Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation of Health and Social Care Services

Literature Review – Restrictive Practices

December 2017

Safer Better Care

Contents

Introduction

The use of restraint or restrictive practices in care settings is fraught with ethical difficulties. Far from being a contemporary concern, efforts to reduce or eliminate the use of restraint in health and social care settings can be traced back to over 200 years ago in England and France.(1) On the one hand, it is argued that some restrictive measures are necessary to keep a person safe and or to protect others. Conversely, many see the practice as a gross infringement on a person's liberty and rights and argue that it should only be used in the most extreme circumstances. Consequently, care service providers face...

> "...ethical dilemmas posed by the need to balance a service's duty of care obligations with the rights of a person...where the behaviour of the person has the potential to cause harm to him/herself or to others. Services also have an obligation to consider staff members' rights, as they are entitled to work in a safe environment."(2)

HIQA's business plan for 2017 commits to carrying out research which will inform a programme of thematic inspections looking at the area of restrictive practices in nursing homes and residential services for people with disabilities. The thematic inspections will focus on the national standards and will look to drive improvement across a range of areas in designated centres for older people and people with disabilities. The key questions and topics to be addressed by this literature review are as follows:

- Describe the relevant legislation, regulations and standards applicable in Ireland and the current practice in relation to restraint.
- Outline the current trends in terms of reducing or eliminating restrictive practices, both nationally and internationally.

To this end, this literature review is the first step in the process of formulating the thematic inspection programme. The review will first look to define restrictive practices and any other relevant forms of restraint that fall under this broad category. The next section will examine the literature which looks at the rationale and prevalence of these practices. The review then discussed literature which has a focus on the use of assessment when considering a restrictive practice. This will be followed by an examination of the literature that gives an overview of the consequences of using restrictive practices. The next section discusses the relevant law and regulations on restraint in the Irish context and also looks at policy, guidance and other relevant grey literature from other jurisdictions. Finally, the review will give an overview of the research and literature that outlines preventative measures and alternatives to restraint. A discussion section will conclude the review.

Methodology

The methodology used for this review was a search of online peer-reviewed journal databases (Wiley, Science Direct, ResearchGate, PubMed) and Google Scholar for specific keywords (for example: "restraint", "restrictive practice", "chemical restraint", "mechanical restraint"). Google searches were also conducted for policy documents, guidance

documents, professional guidelines and other relevant grey literature published in Ireland or internationally. These publications may be from relevant authoritative sources such as Government agencies, non-governmental organisations, professional associations and other regulators. Only literature concerning care of the older person and people with disabilities was considered. The review is not concerned with literature that applies solely to the field of mental health services. However, some of the legislation and guidance in this field has relevance and is discussed, particularly the publications of the Irish Mental Health Commission. Literature which was more than 20 years old and not in English was also excluded.

Definitions

Most studies in this literature review outlined a broad definition for what constitutes a restrictive practice, often followed by a more detailed description of the different categories of restraint*. There is a general consensus that restraint is the practice of intentionally limiting a person's movement and/or behaviour.[3-6] The regulations pertaining to disability services in force in Ireland use the term 'restrictive procedure' which is defined as: "the intentional restriction of a person's voluntary movement or behaviour".[7] A recent definition in a Care Council for Wales document is an example of a broad, plain English definition: "restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do".[8]

There are a range of different types of restraint outlined in the literature. However, those cited most often are physical, mechanical, environmental and chemical. Some articles, particularly more recent ones, sought to introduce additional types of restraint such as social restraint, medical restraint and electronic surveillance. There is also a debate as to whether institutionalised routines and practices which are not person-centred constitute a type of restraint (for example, getting up at the same time, having meals at the same time).[9] The following is a series of definitions and descriptors for each type of restraint in the literature from different authors:

Physical restraint: "any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person".[10]

Mechanical restraint: "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body".[11]

Environmental restraint: "the intentional restriction of a resident's normal access to their environment, with the intention of stopping them from leaving, or denying a resident their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties".[3]

Chemical restraint: "the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary

* The terms 'restrictive practice' and 'restraint' are used interchangeably in the literature and the same will apply in this paper.

for the condition or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes".[12]

Social/psychosocial restraint: "The use of verbal interactions (which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive) and/or threats of social or other tangible sanctions (e.g., response cost programmes), which rely on eliciting fear to moderate a person's behaviour (in contrast to planned interactions or formal programmes designed to educate the person about the natural consequences of their actions and to assist them to make reasoned decisions or choices about appropriate behaviour)".[13]

Seclusion: "the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving."[11]

Electronic surveillance: "this includes electronic tags on people, exit alarms on doors and television cameras (closed circuit television (CCTV)) to monitor people's movement".[9]

Medical restraint: "various medical procedures impinge on people's lives – such as catheters or feeding tubes. Individuals may attempt to remove these (for whatever reasons) and people may take steps to prevent this".[9]

Rationale and prevalence

The use of restraint is sometimes warranted in instances where a person's behaviour presents a serious risk of harm to themselves or to others.[9, 14] Concerns around protection, safety, falls prevention and behaviour control (including the prevention of wandering) are often cited as reasons for the use of restrictive practices.[15-17] In addition, the use of physical restraint was reported in cases where there was resistance to oral hygiene[18], to aid positional support[19], prevent self-injurious behaviour[20] and in order to prevent the removal of tubes and catheters.[15, 21] Mechanical restraint has been cited as a means of preventing self-injurious behaviour in people with intellectual disabilities, albeit with the risk of severe side-effects.[22] Chemical restraint has been cited as a tool to manage behaviours that are challenging in nursing home residents, despite being regarded as an inappropriate treatment.[23]

An Australian study looked at the barriers to eliminating the use of restraint in elder care facilities from the point of view of residents, relatives, staff and medical professionals. It found that a range of barriers existed including a lack of knowledge of alternatives to restraint; fear of falls or injury; staff and resource limitations; communication barriers; inadequate review practices and policy and management issues.[17] A systematic review of literature on the use of physical restraint found that, out of ten studies, five identified physical restraint being used for the benefit of staff and/or the care home (to compensate for understaffing, reduce legal liability and enable the completion of work schedules). Three studies found that physical restraint was used for social reasons (i.e. to prevent certain residents interacting with each other and to maintain a harmonious living and working environment).[24]

Much of the literature cited above is critical of the use of restraint and questions the evidence for its use as a protection and safety measure. Several studies have pointed out the lack of evidence-based data to support the value of restraints in preventing falls and controlling behaviours that challenge.[25, 26] Despite being cited as a falls prevention measure, one study found that the use of restraints was not associated with a significantly lower risk of falls.[27] A systematic review found five studies which examined the impact of physical restraint removal on the incidence of falls and fractures. All five concluded there was no evidence that falls or fractures were increased or decreased as a result of the removal of physical restraints.[28]

Psychotropic medications are associated with chemical restraint. There is conflicting evidence on the efficacy of antipsychotic medications in managing aggressive behaviour in people with intellectual disabilities. A randomised controlled trial found that the use of a placebo produced better results than the psychotropic drugs Risperidone and Haliperodol. The authors thus argued that antipsychotic drugs should not be regarded as an acceptable form of treatment for aggressive challenging behaviour in people with intellectual disabilities.[29] This study references two earlier studies[30, 31] which found that Risperidone was effective in managing behaviour disorders in people with intellectual disabilities.

It can be difficult to assess and compare the prevalence of the use of restraint internationally, primarily due to the differences in defining what constitutes restraint across different studies.[4] There is a broad consensus in the literature that people who are more physically frail and have lower levels of cognitive function are more likely to be subjected to physical restraint.[24] A person with a disability is more likely to be subject to a restrictive practice if they are over 86 years of age, cognitively impaired and diagnosed with dementia.[26]

Other characteristics, such as mobility and gender, were shown to be risk factors associated with the use of physical restraint in nursing home residents in the Netherlands.[32] The inability to perform activities of daily living is also identified as a risk factor for physical restraint.[25] A 1997 study of restraint data from nursing homes in eight countries found low prevalence rates in Denmark, Japan and Iceland (less than 9%), moderate rates in France, Italy, Sweden and the USA (between 15% and 17%) and high rates in Spain (almost 40%).[33]

Below is a selection of prevalence rates for different types of restraint in various care settings:

- Research carried out in Ireland and published in 2012 looked at conflicts and interactions between staff and residents of nursing homes. A total of 1,316 nursing home staff participated in the research by responding to questionnaires anonymously. The research found that the use of restraint beyond what was needed at the time constituted the most frequent form of physical abuse:

    - 8.5% of staff said they observed this happening on one or more occasion
    - 2.4% of staff said that they had committed such an act on one or more occasion.[34]

