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1.0 POLICY:

Sunbeam House Services (SHS) is committed to the provision of Positive Supports for individuals with intellectual disability. It is committed to respond using non-aversive and non-restrictive strategies. It is the policy of SHS to use Restrictive Practices as an intervention of last resort. In line with best practice, the least restrictive strategy for the least amount of time should always be used. The health, safety, welfare and rights of individuals (clients and staff) should always be considered paramount. The use of any form of restrictive practice should only be used if an individual poses a significant threat of serious harm to self or others and there is evidence that all other means have been considered and deemed ineffective, or in the event of an emergency, it is the least restrictive but only method that safeguards the person and/or others.

SHS require that clients are protected from all forms of abuse, including misuse of restrictive practices. Anyone with concerns in respect of the possible misuse of restrictive practices in a location should immediately report it to the Client Services Manager (CSM) or Senior Services Manager (SSM).

The circumstances in which restrictive practices are never used:

- To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual.
- Solely to alleviate operational difficulties or to maintain a smooth running programme, including where there are staff shortages.
- With an individual with a known medical condition, in which restrictive practice is contraindicated in the individuals risk assessment/behaviour support plan.
- Where a functional assessment of the behaviour indicates that a restrictive practice would not be in line with their behaviour support plan.

Purpose

The National Standards for Residential Services for Children and Adults with Disabilities Standard 3.3 (Health Information and Quality Authority (HIQA), 2013) requires that, “People are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being required due to a service risk to their safety and welfare”.

This policy/procedure document is designed for use by teams supported by multidisciplinary staff who may on occasion need to consider the use of a restrictive intervention to ensure the safety and welfare of a person(s) whom they support

2.0 SCOPE:

This policy is for all staff working with adults with intellectual disabilities in SHS.

3.0 LEGISLATION AND OTHER POLICIES

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

- Quality Measures. The Council on Quality and Leadership (CQL) 2005;
- Health Information and Quality Authority National Quality Standards: Residential Services for People with Disabilities, 2013;
- Towards a Restraint Free Environment in Nursing Homes, Department of Health (DOH), 2010;
- Best Practice Guidelines for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities, AOTI, 2010.
- Data Protection Act 1999;
- SHS *Complaints Policy*
- The Universal Declaration of Human Rights, 1948;
- The Mental Health Commission (MHC) – Code of practice, guidance for persons working in mental health services with people with intellectual disabilities, 2009

4.0 DEFINITIONS

4.1 **Restrictive Practices:** refer to the use of mechanical restraint, physical restraint, psychotropic medication as restraint for the purpose of behavioural control to prevent, restrict or subdue a person's movement (MHC, 2008, p.5).

4.2 **Non averise:** A strategy that the person likes, which also supports the person to exercise their rights.

4.3 **Non-restrictive**: A strategy which does not restrict the rights of a person.

4.4 **Behaviours that challenge**: Behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities. (Emerson 1998)

4.5 **Emergency Restrictive Reactive Strategy:** A restrictive reactive strategy that is used in an emergency. For example, holding the person by the arms when they suddenly run out on to the road; locking a door to prevent the person from accessing dangerous equipment in a kitchen.

4.6 **Environmental restraint** is the intentional restriction of a client's normal access to their environment, with the intention of stopping them from leaving, or denying a client their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties. The design, layout, equipping, and operations of SHS locations should be developed in a manner that maximises clients' capacity to exercise personal autonomy and choice.

4.7 **Multi-Disciplinary Team (MDT)** - When an issue arises that may give rise to the consideration of restrictive practices, best practice dictates that the staff do not act in isolation, but rather that a case management meeting is convened involving a wider multidisciplinary team, whose involvement will be necessary throughout the

assessment and intervention process to ensure that restrictive practice is used as a last resort and is the least restrictive possible. Potential team members might include, but are not limited to: Client Services Manager, Keyworker, Physiotherapy, Social Work, Nursing, Community Occupational Therapy, Community Speech and Language Therapy, Psychiatrist, Psychology, Behaviour Specialists, GP, day, residential or respite service staff as well as advocates on behalf of the person. For the purpose of prescribing mechanical restraint for behavioural purposes the MDT must include the discipline of Psychiatry/ Psychology.

