Western Health and Social Care Trust

POLICY FOR THE USE OF RESTRICTIVE INTERVENTIONS WITH ADULT PATIENTS

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Western Health and Social Care Trust

Title:	Policy for the Use of Restrictive Interventions with Adult Patients			
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Within this document the word 'patient' is used also to denote 'client' or 'service user' and refers to any person residing in an in-patient facility or residential care in the Western Health and Social Care Trust (WHSCT). It also refers to any person living in the community and receiving services or intervention from staff working for the WHSCT.

1.0 INTRODUCTION

This policy is concerned with the employment of 'restrictive interventions' (restraint) within the adult and older adult population, Western Health and Social Care Trust. This policy is to be adopted by all staff within the appropriate Directorates and refers to the use of restrictive interventions on Trust premises (i.e. wards, day centres, residential and nursing facilities) and in patients' own homes.

It emphasises the need to prevent the use of restrictive interventions (definition, page 9) in the first place, as well as giving specific guidance on situations where their usage may be deemed essential in order to minimise the risk of injury or damage to patients, their carers, the wider community or staff.

The policy should be considered in conjunction with other relevant and associated policies and procedures and legislation, in particular the following:

- the Trust's Guidance on the *Protection of Vulnerable Adults*;
- the Trust's policy on the *Personal Safety of Staff*;
- the Trust's *Risk Management Policy and Strategy*;
- the Trust's *Procedure for Recording and Reporting Incidents*;
- the Trust's *Procedure for Notification of Serious Accidents and Untoward Events*;
- the Trust's *Consent Policy*;
- the Trust's *Patient Feedback Policy and Procedure*;
- the Trust's policy for the *Prevention of Slips, Trips and Falls for Inpatients;*
- the Trust's policy for the *Management and Treatment Guidelines For Acute Alcohol Withdrawal;*
- the Trust's policy for *Using Bed Rails Safely and Effectively;*
- the *Mental Health (N Ireland) Order 1986* and its associated *Code of Practice*;
- the *Children (N Ireland) Order 1995* and its associated *Guidance and Regulations*;
- the *Disability Discrimination Act 1995*;
- the *Race Relations (N Ireland) Order 1997*;
- the *Human Rights Act 1998*; and
- Section 75 of the *Northern Ireland Act 1998.*
- *Policy on Rapid Tranquilisation*
- *Guideline on the Management of Violent and Aggressive Behaviour of Patients August 2008*

- *Deprivation of Liberty Safeguards (DoLS)* – Interim Guidance, DHSSPS 2010
- *Guidance on Control and Administration of Medicines April 2008 Amended 2009.*
- *Regional Guidelines for the Search of Patients, their Belongings and the Environment of Care within Adult Mental Health/ Learning Disability Inpatient Settings February 2014 PHA/HSCB*

Likewise, the policy should be read in the light of associated policies which the Trust will adopt in the future.

Except in emergencies, decisions about restrictive interventions need to be made after discussion, wherever possible, with the patient, their relatives and friends, as partners in care. It is important to involve the whole care team, including other professionals and agencies that may be helping to support the patient.

1.1 Purpose and scope of the policy

The inappropriate use of restrictive interventions may give rise to criminal charges, action under civil law or prosecution under health and safety legislation. As a general rule, such interventions should only be used when other strategies (which do not employ force) have been tried and found to be unsuccessful or, in an emergency, when the risks of not employing a restrictive intervention are outweighed by the risks of using force. They should be seen as just one part of a broader strategy to address the needs of patients whose actions are harmful or potentially harmful.

Restrictive interventions should always seek to achieve outcomes that reflect the best interests of the patient whose behaviour is of immediate concern and of any others who might be affected by that behaviour. Whether used on a planned or an unplanned (emergency) basis, they should be used only to prevent injury, to avert serious damage to property and to enable appropriate delivery of essential care in a dignified manner. Exceptionally, they may be necessary to ensure that essential medical treatment can be provided. They should involve the minimum degree of force, for the briefest amount of time, to achieve these outcomes.

Any decision to use a restrictive intervention should take account of the prevailing circumstances, and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing a restrictive intervention. Indeed, the use of restrictive interventions generally should be minimised by the adoption of risk assessment and preventative strategies in all cases where it is likely that the use of force might be required.

The circumstances under which a planned restrictive intervention may be used should be formally written up and included in the patient's individual care plan, and every application, whether planned or unplanned, should be recorded formally as soon after its implementation as possible.

All staff that may need to employ restrictive interventions will require training on the use of restrictive interventions and they should only employ specific methods for which they have received formal training.

Trust managers will ensure that the contents of this policy are adhered to at all times, and that it is monitored and reviewed at least every two years, with appropriate amendments effected as necessary.

1.2 Policy statement

The Trust recognises its duties and legal responsibilities to ensure, as far as is reasonably practicable, the health, safety and welfare of its staff, patients and of other people who may be affected by its activities.

This document sets out the policy in relation to the use of restrictive interventions by its staff and by those employed by other agencies commissioned to provide care and treatment on its behalf. It sets out the context in which the Trust expects *all* its patients to be treated.

1.3 Aims of the policy

The policy seeks to ensure that restrictive interventions are used as infrequently as possible and that, when they are employed, they should be used only to prevent injury, to avert serious damage to property and to enable appropriate delivery of essential care in a dignified manner. Restrictive interventions should only ever be used in the best interests of patients and that everything possible is done to prevent injury and to maintain a sense of dignity in the person(s) concerned.

2.0 SERVICE PRINCIPLES, TERMINOLOGY AND LEGAL CONSIDERATIONS

2.1 Principles underpinning the use of restrictive physical interventions

The Trust's value-base in respect of all its patients is built upon the three-fold beliefs that every individual:

- has precisely the same human value as anyone else;
- has a right to live as ordinary a life as possible in his/her local community; and requires the provision of services which both recognise and focus on his/her individuality.

As such, all services provided by the Trust should be based upon the assessed needs of individuals.

Services should respond flexibly and sensitively to the needs of patients and their carers.

They should be provided promptly, effectively and comprehensively, with the aim of ensuring that patients get the right treatment and care at the time it is needed.

The quality of the Trust's services should be measured by the extent to which they provide:

- **privacy** - the rights of individuals to be free from intrusion or public attention;
- **dignity** - recognition of the intrinsic value of people regardless of circumstances, by respecting their uniqueness and their personal needs and by treating them with respect;
- **independence** - opportunities to think and act without reference to another person, including a willingness to incur a degree of calculated risk;
- **choice** - opportunities to select independently from a range of options;
- **rights** - the maintenance of all entitlements associated with citizenship;
- **fulfilment** - the realisation of personal aspirations and abilities in all aspects of life; and
- **respect for diversity** - the acceptance and promotion of individual differences.