- A German study involving eight nursing homes found that approximately 10% of staff reported using physical restraints and 7% used chemical restraints to reduce workloads.[35]

- A study of a psycho-geriatric unit in Germany found that 30.3% of patients had experienced physical restraint within three weeks of first admission. The rate of use was higher in patients with severe cognitive impairments.[25]

- A 12-month study in Victoria, Australia examined the use of three forms of restraint (chemical, mechanical and seclusion) in people with an intellectual disability and/or acquired brain injury. It found that approximately 9% of those studied had been subjected to one or more of these forms of restraint. The instance of chemical restraint far outweighed the other two forms of restraint, accounting for 83% of all reported incidents. Chemical restraint was found to be administered on a routine basis.[36]

- Data gathered from three nursing care settings in the Netherlands found that 49% of residents were subjected to one or more forms of physical restraint. The most common types of physical restraint were bed rails, waist belts and chairs with a table.[37]

- Two separate studies that looked at the prevalence of the use of mechanical restraints found that 7% and 17% of adults with intellectual disabilities were subjected to mechanical restraint in order to prevent self-injurious behaviour.[38]

- An analysis of 30 nursing homes in Hamburg, Germany found that approximately 25% of the nearly 2,400 residents were the subject of a physical restraint, most commonly bed rails. In addition, the researchers found that more than 50% of the residents had a prescription for at least one psychoactive medication, despite their assertion that these medications have been shown to be ineffective in geriatric populations.[39]

- A Norwegian study of 1,501 nursing home residents found that 36.7% of those in 'regular units' were subjected to a form of restraint within a seven day period. The equivalent figure for 'special care units for persons with dementia' was 45%. Mechanical restraint (primarily bedrails) had the highest prevalence in both settings, followed by 'use of force or pressure in activities of daily living'.[40]

- A comparative analysis of care quality indicators in nursing facilities across the 50 states in the USA from the 2000 OSCAR[†] found a large degree of variance in the use of physical restraints. The average percentage (non-risk adjusted) of residents physically restrained ranged from 2.3% in Iowa to 23.1% in Louisiana.[41]

[†] The OSCAR data is collected by state licensure and certification agencies as part of the Medicare/Medicaid certification process, and included 17,072 facilities in 2000.

- A review of incident forms in two service divisions operated by a provider of services to adults with intellectual disabilities in the USA found a prevalence of physical restraint of 5.2% in one division and 7.9% in the other. The use of this form of restraint was reserved for three categories of behaviour: self-injurious behaviour, aggressive behaviour and environmentally disruptive behaviour.[42]

- Research published in 2000 analysed the treatment and management of behaviours that challenge in 500 adults with intellectual disabilities in residential services in the UK. The most commonly-used management strategies for people that had behaviours that challenge were "...physical restraint (used with 44% of people showing challenging behaviour), sedation (35%), seclusion (20%) and mechanical restraint (3%)".[43]

Assessments and review of restrictive practices

The decision to use a restrictive practice should be appropriately assessed and continuously reviewed by service providers. HIQA's own guidance document on restrictive practices in disability services states that "...[e]xcept in an emergency, a full assessment of a person is performed and recorded prior to restrictive practices being used".[12] Many of the guidance and policy documents reviewed in this paper specify what is required of such an assessment.

In New Zealand, Standard 2.2 of the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards states that "Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint". The criteria underpinning this standard are described as follows:

> "In assessing whether restraint will be used, appropriate factors will be taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
>
> a) Any risks related to the use of restraint;
> b) Any underlying causes for the relevant behaviour or condition if known;
> c) Existing advance directive the consumer may have made;
> d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
> e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
> f) Maintaining culturally safe practice;
> g) Desired outcome and criteria for ending restraint (which should be make explicit and, as much as practicable, made clear to the consumer);
> h) Possible alternative intervention/strategies."[44]

An Australian document, focussed on residential care for older people, seeks to support services in promoting a restraint-free environment. It offers guidance on what kinds of assessment can be carried out in relation to the use of restraint. It advises that a comprehensive assessment be carried out in the following circumstances:

- when a person first receives residential care services and has a diagnosis of impaired cognition e.g. dementia
- whenever there is any change in the functioning, situation or behaviour of a resident
- on an ongoing basis as part of a regular review process.(45)

The document provides information on a wide range of factors to consider when carrying out the following types of assessments:

- comprehensive assessment
- physical and functional assessment
- psycho-social assessment
- assessment of the physical environment
- assessments for delirium, depression and dementia.(45)

All of the above assessments are intended to identify factors which may be causing an older person to exhibit behaviours that challenge or behaviours that place themselves or others at risk. The guidance also specifies what should occur if the decision to use a restraint is taken. Any assessment which advises the use of a restraint should be reviewed as soon as possible. The review should query whether the restraint is still appropriate and also serve as an opportunity to trial alternatives to restraint. The restraint-free options listed in the document are in Appendix 1.

A guidance document authored by Quality Insights Pennsylvania[‡] addresses the use of physical restraints in healthcare settings for the elderly. The guidance offers a list of questions which allows service providers to evaluate their assessment tool(s). Some of the questions posed are as follows:

- Does the assessment reflect a multidisciplinary approach?
- Is there documentation of a precipitating event causing or triggering the resident's current situation?
- Does the facility assess and treat underlying medical conditions precipitating the use of physical restraints?
- If a restraint is currently being used, are time frames, situations, or conditions documented in the assessment regarding application or removal of the physical restraint?(46)

The full list of questions is in Appendix 2.

The Department of Health and Human Services, Victoria, Australia published an online resource which describes a standardised care process for physical restraint which

[‡] Quality Insights of Pennsylvania is the Medicare Quality Improvement Organization for Pennsylvania, USA.

includes details on appropriate assessment. The resource is focused on care of the elderly and suggests the following should be included in an assessment:

- a cognitive assessment using the Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS)
- medical history: Is there a diagnosis of dementia? Is there a history of delirium?
- is there a history of behavioural and psychological symptoms of dementia (BPSD)?
- resident's usual routines, likes, dislikes and preferences
- physical assessment (including constipation, sensory impairment)
- pain assessment
- communication ability
- screen for delirium (see SCP: delirium)
- screen for medicines that increase agitation
- mental state (mood disorders, psychosis)
- falls risk assessment
- psychological coping strategies, cultural needs, meaningful activity, boredom, level of stimulation)
- physical environment (noise, lighting, visual cueing).

The resource also makes recommendations for evaluation of reassessment of interventions in two key areas: behavioural and risk of falls. There should be ongoing evaluation of behavioural and falls prevention interventions. When there is a change in circumstances (i.e. a change in behaviour or a fall) then the assessment should be repeated.[47]

Also from Australia, a Department of Health guideline for New South Wales offers advice on managing people with behaviours that challenge in aged care settings. The guidance is targeted at reducing and avoiding the use of restraint and, as with the document above from Victoria, describes what should be covered in an assessment. This includes consideration of the following causative factors: physical, biological, psychosocial, cultural or environmental triggers, or other perpetuating factors including pain. The guidance explains the importance of assessment and the role of the Public Guardian in authorising the use of restraint:

> "Any plan for the restriction of a person's movement and liberty must be based on a specific assessment by a specialist clinician in aged care. The assessment should examine the underlying cause of the behaviour and rule out any possible medical or external causes for the behaviour that can be addressed through other means. This assessment should lead to the development and implementation of a care plan that minimises the need for the use of the restraint and is regularly reviewed by key people involved in the person's care and treatment. The Public Guardian will not consent to the use of a restraint when it is proposed because the service context involves a lack of appropriate resources and untrained staff. In these circumstances, the purpose of the proposed restraint would be seen to be

> attempting to address a service deficiency rather than meeting the individual needs of the resident."[48]

In terms of caring for people with intellectual disabilities, successfully identifying and understanding the cause(s) of behaviours that challenge can assist in devising interventions which can improve the person's quality of life and negate the need for restraints.

