Positive approaches: Reducing restrictive practices in social care

Restrictive Practice

- Restrictive Interventions are defined as: "Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently and - contain or limit the person's freedom DoH (2014).

- Restrictive practice is not confined to physical restraint; it also refers to actions or inactions t.
- that contravene a person's rights
- Physical: “in which a person or a mechanical device restricts someone’s freedom of movement or access to their own body. 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". For example, the use of bed rails may be an acceptable restrictive procedure under certain circumstances.

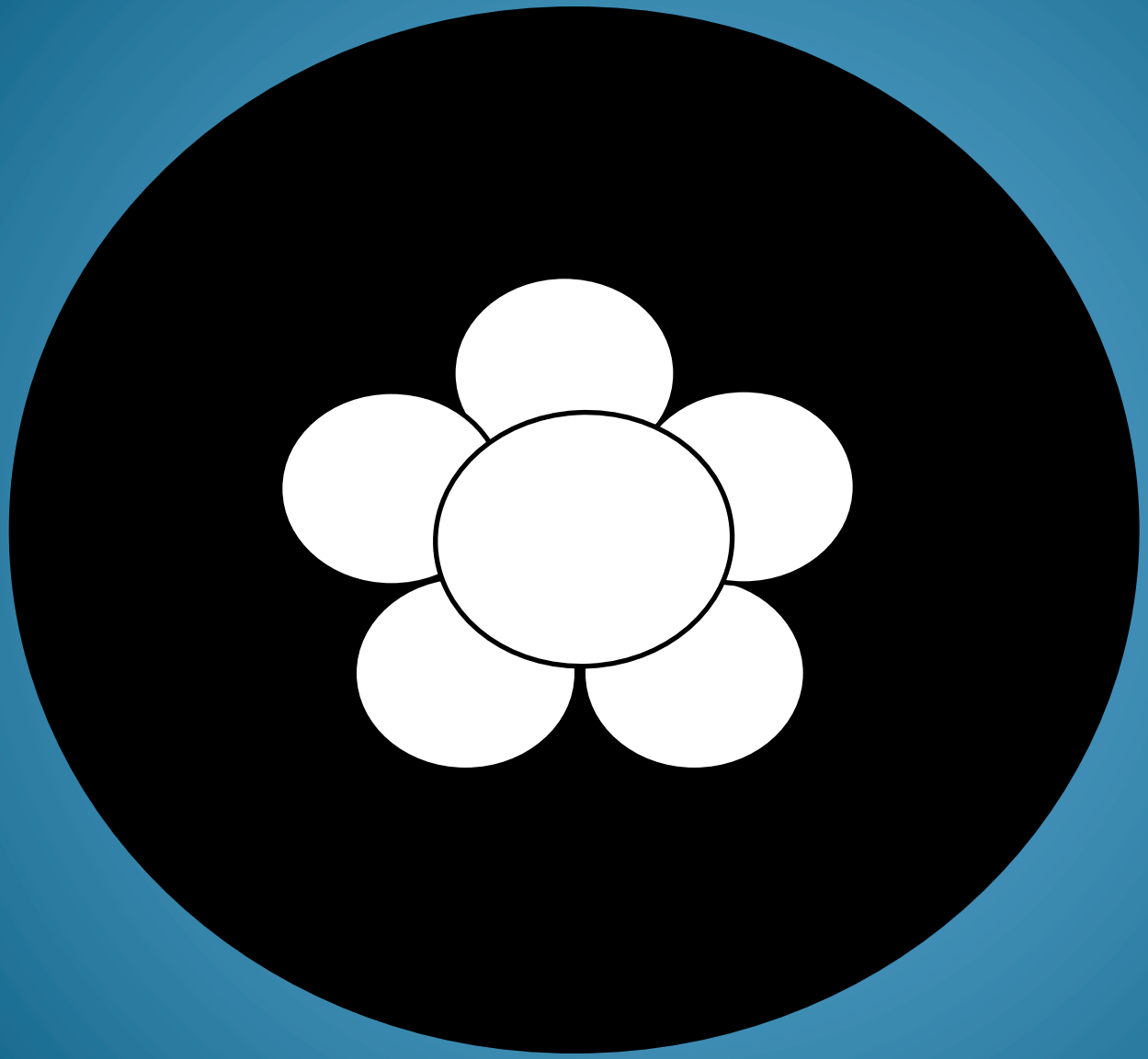
- Mechanical: A device used on a person to restrict free movement such as placing a person in a chair which they are unable to get up from.
-
- Chemical: is the use of medication to control or modify a person's behaviour when no medically identified conditions is being treated, or where the treatment is not necessary for the condition or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes. Administering sedatives to a person who wanders during the night primarily for the convenience of staff is an example of chemical restraint which is not acceptable in any designated centre.

- Environmental: is the intentional restriction of a person's normal access to their environment, with the intention of stopping them from leaving. This also includes denying a person their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties.