In the light of these values and general service principles, and with regard specifically to instances where the action of a patient is either harmful or potentially harmful, Western Trust staff will at all times adhere to the following principles when responding to patients:

- Patients should in *all* situations be treated fairly and with courtesy and respect.
- The management of harmful or potentially harmful behaviour requires a multi-disciplinary approach to the planning of a patient's care and treatment and, where possible, patients (and/or their carers) should be involved in any decisions about their behaviours, including the ways in which they should be responded to by staff.
- All interventions should be lawful and demonstrably in the patient's best interests, based upon a risk assessment (which should include details of any reasons why a specific intervention should not be employed with an individual patient) (Appendix B) and recorded as part of the patient's care plan.
- The preferred option is always to focus upon the use of preventative strategies and to use the least restrictive intervention possible in any given situation.
- Decisions about the use of a specific restrictive intervention should be taken in the light of an appropriate risk assessment, with a view to minimising the potential for loss of dignity to the individual(s) concerned.

- Restrictive interventions should avoid contact that could be misinterpreted as sexual.
- Likewise, no one intervention should ever be intended or knowingly allowed to cause pain to any other person.
- Restrictive interventions should be used as a last resort, when all other options have been explored and exhausted. They should be used for the minimum time necessary, and only to protect life, to safeguard from harm, to prevent serious damage to property or persons and to enable appropriate delivery of essential care in an appropriate manner.
- Staff employing these interventions will have training to ensure they use the procedures to promote the wellbeing and best interests of patients and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.
- Post-incident de-briefing to both staff and patients will follow the use of restrictive interventions.
- Staff will be offered all necessary support, following their involvement in the use of a restrictive physical intervention.
- Restrictive interventions should never be used solely to reduce workload.

2.2 Restrictive Interventions

Definition of Restrictive interventions

Whilst a basic definition of restraint might be 'restricting movement' or 'restricting liberty', many interventions may restrict unintended movement – for example, plaster casts to stop a patient accidentally displacing a fracture – or may unintentionally restrict movement – for example, a nursing home locked at night to protect residents and staff from intruders.

According to established international definitions, included within *Showing restraint: challenging the use of restraint in care homes* (Counsel and Care UK, 2002), restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.' In this context, 'behaviour' means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is 'stopping a person doing something they appear to want to do.'

Types of restrictive interventions

Physical restraint
Involves one or more members of staff holding the person, moving the person, or blocking their movement

Mechanical restraint
Involves the use of equipment; Examples include everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person from getting out of bed. Controls on

freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

Technological surveillance – such as tagging, pressure pads, closed circuit television, or door alarms – is often used to alert staff that the person is trying to leave or to monitor their movement. Whilst not restraint in themselves, they could be used to trigger restraint, for example through physically restraining a person who is trying to leave when the door alarm sounds. These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.

Chemical restraint-
Involves using medication to restrain; this could be regularly prescribed medication – including that to be used as required or over-the-counter medication.

The use of **medication** to control a person's harmful or potentially harmful behaviour is referred to as 'rapid tranquilisation'. Facilities likely to use medication in this way should have in place protocols regarding the use of rapid tranquillisation.

Additional oral medication may only be used to control agitation, distress and / harmful or potentially harmful behaviour when it has been prescribed and reviewed by a registered medical practitioner and included in an individual's care plan. The care plan should detail the circumstances in which such medication is to be used, specify the requirements for observation of the individual(s) concerned after the medication has been given, and document any potential adverse effects from the medication.

Medication may be used in an emergency in combination with other forms of restrictive intervention. It is vital that the sum total of all interventions used is always reasonable and proportionate.

Psychological restraint-
Can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

It is not possible to give a list of what kind of equipment, physical holding, or medication constitutes restraint, as it depends upon the circumstances. A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.

Restrictive interventions may be either **planned** or **unplanned**.

- **Planned** restrictive interventions involve procedures which have been devised as a result of a risk assessment, have been pre-agreed as being essential for the patient's care and well-being in a particular situation, and have been recorded as such in the patient's notes.

- **Unplanned** restrictive interventions includes any range of restrictive activities up to and including an emergency where the use of force occurs in response to unforeseen circumstances.

In either case, staff who employ a restrictive intervention (whether planned or unplanned) retain a 'duty of care' to the patient concerned, and any response they adopt must always be **proportionate** (i.e. the nature and extent of any restrictive intervention that is used must be proportionate to both the actions of the person(s), and the nature of any harm they might be expected to cause). The minimum necessary restrictive intervention should be used at all times, and the procedures employed should be those with which the staff who are using them are familiar and have been trained in, are able to use safely and (except in unplanned situations) are as detailed in the patient's care plan.

Many therapeutic devices (e.g. **wheelchairs**, **standing frames**) can restrict movement. These should never be provided for the purpose of preventing harmful or potentially harmful behaviours. However they might, in extreme circumstances, be used to manage a high-risk situation involving harmful or potentially harmful actions (e.g. by harnessing a person into specialised seating). Such interventions must always be agreed by a multidisciplinary team, in consultation with the patients concerned, their families and advocates, and recorded in individual care plans.

Planned restrictive physical interventions should be: agreed in advance by a multi-disciplinary team, in consultation with the patient, his/her carers; detailed in writing, and included in the patient's care plan as part of a broader strategy for safely managing his/her behavioural difficulties; implemented by an identified member of staff with appropriate training; and recorded in writing as soon after their usage as possible, for monitoring purposes. When a patient is admitted to a ward, or a facility with a locked door, (e.g. keypad access only), an assessment of risk should be completed. If a locked door is assessed to be necessary for a particular patient, this should be documented in the notes. Any decision should be recorded in the patient's individualised care plan and frequently reviewed. If a locked door is not required the patient should be informed of the procedure for leaving the ward. A locked facility is considered to be any area that a patient cannot freely leave.

Another form of restrictive physical intervention is **withdrawal**, which involves removing a person from a situation which is causing anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume their usual activity. Withdrawal may be used in either a planned or an unplanned way, and it can be an entirely appropriate response, in certain situations.

2.3 Legal considerations in the use of restrictive interventions

Any restrictive interventions adopted within the Western Trust must be in accordance with the legal responsibilities and obligations of both the Trust and its individual members of staff, and with the rights and protection which the law affords to patients.

Unless the circumstances at the time provide 'lawful excuse' for the use of force, it is a criminal offence (assault or battery) to use physical force, or to threaten to use force (e.g. by raising a fist or using a verbal threat), against any other person. It is equally an offence (false imprisonment) to lock a person in a room – even if the person is unaware of being locked in – except in an emergency (when, for example, a person being locked in a room as a temporary measure only, to prevent immediate harm or injury and whilst assistance is sought, would provide legal justification). As a general rule, therefore, restrictive interventions should be thought of as illegal – unless there is clear justification for their usage which can withstand legal scrutiny.