> "Realizing that people do not engage in problem behaviour because they have intellectual disabilities is crucial. People with intellectual disabilities engage in problem behaviours because these behaviours serve a function, a purpose."[49]

The use of functional assessments (sometimes referred to as functional behavioural assessments) is one approach which seeks to understand the cause of behaviours that challenge and develop appropriate interventions to address them. Typically, these types of assessments should be preceded by interdisciplinary or multi-method approaches which serve to rule out any physical or mental health problems which may be causing or contributing to the behaviours. Only when medical, dental, psychiatric and pharmacological influences have been successfully treated or ruled out should a functional assessment proceed.[49]

The following components, outlined in Tassé (2006), should be included in a functional behavioural assessment:

1. clear operational definition of the problem behaviour(s)
2. identification of the times, places and circumstances in which the problem behaviour(s) occurs and does not occur
3. identification of the factors that precede the occurrence of the problem behaviour (i.e. antecedents)
4. identification of the factors that follow the occurrence of the problem behaviour (i.e. consequences)
5. experimental functional analysis of antecedents and consequences to observe their causal relationship with the target behaviour
6. development of hypotheses regarding the function of relationship between the problem behaviour and the individual's environment, which then lead to proposed intervention strategies
7. ongoing data collection to monitor/revise hypothesized functional relationship and/or implemented intervention strategies.[49]

Consequences of restraint

Restrictive practices have been shown to result in a range of negative consequences for those who are subject to their use. Physical restraint appears most frequently in the literature in the context of the consequences of restraint. Two studies found that the use of physical restraints extended an older person's length of stay in hospital.[24, 50] The use of bedrails or cotsides has been shown to be particularly problematic. Several research articles

have documented the risks posed by bedrails, including entrapment and falls resulting from people attempting to climb over the rails.[51-53] In the USA, the Food and Drug Administration and the Joint Commission for the Accreditation of Health Care Organisations have issued advisories cautioning against the risks associated with the use of bedrails.[54]

The United States Consumer Product Safety Commission reported 155 fatalities between 2003 and 2012 attributable to the use of adult portable bedrails[§], 93% of which were caused by entrapment. There were an estimated 36,900 injuries caused by adult portable bedrails between 2003 and 2011.[55] As a counterpoint, a systematic review in 2008 of the effect of bedrails on falls and injuries found that bedrails did not appear to contribute to an increased risk of falls or injury. The study also concluded that serious injuries related to bedrails were attributable to the use of outmoded designs or incorrect assembly.[56]

A study involving nursing home residents with dementia concluded the use of physical restraints may lead to cognitive and functional impairment. Interestingly, the study found that there was an additive effect where antipsychotic medications were used concurrently with physical restraints, meaning that the risk factors for cognitive and functional impairment were increased.[57] Another study of nursing homes in the USA found a decline in cognitive performance, ADL performance and increased walking dependence in residents that had been physically restrained.[58]

Mechanical restraint is the second highest cause of death in law enforcement and care services in the UK and USA.[59] The use of mechanical restraint to limit or prevent certain self-injurious behaviour(s) may result in the emergence of other types of self-injurious behaviour(s). Long-term restriction by way of mechanical restraint may also result in muscular atrophy, demineralisation of bones, shortening of tendons, arrested motor development and disuse of limbs.[22] Use of mechanical restraints was described as a form of abuse in a 2006 investigation of the Cornwall Partnership NHS Trust.[60]

Psychotropic medication (used in chemical restraint) has also been shown to have a number of negative side-effects for the recipient. The United States Food and Drug Administration does not approve of the use of these drugs in the treatment of behavioural manifestations of dementia.[61] Psychotropic medications have been associated with a higher incidence of falls in older people.[62, 63] The following is a list of some other negative outcomes of psychotropic medication and chemical restraint:

- agitation
- functional decline
- gait disturbance
- increased fall risk
- memory impairment
- movement disorders
- sedation
- orthostatic/postural
- withdrawal hypotension.[64]

[§] The Food and Drug Administration defines portable bedrails as "...any bed rail product or device that is attachable and removable from a bed, not designed as part of the bed by the manufacturer".

Service-user experiences of restrictive practices in intellectual disability services have been researched in a number of papers.[65-68] All of these studies were with small groups of between 8 and 10 people with varying degrees of intellectual disability. All studies reported that most service users understood that restrictive measures were used for a purpose (for example: to keep the service user safe; to keep those around them safe; to help them calm down). Despite this, service users reported a range of negative consequences while being subjected to a restrictive practice:

- pain and/or discomfort[67, 68]
- injury[65]
- restraint as abuse[66]
- negative emotions/experience[65, 68]
- perceived as a form of punishment[67]
- re-traumatisation**.[67]

Some of the studies mentioned above also sought the perspectives of staff who worked with people with intellectual disabilities. Some staff felt that while a restrictive practice may help some service users to calm down, it had the effect of increasing anger and aggressive behaviour in others. Staff reported sustaining superficial injuries during a restrictive intervention.[65] Staff also expressed a range of negative emotions (frustration, fear, anger, distress) prior to, and during, the application of a physical intervention.[68] It is also argued that the implementation of restraints results in higher costs for service providers and that savings can be accrued through the safe elimination of restrictive practices.[69]

Policy and law on restrictive practices in Ireland

There are several pieces of legislation/regulation that are applicable to the application of restraint in Ireland. A lot of the material is focused on mental health services, the primary piece of legislation being the Mental Health Act 2001. Section 69 of the Act deals with bodily restraint and seclusion:

> "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under *subsection (2)*, to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules".[70]

The Act also requires the Mental Health Commission to devise rules governing the use of restraint and seclusion in approved centres. There have been two versions of these rules published, the most recent coming into force in 2010. The rules set out the procedures governing the use of seclusion and mechanical restraint such as: patient dignity and safety; seclusion facilities; recording; use of CCTV; staff training; and clinical governance.[11] While the above is primarily relevant to mental health services, it is important to note that the legislation and rules governing seclusion and restraint could be applicable in the context of

** In this context, re-traumatisation is the recall of previous abusive or traumatic experiences while being physically restrained.

services for older people or people with disabilities. For example, some people may have a dual diagnosis: an intellectual or learning disability in addition to a diagnosed psychiatric condition.

There are two sets of regulations in the context of social care that deal with the area of restraint: Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) (2013); Care and Welfare of Residents in Designated Centres for Older People (2013). Generally speaking, both sets of regulations require service providers to:

- have policies on the use of restraint
- provide training to staff
- ensure the use of restraint is evidence-based and in line with national guidelines
- use the least restrictive intervention possible
- notify HIQA of the use of restraint
- support residents to manage behaviour that may be challenging.[7, 71]

Various organisations in Ireland have produced documentation and guidance on the use of restraint across a range of services. Most of this literature is focused on physical restraints in the context of care of the older person. Among them include:

- Department of Health – *Towards a Restraint Free Environment in Nursing Homes* [3]
- Health Information and Quality Authority – *Guidance for Designated Centres – Restraint Procedures* [12]
- Health Service Executive – *Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People* [6]
- Association of Occupational Therapists of Ireland – *Best Practice Guidelines for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities* [2]
- Irish Nurses Organisation – *Guidelines on the Use of Restraint in the Care of the Older Person* [72]

The following is a brief description of some of the key aspects of the aforementioned policy and guidance documents. This is intended to provide an overview of the current policy and best practice guidance in Ireland.

Department of Health – *Towards a Restraint Free Environment in Nursing Homes* (2011)

Following the establishment of HIQA, coupled with nationally mandated standards and regulations and registration for nursing homes in 2009, the Department of Health published a policy on restraint in 2011. The policy was devised by a working group and set out an agenda to achieve a restraint-free environment in nursing homes. Much of this policy echoes what is in the regulations pertaining to older people in residential settings. The policy stated that all nursing homes should be committed to a restraint-free environment. In order to achieve this, staff must be familiar with residents' usual conduct, behaviours and means of

communication. Moreover, staff should be familiar with methods of adapting the environment in response to behaviours that are challenging.[3]

The policy states that residents should be permitted to engage in activities involving a personal risk to themselves and that their right to participate in such activities should be respected. The policy makes clear that it should be presumed that all adults have the ability and capacity to make informed decisions about their care. A diagnosis of an intellectual disability or cognitive impairment is not necessarily sufficient grounds to assume that a person lacks capacity. Where a person is demonstrating behaviour that results in a restrictive measure, every effort should be made to determine and alleviate the root cause of this behaviour. The policy goes on to outline how restrictive practices should be assessed, monitored, recorded and reviewed. The policy states that the use of chemical restraint is always unacceptable.[3]

Health Information and Quality Authority – *Guidance for Designated Centres, Restraint Procedures* (2016)

The most recent HIQA guidance document on restraint adopts the principles in the aforementioned Department of Health policy, but the guidance is aimed at residential services for adults and children with disabilities. A measure outlined in the HIQA guidance but not the Department of Health policy is that there should be a staff debriefing after each episode of a restrictive practice. Any such review should be informed, wherever possible, by the resident's feedback on the episode.[12]

Health Service Executive – *Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People* (2010)

As with the Department of Health policy above, this HSE policy has an aim of promoting a restraint-free environment. It cites various legal instruments as underpinning this goal such as European Union law and international conventions and covenants. It states that residents and their representatives or advocates should be consulted in relation to the use of restraint, regardless of that person's capacity.[6]