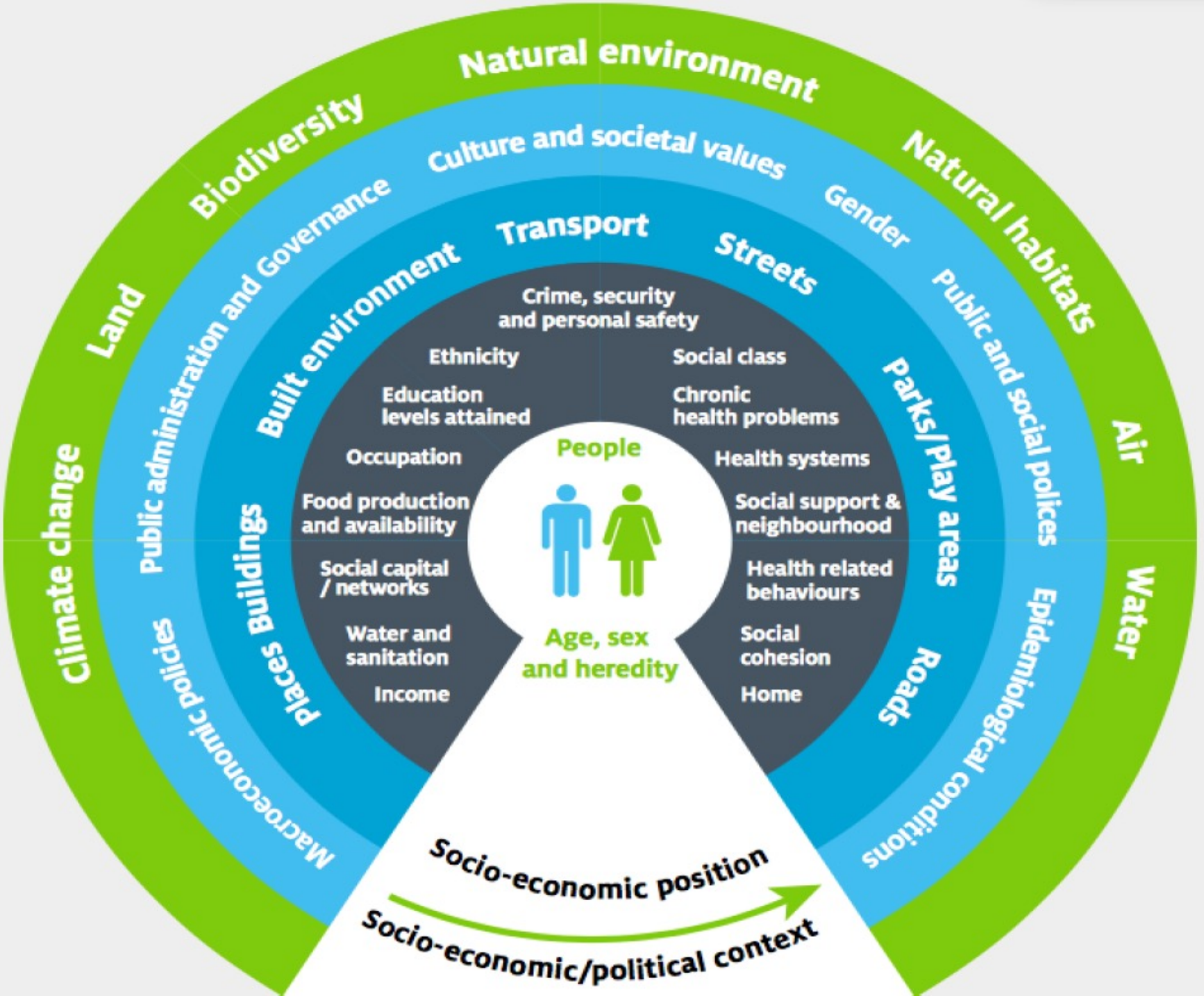
- Cultural restriction: Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group.
- **Other forms of restraint:**
-
- Forced Care Actions: to coerce a person into acting against their will, for example having to be restrained in order to comply with the instruction or request.
- Decision making: Making a decision on the person's behalf or not accepting or acting on a decision the person has made.
-
- Contact with community: Preventing the person from participating in community activities, including work, education, sports groups, community events or from spending time in the community such as parks, leisure centres, shopping centres.
-
- Contact with family and friends: Preventing or limiting contact with the person's friends and family, for example not allowing the person to receive visitors, make phones calls or not allowing contact with a specific friend or family member.

- Inappropriate bed height, this is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed. In addition it also could prevent someone from getting up from the bed easily and safely, i.e. if it is too low or too high
-
- Inappropriate use of wheelchair safety straps. The safety straps on wheelchairs should always be used, when provided for the safety of the user. However residents should only be seated in a wheelchair when this type of seating is required, not as a means of restraint.
-
- Using low chairs for seating, low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

- **Unacceptable Methods of Restriction:**
-
- Withdrawal of sensory aids such as spectacles.
-
- Removal of sensory aids can cause confusion and disorientation.
-
- Isolation:
- It is important to note that residents may be “isolated” for infection control reasons and if a resident is cared for in a side room, when he or she wishes to be on the main Unit, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.



The Person- Centered Nursing Theoretical Framework


Natural environment
Biodiversity
Natural habitats
Land
Air
Climate change
Water
Culture and societal values
Public administration and Governance
Gender
Public and social polices
Transport
Built environment
Streets
Parks/Play areas
Public administration
Places
Buildings
Roads
Macroeconomic policies
Epidemiological conditions
Crime, security and personal safety
Ethnicity
Social class
Education levels attained
Chronic health problems
Occupation
Health systems
People
Food production and availability
Social support & neighbourhood
Social capital / networks
Health related behaviours
Water and sanitation
Social cohesion
Age, sex and heredity
Income
Home
Socio-economic position
Socio-economic/political context

PERSONALISATION

- By the end of this SECTION you should have a better understanding about:
- what personalisation means and why it's important
- where the ideas behind personalisation come from
- how people are putting the ideas behind personalisation into practice
- what a personalised care and support system looks like and what it can offer people
- how you can be a part of making personalisation happen