The use of a restrictive intervention might also give rise to an action in civil law for damages if it results in injury, including psychological harm, to the person concerned.

The guiding principle underlying any form of care to a patient, including the application of a restrictive physical intervention, is that the intervention must be in the patient's 'best interests' – i.e. as defined in terms of the preservation or promotion of the person's life, health or wellbeing.

Also, a 'duty of care' exists for staff, whereby 'reasonable care' must be taken to avoid acts or omissions which are likely to cause harm to a person and/or damage to property. This too means that it may, under certain circumstances, be appropriate for a restrictive intervention to be employed – for example, to prevent a significant risk of harm being caused by a patient running toward a busy road, engaging in self-injury, injuring another person(s), or committing an offence.

When deciding upon whether 'reasonable care' has been exercised, a court is likely to consider:

- any risks which could have been foreseen with a particular course of action including the risks of responding in alternative way(s) in the circumstances, or not at all;
- the extent to which the degree of force that was used was no more than necessary;
- the reasonableness of the response in the prevailing circumstances;
- the likely response of other person(s) with a similar degree of skill and responsibilities; and
- the views of an appropriate body of expert opinion.

This means that planned restrictive interventions should only be used as part of a broader, comprehensive strategy for intervening in a person's care and wellbeing, when the risks of employing an intervention are adjudged to be lower than the risks of not doing so.

It also means that any restrictive intervention should employ the minimum reasonable force to prevent injury or serious damage to property, or to avert an offence being committed.

It should be noted that past records of patients' behaviour can sometimes show that there are set patterns to their behaviour which, if unchecked, are likely to develop into harmful or potentially harmful behaviour. In such cases, it might be appropriate to use restrictive interventions at an early stage.

Under health and safety legislation, the Trust is responsible for the health, safety and welfare of its staff and of others, including patients and visitors who may be affected by our activities. This requires the Trust to assess any risks involved in its work activities, including restrictive interventions, to establish and monitor safe working practices, and to ensure that staff are adequately trained. It should also ensure that staff have access to appropriate information about their patients.

2.4 Deprivation of Liberty Safeguards – Western Trust Good Practice Guidelines

In all cases where patients are considered to be deprived of their liberty, or at risk of being deprived of their liberty, and which fall outside the provisions of the Mental Health (NI) Order, Trust staff should:

a. Ensure consideration is given to alternatives that meet the requirement of adequate care but which fall short of deprivation of liberty.

b. Ensure that decisions are taken and reviewed in a structured way, e.g. through the Care Management process.

c. Ensure a proper assessment of capacity has taken place and decisions are based on proper medical advice from a person qualified to make the judgement.

d. Any restrictions placed on a patient is kept to the minimum necessary in their case.

e. Appropriate information is given to the patient themselves and to their family, friends or carers. Where necessary, there should be involvement of local advocacy services.

f. Ensure proper steps are taken to help patients retain contact with family, friends or carers.

g. Depending on the circumstances, it may be helpful to include an independent element in any review of the care which is being provided.

h. Effective documentation of all meetings, assessments, consultations and care plans is crucial. These should include the involvement of, or consultations with, family, friends or carers and should clearly outline the reasons for any decisions taken and the factors considered.

3.0 MANAGING PATIENTS' AT RISK OF HARM

To facilitate the minimisation of restrictive interventions or reduce the need for physical restraint, an alternative should be considered for specific populations. Table 1 lists some potential alternatives. See Appendix C for a more comprehensive protocol of interventions and alternatives to restraint. This protocol should be followed for any patient where a restrictive intervention is considered.

Table 1

Cognitively Impaired Person	Person who Wanders	Agitated or Violent Person	Person with Impaired Mobility
• wall-mounted white board marker to record day of week & the names of staff • continuous orientation to environment • provide familiar objects from person's home • reality orientation • involving patient in conversation • changing resident's seating arrangements throughout the day • television or radio • listening to music • confused patients near nurses' station	• identify those who are mobile and confused on admission • visual barriers for doors • use of outdoor spaces, walled gardens etc • places of interest (boxes of interesting objects, seating etc) along a long corridor	• rocking chair and recliners • soothing music • offer diversions such as TV or radio • regular assessment of pain • engagement in meaningful activities • moving patients to a calm, quiet environment • expressing compassionate concern for patients and their complaints, needs, privacy issues etc. (Partnership working) • examining what can be done to resolve the cause of the anger	• create path clear of furniture • non-slip floor treatment • mobility aids • use of transfer rails • appropriate shoes and treaded slippers • encouraging consistent use of assistive devices

3.1 Predicting and preventing harm

The causes of harmful behaviour are not always apparent. However, certain factors are linked to a higher chance of their occurring and due attention to these factors can often prevent their taking place. Some of these so-called 'precursor' factors relate to the internal condition of the person concerned, while others relate more to aspects of his/her environment and surroundings.

Examples of **internal precursors** to harmful or potentially harmful behaviour include:

- the presence of physical illness or disability;
- sensory or neurophysiological impairments- e.g. PAIN
- psychiatric or emotional problems;
- certain moods or feelings (e.g. anger, boredom, disappointment, distress or panic);
- increased age;
- the effects of medication/drugs;
- intoxication;
- communication difficulties;
- a lack of understanding (e.g. of timetables, schedules, task requirements, etc); and
- a person's expectations about the nature of any service he/she is receiving (or believes that he/she should be receiving).

Examples of **environmental pre-cursors** include:

- lack of stimulation.
- over-cramped ward conditions (with insufficient personal space and/or opportunity for movement);
- noise levels that are either too high or too low (over stimulation);
- inadequate or inappropriate heating and/or lighting;
- a lack of privacy;
- a lack of opportunity for having one's needs met in a positive way;
- a sudden or unexpected change of routine (e.g. change of ward);
- (recent) significant life changes, such as a change of residence or a bereavement;
- inadequate staffing (in terms of either training and/or numbers);

- an unsympathetic or unhelpful attitude on the part of others, including staff - aggression is less likely in environments which foster trust and mutual respect; and
- an infringement, or perceived infringement, of a person's rights.

These are just examples of what should be considered in people who show harmful or potentially harmful behaviour. Clearly, the better a patient and his/her circumstances are known, the more readily will staff be able to identify the likelihood of any such factors being involved in a particular case.

It should be remembered that internal and environmental precursors generally do not occur in isolation and that harmful or potentially harmful behaviour often results from a combination of the two. For example, a patient may be more likely to exhibit aggression when asked to do something by a member of staff on a day when he/she feels unwell than on a day when he/she is feeling fine. Also, it is worth noting in this sense that harmful or potentially harmful behaviour is often triggered by 'ordinary' events, albeit they can assume a particular significance because of on-going circumstances.

