If physical restraint is specified as part of the reactive strategies, then the physical restraint protocol (see Appendix C) must be completed.

All of the above strategies must be located in the person's Relational Environment as the wider context for understanding the person, their needs and why they behave the way they do. Consider who are the people in the person's life, how strong is their support network, do they have many/any positive relationships, are there positive relationships with family and/or unpaid supporters, do they feel safe around the people they spend time with, are they suffering through loss or bereavement, have they continuity and stability in their

relationships, do they have strong champions in their staff supports, are they a valued part of a their community, do they see enough of the people they love to see?

## 11. Supporting the Supporters

A key part of any behaviour support plan/ stress management plan should be clear strategies that enable the person's supporters be they paid or freely given to keep the person safe in a crisis and for them to stay safe also.

Supporters who are valued and treated in the most respectful way or more likely to also treat those they support in a comparable manner. In the words of the educator Jean Clarke *"People's needs are best met by those whose own needs are met"*.

**De-Briefing**
Staying positive all the time is not easy. We all have ups and downs. Whenever you are working with people your tolerances may well be challenged. The way other people do things, the choices they make, their preferences, may well be different to what you would do. We are all influenced by the emotions these situations generate. This is especially evident in our decision making. How often have you made a bad decision in a bad mood? Or a good decision in a good mood?

Debriefing is a way of talking about these emotions. It's not a mysterious process that you will have done to you after a mission. It's a term used to describe talking about how you feel. The most common use of debriefing is after an incident. An incident can sometimes be "an emotional event". To find effective solutions for how to manage situations, strategies have to be discovered that deal not only with the event but also the emotions that these events generate.

These emotions need to be aired in a constructive way so that our decisions or judgements are not clouded by fear, guilt, anger or doubt. To smooth out the ups and downs and to allow us to treat others around us fairly, we must have the opportunity to let go, or off load our emotions.

There will be some times when you feel that something needs to be done about a person because of the way that they behave. The best way to resolve this issue is to:

a) Find a way to resolve your emotions
b) Find a positive approach to the situation after reviewing all the facts.

For some people, you can clearly see that they spend all day trying to cope with situations by saying I'll deal with that later but never doing so. This can be problematic if this is an emotional issue.

There are also advantages to debriefing before your meetings where problem solving and creativity are required. Both the emotional and creative aspects of the mind use the same side of the brain to process the information. It can be hard to focus on the task at hand if you have unresolved emotional issues relating to an individual you support.

Debriefing has to occur respecting confidentiality as it's your time to talk. It's best done with someone you feel comfortable with and this does not have to be your line manager. The purpose is to off load your emotions not to find a new way of doing things. It is not a problem solving meeting it's talking about how you feel.

Debriefing can occur in the following ways:

- Talking to a trusted colleague
- Talking to line manager
- Talking to BSS/Psychology (where involved)
- Talking to EAP (Employee Assistance Programme).

The organisation recognises the necessity of debriefing for staff and has established systems of support to enable it to happen. It is an activity that all staff recognises as important and is critical to maintaining our wellbeing in our day to day lives.

If someone is debriefing to you then remember:

- Don't judge, just listen
- Don't try and find solutions, just listen
- Don't try and fix, just listen
- Give feedback that shows you are listening.

**Working Alone**

A number of people using the services of Western Care Association have informed us that living and spending time with other people with a disability is not what they want. Consequently, individual support arrangements have been designed around specific individuals. In many of these situations, the people supported find it stressful to have more than one staff member supporting them at a time. This necessitates staff members working in 'lone situations'. Staff members working in such arrangements need to have effective systems in place for calling for support when there is a crisis. Some examples of support arrangements include; a 'telephone tree' of staff members in a locality who agree to respond to crisis situations in relation to specific individuals. Service Managers, BSS, Psychologists and Social Work frequently respond to crisis situations including times that are out of normal hours.

## 12. What are Restrictive Practices

Restrictive practices are techniques or strategies that limit a person's behaviour or freedom of movement, in order to prevent them from harming themselves or others.

