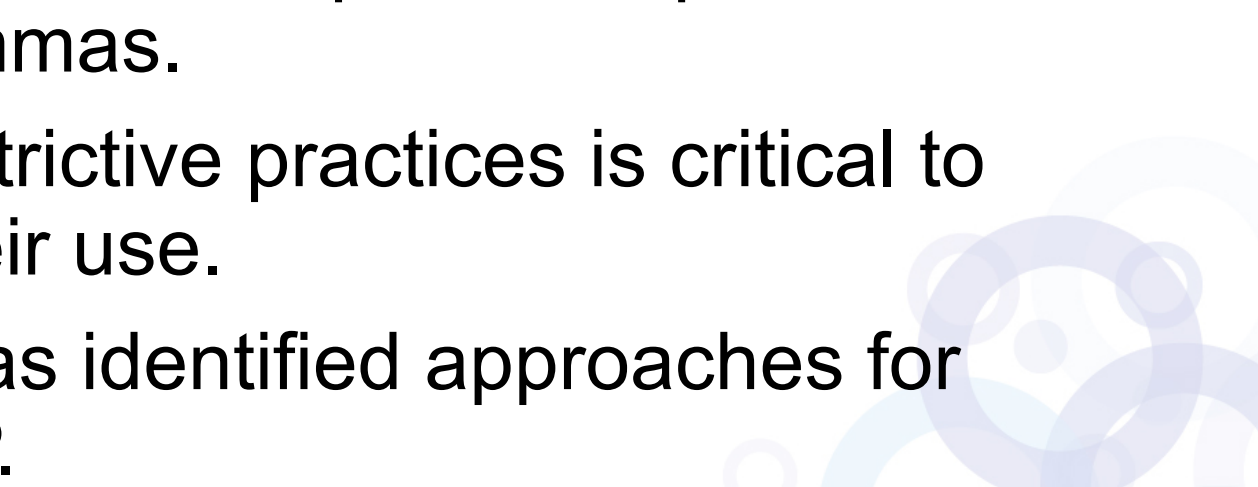


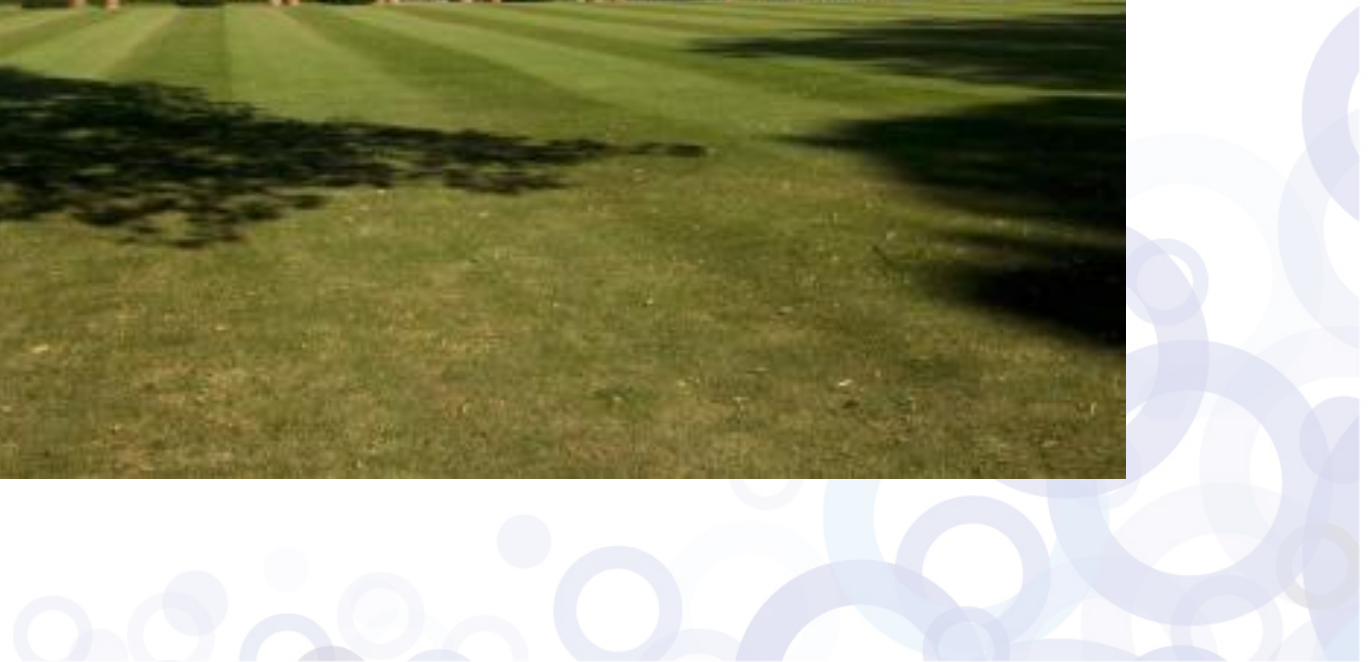
Is the message restraint better when it should be restraint less?