In any case, it is important that staff who find themselves dealing with a patient whose behaviour is likely to become harmful or potentially harmful maintain a confident and competent manner throughout and seek to defuse rather than do anything that might inflame a given situation.

Staff should investigate a possible interaction between internal and environmental factors, and take appropriate action to reduce the likelihood of further harmful or potentially harmful behaviour occurring. A number of strategies may be adopted in this regard, some of which are known as 'primary' and others as 'secondary' prevention strategies.

Primary prevention strategies are concerned with matters *before* any harmful or potentially harmful behaviour is triggered. They require an awareness of any unusual or other events or circumstances which might lead a patient to display harmful or potentially harmful behaviour and, where possible, the making of appropriate and sensitive pre-emptive changes to his/her environment. Such changes should minimise the possible precursors to the patient's harmful or potentially harmful behaviour by ensuring that any likely 'triggers' to it are withheld and by providing appropriate opportunities for the person's needs to be met in alternative and more positive ways instead.
Primary prevention of harmful or potentially harmful behaviour may be accomplished by:

- the number of staff deployed and their levels of competence should correspond to the needs of the patients and the likelihood of a restrictive physical intervention being required;
- care plans which are responsive to individual needs and which include current information on risk assessment which aims to minimise the impact of behaviours on patients, staff and the environment;

- helping patients to avoid situations which are known to provoke harmful or potentially harmful behaviour, for example, settings where there are few options for individualised activities;
- creating opportunities for patients to engage in meaningful activities which include opportunities for choice and create a sense of purpose and self-worth and promote independence based on ability and previous life experiences (see examples documented in Table 1);
- developing staff expertise in working with patients who have challenging behaviours; and/or
- talking to patients, their families and advocates about the ways in which they prefer their harmful or potentially harmful behaviours to be managed – many patients prefer withdrawal to a quiet area to an intervention which involves more restrictive bodily contact.

Secondary prevention strategies focus on what happens *after* it becomes clear that a harmful or potentially harmful behaviour is likely to occur. They seek to defuse or prevent the escalation of such behaviours, and in all cases they should be individualised to the person concerned.

Secondary prevention of harmful or potentially harmful behaviour may be accomplished by:

- providing the patient with options to allow him/her to respond in an alternative way, yet without 'losing face' (e.g. asking if he/she wishes to participate in a favourite activity);
- inviting the patient to talk about his/her concerns, with the possibility of jointly exploring alternative responses in the particular circumstances;
- reducing the level of demands that are placed upon the patient;
- providing more (or, occasionally, less) distance between the patient and the staff; and/or
- Changing the staff and/or peer-group that are present with the patient, particularly to ensure that he/she is separated from anyone likely to inflame a given situation.

Staff should generally minimise eye-contact and speak calmly and quietly - albeit also firmly, to convey a sense of confidence - and the patient should be allowed time to calm down again.

Measures should be taken to maintain the patient's dignity throughout. These measures should be consistent with the level of threat presented, and with the safety both of the patient and of others.

Staff should seek at all times to maintain a clear route to the exit-door, and other staff in nearby locations should be alerted quickly and be prepared to provide assistance if necessary.

Despite the above, it is unlikely that *all* potentially aggressive situations will be defused and staff may still be confronted with patients who present with harmful or potentially harmful behaviours at times.

Also, it should be noted that, where there is clear documented evidence that particular sequences of behaviour are likely to escalate rapidly into harmful or potentially harmful behaviour, the use of a restrictive intervention at an early stage may, potentially, be justified – provided it is clear that primary prevention has not been effective, the risks associated with not using a restrictive intervention are greater than the risks of using a restrictive intervention, and other methods, which do not involve restrictive interventions, have been tried without success.

All prevention strategies should be selected and reviewed to ensure that they do not unnecessarily constrain opportunities or have an adverse effect on the welfare or quality of life of patients affected, including those in the vicinity when an incident occurs. Indeed, in some situations it may be necessary, through a process of risk assessment, to reach a judgement about the relative risks and potential benefits arising from activities which might provoke harmful or potentially harmful behaviours compared with the impact on the person's overall quality of life if such activities are proscribed.

3.2 Risk assessment and planning for restrictive interventions

For every patient who is at high risk Trust staff will update the individual's care plan with the aim of minimising the likelihood of such behaviour reoccurring and inform other members of the multidisciplinary team.

If the behaviour continues to occur, or if the original incident is sufficiently severe as to make a restrictive intervention likely to be required in the future, the updated care plan should include a formal intervention plan.

When a restrictive intervention is indicated, appropriate steps should be taken, by way of a risk assessment and management plan, to minimise the degree of risk presented to both staff and patients.

Risks to patients in using a restrictive intervention include the potential for it to:

- be used unnecessarily, i.e. when other, less intrusive methods could achieve the same outcome;
- cause injury;
- cause pain, distress or psychological trauma;
- become routine, rather than exceptional methods of management;
- increase the risk of abuse;
- undermine the dignity of the staff or patient, or otherwise humiliate or degrade those involved; and/or

- create distrust and undermine personal relationships.

The main risks to staff in using a restrictive intervention include the following:

- suffering injury, or experiencing distress or psychological trauma;
- having their decision to use a restrictive physical intervention challenged in court; and/or
- being made subject to disciplinary action;

On the other hand, the main risks of not intervening in a situation involving harmful or potentially harmful behaviour include the following:

- staff perhaps being in breach of their duty of care;
- patients, staff or others being injured or abused;
- serious damage to property occurring; and/or
- the possibility of litigation in respect of any or all of these matters.

When a requirement for a physical intervention is foreseeable, a risk assessment should be carried out, identifying the benefits and risks associated with the application of different interventions with the person concerned.

All formal risk assessments within the Trust must be carried out in line with the Trust's *Risk Management Policy and Strategy*. This will ensure that potential benefits from an intervention will be evaluated also, so that a fully informed and rounded judgement can be reached about the 'reasonableness' of a particular risk.

The increased proneness of adults who are elderly to negative side-effects from restrictive interventions, due to their higher incidence of physical and medical conditions, for example, needs especially to be included in any risk assessments that are carried out.

Specifically, medical advice must always be sought on the use of restrictive interventions with patients who have Dementia, a history of conditions affecting the neurophysiological (e.g. epilepsy), cardiac (heart), respiratory (breathing), gastro-intestinal (digestion), or musculo-skeletal (muscles, bones or joints) systems.

Staff should be fully trained in using any restrictive intervention recommended following a risk assessment, and it should be recorded and incorporated within the patient's care plan as part of a broader strategy for responding to his/her behavioural difficulties. Also, patients should only be exposed to restrictive interventions which are described in their individual records.

