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Planning the Management of Difficult / Challenging Behaviours

CHALLENGING BEHAVIOUR POLICY: Our Home promotes an environment where people feel safe. Understanding reasons for behaviour is the key to managing it.

REFERENCES:
The Code of Health and Disability Services Consumers' Rights
Privacy Act 1993 / Policy Privacy & Dignity / Policy Restraint Minimisation

DEFINITION: OF CHALLENGING BEHAVIOUR

If it annoys anyone to a point of stress then it is a challenging behaviour:

- Behaviour that might hurt someone [E.g wandering onto the road, hitting].
- Behaviour that needs more staff on duty [E.g. repeat fallers, uncontrolled incontinence, awake all night].
- Inconveniencing other resident who then feels unhappy or stressed / angry [e.g. arguing or going into other residents rooms as though their own, even into their possessions].
- Behaviours that others feel is unacceptable [E.g. nudity in public]
- Whereabouts unknown [Worry over a lost resident can be very stressful to staff].

NB: Strange or quite different behaviour is only a ‘Challenging Behaviour’ if it causes an unhappy / negative reaction in another. In other words, if no - one minds, then its NOT challenging.

Understanding Behaviour

Before we can understand Challenging Behaviour we need to be clear what we mean by Behaviour. Behaviour is anything that you see person a person do – where you can see the action:

- Sitting
- Laughing
- Crying
- Hitting

Emotions ARE NOT behaviours:

- Happy
- Sad
- Anxious

They are FEELINGS. Saying someone is “anxious” tells us little as we all behave differently when we are feeling anxious. One person might bite their finger nails. Another might pace the floor. It is better to be clear about the behaviour arising out of the anxiety. This distinction is vital when we talk about people with Challenging Behaviour. We need to understand how the person is feeling before we can help them.
Managing Challenging Behaviour & Restraints Minimisation

Process for the Management of Challenging Incidences

Incident of Challenging Behaviour

[Staff / Resident or anyone else feels stressed by the behaviour]

Fill in Challenging Behaviour Form

[Forms are in appendix at the end of this policy book so that Services may substitute their own forms if they prefer].

Guidelines are agreed to Manage the Behaviour using Challenging Behaviour Review Form

1. Best Practice Guidelines
2. Clear instructions in Care Planning
3. Understand causes for the behaviour
4. Recognition of what sets it off [triggers]
5. Everyone agreed [family input essential]
6. Needed training initiated
7. Additional resources provided

Problem Managed

Continue to monitor & report any further problems. Be aware that new staff need to understand best approaches.

Problem Continues

Continue to monitor & report any further problems. Be aware that new staff need to understand best approaches.

Multidisciplinary Approach

Care planning shared with resident, family, specialist, Geriatrician, Pain Specialist, or referral made if needs higher level of care.

Good linkages to staff training & support

Incidences of Challenging Behaviour Discussed at Review Meetings

1. Overview of type & frequency compared to desired value [none].
2. Benchmark ourselves against other Services.
3. Best Practice Guidelines accessed wherever problems not resolved / we feel we could do better.
4. Process of constant review & improvement.
5. Ongoing education & networking with other similar services

Calls for Help Recognised

Forms are looked at by Management as soon as possible.

E.g. every morning

NB: See
1. Challenging Behaviour Form
2. Review Form
Appendixes at end of this policy

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Guidelines to Managing Challenging Behaviour:

1. Everyone is an individual – each person is special.
2. Best management will recognise triggers to unwelcome behaviour.
3. Recognising a trigger is the key to PREVENTING the behaviour.
4. Care Planning needs GUIDELINES for responses when the first signs of an unwanted behaviour are seen – when a ‘trigger’ is recognised.
5. Things to do next [de-escalation techniques] need to be clearly written.
6. Everyone needs to understand and agree the approach to take.
7. If there is challenging behaviour of concern, or repeat episodes of unwanted behaviour, as many members of the team as possible should review the plan on Review Form:
   - What happened,
   - Why did it happen,
   - How did we respond,
   - Result of the response
   - Other monitoring / interventions needed.
8. Challenging behaviour occurs at different times over the day and night. Care cannot be planned or evaluated on one nursing shift alone. If behaviour is difficult at night, changes may need to be made during the day – e.g. beware the person spending all day sleeping.
9. Consider the resident who is confused and agitated as not comfortable. All residents have the right to be comfortable - plans should describe how this might be achieved.
10. All humans deserve some control over their person, and their environment. Planning should allow opportunity for choice.
11. Special care: staff may be able to co-ordinate care with families, cultural / religious organisations to meet individual need e.g.: special food, religious ceremonies, conversation in preferred language.
12. Intervention is not always necessary: only if the behaviour is distressing or harming someone else. If no one is bothered by the resident behaviour, then it may be odd, but it should not be considered challenging. Some people are challenged by behaviour when others are not. Rule of thumb: If it annoys anyone to a point of stress then it is a challenging behaviour.
**Stake Holders:** People likely to be involved in the management of resident Challenging Behaviour:

- The resident themself, their partner, their family or an advocate.
- The Team Leader / RN
- The GP
- A cultural advisor, where appropriate.
- Specialist or technical input [psychologists, legal, pain specialist] where appropriate.

