NON Restraint Policy

NON RESTRAINTS POLICY: Our policy focuses upon reducing and managing challenging behaviours rather than to restrain. If we have to restrain someone, then we are unable to manage their behaviour and need to refer to a higher level of care. All staff are made aware of our policy at Induction. The standard aims reduce the use of restraint and to ensure that it is used safely. **Enablers** may provide a person with physical support [postural] or support them feeling safer [bed rails]. These we consider differently and each on its own merit.

REFERENCES:
SNZ 8141: 2007
The Code of Health and Disability Services Consumers' Rights
Health & Safety Policy / Resource: Managing Challenging Resident Behaviour

Informed Consent & Advanced Directives Policy
Privacy Act 1993 / Policy Privacy & Dignity
Interpreter Policy

Definitions of Restraint

Restraint is the implementation of any forcible control by a staff member that;
Limits the actions of a resident in circumstances where the resident is at risk of injuring himself or herself or another person. It intentionally removes their normal right to freedom / or prevents normal access to parts of their own body.

Restraints can be:

Personal – such as being physically held

Physical – such as the use of furniture or equipment e.g. geri tables & cot sides

Enablers – where the resident voluntarily uses equipment to assist them to maintain independence such as a chest harness in a wheelchair, which supports posture and prevents the person slumping forwards.

Chemical Restraint

This is the use of medication to render a person **incapable of resistance**. Such medication is not prescribed by the home; rather, prescriptions are limited to those with valid indicators.

Environmental – where the resident is put in an environment that reduces their level of social contact and/or environmental stimulation. E.g. Dementia Unit.

Seclusion – placing a person at any time and for any duration alone in an area where he or she cannot exit freely. E.g. locking someone in their room.

* Chemical restraint and seclusion are not supported by the policy of this Home in any way.

* As no restraints are used, we do not maintain a Restraint Log.

1.1.1 Please tick which boxes apply:

❑ **The policy of the Home is not to restrain anyone.** The Home is committed to caring for its residents without holding or restraining them unless it is to enable greater independence & wellbeing as agreed in Care Planning. Personal Restraint is where a staff member personally holds someone – this may be to stop them from harming another person or to remove them from an area. This is NOT supported by the policy of the Home. Any incidences are recorded on **DOC - 05 C C**hallenging Behaviour Form. This must be reported to a Manager or Team Leader IMMEDIATELY. It is viewed as staff and resident needing immediate support:

⇒ Staff have failed to manage a challenging behaviour

⇒ Holding someone is NOT viewed as safe for themselves or for that person.

⇒ Holding someone is more likely to escalate the situation [they will resist]

⇒ The person who was restrained now needs to have this infringement of their personal space and rights corrected [they are much LESS likely to be feeling safe or happy after being held].

⇒ Policy is to step away / to take others from danger / to avoid conflict rather to step in and dominate.

⇒ There was risk of skin injury, wrenched muscles, contact bruising.

The only possible exception to holding someone would be if they were confused and about to walk in front of a train or bus. Therefore, unless life is in danger, the policy of the Home is not to personally hold anyone without their permission.

❑ **We Practice Environmental Restraint** – the Home is a special unit for people who need a special environment. The unit is secure & residents cannot leave.

❑ **Bucket chairs may be used for very frail people** – they are seen as enablers as they allow the person to be in communal areas, participating socially, rather than in their beds.

❑ **Cot sides are used** ONLY because the resident requests them and does not feel safe without them. Support bars to aid standing are different from cot sides. They are not considered restraints.

❑ **Harness or other enabler may be used to promote independence.** Where its use restricts normal access to parts of a person's own body it must be considered a restraint. An example is a harness enabling a person to sit upright in their chair rather than slumping forwards because they cannot hold their trunk upright.

Identifying & Recording Restraint Usage in the Home:

⇒ Those requiring Environmental Support in specialised Dementia Units are recommended by Needs Assessment.

⇒ A Restraint Log is NOT kept for those using Bucket Chairs when they are unable to rise from bed or any chair due to frailty or incapacity. Therefore it is the disability rather than the chair that constrains them.

