BIELD HOUSING AND CARE

POLICIES PROCEDURES AND GOOD PRACTICE GUIDELINES

4.0.4 MANAGING RESTRAINT POLICY AND PROCEDURE

POLICY STATEMENT

Bield is committed to respecting the freedom of individuals to make considered choices about matters which affect the course of their lives. Bield is also committed to ensuring that respect for the value and dignity of life has a central place in its approach to delivering Professional Services.

We recognise that the people, whom we support, including those living with dementia, may present with distressed behaviour which may pose a risk to themselves and/or others. We have a duty of care to support them to manage those risks but recognise fully our responsibility to respect their freedoms and to manage distressed behaviour sensitively, effectively and safely, and wherever possible with their informed and expressed consent.

Distressed behaviour can limit a person's ability to participate in and enjoy a valued life in any care setting. It is important to recognise that everyone experiences a range of emotions and that these are expressed in different ways. Where people are limited through physical or cognitive impairment in expressing their emotions verbally, they may express these emotions in other ways, including a variety of distressed behaviours. Some of these behaviours may be harmful to themselves or others.

There are also circumstances where people whom we support are particularly at risk of harm to themselves through physical impairment or illness. We must look at strategies to reduce that risk as part of our duty to keep people safe.

Whether in response to distressed behaviour or risk caused by other factors, we recognise that it may occasionally be necessary and beneficial to the individual concerned to put measures in place which restrict people's choice and freedom and which may be defined as Restraint (see below).

The only acceptable justification for the use of restraint is to reduce an identified, specified risk to the individual concerned and/or others, where it has been established that there is absolutely no alternative that would reduce the risk to an acceptable level.

Many actions by staff, conscious or unconscious, may limit the freedom of the people whom they support, even if the desired intention is to protect the individual. We must always ensure interventions are in the best interests of the individual and not simply to benefit the project.

Those at risk may be:-

Agitated or restless

Likely to fall

Likely to significantly harm themselves or others

Have a limited capacity to understand fully the consequences of their actions.

A balance must be struck between the individual's freedom, and right to take risks, and the level of risk of harm to that individual or others. Where the individual concerned is not capable of recognising the risk they are placing themselves at, or cannot control the risk themselves, it is our responsibility to support them. If (and only if) alternative methods of managing that risk are unsuccessful, we may have to consider restraint.

In every case, the risk must be severe enough to justify the intervention, the intervention must reduce the risk to the individual and/or others and there must be no other workable alternative.

DEFINITION OF RESTRAINT

The Mental Welfare Commission defines restraint as:

"Restraint encompasses a range of actions intended to limit the ability of a person to do something which is felt by another person or persons to be undesirable. Restraint which is exercised without legal authority is a civil wrong and may constitute a criminal offence."

(Mental Welfare Commission, revised June 2002).

"In its broadest sense, restraint takes place when the planned or unplanned, conscious or unconscious actions of staff prevent an individual from doing what he/she wishes to do and as a result places limits on his or her freedom."

(Mental Welfare Commission: Rights, Risks and Limits to Freedom 2006).

'Physical restraint' is defined by The Mental Welfare Commission as:

"The actual or threatened laying of hands on a person to stop him/her from either embarking on some movement or activity, or following it through. The grounds for intervention are that the person's action is likely to lead to hurt or harm to the person or others, or prevent necessary help being given."

For the purposes of this Policy, with reference to the above, Restraint is defined as:

Any Action or Situation that Restricts Someone's Freedom in Mind or in Body.

There are forms of restraint which are physical, but do not come within the Mental Welfare Commission's definition of 'physical restraint'. For the purposes of clarity in this Policy and Associated Procedures, therefore, we divide Restraint into two categories:

1) **INDIRECT RESTRAINT**
   This may include: drug treatments, environmental factors, physical barriers, assistive technology, and restrictive practices and behaviours.

2) **DIRECT RESTRAINT**
   'Direct restraint' means any form of 'hands on' restriction of someone's movement. This conforms to the Mental Welfare Commission's definition of 'physical restraint'.

RELATED LEGISLATION

Health and Safety at Work Act 1974
Management of Health and Safety at Work regulations 1999
Adults with Incapacity (Scotland) Act 2000
The Human Rights Act (1998)
The Mental Health (Care and Treatment) (Scotland) Act 2003
Adult support and Protection (Scotland) Act 2007

RELATED PUBLICATIONS

Rights, Risks and Limits to Freedom
Safe to Wander
Decisions about Technology
Common Concerns with Power of Attorney

These Guidance documents are published by the Mental Welfare Commission and are available on their website:

www.mwscot.org.uk/GoodPractice/Publications/Guidance documents.asp

All Services should have copies available.

