Module Eight

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[Non] Restraints
Trainer's Resources

- Restraint Team
- Guideline Flowchart
- Restraint Log
- Assessment
- Approval
- Risk Assessment
- Consent
- Consumer Support
- Cultural Support
- Review

supporting service providers

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Definition of Restraint

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

1 Personal Restraint [from above].

2

- You could get hurt
- So could the person you are restraining
- Never use to move someone from place to place.

3

Can restrict breathing as chest not able to expand – dangerous.

4 Physical Restraint

- Uses furniture or equipment
- Bucket chairs to be in the lounge

5

We should all be safely restrained when travelling on our roads.

6

This is not to stop him from falling out
It holds him in, buckle at the back.

7

8 Chemical restraint

Renders the person incapable of resistance
Different from medication that is needed.

9

10 Chemical restraint

12 Harness

Enables to sit upright

13 Environmental restraint

Safe place for advanced Alzheimer's

Trainers Resources Restraints

This is an opportunity for discussion. It does not really matter if staff are not clear on the terminology for each kind of restraint. The main thing is for them to realise that any restraint means that staff are deliberately removing freedoms from residents.

Restraints can be:

Personal – such as being physically held

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

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

Chemical Restraint

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

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

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

Chemical restraint and seclusion are not supported by the policy of this Home in any way. A Log of restraint usage is kept – if no restraints the log is empty.

Please tick which boxes apply to our Home.

- ☐ The policy of the Home is not to restrain anyone.
- ☐ Environmental – the Home is a special unit for people who need a special environment.
- ☐ Bucket chairs may be used for very frail people – they are seen as enablers as they allow the person to be in communal areas, participating socially, rather than in their beds.
- ☐ Cot sides are used because the resident requests them and does not feel safe without them.
- ☐ Harness or other enabler gives the client more independence but its use restricts normal access to part of their own body so it is a restraint.

Legal aspects of restraining

Staff who restrain a resident without the restraint being approved by our restraints team may be breaking the law. Holding someone without cause, may well be seen as assault [especially where staff are not managing challenging behaviours, rather placing themselves in argumentative situations].

Example:

Ruth lives in a mental health community support home. She is due for a blood test for dilantin levels because she has seizures. She does not want her early morning blood test and stubbornly stays in bed. Staff come in and pull all her blankets off as this often results in her getting up. This morning she refuses. Staff come in and try and sit her up in bed. Ruth tries to hit at them so they restrain her on the floor with two people holding her down “for her own safety”. Ruth cries and concedes and gets dressed and has her blood test.

Discussion questions:

Was this OK? Was it really necessary to restrain Ruth on the floor to have her ready for the blood test [remember the visiting lab staff were waiting]?

Answers:

This was common assault. Discuss other ways that this could have been managed, including scheduling the test later in the day in future.

Resident safety & risk assessment

Before anyone is restrained risk needs to be assessed with the restraint and without it.

Practical Exercise:

Jenny has had a dense stroke. She can no longer sit up unaided or stand. The bucket chair enables her to be in the lounge, rather than all alone in her room. It enables her to participate in social activities by being an observer.

Use the risk assessment form below to decide if the risk using the bucket chair is greater or less than not using it. Repeat the exercise for Ruth, remembering that she will have blood tests, just not early in the morning.

Risk Assessment Form

To be used by the Restraints Group PRIOR to deciding ANY restraint usage.

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

SCORE

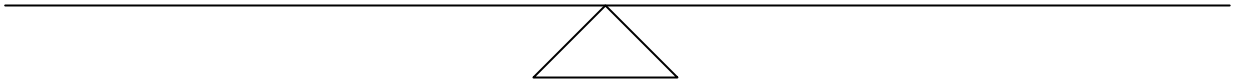
WITHOUT RESTRAINT

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

SCORE

WITH RESTRAINT

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



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

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

RN / Manager's signature: _____ Date: _____

Team Member signature: _____ Date: _____

Doctor's signature: _____ Date: _____

Challenging Behaviour & communication techniques

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

NB: Staff with an authoritarian approach [staff who tell residents what to do] may find that this inspires resistance and may need to realise that it is their behaviour, not resident behaviour, that needs to change. Where there is a problem with challenging resident behaviour it is a good idea to ask which staff member does **NOT** have a problem with this person – then ask how they care for / deal with this person. See also Module 7: Managing Challenging Behaviours.

Aversion versus non aversion techniques – ethical issues

Aversion is where people are discouraged from doing something for fear of what will happen.

Example: Child will not touch the stereo or mother will smack their hand.

Example: Resident will not be in the lounge late at night or staff will **send** them back to their room and staff threaten to take away privileges, like attending church.

Disadvantage: Aversion Techniques **ONLY** work when the authority person is there.

Example: Mother goes outside so child turns all the 'nobs' on the stereo.

