SOS Kilkenny clg

Policy & Procedures on Restrictive Practices

Developed By:	Authorised By:	Date:
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1.0 Purpose of Policy

1.1 SOS Kilkenny clg is committed to a Human Rights Based approach to restrictive practices and are committed to a restraint-free environment. This is achieved by:

- 1.1.1 Adapting a person centered approach to care
- 1.1.2 Staff are aware of a person's needs
- 1.1.3 Conducting comprehensive assessments identifying any issues that may be contributing the use of restrictive practices such as:
  - 1.1.3.1 Physical
  - 1.1.3.2 Medical
  - 1.1.3.3 Psychological
  - 1.1.3.4 Emotional
  - 1.1.3.5 Social
  - 1.1.3.6 Environmental
- 1.1.4 Monitoring, recording and reviewing the use of restraint
- 1.1.5 Ensuring that our policies are in line with national policies

1.2 The purpose of the policy is to provide guidance to staff, people supported by the service and their families in relation to the use of restrictive intervention in line with best international practice.

1.3 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.

1.4 SOS Kilkenny is committed to ensuring that adults who engage in behaviours of concern are entitled to the same rights and safeguards as any other adult in society and that they are supported in environments that are positive, respectful, safe and inclusive.

1.5 The purpose of a policy in relation to supporting people who challenge us is to ensure that the practices, strategies, plans and interventions that we use to work with people are of the highest standards.

1.6 SOS Kilkenny is committed to 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.

1.7 SOS promotes provision for meaningful activities for people supported which are engaging and offer opportunities for new experiences. The activities will promote opportunities for residents to remain active and involved in their community therefore reducing the likelihood of responsive behaviours which may result in restrictive practices.

2.0 Scope of the Policy

2.1 This Policy applies to all employees of S.O.S. Kilkenny clg.

3.0 Current Legal Context

3.1 Procedures that limit or restrict personal freedoms are only carried out in accordance with the national and international laws governing such actions. Human Rights Law has a bearing on the use restrictive practices, in the Constitution of Ireland:

3.1.1 All citizens shall, as human persons, be held equal before the law (Article 40.1)

3.1.2 The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen (includes right to bodily integrity and right to privacy)

3.1.3 No citizen shall be deprived of his personal liberty save in accordance with law (Article 40.4.1) International Human Rights Law places an obligation on the government, public bodies and other duty bearers (disability service providers) not only to protect human rights, but also to support the enjoyment of human rights by all persons.

3.1.4 Ireland has ratified a number of pieces of international human rights laws. These include The International Covenant on Civil and Political Rights (ICCPR): The European Convention on Human Rights (ECHR), the United Nations Convention of the Rights of Person with Disabilities (UNCRPD). Which include some of the following rights:

3.1.4.1 No one shall be subject to torture or to inhuman or degrading treatment or punishment. The State must itself refrain from subjecting anyone within its jurisdiction to treatment or punishment that meets the 'threshold' of being torture, inhumane for degrading treatment

3.1.4.2 The State should have laws in place to adequately protect vulnerable group from ill-treatment.

3.1.4.3 The State should have procedural procedures in place to enable effective investigation to be carried out in a prompt and independent manner leading to sanctions for any violation.

3.1.4.4 Everyone has the right to liberty and security of person. No one shall be deprived of his liberty in accordance with a procedure prescribed by law – exceptions Crime, infectious disease, persons of unsound mind

3.1.4.5 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court

3.1.4.6 Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

3.1.4.7 No one is deprived of liberty in an arbitrary fashion. Deprivation of liberty is not confined to the classic case of detention following arrest or conviction, but may take numerous other forms (i.e. the placement in social care institutions).

4.0 Assessment

4.1 The decision to use restrictive practices should be appropriately assessed and subject to ongoing review. Carrying out a comprehensive assessment of a person's health and social care needs is a key requirement to ensure that care is appropriate and safe.

