Managing Challenging Behaviour & Non Restraint Policy

Preventing Abuse & Neglect
INDEX

Managing Challenging Behaviour

Aims and Objectives  Page 2
Planning the Management of Difficult Behaviours  Page 3
Definition of Challenging Behaviour  Page 4
Guidelines for Managing Challenging Behaviours  Page 5
Spark of Life Solutions to Challenging Behaviours  Page 6
Triggers to Challenging Incidences  Page 7
Environmental Approach to Managing Challenging Behaviours  Page 9
Keeping Staff Safe  Page 10
Defusing & Debriefing  Page 11

NON Restraint Policy

Definitions of Restraint  Page 12
The Home’s Restraint Policy  Page 13
Identifying and Recording Restraint Usage  Page 14
Process for Initiating Restraint  Page 15
Risk Assessment Form  Page 16
Collaborative Assessments  Page 17
Guideline for the use of Geriatric or ‘Bucket Chairs’  Page 18
General Restraint Training  Page 19
Round Table Training for Difficult Behaviours  Page 20
Approval Process  Page 22
Consent Form for Restraint  Page 23
Restraint is not practiced for Behaviour Control  Page 24
Quality Review of restraints  Page 25
Restraint Log  Page 26
Managing Challenging Behaviour & NON Restraint Policy

Aims & Objectives:

1. Our service will provide a safe home-like environment for our residents.

2. Before work commencement, all new employees (family and contractors) will understand that we are committed to a non restraint policy.

3. The use of Restraint is ACTIVELY avoided.

4. Challenging Behaviours are viewed as a resident not feeling sufficiently safe.

5. Such behaviours are considered compassionately and minimised.

Quality System supported by Healthcare Help Benchmarks among other like providers

Five Folder Colour - Coded System:

Red  =  Exceptions
Green =  Meetings
Blue  =  Training
Yellow = Audits & Surveys
Black = Hazard ID & Building Maintenance
        Evacuations & Emergency Planning

Signed: ___________________________________________

Authorised by Manager

Date____________________________________

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:**

**SNZ 8141: 2007**
The Code of Health and Disability Services Consumers’ Rights
Privacy Act 1993 / Policy Privacy & Dignity / Policy Restraint Minimisation

**DEFINITION: OF CHALLENGING BEHAVIOUR**

That the behaviour inspires **stress** in another person, then it is a challenging behaviour:

- Struggling with or Hitting [kicking or biting] another person. Hitting or kicking a table or walls or throwing an object.
- Yelling [name calling or unwelcome remark] [pointing of fingers & raised voice]
- Leaving the Home without telling anyone
- Repetitive Behaviours including need for cigarettes or wandering and awake at might or repeat incontinence that distresses staff
- Needing or expecting additional care beyond what staff are able to provide
- Unwelcome touching or advances

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 it is 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

Saying someone is “anxious” DOES NOT describe a Challenging Behaviour.

DOC -05 C Challenging Behaviour Form encourages staff to document Challenging Behaviour and to realise WHY the behaviour has arisen so that it may be recognised early in future and PREVENTED.
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.

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

Incidents 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 where ever 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

Problem Continues

Continue to monitor & report any further problems. Be aware that new staff need to understand best approaches.
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 may be 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 human beings 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.
Challenging Behaviours arising out of unmet needs:

<table>
<thead>
<tr>
<th>Unmet Physical needs</th>
<th>Unmet Environmental Needs</th>
<th>Unmet Emotional Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
<td>Missing their own home</td>
<td>To be needed and useful</td>
</tr>
<tr>
<td>Constipation</td>
<td>Need for peace &amp; quiet</td>
<td>To have opportunity to care</td>
</tr>
<tr>
<td>Thirst or hunger</td>
<td>Lack of pleasant sounds or smells</td>
<td>To love and be loved</td>
</tr>
<tr>
<td>Infection</td>
<td>Need to personalise the environment</td>
<td>To have self esteem boosted</td>
</tr>
<tr>
<td>Pain</td>
<td>Never goes on outings</td>
<td>To have the power to choose</td>
</tr>
</tbody>
</table>

Behaviours that arise when needs are not met are:

- Repetitive behaviours [requests, pacing or smoking]
- Accusations
- Verbal and physical aggression

**Step Wise Approach – ask what needs are not being met?**

**Step 1:** Check for unmet physical and environmental needs and solve these.

What is the need?