RELATED POLICIES AND PROCEDURES

4.0.1 Risk Taking
4.0.2a Safeguarding Adults
4.0.3 Responding To Stress/Distressed Reactions
4.0.4 Managing Restraint Procedure and Guidance
4.1.7 Violence at Work and Reporting Violent Incidents
4.2.1 Assessment, Support Planning and Review4.7.1 Managing Specific Health Conditions
4.8 Medication Policy and Procedures
3.11 Power of Attorney

PRINCIPLES

In considering implementation of any measures of Restraint, we are committed to adhering to the following principles:

1) Risk taking is a part of daily living. To eliminate risk taking would restrict the individual's right to independence, dignity, choice and self-determination.
2) Management of risk in any care or support setting must be carried out, wherever possible, with the consent of the individual concerned.
3) Where the individual concerned does not have capacity to understand any risk to themselves or others, any decision regarding the management of that risk must involve consultation and agreement with relevant parties as outlined in procedure.

4) Where any form of restraint is being considered, there must be full consultation, as in 2) and 3) above.
5) Before any method of restraint is employed, alternative methods of avoiding or managing the behaviour or situation must be considered.
6) Any method of restraint employed must be the least restrictive option, must be beneficial to the person, necessary, and employed for the shortest time possible.
7) Direct (physical) restraint must be considered at all times as a last resort.
8) In exceptional circumstances where restraint is unplanned, this must be reported and recorded immediately and full consultation must take place with all relevant parties according to procedure.
9) If staff members are considering actions involving any method of restraint, they must do so in strict adherence to Procedure.

HUMAN RIGHTS

Any person receiving care or support in our Service of any kind has the same human rights as any individual in the wider community. We recognise that all people whom we support should have freedom of choice and movement, unless there are very good reasons to deny this.

The overriding principle of this Policy is that the use of restraint should be avoided wherever possible and that alternatives to restraint should always be considered first.

TRAINING

- All staff must cover this Policy and Procedure in induction training.
- Copies of 'Rights, Risks and Limits to Freedom', and 'Safe to Wander' should be made available to staff.
- The Policy, Procedure and these Publications should be discussed with new staff members as part of their induction and supervision.
- All staff members must read and refer to the Policies and Procedures relating to Risk Taking (4.0.1) Safeguarding Adults and Children (Scotland) (4.0.2), Responding to Stress/Distressed Reactions (4.0.3) and Violence at Work and Reporting Violent Incidents (Health and Safety Manual 4.17).
- All staff should complete the 'Managing Stress and Distressed Reactions' Course.
- Where considered appropriate, Managers should consider nominating staff members for 'Non-Violent Interventions' Training.
- Where any form of direct restraint is anticipated, advice and training for staff should be sought from local Health and Social Care Practitioners and Bield's training Department.
- Except in very unusual circumstances, Bield staff will not be trained in methods of physical restraint. Staff should always try to de-escalate a situation or withdraw and seek support.

FORMS OF RESTRAINT

INDIRECT:

Chemical (Medication) –
The use of medication routinely which has been prescribed 'PRN or as required' for managing distress

Covert Medication

Environmental –
Arrangement of furniture, difficulty of access to certain areas, locked doors or any other factor inhibiting freedom of movement for an individual.

Mechanical –
Bed rails, wheelchair lap belts, reclining chairs

Assistive Technology –
Passive alarms (e.g. pressure pads, door alarms, fall and movement sensors), electronic 'tags', GPS in mobile phones
[CCTV – In Bield Services, CCTV is only used for external security, and would not be used for surveillance of individuals.]

Behavioural/Cultural –
Any aspect of staff behaviour or attitude, or any accepted culture in the care and support setting, which inhibits one or more individuals from exercising choice

In attention to individual Support Needs – e.g. failure to ensure that someone has their call button to hand to summon assistance, or walking aid within reach

DIRECT:
Any form of 'hands on' physical intervention that restricts the movement of an individual or guides them against their will.

AVOIDING RESTRAINT

Strategies for avoiding the use of restraint follow Good Practice Guidelines for Managing Stress/Distressed Behaviour and include:

- Calm (attitude and voice)
- Distraction
- Enabling (for example, supporting someone, who would be at risk if they left the premises alone, to go out with company)
- Stepping back from the situation (if safe and reasonable to do so)
- ABC tool: The Behaviour Support Module of Caresys is designed using the ABC (Antecedent – Behaviour – Consequence) tool. When someone exhibits distressed behaviour of any kind, you should record the incident in the Behaviour Support Module. Using the tool will help you to identify possible triggers to the person's distressed behaviour and help you to work out strategies for avoiding it.