Association of Occupational Therapists of Ireland – *Best Practice Guidelines for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities* (2010)

This guidance document is directed at occupational therapists working with people with intellectual disabilities. Notwithstanding this, its principles can be extended to any professional or care staff that interacts with a person with intellectual disabilities. It describes restrictive interventions as potentially abusive and a denial of a person's human rights. As with other policies or guidance documents it asserts that restraint-free environments should be promoted at all times. The guidance identifies the particular difficulties posed in the context of people with intellectual disabilities and any associated limited capacity to consent. It identifies legal gaps in terms of protecting those with limited

capacity[††]. Due to the nature of occupational therapy interventions, much of the guidance in this document focuses on the application of mechanical restraints. The guidance proceeds to describe guiding principles under the following headings:

- **Person-Centred Approach** – All decisions relating to the design, development and delivery of a service should involve the person receiving care and take account of their unique capabilities, needs and preferences.
- **Best Interest** – Any consideration of what is in the person's best interests should permit a certain level of risk, termed the 'dignity of risk'. Restrictive interventions should only be considered where their risk or negative effects are less than the risk posed to the person by their choices or behaviours.
- **Involvement of the Person –** the person exhibiting behaviours that challenge or posing a risk to themselves should, wherever possible, be included in any consideration of the use of restraint. Relatives and advocates should also be consulted.
- **Identifying and Understanding Underlying Causes of Behaviour –** Every attempt should be made to identify, understand and negate the underlying cause of the behaviour in the person prior to the use of restrictive practices. Exceptions are made in cases of serious risk.
- **Team Responsibility –** any decision to use restrictive measures should have multi-disciplinary input.
- **Last Resort and Least Restrictive** – The use of restraint should be a last resort and the measure should be the least restrictive. This is in line with Regulation 5 of the regulations pertaining to residential services for people with disabilities.[(2)‡‡]

Irish Nurses Organisation – *Guidelines on the Use of Restraint in the Care of the Older Person* (2003)

These guidelines are aimed at nurses working with older people. The document provides definitions for restraint and describes the different forms of restraint, along with their consequences. It advocates for the reduction or avoidance of restraint by using the 'Four A's' suggested in Quinn (1994).[(73)] These are:

- **Attitude** - this is the development of the attitude of "last resort, not first choice."
- **Assessment** - this involves the careful systematic assessment of patient mobility, mental status and behavioural cues.
- **Anticipation** - consider the application of knowledge of treatment interventions, therapeutic goals and the needs of older people.

[††] The subsequent introduction of the Assisted Decision-Making (Capacity) Act, 2015 addresses some of these gaps.

[‡‡] (5) The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation—

(*a*) every effort is made to identify and alleviate the cause of the resident's challenging behaviour;
(*b*) all alternative measures are considered before a restrictive procedure is used; and
(*c*) the least restrictive procedure, for the shortest duration necessary, is used.

- **Avoidance** - the implementation of alternative nursing measures to accomplish treatment goals without physical restraint.

The guidance goes on to outline methods or techniques that may reduce restraint such as the Sonas programme[§§], music therapy, reality orientation, multi-sensory rooms and reminiscence therapy. If restraints are deemed necessary, the guidance outlines the following principles for their use:

- beneficence: the intention to do good
- non-maleficence: the intention to do no harm
- justice: to treat all clients fairly and equally
- autonomy: to aid and respect the patient/client's right of self-determination.[72]

Deprivation of Liberty

A further area of concern in relation to restraint is the related issue of deprivation of liberty. At present, there is no legal framework on who has statutory responsibility for making a decision that a person should not leave a care facility for health and safety reasons. Depriving a person of the liberty to leave a care facility would constitute a form of restraint, most probably an environmental form of restraint (locked door, keypad lock). This legislative gap means that Ireland is not in compliance with Article 14 of the Convention on the Rights of Persons with Disabilities.[74] It is proposed that this will be addressed in the forthcoming Disability (Miscellaneous Provisions) Bill, 2016.

The Irish Human Rights and Equality Commission (the Commission) has published general observations on the proposed bill, paying particular attention to the proposals to address deprivation of liberty concerns. One observation made by the Commission is that the bill should seek to address deprivation of liberty in all settings rather than limiting it to residential care facilities. The report goes on to discuss the proposed legislation in the context of Article 5 of the European Convention on Human Rights.[74]

Policy, best practice and guidance from other jurisdictions

The following section will give an outline of some key policy and guidance documents from outside of Ireland. It is not possible to give a comprehensive overview of each document. Rather, the key points and notable features are presented. The reader is encouraged to consult the full documents should they require more detailed information.

Positive and Proactive Care: reducing the need for restrictive interventions (2014) - England

This guidance document, published by the Department of Health, was produced in order to address a range of concerns relating to the use of restraint in care settings in England. These concerns centred around the Winterbourne View Hospital scandal; the CQC inspection of almost 150 learning disability in-patient services on foot of that scandal; and the

[§§] The Sonas programme is an evidence-based, therapeutic activity for people who have dementia.

publication of a report by Mind which found significant variations in the use of restraint in services across England.

The guidance adopts six key principles:

- Compliance with the relevant rights in the European Convention on Human Rights at all times.
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations.
- People must be treated with compassion, dignity and kindness.
- Health and social care services must support people to balance safety from harm and freedom of choice.
- Positive relationships between the people who deliver services and the people they support must be protected and preserved.

The guidance summarises a range of actions which it states "...will ensure that people's quality of life is enhanced and that their needs are better met which will reduce the need for restrictive interventions, and that staff and those who provide support are protected".[10] The following are some of the actions worthy of note:

- All services where restrictive interventions are used must have an identified board level, or equivalent, lead for increasing positive behaviour support planning and reducing restrictive interventions.
- In those services where people can reasonably be predicted to be at risk of being exposed to restrictive interventions, individualised support plans must incorporate the key elements of behaviour support plans. Plans for the use of restrictive interventions must not include the physical restraint of people in a way that impacts on their airways, breathing or circulation, such as face down restraint.
- Plans for the use of physical or mechanical restraint must not include the deliberate application of pain in an attempt to force compliance with instructions. Painful holds or stimuli cannot be justified unless there is an immediate threat to life.
- Service commissioners must be informed about restrictive interventions used for those for whom they have responsibility.
- Services must publish a public, annually updated, accessible report on the use of restrictive interventions which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.[10]

***Rights, risks and restraints - An exploration into the use of restraint in the care of older people* (2007) - England**

This study was undertaken by the Commission for Social Care Inspection and focussed on the use of restraint in older people. The study examined the use of restraint from the point of view of the person being restrained and also from the perspective of staff who were faced with the dilemma of having to use a restrictive intervention. The study found that most care staff said they used restraint as a means of keeping a person safe. However, the study argued that the use of restraint "...may reduce the number of minor accidents but increases the risk of more serious outcomes for older people."[9]

The Commission for Social Care Inspection noted the inherent difficulties in defining what constitutes restraint. Participants in the study argued for as broad a definition as possible as this would capture a wide range of people's experiences. The conclusion of the study put forward four values which should be borne in mind when considering the use of restraint:

- respect for the dignity of older people
- respect for autonomy
- promoting overall well-being
- promoting self-reliance.

The study goes on to say that other important factors in the reduction or prevention of the use of restraint are clear policies which are understood by staff; the culture of care in a care setting; and, the training and supervision of staff.[9]

***Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (2008) – New Zealand**

These Ministry of Health standards were introduced in 2008*** and govern the use of restraint in health and disability services in New Zealand. The standards are split into three sections: restraint minimisation, safe restraint practice, and seclusion. The stated aim of the standards is to reduce the use of restraints and encourage the use of the least restrictive practices. The foreword to the standards states the following:

> "Restraint should be seen in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context".[44]

The standards make specific reference to 'enablers' stating that both restraints and enablers restrict the normal freedom of movement of people. The standards state that it is not the properties of the equipment that are of concern. Rather, it is the intent of the intervention. Psychotropic medication as a form of chemical restraint is also in breach of the standards; their use is limited to valid therapeutic interventions. In fact, two policy documents from New Zealand district health authorities identify chemical restraint as a form of abuse.[75, 76]

*** At the time of writing the Ministry of Health were in the process of revising these standards.

National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector **(2014) – Australia**

This framework document was produced by the Department of Social Services, Australia. It constitutes a collective approach across all states and territories in Australia to introduce measures which will reduce or eliminate the use of restrictive practices in disability services. The framework was introduced in tandem with a reformed National Disability Insurance Scheme which altered the way in which disability services were accessed and funded. The insurance scheme included a quality assurance and safeguard system which made provision for the reporting of the use of restrictive practices.[77]

The framework is underpinned by the following high-level guiding principles:

- human rights
- person-centred focus
- a national approach
- delivering quality outcomes and safe work places
- accountability through documentation, benchmarking and evaluation – working towards transparent and consistent reporting
- collaboration between service providers
- raising awareness, providing education and facilitating accessible information about restrictive practices.