How can we solve it?

**Step 2:** Realise unmet emotional needs and solve them. Emotional needs may be the most difficult to solve. Staff are taught to realise that we all have the same needs, no matter if well or dependant, young or old: the need to love and be loved, and the opportunity to wake up and look forward to doing something that gives a sense of satisfaction or achievement.

Realising unmet needs and finding solutions goes to the core of the problem and enables the problem behaviour to dissolve or disappear rather than minimising or managing it. Meeting residents essential needs helps prevent challenging behaviours.

Jane Verity Spark of Solutions are considered during Planning of Resident Care and are introduced to staff during education sessions.
Triggers to Challenging Incidents

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

Common examples:

Provation:

- Verbal taunts, gestures, physical contact. Staff may provoke someone by keeping them waiting, telling them resident 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 resident is frustrated by physical disability [e.g. not being able to communicate as they once could]
- A resident is frustrated that busy staff have not understood their request and need to have action “now”.
- 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.
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 counterproductive.

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

- 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.
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 that ‘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 may help a distressed staff member..

1. Each person involved can fill in DOC – 05 C 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.
NON Restraint Policy

NON RESTRAINTS POLICY: Our policy focuses upon reducing and managing challenging behaviours rather than to restrain. If we have to restrain someone, then we are unable to manage their behaviour and need to refer to a higher level of care. All staff are made aware of our policy at Induction. The standard aims reduce the use of restraint and to ensure that it is used safely. **Enablers** may provide a person with physical support [postural] or support them feeling safer [bed rails]. These we consider differently and each on its own merit.

REFERENCES:
SNZ 8141: 2007
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. Dementia 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.
* As no restraints are used, we do not maintain a Restraint Log.
1.1.1 Please tick which boxes apply:

☐ The policy of the Home is not to restrain anyone. The Home is committed to caring for its residents without holding or restraining them unless it is to enable greater independence & wellbeing as agreed in Care Planning. Personal Restraint is where a staff member personally holds someone – this may be to stop them from harming another person or to remove them from an area. This is NOT supported by the policy of the Home. Any incidences are recorded on DOC - 05 C Challenging Behaviour Form. This must be reported to a Manager or Team Leader IMMEDIATELY. It is viewed as staff and resident needing immediate support:

⇒ Staff have failed to manage a challenging behaviour
⇒ Holding someone is NOT viewed as safe for themselves or for that person.
⇒ Holding someone is more likely to escalate the situation [they will resist]
⇒ The person who was restrained now needs to have this infringement of their personal space and rights corrected [they are much LESS likely to be feeling safe or happy after being held].
⇒ Policy is to step away / to take others from danger / to avoid conflict rather to step in and dominate.
⇒ There was risk of skin injury, wrenched muscles, contact bruising.

The only possible exception to holding someone would be if they were confused and about to walk in front of a train or bus. Therefore, unless life is in danger, the policy of the Home is not to personally hold anyone without their permission.

☐ We Practice Environmental Restraint – the Home is a special unit for people who need a special environment. The unit is secure & residents cannot leave.

☐ 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 ONLY because the resident requests them and does not feel safe without them. Support bars to aid standing are different from cot sides. They are not considered restraints.

☐ Harness or other enabler may be used to promote independence. Where its use restricts normal access to parts of a person’s own body it must be considered a restraint. An example is a harness enabling a person to sit upright in their chair rather than slumping forwards because they cannot hold their trunk upright.
Identifying & Recording Restraint Usage in the Home:

⇒ Those requiring Environmental Support in specialised Dementia Units are recommended by Needs Assessment.