**Triggers to Challenging Incidents**

Short-term triggers are events that ‘spark off’ a challenging behaviour.

Common examples:

- **Provocation:**
  - Verbal taunts, gestures, physical contact. Staff may provoke someone by keeping them waiting, telling them what to do, talking about them rather than with them without even realising it.

- **Because of Failure:**
  - Unwanted behaviours come from feelings of worthlessness and unhappiness. These behaviours flag the need for greater care.

- **Miscommunication:**
  - A simple misunderstanding between residents [or staff or visitors] with different ideas about how they see things.
  - Can be related to dementias or medical conditions where people now lack understanding.

- **Frustrating Situations:**
  - A relatively insignificant request, demand or action may trigger an outburst of behaviour that has been building for some time.

- **Invasion of Personal Space:**
  - This can involve territory [own room], proximity [in personal space] or personal possessions. Infringements can trigger an incident. Staff need to set boundaries and to be sensitive.
Disappointment:
- Especially if related to a failure [inability to achieve]
- May also be seen as loss [grieving for past ability / health now gone]

Limit Testing:
- People need to know their boundaries.
- If we relent to repetitious request we teach that it is an effective way of getting something.
- If everyone is consistent about agreed limits, residents learn boundaries to behaviour [it does no good to test the limit – it’s fixed].

Behaviour out of Fear
- Can be violent / beware if someone feels trapped.
- We need to provide a place where residents feel safe.
- Examples
  - Family failing to visit as expected / desired
  - Altercation with another resident
  - Delusions or hallucinations
  - Night time
  - Grieving former better health

Physical sensations inspiring fear:
  - Hunger or thirst
  - Pain or inability to move about,
  - Tiredness, noise or other irritation
  - Heat or cold
  - Sexual frustration, or pre-menstrual tension.

Intoxication & Unreality
- Alcohol can lead to excited or inappropriate behaviour that staff do not like including increasing the risk of vomiting & incontinence
- Increasing falls risk
- Making moving & handling carry much more risk

Drug Induced Psychosis:
- Marijuana can change perception limiting focus & concentration
- Illegal drugs usually trigger excitement, even hallucination [or changed perception] and delusions.
Key Points to an Environmental Approach to Avoiding Challenging Behaviours:

- Create a sense of warmth, comfort and control.
- A place where residents feel safe.
- Integrated approach by staff – no playing one off against another.
- Good reporting channels:
  - Use Challenging Behaviour Report Forms
  - Fast follow up to support the resident and staff.
- Incidences quickly drawn to Management attention.
- Monitor people with known unwelcome behaviours adequately – you might need extra staff time for them.
- Multi-disciplinary approach [refer to specialist as appropriate].
- Clear individualised Care Planning that identifies problems and concerns.
- Identify individual triggers.
- Clearly state de-escalation techniques.
- Avoid excess stimulation.
- Peace & Quiet: Noise and confusion and high emotion will be felt by residents – staff should not create great amounts of noise; rather, they are most professional quietly working in the background in the Home.
- Clear staff roles and adequate staffing levels help minimise problems.
- Interesting things to do so residents don’t want to / need to behave in a challenging way for attention, or out of boredom.
- Beware of an audience inciting a situation.
- Disorganisation and staff conflict are most counter productive.

**Punishment Guideline – What NOT to do [punishing is NOTOK].**

- Physically asserting power eg: holding so as to restrain, pushing, hitting or shaking / hurting in any way.
- Emotional threats, raising your voice.
- Telling someone off / telling someone what to do.
- Telling someone NOT to do something in an unkind way.
- Talking to a resident as though they had to do as they were told.
- Withdrawal of privileges.
Managing Challenging Behaviour & Restraints Minimisation

Keeping Staff Safe

Recognise the signs of an Angry Person

- Angry face / Rapid breathing / Flared nostrils.
- Clenched fists and teeth.
- Yelling
- Restlessness, repetitive movements.
- Pacing, gesticulating, and violent gestures, for example pointing.