⇒ If cot sides are requested by the resident or their family [and approved] then they must be recorded on the Restraint Log. Sometimes people who have had cot sides for 'years' now do not feel safe without them and may feel that they 'need' them. The Home does not view them as ideal because of the risk of skin damage rubbing against them or confused people harming themselves climbing over them.

⇒ Use of enablers are recorded in the Restraint Log also. Harnesses or other enablers should only be used upon clinician recommendation, with the full informed agreement of the resident and their family and only according to instructions agreed in Care Planning.

⇒ Feeding Tables that attach to the front of chairs are Physical Restraints unless the resident is capable of removing it themselves. Feeding Tables are not considered a restraint when a staff member is in the room and supporting the resident to enjoy their meal and the staff member can remove the table upon request. The moment that staff member leaves the room the resident is restrained. This kind of restraint is NOT supported by the policy of the Home.

Restraint Log

- ✓ The Restraint Log is a record of people who use restraints or enablers in the Home
- ✓ Logs date Restraint commenced & when it ceased
- ✓ Names people who were restrained

Risk Management

Use the Risk Management Form to guide assessment of risk for EACH restraint considered. Compare the risk of harm to resident with restraint to the risk of harm without it.

Consider both the **DEGREE** of risk and the **LIKELIHOOD** of harm.

↓ How badly ↓ How likely

Process for Identifying & Recording Restraint Use

In considering restraint use, all other alternative must be considered first.

- Consideration of restraint usage may be through resident request or clinician recommendation.
- We seek resident and family perspective for greater understanding.
- We need to evaluate the problems we are trying to overcome:
  - ⇒ Underlying causes [that may be able to be rectified]
  - ⇒ Look at previous use of enablers was successful or if others have been helped by using this proposed restraint'
  - ⇒ Include contradictions to the use of restraint, e.g. cultural
  - ⇒ Be guided by any existing Advanced Directives
  - ⇒ Consider the benefits of using the device / chair
- We consider all possible alternatives to restraint **FIRST**.
- We need to assess adequacy of staff training and education for the proposed restraint.
- Consider the risk of any restraint versus not using any restraint.
- If care is likely to be enhanced and risk reduced then the resident and / or their family sign approval for the restraint. They also need to be part of ongoing review where ever this is possible.
- All parties agree when it might be used.
- Frequency of monitoring, observation and evaluation is decided according to risk.
- One person must assume the role of Restraint Coordinator for that restraint to monitor and review its usage if it is agreed upon.
- The restraint is documented in Care Planning
- Staff are made aware of care in using the restraint, limitations and possible risks

Checklist:

What are the possible alternatives?

Have we considered the least restrictive way to solve the problem?

Have we assessed the **Risk** with the restraint and the **Risk** without the restraint [use form on the next page]

Have we considered Resident Rights & Feelings

Have we assessed the risk of infringing on cultural grounds

The Home prefers NOT to restrain. If someone needs restraining on behavioural grounds to keep them safe then assessment to go to a higher level of care may be needed.

Restraints Risk Assessment Form: R- 01

To be used PRIOR to deciding ANY restraint usage.
Alternatives have been considered and there is NO Less restrictive restraint available

Please score in box to give Assessed Risk e.g A1 Life threatening and likely, or C3 Minor and unlikely (remote possibility)

SCORE

WITHOUT RESTRAINT

HARM	LIKELIHOOD
A life threatening	**1** likely
B serious injury	**2** possible
C minor injury	**3** unlikely

SCORE

WITH RESTRAINT

HARM	LIKELIHOOD
A life threatening	**1** likely
B serious injury	**2** possible
C minor injury	**3** unlikely

Risk may be minimised by:

[e.g. applying pads to limbs, soft pillows, lowering height beds chairs, providing entertainment (books or music), regular supervision, other resident company, ameliorating cultural risk etc]

As many members of the Restraint Group as possible should contribute to the risk assessment

Designation / Role
[Family, doctor, RN, caregiver, etc]

Sign:_____ _____

Sign:_____ _____

Sign:_____ _____

Review co-ordinator:_____[name] Desig: _____

Must be reviewed before:_____[date]

Assessment

1.1.2 Collaborative Assessments

Assessments by staff, as discussed earlier, are more robust where outside experts are part of the process. The decision to restrain someone should not be taken lightly nor be the decision of one person alone. We need to look upon this person as we would our own parent and consider their feelings:

- Are we providing care where they feel comfortable and safe?
- What are realistic goals?
- Why there is a problem and what happens to cause it?
- How the resident / service user feels about this.
- Are there any early signs that warn us so we can PREVENT the problem?
- Does the resident feel safe? Are they safe?
- Are they making others less safe?
- What LEAST restrictive restraint is being considered?
- How might that affect the resident / service user and their family?
- Have the family been part of the risk assessment & planning process.
- If we do minimise the risk of the restraint [make it safer – e.g pillows under legs of frail person in bucket chair, protective stockings.
- Specific cultural needs and how these would be best met

Cultural Recognition

When considering the need for restraint needs of all cultural groups must be taken into account. Staff need to understand the resident's beliefs to minimise the risk of cultural infringement during the use of restraint. Where the resident and their family are part of the planning process this is a learning curve for everyone and counselling is part of this process. External cultural advice may need to be sought. In the most unlikely event that objects of religious or cultural significance needed to be removed, because resident safety was compromised, we need to re evaluate what we are doing? Our policy is not to remove items of particular significance from people. Cultural needs of residents' must be known and met during restraint use. This generalises to all cultures.

1.1.3 Use of Enablers

Geriatic or Bucket Chairs / Harness for Disability Wheel Chair:

Use is documented in Care Planning. Resident Dignity & Privacy is of paramount importance.

Monitoring frequency is agreed among all stake holders

Reviews are documented as part of ongoing Care Planning

Please follow the general guide on the next page

General Guideline for the use of Bucket Chairs

Candidates:

♥ The resident is not able to sit up in a lounge chair or on the couch without falling over or off it.

♥ The resident is unable to get up from an ordinary bed or chair [therefore it is not a restraint it is an enabler]

♥ Residents who would otherwise be left in their beds are now enabled to be in the common rooms and participate in activities and daily events.

↯ Not to be used to keep resident in one place and 'cast' unable to get up.

↯ Not to be used for mobile residents unless:

- The chair helps elevate their limbs for medical reason
- They can get out themselves

Length of Time in the Bucket or Geriatric Chair

♥ No more than two hours without a change of position

♥ Changes of position must be made in the residents' own room [return the chair to the room]. NO TURNING PEOPLE IN THE LOUNGE or treatment rooms.

♥ Small adjustments to position and pillows ARE permitted / expected in the lounge.

♥ Ensure natural body positioning as close to stroke position as possible according to resident need.

♥ NEVER crank the resident neck forwards with fat pillows [it is likely to hurt later].

♥ Check continence at each change of position and support the resident as needed.

♥ Help the resident with passive exercises [this enhances comfort and reduces stiffness]

Positioning:

Left side / right side / back alternating according to resident comfort and need. Longer time may be spent in favoured or more comfortable positions. When on left or right side the resident is only partially to either side rather than completely on the side.

Guideline for Harness for use in Disability Wheel Chairs:

Harness should be fitted and recommended by Occupational Therapists / Specialist doctors.

Please seek specific guidance in the Harness form the issuing Health Professional.

Harness prevents access to other parts of the body so this will need to be carefully considered.

Length of time harness may be on will differ individually.

1.1.4 Managing Challenging Behaviour & Restraints Training

Staff learn our non restraint policy at induction and when 'buddied' with other staff prior to commencing work proper.

Managing Challenging Behaviour & Restraints Training is offered to all staff at least annually AND when ever incidents show that staff are not coping with resident behaviour OR when staff are witnessed behaving in a "NON conciliatory" manner towards residents.

Competency is assessed as part of training, and through incident reporting. **Personal restraint** is not endorsed by the Home, so rather than teaching holding techniques, we teach 'de-escalation' and 'struggle avoidance'. Staff are trained to move people to a place of safety and call for help where faced with violence.

For example: A resident is disagreeing with a staff member and has cast her plate of food in the direction of the staff member. If that staff member walks away from the resident [without reprimand] then the resident is left with no one to fight with. Staff should NOT challenge this resident – just check that other residents are OK and leave the person in peace. A competent staff member should approach, when the time is right, with a different agenda, ignoring the plate, softly and kindly to rebuild trust. Had the staff member reprimanded the resident [escalating the situation] a training session for ALL staff would need to follow.