⇒ A Restraint Log is NOT kept for those using Bucket Chairs when they are unable to rise from bed or any chair due to frailty or incapacity. Therefore it is the disability rather than the chair that constrains them.

⇒ If cot sides are requested by the resident or their family [and approved] then they must be recorded on the Restraint Log. Sometimes people who have had cot sides for ‘years’ now do not feel safe without them and may feel that they ‘need’ them. The Home does not view them as ideal because of the risk of skin damage rubbing against them or confused people harming themselves climbing over them.

⇒ Use of enablers are recorded in the Restraint Log also. Harnesses or other enablers should only be used upon clinician recommendation, with the full informed agreement of the resident and their family and only according to instructions agreed in Care Planning.

⇒ Feeding Tables that attach to the front of chairs are Physical Restraints unless the resident is capable of removing it themselves. Feeding Tables are not considered a restraint when a staff member is in the room and supporting the resident to enjoy their meal and the staff member can remove the table upon request. The moment that staff member leaves the room the resident is restrained. This kind of restraint is NOT supported by the policy of the Home.

Restraint Log

✓ The Restraint Log is a record of people who use restraints or enablers in the Home
✓ Logs date Restraint commenced & when it ceased
✓ Names people who were restrained

Risk Management

Use the Risk Management Form to guide assessment of risk for EACH restraint considered. Compare the risk of harm to resident with restraint to the risk of harm without it.

Consider both the **DEGREE** of risk and the **LIKELIHOOD** of harm.

- How badly
- How likely
Process for Identifying & Recording Restraint Use

In considering restraint use, all other alternative must be considered first.

- Consideration of restraint usage may be through resident request or clinician recommendation.
- We seek resident and family perspective for greater understanding.
- We need to evaluate the problems we are trying to overcome:
  - Underlying causes [that may be able to be rectified]
  - Look at previous use of enablers was successful or if others have been helped by using this proposed restraint’
  - Include contradictions to the use of restraint, e.g. cultural
  - Be guided by any existing Advanced Directives
  - Consider the benefits of using the device / chair
- We consider all possible alternatives to restraint FIRST.
- We need to assess adequacy of staff training and education for the proposed restraint.
- Consider the risk of any restraint versus not using any restraint.
- If care is likely to be enhanced and risk reduced then the resident and / or their family sign approval for the restraint. They also need to be part of ongoing review where ever this is possible.
- All parties agree when it might be used.
- Frequency of monitoring, observation and evaluation is decided according to risk.
- One person must assume the role of Restraint Coordinator for that restraint to monitor and review its usage if it is agreed upon.
- The restraint is documented in Care Planning
- Staff are made aware of care in using the restraint, limitations and possible risks

Checklist:
What are the possible alternatives?
Have we considered the least restrictive way to solve the problem?
Have we assessed the Risk with the restraint and the Risk without the restraint [use form on the next page]
Have we considered Resident Rights & Feelings
Have we assessed the risk of infringing on cultural grounds
The Home prefers NOT to restrain. If someone needs restraining on behavioural grounds to keep them safe then assessment to go to a higher level of care may be needed.
Restraints Risk Assessment Form: R- 01

To be used PRIOR to deciding ANY restraint usage. Alternatives have been considered and there is NO Less restrictive restraint available

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>
</tr>
</thead>
<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:__________________________________  __________________________

Review co-ordinator:___________________________[name] Desig: __________________

Must be reviewed before:___________________________[date]

Assessment
1.1.2 Collaborative Assessments

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 there 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 minimise the risk of the restraint [make it safer – e.g pills 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. Staff need to understand the resident’s beliefs 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. In the most unlikely event that objects of religious or cultural significance needed to be removed, because resident safety was compromised, we need to re evaluate what we are doing? Our policy is not to remove items of particular significance from people. Cultural needs of residents’ must be known and met during restraint use. This generalises to all cultures.