Personalisation. Transition into care homes

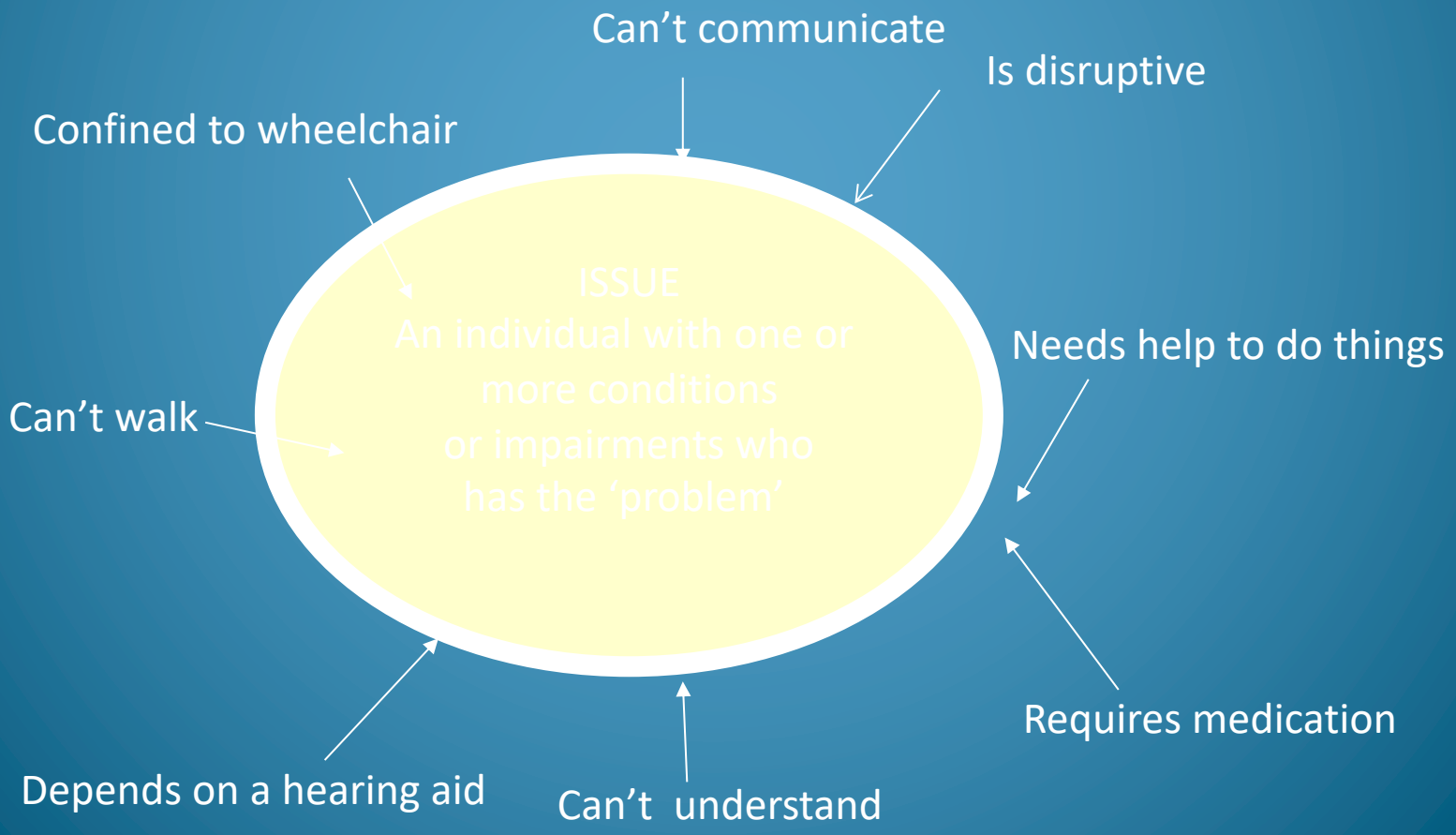
- What would it be like for you?
- What are you leaving behind?
- Do I pay to be here?
- Do I pay for meals?
- Who are all these people?
- What are your roles?
- Can I leave?
- Can my family visit at any time?
- Can I go out whenever
- Is there someone who will support me?
- Do I know who to go to if I had a concern?
- If I felt threatened who do I go to?

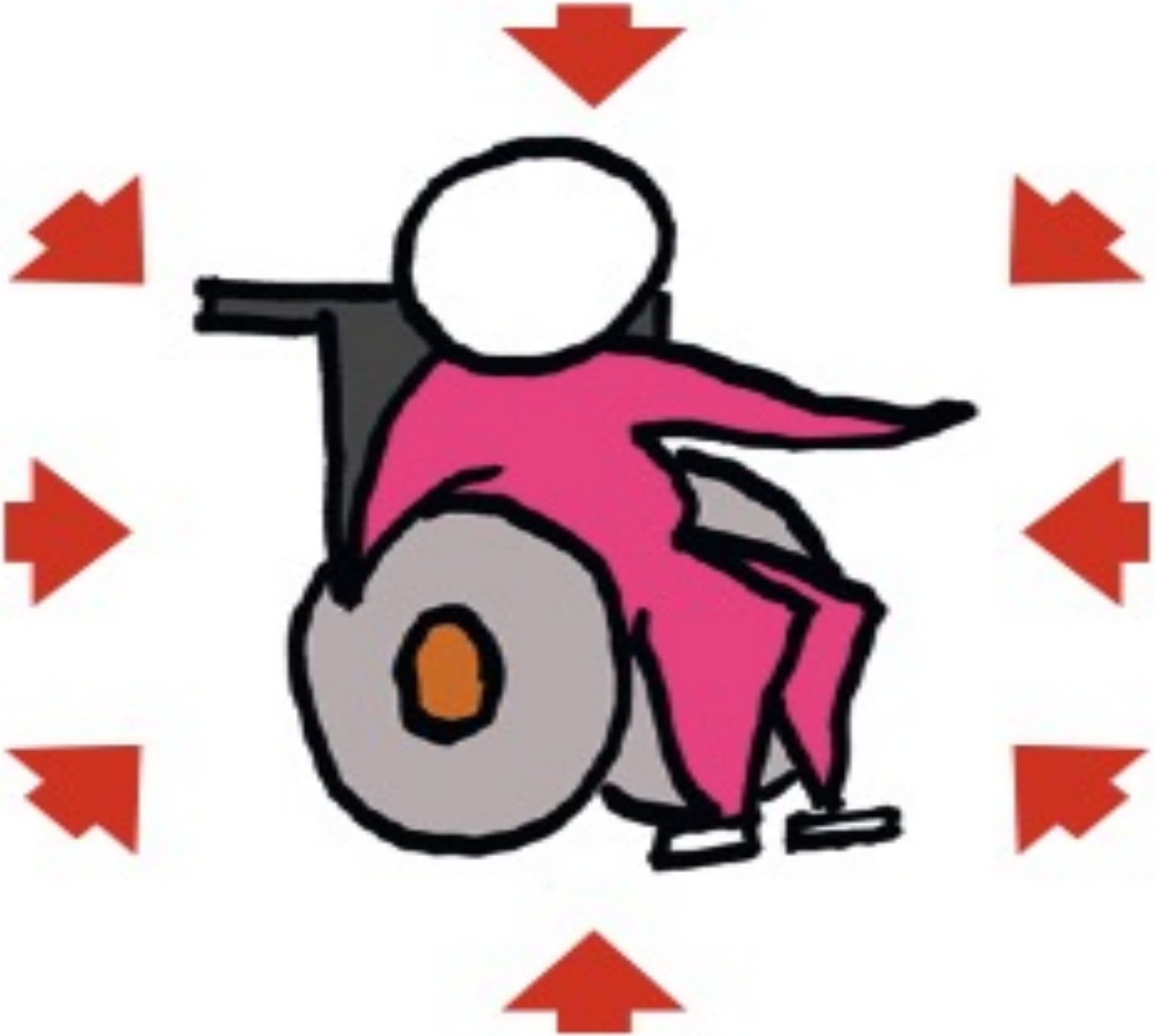
- Can I have a beer, vodka, wine with my dinner?
- Can I bring my dog to stay with me?
- Etc etc etc