If restrictive practices are in place then they must be highlighted on the rights checklist, reviewed by the Rights Review Committee and clearly outlined in an individuals' PRMP.

Restrictive practices are never the preferred option, and should only be used as a last resort in extraordinary circumstances where personal safety is at risk to keep the person and/or others safe.

Under HIQA regulations, a written report must be provided to the Chief Inspector of HIQA at the end of each quarter in relation to "any occasion on which a restrictive procedure including physical restraint is used".

Examples:

- Prevented from accessing places in community that others can
- Not being able to freely access their own possessions
- Not having access to all areas of their environment through locked doors, areas, etc. and not having keys or codes to freely come and go
- Being able to access and use all appliances in their environment as they wish, e.g. If they wish to make a cup of tea, having access to kettle to do so
- Access to food and choices being limited
- Concealed medication
- Access to money to purchase items of their choosing
- Limits being placed on someone around how much they smoke drink tea/coffee/alcoholic drinks
- Consequences used in relation to their behaviour, e.g. If you do that, you won't be allowed ring/visit/talk to your mother
- Not allowed pursue intimate relationships if they wish
- Inappropriate use of devices to manage safety of an individual, e.g. lap-belts, modified seat belts/harnesses.

## 13. Use of Restraint in Western Care Association

The legal position on restraint can be summarised as:

***In general, the application of restraint on a person, without their consent, is unlawful.***

The use of restraint must be considered in the wider context of rights conferred under the Irish Constitution (*Bunreacht Na hÉireann*) and in the context of the European Convention on Human Rights (ECHR). From these, the following principles can be said to derive:

a) Use of restraint on another person is, on its face, an interference with the person's constitutional right to bodily integrity/personal liberty

b) Interference with a person's right to bodily integrity/personal liberty may be permissible, if necessary to protect another constitutionally related right - for example to protect a person (either the person in question or another) from imminent risk of harm

c) The extent of the restraint used must be proportionate to the risk of harm or injury

d) From a European Convention on Human Rights perspective, in the absence of detention in a criminal or similar context, the use of restraint (physical or chemical) can only be justified if it is a medical or therapeutic necessity. The standard of proof required to establish this is high

e) The use of restraint beyond what is necessary to meet this purpose, may be found to be inhuman and degrading treatment of a resident and constitute a violation of the residents human rights under Article 3 of the European Convention on Human Rights.

The courts have recognised that within the bundle of personal rights guaranteed under Article 40 of the Constitution, is included a right to bodily integrity. The European Convention on Human Rights, which following the passing of the European Convention on Human Rights Act 2003, has been implemented in Ireland, provides at Article 3 that:

*"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."*

Government policy on restraint is summarised as:

*"To eliminate the use of restraint or where this is not possible, to restrict the use of all forms of restraint to those exceptional emergency situations where it is absolutely necessary. Where restraint is deemed as necessary it should only be applied in accordance with the law and best professional practice".*

**Paramountcy Principle**
In unplanned emergency situations, staff may be faced with situations where the safety and well-being of the person or others are at serious risk, staff in those circumstances are authorised under Duty of Care to follow the Paramountcy principle that is - they can use the minimum amount of reasonable force for the shortest time necessary to protect the person or others from serious harm.

**Review Meeting**
After such an event, debriefing must be offered to staff and service users involved. An Incident Form must be completed and if the incident is in the highest Severity Level 5 category a Critical Incident Review must take place in line with the Incident Reporting Procedures. This review meeting will be chaired by the Regional Services Manager. If the incident is at Severity Level 4 category a Critical Incident Review will take place at local team level and will be chaired by the Frontline Manager. For further details, see the Incident Reporting Procedure.