Sharon Paley – Principal Advisor
Restrictive Practice Standards

Context

- Practice based conversation & discussion.
 - Nationally and internationally there is increased evidence, discussion and legislation.
 - The use of restrictive practices present us with ethical dilemmas.
 - Defining restrictive practices is critical to reducing their use.
 - Research has identified approaches for reducing RP.
- 

My story



Wise words.....

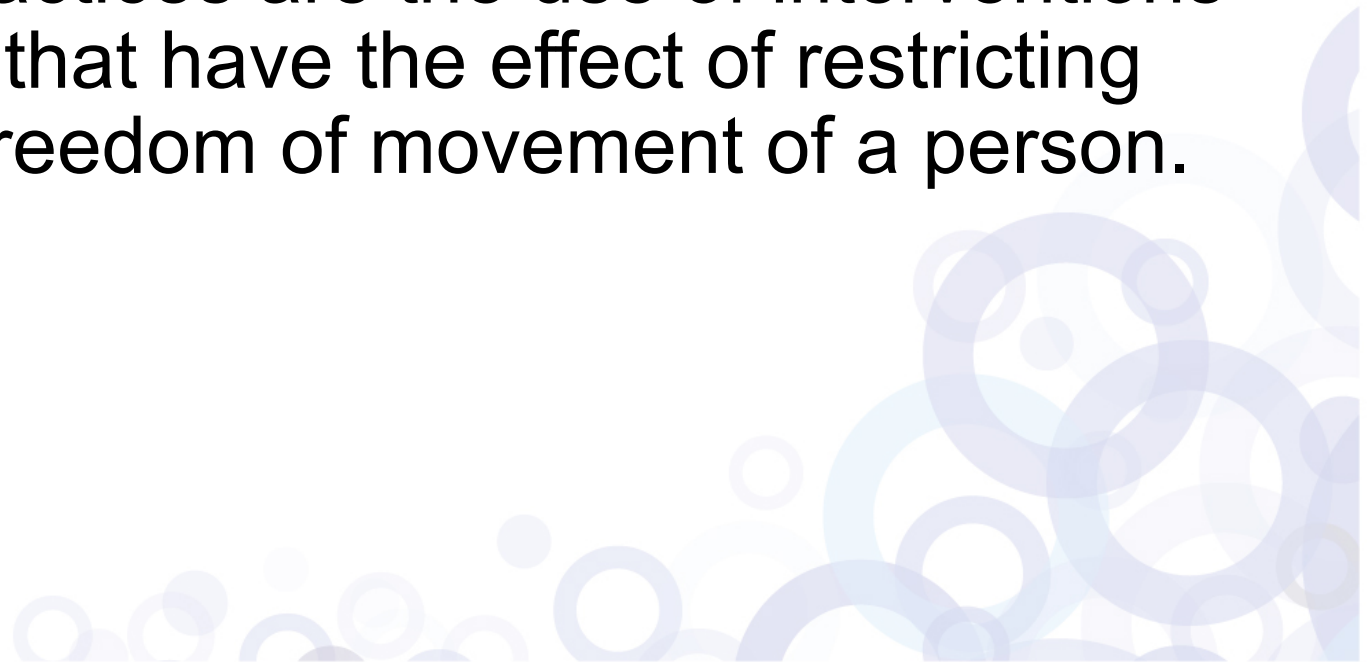
‘ having led and implemented guidance and educated staff to restraint better it is now time to lead a restraint reduction strategy’

Professor David Allen 2008



Defining restrictive practice

Restrictive practices are the use of interventions or strategies, that have the effect of restricting the rights or freedom of movement of a person.



Defining restrictive practice

- Seclusion
- Containment
- Physical restraint
- Mechanical restraint
- Restricting access to objects
- Chemical restraint



What we know (Emerson 2002)

Less severe intellectual disability is associated with increased risk of physical restraint and seclusion in children

Having poor expressive communication correlates with increased risk of being exposed to physical restraint in children

Attending special school or living in residential care increases the risk of being exposed to seclusion or physical restraint

Being from a minority ethnic group increases risk of exposure to RP across the age range

A diagnosis of any mental illness positively correlates with the use of chemical restraint

Higher staffing ratio is associated with increased risk of physical restraint for adults, living in a residential care home correlates with increased risk of sedation for adults.

What we know

Exposure to restrictive practices cause negative (even trauma) responses Paterson et al 2018.

Practice (restraint) is not evidence based
Duxbury et al 2018, Lebel et al 2012.

Restrictive practices, causes injury and even death.
Milliken 1998, Nunno & Holden 2006, Paterson and
Badley 2009, Dale 2011, Masters 2017.

There is limited
evidence that RP
use is effective
Day 2007, Jones
and Tombers
2002, Allen 2011.

Most training programmes that
deliver restraint training have
not been (independently)
evaluated Leadbetter 2009.

Use of restrictive
practice may increase
risk of injury to people
(Parkes 2011, Parkes
2012).

