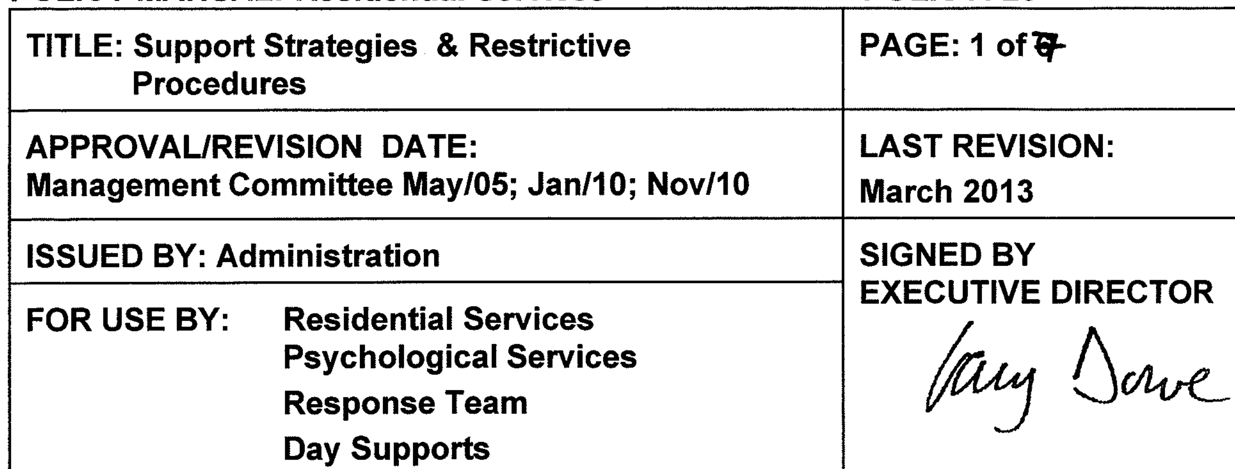
COCHRANE TEMISKAMING RESOURCE CENTRE



POLICY MANUAL: Residential Services **POLICY: 20**

TITLE: Support Strategies & Restrictive Procedures	**PAGE: 1 of 7**
APPROVAL/REVISION DATE: **Management Committee May/05; Jan/10; Nov/10**	**LAST REVISION:** **March 2013**
ISSUED BY: Administration	**SIGNED BY EXECUTIVE DIRECTOR**
FOR USE BY: **Residential Services** **Psychological Services** **Response Team** **Day Supports**	

POLICY STATEMENT

CTRC advocates that support strategies will ensure human rights and follow mandatory requirements as outlined in the Services & Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008. Adherence to Ministry Guidelines and the Policies and Procedures of CTRC are imperative.

PURPOSE

1. To provide guidelines for persons providing direct care around the utilization of behaviour intervention techniques, within a person centred context.

2. To ensure consistent standards for support strategies are understood and utilized, and that these standards promote the most positive and least intrusive support for individuals.

3. To increase confidence and morale, to improve overall safety and to minimize the number of physical interventions and restrictive procedures needing to be utilized by persons providing direct care.

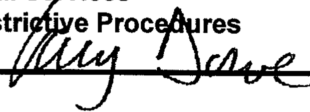
GUIDING PRINCIPLES

1. CTRC is committed to uphold the human rights of each individual, to act in their best interest and to provide support and counselling to enable individuals to meet their needs and wishes.

2. All behaviour intervention techniques will attempt the most positive and least intrusive support necessary to achieve the desired outcome.

3. All formal approaches to behaviour intervention must be documented for clarity and consistency and in cases of restrictive procedures, receive prior approval and utilize and demonstrate the principle of most positive and least intrusive.

4. Crisis intervention is an integrated process with therapeutic responses providing the best chance of calming one's behaviour. All intervention will be identified to allow for the least intrusive and restrictive strategies first and yet prepare those doing the intervention, when needed, to control overt physical aggression.



5. It is the responsibility of those providing direct care to prevent the escalation of behaviour, or if not preventable, to reduce the risk of injury to all parties while maintaining an effective and therapeutic alliance with the individual.

6. CTRC commits to quality training standards to assist persons providing direct care in responding to maladaptive behaviours and maintaining a professional attitude during interventions.

PROCEDURE:

1. CTRC endorses the use of behaviour intervention techniques that assist an individual to develop strategies to manage their own behaviour and that promote positive support for the individual.

2. Any use of restrictive procedures (i.e. any technique or practice that imposes restriction or limits on the rights of an individual will maintain a focus of most positive and least intrusive, and must be carefully monitored. Such procedures will not be used, except:

   a. As an emergency intervention to restrain or control behaviour of an individual in situations where it is necessary for immediate protection of the individual, others, property, or self.

   b. When such procedures are an integral component of a formal, written, and authorized program and where it can be demonstrated that the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.