**Physical Restraint Protocol**
The following safeguards must be strictly adhered to:

a) A physical restraint protocol must be completed detailing the circumstances and practice permitted (Appendix C)
b) This protocol must be attached to the person's *personal risk management plan and* consent for its use must be obtained from the person or the person's advocate
c) The safety of the person and of those carrying out the procedure must be paramount at all times
d) After all instances where physical restraint has been employed an incident injury form must be completed
e) All instances of physical restraint in the Association must be collated and a report must be submitted to the Executive Director on a quarterly basis.

# 14. Types of Restraint

**Physical Restraint**

*Physical restraint is the use of physical intervention (by one or more persons) for the purpose of preventing the free movement of an individual's body.*

**Use of Physical Restraint**
Physical Restraint must only be used when an individual poses a significant threat of harm to self or others and it is considered the safest intervention at that time. It must only be considered when all other options have been exhausted and only then for the least time necessary in order to prevent immediate harm.

Where the use of physical restraint is foreseeable a risk assessment must be undertaken and a *Personal Risk Management Plan* (PRMP) is completed for the person concerned.

The potential hazards associated with each physical intervention must be identified and the level of risk associated with each intervention determined for.

Except in the case of extreme emergency the use of restraint should be discussed with the individual and their Circle of Support as part of the development of their *Personal Risk Management Plan* (PRMP) and recorded.

There must be evidence that the consent process has been adhered to the specific service user on which it is being applied.

In the event that this communication regarding prior consent does not occur, a record explaining why it has not occurred must be entered in the individual's record.

Special consideration should be given when restraining individuals who are known by the staff involved in applying the restraint, to have experienced physical or sexual abuse.

The individual must be monitored throughout the use of restraint to ensure his or her safety, dignity, health and wellbeing.

Only staff that have completed the three day course are authorised to engage in physically restraining a person. Western Care Association and Studio III also stipulate that only the procedures that have been taught on designated courses or during bespoke training events must be used.

An incident form must be completed after every instance of physical restraint.

- If the incident severity is at level 4 or 5 a Critical Incident Review should be held in accordance with the Incident Reporting Procedure guidelines. The purpose is to assess the circumstances, to learn from the event and examine all options that might lessen the need for similar events in the future. However if there is an incident in which this type of physical restraint is used even if it is scored lower than severity level 4 there should be a review of the practice by the Frontline Manager with the staff involved because of the particular and unusual nature of this response. The review of the incident should follow the same process used in Critical Incident Reviews.

**Occasions where physical restraint must never be used:**
There are circumstances where physical restraint must never be used and these include:

a) To demonstrate authority, enforce compliance, inflict pain, harm to punish or discipline an individual
b) Solely for the convenience of staff including where there are staff shortages
c) Where an individual has a known psycho-social/ medical condition in which physical restraint would be considered detrimental
d) Where the risk of harm from the restraint becomes greater than the risk posed by the physical aggression.

## Chemical Restraint

*Chemical Restraint is the use of medication to control or influence behavior, mood or level of arousal.*

## Psychotropic Medications

Definition: "*Psychotropic medication is any medication capable of affecting the mind, emotions and behaviour".*

a) When psychotropic medications are prescribed by a suitably qualified professional to treat a defined mental health condition it is not considered a restrictive practice. People prescribed psychotropic medication in this instance should have the benefit of being assessed by a psychiatrist and the medication must be reviewed within the recommended time periods

b) Where psychotropic medicines are prescribed to assist with the management of behaviour of concern it is considered a restrictive practice and the person's life must be examined in detail and practical ways of enriching the person's life must be identified and systematically implemented

c) Ideally each person's that is prescribed psychotropic medication in relation to behaviours of concern should have a multi-element Behaviour Support Plan/Stress Management Plan that includes strategies that enable the person to de-stress and to reduce their anxiety

d) Wherever possible, the person's medication should be reviewed at the recommended times by the Consultant Psychiatrist.