Barriers to reducing RP

The physical environment increases risk to people, stigmatisation and paternalistic ideas/approaches, Brophy et al 2016

Inability (of staff) to identify restrictive practice use, Paley - Wakefield 2013

Research suggests that some staff are resistant to the idea RP can be reduced
Kinner et al 2016

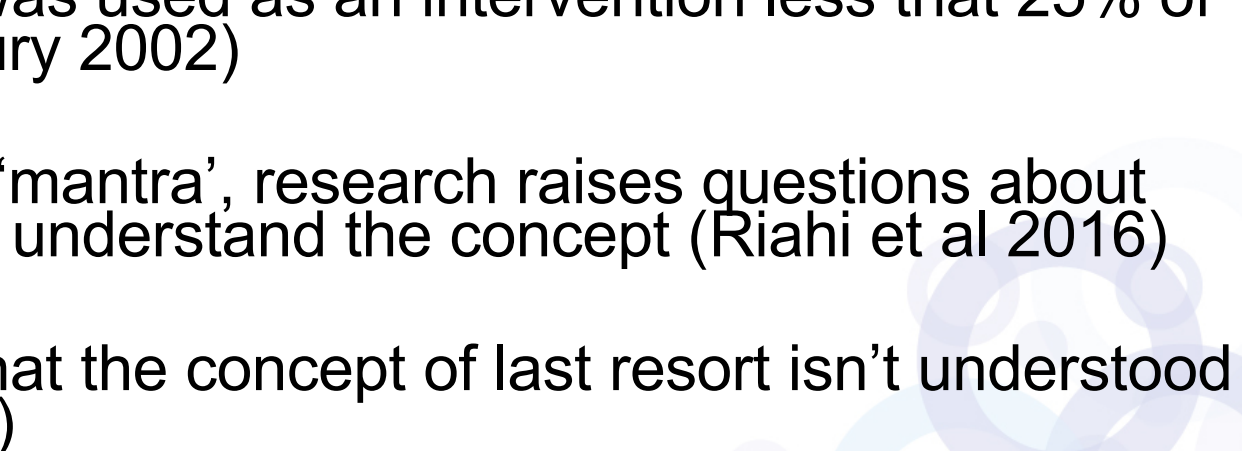
Organisational culture that has relied on restrictive practices to manage risk and safety – toxic culture- Nunno 2019

Lack of effective leadership and necessary skills, knowledge and ability to reduce restrictive practices, Colton 2004, Huckshorn 2006.

Organisational investment is particular type of training and development and a belief this increases safety (of staff) Allen 2001

Lack of functional assessment and badly designed behaviour support interventions.
Hodgets et al 2010, McDonnell 2018.

Decision making (about RP use)

- Nurses agreed just 22% of the time; and
 - nurses with less than 3 years clinical experience made the most restrictive recommendations (Holdzworth & Willis 1999).
 - De-escalation was used as an intervention less than 25% of the time (Duxbury 2002)
 - Last resort is a 'mantra', research raises questions about whether nurses understand the concept (Riahi et al 2016)
 - There's belief that the concept of last resort isn't understood well (CBF 2019)
- 

Conversation questions?

Do authorising (procedurally/ legislatively lead) environments.....

Hamper restraint reduction approaches?

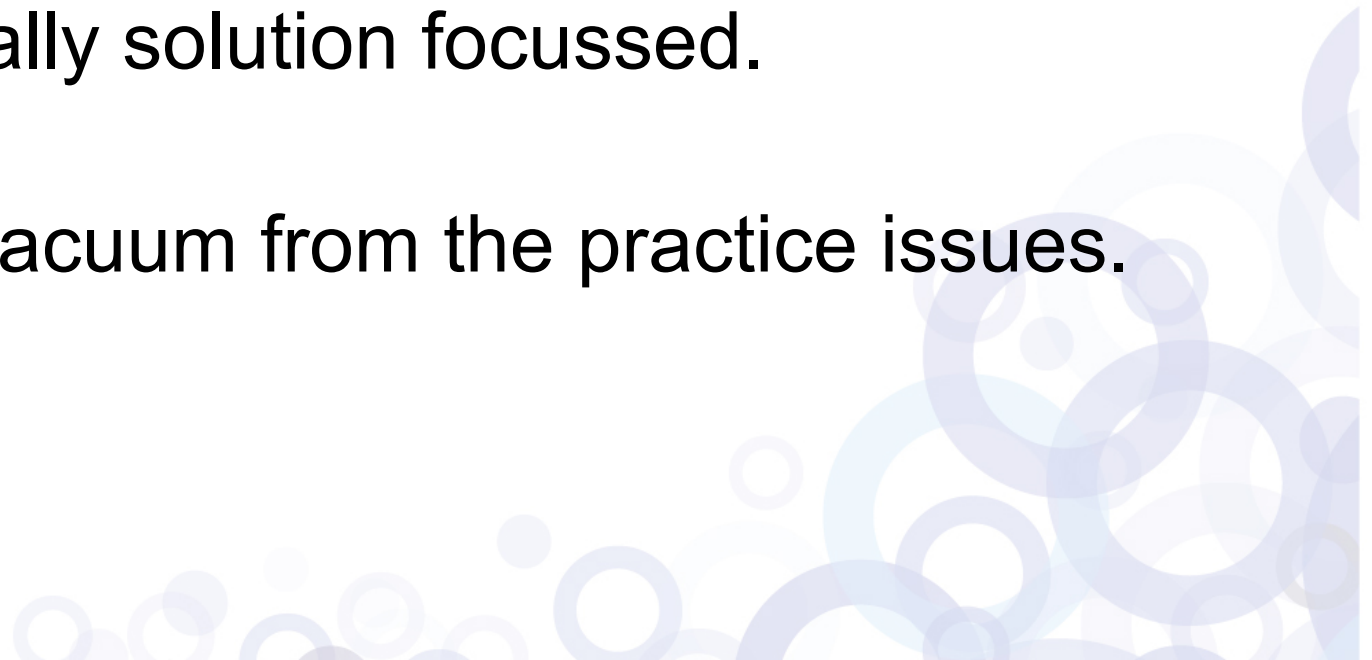
Focus on how the RP will be planned/ occur?