Medical Model	Person-Centered Care Model
Hierarchical • Care is dictated to patient. • Patient has little to no choice in treatment or care. • Patient's expertise in own health is seldom or not taken into consideration.	Team based • Participant and staff are equal and care is collaboratively agreed upon. • Participant knowledge of self and choice is integral to improving health. • Participant expertise in own life is paramount to determining course of care.
Views the patient as multiple unrelated diseases. • Treats the disease and not the person • Diagnoses are treated individually and separately without considering the interaction of diagnosis or patient's own motivation to treatment or feelings. • Medical diagnoses are viewed as more important than cognitive or emotional.	The participant is viewed as a whole human being, not a disparate set of diagnoses which much be "treated". • Treats the person and not the disease. • The human being is considered and understood first, then overall health goals of the participant. • The interaction of diagnosis is crucial as well as the participant's personal qualities and choices in regards to life and well-being. • All diagnoses are as important as the participant views them to be and how they affect one another.
Clear boundaries between participant and expert.	Healing occurs within the relationship between staff and the participant.
Language • Judgmental • Clinical and detached: impersonal, builds boundaries. • Problem and goals written in clinical language and are the staff's observation of what the patient's problems are. • Example: Refers to patient in documentation as "patient" (or "participant")	Language • Removes stigma and judgement • Personal and relationship focused, increases view of the participant as a human, not as "work". • Problem & goals written in functional language of the participant. • Example: Refers to participant the name by which they would like to be called "Mrs. Smith" or "Jane".