3.3 Using restrictive interventions proactively

Restrictive interventions will generally be used reactively. However, it might occasionally be deemed in a patient's best interests to use an intervention as part of a proactive strategy which is likely to require the application of a (reasonable) degree of force.

Where this approach is employed, a clear rationale for using the restrictive physical intervention, endorsed by a multi-disciplinary meeting which includes, wherever possible, the patient, family members and an independent advocate, should be established in writing. This intervention will become part of the patient's documented care plan. In accordance with best practice, the patient's care plan will be reviewed regularly with the multi-disciplinary team, as per good practice review.

Patient Assessment

• When placing a patient in restraints, assess the patient (patient's clothing) and areas within the patient's reach (e.g., bedside table and drawers) to assure that he/she does not possess or have access to items that could cause harm (sharp objects, matches, lighters).
• The physician and/or qualified staff must evaluate and document that the restrictive intervention does not pose an undue risk to the patient's health in light of his or her physical and or mental health.
• Individuals who have been restrained must be monitored continuously through observation by an assigned staff member. Documentation of this monitoring should occur every fifteen minutes or as prescribed by the multi-disciplinary assessment on the restrictive intervention monitoring record.
• Assess and document circulation (including skin integrity), movement, and sensation every hour. Offer appropriate range of motion, hydration, toileting, and other relevant care every two hours while awake.
• Provide all usual and customary care for patients who have been restrained.

3.4 Using restrictive interventions in emergency situations

Despite the best efforts of staff at preventing harmful or potentially harmful behaviour, the Trust recognises that there will be times when emergency restrictive physical or chemical interventions will still be needed (i.e. where such are needed to avoid injury or serious damage to property). Staff should always be guided in such instances by the best interests of the individuals involved. Physical restraint, rapid tranquilisation and observation should only be used when de-escalation has proved insufficient.

Before using an emergency restrictive intervention, the staff concerned should be satisfied that the possible adverse effects of the intervention (e.g. injury or distress) will be less severe than the adverse effects which might occur without the use of the restrictive intervention. Before taking any action staff should review the circumstances, search to understand the experience from the perspective of the patient, and assess what actions are to be taken. The relative risk of doing something versus not doing something should be risk assessed and the decisions recorded.

Emergency interventions - just like those which are planned - must always be applied using the minimum amount of force for the least amount of time required, and with a view to maximising the safety of everyone involved. In particular, no physical intervention should ever be intended or knowingly allowed to cause pain. Likewise, any restrictive physical intervention that is used should avoid any contact that could be misinterpreted as sexual. The protocol that should always be followed for any emergency restrictive intervention can be found in Appendix D. Staff should familiarise themselves with this protocol and refer to it before using any restrictive intervention.

The procedures to be followed after an emergency intervention are exactly as for planned physical interventions. Full details must be recorded in the patient's file and reported as soon as possible both to his/her main carer and to the member of staff's line-manager.
Additionally, however, once an emergency intervention is used for a particular patient, immediate steps must be taken to develop for that patient both primary and secondary prevention strategies and a programme of planned responses to any such future behaviours.

3.5 Harmful or potentially harmful behaviour

The issue of using a restrictive intervention is most likely to arise in relation to behaviours associated with an increased risk of damage or injury. Accordingly, the Trust affirms that physical interventions should *only* be used when any or all of the following four categories of behaviour either have already occurred or are considered imminently likely to occur:

- aggression or violence towards self;
- aggression or violence towards others;
- seriously destructive behaviour; and
- behaviour in which no regard is shown for the safety of either self or others.

Weapons

For the purpose of this document a weapon is defined as:

"Any object that is made, adapted or intended to be used to cause physical injury to a person"

A Concise Dictionary of Law (1192) pp 282
Oxford University Press, Oxford

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others. Trust does not provide training on weapon disarmament. Judgements must be made using professional knowledge and experience, risk assessment and management of aggression training.

Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation. This may mean contacting the police.

Involvement of Police Service in Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the staff member in charge of the unit to action appropriate assistance.

The use of police for assistance will trigger the completion of an untoward incident review.

3.6 Restrictive physical interventions and consent

Patients must always be given full information on any restrictive physical intervention that is proposed as part of their management or care. Once this has been given, attempts should be made to obtain the consent of the patient for the use of the proposed intervention. The wishes of the patient must be dominant, although the views of relatives and advocates, and the expert advice of other professionals should be sought.

Even in the absence of a patient's consent, it may still be necessary to apply a restrictive physical intervention at times – although only provided if the intervention is demonstrably in the patient's best interests. Indeed, it is important to note that *not* applying a particular intervention could, in certain circumstances, be construed as a breach of a 'duty of care'.

All interventions proposed *without* a patient's consent (or, in the case of an adult without capacity) should be carried out in accordance with the Trust's values and service principles as set out above, in section 2.1 of this policy.

All patients (and/or carers) to whom this policy relates should have access to both the policy itself and the Trust's patient feedback policy and procedure

3.7 Individual care plans and formal intervention plans

An **individualised person centred care plan** will be drawn up for every patient receiving services from the Trust. Care plans should be reviewed and updated regularly and should be individualised to each patient's psychological, emotional, social and medical needs.

In the case of those who present with on-going harmful or potentially harmful behaviour, this will include a **formal intervention plan**, providing details of both primary and secondary prevention strategies and procedures for staff to follow should any such behaviour occur.

Where appropriate, individualised care plans should be drawn up in such a way as to enable staff to respond effectively to episodes of dangerous or potentially dangerous behaviour while at the same time ensuring the safety of everyone concerned. Person centred care plans are central to managing behaviour that staff find difficult.

Intervention plans should be drawn up only after a full assessment and discussion has taken place, including consideration of the multi-disciplinary team and established good practice in relation to the proposed intervention. This may also involve seeking advice from the Trust's legal advisers.

Intervention plans should include written details of the following:

- information about the patient and his/her behaviour(s), including any which may require a restrictive intervention, obtained by a thorough, multidisciplinary assessment;
- assessment and evaluation of all alternative approaches, whether already tried or not, including any contra-indications to the use of restrictive interventions;
- evaluation of the possible risks associated with a given intervention, against the risks of not adopting a restrictive intervention;
- a record of the views of patients, if possible, or of family members, carers or advocates in the case of adults with reduced capacity;
- a system for recording behaviours and the use of restrictive interventions, on the Trust's Incident Report Forms, which will be on pre-printed and individually numbered pages;
- a description of the specific intervention techniques which are sanctioned, and the frequency with which they will be reviewed;
- a description of those staff who are trained to use the specified interventions with the patient concerned;
- the ways, in which the intervention plan will be reviewed, the frequency of review meetings and the members of the review team involved;
- the maximum length of time that a restrictive intervention should be used on any single occasion, thereby ensuring that all restrictive interventions are time limited based on the assessed needs of the patient; and
- all patients, or family members, carers or advocates in the case of adults with reduced capacity, must sign intervention plans. Reasons for non-signature must be documented.