PLANNED RESTRAINT

When any measure of Planned Restraint is being considered, you should ensure that you are adhering to the principles outlined in Bield's Restraint Policy.

You must consider first whether the intervention is justified: i.e. whether the risk entailed is sufficiently great that intervention cannot be avoided.

You must also consider whether less restrictive strategies for avoiding or managing the situation has been considered. This must be documented in the person's Support Plan.

The Planned Measure(s) must be fully discussed with the person concerned and their representative/power of attorney if they have one, the Manager of the Service, Line Manager and other involved professionals (GP, Social Worker). If the person does not have family or someone to represent them, you should ask them if they would like support from your local advocacy service.

All discussion must be fully recorded.

In the case of medical treatment, where the person lacks the capacity to understand the proposed measure(s), the GP must issue a Section 47 Certificate which specifically covers the proposed measure(s). If there is a Power of Attorney in place, they must be fully consulted and their agreement sought.

*NB 'Medical Treatment' as defined in the Adults with Incapacity Legislation may cover personal care, where it is necessary for the prevention of infection, and maintenance of skin integrity and health. However, if at any point it becomes unavoidable that direct, hands-on restraint is used at any time when carrying out personal care, guidance from the Mental Welfare Commission makes it clear that a Power of Attorney could not authorise this, and it would not be covered by a Section 47 Certificate:

'Where it is likely that restraint is required on a regular basis, we consider that an application for the appropriate powers should be made in a guardianship order. The power in the order should be specific and indicate that restraint may be required.'

(*Mental Welfare Commission: 'Common Concerns with Power of Attorney' July 2015*)

Where other measures of restraint (technological, mechanical or direct restraint as defined by Policy) are being considered, and the person concerned does not have the capacity to give informed consent, application should be made for a guardianship order.

In all cases, a Planned Restraint Support Need must be drawn up, along with a Risk Plan. The Support Need and Risk Plan should clearly describe:

- The circumstances of the risk
- Who has been involved in discussion of the risk
- Whether a section 47 certificate is in place that covers the measures being taken
- Why the measure being put in place is considered necessary (refer to Principles in the Policy)
- The circumstances in which the measure being considered may be used
- How the risk is to be monitored and reviewed

In the case of planned direct restraint you must also be clear that only staff members who have been trained in Non-Violent Interventions may carry out the Procedure as outlined.

Actions should be specific and detailed. You must also be very clear that direct restraint will only be used when there is no alternative and it is considered necessary for the welfare of the person concerned.

Monitoring and Review:

It is essential that any measure of restraint is monitored carefully and reviewed regularly to establish:

- How frequently it is being used
- Whether it is effective
- Whether it remains necessary

Any use of the measure of restraint must be recorded in Daily Records on Caresys.

Timing for Review should be agreed with all those involved in the original discussion. Reviews should also, wherever possible, include all involved.

UNPLANNED RESTRAINT

In the event of any incidence of unplanned restraint, the following steps must be taken:

- The matter must be reported immediately to the Manager of the Service and Line Manager.
- The Incident must be recorded in the Daily Notes of the person concerned, and an Incident Report completed on Caresys (or on an Incident Report Form for Services not using Caresys). In the case of a violent incident, the report should be forwarded to the Health and Safety Manager, and a report also sent to the Care Inspectorate.
- A discussion must take place as a matter of priority with all involved parties (as above in Planned Restraint) to ascertain whether, and what action is necessary to reduce the risk of harm to the person concerned and/or others. If this involves any measures of Planned Restraint, follow the Procedure as above.
- The Manager of the Service should consider and seek advice as a matter of priority on Training Needs for staff members.

FORMS OF RESTRAINT

INDIRECT RESTRAINT (as defined in the Restraint Policy)

Indirect restraint includes any measures or actions other than 'hands on' interventions which have the potential to restrict a person's freedom in mind or body, even if the person concerned is in agreement to the measure(s). It also includes actions or attitudes of staff in our services which inadvertently restrict people's freedom.

Chemical Restraint:
PRN sedation: 'As required (PRN)' medication can be beneficial in certain circumstances for some of the people we support who may be experiencing difficulty or distress. This includes drugs which have a tranquillizing, or sedative, effect. It is essential, however, that it is only used when alternative means of managing distress have failed.

Inappropriate use of 'as required (PRN)' medication is a form of restraint. Staff must therefore be very specific in the use of PRN medication and follow the guidelines in 4.8.2/4.8.3 Medication Policy and Procedures. Use of any PRN medication must be regularly reviewed with the prescribing medical professional, the individual concerned and others involved.