Personal Space

- Closeness can be seen as a threat [especially standing above someone].
- Personal space differs between cultures. Most people have a bubble of personal space around them that we need to respect. Stand outside peoples personal space – e.g. slightly out of arm’s reach.
- Avoid pointing at or touching angry people, or entering their personal space. Look at your own posture – is it confrontational? Looking down is more calming than ‘eye balling’ someone.
- Use touch with discretion – touching may cause someone to lash out.

Voice Tone and Volume

- By altering tone and volume we can change words into an insulting or sarcastic message. Better to say nothing unless your tone is kind & caring.
- Speak quietly & slowly, using short sentences.
- Talk in private, acknowledge & accept resident’s anger. Listen to let them get it out [it may be well worth the time taken].

Eye Contact

- Eye contact with the person is important. It can show care & concern.
- Use an open receptive facial expression.
- Never stare.
- Remember cultural issues. Behaviour may be different in another culture from what you expect.
De-Fusing and De-Briefing

De-Fusing is therapeutic. It allows staff involved to share their feelings, and emotions about incidents at work allowing them time to talk about how they experienced the incident from their perspective. Support should be confidential.

Reporting an incident of challenging behaviour is de-fusing. See appendix 1 of this policy.

1. Each person involved can fill in an incident form if they wish.
2. Taking a professional stance and just reporting events can be helpful.
3. Looking at WHY an incident occurred rather than WHAT happened often helps staff see it more professionally.
4. The commonest mistake staff make is not realising how the person exhibiting the behaviour feels, thereby not understanding that they need our help and care. That they may not be able to reason as we do, and by expecting them to, they can only fail.

De Briefing

Prevents or reduces the chance of the same happening again by recognising triggers and patterns of behaviour. Ask what can we do differently, what did we do right, what else is needed?

Good management will ‘de brief’ staff after any challenging behaviour episode. Small team meetings, monthly staff meetings, one on one discussions are good ways to look at how we can all work together to make our Home as nice and as safe feeling as we possible can for residents and for staff. De briefing that makes linkage with future training helps this process.
Restraints Policy and Guidelines

RERAINTS POLICY: The standard aims reduce the use of restraint and to ensure that it is used safely. Some restraints are requested voluntarily as they enable the person to either feel safer or to provide physical support [postural]. Our policy focuses upon reducing and managing challenging behaviours rather than to restrain.

REFERENCES:
The Code of Health and Disability Services Consumers’ Rights
Health & Safety Policy / Resource: Managing Challenging Resident Behaviour
Informed Consent & Advanced Directives Policy
Privacy Act 1993 / Policy Privacy & Dignity
Interpreter Policy

Definitions of Restraint

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

Restraints can be:

Personal - such as being physically held

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

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

Chemical Restraint

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

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

The Team

The Team consists of the Manager or their delegate, Team Leader or RN, members of the Health & Safety Committee and other staff, as appropriate. Each six - 12 months they agree and review:

- All restraint policy & procedure [doctors may be invited to endorse the policy]
- The content and competencies of the Home Education Package annually.
- Incidences of Challenging Behaviour.

For incidences of challenging behaviour, key members from the team will:

- Assess all information available
- Discuss all means of prevention
- Assess adequacy of staff training and education
- Listen to family who may provide valuable information resource
- Have team review meetings to decide care guidelines.
### Restraint Log

<table>
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<th>Log Number</th>
<th>Name of Resident</th>
<th>Date Restraint Commenced</th>
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Training

All staff must receive this training PRIOR to being involved in any care requiring restraint! A record of this training is kept. Competency is tested annually.

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

Staff need to be trained at induction and to have refreshers when incidences of Challenging Behaviour arise or at least annually. Competency is assessed as part of training, and through incident reporting. **Personal restraint** is not endorsed by the Home, so rather than teaching holding techniques, we teach de-escalation and struggle avoidance. Staff are trained to move people to a place of safety and call for help where faced with violence.

Before **ANY** restraint can be used it must be approved.

**Approval Process**

The Team Leader is responsible for leading the Restraint Approval Group and maintaining the approved standard. The Approval Group consists of the Manager, Team leader, a resident advocate, or a GP, or komatua, decided as appropriate, according to individual client need, including suitably qualified person.

............................................................ [state who] fills the Restraint Co-ordinator role.
ASSESSMENT: Based on resident physical & psychological health

In considering restraint use, all other alternative must be considered first. For each form of restraint, key members from the approval group will look at:

- Discuss present care.
- Evaluate the problems from challenging behaviour reports - calling on outside consultant at Manager discretion.
  - Include contradictions to the use of restraint, e.g. cultural
  - Underlying causes [that can be rectified]
  - Existing Advanced Directives
  - Previous restraint episodes [whether successful]
  - past history of abuse where person held against their will
  - grounds for needing the restraint [e.g. safety of others]
- Look at all possible alternatives to restraint.
- **Assess adequacy of staff training and education.**
- Hear family perspective for greater understanding.
- Seek greater understanding of the service user / resident.
- Consider the risk of any restraint versus non restraint.
- Decide frequency of monitoring, observation and evaluation requirements.
- Decide when it might be used.
- Elect person responsible for initial assessment - and set date
- Review by as many people in the group as possible - and set date.