Lack provision of guidance for staff on how to reduce the use of RP?

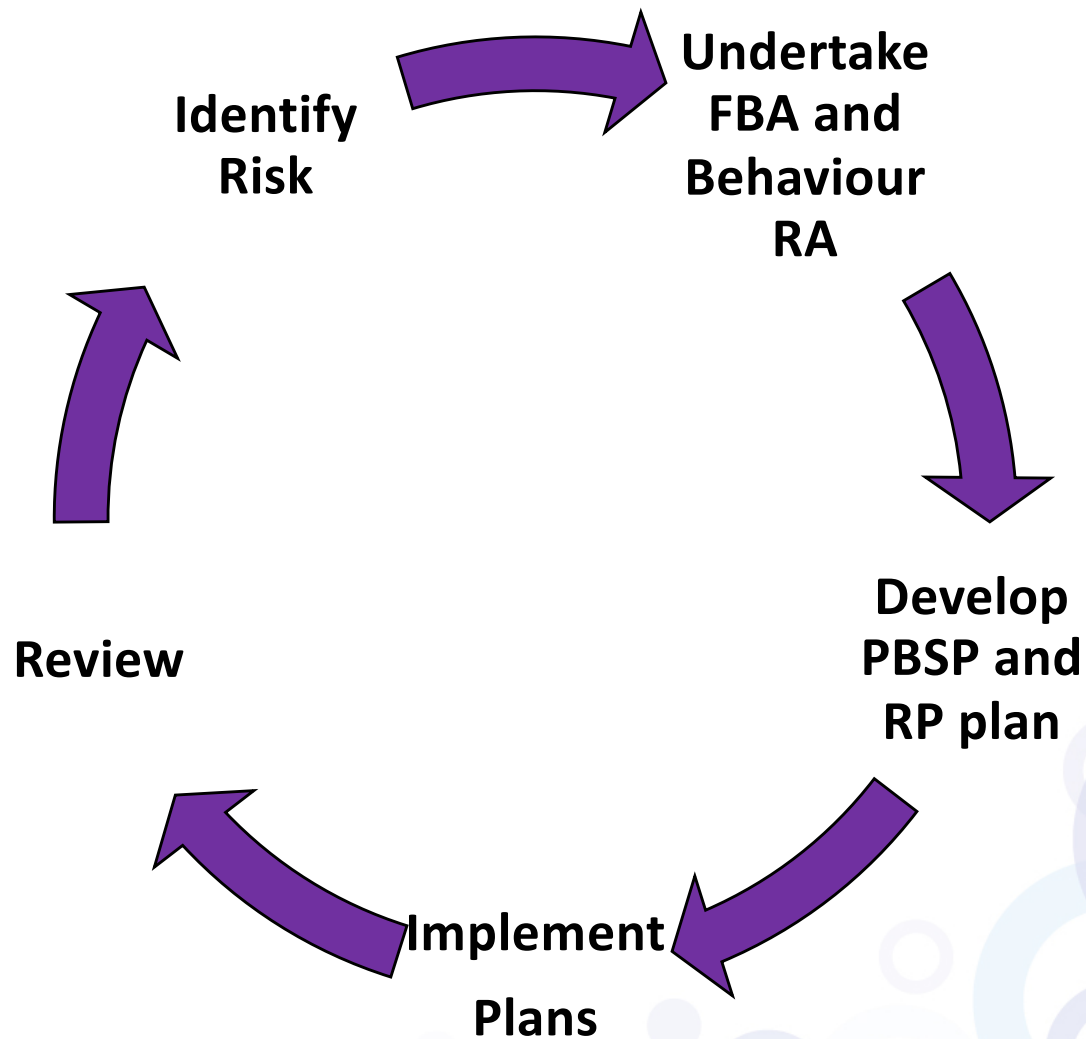
Increase use of RP without consideration of all the relevant circumstances?

Legislation & procedures

- Provide a framework, absolutes and guidance.
- Often prescribe rather than describe.
- Are not usually solution focussed.
- Occur in a vacuum from the practice issues.