5.0 ROLES & RESPONSIBILITIES

5.1 The Client Services Manager ensures:

- That access and support is provided to any individual who is involved in or witnessed a behavioural incident of a serious nature. This can be done informally, by facilitating a break and talking with the individual or formally through the Employee Assistance Programme (EAP).
- That training needs are identified in their area and highlighted to the training department.
- That a case management meeting involving a wider MDT is convened when consideration is being given to a restrictive practice (with the exception of emergency restrictive practices)
- That minutes are recorded for all case management meetings and the *Positive Behaviour Support Plan* is updated with the MDT decision.
- That a referral is made to the Rights Review Committee if a restrictive practice is agreed.
- That all *risk assessments* are recorded in the client's file.
- That Positive Behaviour Support Plans are in place where appropriate and reviewed as required.
- The staff in their locations are clear on their roles and responsibilities with regard to restrictive practices.
- A debrief is carried out following the use of a restrictive procedure with each person, their advocate and relevant staff members to review the use of the intervention and record the learning.

5.2 All staff ensure:

- That appropriate documentation is maintained in accordance with procedure being used.
- The restrictive reactive strategy is carried out as authorised by the MDT and outlined in the Positive Behaviour Support Plan.
- That they communicate effectively with families/other staff members and individuals as set out in the procedure.
- That they are familiar with the use of emergency restrictive practices, and reporting procedures are followed
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5.3 Multi-Disciplinary Team or Clinical personnel ensure:

- Appropriate clinical personnel together with the team directly responsible for the care of the individual authorise the restrictive practice in writing. Each service user who uses or has to abide by any restrictive practice should have a clearly outlined prescription for its use. The prescription should be a team based prescription and should specify the conditions for and duration of use, any special requirements and monitoring and review mechanisms. The prescription must include appropriate timeframes for reviewing the need and use of the restrictive practice. The prescription should be recorded in the individual's *Positive Interventions Plan*.
- There is evidence that the consent process has been adhered to.
- That no single opinion or report alone influences decision on authorisation of the restrictive practice.
- That local processes include a documented record of the full team's views which is brought to the attention of the prescribing members of the MDT.
- Authorisation is documented in the individual's Positive Behaviour Support Plan with an agreed review date in place.
- The strategy details the restriction to be implemented, the circumstances, the duration and any specific precautions.
- Authorisation of the restrictive practice is only agreed where a current physical/medical report or functional assessment does not contraindicate use of the restrictive practice. The MDT determines if a medical report is required.

5.4 Rights Review Committee ensures:

- That due process has been followed in imposing a rights restriction on an individual.

5.5 Monitoring:

Levels of aggression will be monitored by the staff team initially. Monitoring will also be carried out by Client Service Managers and Senior Service Managers. The SHS Protection and Safeguarding Committee will also monitor and conduct monthly trend analysis of all adverse events and prepare a report for the Senior Management Team (SMT). This monitoring process is essential in determining training needs/ support needs. The monitoring process will be carried out by the following:

- Daily records
- Adverse Incident forms
- Reports directly to CSM/SSM
- Report to Safeguarding Committee

6.0 PHYSICAL RESTRAINTS

6.1 Definitions

6.1.1 **Physical restraint** is the use of any part of the person's body for the purpose of stopping the person from engaging in a given behaviour. For instance, grasping the person so that the person cannot easily move. Thus, the individual is physically prevented from engaging in the behaviour for a period of time by means of bodily contact (Royal College of Psychiatrists Report,

2007). CPI training provided by the organisation demonstrates the limited types of physical restraint that may be used in emergency circumstances.

6.1.2 **Emergency use of Physical Restraint** is the use of physical restraint which has not been approved in advance and is not part of the agreed *Positive Behaviour Support Plan*. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation]. A review of the PBSP will be required in order to review the interventions.

6.2 Legal Background

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:

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

2. 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.

3. The extent of the restraint used must be proportionate to the risk of harm or injury.

4. 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.

5. The use of restraint beyond what is necessary to meet this purpose, may be found to be inhuman and degrading treatment of a client and constitute a violation of the client's 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."*

Security and monitoring systems in locations and the legal issues they give rise to are very closely related to those governing the use of restraint. Where there is a restraint of personal liberty by the use of such systems or devices, the principles 1-5 outlined above are applicable to such use.

In general, the use of systems or devices that intrude on a person's privacy, without their consent, is unlawful.

(Source: Towards a Restraint Free Environment in Nursing Homes, DOH, 2010)

6.3 Supporting Staff

An aggressive outburst or attack can be extremely distressing and disturbing for staff both immediately after its occurrence, and in the longer term, if unresolved.
Staff can often harbour feelings of resentment and frustration towards:
(a) The client who was violent;
(b) The organisation for placing them in a vulnerable position.

Staff support will be offered in a two-tier manner:

1. As soon as possible after events staff should discuss their fears/feelings etc. either in the form of staff meetings or with the Client Service Manager and/or Senior Service Manager.

2. Within 48 hours of an aggressive incident, a debriefing meeting will take place involving if possible the Client Service Manager and those staff involved in the incident. The management of debriefing meetings may require training for Client Service Managers.