Example: Resident forgets what they are told and returns to lounge to be 'growled at' and 'reported for night wandering'.

Example: Other staff on duty so resident enjoys a cup of tea before happily returning to their room with the kind staff.

Have staff think of aversion techniques that they have witnessed. Discuss:

- With holding privileges
- Holding the power
- Being bossy
- Forgetting dignity & respect
- Would they want this for their own parents?

Then talk about agreed methods of eliminating the unwanted behaviours.

De-escalation techniques are discussed in Module 7 Challenging Behaviour

Revise Managing Challenging Behaviours:

1. Recognising confusion / dementia & repeat behaviours.
2. Understanding resident perspective / triggers to challenging behaviour.
3. Cool off time [discuss how people generally cannot stay angry over time]
4. Not to argue [residents cannot fight with themselves]/ step away.
5. Understanding the common mistake of elevating confused or disabled people to the status of ordinary people [like arguing with a child] and expecting behaviours that they are incapable of.
6. Staff looking at themselves [own anger / body language / loudness / kindness?]

Thus restraint is not needed.

Rights

Residents in the power of staff – this is an opportunity for discussion

Points to raise:

- Is this really a home for residents or is it a staff work place?
- How quietly do staff speak?
- Do we hear staff talking loudly about what work needs doing next, or what is happening out of work hours?
- Staff will know who [if anyone] is telling residents off or telling them what to do. By making all staff realise this is not OK peer pressure can be effective in bringing change / you may become more aware of where problems arise.

It is important to compare the rights of staff and the rights of residents.

- Granted, residents don't have the right to harm or annoy others.
- Management support needs to closely follow problem behaviours.
- It should be summoned by filling in Challenging Behaviour Forms.
- Where there is conflict / staff not coping Manager support is needed.

Assessment

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

- Are we providing care where residents feel comfortable and safe?

- Look at Module 7: Environmental Approach to Challenging Behaviours

Things to consider BEFORE we look to restraining

- What are realistic goals for this resident?
- Why is there a problem and what causes it?
- How does resident / their family feel about this.
- Are their any early signs that warn us so we can **PREVENT** the problem?
- **What** is needed that we **are not providing** [e.g. something to look forward to / a sense of achievement / opportunity to fell loved & to love]
- Does the resident feel safe? Are they safe?
- Are they making others less safe?
- What LEAST restrictive restraint is being considered?
- How might that affect the resident and their family?
- Have the family been part of the risk assessment & planning process.
- If we were to use a restraint what things will make it safer – e.g pillows under legs of frail person in bucket chair, protective stockings.
- Specific cultural needs and how these would be best met.

Cultural Recognition

When considering the need for restraint needs of all cultural groups must be taken into account. Where the resident and their family are part of the planning process this is a learning curve for everyone and counselling is part of this process. External cultural advice may be needed. Auditors talk of objects of significance that might need to be removed [where resident safety is compromised] but this is not needed in our care as we do not fight and struggle to restrain anyone.