**NB: The policy of the Home is NOT to restrain, so in the event that someone is unable to be harmoniously managed, it is likely that a greater level of care might be required for that person.**

Discontinuation of Restraint:

- No longer needed
- It is causing undue distress
- Risk to the person restrained is GREATER than the risk of not restraining
- The restraint is compromising professional relationships with staff.
Managing Challenging Behaviour & Restraints Minimisation

Any restraint in use needs to have back up information for staff, in the event of difficulty, staff need to know who to call and that assistance is available.

Challenging Behaviour management needs clear documentation in Care Planning so that staff are guided in their care. The Team Leader is responsible for gathering staff together and discussing / explaining the methods of care that best prevents the challenging behaviour from arising, or if it does arise - how to best manage it. If everyone shares the same approach we may succeed better. Some staff will need more support than others - this is evidenced by challenging behaviours only happening on one shift or when certain people are on duty. Staff with an authoritarian approach may find that this inspires resistance and may need to realise that it is their behaviour, not that of the resident, that needs to change. Where there is a problem with challenging resident behaviour it is a good idea to ask which staff member does NOT have a problem with this person - then ask how they care for / deal with this person. However, should restraint approval be granted, the Team Leader, Medical Practitioner and the resident [or their welfare guardian/advocate/family must sign a consent. Restraint cannot be used without family knowledge / approval.

**APPROVAL PROCESS**

Restraining someone is a LAST RESORT when nothing else works.

It is a decision made by an appropriate Health Professional

Restraint is only possible in correct environment & with adequate resources.

First Consider:

What are the possible alternatives?

We prefer the least restrictive way to solve the problem?

We look at **Risk** with and **Risk** without restraint [use form below]

Risk includes people Rights & Feelings

We look at the risk of infringing on cultural grounds

The Home prefers NOT to restrain. If someone needs restraining we will look at having the person assessed to go to a place of greater care.
## 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)

<table>
<thead>
<tr>
<th>HARM</th>
<th>LIKELIHOOD</th>
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<tbody>
<tr>
<td>A life threatening</td>
<td>1 likely</td>
</tr>
<tr>
<td>B serious injury</td>
<td>2 possible</td>
</tr>
<tr>
<td>C minor injury</td>
<td>3 unlikely</td>
</tr>
</tbody>
</table>

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

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

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

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Sign: ____________________________

Review by: _______________________[date]

Review co-ordinator: _______________________[name]
Consent Form for Use of Restraint

Name of Resident:                                                                 Date:

Type of restraint:

Reason for restraint use:

☐ Bed rails - falls out of bed / requests them and feels safer with them
☐ Bucket chair [an enabler that allows greater participation in the social program]
☐ Harness [enabler that assists to sit upright in a chair rather than falling forward].
☐ Other:

I feel that I fully understand and support the decision to restrain__________________________

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

☐ I feel that I understand the risks of NOT restraining compared to the risks of restraining
__________________________ and have decided NOT to restrain is the best option.

Resident

To be completed by the resident/ resident’s welfare guardian / family advocate.

NB: The risk of falling, or other injury, may be preferred to the risk associated with restraint.

Signature:_________________________  Date: ____________________

Print Name: _______________________

Additional Comment / Monitoring Requirement:

RN / Manager’s signature: _______________  Date: ___________

Team Member signature: _______________  Date: ___________

Doctor’s signature: _______________  Date: ___________
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 they feel comfortable and safe?
- What are realistic goals?
- Why there is a problem and what happens to cause it?
- How the resident / service user feels about this.
- Are their any early signs that warn us so we can PREVENT the problem?
- Does the resident feel safe? Are they safe?
- Are they making others less safe?
- What LEAST restrictive restraint is being considered?
- How might that affect the resident / service user and their family?
- Have the family been part of the risk assessment & planning process.
- If we do 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. The resident / service user and their family [whanau] must be consulted with regard to the resident’s value / belief system to minimise the risk of cultural infringement during the use of restraint. Where the resident and their family are part of the planning process this is a learning curve for everyone and counselling is part of this process. External cultural advice may need to be sought to ensure that cultural safety is ensured. If the need arises for any objects of significance to be removed [where resident safety is compromised] this is done appropriately and safely. Cultural needs of residents’ must be known and met during restraint use. This generalises to all cultures.
Risk Management

Use the Risk Management Form to guide assessment of risk. Compare the risk of harm to the service user/resident with restraint to the risk of harm without it. Consider both the DEGREE of risk and the LIKELIHOOD.