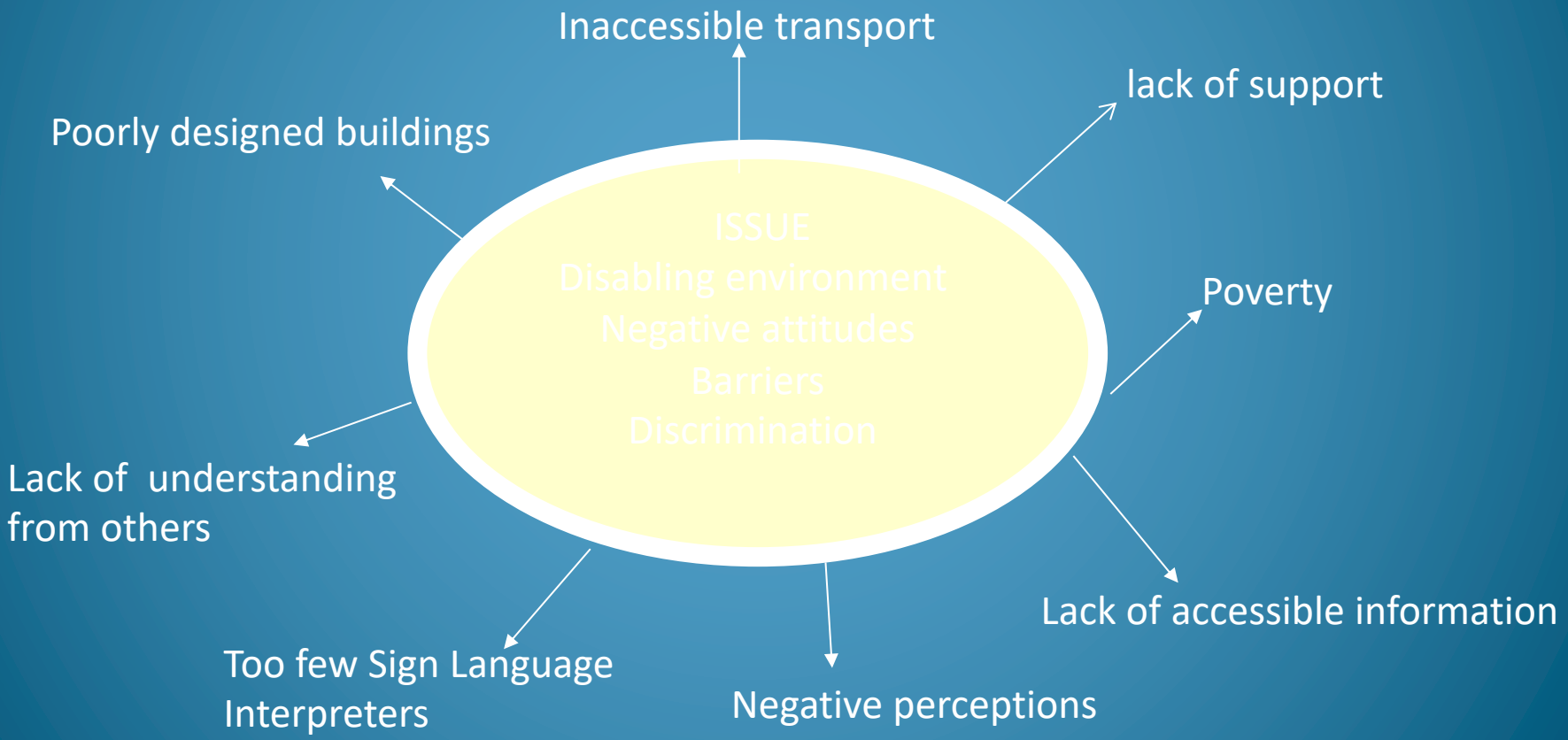
Medical model

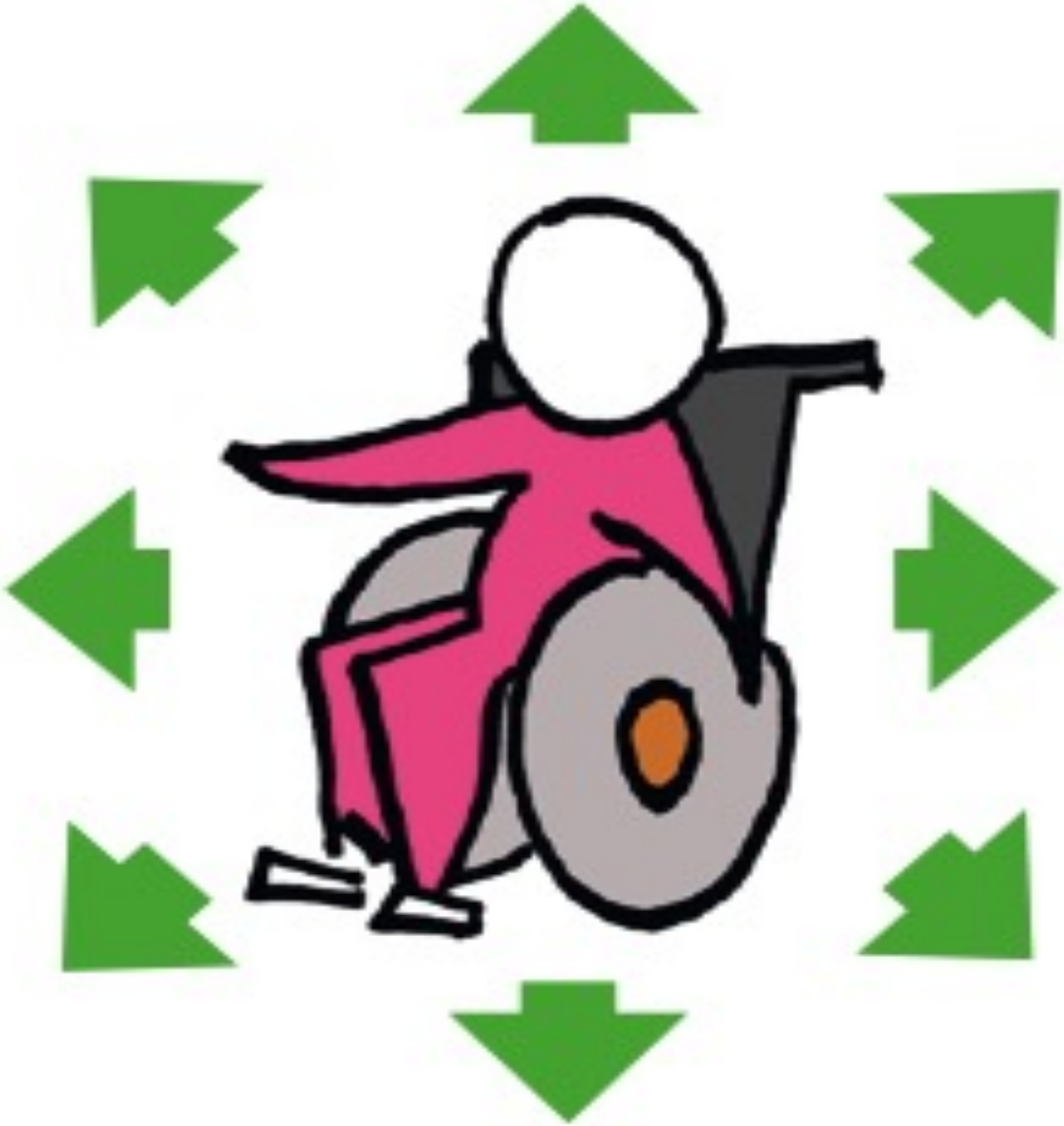
- The medical model sees the disabled person as the problem that needs to be fixed or changed





The social model of disability





Medical model vs. Social model

Medical model	Social model
The individual is the problem.	The barriers are problems created **society.**
The individual needs to change.	The barriers need to be removed.
Disabled people become the victim, client, have no responsibilities an are disempowered.	Disabled people have independence, control and choice.
Information on impairments is used to categorise people.	Information on access needs is on a need to know basis to ensure inclusion.

The Principle of Normalization

- Theory of influence in the field of intellectual disability.
- Deeply rooted in the efforts to reform institutions – “agonizing death struggle of the institutional model” (Wolfensberger).
- Architects: Bank-Mikkelsen, Nirje and Wolfensberger

What is the Principle of Normalization?