Note: Volunteers will not work with individuals with challenging behaviour as described in 15(2) of the Quality Assurance Measures of the Services and Supports to promote the Social Inclusion of Person with Developmental Disabilities Act, 2008.

3. Techniques to manage inappropriate behaviour will not be used for disciplinary purposes, for convenience or as a substitute for an active program plan.

4. All persons providing direct care, as part of his or her orientation, will be informed of his or her responsibilities to support and work with individuals in ways that promote growth and development, with an emphasis on consistent positive interaction occurring between the individual and those persons providing direct care.

   The following are important components:
   - teaching people to interact with each other in a socially acceptable manner
   - utilizing opportunities to teach and reinforce skill acquisition
   - identifying impediments to learning and acquisition of skills, and adjusting supports to deal with identified impediments

possible

- encouraging people to take risks, with reasonable safeguards being offered to prevent injury or harm
- providing individuals with opportunities and needed supports, for choice, decision making and self-management
- seeking out and utilizing and encouraging appropriate and purposeful activities that are preferred or of interest and benefit to the individual
- ensuring that the persons preferences play a key role in daily decision making

5. Behaviour escalation does not occur by itself. Any person intervening with an individual must maintain awareness that his or her behaviour has tremendous impact on the person.

6. All behaviour has meaning. In determining the best approach, it is important to investigate what the behaviour means, and how it happens. Knowledge of a individual's strengths, challenges and typical patterns of behaviour can assist in minimizing crisis situations through early intervention.

7. Intervention with an acting out individual must avoid overreaction and under reaction. Verbal interventions skills are utilized to intervene with a verbally acting out individual and safe physical intervention techniques are utilized to control the individual.

8. It is not enough for persons providing direct care to demonstrate the inadequacies of the individual's present behaviours. The individual also needs to learn new ways of handling crisis situations more effectively and appropriately. If new ways are not taught, it is unlikely the negative behaviours will change.

9. Interventions related to situations in which people exhibit aggression, disruptive or out-of-control behaviours, will follow a non-violent crisis intervention model and will be utilized with sufficient safeguards and supervision to ensure the health, safety, security and welfare of all persons in the immediate area and property.

10a. The Services & Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008, Section 17, General Behaviour intervention, Strategies, Training, states that all direct care staff will successfully complete a training program that includes training in the use of physical restraint and subsequent refresher courses.

This minimally will include an initial 12 hours of mandatory formalized training in non-violent crisis intervention (CPI) within 30 days of the direct care staff commencing employment and a 4 hour refresher training session annually thereafter.

Any person who has and can produce evidence of such training can be considered for exemption from the 12 hours of training. Such a decision will be approved

through the Manager/Director.

10b. Any person required to have CPI training, as identified above, who fails to obtain such training within the required time, will:

- in the case of such training not being available, be assessed regarding the ability to provide needed supports by the Director/Executive Director, and where in the opinion of the Director/Executive Director , such ability is a concern, be considered for alternative placement or restricted duties, until such training can be obtained; or

- in situations where the individual fails the training or fails to attend the training without just cause or authorization, be suspended from his or her duties, or transferred to an alternative position, as determined by the Executive Director, until he or she successfully completes the training

- The Director/Executive Director will determine the necessity of CPI training for other persons working in close proximity to individuals who exhibit aggressive, disruptive or out of control behaviours.

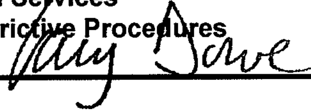
10c. A CPI refresher course will be conducted annually for each direct care staff member where their understanding and application of the subject matter is assessed and recorded.

11. Behaviour intervention strategies being utilized will be documented in the individual's file and shared with all persons working with that individual. Any strategy that may include any form of negative consequences will:

- be documented, and be on the individual's file
- be part of a clearly outlined strategy, that identifies the goal and method, data collection and review
- only be approved when it can be justified by those responsible and making the decision that more positive and less restrictive techniques are not likely to be effective

12a. Each individual who demonstrates behaviours that could be self-injurious or endanger the health or safety of others, or damage to property that may lead to injury must have a clearly defined set of procedures outlined in his or her file that follows the least intrusive model. Such procedures are to detail these behaviour(s), rationale for the procedures, proactive strategies that will prevent or reduce the potential of crisis development, and responses at each level of the crisis development model.

b. All such procedures must be approved in writing by a psychologist or psychological associate, and must take into account any health and other risk factors of the individual, including asthma, heart condition, age, former broken bones, pins, etc. Therefore, consultation with Health Services may be required.



c. All persons providing direct care must be aware of such procedures.

d. Where applicable, such strategies will seek consultative assistance from the multi-discipline team, e.g. from psychology, psychiatric, medical, and /or mental health, residential, CPI training, etc.