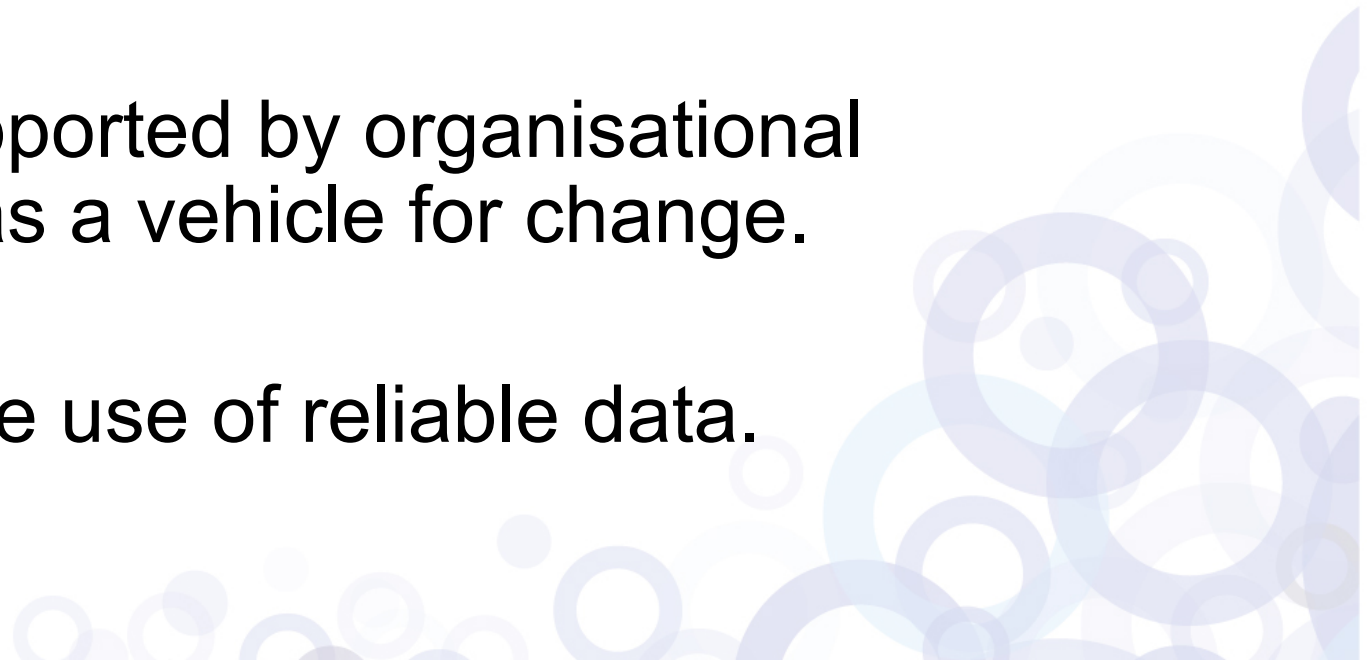


Cycle of inaction

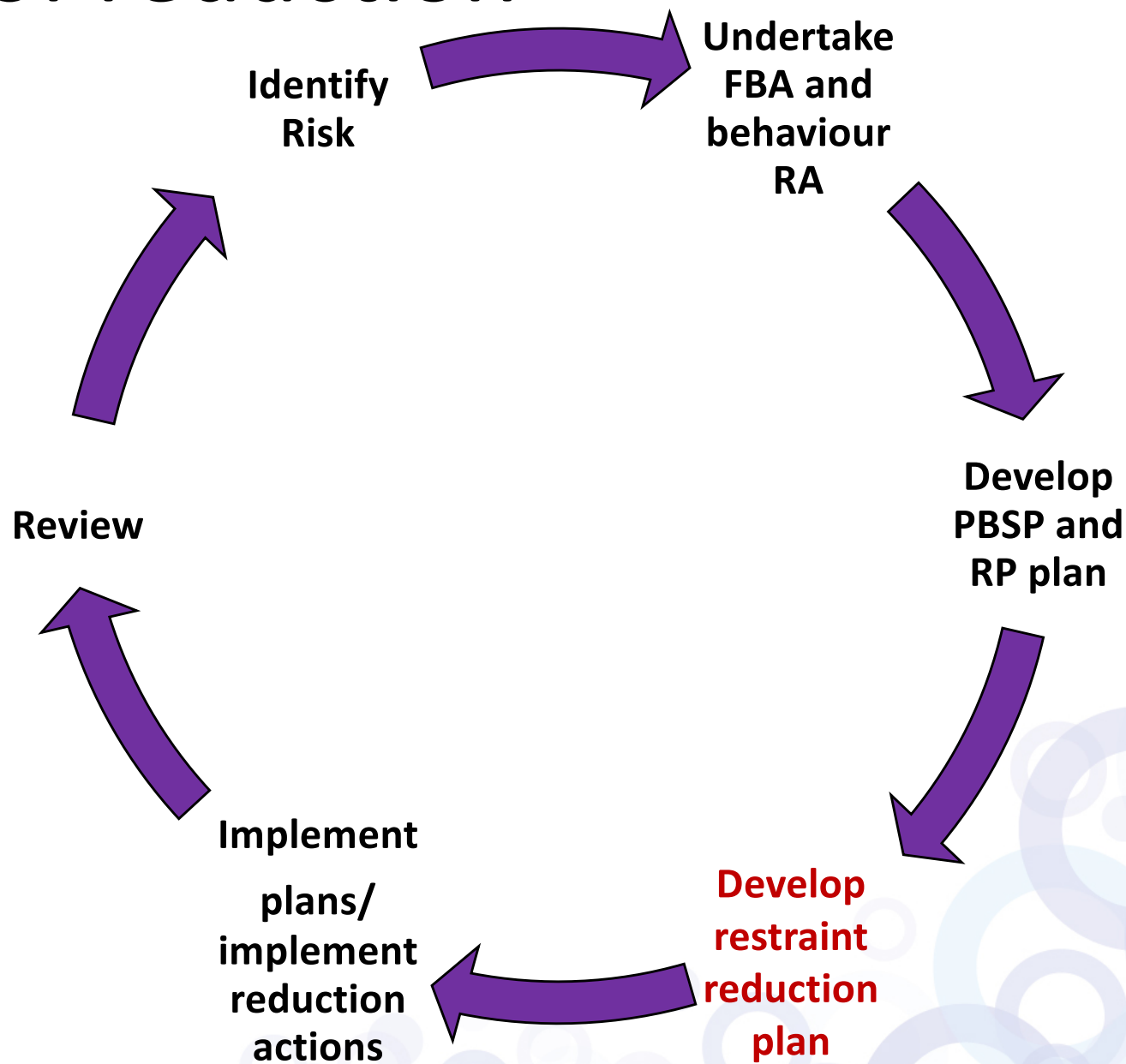


Restraint reduction is complex

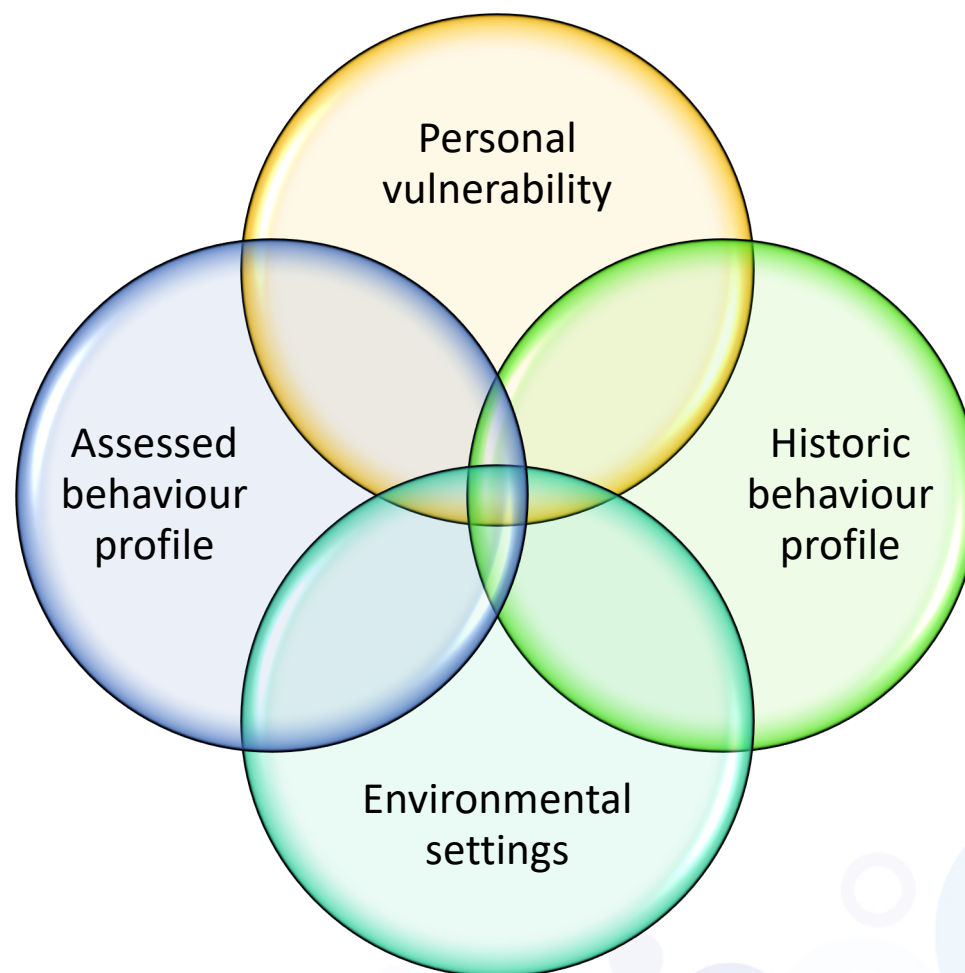
- Requires resources and time.
- Requires consistency, skills, knowledge and ability.
- Must be supported by organisational leadership as a vehicle for change.
- Relies on the use of reliable data.



Cycle of reduction



Assessing the persons risk profile



Individual restraint reduction action (adapted from Paley-Wakefield 2014)

Identifies specific behavioural objectives, based on evidence based FBA & RA.

Ensures the persons lifestyle/ educational/ occupational needs are identified.

Considers the healthcare needs of the person.