## PRN (Psychotropic) Medication

Definition: *From the Latin pro re nata: 'where necessary/needed'. Also can be referred to as 'Once off medicine'*

a) All persons living in our services who are prescribed PRN psychotropic medicine must have a PRN Protocol completed by their named staff (See Appendix D)

b) All administrations of PRN of Psychotropic medication must be recorded on an Incident/Injury form and the PRN box must be ticked appropriately

c) The name of the medicine and the dose administered must be recorded on the incident form

d) The circumstances in which the PRN psychotropic medicine was administered must be fully explained in the narrative section of the Incident form

e) Where people are administered PRN psychotropic medicine prior to a medical/dental appointment evidence must be shown of the steps taken to desensitize the person to the aversive experience and/or the non-medication methods employed to reduce the person's stress and anxiety associated with particular medical/dental appointments

f) All administrations of PRN Psychotropic that occur in the Association must be collated and presented to the Executive Director on a quarterly basis

g) Where a person is prescribed PRN Psychotropic medicine and it has not being administered in the previous six months, the Consultant Psychiatrist must be informed and the advice of the Psychiatrist must be sought in relation to having the prescription discontinued.

## Mechanical Restraint

*Mechanical restraint is the use of devices, garments or equipment attached or adjacent to the individual's body that they cannot easily remove and prevents or limits the free movement of an individual's body.*

**Use of Mechanical Restraint**
Equipment which promotes the independence, comfort and/or safety of an individual are prescribed for many individuals we support in Western Care. When seating system/positional devices are prescribed for a person the details of use should be documented by the prescribing therapist. There should be a clear rationale describing why the item has been prescribed for the individual and in what circumstances it should be used and not used. This information should be held on the person's IP folder.

If equipment is being used in a service in a manner other than that for which it has been prescribed than it may constitute physical restraint

Any means of mechanical restraint used in an emergency situation must never compromise the safety of the individual being restrained.

**Examples**

- **Seating:** Chairs with tilt-in-space options, this means the seat can be tipped back as the backrest is reclined, potentially preventing the person from standing

- **Seat belts:** Seat belt is required as standard for safe transit on manual self-propelled and transit wheelchairs, in addition to several models of comfort chair. If the person is unable to have the belt opened at other times(when not in transit) or as they wish then belt can be viewed as restraint

- **Chest harness:** This is provided to people who are unable to independently maintain a midline seated position (i.e. if they fall to one side on sitting upright). The harness has clips at each hip and is fastened to the wheelchair. If the person wishes to open the harness then they should have support to do so or item may be considered restraint

- **Groin strap:** For use by people who may slope forward and slide out of the wheelchair. Two clips are fastened on each thigh. Should the person be unable to get support to unfasten the clips, then the device becomes a restraint

- **Splints:** Are prescribed when there is high potential that the person may lose range of motion, to protect joint integrity, to maintain palmer arches and to prevent pain and overuse in some instances. If they are used for any other purpose then they are considered a form of restraint

- **Lap trays:** These are used to enable feeding and a variety of other activities. They are secured using Velcro, being screwed into place, or by various other means of attachment. Where they prevent a person from getting out of their chair, their use may constitute a restraint. When in place on a person's seating system, their use must be for functional activities. Outside of requirements specified by the seating prescriber, lap trays should not be in situ on the seating system

- **Cot Sides:** These are used where there is a known risk and/or high risk that someone may fall out of the bed through movements they make while sleeping .They should never be used to prevent someone from getting out of bed if they wish to.

In order to prevent use of equipment as restraint, then for each piece of equipment used there should be a clear rationale developed with prescriber as to why it is in use and when it is to be used. This information must be in the person's IP Folder

If equipment is being considered for use in any other circumstances then the following actions must take place:

a) The person's Circle of Support must be convened and the rationale for considering the use for postural support appliances in non-approved way must be fully outlined and all the alternative strategies that have employed must be listed and reasons why they did not succeed must be fully explained

b) The Occupational Therapist must be requested to visit the person and again the reasons for considering such action must be fully explained to the OT. If the OT objects to such planned use, then the planned use must not take place

c) If the OT approves the planned use, then the circumstances in which it may be employed must be fully written-up in the person's *personal risk management plan* PRMP

d) The Rights Checklist for the person must be completed and details of the use of postural support appliances in these circumstances must be highlighted in the checklist.