Annual Restraint Training includes:

- Definition of Restraint / our NON Restraint policy & procedures
- Types of restraint
- Legal aspects of restraining
- Resident safety & risk assessment
- Challenging Behaviour & communication techniques
- Aversion versus non aversion techniques – ethical issues
- Alternatives to restraint use
- De-escalation techniques [see Managing Challenging Behaviour Training Module Seven]
- Comprehensive assessment – description, history, antecedents, consequences.
- Rights of family & family involvement
- Record keeping
- Physical, psychological & cultural risk
- Increased need for dignity privacy & cultural safety

Understanding is tested with an assessment of knowledge. See Training Module Eight [Non Restraints] Trainers Resources.

Round Table Training for Difficult Behaviours

Where staff are finding individual residents difficult to manage, training may focus upon these residents. Incident Reports on DOC – 05 C call attention to incidences of Challenging Behaviour. We have categorised Challenging Behaviour:

- Struggling with or Hitting [kicking or biting] another person. Hitting or kicking a table or walls or throwing an object.
- Yelling [name calling or unwelcome remark] [pointing of fingers & raised voice]
- Leaving the Home without telling anyone
- Repetitive Behaviours including need for cigarettes or wandering and awake at night or repeat incontinence that distresses staff
- Needing or expecting additional care beyond what staff are able to provide
- Unwelcome touching or advances

Challenging Behaviour needs clear documentation in Care Planning so that staff are guided:

⇒ Round table discussion makes for a unified plan

⇒ It helps staff realise ALL aspects of a resident problem

⇒ Staff are encouraged to see the Resident as a Person with NEEDS someone that a family loves and cares about and to learn about their lives.

⇒ If everyone shares the same approach we may succeed better.

⇒ Communication problems are considered. Staff may not understand the needs of residents with challenging behaviours.

⇒ Round table discussion realises resident need over 24 hours rather than on individual shifts [e.g. slept all day no problem at all until the night shift]

⇒ Family members or some staff may know much more about this resident and therefore understand their problems

⇒ Some staff will need more support than others – this is evidenced by challenging behaviours only happening on one shift or when certain people are on duty.

⇒ Staff who are less "conciliatory" may find that a "bossy" approach earns more resistance from residents. These staff need to be helped to realise that it is their behaviour, not that of the resident, that needs to change. Where there is a problem with challenging resident behaviour it is a good idea to ask which staff member does NOT have a problem with this person – then ask how they care for / deal with this person.

Training Program Managing Challenging Behaviour & Restraints

At Induction
AIM: Staff realise that restraint is not supported by policy of the Home.

Staff learn residents with special needs re behaviours and understand how these are best managed.

Challenging Behaviour Training

AIMS: Know categories of Challenging Behaviour:
- Clear about what how to report
- Understand about triggers to behaviours
- De-escalation Techniques
- Non coercive communication

Restraint Training

AIMS: Know definitions of restraint:
- Clear about what comprises restraint & enabler
- Collaborative care including Communication
- Good knowledge of Alternative Interventions to Restraints

Additional Training

AIM: For staff to understand the needs of new people arriving in the Home

For staff to understand those with greater needs:
- Dementias
- Brain injury or disability

Tests Understanding

AIM: Assessments of knowledge will test basic understanding:
- Recognising triggers
- Defusing
- Conciliatory approach
- Meeting basic needs

NZQA Training needed for those working in Dementia Units.

Assessment of Knowledge

AIM: Can fill in forms competently recording incidences of Challenging Behaviour

Problem Based Learning where groups solve common situations staff might face.

Assessment of Knowledge

AIM: Understanding of the use of enablers.
To realise legal responsibilities

Problem Based Learning where groups solve common situations they might face.

Assessments of Knowledge

AIM: To gain training to the level required for the setting

Good understanding of an Environmental Approach to Behaviours

External Expert Training & Resources are utilised.