Sedative medication:
Sometimes drugs which have a sedative effect (e.g. anti-psychotic drugs and some anti-depressants) may be prescribed to be given routinely. This may where distressed/ disturbed behaviour is thought to be caused by an underlying mental health condition.

It is vital in these circumstances that a full assessment of the individual's condition, and the cause of their symptoms, has been carried out by the prescribing medical practitioner in consultation with staff, and that alternative means of managing symptoms have been fully explored before this kind of medication is considered.

It is also essential that wherever possible, the individual concerned is consulted and agrees to the prescription, having been given full information about the medication being prescribed, including the reason for its prescription and possible side-effects. Where he/she is not capable of giving fully informed consent, welfare attorneys and welfare guardians appointed under the Adults with Incapacity (Scotland) Act 2000, if granted the power, may give consent to certain treatments. Part 5 of the Adults with Incapacity (Scotland) Act 2000 makes provision for the medical treatment of adults with impaired capacity and part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the treatment of mental disorder. In cases where a person with a mental disorder is incapable or refuses to consent to tranquillizing/sedative drug treatment, and the treatment is considered necessary, the use of these acts must be considered.

Covert Medication:
This is the administration of any medication to an individual without their knowledge, e.g. disguised in food or fluid, where the individual has declined to take the medication by other means.

The administration of medication, for whatever reason, without the consent or knowledge of an individual, is potentially an assault and should only be considered in exceptional circumstances. The Mental Welfare Commission has produced guidance on the covert use of medication:

http://www.mwcscot.org.uk/media/140485/covert_medication_finalnov_13.pdf

In order for a person with welfare power of attorney to be able to make a decision regarding medical treatment of the person concerned, a section 47 certificate must be in place.

See also 4.8.2 and 4.8.3 Medication Policy and Procedures.

Environmental Restraint:
Environmental restraint includes any restrictions to people's freedom of movement within a communal space.

Restraint of this nature may be caused inadvertently – e.g. furniture arranged in such a way that it obstructs people's movement. Staff in Services should be vigilant to avoid this kind of restriction for people using their Service.

Other forms of restraint of this nature include outside areas that cannot be freely or easily accessed, stairs, doors that cannot easily be opened and locked doors. Some restrictions of this nature are unavoidable due to the construction and design of the building. It may be possible to remove other restrictions (e.g. difficult outside access) where practically and financially possible.

Locked doors are the most common of environmental restraint and may occur for a number of reasons:

- Reasons of safety e.g. to prevent crime particularly at night
- To ensure privacy/prevent unauthorised entry
- To protect individuals and staff
- To prevent people from wandering outside and putting themselves at serious risk of injury

There are a number of systems that can be put in place to minimise restrictions on individuals we support. These include:

- Coded number pads and other electronic devices which allow competent individuals to use the door
- 'Slow door' delayed opening devices
- Door alarms

Staff need to consider the balance between individuals' self-determination and the duty of care, without putting anyone at unnecessary risk. Doors should be locked only after careful consideration of individual needs, and when all alternatives have been fully explored. The position of individuals who do not need the door locked must equally be fully considered, so that they have the ability to come and go as they please. Everyone should have written information and instruction on how to come and go from the project.

Mechanical Restraint:

Bed Rails: Bed rails may be useful in certain specified circumstances, when an individual is at risk of falling out of bed at night. Some people may feel safer if they have bed rails in place. Bed rails should never be used as a measure to prevent someone from getting out of bed. They increase the risk of serious injury if the individual concerned tries to climb over them to get out of bed.

Wheelchair Lap Belts:

Wheelchair lap belts should be used only as a safety measure when transporting a person from place to place and there is a danger of them slipping or falling out. They should not be used to confine anyone to the chair against their will, whether moving or stationary.

Reclining Chairs:

Many people enjoy resting or sleeping in reclining chairs, but some are unable to operate the chairs themselves, or to rise from them unaided. Unless they have the means to summon support to rise from the chair when they wish, this would amount to restraint.

Technological Restraint

This includes a variety of electronic devices, some of which are specifically intended to help individuals to retain independence, but which nonetheless can place restrictions on a person's freedom of movement, or interfere with their choice or privacy. Such devices are also categorised as 'passive' restraint. They include:

'Wandering Technology', e.g. GPS monitors, electronic 'tagging' devices, 'Buddy' system.