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 - not in the communal area.

Consent & Client Participation

Where the resident/service user cannot fully understand the reasons for restraint [including enablers] then consent is sought from family. It is always preferred that the resident themselves are part of the restraint Group and are considered the key stake holder.

Consumer Support and Communication

Residents, their families need to be part of individual reviews. They need to be consulted about any decisions related to their family member's care - this is specially necessary should personal items need to be removed. Information about any restraint considered must be in a form that the resident/service user or their family/advocate can understand.

Since bucket chairs and enablers are the only restraint likely to be used in the Home debriefing is not usually required. However, should this be needed then appropriate staff or external support would be provided.

Monitoring & Review

Monitoring needs to consider:

Physical Needs:
- health
- nutrition,
- hygiene, comfort & safety
- frequency of care
Psychological Needs:
- support, comfort, privacy & dignity
- orientation to time and place
- communication opportunity

Cultural Needs:
- Access to family & to support networks
- Appropriate support
- Cultural objects valued by the person cared for and protected.

**Individual Review:**
Clients using harnesses and bucket chairs and cot sides require careful monitoring [see Restraint Monitoring form. Frequency of monitoring is agreed among the restraint group and documented in Care Planning. Review is 3 – 6 monthly or more frequently as decided by the Team. See Individual Restraint Review Form.]

Accurate accounts of Restraint Episodes are required. This is according to the frequency & duration of the restraint. This must also include:
- Reassessment of reason for the restraint in the first place
- Reconsider alternatives
- Degree of success the restraint is having [or not]
- Family input & perspective
- Short term outcomes/ long term outcomes
- Peoples observations, particularly the resident perspective
- Assessment of ANY injuries sustained during restraint [may inspire review!]
- Support people available
- General observations
- Consideration of less restrictive form of care.
- Alternatives and other options
- Staff ability to manage the restraint as required.

Frequency of recording should be practical. Sufficient to ensure good communication between shifts, and to record that staff tasks are done regularly enough for resident comfort. We do not like to record unnecessarily.
Quality Review of Restraints:
This is undertaken at least annually. If no one in the Home is restrained focus is
generalised towards Managing Challenging Resident Behaviours. The Manager
usually calls upon external consultant for support with this review. If service users /
residents are restrained then the review may be six monthly. These are the set
agenda items:

1. Type volume frequency & duration of restraints in home
2. Compliance with policy. Checklist for each restraint in use:
   - Dignity & Respect
   - Resident Rights
   - Privacy
   - Advocacy (family)
   - Culturally appropriate
   - Recognising special needs
   - Assessment is ongoing
   - Approval processes, policies and procedures.
3. Whether alternatives to restraint have been identified as part of the plan of
care.
4. Communication effectiveness with family / family participation for each
   restraint. Those who are restrained OR show challenging behaviours are
discussed individually.
5. Support provided to residents and staff involved.
6. The effectiveness of individual restraint evaluation and review.
7. How periods of restraint are monitored and observed.
8. Staff competency and training includes assessing the competence of trainers.
9. The appropriateness and effectiveness of restraint related education.
10. Progress towards a restraint free environment.

Quality review findings and recommendations are used to improve our service and
resident safety considering current Best Practice Guidelines. Monthly audits of
Challenging Behaviours are inputted in the Benchmarking Stats Program and
reviewed by outside consultant at least quarterly and Service Review.
Managing Challenging Behaviour & Restraints Minimisation

Restraint Guideline Flowchart

1. **Precipitating Events Identified**

2. **Behaviour identified & documented**

3. **Can we prevent this behaviour?**
   - **Yes**: Formulate Guidelines, Document guidelines in Care Plan, All staff know guidelines
   - **No**: Restraint Group Meet, Consider least restrictive restraint [Least to greater]

4. **Explore alternative strategies**

5. **Identify & document risk of restraint**

6. **De-escalation techniques**
   - Environmental change
   - Toileting / continence
   - Activity / enjoyment
   - Care management
   - Companionship
   - Behavioural modification
   - Reduction in discomfort
   - More

7. **Informed consent documented plan agreed monitoring logged in register review date agreed coordinator agreed**

8. **Restraint group meet review restraint [benefit vs distress]**
Checklist for Restraints Group
[To be used in conjunction with Flow Chart]

Name of Resident__________________________________________ Date______________

Behaviour has been identified and documented [Try and make assessment over 24 hour period, more than one assessor, more than a snapshot in time – look for the bigger picture].

Behaviour is seen by staff as challenging [A social or a safety challenge]

Restraint Group meets – always include significant family / whanau / where possible at initial planning stage.