4.2 In the context of the use of restrictive practices, an assessment should gather information on what current practices in relation to the person's care could be considered restrictive. SOS adopts a questioning attitude to any restrictive practices that are in place prior to a person being admitted to a service. This will ensure that practices that have become routine or that are institutional in nature will be reconsidered in terms of their necessity and proportionality.

4.3 Over time, people's needs and requirements for support change — therefore ongoing assessment and review are essential to ensure that a person is receiving good care.

4.4 Assessments should be multidisciplinary and may include the following:

4.4.1 physical and functional assessment

4.4.2 psycho-social assessment

4.4.3 assessment of the physical environment

4.4.4 Assessments for delirium, depression and dementia.

5.0 Consent

5.1 In line with the Assisted Decision-Making (Capacity) Act, 2015, capacity should be viewed in functional terms. Where a person lacks decision-making capacity in one matter at a particular time, it does not follow that they lack capacity in other matters or at another time. The capacity of a person supported should be subject to ongoing and frequent review.

5.2 People supported are empowered to exercise choice in their day-to-day lives, including partaking in activities that may involve an element of positive risk-taking. SOS will so far as is practicable facilitate a person's choice and preferences as long as there is a sensible balance between their individual needs and preferences and the safety of themselves and other people giving in the house.

5.3 In keeping with the person-centered approach SOS will seek the informed consent of people prior to any use of restrictive practices.

5.4 In order to obtain consent, SOS will clearly explain the rationale for using any form of restrictive practice and outline the potential risks.

5.5 This information should be communicated to people supported in a format that they can understand.

5.6 Where a person does not have the capacity to consent, SOS will consult with the person's legal representative. Where there is no appointed legal representative, SOS will seek to consult with someone who would know the person's will and preference or a suitable independent advocate to ensure that the plan of care respects the resident's privacy, dignity and rights.

5.7 There may be occasions where a person requests the use of a restrictive practice. An example of this is where someone asks for bedrails to be put up as they feel it is safer and prevents them falling out of bed. In such circumstances, SOS will strive to meet the needs and preferences of the person while also ensuring that they are fully aware of the potential risks of using any form of restraint and the available alternative approaches.

5.8 The provider should ensure that the person supported is fully aware of any potential risks such an intervention may pose in order that they can make a fully informed choice and decision.

5.9 Circumstances may arise where it is necessary to use a restrictive practice without the person's informed consent. This can happen in an emergency situation where it is necessary to prevent harm or immediate danger to the person or other people. In cases such as these it is important to hold a de-briefing session as soon as possible after the event.

6.0 Prohibited Practices

6.1 These are practices that may **never** be used and any use of these practices may result in disciplinary action. Examples of such practices include, but are not limited to:

6.1.1 Corporal punishment- the deliberate infliction of pain intended to punish a person or change his/her behavior.

6.1.2 The withholding of food or deferral of meal.

6.1.3 The withdrawal of personal possessions

6.1.4 The withdrawal of the right to go home or to contact home. Using conditions of discomfort (e.g. leaving a person in wet/soiled clothes: creating an uncomfortable environment to encourage movement/compliance)

6.1.5 Acts of harassment, threats, humiliation, derisory or sarcastic comments, constant shouting or verbal abuse.

6.1.6 Withdrawal of opportunities to engage in social activities.

7.0 Restrictive Practices

7.1 When it is appropriate to use restrictive practices:

7.1.1 While SOS strives to deliver care in a restraint-free environment the use of restrictive practices may be warranted when there is a real and substantial risk to a person and this risk cannot be addressed by non-restrictive means. A restrictive practice is used to prevent more serious harm occurring. Examples of this may include:

7.1.1.1 Looking the door of a kitchen area where a person may be assessed as being at risk of injury from scalding or coming into contact with harmful chemicals

7.1.1.2 applying a mechanical restraint to a person during transport to prevent them unfastening their seat belt