3. Following debriefing, if it emerges that staff require further support in dealing with the incident, the Company will provide this by appropriate means as necessary.

4. In addition to our existing internal employee support service provided by Staff Counselling Psychologist, SHS also offer an external counselling and information services, provided independent by VHI Corporate solutions. Through the VHI corporate solutions EAP service, free professional counselling and information services will be available to all staff and their family. You will be able to talk to a counsellor on the phone 24 hours a day, 365 days per year. You can also see a counsellor locally for face to face counselling.

6.4 Alternative Non-Restrictive Practrices

In order to ensure that restrictive practices are only used as a last resort and are the least restrictive possible means of managing challenging behaviour, staff should consider all alternative non-restrictive practices first.

A range of alternative strategies that should be considered prior to the multi-disciplinary team decision to employ a mechanical or any other form of restraint includes:

- Good environmental design e.g. points of interest provided in the building, natural flow through the building, avoidance of 'dead ends', use of colour/surface treatments to designate areas, use of visual symbols, open access to safe outdoor space, clear line of vision for staff in communal areas.
- Padding the environment e.g. furniture, doorways, walls.
- Temperature, light and noise levels monitored and controlled.
- Overcrowding avoided.
- Use of calm or relaxing environments (e.g. quiet room, multi-sensory room).
- Subjective barriers instead of locked-off areas e.g. cloth panels/covers to camouflage doors or door knobs
- Mattress on the floor or a low-to-floor bed.
- Purposeful activity that is meaningful for the individual and provides the appropriate level of stimulation.
- Opportunity for physical exercise.
- 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).
- A communication strategy e.g. objects of reference, PECS, visual timetables, etc.
- Psychological strategies e.g. social stories, transitional objects, etc.
- Sensory strategies e.g. sensory diets, etc.
- High densities of social reinforcement delivered non-contingently throughout the person's day.
- Avoidance of situations known to provoke behavioural issues for an individual.
- *Positive Behaviour Support Plans* and *care plans* kept up-to-date and containing current risk assessments.
- Service user, family and advocates involved in discussions about the ways in which he/she prefers to be managed in instances when he/she poses a significant risk to self or others.
- Early stages of behavioural sequences that are likely to escalate are recognised and diffusion techniques are employed.

- Staff observation levels are adapted to take account of differing needs and levels of risk at different times of day/night.

- Staff are provided with adequate training in challenging behaviour and positive behavioural support strategies.

- The number and skill level of staff corresponds to the needs of the service users and the likelihood of behavioural issues arising.

- Padded clothing to reduce risk of injury from falls or self-injury e.g. knee pads, hip protectors, helmets. The social stigma that can result from the use of protective clothing or helmets should be considered and balanced against the frequency of falls/self-injury and the seriousness of the injury risk.

6.5 Guidelines on the use of Physical Restriants

Being restrained can be a frightening, even traumatic experience. Restraints can negatively interfere with the relationship between caregivers and the person being restrained. In fact, if people are restrained too often, they may begin to feel that they have no control over their lives. For these reasons and others, restraints should only be used when a person's behaviour is MORE dangerous than the danger of using restraints.

If a client is to be restrained, it must be used only as a last resort. The purpose of restraint is to protect and not to punish. A restraint should only be used when a client is a danger to himself or others, and when all other means of de-escalation have been exhausted.

Even in those moments, an assessment is still necessary to determine the best course of action to maintain the **Care, Welfare, Safety and Security** of all. There may be times when other strategies, such as continuing verbal intervention, removing dangerous objects, using **Personal Safety Techniques** and calling for further assistance, would precede - and possibly prevent any physical intervention.

A physical restraint is an emergency procedure comparable to CPR or first aid. As with any emergency response procedure, staff members need to practice these skills on a regular basis. The goal is for staff to continually assess for signs of Tension Reduction and identify opportunities to re-establish a Therapeutic Rapport with the individual.

Remember, the best way to eliminate the dangers of restraints - to you and to those in your care - is to eliminate the need for restraints at all.

Except in the case of extreme emergency the use of restraint should be discussed with the individual and their family and/or their advocate as part of the development of their Positive Behaviour Support Plan, and recorded. There is evidence that the consent process has been adhered to.

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

The duration of the period of restraint must be the minimum necessary to protect the individual being restrained, or others, from immediate and serious harm, in accordance with the individual's agreed plan.

Special consideration should be given when restraining individuals who are tactile defensive, or 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.

The relevant documentation/protocols, as appropriate to the use of restraint are completed.