The framework states that all service providers that receive funding under the National Disability Insurance Scheme should implement a set of key core strategies for reducing or eliminating the use of restrictive practices. There are six such strategies which are based on a comprehensive review of research literature. The six strategies are as follows:

- **Person-centred focus** – This includes the development and regular review of individualised support plans based on evidence-based risk assessments. These plans should include the perspectives of the person receiving care and their families, carers, guardians and advocates.

- **Leadership towards organisational change –** This strategy highlights the need for managers and organisation leaders (including those in governmental and non-governmental organisations) to prioritise the reduction of the use of restrictive practices within services.

- **Use of data to inform practice –** The collection and analysis of data is an important tool in reviewing and re-assessing the use of restrictive practice. It is also a useful tool in terms of national data collection.

- **Workforce development –** The research which the framework was based on showed that when disability support staff that have a good understanding of positive behaviour support, functional behaviour assessment, de-escalation techniques and restrictive practice alternatives it is possible to reduce the use of restraint.

- **Use within disability services of restraint and seclusion reduction tools –** Use of restrictive practice reduction tools and techniques should be based on core assessment and prevention approaches. The results of such assessments and approaches should be integrated into each person's support plan.

- **Debriefing and practice review –** The use of restrictive practices should be regularly reviewed. Specifically, the use of restraint in an unanticipated or emergency situation should be followed by a 'post-event' debrief as soon as possible after the event, led by an appropriately senior staff member.(77)

Evidence-based guidelines to reduce the need for restrictive practices in the disability sector (2011) – Australia

This guidance document was produced by the Australian Psychological Society with the stated aim of reducing the prevalence of restraints by increasing the use of positive behaviour support programmes. The guidelines are intended for use by practising clinicians who are working with individuals that have an intellectual or developmental disability. Similar to the regulations in Ireland, the guidelines make reference to the clinician's responsibility to develop support plans where restraint is only used as a last resort, and the least restrictive option should be chosen. They also state that the clinician should always work within the parameters of the various international (UN Convention on the Rights of Persons with Disabilities), national and regional legislation and guidance.(78)

Critically, the guidance advises that a formal assessment of a person must not take place until the clinician is assured that the fundamental human rights of that person are being met. These rights include having a safe environment to live in, respect from staff and service providers, engagement in regular activities and adequate social and community access. Other guidelines in the document are broadly similar to what is found in other best practice literature. For example:

- clinicians should work within a positive behaviour support framework
- there should be a person-centred planning approach
- the development of support plans should be done in conjunction with an interdisciplinary team
- staff should have training in managing behaviours that challenge
- behaviour support plans should be in language that is easily understood by all those on the support team.(78)

Disability Services Procedure - Restrictive practices for general disability services (full legislative scheme) (2014) – Queensland, Australia

This document, produced by the Department of Communities, Child Safety and Disability Services, is a procedure dealing with the use of restrictive practices under the 'full legislative scheme' for general disability services in Queensland, Australia. An interesting feature of this procedure and the associated legislation is the requirement to formulate a statement on the use of a restrictive practice. The legislation states that if a service provider is considering the

use of a restrictive practice for someone with an intellectual or cognitive disability, they must first provide a statement to that person and to a person with "sufficient and continuing interest in the adult". The statement must be in an approved form and include the following information:

- why the relevant service provider is considering using restrictive practices in relation to the adult
- how the adult and the interested person can be involved and express their views in relation to the use of restrictive practices
- who decides whether restrictive practices will be used in relation to the adult
- how the adult and the interested person can make a complaint about, or seek review of, the use of restrictive practices.

In addition, the service provider must explain the statement to the adult:

- in the language or way the adult is most likely to understand
- in a way that has appropriate regard to the adult's age, culture, disability and communication ability.(79)

The procedure also directs that the development of a positive behaviour support plan must have regard to the model positive behaviour support plan. This model plan is developed by the Chief Executive of the Department of Communities, Child Safety and Disability Services and is made available on the Department's website. This requirement seeks to ensure that the development of positive behaviour support plans is evidence-based and informed by up-to-date best practice.(79)

Physical restraint in disability services - Current practices, contemporary concerns, and future directions **(2009) – Victoria, Australia**

This report was commissioned by the Office of the Senior Practitioner, Department of Human Services, Victoria to contribute to the development of evidence-based policy and practice in the use of restraint for people with a disability who may exhibit behaviour that challenges. The report charts the development of the 'non-restraints movement' and examines current policy direction in other jurisdictions. It also looks at the legislative environment in different states in Australia and the barriers to achieving a minimal restraint or restraint-free environment.

It makes a number of recommendations for the consideration of the Office of the Senior Practitioner. It outlines what types of restraint should be recognised and includes social restraint which was defined earlier in this review. It also discusses 'response cost strategies'[†††] and argues that these should be considered restrictive practices for the purposes of reporting to the Office of the Senior Practitioner. The report recommends that the damaging long-term psychological effects of social restraints should form part of staff training and education programmes. Mandatory staff education programmes should also have a focus on the techniques of positive behaviour support and verbal and environmental

[†††] This is defined in the report as the "..., the withdrawal of an identified positive reinforcer contingent on the occurrence of a defined behaviour". An example of this type of restraint may be a care staff member saying that a person will not receive a food treat or go on a social outing if a certain behaviour occurs/does not occur.

de-escalation techniques. The report also recommends that the Office of the Senior Practitioner should publish a quarterly report on the instances of restraint and seclusion.[13]

Positive Approaches: Reducing Restrictive Practices in Social Care **(2016) - Wales**

The Care Council of Wales produced this resource as an aid to social care workers. The contents provide "...practical examples of a range of positive and proactive approaches and ways of working that support safe practice, and can reduce the need for restrictive practices".[8] The learning resource is relevant to a range social care settings for adults, children and young people including dementia, autism and acquired brain injury. It also applies in settings where there may be mental health needs, substance misuse or emotional/behavioural issues.

The resource is split into five sections which are based upon the values and principles that inform the Social Services and Well-being (Wales) Act, 2014. The sections are as follows:

- voice and control
- prevention and early intervention
- well-being
- co-production
- multi-agency approaches.

Each section then contains a number of case studies which readers are invited to reflect on and consider how they would respond. The last part of the resource includes definitions of the different types of restraint and uses hypothetical examples which illustrate when these are or are not appropriate to use. All of the examples show that restrictive practices should only be used if they are in the best interests of the person or for the safety of the person or those around them. The examples of when restrictive practices are not appropriate focus on their use to limit a person's movement, to facilitate staff tasks, or as response cost measures.

Of note, the resource provides an example of where chemical restraint (referred to as 'use of medication') is acceptable. The example refers to a person with dementia who has broken a tooth, is clearly in pain, and is refusing to eat or drink as a result of the pain. The person will not open their mouth to allow anyone look at their teeth. It is agreed by her care team, family and GP that it is in the person's best interests to prescribe the use of sedation to allow for the necessary dental treatment. Many of the examples refer to a 'best interest meeting' being convened to agree on the use of a restrictive practice where the person's actions are a threat to their safety or welfare. These meetings typically include the person's family, their care team and other relevant professionals involved in the person's care.[8]

A Review of the Literature on Restraint and the use of Bedrails **(2015) – Northern Ireland**

This study, a collaboration between the Ulster University and the practice development unit of Nursing Homes Ireland, examines the use of bedrails in nursing homes. In its findings on the research of the use of bed rails in nursing home settings, the review states that there is

"...a complete dearth of such literature in its application and exploration within nursing home environments, with only limited reported [sic] from the USA".[80]

Despite the limited research in the area, the review makes a number of recommendations. Of note in the context of this review are the following:

- Bedrails should not be used where a person is severely confused and mobile enough to climb over them.
- The routine use of bedrails **or** their complete elimination are not considered appropriate caring interventions.
- Where a person lacks decision-making capacity, staff must act in that person's best interests and regularly assess and review the use of bedrails.
- While acknowledging the limited evidence base, the review states that the evidence "...does not support the prevailing orthodoxy that bedrail use should be eliminated or strictly curtailed on the basis of bedrail effects on falls, injury in falls or direct injury, and suggests wholesale bedrail reduction may increase the risk of falls".