7.1.1.3 Physically holding a person back to prevent them causing harm to another person.

7.2 Definition- A restrictive procedure is a practice that:

7.2.1 Limits an individual's movement, activity or function

7.2.2 Interferes with an individual's ability to acquire positive reinforcement

7.2.3 Results in the loss of objects or activities that an individual values or

7.2.4 Requires an individual to engage in a behaviour that the individual would not engage in given freedom of choice (HIQA Guide to Designated Centers: Restraint Procedures 2016)

8.0 Restrictive Procedures include –

8.1 Physical or Mechanical restraint, in which a person or a mechanical device restricts a person's freedom of movement or access to their own body Examples include:

8.1.1 The use of bed rails which may be an acceptable restrictive practice

8.2 Chemical restraint, is the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the condition or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes.

8.3 Environmental restraint, is the intentional restriction of a person's normal access to their environment, with the intention of stopping them from leaving. Includes denying a person their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties.

8.4 See Appendix 1 for examples of restrictive practice.

9.0 Implementation of Restrictive Practices:

9.1 Implementation of Restrictive Practices must be considered by the SOS Human Rights Committee and must have a risk assessment conducted.

9.2 Restrictive practices should never be used to ameliorate any deficiency of service, lack of professional skill of defects in the environment.

9.3 All alternatives must be attempted before restrictive practices are used.

9.4 The use of evidence based best practice as the benchmark for alternatives to restrictive practices must employed and at all times the implementation of evidence based practice prior to or concurrently with restrictive practices as a means of reducing or removing the restriction must be explored. .

9.5 The least restrictive effective intervention must always be used, as a last resort, for the minimum amount of time, in the least restrictive environment by committing to the following actions:

9.6 A restrictive practice may only be implemented when there has been consideration of the impact of the intervention on the rights and wellbeing of others who share the person's environment

9.7 The restrictive practice is considered in the context of the person's behavior support plan.

9.8 The person must provide informed consent in relation to all matters that affect them and understands the nature and consequence of their consent. When there is uncertainty about the person's capacity and there is an absence of engaged family members, carer advocate, SOS will seek the advice of Sage or another Independent Advocacy Service.

10.0 Restrictive practice/intervention should only be used;

10.1 In the event, that there is an immediate risk to the person or others.

10.2 In conjunction with clinical supports and behaviour support plans, where necessary, (e.g. occupational therapy may be required in one case, psychology in anther, behaviour support in another.)

10.3 When staff are trained in the prevention and use of restrictive practices.

11.0 Risk Management Process for Restrictive Practices.

11.1 There are occasions where a person may wish to partake in an activity which may carry a certain element of risk (for example, a bicycle ride or a cookery course). This is sometimes referred to as positive risk-taking. It is important that people are supported to live meaningful lives. Part of living a meaningful life involves an element of risk. The potential risk (injury) against the benefits to the person (enjoyment, learning new skills, socialisation) must be considered. If a person chooses to partake in something that involves a level of risk, and they are aware of these risks, then SOS should be supportive of their choice. SOS will undertake a full risk assessment to identify where they can mitigate the risks while still supporting the person to undertake the activity.

11.2 All restrictive practices must have a 'Risk Assessment' conducted in conjunction with the individual (where applicable), staff and management of the individual department and / or house. Consent must be given by the individual, their carer or family member for a restrictive practice to be implemented.

11.3 Risk assessments carried out on an individual must be filed in the individual's personal file, risk assessments carried out pertaining to the environment, and / or generic items must be filed in the department / house Risk Register folder.

11.4 All 'Risk Assessments' must be signed by the individual (when possible), staff, front line manager and senior manager for the particular area.

11.5 It is the responsibility of the programme / department manager/team leader to determine the level of risk present and ensure that the risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the individuals quality of life have been considered.