**Environmental Restraint**

*Environmental Restraint is the intentional restriction of an individual's normal access to the environment, with the intention of stopping them from leaving, or denying them their normal means of independent mobility, means of communicating or the intentional taking away of ability to exercise civil and religious liberties.*

**Use of Environmental Restraint**

These practices should never be the preferred option, and should only be used as a last resort in extraordinary circumstances where personal safety is at risk to keep the person and/or others safe.

It may be considered necessary to curtail a person's access to their environment for their own safety. If these practices are in place, then they must be clearly outlined in individual's PRMP and should be based on the risk of something that has occurred and have a clear plan for addressing this so that person is not curtailed indefinitely.

Some examples of these are:

- Prevented from accessing places in community that others can
- Not being able to freely access their own possessions
- Not having access to all areas of their environment through locked doors, areas, etc. and not having keys or codes to freely come and go
- Being able to access and use all appliances in their environment as they wish, e.g. If they wish to make a cup of tea, having access to kettle to do so.

# 15. BIBLIOGRAPHY AND REFERENCES

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- Enabling People to enjoy Best Possible Health- (Western Care Association Policies and Procedures) SP 23.1
- Incident Reporting Procedure - (Western Care Association Policies and Procedures) SP 20.3
- Medication Procedure- (Western Care Association Policies and Procedures) SP 23.2
- Personal Risk Management Plan - (Western Care Association Policies and Procedures) SP 20.2
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- Behaviours that Challenge-(Saint John of God Community Services Limited 2009)
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- Positive behaviour support-getting it right from the start; Facilitators reference manual 2009.
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- Procedural guidelines for Assessment and Intervention Approaches when working with service users who present with Behaviours that Challenge Service Delivery –(Brothers of Charity Galway, 2008)
- Challenging Behaviour: A unified approach (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007).

## Framework for Developing Multi Element Behaviour Support Plans

| **Change the environment**. | **Skills Teaching:** | **Short-term change strategies that may include:** | **Immediate Response Strategies:** *(What helps when the behaviour occurs- always start with least restrictive*): |
|---|---|---|---|
| **Gather personal background information that leads to:**<br>• Increased opportunities to engage in a variety of activities.<br>• Introduce physical exercise into the person's daily routine (Ensure medical check is done prior to introducing any vigorous exercise).<br>• Create predictability in the person's day/week. Introduce schedules that show the person where they will be; and what they will be doing throughout each day.<br>• Provide consistency in how the person is supported.<br>• Increase positive interactions with the person across the day/week.<br>• Find out what a *Good Day* would be for the person and try and ensure at least some of what constitutes a Good Day occurs across the day/week. | **General Skills:**<br>• Teach the person general life skills to increase independence.<br>• Enable person to communicate more effectively.<br><br>Teach the person coping skills to be better able to cope with feeling frustrated or angry.<br><br>Functionally Equivalent (replacement skills)<br>When the function of the behaviour is known we need to teach the person a more efficient socially appropriate way of achieving the result than resorting to the behaviour. | • Reinforcing specific behaviours.<br>• Avoid situations that can cause stress for the person.<br>• Develop strategies that will increase engagement | • Redirection- try to distract the person by offering another activity.<br>• Talk to the person and try to find out what the problem is.<br>• What is the person trying to communicate via their behaviour?<br>• Respond to early signs of the behaviour.<br><br>Know how to respond to serious episodes of the behaviour. |

**APPENDIX B**

**Responding to a New Referral: Information Gathering Process**

*Dear_____,*

*Thank you for referring _____ (Name of person) to the Behaviour Support Service. In order for me to respond in the most efficient & effective manner I would be most grateful if you would provide the information requested below.*