The review concludes by calling for more research on the use of bedrails in nursing home settings, particularly more rigorous empirical research. In the absence of this the authors state that care staff and service providers must adhere and comply with the relevant legislation and guidance in their respective jurisdictions.[80]

The ethical issues linked to restrictions of freedom of people with dementia **(2012) – Europe**

This Alzheimer Europe report examines the ethical issues around the loss of freedom that is experienced by many people who have dementia. It looks at how a person's freedom is impacted from a number of different perspectives: freedom to choose one's residence; freedom to live in the least restrictive environment; freedom to act according to individual attitudes, values and lifestyle preferences; freedom to play an active role in society.[81] Each section has a set of recommendations on a range of issues (for example: driving, voting, making decisions with legal implications).

Of interest to this review are the recommendations around the use of restrictive practices. These recommendations are targeted at distinct groups such as care professionals, service providers, policy makers and informal carers. Some of the recommendations worthy of note are as follows:

- A legal framework and guidelines should be developed to protect people with dementia against the use of restraint.
- A definition of restraint should be included in the framework and guidelines which covers physical, chemical, psychological, electronic and environmental measures but is sufficiently broad to include any other measures which serve as a means of restraint through the way they are applied.
- Governments should set targets to reduce the prescription of antipsychotic medication for people with dementia.

- Restraint should only be tolerated in extreme situations where the physical and mental integrity of the person with dementia is in serious and imminent danger.
- The restraint of a person with dementia who is unable to consent should be permitted only after discussion within a multidisciplinary care team and with the relatives, carers and advocates of the person with dementia.
- Before considering how to deal with behavioural and psychological symptoms of dementia and challenging behaviour, it should be determined for whom such symptoms and behaviour are disturbing.
- Care establishments should develop and implement a policy of zero tolerance of restraint.
- More research should be carried out into the use of restraint at home.
- Care establishments should discuss with the carers and relatives of residents with dementia the need to promote autonomy and of the necessity to allow some degree of risk.

The report also highlights significant developments in some EU countries regarding the legislative treatment of the use of restrictive practices. For example, the concept of electronic surveillance as a form of restraint has now been added to the official legal definition of restraint in the Netherlands and Austria. In addition, some countries have moved to include the use of coercive measures[‡‡‡] as a form of restraint. In the Netherlands, the Care and Coercion Bill requires that coercive measures are reported by service providers.(81)

Supports for Individuals with Complex Service Needs **(2016) – Alberta, Canada**

This online policy resource is available on the Alberta Human Services website and gives an overview of policy in relation to people with developmental disabilities. It outlines the responsibilities for health service managers and staff to have appropriate training, conduct effective risk management, and develop behavioural support plans. Of note for this review is how the policy describes the appropriate responses to behaviour that challenges or 'anticipated situations'. In the first instance, where a behaviour is thought likely to occur, staff should seek to use a 'planned positive procedure'. This may include discussing the person's choices in a given situation or teaching appropriate skills or behaviours. Where a planned procedure cannot be implemented, the next step is a planned restrictive procedure. The goal of such a procedure is to ensure the safety and well-being of the individual or others, or to prevent major damage to property. The policy clearly states that such a procedure, by its nature, is a restriction on the person's rights, freedom, choices or self-determination.(82)

The policy proceeds to describe how a behavioural support plan should be developed. Prior to the development of such a plan, staff are required to carry out a functional assessment which seeks to determine the purpose or function of any behaviour. A functional assessment should include the following:

- a risk assessment

[‡‡‡] The use of coercive measures would likely fall under the definition of social/psychosocial restraint.

- a medical assessment that may include a physical exam, a psychiatric exam, or both
- a review of the individual's past history as it relates to the behaviour of concern
- a review of previous strategies used to address the behaviour of concern
- consultations with relevant professionals (such as physician, orthodontist, denturist, surgeon, psychiatrist, psychologist, behavioural specialist, speech language pathologist, occupational therapist, physiotherapist, dietitian)
- an environmental assessment that examines how an individual feels about the different programs and environments and how well-adapted those programs and environments are to the individual, and
- a communication assessment that explores how an individual communicates and how well their caregivers understand the individual.[82]

A behavioural support plan is then developed based on the findings of the functional assessment. The plan must include the following:

- a description of the situation or behaviour(s) of concern
- an outline of desirable behaviours and overall objectives
- planned positive procedures to support behaviour change, and where applicable, planned restrictive procedures that will be used to address the behaviour
- an implementation plan
- a strategy to decrease or eliminate as much as possible the need for the planned restrictive procedure
- termination criteria for the planned restrictive procedure
- necessary training requirements for staff to carry out the plan
- timelines for reviewing the plan
- methods to gather and report data and to evaluate the effectiveness of the plan.[82]

Finally, the policy outlines what are described as prohibited procedures. These are not to be used, even in emergency situations. Prohibited procedures include the inappropriate use of restrictive procedures or the use of any physical acts that cause pain. The use of prohibited procedures is considered abuse and should be reported accordingly.[82]

Confederación Española de Organizaciones de Mayores (CEOMA) [Spanish Confederation of Organizations of the Elderly] – **Spain**

The CEOMA organisation is a Spanish advocacy group for older people. It has developed a policy of zero-tolerance towards restraint of people with dementia in nursing homes. CEOMA carries out an accreditation programme for nursing homes that wish to have a restraint-free service. As of February 2016, CEOMA had accredited more than 50 nursing homes as being restraint-free, with a further 20 working towards accreditation.[83]

The original intention of the CEOMA programme was to reduce the prevalence of restraint in nursing homes, rather than its complete eradication. However, it was found that reductions in the use of restraint were only temporary and that care staff and managers sought other more subtle means of restraint. In general, it was observed that after six months, use of

restraint had returned to levels observed prior to the intervention. The decision was then taken to pursue a zero-tolerance approach which was shown to deliver better results. One of the main reasons offered for the success of this approach was the cultural shift it engendered in organisations, particularly those that achieved a restraint-free environment for more than three months.[84]

Prevention and alternatives to restrictive practices

Much of the contemporary literature on the use of restraint in care settings is focused on reducing or eliminating its use. Indeed, as referenced earlier, it is the stated policy of Ireland's Department of Health that nursing homes should seek to have a restraint-free environment.[3] The HSE policy in relation to people with disabilities also sets a goal of a restraint-free environment.[6] This section of the review will give an overview of the literature and research that is focused on prevention and alternatives to restraint.

> "A clear evidence base demonstrates that restraint reduction is perfectly possible. We have, as they say, the technology, but do we have the will? Reducing restraint requires a paradigm shift which recognises that much challenging behaviour arises from shortcomings in service quality rather than from the pathology of service users."[85]

Education and Training

Education on restraint and training on the alternatives to physical restraint has been shown to reduce its use and change staff attitudes in a number of studies.[19, 26, 86-89] One study in 16 nursing homes across the USA used an educational intervention with nursing staff and found a 90% reduction in the use of physical restraints. This was achieved without an increase in serious injuries. While minor injuries and falls did increase, the authors concluded that restraint use could be dramatically reduced following a comprehensive assessment and the use of alternatives to restraint.[90] The development of an audit and feedback process to implement best practice in the use of physical restraint in one residential aged care facility in Australia was found to reduce the instances of the use of physical restraint.[91] Another study looked at the effect of extensive training and education for nursing staff on the use of physical restraints. It found physical restraint use was reduced as a result of the training and that there was no associated increase in behavioural problems or falls.[92] An educational intervention with nurses in an intensive care unit found there was a reduction in the use of restraints after the intervention programme. The interventions included "...providing visual and hearing aids, frequent communication and reorientation with patient, familiar objects from patient's home in the room, attempt consistent nurse staff [sic], allow television during the day with daily news, and non-verbal music".[93]

While the studies outlined above show evidence of the value of education and training interventions, others have advised caution. Many training programmes on physical intervention techniques are said to be provided in an unregulated market environment where the content and material lacks valid research evidence. Further to this, many of the commercially available proprietary training packages are not evaluated or are evaluated

internally – by the person or company delivering the training – raising questions about its validity.[94]

Positive Behaviour Support

Much of the literature in earlier sections of this review shows that behaviours that challenge are regularly a trigger or rationale for the use of a restrictive practice. Consequently, strategies and techniques that limit the instances of such behaviours will, in theory, lead to a reduction in the use of restraints. There is an acknowledgment that behaviours that challenge are socially constructed and are a product of the interaction between a person and their environment. In this light, functional assessments and a framework of positive behaviour support are prerequisites to effectively manage behaviours that challenge and reduce the need for restrictive interventions.[95]

The concept of positive behaviour support is a recurring topic in the literature on preventing restraint. It is defined as "...an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to first enhance the individual's quality of life and, second, to minimize his or her problem behaviors".[96] Positive behaviour support involves assessments that look beyond the behaviour of a person and seek to understand the causes or triggers of the behaviours. These causes may be social, environmental, medical, cognitive or emotional.[97] The approach is one of behaviour change as opposed to behaviour management.[98]