Where a restraint is being used to manage behaviour consideration must be given to the possibility of the individual becoming restraint dependent. Attention should be given to minimising its use to ensure the individual does not become restraint dependent.

6.6 Understanding the Risks and Dangers of a Physical Restraint

The events leading up to a crisis situation, and the struggling that occurs during a restraint, can result in a lot of stress for the individual being restrained. This negative stress is sometimes called distress. Consequently, it is not unusual for a restrained individual to show signs of distress, both physically and emotionally. Always keep in mind that the acting-out person might have health problems. As such, everyone being restrained should be considered at risk. It is also important to understand that in some cases, restrained individuals have gone from a state of no distress to death in a matter of moments. This policy and procedures reflects how staff can monitor these signs of distress and identify what protocol should be followed.

Some restraints are more dangerous than others. For example, face down (prone) floor restraints and positions in which a person is bent over in such a way that it is difficult to breathe, are extremely dangerous. This includes a seated or kneeling position in which the person being restrained is bent over at the waist and any face down position on a bed or mat. Restraint related positional asphyxia occurs when the person being restrained is placed in a position in which they cannot breathe properly and is not able to take in enough oxygen. Death can result from this lack of oxygen and consequent disturbance in the rhythm of the heart. Staff members must be especially careful not to use their own bodies in any way that restricts the restrained person's ability to breathe. This includes sitting or lying across a person's back or stomach. When someone is lying face down, even pressure to the arms and legs can impact that person's ability to breathe effectively.

All of these positions may interfere with a person's ability to breathe. While they are different, these positions share a common factor: When forcefully maintained, each of them could prevent the diaphragm (the largest muscle of respiration) from working. If the diaphragm is not allowed to move down into the abdomen, breathing is seriously restricted. In fact, when a forcefully maintained position hinders both

chest and abdomen movement, the result can be fatal. SHS prohibits the use of floor restraints or any restraint that prohibits the person's ability to breathe effectively.

When confronted with an emergency situation, always consider the option of disengaging. If the person is not a danger to themselves or others while on the floor, staff may make the decision to move away and give a clear directive.

Provided restraints are used with these guidelines in mind, and fully in keeping with interventions taught during approved staff training, Sunbeam House Services will fully support staff in its use. Sunbeam House Services recommends that all staff attend CPI Training, which will clearly explain and demonstrate when and how to carry out restraint techniques.

6.7 Emergency Use of a Physical Restraint

In the event of an emergency situation arising staff should take all reasonable and proportionate steps to maintain the safety of the individual and those in the environment.

Assistance is summoned as soon as practicably possible.

Appropriate and proportionate crisis management strategies are implemented.
In an emergency situation where the use of restraint has not been previously authorised, and where an individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe, restraint may be initiated by the staff on duty. Staff who initiate the procedure must be trained in CPI, and are responsible for completing the incident report.

The emergency use of restraint should be reviewed by the MDT involved in the care and treatment of the individual within 72 hours of the episode. Where this review does not occur within this timeframe, the reasons must be documented in the individual's record.

In the case of use of emergency restraint being used more than 3 times in a six month period, this review should lead to a planned *Positive Behaviour Support Plan* put in place.

6.8 Recording

The use of restraint is recorded in accordance with the individual's Positive Behaviour Support Plan.

Each episode of physical restraint should be clearly documented as per *Adverse Event* Reporting requirements. This record should include, but is not limited to the following:

- The reasons for its use;
- Date and duration of its use;
- Alternatives which were implemented and unsuccessful and the reasons why or considered and deemed ineffective and the reasons why;
- If the behaviour resulting in physical restraint was the same behaviour as that in previous incidents.
- Members of the team involved directly in management of the physical restraint episode;

The assessment prior to, during, and after episodes of restraint, must be carefully documented in the individual's record. A record is made of the individual's level of distress, their physical status, mental status and presenting behaviour. The record is signed by two staff members including the designated staff member.

Adverse events, including psychological disturbance, resulting from restraint, must be documented and reported as per Adverse Event Reporting requirements. Any injuries to staff or clients resulting from the episode or the restraint must be completed as per Adverse Event Reporting requirements. Communication with an individual's next of kin or advocate in relation to the use of physical restraint is dictated by the individual's Positive Behaviour Support Plan.

A contemporaneous account of the use of physical restraint must be placed in the individual's record on each occasion, to include a description of the type of physical restraint used, the reasons for its use and the duration of its usage.

7.0 MECHANICAL RESTRAINTS

7.1 Definitions

Mechanical Restraint: The application and use of materials or aids such as: belts, helmets, clothing, straps, cuffs, splints, specialised equipment designed to restrict the free movement of an individual. This does not include the use of devices for therapeutic purposes relating to postural and orthopaedic needs (DHS, 2007, p.3). Any means of mechanical restraint used in an emergency situation must not compromise the safety of the individual being restrained.