Guideline for the use of Bucket Chairs

Work Instruction

Guideline for Managing Challenging Behaviours and Keeping Safe

Restraint Flow Chart

www.HH.NET.nz

FREE DOWNLOAD
[work instructions]

Training Resources from External Trainers:

DHB
Experts

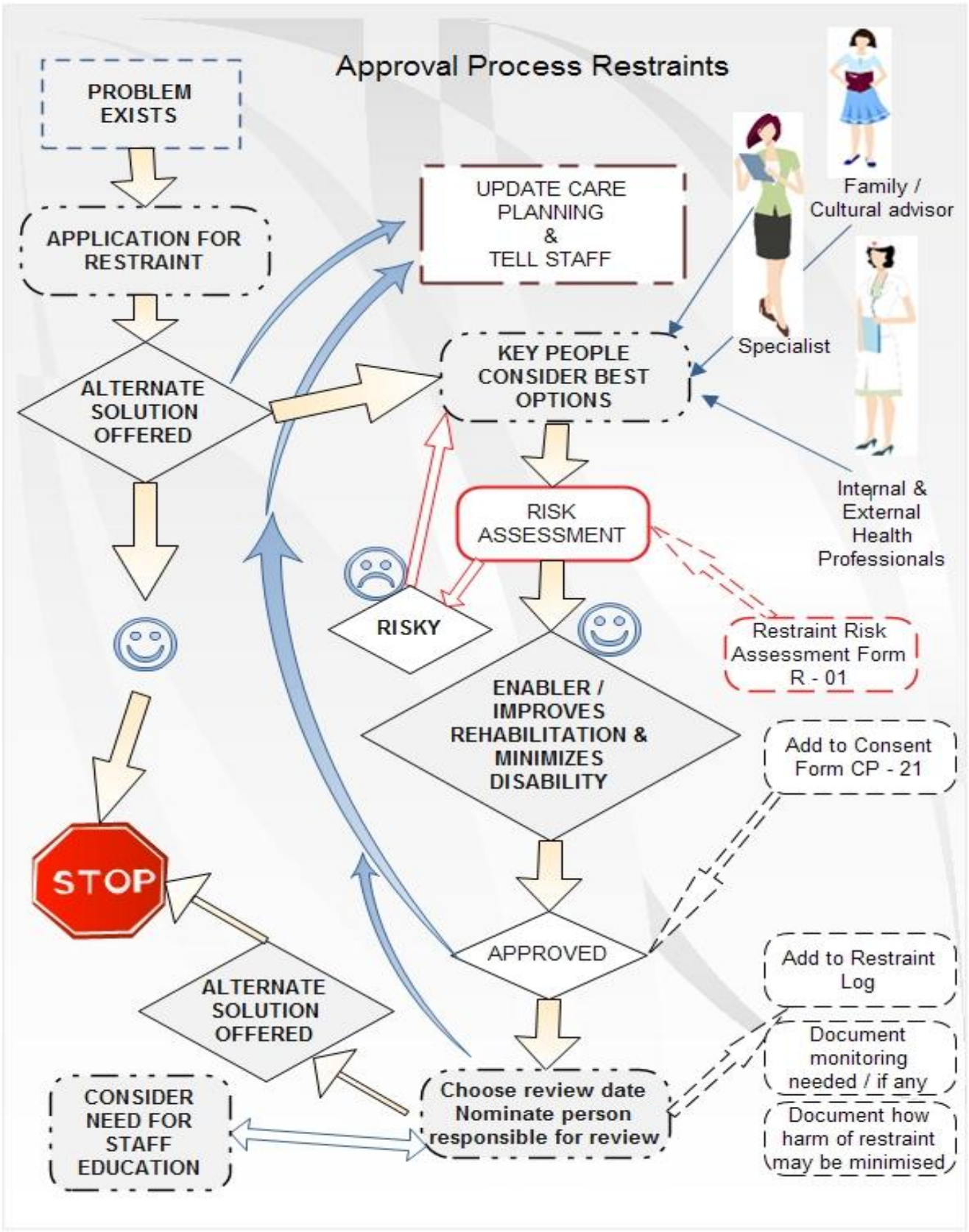
2.1 Safe Restraint Practice

2.1.1 Induction & ongoing education teaches the Home's restraint policy:

Any restraint mustmust FIRST be APPROVED

⇒ If residents or their family request restraint [such as cot sides] these must first be approved.