There is an evidence-base to support the use of positive behaviour support in reducing behaviours that challenge.[78, 99] The benefits of positive behaviour support are such that the practice is now being extended to fields outside of intellectual disability such as schools.[99] The following are some of the basic interventions of the positive behaviour support approach outlined in a British Institute for Learning Disability publication:

- Altering the known conditions that may increase the chances of behaviours that challenge arising (e.g. environmental factors such as space, light; social factors such as activity levels or the number of people in a care setting)
- Changing certain triggers for behaviour (e.g. interpersonal style, increasing choices, reducing demands)
- Teaching new competencies in the person exhibiting the behaviours (coping skills)
- The use of differential and non-contingent reinforcement[§§§]
- Specifying changes in carer behaviour and in systems of delivery
- Reactive strategies (e.g. distraction, evasion, minimal restraint).[99]

Human Rights-Based Approach

[§§§] **Non-contingent reinforcement** seeks to dissociate a behaviour from its desired outcome (reinforcer). This is achieved by delivering the reinforcer at set time intervals as opposed to when a behaviour occurs. An example may be giving access to a particular room/space to a person every 30 minutes where previously they would have accessed it after an episode of a behaviour that challenged.

Differential Reinforcement is where reinforcing only occurs when the appropriate behaviour or response is observed, and applying 'extinction' to all other responses. Extinction is the discontinuing of a reinforcement of a previously reinforced behaviour.

There is an emphasis in the literature on encouraging a human rights-based approach to restrictive practice: "...recently, there has been an emergence of the application of a human rights paradigm to clinical practice and service delivery to people with learning disability and challenging behaviours."[100] Restraints, by their very nature, impinge on a person's right to liberty, freedom of movement and dignity; these principles are features of the Universal Declaration of Human Rights [101] and the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[102] Issues arise where rights contained in the above articles come into conflict and need to be balanced. For example, the CRPD asserts a person's right to liberty while also stating that States take "...all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk".[102] This exposes the fundamental difficulty between balancing a person's right to be safe and enjoy good health against their right to live free from restrictions.

The rights of older persons are also infringed through the use of restrictive practices, particularly so in the case of those with dementia:

> "It is widely recognized that people living with dementia are frequently denied their human rights both in the community and in care homes. In many countries people living with dementia are often physically and chemically restrained, even when regulations are in place to uphold their rights. Furthermore, people living with dementia can also be victims of abuse."[103]

In the Irish context, people in care have rights under the constitution and also under the European Convention on Human Rights. Ireland is a signatory to the CRPD but has not (at the time of writing) ratified the convention.

Many countries have adopted legislative measures which articulate a citizen's human rights in the context of restrictive practices. Australia is viewed as a country where there is a growing interest in protecting the rights of people with disabilities who are subject to restrictive practices and several Australian states have enacted legislation to this effect.[104] For example, in the state of Victoria, if a service providers wishes to use a restrictive practice, it must make an application to the chief executive of the government department responsible for the administration of disability services. Victoria established the position of Senior Practitioner and the office holder has specific responsibility for overseeing the use of restrictive practices in people with disabilities. Each person subject to a restrictive practice must have a behaviour support plan and each incidence of restraint must be reported to the Senior Practitioner.[104] The implementation of these strategies led, on average, to an 8% reduction in the use of restraint and seclusion over a four year period. This was primarily due to a reduction in the use of chemical restraint.[104]

There are two forthcoming legislative measures that will have a bearing on the use of restrictive practices in Ireland. Firstly, the Disability (Miscellaneous Provisions) Bill, 2016 is intended to address the remaining legislative barriers that are preventing Ireland from ratifying the CRPD. As referenced earlier in this paper the Bill will also provide a legal framework around deprivation of liberty. Such a provision will elucidate the rights of persons in residential care facilities who are restrained by not being allowed to leave a facility on health and safety grounds. There will also be an appeals mechanism. Secondly, the Assisted

Decision-Making (Capacity) Act 2015 addresses the legislative shortcomings in terms of adults who may lack capacity to make decisions; it is also a prerequisite to Ireland ratifying the CRPD[****]. It replaces the 'all or nothing' approach to assessing capacity with a functional assessment that is time and issue-specific.[105] The Act makes provision for a person who lacks capacity to appoint a decision-making assistant, co-decision-maker or trusted person to assist in or make decisions on their behalf. This will include decisions about care and treatment and will likely mean that a person appointed by a person in care will need to be consulted about the use of any restrictive measure and consent to same.

Other measures to reduce restraint use

Some restrictive practices are used in a planned way to allow certain necessary procedures to be carried out (for example, dental examinations or catheterisation). One study showed that care staff did not carry out oral examinations of residents because to do so would have required the use of a restrictive measure.[106] As such, while restraint might be avoided by not carrying out certain medical or diagnostic procedures, it is clear that the person's health or welfare may be compromised as a result. Again, this exposes the difficulty in balancing competing fundamental rights. Another study involving three nursing homes in the United States found that interventions by an advanced practice nurse were successful in reducing restrictive bed rail usage.[54]

Another topic mentioned in the literature on reducing restraint is the concept of 'fading'.[20, 22, 107] This involves the gradual decrease of a particular type of restraint, often mechanical. The fading is done to a point where the restraint is less restrictive than when it was first applied while achieving similar results. An example may be where a person's arms are mechanically restrained in order to prevent them repeatedly hitting their head. The rigidity of the restraints is progressively reduced, thereby allowing the person greater mobility. Some studies have shown this to be an effective method of reducing self-injurious behaviour, albeit with the risk of alternative types of behaviour emerging in some instances.[20, 107]

Discussion

This paper has sought to review the available literature on restrictive practices, both in Ireland and internationally. The definitions set out at the start of the paper reflect the current thinking in the research, policy and legislation covered in this paper. Much of the focus in contemporary research is on measuring the prevalence of restraint, critiquing its effectiveness, describing the outcomes, and trialling alternatives. It is difficult to make international comparisons on the use of restraint in care settings due to differences in what constitutes restraint and how it is defined. However, as shown in the research outlined in the Rationale and Prevalence section, there is a wide variance in rates of restraint. There is a significant body of research which suggests that restraints are ineffective, particularly physical restraints. For example, the notion that physical restraints are necessary to prevent falls has been challenged by research which suggests that their removal does not lead to any significant increase in injuries from falls. There has been a good deal of research on the

[****] At the time of writing there are some sections of the Act which have not yet been commenced.

negative consequences of various types of restraint. Among these are: injuries or fatalities due to entrapment; functional impairment; pain; and negative emotions or experiences. In addition to this is the assertion that a person's fundamental human rights are violated when they are restrained. This paper also reviews several research articles and guidance documents which outline alternatives to restraint such as positive behaviour support, education and training, a human rights-based approach and legislative measures.

This literature review is intended to inform a thematic quality improvement programme across designated centres for people with disabilities and older people. There are notable differences in how restrictive practices are implemented in both settings. In addition, many of the guidance documents and legislative measures discussed in this review are specific to one group as opposed to addressing both collectively. Notwithstanding this, the overarching principles and general thrust in terms of guidance and policy are broadly similar across both. In general, there is a recognition that restrictive practices are an infringement of a person's fundamental rights and freedoms and that their use should be limited to emergency situations. This principle applies equally to older people and people with disabilities. In addition, the traditional view that some forms of restraint are in the person's best interests are being challenged by a growing body of research and policy which suggests that they are often unsafe; are used to facilitate service or staff needs; are not person-centred; and are used despite the availability of alternatives.

Several guidance documents and resources detailed in this paper give an outline of best practice in terms of assessment and restraint. In general, an assessment should be sufficiently comprehensive to identify any risk factors for restraint. As has been demonstrated elsewhere in this paper, restraint is often used in response to behaviours that challenge or as a means to keep people safe. As such, any assessments should seek to identify the underlying causes of such behaviour or safety risks – with a view to reducing or eliminating them – and thereby avoiding the use of restraint. There does not appear to be any universally accepted or validated tool for this purpose but much of the literature on assessment converges on the same points. Assessments should examine a range of factors: personal history, physical condition, pain, psycho-social, physical environment, mental health, behaviour functions. In addition, assessments should have multi-disciplinary input and look to glean as much information as possible from the person being assessed as well as those who know them well.