*Please answer the questions in the most brief and succinct manner possible*

**Contact numbers:**

**Named staff:**

**Link Staff:**

| | |
|---|---|
| Has permission being granted by the family/adult for behaviour support? | Yes ____ No ___ |
| Have all the permission forms being signed? *(E.g. database*) | Yes ____ No ___ |
| Is there a personal risk management plan in place? | Yes ____ No ___ |
| Is there currently a Behaviour Support Plan in place? | Yes ____ No ___ |

**Please list the behaviours of concern. Be specific do not use subjective terms such as aggressive or attention seeking. Include the frequency and intensity of each behaviour of concern**

**Behaviours of concern are:**

- **Describe what strategies/interventions have been recommended, implemented and or attempted previously? Who made the recommendations?**

- **What worked/did not work for the person?**

- **List any other disabilities/challenges experienced by the child/adult: What support strategies/interventions were put in place to support the child/adult with those additional disabilities**

- **List the services/supports/disciplines that the child/adult has availed of previously e.g**. (SLT/OT/Social Work/Physiotherapy /Psychology/ Behavioural Consultant).
- **Please provide brief summaries of the support recommendations from those Disciplines.**
- **List the support recommendations that are currently being implemented with the child/adult.**

| |
|---|
| • **List the name and contact number of services/supports/disciplines that are currently involved with the child/adult e.g**. (SLT/OT/Social Work/Physiotherapy/Psychology) |
| • **How does the child/person communicate? What communication system is in place?**<br>• **Is the communication system effective for the child/adult?** |
| • **List any medical issues that are of concern (include list of medications).** |
| • **List the environments/settings that the child adult uses (school/centre/respite/foster family/transport/sports centre/community clubs etc.** |

## Physical Restraint Protocol

- In any instance where physical restraint may have to be considered in order to protect the safety of a person or other persons then a physical restraint protocol must be completed and attached to the person's *Personal Risk Management Plan* (PRMP).Because physical restraint is a Rights Restriction a Rights Checklist must be completed for all persons who are at times physically restrained.

- Family members/advocates must be given a copy of the *Personal Risk Management Plan (*PRMP) containing the physical restraint protocol to read and only if they authorise its use and sign the *Personal Risk Management Plan* (PRMP) accordingly, only then can the physical restraint procedure be employed.

- On each occasion that physical restraint has been used an Incident form must be completed and the physical restraint box must be ticked. Family members/advocates must be informed when a person has been restrained based on the agreed communication arrangements with the person and family.

- The Regional Services Manager (RSM) for the Area must be furnished with a copy of the P*ersonal Risk Management Plan* (PRMP) containing the protocol and their approval must be sought.

- Because the Law specifies that any unwanted physical contact can constitute aggravated assault, we must only engage in physical restraint when all other approaches have been exhausted, and only then when the personal safety of the person or others are at serious risk. The physical restraint procedure must comply with that taught by the Managing Challenging Behaviour Trainers in Western Care Association. These trainers work under the auspices of Studio 3 Training Systems which is a British Institute of Learning Disability (BILD) Accredited company.

- Only staff members who have completed the Managing Challenging Behaviour (MCB) three day Training and who have been issued with certificates from that training can engage in physical restraining a person who receives supports from Western Care Association.

**But in an emergency situation where there is a risk of serious injury to a person or others, then any staff member can use the minimum amount of physical restraint necessary in order to protect life and prevent serious injury.** (This is authorised under the Paramountcy Principle)

**Please request signed consent for the use of physical restraint from those listed below.**

- The person _____
- Family/advocate _____
- Front Line Manager _____
- Named Staff _____
- Regional Services Manager _____
- BSS _____

## REVIEW OF THE PHYSICAL RESTRAINT PROTOCOL

Please state when this protocol will be reviewed, on what regular basis (e.g. every 6 months and by whom).

| |
|---|
| |

| |
|---|
| Please verify that all staff members who physically restrained the person had completed the 3 Day Managing Challenging Behaviour Course **Yes**_____ **No**_____ |
| How many times was **unplanned** physical restraint used with this person in the last twelve months? |
| Please describe below the circumstances where you would consider using physical restraint with this person? |