Dignity and Privacy

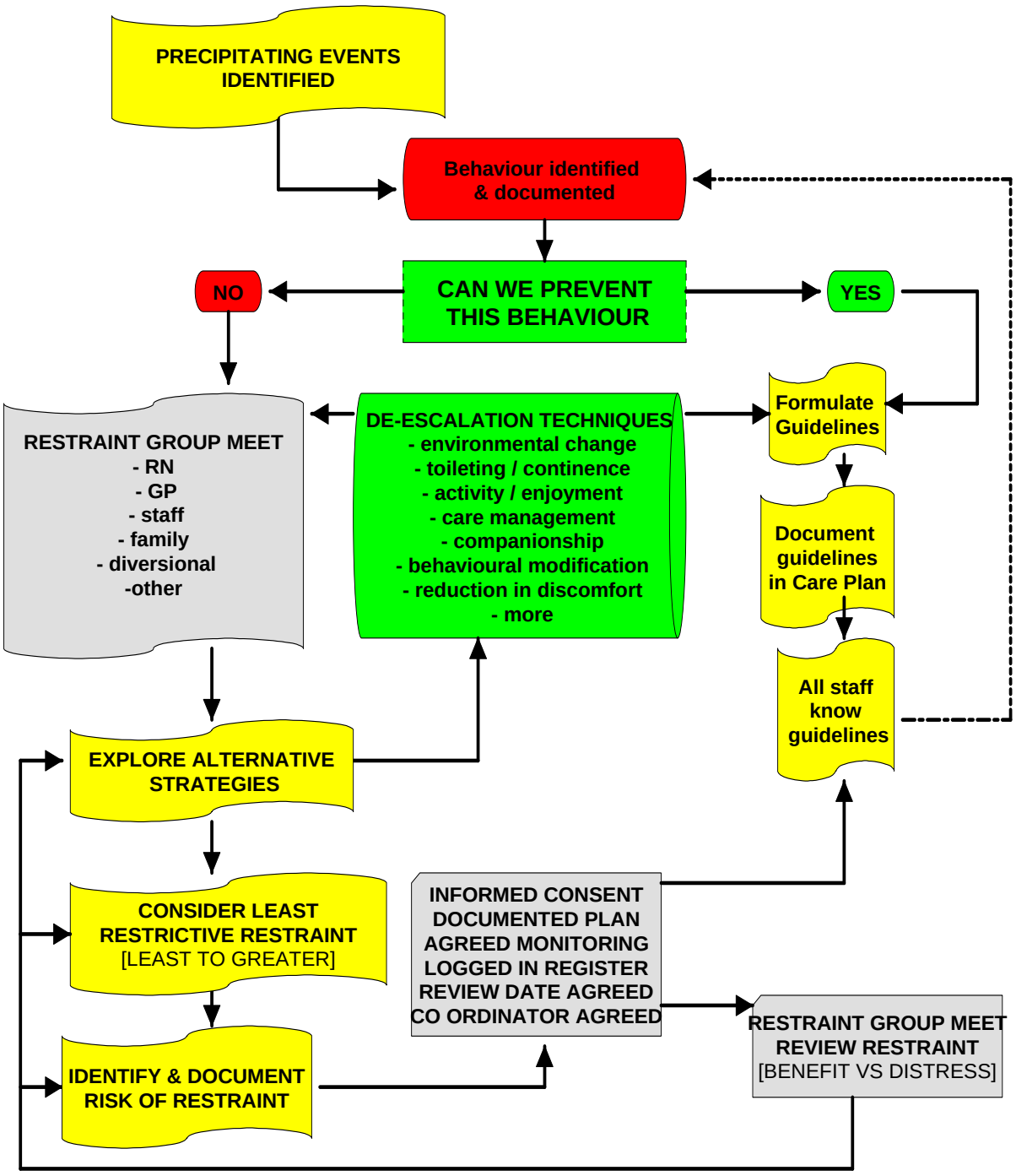
Resident privacy & dignity is considered and protected at all times:

E.g. if a frail person is in a bucket chair they will be taken to their room to be turned or cleaned. Such care must not happen in the communal area.

We claim to be restraint free. Discussion topics:

- Can we keep residents safe and happy without holding them?
- Can we help them feel happy when they are distressed?
- Do their families understand the difficulties that we face?

Restraint Guideline Flowchart



Assessment of Knowledge Restraints

What is a "restraint?"

Please name two kinds of restraint.

Do you think that it's OK to restrain people? YES NO

Would you physically hold onto an old person to stop them from walking away from you? YES NO

Would you physically hold onto an old person to stop them from walking out on the road and getting hit by a truck?

YES NO

What kind of restraint is that? Please tick the correct answer.

- ☐ Chemical
- ☐ Physical
- ☐ Personal
- ☐ Environmental
- ☐ An enabler

Please tick the boxes below if you know residents who have had the kinds of restraint listed below:

- ☐ Lap boards and Geri tables
- ☐ Bed rails
- ☐ Bucket chair
- ☐ Lap belt or wheel chair belt to tie them in
- ☐ Harness to hold someone upright in a chair

What do you think? Did they really need this restraint? YES NO

What could we have used instead?

Sign..... Designation..... Date.....

Trainer ..... . Designation..... Date.....

Trainers Resources Restraints

Revision & Assessment of Knowledge Restraints

Please look at the pictures below. Please circle the correct answers. One or more may be circled:

Which boxes show environmental restraint? 1 2 3 4 5 6 7 8 9 10 11 12

Which boxes show personal restraint? 1 2 3 4 5 6 7 8 9 10 11 12

Which boxes show physical restraint? 1 2 3 4 5 6 7 8 9 10 11 12

Which boxes show chemical restraint? 1 2 3 4 5 6 7 8 9 10 11 12

Which boxes show an enabler? 1 2 3 4 5 6 7 8 9 10 11 12

1 	2  You could get hurt So could the person you are restraining Never use to move someone from place to place.	3  Can restrict breathing as chest not able to expand – dangerous.
Using furniture or equipment Bucket chairs to be in the lounge  	5  **We should all be safely restrained when travelling on our roads.**	6  This is not to stop him from falling out It holds him in, buckle at the back.
7 	8 Renders the person incapable of resistance Different from medication that is needed.	9 
10 	11 Harness  sit upright	12  **Safe place for advanced Alzheimer's**

Sign..... Designation..... Date.....

Trainer ..... . Designation..... Date.....

Training Signing Sheet

Topic: Restraints Trainer: _____

Date:_____

PLEASE PRINT CLEARLY
I have undergone the above training. I have been shown and understand what was demonstrated. Anything that I did not understand, I asked for and received adequate explanation.

First Name	Surname	Signed Employee