A restrictive intervention should remain part of a patient's intervention plan only for the shortest period possible. For that reason, and also because of possible side-effects, intervention plans need to be regularly reviewed, with each review including a (revised) assessment of risk.

3.8 Safety issues in the use of restrictive physical interventions

The WHSCT Trust is committed to providing its entire direct-care staff with training in preventative, de-escalation and disengagement techniques in relation to harmful or potentially harmful behaviour. Selected staff (as detailed in the procedures and guidelines documents for the respective programmes of care) will also be trained in appropriate restrictive physical intervention procedures. The Western Trust currently uses MAPA (Management of Actual

and Potential Aggression) Training, facilitated by HSC Clinical Education Centre (CEC).

All members of staff will be expected under all circumstances to adhere to the principles of such training in their dealings with patients and to attend for update training as required by their service area.

Irrespective of the precise form of training recommended within the Trust, individualised formal intervention plans giving the exact conditions under which restrictive physical interventions are to be used should be drawn up and set out clearly in written form.

The health and safety of everyone concerned must remain of paramount importance throughout the application of a particular restrictive physical intervention.

Specifically, this means that any such intervention must be **stopped immediately** if a patient develops any of the following:

- breathing difficulties (including very rapid breathing);
- fits or seizures;
- vomiting;
- blueness of the hands or other body parts (indicating reduced blood flow);
- paleness or yellowing of the skin (suggestive of restricted blood flow); or
- bone fractures or joint dislocations.

At the same time, any necessary medical intervention should be secured as a matter of urgency.

3.9 Documenting the use of restrictive interventions

Any use of a restrictive intervention must be documented fully and as quickly as possible. A Restrictive Intervention Monitoring Sheet (Appendix E) should be completed for each planned or emergency restrictive intervention.

Additionally, as a minimum, the following must be recorded in the patient's notes and records:

- medical staff must be informed if a restrictive intervention is used with a patient;
- the names of patient(s) and staff involved;
- the date, time and location of the incident;
- the names of any witnesses;
- a description of events leading up to the incident, including strategies used prior to the implementation of the restrictive physical intervention;

- a description of the incident and the restrictive intervention employed, along with times;
- a description of the ending of the incident;
- a note of any injuries to patient(s) and/or staff, plus appropriate action taken;
- a description of any damage caused to property, etc;
- a note of any additional action taken;
- a note of those informed of the incident (i.e. managers, carers, etc);
- any recommendations as to the management of any future such incidents;
- the date of the record, along with the name and signature of the person completing it;
- A Trust Incident Report Form must also be completed.

Please refer to Appendix A – Guide on use of Restrictive Intervention Policy

4. EQUALITY STATEMENT

In line with duties under the equality legislative (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this guidance should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this guidance is:

Major impact ☐
Minor impact ☒
No impact ☐

5. MANAGEMENT RESPONSIBILITIES

5.1 General responsibilities

With regard to *any* form of intervention within the Trust, managers within each programme of care will be responsible for ensuring the following:

- that members of staff work at all times within the law and in line with the Trust's values and service principles (see above, section 2.1);
- that patients' needs are properly assessed and met, having due regard to the needs of both formal and informal carers and staff; and
- that the principle of safety is promoted at all times.

With regard specifically to interventions for managing harmful or potentially harmful behaviour, Directors are responsible for the development and implementation of procedures and guidelines specific to each individual

programme of care. All such procedures and guidelines must be consistent with this policy.

Managers are responsible for ensuring, insofar as possible, that any given Trust setting has on-hand at all times a sufficient number of trained staff to ensure that the contents of this policy and of any associated procedures and guidelines can be appropriately and safely implemented.

Where staff shortages impact on the Trust's ability to manage harmful or potentially harmful behaviour, managers have a responsibility to notify senior colleagues at once.

5.2 Post-incident management and debriefing

Following an application of a restrictive intervention, any staff and patient(s) involved should be given separate opportunities, as soon as they have regained their composure, to talk about what has happened in a calm and safe environment. Such sessions should seek to discover exactly what occurred and the effects on those involved – neither to apportion blame nor to punish anyone.

If there is any reason to suspect that any person involved in a restrictive intervention has experienced injury or severe distress, medical attention should be sought just as quickly as possible.

To help protect the interests of patients who are exposed to restrictive interventions, it is good practice to involve, wherever possible, their family, carers and/or independent advocates in planning, monitoring and reviewing how and when such interventions are used. They should also have been provided with information on how to make a complaint within the Trust.

Staff debriefing sessions should focus on any resulting needs of the member of staff concerned, and if any help (e.g. a medical referral and/or referral to the Trust's Staff Care Scheme) is required, this should be facilitated. Staff should also be made aware of the possibility of support from their professional body or trade union, if appropriate.

Line managers should also, where appropriate, seek medical advice as to the advisability of the member of staff resuming his/her duties.

In line with the Trust's policy on the *Personal Safety of Staff*, any need for professional support should be assessed and discussed with the member(s) of staff and, if the incident involved any form of direct physical assault, debriefing sessions should also seek to establish whether police involvement is being sought by the member(s) of staff concerned.

All records and documentation in relation to an incident should be reviewed and completed as necessary in a debriefing session. The exact circumstances of the incident, including events that preceded it and actions taken afterwards,

should be discussed and reviewed, with the dual aims of reviewing current practice and of minimising the risk of any further such incidents occurring.

A record of all debriefing sessions, and of any actions taken subsequently, must be kept by the line manager(s) concerned.

5.3 Staff training

A training strategy for staff within the Trust's programmes of care will be developed in relation to this policy, including a rolling programme of awareness sessions on the contents of the policy.

Every staff member who is likely to encounter patients who present with harmful or potentially harmful behaviour should attend at least one initial such session. Thereafter, Trust managers will be responsible for ensuring that all new staff are familiarised with the contents of this policy and afforded appropriate training.
Managers will also ensure that all direct-care members of staff receive training in preventative, de-escalation and disengagement techniques in relation to harmful or potentially harmful behaviour, with selected staff trained additionally in the application of restrictive physical interventions. The nature and extent of this training will depend upon the characteristics of the patients likely to require such an intervention, the behaviours they present and the responsibilities of individual members of staff.

Training will be provided only by instructors with appropriate experience and qualifications.

'Refresher' training will be provided as detailed in the procedures and guidelines produced by each programme of care within the Trust.
Only members of staff who have successfully completed a designated training programme for a particular intervention strategy should operate that strategy in the course of their employment.