Door alarms to alert staff when someone leaves their flat

Movement Sensors

Pressure pads which sound an alarm when someone gets out of bed or out of a chair

Fall Sensors

This list is not exhaustive, and will grow as new technology develops. Staff need to be vigilant when any technological interventions are being considered to keep people they are supporting safe. Always consider whether there is any restriction on the person's freedom involved in the measure being considered and if so, follow Procedures correctly.

Behavioural/Cultural:

Restrictive or Restraining Practices/Behaviours: It is possible that individuals may find themselves restricted in their daily lives by the behaviours or practices of those who are caring for them – no matter how well-intentioned. Used repeatedly, or habitually, these constitute restraint.

These practices/behaviours might include:

Moving a walking aid away from the chair where the person is sitting. This may be done to avoid trip hazards – e.g. in a busy dining area – but nonetheless will prevent that person from being able to rise from the chair when they wish without assistance.

Moving someone with poor mobility from place to place in a wheelchair for speed and convenience, when they might prefer to walk with assistance.

Forgetting to ensure that someone has their call button on their person, or within reach.

Encouraging someone to sit in a communal area where they can be more easily supervised, when they would prefer to be elsewhere.

Telling someone what is going to happen – e.g. 'I'll take you through to the dining room for lunch now' – rather than making it clear that they have a choice in the matter.

Making someone feel that staff are too busy, so that they don't feel they should ask for assistance.

Maintaining a strict routine of activities through the day, which people might feel obliged to follow, even if that would not be their choice.

Making choices for someone because they have made that choice before and it is assumed they will always make that choice – e.g. 'John won't want tea – he likes milk at night.'

Attitude and voice: Individuals may be inhibited by staff who have an authoritative or bossy attitude, or if they are made to feel as if they are 'being a nuisance'. This may prevent some people from speaking out and voicing their choices and opinions. Other people may react with frustration or anger.

Managers should ensure that they foster a positive culture of enablement in their Services and that their staff teams are guided by example and through learning, support and supervision to support people in a manner that respects their rights and freedoms.

Unless people we support are actively encouraged to make choices, give their opinions and express their wishes, and unless they feel that they are listened to, they will be restricted in how they live their lives.

DIRECT RESTRAINT (as defined in the Restraint Policy)

Direct Restraint includes any kind of 'hands on' intervention which restricts someone's actions or movement. Placing oneself in front of someone as a barrier to them going out of a door is also a form of Direct Restraint. Direct Restraint is a last resort and should only be used in exceptional circumstances.

Unplanned Direct Restraint: Occasionally circumstances arise when staff feel that it is necessary to act in a way that restricts a person's movements, in order to carry out tasks that are necessary for preventing skin damage or infection, or to prevent them from harming themselves or other people. In all cases, staff members must be confident that they have exhausted other alternatives for managing the situation, or that the situation is extreme enough (i.e. an emergency) to warrant their actions. In the event of such an occurrence, the matter should be reported immediately and appropriate actions taken according to Procedure (above).

RESTRAINT/RESTRICTION GOOD PRACTICE PATHWAY

ABC TOOL (Behaviour support module on Caresys)

Observe, record and analyse any episodes of distressed behaviour to identify possible triggers. Consider strategies to prevent the behaviour happening.

Take steps using a multi-disciplinary approach to establish whether there is a reversible underlying cause for the behaviour, either medical or psychological, for example; pain, discomfort, infection, medication, noise, etc.

If these measures are unsuccessful:

CONSIDER THE RISK

This should take full account of the risk to the individual concerned, while recognising his/her rights. Does the risk as assessed justify the intervention being considered?

CONSULT

Discuss the proposed measure(s) with the individual concerned, welfare power of attorney/guardian (if applicable), family carers and involved professionals. Always consider whether it might be beneficial for an advocate to be present. If technological intervention of any kind is proposed, explain how the device works, and what its benefits are. Explain how and when it will be used.

PLAN AND RECORD

A Planned Restraint Support Need should be put in place, along with a Risk Plan. The Support Plan should outline clearly what measures are being put in place, the desired outcome (i.e. the benefit you hope to achieve) and what actions are to be taken. The Risk Plan should clearly state the reasons why the measure(s) are being put in place – what the risk is, and how high, how it is to be managed and who has been involved in the decision making process.

A timetable for Regular Review of the Support Plan and Risk Plan should be included in the Plans.

INFORM

Inform all staff involved of the Support Plan and explain clearly what their responsibilities are.

MONITOR

The frequency of use of the Planned Measure, its effectiveness in managing the distress, and its effects on the individual concerned should be recorded daily.

REVIEW

Planned reviews should involve as far as possible the individual and all parties involved in the original decision. Reviews should always work on the same principles as the decision.