- *'A concept (originating in Scandinavia and further developed in North America) that emphasises the desirability for people with a learning disability to live a lifestyle as close as possible to the norms of the surrounding society'* (Thomas and Pierson 1996).

- It's aim was to assist individuals into 'socially valued life conditions and socially valued roles' (Wolfensberger and Thomas 1983:24)

The Principle means “that you act right when you make available to all persons with intellectual or other impairments or disabilities those patterns of life and conditions of everyday living that are as close as possible to, or indeed the same as, the regular circumstances and ways of life of their communities and their culture (Nirje, 1999)

- The Principle of Normalization has its roots in in post WWII Scandinavia in the 1950s and 60s when families of children with mental retardation demanded that their children receive the same opportunities as everyone else.
- Scandinavian countries have a long tradition of democracy, liberalism and welfare state ideals.

In 1959, the head of the Danish mental retardation service, Bank-Mikkelsen promoted legislation ‘Danish Mental Retardation Act’ which included the principle of ‘*letting the mentally retarded obtain an existence as close to the normal as possible’* (Wolfensberger, 1972, p. 27)

- By 1967, Swedish law embraced the concept and the executive director of the Swedish Association of Retarded Children described the principle as '*making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society'* (Nirje, 1969, p.18).

- These two definitions are based on an assumption of basic **human rights** to an existence as close to normal as possible.

(Neither of these definitions placed strong emphasis on the interpretation of disabled people as devalued members of society).

rje's definition (1925-2006)

- "*Making available to the mentally handicapped patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society*".

- Nirje wrote the chapter '*The normalization principle and its human management implications*' in 'Changing patterns in residential services for the mentally retarded' (1969, Washington,D.C.: President's Committee on Mental Retardation).

- His vision was to structure supports consistent with:

- Normal rhythm of the day;
- Normal rhythm of the week;
- Normal rhythm of the year;
- Normal life cycle developmental experiences;
- Normal right to choices and self-determination;
- Normal sexual patterns of their culture;
- Normal economical patterns of their society;
- Normal environmental patterns of their community.

- When Nirje, Grunewald (head of Swedish MR service) and Bank-Mikkelsen visited the US between 1967-69, Bank-Mikkelsen said cattle were taken care of better in Denmark that the residents in the US institutions they visited.

- This statement received much media attention in the US. However, it was Nirje who articulated a new vision for services for the people with mental retardation.

5 Reactions to the Normalization Principle

- Benevolent and **polite rejection** (speakers did not know the realities about the lives of the handicapped) - common from parents
- **Hostile rejection** from service professionals
- **Non-comprehension** – it was so remote from what people knew and were able to conceptualize
- An "*aha*" response – what was being said made profound sense; most likely from ordinary citizens
- Those who were open to learning more about Normalization but who did not agree with parts of it because they held high order beliefs (e.g. religious, political, socio-economic) that clashed with Normalization

SOCIAL ROLE VALORISATION (SRV)

Social Role Valorization

Wolfensberger used **deviance theory** as a way to explain the stigma associated with those who are different.

Wolfensberger and Thomas (1983):

- Subhuman organism
- Menace
- Unspeakable object of dread
- Object of pity
- Holy innocent
- Diseased organism
- Object of ridicule
- Eternal child

- These term **label**, **devalue** and lead to ideas of **social control**.

- Wolfensberger used deviance theory as a way to explain the stigma associated with those who are different.

- He believed people should be able to have socially valued roles within their communities – this is the essence of social role valorization.

- *'people will play the roles they are assigned'*.

Social Role Valorization (SRV)

- Wolfensberger was not satisfied with the term normalization and in 1983 developed a new term to replace it 'social role valorization' and he wanted more than a name change.

- The goal of socially valued roles required effort in 2 areas:

  - Enhancement of people's social image or perceived value in the eyes of others,

  - Enhancement of their competencies

…in other words, Wolfensberger believed people with disabilities should be able to have socially valued roles within their communities:

‘..*a person’s behaviour tends to be profoundly affected by the role expectations that are placed upon him. Generally people will play the roles that they have been assigned…*’.

Summary of meaning of these themes

1. It is essential that to raise the level of consciousness among human service workers to the reality of the experiences of Pwd.
2. Social Imagery is an important determinant of how we react to situations – social imagery can be improved.
3. Previous experiences create Mindsets and Expectancies which often dictate future reactions but they can be influenced by education and experience.
4. Roles are a major component of how we live our lives - these roles may be forced upon people and create deviancy; new roles can be found and deviancy avoided.
5. Personal Competency is important for role acquisition. The Developmental Model states that all Humans are capable of learning and changing through experience.