*Describe all the proactive & reactive strategies that you would employ to lessen or eliminate the need for using physical restraint?*

*Describe in detail the physical restraint procedure that is used as a last resort with this person?*

*If other than the 'Walk-Around' physical restraint procedure was used, please specify if 'Bespoke Training' has been provided by MCB Trainers for staff members supporting this person?*

***Yes*_____ *No*_____**

*Date of Bespoke Training*_____

*List names of staff members who took part in the Bespoke Training:*

| Developing a PRN Protocol | |
|---|---|
| **Date:** | |
| **Name:** | |
| | |
| **Address:** | |

**Purpose of this form.**

This document is designed to help you to write a PRN protocol which will form part of the person's PRMP and will be attached to the person's PRMP. It will also help you to collect the necessary information to generate solutions and make decisions with the person and his/her circle of support. The form will help to clarify procedures that will be used in reviewing the effectiveness of those procedures.

## THE CURRENT SITUATION

**What are the current challenges for the person that has resulted in the need for use of PRN medication?**

*This section will need to include information on any significant changes or unmet needs for the person, etc. which can be completed in bullet points.*

**Proactive supports**

**What supports generally needs to be in place for the person? Describe what is being done to reduce the person's stress levels:**

| **Reactive strategies prior to the administration of PRN medications** |
|---|

*Are there any strategies that could be used to diffuse the situation or tried prior to the giving of PRN medication?*

| |
|---|
| |

| **What are the behaviours of concern and what do they look like?**<br><br>**Behaviours of concern – what to observe for.** |
|---|

*Describe each behaviour of concern in a manner that the behaviour can be identified/observed easily by others. (Do not use terms such as 'attention seeking or agitated')*

| **Behaviour of concern** | **Description** |
|---|---|
| | |
| | |
| | |
| | |
| | |

| **FUNCTION OF THE BEHAVIOURS** |
|---|
| **Has the function or functions of the behaviour been identified? If yes, please describe:** |
| |

## APPENDIX D

| PRESCRIBED PRN MEDICATION AND DOSAGE |
|---|

*List the prescribed medication and dosage, including maximum number of dosages within 24hr period.*

| Medication | Dosage | Interval between administration & Max dosage in 24hrs |
|---|---|---|
| | | |
| | | |
| | | |

*List the medication side effects for each medication and what to observe for:*

| Medication | Side effects | Observe for: |
|---|---|---|
| | | |
| | | |
| | | |

| CONDITIONS FOR ADMINISTERING PRN MEDICATION<br>At what point will I need to administer the PRN medication? |
|---|

What behaviours need to be in place?

| |
|---|
| |

How frequently does the behaviour need to occur?

| |
|---|
| |

At what level of severity/arousal will the medication need to be given?

- Frequency of identified behaviours
- Severity of identified behaviours

| |
|---|
| |

## EXPECTED RESULTS FROM THE ADMINISTRATION OF THE PRESCRIBED MEDICATION

*List the expected behaviours resulting from taking the PRN medication*

What do you expect to see when the medication has been administered?

| |
|---|
| |

How much time do you expect to elapse before the medication to starts to work for the person?

| |
|---|
| |

## RECORDING AND COMMUNICATING THE ISSUING OF PRN MEDICATION

- Incident Form
- MR2 – Medication Administration Form
- Agreed form of communication to person, family, and other supporters.

**List the agreed form of communication to each person in the event that PRN medication has been given.**

| Name | Agreed communication | Contact details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Ensure debriefing is offered to the person when the situation is calm**

**APPENDIX D**

## CONSENT TO MEDICATION, AGREEMENT OF PROTOCOL AND REVIEW PERIODS

**Please obtain signed consent for the administration of PRN (Psychotropic Medication) from those listed below.**

- The person _____
- Family/advocate _____
- GP _____
- Psychiatrist _____
- Regional Services Manager_____
- Front Line Manager _____
- Named Staff _____

## REVIEW OF THE PRN PROTOCOL

Please state when this protocol will be reviewed, on what regular basis (e.g. every 6 months and by whom.