Precipitating events have been identified

Can we prevent this behaviour?

Incorporate preventative measures in care planning and inform all staff [Look to increase resident perception of their own safety / reduction in resident perceived discomfort]

List de-escalation techniques in care planning and inform all staff

Alternative strategies to restraint usage explored first

Consider least restrictive form of restraint. [Some residents may request some forms of restraints e.g. enablers, bedrails, special bucket chairs].

Consider the risk - identify and document.

Log initiation of restraint in Home Restraint Register

Nominate person to coordinate THIS restraint’s use

Nominate date for first review [Review should include as many members of the Restraint Group as possible / sensible.

Use this checklist as a guideline only.

Do not feel that you need to move down the list - the goal is to AVOID the use of restraints, if at all possible. The less boxes checked, the better.

The true challenge is avoidance of the need for restraint while still keeping all residents and care givers safe.
Restraint Monitoring Form

Resident Name: _______________________________  Date: _______________

Type of restraint agreed by group: __________________________________________

Maximum time that restraint may remain in use is:____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Restraint on</th>
<th>Restraint off</th>
<th>Comments</th>
<th>Signed</th>
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Issue Number: 02
Resource Policy © HH.NET Ltd
Issue Date: 01.08.08
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### Individual Resident Restraint Review Form

**Use to initiate Restraint Usage and to Review Restraint Usage**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Persons present:**

**It appears that use of the restraint was the correct decision:**

- Yes [ ]
- No [ ]

**Why? Why not?**

**Resident / Service User / Family perspective:**

**What was learnt from the use of the restraint?**

**Is the restraint being used according to what was approved?**

- Yes [ ]
- No [ ]

**Is there adequate documentation of monitoring?**

- Yes [ ]
- No [ ]

**State:**

**Is restraint still required and why?**

**Is there a less restrictive alternative?**

- Yes [ ]
- No [ ]

**Does the Care Plan reflect the Restraint in its present form?**

- Yes [ ]
- No [ ]

**State any updates needed.**

**Note – changes need update to consents as well.**

**Review completed by:**

- Signed ____________________ Doctor _______________
- Signed ____________________ Residents Family or Advocate _______________
- Signed ____________________ Manager or RN _______________

**Date of next Review:**
# Appendix 1: Challenging Behaviour Form

## Assessment of Challenging Behaviour

*To be used by all Care Staff concerned by resident action or behaviour*

<table>
<thead>
<tr>
<th>Resident: __________________________</th>
<th>Date: ________________</th>
<th>Time: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person / people making observation:</td>
<td>______________________</td>
<td>&amp; their designation (all sign)</td>
</tr>
</tbody>
</table>

1. **Were there any early warning signs?**

2. **What did the behaviour look like [Who did what when]?**

3. **How long did it last / did anything make it worse?**

4. **What got damaged (if anything)**

5. **Who got hurt (if anyone) & describe injury [or damage]**

6. **CLIENT PERSPECTIVE: What happened before the behaviour started?**

7. **Contributing factors: (family, medical, environment, social, care given)**

8. **What lead to the behaviour [including nothing going on i.e. boredom]**

9. **What we did to prevent this happening again:**

Please write on the back if you need more space. Write N/A [not applicable] in boxes not required.
Appendix 2: Challenging Behaviour Review Form

Challenging Behaviour Review Form

Use to document staff review of Challenging Behaviour.

First signs of problem

Describe

What makes it worse?

E.g. ignored, growled at.

WHY – What is causing this behaviour

SOLUTIONS

1. Stop [yes I know you are probably rather busy]
2. One person recognise this person [face to face / by name / friendly / at their eye level]
3. ....

Describe the challenging Behaviour

E.g. bored, nothing to do, no visitors, substance use recently
Abuse and Neglect Policy

**ABUSE AND NEGLECT POLICY:** Service users will not be subject to abuse or neglect as a result of service delivery. Care staff will be aware of indicators of abuse [within the service and in everyday life] and know how to report them appropriately.

**REFERENCE:** Elder Abuse & Neglect (A Handbook for those working with Older People). Information from this Handbook was utilised in writing this policy – with thanks. Maori Health Plan, Health and Disability Code of Rights, 1996; Exception Reporting Policy

**DEFINITIONS OF ABUSE & NEGLECT:**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Hurting</th>
<th>Injuring</th>
<th>Bruising</th>
<th>Breaking</th>
<th>Scratching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological/Emotional</td>
<td>Saying words that cause: stress fear upset alarm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual</td>
<td>Touching anywhere not welcome Being too close Using threats and force for own gratification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Material/Financial</td>
<td>Incorrect use of money or property</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Abuse of Freedom of Choice**
Those in care may have their carer’s ideas imposed upon them. Each person is different and staff need to realise:

⇒ The resident / service users needs and abilities
⇒ The needs of the wider family/whanau
⇒ Cultural and ethnic differences.