Emergency use of mechanical restraint is the use of mechanical restraint which has not been approved in advance and is not part of the agreed individual Positive Behaviour Support Plan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

Postural Support Appliance/Equipment as a means of mechanical restraint: Any postural support appliance/equipment that is not being used for the purposes for which it was supplied or manufactured (ie. for postural support) and which is used to manage behaviour comes within the remit of this Policy. There must be evidence that

the use of such equipment for this purpose has been subject to due consideration and its use outlined in the individual's Positive Behaviour Support Plan.

Postural Support appliances/equipment used for postural support and prescribed by the physiotherapist or occupational therapist does not come within the scope of this policy. Such appliances/equipment can only be referred to as 'Mechanical Restraint', if used for a purpose other than that for which they were supplied or manufactured. Guidelines outlining best practice in terms of supply, use and maintenance of postural supports are available in the Postural Supports Policy.

Environmental Restraint is defined as the use of environmental or mechanical devices used to restrict movement. These include but are not limited to bed rails, recliner chairs, locked doors or locked facilities. Denying a client their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties is also an environmental restraint. This policy must be followed with regard to all environmental restraints

7.2 Procedure on the use of Mechanical Restraint

- 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. Where the use of restraint is foreseeable a risk assessment must be undertaken. The potential hazards associated with each mechanical intervention must be identified and the level of risk associated with each intervention determined for the specific service-user on which it is being applied. This must be documented.
- All alternative interventions to manage the individual's unsafe behaviour must have been considered and the process recorded.
- Except in the case of extreme emergency the use of a mechanical restraint should be discussed with the individual and their family and/or their advocate as part of the development of their Positive Behaviour Support Plan, and recorded. There should be evidence that the consent process has been adhered to.
- In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.
- The duration of the period of mechanical restraint must be the minimum necessary to protect the individual being restrained, or others, from immediate and serious harm, in accordance with the individual's agreed Positive Behaviour Support Plan.
- The relevant documentation/protocols, as appropriate to the use of restraint are completed and stored in the client's file.
- Where a restraint is being used to manage behaviour consideration must be given to the possibility of the individual becoming restraint dependent. Attention should be given to minimising its use to ensure the individual does not become restraint dependent.
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7.3 Recording

- The use of restraint is recorded in accordance with the individual's Positive Behaviour Support Plan.
- The individual must be monitored as per their individual Positive Behaviour Support Plan throughout the use of restraint to ensure his or her safety, dignity, health and wellbeing.
- The assessment prior to, during, and after episodes of restraint, must be carefully documented in the individual's record. A record is made of the individual's level of distress, their physical status, mental status and presenting behaviour. The record is signed by two staff members including the designated staff member.
- Adverse events, including psychological disturbance, resulting from restraint, must be documented and reported as per Adverse Event Reporting requirements. Any injuries to staff or clients resulting from the episode or the restraint must be completed per Adverse Event Reporting requirements.

  Communication with an individual's next of kin or advocate in relation to the use of mechanical restraint is outlined in the individual's Positive Behaviour Support Plan.

  Where any new or emergency mechanical restraint is implemented, a record of its usage must be made at least every 15 minutes for the initial 48 hours. This record should detail the individual's level of distress, their physical status, mental status and presenting behaviour during the preceding 15 minute period. If the mechanical restraint is continued beyond 48 hours the frequency of recording may be reduced (in agreement with the MDT) and will be dictated by the individual's needs and responses.

- The frequency of observation may be decreased in accordance with the individual's response, needs and clinical assessment as recorded in the individual's Positive Behaviour Support Plan.

7.4 Reviewing the use of Mechanical Restriants

- The use of approved mechanical restraint should be reviewed by the MDT involved in the care of the individual within 72 hours or earlier if any concerns arise. Thereafter review should occur after 3 months, or earlier if required. If the restraint is to continue being used, it must be further reviewed as outlined in the prescription or earlier if required.
- The review considers all the evidence for continuing or discontinuing the restraint and other important factors, including the reasons why interventions were deemed unsuccessful or ineffective. The review should also consider plans to reduce or eliminate the use of the mechanical restraint for the individual. The outcome of this review and a plan and date for future review should be recorded in the individual's record.
- The individual should be involved in the review process unless they do not have the capacity to do so (at this time), or their involvement is prejudicial to their mental health, well-being or emotional condition. In such cases family

member/parent/advocate acting on behalf of the individual should be involved in the review process.