Likewise, staff should only use restrictive interventions in which they have received appropriate training and in the application of which they have been assessed as competent. It is never appropriate for staff to modify any techniques they have been taught.

A record should be kept of which staff may use the different restrictive interventions.

6. MONITORING AND REVIEW OF THE POLICY

Managers and staff are responsible for ensuring that the contents of this policy are adhered to at all times. Specifically, they will be responsible for:

- maintaining systematic records and a system for reporting and reviewing incidents;
- monitoring trends over time with respect to the use of restrictive interventions with individual patients, identifying overall trends in the use of such interventions throughout the Trust and sharing these across Directorates;
- monitoring and reviewing local practice in the light of feedback within the context of clinical governance or other systems of accountability;
- developing staff training programmes, including regular updating and refresher training; and
- ensuring that staff recruitment, training and work rotas are adjusted as necessary, to ensure that staff with appropriate levels of expertise are available to patients who may require the application of restrictive interventions.

Documentation in the use of restrictive physical interventions will be monitored to ensure that all groups of patients are treated fairly. Each programme of care will be expected to obtain information for monitoring purposes to ensure that no group is adversely affected by the policy's implementation.

7. REFERENCES AND ACKNOWLEDGEMENTS

In preparing this policy, the Western HSC Trust wishes to acknowledge in particular the information and guidance provided in the following documents:-

'Guidance on Restraint and Seclusion in Health and Personal Social Services', Department of Health, Social Services and Public Safety (2005).

'"Let's Talk About Restraint" Rights, Risks and Responsibility', Royal College or Nursing (2008).

'Physical Restraint – Part 1: Use of Acute and Residential Care Facilities'. Best Practice, 6 (3) pp 1-6 (2002).

'Physical Restraint – Part 2: Minimisation in Acute and Residential Care Facilities'. Best Practice, 6 (4) pp 1-6 (2002).

"Avoiding Restraint in Older Adults with Dementia" Cotter, V.T., Evans, L.K. The Hartford Institute for Geriatric Nursing, New York University, College of Nursing (2007).

"*Quality of Life Outcomes for People with Alzheimer's Disease and Related Dementia – Care Planning Tool for Providers"*. Wisconsin State-wide Advisory Committee (2004).

"*Use of Restraints: Patient Care Policy"*. North-western Memorial Hospital (2005).

"*Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioural Health*". American Psychiatric Association

This policy will be reviewed by not later than August 2016

ACKNOWLEDGEMENTS

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Ms Maureen Kelly, Chair of Trust Zero Tolerance and Security Working Group

8. APPENDIX

An individual's response is usually caused by interplay between any chronic or acute health conditions, cognitive impairment, past experiences, previous coping strategies and current environment. A thorough assessment will help to identify reasons for behaviour for each patient. Appendix C should be used as a protocol for interventions and/or alternatives to restrictive interventions.

Patient Assessment

- When using a restrictive intervention with a patient, assess the patient (patient's clothing) and areas within the patient's reach (e.g., bedside table and drawers) to assure that he/she does not possess or have access to items that could cause harm (sharp objects, matches, lighters).
- The physician and/or qualified staff must evaluate and document that the restrictive intervention does not pose an undue risk to the patient's health in light of his or her physical and or mental health.
- Individuals who have been restrained must be monitored continuously through in-person observation by an assigned staff member who is competent and trained**.** Documentation of this monitoring occurs every fifteen minutes on the restrictive intervention monitoring record.
- Assess and document circulation (including skin integrity), movement, and sensation every hour. Offer appropriate range of motion, hydration, toileting, and other relevant care every two hours while awake.
- Provide all usual and customary care for patients who have been restrained.

APPENDIX A:

Summary and Guidance on the Policy for the Use of Restrictive Interventions with Adult Patients

Definition of Restrictive interventions

Whilst a basic definition of restraint might be 'restricting movement' or 'restricting liberty', many interventions may restrict unintended movement – for example, plaster casts to stop a patient accidentally displacing a fracture – or may unintentionally restrict movement – for example, a nursing home locked at night to protect residents and staff from intruders.

According to established international definitions, included within *Showing restraint: challenging the use of restraint in care homes* (Counsel and Care UK, 2002), restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.' In this context, 'behaviour' means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is 'stopping a person doing something they appear to want to do.'

Types of Restrictive Interventions

Physical restraint
Involves one or more members of staff holding the person, moving the person, or blocking their movement

Mechanical restraint
Involves the use of equipment; Examples include everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

Chemical restraint
Involves using medication to restrain; this could be regularly prescribed medication – including that to be used as required or over-the-counter medication.

Psychological restraint
Can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

Indications for Use

The application of restrictive interventions must be based on the assessed needs of the patient, discussed and agreed with the multi-disciplinary team and used in conjunction with or after exploring alternatives to the use of restrictive intervention.

The steps below must be undertaken when considering application of restrictive interventions.

- Restrictive interventions should always seek to achieve outcomes that reflect the best interests of the patient whose behaviour is of immediate concern and of any others who might be affected by that behaviour.

- Restrictive interventions should only be used only to prevent injury, to avert serious damage to property and to enable appropriate delivery of essential care in a dignified manner. Exceptionally, they may be necessary to ensure that essential medical treatment can be provided. Restrictive interventions may be either **planned** or **unplanned**.

- Except in emergencies, decisions about restrictive interventions need to be made after discussion, wherever possible, with the patient, their relatives and/or advocate. It is important to involve the whole care team, including other professionals and agencies that may be helping to support the patient.

- Any decision to use a restrictive intervention should be based upon a multi-disciplinary assessment of the risks associated with the intervention compared with the risks of not employing a restrictive intervention. Risk should be assessed using **Appendix B** of policy.

- The minimum necessary restrictive intervention should be used at all times and alternatives must first be tried and documented (see **Appendix C** for a protocol of interventions and alternatives to restraint).

- The protocol that should always be followed for any emergency restrictive intervention can be found in **Appendix D**. Staff should familiarise themselves with this protocol and refer to it before using any restrictive intervention.

- Any use of a restrictive intervention must be documented fully and as quickly as possible. A Restrictive Intervention Monitoring Sheet (**Appendix E**) should be completed for each planned or emergency restrictive intervention.

- A Trust Incident Report Form must also be completed for all emergency restrictive interventions.

APPENDIX B: RISK ASSESSMENT / RESTRICTIVE INTERVENTIONS

Please affix addressograph here if available.
Patient's Name : .....
Hospital number. .....
D.O.B: ..... *Age:* .....
Address: .....
.....

Location: .....

Ward: .....

Room: .....