⇒ Follow Restraint Approval Flow Chart:



2.1.2 Documentation for approved enablers:

⇒ Resident Review Meeting Form may be used to document multidisciplinary discussions [Form CP – 11]

⇒ Restraint Risk Assessment Form [R – 01]

⇒ Restraint Consent Form [R – 02]

⇒ Care Planning will Document the Enabler Use

- Care Planning will describe least restrictive methods of care possible for the resident.
- Use of any form of restraint must give clear explicit instructions
- This will include when to use, how to apply and guides to duration of usage

2.1.3 Review of the approved [restraint] enabler is decided according to:

⇒ The likelihood of harm from using bucket chair, harness or cotsides.

⇒ Scope for improvement

⇒ Possibility of decline in condition

⇒ New products becoming available or affordable that are superior

⇒ First review date MUST be decided when the enabler [restraint] is approved.

⇒ The next review date is nominated each review.

⇒ Reviews should be brought forward if the enabler / restraint is no longer needed or no longer working or a less restrictive alternative becomes available.

⇒ Two years is the maximum permitted time between reviews.

One person assumes responsibility as coordinator for each enabler in use.

For example the RN, physiotherapist, team leader or other nominated role. If the person filling this role is replaced the new person carries the responsibility as the coordinator.

2.2.1 Assessments

The policy of the Home is not to restrain. This includes personally holding someone.

Suitably skilled advice is sought for the management of:

- Physical disabilities where a device promotes independence
- The risk of a resident harming themselves or others and key indicators [staff alerts]
- Assessments are comprehensive and include family and other support people as much as possible. Care planning incorporates culture, background, gender etc comprehensively]
- Assessments also take into considerations past history of trauma both physical and emotional that a person may have suffered.
- These are considered greater reason for NOT restraining

Consent Form for Use of Restraint [R – 02]

Name of Resident: Date:

Type of restraint:

Reason for restraint use:

- Bucket chair [an enabler that allows greater participation in the social program]
- Harness [enabler that assists to sit upright in a chair rather than falling forward].
- Other:

I feel that I fully understand and support device or method described above. I understand that this is the LEAST restrictive option available at this time.

☐ I consent to the recommended restraint being used under the conditions specified in Care Planning.

☐ I feel that I understand the risks of NOT restraining compared to the risks of restraining _____ and have decided NOT to restrain is the best option.
Resident / Family or Advocate

To be completed by the resident/ resident's welfare guardian / family advocate.
NB: The risk of falling, or other injury, may be preferred to the risk associated with restraint.

Signature:_____ Date: _____

Print Name: _____

Additional Comment / Monitoring Requirement / Method of minimising risk of harm [e.g soft pillows under legs].

RN / Manager's signature: _____ Date: _____

Team Member signature: _____ Date: _____

Doctor's signature: _____ Date: _____

2.0 Restraint is not practiced for behaviour control

Quality Review of Restraints

The Home conducts an annual Quality Review of restraints. As no one in the Home is restrained focus is generalised towards Managing Challenging Resident Behaviours. The Manager usually calls upon external consultant for support with this review. If service users / residents are restrained then the review may be six monthly. These are the set agenda items:

1. Type volume frequency & duration of any enablers in the Home
2. Compliance with policy. Checklist for each enabler:

- ☐ Dignity & Respect
- ☐ Resident Rights
- ☐ Privacy
- ☐ Advocacy (family)
- ☐ Culturally appropriate
- ☐ Recognising special needs
- ☐ Assessment is ongoing
- ☐ Approval processes, policies and procedures.

3. The alternatives to restraint that have been identified as part of the plan of care.
4. Communication effectiveness with family / family participation for the enabler. Those showing challenging behaviours are discussed individually.
5. Support provided to residents and staff involved.
6. The effectiveness of individual Care Planning where there are behavioural problems.
7. Monitoring & observations.
8. Staff competency and training includes assessing the competence of trainers.
9. The appropriateness and effectiveness of restraint related education and education for Challenging Behaviours..
10. Progress towards a restraint free environment.

Quality review findings and recommendations are used to improve our service and resident safety considering current Best Practice Guidelines.

3.0 Seclusion is not practiced in the Home.

Restraint Register

Log Number	Name of Resident	Date Restraint Commenced	Date Restraint Ceased
1.			
2			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16			