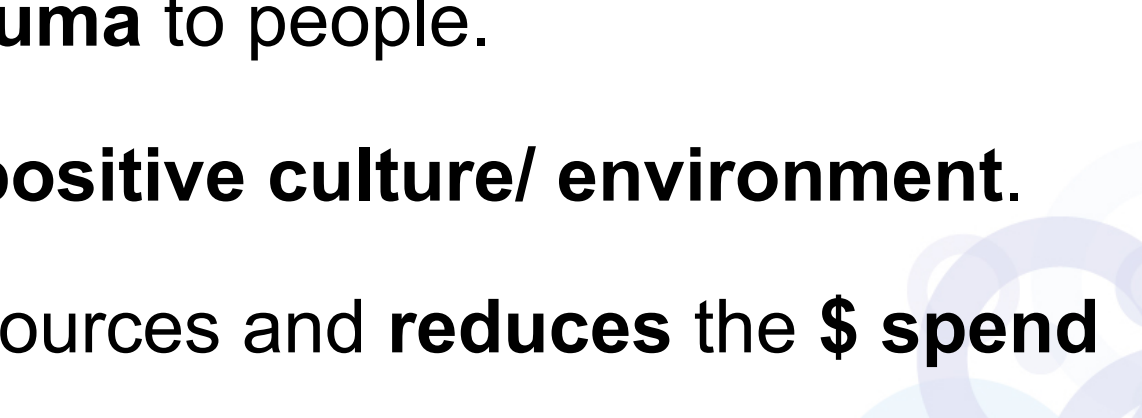
Is delivered by staff who are trained & deliver the primary and secondary behaviour strategies.

Responds to and reduces the persons risk vulnerability profile.

Is informed by reliable data and information with ongoing review.

Identifies key advocates, supports and friends.

Benefits of reducing RP

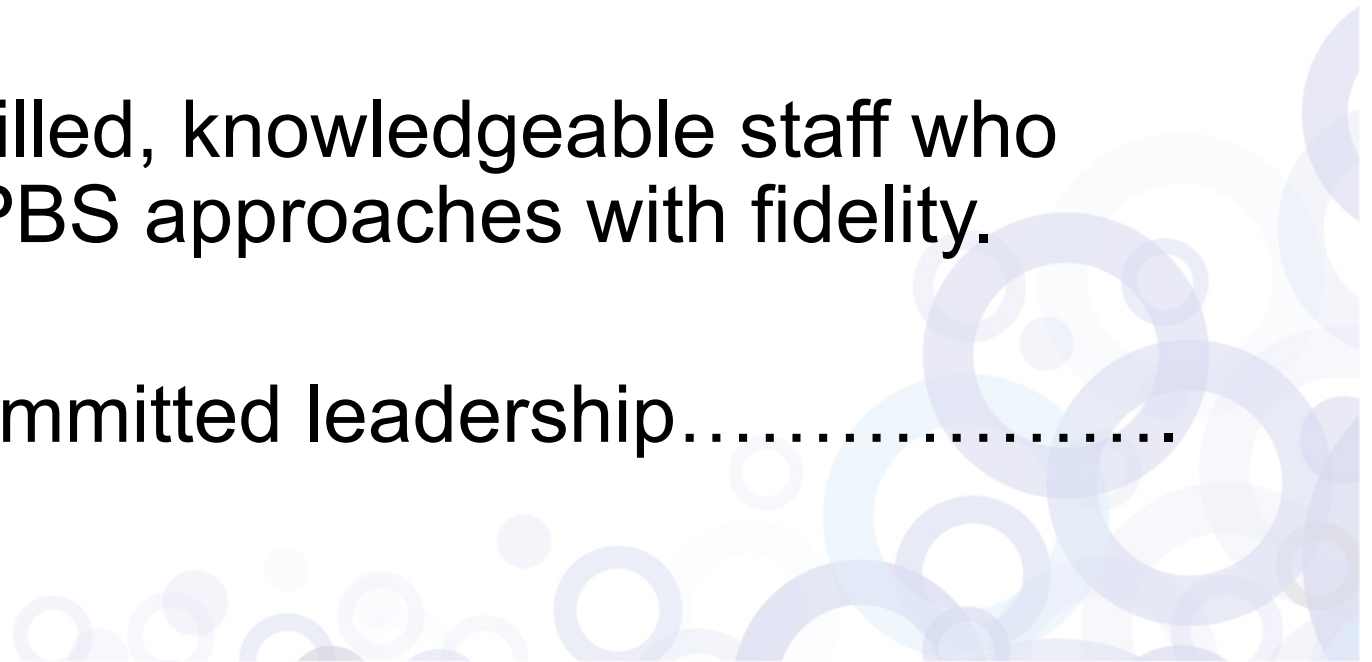
- **Reduction in sick days** of staff and work cover claims.
 - **Reduces risk** to people.
 - **Reduces trauma** to people.
 - Promotes a **positive culture/ environment**.
 - Releases resources and **reduces the \$ spend** overall.
- 

Why is this important?