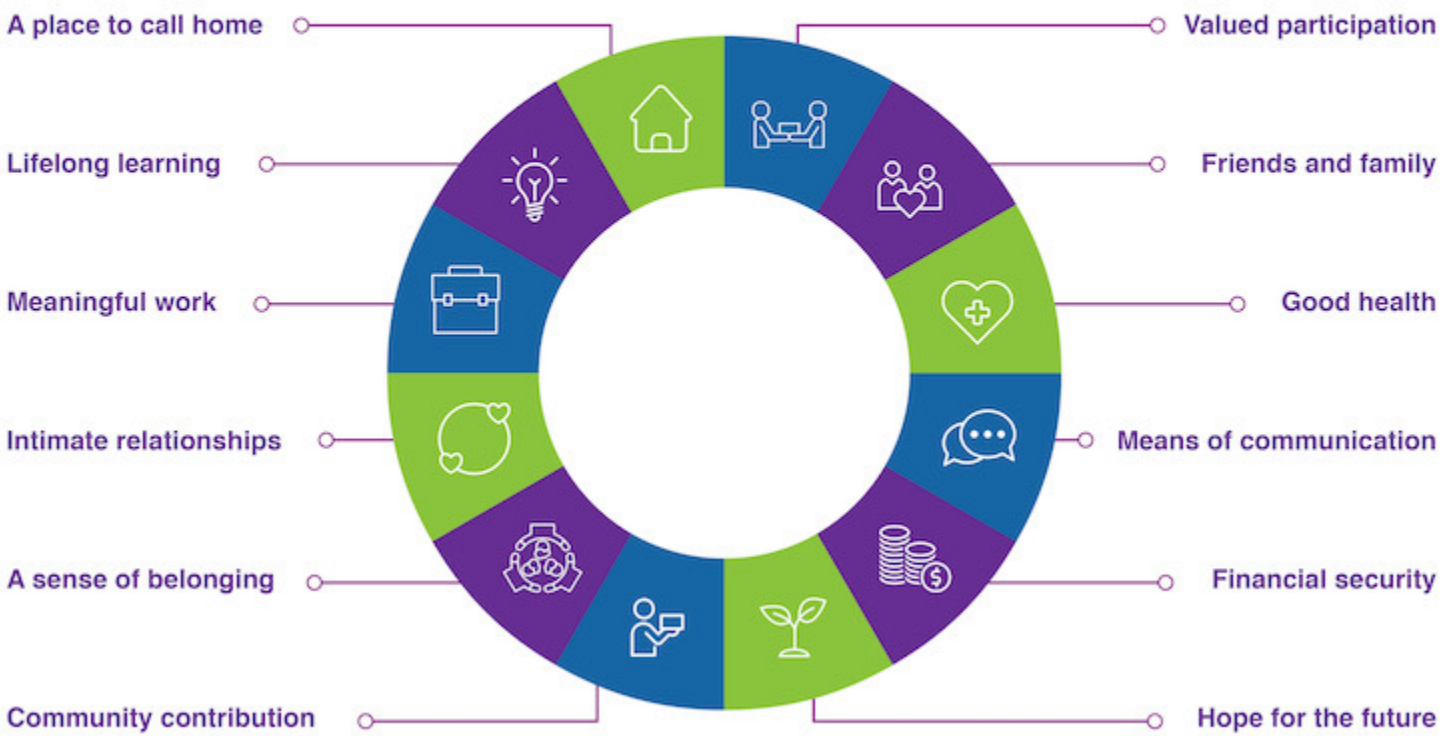
6. It is important that any measures taken to improve the plight of societally devalued people is Relevant, Potent and Coherent. Failure will compromise such measures.
7. If people who are not societally devalued are able to meet with people from devalued classes and experience positively such contact, they will understand better the commonality and basic humanity that they share. Such relationships can be encouraged.
8. Imitation is one of the most potent forms of learning known. It is important that people from devalued groups have suitable experiences and role models for imitation.
9. Personal Social Integration and Valued Social Participation are particularly valuable for people at risk of devaluation.
10. For those already at risk of social devaluation, it is possible to overcome and avoid future negativity by the use of Positive Compensation

What Is a Good Life?

The good life is what we all strive for in life. But what do we mean by the good life? If we think about ‘what makes up the good things of life’ this is a good place to start. What is important to all of us?

Having friends and being a friend
being a life long learner
having financial security
having a job
having a life partner
owning a home

The good things in life for all



- Restrictive practices are ethical, legal and clinical violations of fundamental human rights that may lead to poor care outcomes. As much as possible, aged care services should aim to create and maintain a restrictive practice-free environment.
- This is the recommended standard of care and will prevent residents from suffering unnecessary harm and trauma.

- Positive approaches involve working with the person and their support systems to:
- • try to understand what someone is feeling and why they are responding in the way they are
- • where possible, make any necessary changes and intervene at an early stage to try to prevent difficult situations
- • understand what needs to be planned and put into place to support the person to help them manage distressed and angry feelings in a way that reduces the need for behaviour that challenges and any restrictions. Understanding and working in a way that promotes positive and proactive approaches means that we need to:
- • have a positive attitude towards the people they support
- • have the right skills and knowledge
- • be well-trained
- • be supported by regular supervision and learning and development.

There are lots of ways of working with people using positive approaches. These can involve making small yet significant changes, which can have a big impact on how a person feels and behaves.

They could include:

- making changes to a person's environment or living space, such as changing the colour of the walls
- avoiding any sudden change or changes in routine
- using aromas to help someone settle (for example, in the bath before settling for bed)
- playing calming music or any music that someone may like or need
- giving people opportunities to take part in activities that are meaningful to them.

Core values and principles of practice Drogheda Services

- The principles and values are:
- • putting a person and their needs at the centre of their care, and giving them a voice in, and control over, the outcomes that will help them achieve well-being
- • being able to access advice and support at an early stage, to retain a good quality of life and reduce or delay the need for longer term care and support
- • helping people achieve their well-being in every part of their lives • involving people in how services are designed and provided, recognising the knowledge and expertise they can bring
- • strong partnership working between all agencies and organisations is essential to improve the wellbeing of people in need of care and support, and carers in need of support.

What do we mean by positive and proactive approaches?

- Positive and proactive (or preventative) approaches are based upon the principles of person-centred care:
- • getting to know a person
- • respecting and valuing their histories and backgrounds, and understanding: – their likes and dislikes – their skills and abilities – their preferred communication style and support structures
- • understanding the effect their environment has upon them and using this to identify ways to support people consistently in every aspect of the care that they receive
- • developing and monitoring plans that outline a person's needs, desired well-being outcomes and the ways they will be supported to achieve these. Developing good relationships is crucial, and you should always use positive and proactive approaches.

- They are essential when someone is:
- • stressed
- • distressed
- • frightened
- • anxious
- • angry and at risk of behaving in a way that challenges their safety and/or the safety of others.

Behaviours that challenge can stop people from taking part in social and learning opportunities and activities they enjoy. The following example shows how important a proactive approach, such as Active Support, can be and the effect it has on Alice and those around her.

Case example: Alice

Alice lived in a house with twelve other women.