**REMEMBER:** Choice is good. Choice is part of everyday life. Do not rob those in our care of their choices, even though they may be limited by their abilities.

**Neglect**
Neglect is failing to provide the care that another needs and is relying on.

1. **Active Neglect** is conscious and intentional deprivation.
2. **Passive Neglect** is the result of the carer’s inadequate knowledge, infirmity or lack of trust in prescribed services.

The person being abused or neglected may not seek help because:

⇒ They are not capable of making a report [DON’T EVEN REALISE]
⇒ Because they feel ashamed
⇒ Fear of what might happen (perhaps to staff member or a family member)
⇒ They believe that no one can really help them
⇒ Fear of being blamed
Some People are MORE at Risk:

⇒ Those depending on other people for all or part of their care
⇒ With mental, physical or emotional disabilities
⇒ Communication difficulties
⇒ Feelings of low self-esteem
⇒ Those with limited social contacts and networks and isolation from ethnic support groups.

People More at Risk of Abusing

1. Caring for a dependant person can be extremely stressful. Most people in a position of trust are very caring. However, abuse or neglect can begin where inadequate support, supervision or training leaves a care giver unable to cope with the large demands they feel.

Risk Factors for Carers

⇒ Lack of training, support and supervision
⇒ Stress in other areas of their life such as finances or health
⇒ Previous family conflict and tension
⇒ Difficulty controlling feelings of anger and frustration
⇒ Background of mental health problems
⇒ Background of alcohol or drug related problems
⇒ Poor support and/or social networks
⇒ Feelings of low self-esteem.

2. It is possible for the person being cared for to [purposely] abuse the carer or to continually frustrate and stress them. This can be:

   a) Physical / emotional out of frustration with their own situation or
   b) Physical / emotional due to dementia, mental disability or as the result of head injury.

Conflict is the first indicator of either of the above situations. Managers need to recognise this and provide additional monitoring and support where ANY KIND of conflict is reported.

RISK: Things can change overnight for good care givers. Then they fail to cope with the person they are caring for. For example life stressors like: husband walks out, huge money worries, sickness or death of whanau member.
General Signs of Neglect & Abuse

The following signs might be a “red flag” to us that something is not quite right:

⇒ The service user shrinking away from another person, as though in fear
⇒ Acting worried or anxious when there is no good reason for it
⇒ Irritable or overly emotional
⇒ Presenting as helpless, hopeless and sad
⇒ Use of contradictory statements not resulting from mental confusion
⇒ Letting their carer do all the answering for them
⇒ Not making eye contact

More specific indicators:

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasions</td>
<td>Bed sores</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Dirty clothing</td>
</tr>
<tr>
<td>Bruises</td>
<td>Crusty eyes</td>
</tr>
<tr>
<td>Bums</td>
<td>Injuries not covered / dressed</td>
</tr>
<tr>
<td>Cuts/lacerations</td>
<td>Over-sedation</td>
</tr>
<tr>
<td>Grip marks</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Dislocations</td>
<td>Not taken for medical care when it is needed</td>
</tr>
<tr>
<td>Sprains</td>
<td></td>
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<tr>
<td>Welts</td>
<td></td>
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</tbody>
</table>

It is important to consider injury carefully.

**Does the explanation fully explain the harm from the injury? It is not our job to judge, just to report if we are concerned.**

<table>
<thead>
<tr>
<th>Some Indicators of Psychological Abuse</th>
<th>Indicators of Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resignation</td>
<td>Bruising or bleeding in genital area</td>
</tr>
<tr>
<td>Mental confusion</td>
<td>Venereal disease</td>
</tr>
<tr>
<td>Fear [Shrinking away]</td>
<td>Difficulty in walking or sitting</td>
</tr>
<tr>
<td>Marked passivity</td>
<td>Pain or itching in the genital area</td>
</tr>
<tr>
<td>Shame</td>
<td>Recoiling from being touched</td>
</tr>
<tr>
<td>Anger</td>
<td>Fear of bathing or toileting</td>
</tr>
</tbody>
</table>
REMEMBER: It is important not to jump to conclusions. Bruising or other injury might have been accidental. Be more concerned where more than one indicator is present or where injury happens more than once.

Indicators of Financial/Material Abuse
- Disappearance of possessions
- Someone managing service users finances when they don’t need to
- Conserving of inheritance: not using funds for the person that needs them.
  Examples are failing to spend savings for care so as not to erode inheritance.