- If the approved mechanical restraint is not required in a three month period it should be removed from use and from the individual's Positive Behaviour Support Plan. In the event of a situation arising again in the future whereby such restrictive interventions are required, emergency procedures as per policy should be followed.
- If the individual or their advocate objects to application of the restraint, the plan is reviewed in light of this objection by the MDT and the Rights Review Committee.
- Where the individual or their advocate objects to any restrictive procedure, they are advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2013, Standard 1.1.8.

7.5 Emergency use of Mechanical Restraints

- Emergency use of mechanical restraint is the use of mechanical restraint which has not been approved in advance and is not part of the agreed individual Positive Behaviour Support Plan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation]
- In the event of an emergency situation arising staff should take all **reasonable and proportionate** steps to maintain the safety of the individual and those in the environment.
- Assistance is summoned as soon as practicably possible.
- Appropriate and proportionate crisis management strategies are implemented.
- The emergency use of a mechanical restraint should be reviewed by the MDT involved in the care and treatment of the individual within 72 hours of the episode.
- In the case of use of emergency restraint being used more than 3 times in a six month period, the review should lead to a Positive Behaviour Support Plan being put in place or the current Positive Behaviour Support Plan reviewed.

7.6 Negative Side Effects of Mechanical Restraint Use

In addition to the crucial issues relating to the individual's human and legal rights, dignity and consent that must be considered before embarking on any strategy involving a restrictive practice, it is also important to consider the psychosocial and physical side effects that may result from mechanical restraint use. In a recent review of the use of restraint with people with intellectual disabilities who engage in self-injurious behaviour, Jones et al., (2007) summarised some of the side effects commonly reported by studies in this area:

- Increased social attention gained from the wearing of a mechanical restraint can, for some individuals, serve to reinforce behaviour, thereby maintaining/increasing rates of self-injurious behaviour.
- For some individuals, the restraint may come to be seen as an escape mechanism from compulsive self-injurious behaviour. This acts against their becoming motivated to learn more appropriate/positive strategies.

- Preventing one form of self-injurious movement pattern may lead the person to develop other alternative forms of self-injurious behaviour as a replacement.
- Mechanical restraint use can lead to disruption of opportunities to engage in purposeful everyday activities, reduced interaction with others and reduced access to community places.
- Unless adequate training and monitoring is ensured, there can be a risk of incorrect or forceful application of mechanical restraints and a resultant risk of physical injury to the individual or to staff.
    - Prolonged and/or regular use of mechanical restraint can lead to:
    - muscular atrophy and shortening of tendons,
    - demineralisation of bones,
    - arrested motor development, and/or
    - disuse of limbs
- Watson (2001) has referred to some additional psychological effects that can ensue from mechanical restraint use: depression, cognitive decline, emotional isolation, confusion and/or agitation.

7.7 Planning for Fading and Eventual Removal of Mechanical Restriants

Restraints should only be used as short-term strategies and planning for fading of the restraint should begin from the outset, before it is ever used with the person (Paley, 2008). It may be possible to select a mechanical restraint with design components that will enable it to be faded and the level of restriction reduced easily (e.g. elbow splints with adjustable ROM (restriction of movement) or removable/gradable padding/filling).

8.0 ENVIRONMENTAL RESTRAINTS

"Time out" (also known as social exclusion) is a form of behavioural modification that involves temporarily separating a person from an environment where unacceptable behaviour occurred.

Time out will only be used as a last resort when all other interventions have failed and when the person is in imminent or actual danger to themselves or others. During Time Out staff must record start and end times; remain in visual contact with the person at all times, and record their observations every few minutes. A Rights Restriction must be sent to the RRC.

Environmental restraints include the use of environmental or mechanical devices used to restrict movement, these include but are not limited to bed rails, recliner chairs, locked doors or locked facilities. A key issue that must be assessed before considering environmental restraint is the level of risk caused to the person by wandering or entering/leaving specific areas. Monitoring technologies can be a useful alternative to environmental restraint, but they should never be used unless there is significant risk of falls, injury or persons absenting themselves. They may be a positive strategy if used to maintain independent mobility, physical activity, dignity and a perception of freedom and if they prevent recourse to more restrictive strategies (e.g. locked-off areas or chair straps/trays). Some of the drawbacks of such technologies are that they can give a false sense of security to staff (e.g. the person may come to harm before staff have time to respond to the alert); that they can raise the person's distress levels e.g. if the alarm sounds frequently, necessitating frequent interventions by staff; and that they can be used to justify lower than desirable staffing levels.

If considering the use of high sides or bed rails on a bed, the CSM should ensure an assessment is completed.