11.6 It is the responsibility of the programme / department manager to determine the time frame for each risk assessment based on the level on risk outlined in the risk assessment, i.e. twelve months / six months / three months or a shorter period depending on the circumstances. No restrictive practice should be in place longer than 12 months without a review with multi-disciplinary input in order to negate the requirement of the restrictive practice.

11.7 Action plans within the 'Risk Assessment' that indicate the need for a restrictive practice to me implemented must be referred to the appropriate senior manager in order for decisions to be taken to manage the risk identified. (I.e. it may require additional resources)

11.8 The completed risk assessment must be brought to the attention of all staff working in the area in a clear and understandable manner taking account of the level of training, knowledge and experience by the line manager.

11.9 Review to take place quarterly on all risk assessments.

12.0 Emergency/Unplanned Restrictive Practices

12.1 While every effort is made to assess a person prior to the use of a restrictive practice, this may not always be possible. In cases of an emergency or crisis, it may become necessary to restrain a person in order to ensure their safety or the safety of others.

12.2 Restraint may also be necessary to facilitate a person receiving urgent medical care, with due regard to any advance healthcare directive which the person has in place.

12.3 In the event of use of an unplanned restrictive/ practice it is necessary that:

12.3.1 Staff have sufficient guidance and supervision in using unplanned restrictive practices.

12.3.2 Staff are trained in Studio 111 Low Arousal Techniques.

12.3.3 The minimum amount of force is used to ensure the safety of all involved.

12.3.4 The unplanned restrictive intervention is discussed at a review meeting and is followed up by a risk assessment and a plan detailing action to be taken in a similar situation drawn up which describes definitive criteria regarding future management of such incidents there can them be termed "planned interventions". These "planned interventions "will require consideration by The Human Right Committee.

12.3.5 A debriefing session for staff to offer support following any unplanned restrictive practice/intervention.

13.0 Recording

13.1 SOS Kilkenny Clg. collates all restrictive practices data on an "Organisational Restrictive Practices Register". [Appendix 3] This register located in the Risk / Restrictive Practice Register in the location and is managed and monitored by the Manager and sent to the CEO to be reviewed quarterly.

13.2 Each location maintains a "Local Restrictive Practices Register" [Appendix 4] which is managed by the programme manager or team leader. The information on this register in turn is populated onto the "Organisational Restrictive Practices Register".

13.3 A Person Supported Risk/Restrictive Practice Register [Appendix 5] is located in section 4 of the personal file with the Risk Assessments. This form is updated when a new risk assessment has been written or reviewed.

13.4 Individual Restrictive Practice Risk Assessments are reviewed quarterly as per the SOS Risk Management Policy guidelines.

13.5 Incidents of restraint are reported to HIQA in the Quarterly Returns in accordance with regulatory requirement

14.0 Staff Education and Training

14.1 SOS provides mandatory Studio III Low Arousal Approaches to Challenging behavior to all staff with refresher training every 3 years.

14.2 The Low Arousal Approach emphasises a range of behavior management strategies that focus on the reduction of stress, fear and frustration and seeks to prevent aggression and crisis situations. The low arousal approach seeks to understand the role of the 'situation' by identifying triggers and using low intensity strategies and solutions.

14.3 Studio III training includes training in the use of physical restraint-"The Walk Around".

14.4 Staff members are in receipt of supervision as per SOS Quality Conversations Policy.

14.5 Debriefing after critical incidents from their Manager/Team leader, Behavior Support and or Social Work Department.

15.0 Governance in High Support Areas and the Use of Restrictive Practices:

15.1 Staff are managed by a team leader/ manager who in turn is managed by an Assistant Director of Service, who reports to the Director of services. Areas of high support are supported by the behaviour support department to ensure behaviour support plans are up to date, reviewed and effective and learning from incidents put into practice. These areas are supported by monthly Studio III consultant psychology visits to discuss behaviour support strategies and promote reflective practice within the team. At a minimum monthly team meetings are observed or more frequently and are minuted.

15.2 Please see Appendix 2 for examples of alternative Non Restrictive Interventions.

16.0 Appendix 1: Examples of Restrictive Interventions:

16.1 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.