NOTE: Where someone freely chooses to regularly give another some money, this is not necessarily financial abuse, even though the person have a disability. The deciding factor is that this is the informed decision of the giver. Cultural considerations and the mana [pride] that financial contribution brings may be important considerations to the giver. Different cultures may view this differently.

Recognising Carer Stress:
When abuse by the carer is suspected, it is important to think about stresses that could be influencing the carer’s behaviour, for example; determining the state of their physical and psychological health.

Reporting / Intervention Guideline
1. Remember, you have a duty to do something.
2. Make sure the person you are concerned about is safe.
   - To a senior person or to the manager
   - In ones own life, it may be best to report concerns to komatua, older relatives or others with the person’s best interests at heart.
   - Remember, where a person is afraid of what might happen if they report, suspected abuse can be reported to Social Welfare anonymously.
4. Complete an Incident/Accident Form

Debriefing
After any reporting of neglect or abuse, the Manager carries the responsibility for debriefing staff. This presents opportunity for further staff education.

Caring for the carer is one very important way to prevent abuse.
Staff Training

Training Resource Module 10: Prevention of Abuse & Neglect is available to staff immediately after general induction. The RN holds in house training for new staff and can use the Training Module as a refresher. Staff can work through the Module individually at their own pace or in groups assisted by the RN or other educators selected by management. Assessments of Knowledge help gauge staff understanding.

HH.NET Module 10 Training includes scenarios [real life situations] where staff are given the opportunity to discuss how they would react in certain situations. It includes reporting responsibility, processes and practice in using forms to document concerns.

NB: It is important for management to realise that in situations where abuse or neglect is disclosed, it is far more likely to be verbal and to a trusted source – therefore management need to be perceived as trustworthy [or listen to those someone trusted]. The reporter is often UNLIKELY to want to document that they have ‘told on’ another. To find out about suspected abuse / emotional bullying / disrespectful manner of fellow workers management will gain far more information by listening, than insisting upon form filling. Accurate documentation is essential – staff making report should use their own words. If staff do not want to document their concerns, then management may write up report received by them verbally [without revealing source]. Management then need to act accordingly – inclusive of accessing appropriate external help if needed. Not heeding report is equivalent to condoning.
Reducing Discrimination & Promoting Community Acceptance

POLICY
To promote community acceptance of people with physical and mental health problems. This is achieved by:

- Awareness programmes
- Initiatives of the project to counter stigma and discrimination of those affected by mental illness
- Effective consumer participation in service planning and design.

REFERENCES:
SNZ 8143: Part 18
Privacy Act
Code of Rights.

PROCEDURE:
Clients and their families:

- Clients may attend workshops and/or initiatives such as the Project to Counter Stigma and Discrimination of those affected by mental illness / CMA.

- Consumers and their families have a constant say in the quality improvement of the service through resident / service user surveys. The results of these surveys are used to improve service delivery [agenda item at Service review].

- Consumers of the service will have realistic plans which reflect their personal goals and not just the priorities of the Home.

- Appropriate and fair remuneration for any work by residents, including a proper plan of support during and after any work initiative initiative.

Staff Respecting Clients [all levels of the organisation from board members through to care staff]:

The Manager is responsible for ensuring that staff respect the individual worth of individuals, regardless of their mental illnesses by:

- Staff are trained to understand the complex issues surrounding discrimination against peoples with physical differences, disabilities. Training involves self
examination of beliefs, attitudes and behaviour. Staff also learn the legal ramifications of discriminatory behaviour. This is part of induction.

- Performance appraisals of all staff include - a component of assessment in terms of the staff member’s degree of sensitivity to the issues surrounding discrimination for consumers and their families.

- Deterring any staff discrimination i.e. the use of discriminatory language or activity. This would merit immediate attention [education] and, depending on the nature of the discrimination, considered serious misconduct that could result in disciplinary actions.

- Staff are trained NOT to condone ANY discriminatory comment [no matter how trivial it may seem].

- A culture of racial harmony is promoted [encompassing ALL cultures and religions] despite outside influences and personal prejudices.
Definition Lost Resident / ‘AWOL’:

Resident can not be found / has left ‘Home’ without telling anyone.

Preventative Actions:

1) Establish at hand-over:
   - Who is on leave?
   - Who is at home?

2) Check communication book and sign you have read it.

3) Management: have a missing person profile ready for those known to wander / get lost. Alzheimers Society have a template that includes a photo.

If you Discover someone missing:

4) Ask others when they were last seen.

5) Methodical search:

   **Inside**
   - room by room
   - **ALL** rooms
   - include those not generally used.

   **Outside**
   - place by place

6) Seek assistance: Ring the Manager.

7) Respond to instruction. Manager makes the decision to call Police.

8) If you go looking make sure that enough people remain at the Home to keep everyone else safe. Plan your search and search methodically.