Care Staff were finding it difficult to support her in her home and in her community at times, as she would often remove all her clothes, sometimes several times a day. The team carried out an assessment to understand why Alice was behaving in this way. The assessment showed that Alice's behaviour mostly happened when she was unoccupied. Workers were trained in the Active Support Model to increase Alice's participation in activities. This resulted in Alice being much busier and enjoying a lot of interaction with workers. Six months after this change, Alice rarely removed her clothes inappropriately.

- **What is Active Support?**
-
- Active Support is helping people to be actively, consistently, and meaningfully engaged in their own lives regardless of their support needs.
-
- Be Engaged: Doing things; Participating; Spending time with others; Making decisions; Making choices. People without disabilities spend nearly 90 % of their time in purposeful engagement. How does that compare?
- Actively : Each day; Through-out the day whenever there is an opportunity;
- Consistently: With approaches that provide enough structure and predictability that people experience comfort, continuity, and have a better ability to be engaged;
- Meaningfully: In ways that increase competence and opportunity; in ways that help people be and stay connected to others (socially); in ways that provide enhanced esteem; in ways that are focused on needs, preferences, and goals of the person.

- **Why Bother with Active Support?**
-
- Studies have shown that even in community settings:
  - People supported are often disengaged.
  - Staff time is spent *doing for or to* rather than supporting to do.
  - People with the highest need have the lowest amount of engagement
-
- **What are Active Support Philosophies?**
-
- Engagement for the sake of engagement; but not activity for the sake of activity.
- Activities are meaningful to the person.
- *All* are included regardless of support needs.
- There is a commitment to make it happen as an individual and a team.

PRINCIPLES

- People with disabilities are entitled to lives which are as full as anyone else's. Although every one of us differs, there are some core things we all have in common. It is important for most people to:
- • be part of a community
- • have good relationships with friends and family
- • have relationships that last
- • have opportunities to develop experience and learn new skills
- • have choices and control over life
- • be afforded status and respect ... and ...
- • be treated as an individual.

ACTIVE SUPPORT

- Active Support has 3 components:
- 1. Interacting to Promote Participation. People who support the individual learn how to give him or her the right level of assistance so that he or she can do all the typical daily activities that arise in life.
- 2. Activity Support Plans. These provide a way to organise household tasks, personal self-care, hobbies, social arrangements and other activities which individuals need or want to do each day and to work out the availability of support so that activities can be accomplished successfully.
- 3. Keeping Track. A way of simply recording the opportunities people have each day that enables the quality of what is being arranged to be monitored and improvements to be made on the basis of evidence.
- Each component has a system for keeping track of progress, which gives feedback to the staff team and informs regular reviews.

What do we mean by ‘restrictive practices’?

- Restrictive practices Restrictive practices are a range of activities that stop people from doing the things they want to do or encourages them to do things they don’t want to do.
- They can be obvious or subtle.
- They should be understood as part of a spectrum – from limiting choice to a reactive response to an incident or emergency, or if a person is going to seriously harm themselves or others.
- When thinking about restrictive practices, it’s important we also understand how to use positive and proactive approaches to reduce their use.

- Case study: Megan This case study shows how people are sometimes prevented from doing or having the things they would like – sometimes for good reason. As you read through Megan's situation:
- • ask yourself how you could justify limiting Megan's choice to drink coffee and tea when she wanted.
- Megan has an acquired brain injury and a long history of making herself physically unwell with caffeine overdoses, which have resulted in her being admitted to hospital on a number of occasions. Megan would drink coffee from the jars and hide tea bags to eat when she was not supervised. In her previous home, she had no access to the kitchen and could only have caffeine-free drinks. Initially in her new home, it wasn't safe to let her into the kitchen to make drinks as she became very stressed and aggressive when she couldn't access the freely available jars of coffee and teabags.

- Care Staff have now made gradual progress with Megan. She is using the kitchen with support and can make her own drinks using sachets of coffee rather than coffee from a jar.
- There are occasional blips where there's a breakdown in communication between Megan and a social care worker, but generally it's working well. Megan can make herself drinks, which is important to her, and keep physically well, too, which is important for her.

Individual Placement Plan Activities and Interests

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
In house activities Hobbies Weekend activities Interent/phone				

Individual Placement Plan Family/Relationships/Contact

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Support Identified access plan Wife Son Daughter other Specific relationships Friends				

Individual Placement Plan Health

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Healthy Eating Personal Hygien/oral Hygiene Continence Medical conditions				

Individual Placement Plan Health

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Responsive Behaviours Ongoing Support Walking				

Individual Placement Plan Education and Development of skills

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date

Individual Placement Plan Social Skills and Community

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Develop and maintain and sustain relationships with staff and People we live with Personal Relationships Social Skills e.g hairdresser, pub				

Individual Placement Plan Individual and Identity

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Identity/Culture Being in Care Religion Gender/Sexuality Rights/Voice				

Individual Placement Plan
Self Care and Independent Living Skills

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Maintain and further develop independent living skills through daily chores Value and use of money Personal shopping				

Individual Placement Plan Preparation for Leaving Care

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Support Identified access plan Wife Son Daughter other Specific relationships Friends				

Individual Placement Plan Emotional and Psychological

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Transition into Care Your Future Living Therapeutic Plan Improve reflective abilities Cognitive ability				

Individual Placement Plan
Individual Therapeutic Plan-Neurosequential Pathway

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Safety, Consistency and Routine Sleep Hygiene Relaxation Nuturing Care Sensorimotor Activities Play/Activities Sharing and turn taking Regular 1:1 time with another adult Attunement/Empathy				

Individual Placement Plan Individual Therapeutic Plan- Neurosequential Pathway

Identified need	Actions to be taken to meet identified needs	Action Taken by	Action Start Date	Action Review Date
Boundaries/Structures Self Soothing skills Patterned/Repetitive Grounding/Mindfulness Up down regulating activities Sensory Diet				