1.1.3 Use of Enablers

Geriatic or Bucket Chairs / Harness for Disability Wheel Chair:
Use is documented in Care Planning. Resident Dignity & Privacy is of paramount importance.
Monitoring frequency is agreed among all stake holders
Reviews are documented as part of ongoing Care Planning
Please follow the general guide on the next page
General Guideline for the use of Bucket Chairs

Candidates:

❤️ The resident is not able to sit up in a lounge chair or on the couch without falling over or off it.
❤️ The resident is unable to get up from an ordinary bed or chair [therefore it is not a restraint it is an enabler]
❤️ Residents who would otherwise be left in their beds are now enabled to be in the common rooms and participate in activities and daily events.

✈️ Not to be used to keep resident in one place and ‘cast’ unable to get up.
✈️ Not to be used for mobile residents unless:
- The chair helps elevate their limbs for medical reason
- They can get out themselves

Length of Time in the Bucket or Geriatric Chair

❤️ No more than two hours without a change of position
❤️ Changes of position must be made in the residents’ own room [return the chair to the room]. NO TURNING PEOPLE IN THE LOUNGE or treatment rooms.
❤️ Small adjustments to position and pillows ARE permitted / expected in the lounge.
❤️ Ensure natural body positioning as close to stroke position as possible according to resident need.
❤️ NEVER crank the resident neck forwards with fat pillows [it is likely to hurt later].
❤️ Check continence at each change of position and support the resident as needed.
❤️ Help the resident with passive exercises [this enhances comfort and reduces stiffness]

Positioning:
Left side / right side / back alternating according to resident comfort and need. Longer time may be spent in favoured or more comfortable positions. When on left or right side the resident is only partially to either side rather than completely on the side.

Guideline for Harness for use in Disability Wheel Chairs:
Harness should be fitted and recommended by Occupational Therapists / Specialist doctors.
Please seek specific guidance in the Harness form the issuing Health Professional.
Harness prevents access to other parts of the body so this will need to be carefully considered.
Length of time harness may be on will differ individually.
1.1.4 Managing Challenging Behaviour & Restraints Training

Staff learn our non restraint policy at induction and when ‘buddied’ with other staff prior to commencing work proper.

Managing Challenging Behaviour & Restraints Training is offered to all staff at least annually AND when ever incidents show that staff are not coping with resident behaviour OR when staff are witnessed behaving in a “NON conciliatory” manner towards residents.

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.

For example: A resident is disagreeing with a staff member and has cast her plate of food in the direction of the staff member. If that staff member walks away from the resident [without reprimand] then the resident is left with no one to fight with. Staff should NOT challenge this resident – just check that other residents are OK and leave the person in peace. A competent staff member should approach, when the time is right, with a different agenda, ignoring the plate, softly and kindly to rebuild trust. Had the staff member reprimanded the resident [escalating the situation] a training session for ALL staff would need to follow.

Annual Restraint Training includes:

- Definition of Restraint / our NON Restraint 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 [see Managing Challenging Behaviour Training Module Seven]
- Comprehensive assessment – description, history, antecedents, consequences.
- Rights of family & family involvement
- Record keeping
- Physical, psychological & cultural risk
- Increased need for dignity privacy & cultural safety

Understanding is tested with an assessment of knowledge. See Training Module Eight [Non Restraints] Trainers Resources.
Round Table Training for Difficult Behaviours

Where staff are finding individual residents difficult to manage, training may focus upon these residents. Incident Reports on DOC – 05 C call attention to incidences of Challenging Behaviour. We have categorised Challenging Behaviour:

- Struggling with or Hitting [kicking or biting] another person. Hitting or kicking a table or walls or throwing an object.
- Yelling [name calling or unwelcome remark] [pointing of fingers & raised voice]
- Leaving the Home without telling anyone
- Repetitive Behaviours including need for cigarettes or wandering and awake at night or repeat incontinence that distresses staff
- Needing or expecting additional care beyond what staff are able to provide
- Unwelcome touching or advances