If the patient presents with any of the following main risk indicators then the following risk assessment and interventions must be initiated

	RISK FACTORS	Y	N		RISK FACTORS	Y	N
A	Risk of physical violence towards self or others			H	Risk of removal of essential drains		
B	Risk of falling out of bed with cot sides in situ			I	Risk of damage / contamination to major wound sites		
C	Serious risk of falls			J	Risk of excessive fatigue due to excessive pacing / agitation		
D	Other behaviour which present risk to self or others			K	Risk of damage / contamination of minor wound		
E	Risk to airway			L	Risk of laceration or bruising		
F	Removal of essential cannulae			M	Risk of increased discomfort		
G	Risk of removal of NG / NJ / PEG feeding tubes and subsequent malnutrition or aspiration			N	Risk to patient dignity		

If 'Yes' to any of the questions above or you still remain concerned, please complete the care plan below.

Assessment of Risk Factors	Interventions	Assessment Describe interventions initiated
Sensory Status	Check whether hearing aids and glasses are needed, working or missing. Leave glasses and/or hearing aid within easy reach.	
Drug Interaction	Make adjustments to medications as indicated.	
Physiologic Reaction	Treat as appropriate to physiologic factor based on assessment (i.e. correct electrolyte imbalance). Treatment of fever. Reorientation to room Allow familiar possessions Facilitate family/significant others presence Toileting, incontinence aids Relocate patient closer to nursing station. Frequent Observation.	
Pain and / or Discomfort	Administer analgesics Repositioning of patient or equipment Facilitate elimination Treatment of fever	
Reaction to Environment	Adjust lighting Adjust noise level Adjust room temperature Reorientation to room Allow familiar possessions Facilitate family/ significant others presence or involvement Where possible assign same staff Bedside light left on overnight Ensure appropriate signage within environment Provide diversionary activities.	
Psychological Factors	Non-confrontational Repeatedly use verbal explanation Communicate clearly, slowly, calmly Explain who you are & what you are doing.	

If there is a need for Restrictive Intervention & patient is still exhibiting behaviour that is deemed a threat to self or others, please complete sections overleaf.

APPENDIX B: (Cont'd) **RISK ASSESSMENT / RESTRICTIVE INTERVENTIONS**

Application of Restrictive Interventions

Multi-Disciplinary Team agreeing on Restrictive Intervention:

Designation	Full Name	Date	Signature
Doctor			
Nurse			
AHP			
Patient/Guardian/Advocate			
Other:			

Types of Restrictive Intervention to be Utilised

		Yes	No
Chemical:	Prescribed Medication		
Physical / Mechanical:	Holding Patient		
	Bedrails		
	Lap Strap		
	Closed / Locked Door		
	Seating		
Others:	Specify:		

Date	Type of Restriction Applied	Start Time	Duration of Intervention	Describe the Monitoring to be Undertaken with this Intervention (Complete Monitoring Evaluation Sheet)	Signature

APPENDIX C: Interventions / Alternatives to Restrictive Interventions

Alternative interventions should be tried and documented before any restrictive interventions is introduced

Potential Causes of Behaviours

Sensory Status	Drug Interaction	Physiologic Reaction	Pain and/or discomfort	Reaction to environment	Psychological Factors
• Poor sight • Hearing difficulties	• Review drug profile	• Hypoxia • Metabolic • Nueroimpairment • Sundowning • Wandering • Infection • Dehydration	• Surgical Pain • Chronic Pain • Presence of tubes, lines and/or drains • Full bladder • Constipation • Hunger • Fatigue	• Lighting • Equipment / noise level • Room temp • ICU psychosis • Tactile • Unfamiliar surroundings • Caregiver approach • Boredom	• Fear • Depression • Anxiety • Previous experience of abuse or trauma history • Paranoia

Alternatives to Restrictive Interventions

Sensory Status	Drug Interaction	Physiologic Reaction	Pain and/or discomfort	Reaction to environment	Psychological Factors
• Check whether hearing aids and glasses are needed, working or missing. • Leave glasses and/or hearing aid within easy reach.	• Make adjustments to medications as indicated.	• Treat as appropriate to physiologic factor based on assessment (i.e. correct electrolyte imbalance). • Treatment of fever. • Reorientation to room • Allow familiar possessions • Facilitate family/significant others presence • Toileting, incontinence aids • Relocate patient closer to nursing station. • Frequent Observation.	• Administer analgesics • Repositioning of patient or equipment • Facilitate elimination • Treatment of fever	• Adjust lighting • Adjust noise level • Adjust room temperature • Reorientation to room • Allow familiar possessions • Facilitate family/ significant others presence or Involvement • Where possible assign same staff • Bedside light left on overnight • Ensure appropriate signage within environment • Provide diversionary activities.	• Non-confrontational • Repeatedly use verbal explanation • Communicate clearly, slowly, calmly • Explain who you are & what you are doing.

Re-Assess the Need for Restrictive Intervention

YES	NO
Alternatives implemented, patient still exhibiting behaviour that is deemed a threat to self or others.	Patient no longer exhibiting behaviour that is deemed a threat to self or others
Continue use of restrictive intervention and follow monitoring & documentation requirements as outlined in policy.	Stop restrictive intervention and document removal, note date/time on restrictive intervention monitoring sheet.

APPENDIX D: Using Restrictive Interventions in Emergency Situations

Implement De-escalation techniques	• Always identify yourself • Communicate clearly, slowly, calmly • Ask the patient how you can help • Ask patients if they are hurt (assess for medical problems) • Ask patients if they were having some difficulty or what happened before they got upset • Remember why the patient is in the hospital • Find a staff member that has a good rapport/relationship with the patient and have him or her talk to the patient. Let the patient know you are there to *listen* • Use team or third-party approach. If patient is wearing down one staff, have another take over (10 minutes of talking might avoid a restraint incident) • Allow quiet time for patients to respond — silent pauses are important • Respect needs to communicate in different ways (recognize possible language/cultural differences as well as the fear, shame, and embarrassment the patient may be experiencing) • Face the patient; always call the patient by their preferred name; use gestures; relax & smile
↓ ***If problem persists call for Assistance***	
↓ ***Request Medical review of patient by appropriate medical personnel***	
↓ ***Disengagement Techniques (MAPA principles)***	• Use least invasive method to deliver care • Discontinue invasive treatments as early as possible
↓ ***Debrief***	
↓ ***Complete Restrictive Intervention Monitoring sheet***	• See Appendix E
↓ ***Complete Untoward Incident Form***	
↓ ***Record Intervention in patients case notes***	
↓ ***Develop programme of planned responses for any future behaviours***	

APPENDIX E: RESTRICTIVE INTERVENTIONS MONITORING

Please affix addressograph here if available.
Patient's Name : .....
Hospital number. .....
D.O.B: ..... *Age:* .....
Address: .....
.....

Location:
.....

Ward:
.....

Room:
.....

Date	Type of Intervention	Time	Monitoring Check Made	Next Time Monitoring Check	Signature