Alternative methods should be considered before using bed rails for example the use of a variable height bed to bring it closer to the floor, use of wedges/bolsters, alarm system used to alert staff that someone has moved from their normal position, something placed on the floor to cushion a fall (this would also have to be assessed as a slip/trip hazard as well).

The CSM will ensure a risk assessment is carried out for each occupant for whom high sides or bed rails are being considered and the findings of the risk assessment held in the client's file. An assessment of the bed, mattress and occupant must also be carried out to ensure that the fitting of bed rails do not pose additional risks, and that the bed and mattress and rails meet the correct gap dimensions according to BSEN 60601-2-52:2010. A regular assessment of bedside rails must be carried out for each client where they are used and during the night staff must check and record the client in the bed at frequent intervals or at more regular intervals as needs be.

Types of mechanical and environmental restraints, listed from least restrictive to most restrictive, are presented below:

A) Practices that track or limit free mobility (Environmental Restraints):

- Monitoring technologies e.g. personal movement sensors (within a specific area or GPS); surveillance (CCTV, monitors); boundary-crossing alarms fitted to doorways, windows or corridors; bed-leaving alarms and floor sensor pads.
- Locked cupboards/drawers.
- Delayed door opening systems.
- Furniture arrangement to impede mobility.
- Gates across entry points or stairs.
- Locked doors e.g. keypads, double handles, high handles on doors.

B) Practices that restrict or prevent movement or part(s) of the body:

- Modified clothing e.g. clothing designed to be difficult to remove or to prevent access to particular body parts.
- Tied/restrictive clothing i.e. clothing designed to limit movement.
- Hand/finger restraints e.g. gloves, mitts.
- Elbow/wrist restraints e.g. splints, gaiters, wrist cuffs.

C) Practices that restrict or prevent mobility and/or restrain the whole body:

- Transfer belts or reins.
- Removal of footwear, walking aid or wheelchair.
- Turning off powered wheelchair.
- Removal of aids required for communication e.g. glasses, hearing aids, communication aid.
- Switching off the power on a person's alternative or augmentative communication device.
- Trays/tables in front of chairs/beds (except for the period of time that they are used for purposeful activities or meals).
- Chair/wheelchair tilted backwards.

- Cot/bed side rails or high sides for any person over 4 years of age.
- Wheelchair specifications designed to restrict independent propulsion e.g. application of attendant-controlled brakes, small transit wheels when a person has the ability to self-propel.
- Bus/car harness.
- Wheelchair/armchair/shower chair/toilet/ straps & harnesses.

9.0 USE OF MEDICATION FOR BEHAVIOURAL PURPOSES

Psychotropic medication for behavioural purposes is a restrictive practice and shall only be used in combination with other non-pharmacological interventions. In line with best practice, the lowest effective dose of medication should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount; and medication should only be used to control behaviour if the behaviour is due to a diagnosed underlying psychiatric condition that responds to medication or in a narrow group of situations (see below) where behavioural interventions alone have not been effective. The use of such medication for behavioural management should be reviewed regularly by relevant medical personnel. If Psychotropic Medication is prescribed as part of crisis management this should be reviewed and reduced as the crisis resolves.

The purpose of this policy is to ensure that Psychotropic Medication is only prescribed for people with intellectual disabilities after a full medical assessment (Psychiatrist/GP) and with a targeted mental illness as the rationale for prescribing it.

Exceptions to this include whereby a mental illness is not diagnosed psychotropic medication may be prescribed and administered if:

- The use of the medication promotes the Positive Behaviour Support Plan by reducing anxiety and increasing quality of life through the plan
- The occasional prescribed use of anxiolytic medication to facilitate an individual availing of an important health maintenance appointment that anxiety would prevent them from availing of (e.g. hospital visit, dental procedure, MRI etc.)
- In the case of a person without mental illness who manifests regular behaviours that challenge of an aggressive nature and the medication has been demonstrated to reduce the frequency and/or intensity of the behaviour the medication if prescribed will be a feature of the service users plan
- In the case of a person who displays intermittent serious behaviours that challenge where the use of P.R.N. Psychotropic Medication has been shown to help in the safe management of such behaviours that challenge
- The above three points should be considered as forms of restraint.

9.1 DEFINITIONS

P.R.N. Medication P.R.N. (Abbreviation meaning "when necessary", from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed). This abbreviation is used in prescriptions and/or medication kardex when the medication is used only in certain circumstances particular to the individual in question. For the purposes of this document the circumstances are in response to

behaviours that challenge and/or circumstances that are known to precipitate such behaviours where medication has been shown to be effective.

9.2 PROCEDURE

Use of Psychotropic Medication for Behavioural Purposes

Psychotropic Medication for behavioural purposes must only be used when an individual poses a significant threat of harm to self or others and assessment has shown that no other intervention alone is helpful.