Positive behaviour support appears in a number of research, policy and guidance documents internationally. Clearly, if services can assist people in managing or eliminating behaviours that challenge, it follows that they can reduce restrictive practices. Indeed, there is evidence to support the efficacy of the positive behaviour support approach in reducing behaviours that challenge. A key element of this approach is the development of a positive behaviour support plan and much of the guidance and policy discussed in this review gives an overview of how these plans should be formulated. Of note, services in Queensland are required to use a 'model' positive behaviour support plan which is made available online. This is to ensure that plans are evidence-based and up-to-date in terms of best practice. Allied to the positive behaviour support approach is the use of a functional assessment and many of the guidance documents detail how such assessments should be carried out. Also in

Australia, guidance produced by the Australian Psychological Society aimed at reducing the use of restraint states that clinicians should not carry out an assessment of an individual unless they are assured that the fundamental human rights of that person are being met. This is an acknowledgment that a person's behaviour is most often a product of their living environment, relationships, routines or access to certain needs and basic rights as opposed to any underlying psychological issues.

In Ireland, national policy states that services should pursue a restraint-free environment. In practice, it is difficult to establish whether any designated centres have achieved this goal. The regulations pertaining to services for older people and for people with disabilities allow the use of restraint when it is in accordance with national policy and, in the case of disability services, evidence-based practice. There are no models of accrediting services as being restraint-free as is the case in the earlier discussion in this paper of such a programme in Spain. Similar to policy and guidance in other jurisdictions, the approach to restraint in Ireland is one of using the least restrictive measure for the shortest time possible; staff training; and, in the case of disability services, adopting a positive behaviour approach. As discussed in the section on Prevention and Alternatives, Ireland is presently introducing legislation which will clear the way to ratifying the CRPD. This will have an impact on the procedures around using restrictive practices for people with disabilities and older people.

Internationally, much of the policy, guidance and legislation is broadly similar to what is found in Ireland. However, there are some notable features which are worthy of revisiting. In England, the *Positive and Proactive Care* document suggests that services that use restrictive interventions should have a dedicated person at board level responsible for positive behaviour support and reducing restrictive practices. This document also suggests that services should publish an annual report on their use of restrictive practices and detail the strategies they are pursuing to reduce these. Leadership and governance is also one of the six strategies and a key focus in the Australian *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.* The achievements in reducing restraint and seclusion in Victoria, Australia is neatly summarised in the following:

> "Victoria's success in reducing restraint and seclusion use in disability services was the result of a broad-based structural response. This included supportive legislation, national and state level policy regarding the human rights of people with a disability, government funding for the education of disability support workers, the establishment of research projects to examine the potential factors leading to restraint and seclusion and the prevention of restraint and seclusion. Leadership, inter-agency collaboration, mandatory data reporting and analysis and a targeted workforce development strategy are clearly some of the critical elements to reinforce a rights-based legislation in order to address these challenges."[(108)]

The above quotation serves to underline the importance of a coordinated approach to reducing restraint, one which addresses a range of key factors: legislation, education of support workers, research, collaboration and data reporting.

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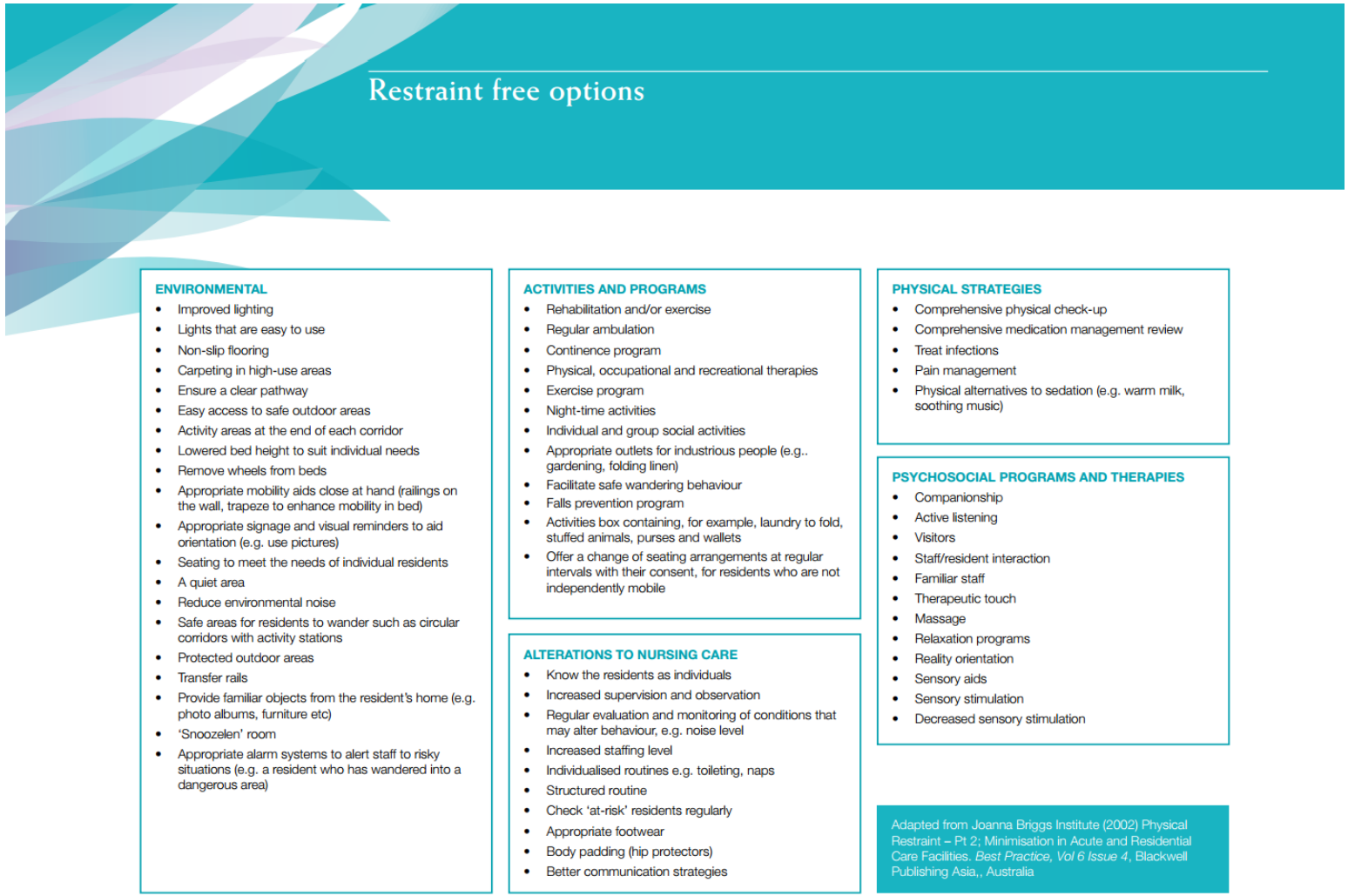
Appendix 1



Source - Decision-Making Tool: Supporting a Restraint Free Environment in Residential aged care (Department of Health and Ageing, Australia)

Appendix 2

1. Is there a system to perform basic assessments, including medical history review and physical examination, to rule out acute illness for residents currently using restraint devices, being considered for a device, or had an incident or event requiring assessment for restraint?

2. Does the assessment reflect a multidisciplinary approach?

3. Is the involvement of the resident and/or legal guardian (if the resident chooses to have them involved) documented in the assessment?

4. Does the assessment include obtaining information from resident, family, or caregivers regarding the resident's previous life experiences, interests, and social patterns in order to provide an individualized approach and intervention to restraint-free care?

5. Is there documentation of a precipitating event causing or triggering the resident's current situation?

6. If an event (falls, behaviors) is triggering the assessment, does the assessment state what happened, who was present, where the event took place, and what time of the day it happened?

7. Does the facility assess and treat underlying medical conditions precipitating the use of physical restraints?

8. Are the following factors considered in the assessment of underlying medical issues precipitating the use of physical restraints:

- Gait
- Cognition
- Communication
- Environment
- Medications
- Cardiovascular insufficiency
- Infections
- Hyperglycemia/hypoglycemia
- Dehydration
- Sleep
- Pain
- Wandering

9. If a restraint is currently being used, is the type of restraint and reason used stated on the assessment?

10. If a restraint is currently being used, are time frames, situations, or conditions documented in the assessment regarding application or removal of the physical restraint?

11. Does the assessment include the following information regarding the intervention provided:

- Person/discipline responsible for implementing and monitoring the intervention?
- Action plan or future trials of alternate interventions?
- Improvement of function?
- Permit or prevent the resident to access their body?
- Least restrictive option?
- Provide the highest level of function?
- Documentation to support that the intervention succeeded or failed and why?
- Alternate interventions?
- Outcomes of trial of alternate interventions?
- Identification of potential problems or risk factors of restraint removal?

Source - Physical Restraints: A Reduction & Elimination Toolkit (Quality Insights Pennsylvania)

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