## Important

- If the PRN psychotropic medication has <u>not</u> been administered in the past six month, please inform the Psychiatrist or GP and request their opinion as to the possibility of discontinuing the PRN prescription.
- If PRN psychotropic medication has been administered on a frequent basis e.g. please refer to the psychiatrist and or prescriber.

## APPENDIX E

# Example of a Low Arousal Approach applied to an Individual

The low arousal approach is vital in interacting with XXXXX, especially when she is agitated, shouting and/or hitting out.

**The strategies listed below are to only be used when XXXXX is anxious, agitated, frustrated etc.**

**Translating Low Arousal for XXXXX**

| | **Strategies for XXXXX in HIGH AROUSAL STATE** |
|---|---|
| Appear calm | Make sure you are able to appear calm when XXXXX is agitated, etc. |
| Eye contact | XXXXX does not mind people maintaining eye contact with her. She expressed a preference for the person to do so. |
| Distance | Give and maintain some distance from XXXXX when she is agitated, etc. throughout all interactions in this form.<br><br>XXXXX will seek out space for peace and quiet, requiring distance from others. |
| Speech/Language | Ask XXXXX if she is OK, etc. in a calm relaxed manner. |
| Touch | XXXXX prefers not to be touched when she is agitated. |
| Listening | When listening to XXXXX start off by standing at arms-length, ask her if she is ready to talk and can hear you. If she has her hands over her eyes ask her to remove them when she is ready. Start the discussion for XXXXX by asking her "What is the matter?" |

| | |
|---|---|
| | Using words such as wrong is not useful for XXXXX. This can keep her focused on what she views as her wrong doing, as opposed to her working through the issue to a resolution with closure. |
| Distraction | The following strategies were developed with XXXXX:<br>• Go for a walk<br>• Do some paperwork<br>• Have a drink of water<br>• Have a cup of tea<br>• Be reminded to breath deeply & relax<br>• Be invited to sit down and relax<br>• For somebody to explain why certain things cannot be done or take place. It is important that the explanation is given when XXXXX is able to listen.<br>• Saying prayers<br>• For people to find you a number of things you can help with at work/home<br>• To talk when you are feeling more relaxed about what is wrong or not working for XXXXX. |
| Removing others | XXXXX will remove herself from the situation to her bedroom, art room, office, etc. at work. |
| Talking to the person & colleagues | XXXXX would like the person supporting her to knock on the door, check if she is OK and offer a drink. Start the discussion with XXXXX using the following:<br>• How are you?<br>• Are you feeling better?<br>• What's the matter XXXXX?<br><br>Give XXXXX the opportunity to discuss what happened, including feelings and events. It is very important that we simply acknowledge XXXXX's feelings e.g. "It's my fault," and acknowledge by saying "So you feel it's your fault". Then see if XXXXX can move on to discuss what her difficulty was, and strategies she could use in the future. This discussion will need to have closure for XXXXX in the form of a hug/shaking of hands, and reminder of what she will be doing next. |
| Recording the behaviours | Incidents to be recorded at work using WCA Incident/Injury logs **and/or** XXXXX's STAR charts. XXXX to phone in details of any incidents at home. |

| General Arousal Strategies for XXXXX | |
|---|---|
| Appear calm | N/a |
| Eye contact | Maintain eye contact. XXXXX enjoys this. |
| Distance | XXXXX enjoys close physical contact. |
| Speech/Language | Calm manner at all times. |
| Touch | XXXXX enjoys appropriate touch. |
| Listening | XXXXX enjoy people listening to her |
| Distraction | N/a |
| Removing others | N/a |
| Talking to the person & colleagues | N/a |
| Recording the behaviours | N/a |

| Actions |
|---|