Psychotropic Medication for behavioural purposes should only be prescribed by their medical practitioner. The prescription must specify the medication to be used, the circumstances of its use, the dosage, frequency and period covered by the prescription. If it becomes a long term prescription the person should be reviewed by a consultant psychiatrist.

Any person prescribed **Psychotropic Medication** for behavioural purposes must have a Positive Behaviour Support Plan. The plan needs to be regularly reviewed and updated.

The individual and their family and/or their advocate should be informed and involved, where appropriate (with individual consent) for the use of Psychotropic Medication for behavioural purposes and the associated treatment plan, including the reasons for it, potential side effects and signs of success. Where the individual lacks capacity to consent, the individual's family member, as appropriate, should be involved in decisions regarding its use.

In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record. There is written evidence that the consent process has been adhered to.

- In all MDT deliberations on the use of Psychotropic Medication for behavioural purposes, processes (to include documentary evidence) must be in place to ensure that no single opinion or report alone influences the decision on the prescription.
- Local processes must be in place to ensure that documented records of the full team's views are brought to the attention of the prescribing medical practitioner.
- Approval must only be provided where a current physical/medical report or functional assessment does not contraindicate the use of Psychotropic Medication for behavioural purposes.
- A referral is made to the Rights Review Committee outlining the process undertaken in regard to authorisation of the use of Psychotropic Medication (including P.R.N.) for behavioural purposes

9.3 REVIEWING THE USE OF PSYCHOTROPHIC MEDICATION FOR BEHAVIOURAL PURPOSES

- Frequent medical monitoring of the dosage and assessment of its continuing need should be carried out as long as the medication is prescribed.
- The prescription must be reviewed by a Psychiatrist in consultation with the appropriate staff at least every six months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used. This review must be recorded in the individual's clinical notes and personal profile plan.
- Both the above reviews must report:
    - Precipitating factors.
    - Duration of event.
    - Frequency of events.
    - Therapeutic effects of the medication.
- The individual should be involved in the review unless they do not have the capacity to do so, or their involvement might be prejudicial to their mental health, well-being or emotional condition. In which case a family member/parent/other carer/advocate acting on behalf of the individual should be involved in the review process.
- If the individual or their advocate objects to the restrictive procedure. They will be offered additional supports and information to help make a more informed choice. They are also advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

9.4 THE USE OF PRN PSYCHOTROPHIC MEDICATION FOR BEHAVIOURAL PURPOSES

- The decision to use P.R.N. Psychotropic Medication for behavioural purposes is taken in accordance with the agreed individual *Restrictive Reactive Plan* and supervised by the Psychiatrist.
- The prescription must be reviewed by a Psychiatrist at least every six months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used.
- Where Psychotropic Medication for behavioural purposes is being given as P.R.N. and being used with increased regularity over a period of one week, the person should have a mental health review by a Psychiatrist and strong consideration given to the prescription of regular medication rather than emergency/PRN Psychotropic Medication.
- P.R.N. Psychotropic Medication for behavioural purposes should only be given if it is written up on the appropriate form (usually known as a drug kardex) and signed by a Psychiatrist or a medical practitioner.
- Each time P.R.N. Psychotropic Medication is used for behavioural purposes it should be clearly documented and a copy placed in the individual's record, (*record of administration of PRN psychotropic medication*). This documentation should include, but is not limited to the following:

  - If the behaviour resulting in the prescription of Psychotropic Medication is the same behaviour as that addressed in the Positive Behaviour Support Plan
  - The individual's level of distress, their physical status, mental status and presenting behaviour is recorded at the time of dispensing the PRN. Psychotropic Medication and regularly for at least an hour afterwards. During this time it is necessary to observe the emotional and physical health of the person and to seek medical advice if required.
- Communication with an individual's next of kin or advocate in relation to the use of P.R.N. Psychotropic Medication for behavioural purposes is dictated by the individuals agreed within the positive behaviour support plan.
- If the use of P.R.N prescribed for behavioural purposes is not required for use in a six month period it should be removed from the person's kardex. In the event of a situation arising again in the future whereby P.R.N is required for behavioural reasons emergency procedures as per policy should be followed

9.5 MEDICATION FOR RESTRAINT SHOULD NOT BE USED

- Where it is contraindicated by the individual's medical condition in accordance with the individual's risk assessment;
- Where the possible benefits of the medication are outweighed by the risk of side effects;
- To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;
- Where it is deemed unsafe to do so;
- Medication for restraint should not be used to alleviate operational difficulties or to maintain a smooth running programme. For example, medication for restraint should not be used as a response to staff shortages.