16.2 Locked cupboards/drawers. [e.g. cleaning products]

16.3 Delayed door opening systems.

16.4 Furniture arrangement to impede mobility.

16.5 Gates across entry points or stairs

16.6 Locked doors e.g. keypads, double handles, high handles on doors.

16.7 Modified clothing e.g. clothing designed to be difficult to remove or to prevent access to particular body parts.

16.8 Tied/restrictive clothing i.e. clothing designed to limit movement.

16.9 Hand/finger restraints e.g. gloves, mitts.

16.10 Elbow/wrist restraints e.g. splints, gaiters, wrist cuffs.

16.11 Transfer belts or child reins.

16.12 Removal of footwear, walking aid or wheelchair. Turning off powered wheelchair.

16.13 Removal of aids required for communication e.g. glasses, hearing aids, communication aid. Switching off the power on a person's alternative or augmentative communication device.

16.14 Trays/tables in front of chairs/beds (except for the period of time that they are used for purposeful activities or meals).

16.15 Chair/wheelchair tilted backwards.

16.16 Cot/bed side-rails or high sides for any person over 4 years of age.

16.17 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.

16.18 Bus/car harness / Child locks

16.19 Wheelchair/buggy/armchair/shower-chair/toilet/ straps & harnesses. *Association of Occupational Therapists of Ireland (AOTI) Practice Guidelines (2010)*

17.0 Appendix 2 Examples of Alternative Non-Restrictive Interventions:

17.1 Good environmental design e.g. points of interest provided in the building,

17.2 natural flow through the building, avoidance of 'dead ends', use of color/surface treatments to designate areas, use of visual symbols, open access to safe outdoor space, clear line of vision for staff in communal areas.

17.3 Padding the environment e.g. furniture, doorways, walls.

17.4 Temperature, light and noise levels monitored and controlled

17.5 Overcrowding avoided.

17.6 Use of calm or relaxing environments (e.g. quiet room, multi-sensory room).

17.7 Subjective barriers instead of locked-of areas e.g. cloth panels/covers to camouflage doors or door knobs.

17.8 Mattress on the floor or a low-to-floor bed

17.9 Purposeful activity that is meaningful for the person and provides the appropriate level of stimulation.

17.10 Opportunity for physical exercise.

17.11 Exploration of the person's 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).

17.12 Communication strategies e.g. object of reference, PECS, visual timetables.

17.13 Psychological strategies e.g. social stories, transitional objects.

17.14 Sensory strategies e.g. sensory diets etc.

17.15 High densities of social reinforcement delivered throughout the person's day.

17.16 Avoidance of situations known to provoke behavioural issues for a person.

17.17 Positive behavioural support plans and care plans kept up-to-date and containing current risk assessments.

17.18 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.

18.0 SOS Policies

18.1 This policy is read in conjunction with the SOS Risk Management Policy

18.1.1 Policy & Procedure for Safe & Responsible Medication Management

18.1.2 Policy of Behaviours that Challenge

18.1.3 Safeguarding Vulnerable Adults

18.1.4 Human Rights Handbook

18.1.5 All supporting documentation is available on the Data Management System

19.0 References/Bibliography

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19.2 Association of Occupational Therapists of Ireland, (2010), *Best Practice Guidelines for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities*

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19.5 COPE Foundation (2008) *Vision 2013: Strategic Direction 2008-2013* Department of Human Services (DHS), State Government of Victoria (Australia) (2007). *Disability Act 2006: Restrictive Interventions Implementation Guide.*

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19.9 Mental Health Commission (2006a*), Mental Health Commission Rules Governing the use of Seclusion and Mechanical means of Bodily Restraint.* Mental Health Commission (2006b) Mental Health Commission Code of Practice Reference Number: COP-S33 (3)/02/2006; *Code of Practice on the Use of Physical Restraint in Approved Centres.*

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19.11 Paley, S. (2008). *Use of Mechanical Devices: restrictive physical intervention principles for practice*. British Institute of Learning Disabilities.