13. On a regular or as required basis, the individual, Health Services, Psychological and/or Residential Services and/or Client Support Services will meet to formally review the use of these restrictive procedures. In addition to monitoring the effectiveness of the procedures, the multi-discipline team will ensure the procedures continue to meet legal and legislative requirements.
    - Psychological Services will normally chair the review meetings.
    - Psychological Services will contact the multi-discipline team to establish review dates.
    - Review meetings will on average be held every 6-8 weeks, when an active case, but no longer than once every 6 months.
    - Any deviation as to the frequency of review meetings will be part of the review meeting and reasons documented.

14. Written programs must outline steps to assist the individual in learning alternative behaviours. The program must specify proactive steps to diminish the use of restrictive procedures where possible, outline the procedure(s) that can be used where there is risk of injury or property damage, and a reporting procedure. Documentation strategies and a review date are critical components of such a plan.

15. The individual, and those involved in planning with the person, is to be encouraged, where applicable, to participate in program development.

16. Any restrictive procedure falling in the most restrictive categories, i.e., closed door is only used after a written program has also been approved, and signed, by the Executive Director/designate.

17. Such programs will include informing the individual and guardian or supported decision maker as applicable, and any key person(s) involved in planning with this person. Documentation must be placed on file as proof that such individuals were informed. In cases where there is dissent in appropriate procedure, they will convene a meeting of the parties, and determine a resolve.

18. In an emergency situation, where an unanticipated behaviour requires immediate intervention to protect the individual or others from injury, and where there is no written program in place, a restrictive procedure that falls into the most restrictive category can be used. In addition, based on extraordinary circumstances resulting in an emergency situation, a more restrictive intervention than what is identified in a formal program may need to be used. Such a procedure chosen:

a. Is to be the least restrictive necessary, and for the briefest time necessary to control the behaviours that place the individual or others in imminent danger
b. Must be fully documented in a Critical Incident Report, to be directed to the Manger/Director, in a timely fashion
c. Will be reviewed by the Manager/Director and individual who did the procedure, with the review to include exploration of possible causes for the behaviour
d. Where it seems likely that the behaviour will occur again, or should it occur again, must be included in a fully written program, or alternatives identified, and approved through the Manager/Director and Executive Director.

19. In more significant situations, where there is risk of personal injury, or where the person intervening in his or her opinion is not capable of appropriate intervention, the first (or next) step should be to call for outside support. This can include calling additional staff, or the Police. No person is expected to subject themselves to undue harm or danger. In general, this will be part of the individual's written program, unless one is responding to an emergency.

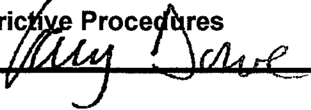
20. CPI techniques for physical intervention will be the only approved techniques for those providing direct care. Use of any technique not sanctioned within CPI is not permitted, and will be viewed as abuse, and thus grounds for disciplinary action.

21. Prescribed medication, including PRN's, used to assist an individual in calming themselves, is considered an intrusive measure, and will only be administered according to the recommendations and instructions of a qualified medical practitioner (the protocol). All such instructions are to be documented in the individual's file and any use of such medications documented.

22. Health Services reviews all medications and medication protocols on a monthly basis to determine whether they are still necessary and effective. More elaborate PRN protocols for challenging behaviour will be reviewed at least every 6 months by the individual's support team and can be initiated by any member of the support team (e.g., Psychological Services, Health Services, and Group Home Supervisor). Based on these reviews, a determination of whether to modify, discontinue or maintain the PRN medication and PRN protocol will be made.

23. At times, the individual may choose, or be encouraged, to go to their room, or some quiet location, as an appropriate response to a behavioural situation to regain control. This is to be distinguished from physical placement of a person in his or her room, as a place to calm, in which egress from that room is prevented.

24. All incidents that utilized "time out" will be fully documented in a Critical Incident Report, to be directed to the Manager/Director or to the Executive Director in the absence of the Manager/Director. These are to be faxed within a 24 hour period to the main office and the original forwarded as per usual office mail. Refer to General Operations Policy # 18, Serious Occurrence Reporting.



25. Psychological and Residential Services will ensure that all restrictive procedures are summarized monthly per individual or as required, as to type and regularity. Patterns will be observed, possible causes of maladaptive behaviours, positive result, and safety issues, with changes being made accordingly, such that ongoing attempts are evident and encouraged to reduce the number and type of restrictive procedures and interventions for the person.

26. This policy is the same as Professional Resource Team Policy, # 14, Support Strategies & Restrictive Procedures.