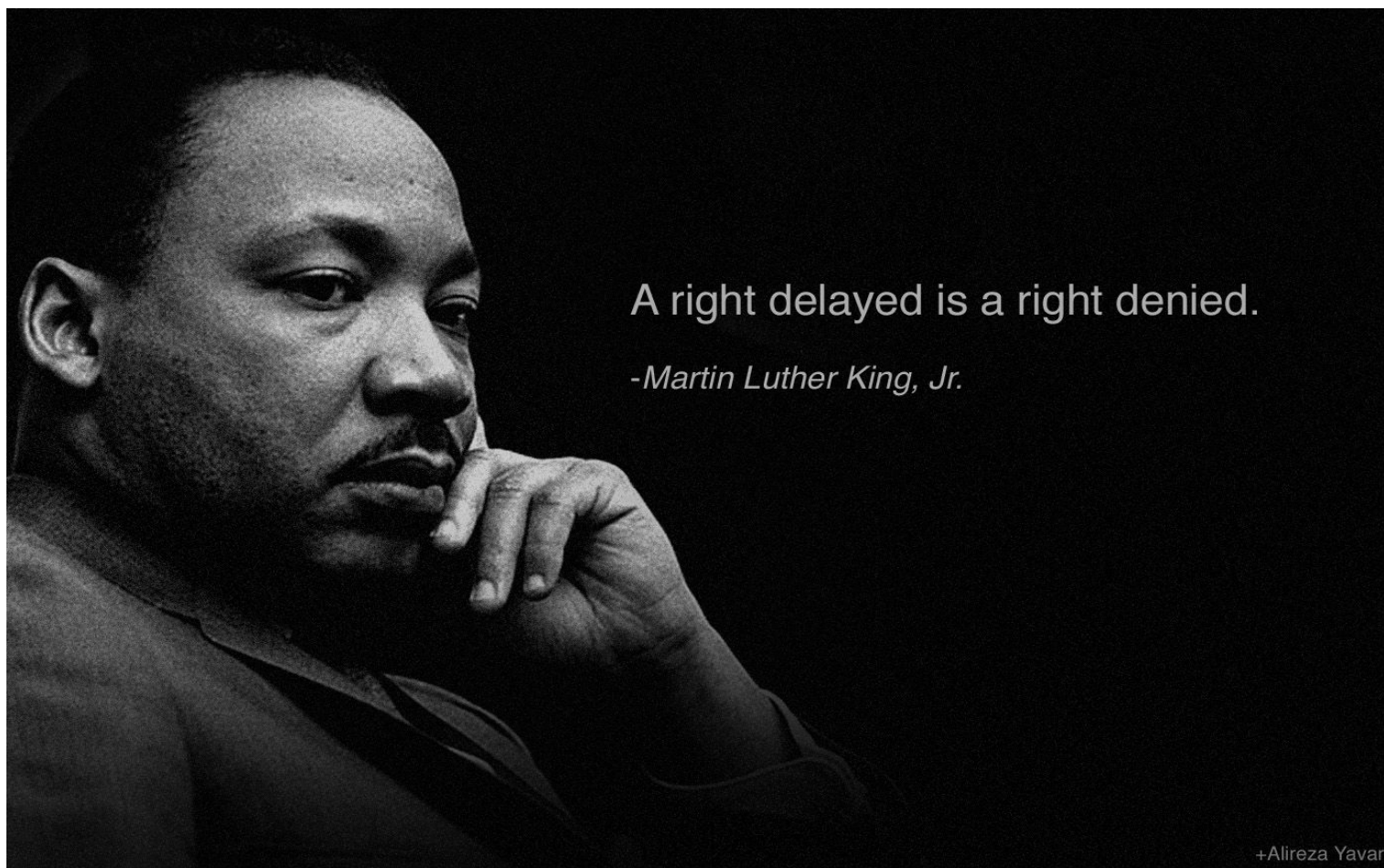
| | | | | | |
|--------------------|----|------|--|---------------------|--|
| Geoffrey Hodgkins | 37 | 2004 | St James' Hospital | Schizophrenia | Physically restrained several times, including hyper-flexion over a sofa. Reported to have lost consciousness during transport to hospital whilst strapped face down on an ambulance trolley. |
| Gary John Williams | 46 | 2006 | Bro Cerwyn Medical Centre, Withybush | Schizophrenia | Lost consciousness and died after being restrained by nursing and security staff face down for some 25 minutes. |
| Anthony Pinder | 42 | 2004 | Craegmore Healthcare, North Lincolnshire | Learning disability | Details not known. |
| | | | | | Died subsequent to a period of prone restraint lasting approximately 1 hour 40 minutes and implemented following an episode of self-injury. During the restraint episode he was sat on by staff members, one of whom weighed 22 stone. Narrative verdict: 'died after a long period of agitation and restraint'. |

Implementing restraint reduction

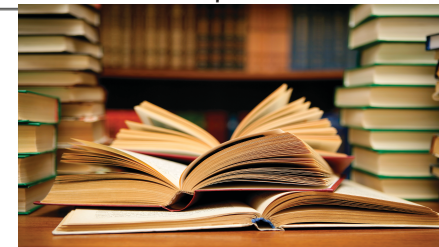
- Must start the day that a plan (to use RP) is implemented.
- Requires resources up front.
- Requires skilled, knowledgeable staff who implement PBS approaches with fidelity.
- Requires committed leadership.....



***TO DELAY IMPLEMENTING RESTRAINT
REDUCTION PLANNING IS TO DENY A
HUMAN RIGHT***



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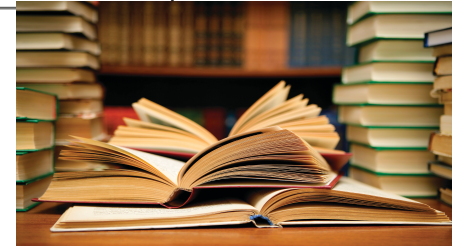
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