Challenging Behaviour needs clear documentation in Care Planning so that staff are guided:

⇒ Round table discussion makes for a unified plan
⇒ It helps staff realise ALL aspects of a resident problem
⇒ Staff are encouraged to see the Resident as a Person with NEEDS someone that a family loves and cares about and to learn about their lives.
⇒ If everyone shares the same approach we may succeed better.
⇒ Communication problems are considered. Staff may not understand the needs of residents with challenging behaviours.
⇒ Round table discussion realises resident need over 24 hours rather than on individual shifts [e.g. slept all day no problem at all until the night shift]
⇒ Family members or some staff may know much more about this resident and therefore understand their problems
⇒ 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 who are less “conciliatory” may find that a “bossy” approach earns more resistance from residents. These staff need to be helped 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.
### Training Program Managing Challenging Behaviour & Restraints

#### At Induction
**AIM:** Staff realise that restraint is not supported by policy of the Home.

Staff learn residents with special needs re behaviours and understand how these are best managed.

#### Challenging Behaviour Training
**AIMS:**
- Know categories of Challenging Behaviour:
  - Clear about what how to report
  - Understand about triggers to behaviours
  - De-escalation Techniques
  - Non coercive communication

#### Restraint Training
**AIMS:**
- Know definitions of restraint:
  - Clear about what comprises restraint & enabler
  - Collaborative care including Communication
  - Good knowledge of Alternative Interventions to Restraints

#### Additional Training
**AIM:** For staff to understand the needs of new people arriving in the Home

For staff to understand those with greater needs:
- Dementias
- Brain injury or disability

### Assessments of Knowledge

#### AIM:
- Assessments of knowledge will test basic understanding:
  - Recognising triggers
  - Defusing
  - Conciliatory approach
  - Meeting basic needs

NZQA Training needed for those working in Dementia Units.

#### Assessment of Knowledge
**AIM:** Can fill in forms competently recording incidences of Challenging Behaviour

Problem Based Learning where groups solve common situations staff might face.

#### Assessment of Knowledge
**AIM:** Understanding of the use of enablers.
To realise legal responsibilities

Problem Based Learning where groups solve common situations they might face.

#### Assessments of Knowledge
**AIM:**
- To gain training to the level required for the setting

Good understanding of an Environmental Approach to Behaviours

External Expert Training & Resources are utilised.

### Training Resources

- Guideline for the use of Bucket Chairs
- Work Instruction
- Guideline for Managing Challenging Behaviours and Keeping Safe
- Restraint Flow Chart
  - [www.HH.NET.nz](http://www.HH.NET.nz)
  - FREE DOWNLOAD [work instructions]
- Training Resources from External Trainers:
  - DHB Experts
2.1 Safe Restraint Practice

2.1.1 Induction & ongoing education teaches the Home’s restraint policy:

Any restraint must FIRST be APPROVED

⇒ If residents or their family request restraint [such as cot sides] these must first be approved.
⇒ Follow Restraint Approval Flow Chart:
2.1.2 Documentation for approved enablers:

⇒ Resident Review Meeting Form may be used to document multidisciplinary discussions [Form CP – 11]
⇒ Restraint Risk Assessment Form [R – 01]
⇒ Restraint Consent Form [R – 02]
⇒ Care Planning will Document the Enabler Use
  - Care Planning will describe least restrictive methods of care possible for the resident.
  - Use of any form of restraint must give clear explicit instructions
  - This will include when to use, how to apply and guides to duration of usage

2.1.3 Review of the approved [restraint] enabler is decided according to:

⇒ The likelihood of harm from using bucket chair, harness or cotsides.
⇒ Scope for improvement
⇒ Possibility of decline in condition
⇒ New products becoming available or affordable that are superior
⇒ First review date MUST be decided when the enabler [restraint] is approved.
⇒ The next review date is nominated each review.
⇒ Reviews should be brought forward if the enabler / restraint is no longer needed or no longer working or a less restrictive alternative becomes available.
⇒ Two years is the maximum permitted time between reviews.