19.12 Rickard-Clarke, Patricia T., (2017) *Person centred Master Class, Deprivation of Liberty*, Sage Support and Advocacy Service

19.13 Sellars, C. (2005), *Risk Assessment in People with Learning Disabilities*. PBS Blackwell: Oxford.

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19.15

[Source: Code of Practice for the Elimination of Restrictive Practices;
***Disability Services Commission Australia*; Accessed: 14.02.2018]**

Restrictive Practice

The definitions for the terms 'restrictive practice', 'chemical restraint', mechanical restraint, 'physical restraint and 'seclusion' are from the 'National Framework for Reducing and Eliminating the Use of Restrictive Practices' (2014).

A 'restrictive practice' is defined as any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm.

Chemical restraint

A 'chemical restraint' means the use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment, of a diagnosed mental disorder, a physical illness or physical condition.

PRN medication

Most medications are prescribed with instructions that they should be taken once in the morning, three times a day, etc. The term 'PRN' is a shortened form of the Latin phrase, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that is not to be taken at regular times but only at times when it is necessary that symptoms are relieved.

Environmental restraint

An 'environmental restraint' restricts a person's free access to all parts of their environment. Examples of environmental restraints include but are not limited to:

- barriers that prevent access to a kitchen, locked refrigerators and restriction of access to personal items such as a TV in a person's bedroom

- locks that are designed and placed so a person has difficulty in accessing or operating them

- Restrictions to the person's capacity to engage in social activities by not providing the necessary supports they require to do so.

Mechanical restraint

To be consistent with the international research evidence, it is important to differentiate mechanical vs. physical restraints. A 'mechanical restraint' means the use of a device (may include any mechanical material, appliance or equipment) to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes. For

purposes may include the use of a device to assist a person with functional activities, as part of occupational therapy, or to allow for safe transportation.

Physical restraint

A 'physical restraint' means the sustained or prolonged (e.g. a physical force or action lasting longer than approximately 30 seconds, that is not a reflexive manual restraint) use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing a person's behaviour. Physical restraint is distinct from the use of a hands-on technique in a reflexive (e.g. momentary contact to guide or redirect a person, lasting for no more than approximately 30 seconds) way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

(McVilly, K, 2008, 'Physical restraint in disability services: current practices; contemporary concerns and future directions'. A report commissioned by the Office of the Senior Practitioner, Department of Human Service, Victoria, Australia)

Organisational Restrictive Practice Register
Review Quarterly / January – April – July – October
To be completed and copied to CEO by Team Leader/Manager at the end of each quarter.

Signed By;_____Date:_____
Role: _____ _____ Designated Centre: _____ _____

Type of Restrictive Practice • Environmental • Physical • Mechanical • Chemical	**Details of Restriction**	***Number of People impacted***	**Person Supported Unique Identifier Number**	**Date Assessed**	**Risk Rating**	**Color Code**	**Review Date**	**Referral to Human Rights Committee Y/N Date Agreed**

Local Restrictive Practice Register
[Details of any occasion where restraint was used]

***Designated Centre*_____** ***House/Location*_____**

Type of Restrictive Practice • Environmental • Physical • Mechanical Chemical	***Number of People impacted***	***Details of Restraint***	***Frequency of Use***	***Impact on Person/s Supported***	**Person Supported Unique Identifier Number**

Person Supported Risk / Restrictive Practice Register
Review Quarterly / January – April – July – October

Person Supported_____

Type of Risk Assessment	Restrictive practice Y/N	Date Risk/ Restrictive Practice Assessed	Risk Rating	Color Code	Review Date	Risk Assessment on File Yes/No	Quarterly Review Form completed Y/N	Impact on the person supported	Referral to Human Rights Committee Y/N	Date intervention was agreed