One person assumes responsibility as coordinator for each enabler in use.
For example the RN, physiotherapist, team leader or other nominated role. If the person filling this role is replaced the new person carries the responsibility as the coordinator.

2.2.1 Assessments

The policy of the Home is not to restrain. This includes personally holding someone.
Suitably skilled advice is sought for the management of:

♥ Physical disabilities where a device promotes independence
♥ The risk of a resident harming themselves or others and key indicators [staff alerts]
♥ Assessments are comprehensive and include family and other support people as much as possible. Care planning incorporates culture, background, gender etc comprehensively]
♥ Assessments also take into considerations past history of trauma both physical and emotional that a person may have suffered.
♥ These are considered greater reason for NOT restraining
Consent Form for Use of Restraint [R – 02]

Name of Resident:                                                                 Date:

Type of restraint:

Reason for restraint use:

☐ 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 device or method described above. I understand that this is the LEAST restrictive option available at this time.

☐ 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 / Family or Advocate]

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 / Method of minimising risk of harm [e.g soft pillows under legs].

RN / Manager’s signature: ________________ Date: ________________

Team Member signature: ________________ Date: ________________

Doctor’s signature: ________________ Date: ________________
2.0 Restraint is not practiced for behaviour control

Quality Review of Restraints
The Home conducts an annual Quality Review of restraints. As 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 any enablers in the Home
2. Compliance with policy. Checklist for each enabler:

- Dignity & Respect
- Resident Rights
- Privacy
- Advocacy (family)
- Culturally appropriate
- Recognising special needs
- Assessment is ongoing
- Approval processes, policies and procedures.

3. The alternatives to restraint that have been identified as part of the plan of care.
4. Communication effectiveness with family / family participation for the enabler. Those showing challenging behaviours are discussed individually.
5. Support provided to residents and staff involved.
6. The effectiveness of individual Care Planning where there are behavioural problems.
7. Monitoring & observations.
8. Staff competency and training includes assessing the competence of trainers.
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.

3.0 Seclusion is not practiced in the Home.
## Restraint Register

<table>
<thead>
<tr>
<th>Log Number</th>
<th>Name of Resident</th>
<th>Date Restraint Commenced</th>
<th>Date Restraint Ceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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>
<td></td>
<td></td>
<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
⇒ Out of fear of the abuser ⇒ 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-esteeem
⇒ 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>Burns</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>
</tr>
<tr>
<td>Welts</td>
<td></td>
</tr>
</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.**

**Some Indicators of Psychological Abuse**

- Resignation
- Mental confusion
- Fear [Shrinking away]
- Marked passivity
- Shame
- Anger

**Indicators of Sexual Abuse**

- Bruising or bleeding in genital area
- Venereal disease
- Difficulty in walking or sitting
- Pain or itching in the genital area
- Recoiling from being touched
- Fear of bathing or toileting

**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 may be 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.
- Residents may attend workshops and/or initiatives such as the Project to Counter Stigma and Discrimination of those affected by mental illness / CMA.
- Residents have a constant say in the quality improvement of our service through resident meetings & surveys. The results of these surveys are used to improve service delivery [agenda item at Service review].
- Residents will have realistic plans which reflect their personal goals and not just the priorities of the Home.
- Appropriate and fair remuneration is given for any work by residents, including a proper plan of support during and after any work initiative.

The Manager is responsible for ensuring that staff respect the individual worth of individuals, regardless of mental illness or disability:

- Staff are trained to understand the complex issues surrounding discrimination against peoples with differences & disabilities. Training involves self examination of beliefs, attitudes and behaviour. Staff also learn the legal ramifications of discriminatory behaviour. This is a practical aspect of induction.
- Performance appraisals of staff include sensitivity to the issues surrounding resident well being.
- Deterring 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 a misconduct that could result in disciplinary action if it were not realised and amended.