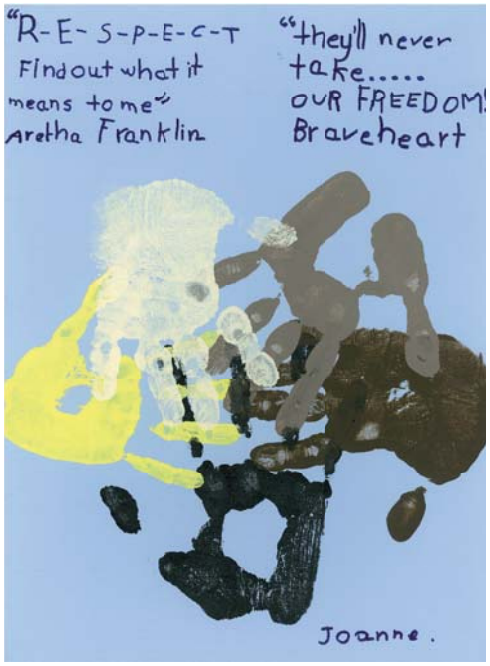
human services

Senior Practitioner
Physical Restraint Direction Paper – May 2011

Supporting people to achieve dignity without restraints

A Victorian Government initiative

State Government Victoria



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Definitions

'Emergency' means a sudden state of danger requiring immediate action to prevent or manage a serious and imminent risk of harm to the person or to another person or people.

'Physical assistance or physical guidance' means the use, for the purpose of the wellbeing and support of a person with a disability, of **non-coercive physical contact** to enable activities of daily living or for therapeutic purposes:

- to perform activities of daily living, such as physically assisting a person with dressing or shaving
- to develop or acquire new skills such as physically assisting a person to prepare dinner where it may involve physically guiding the person's hand to use a kitchen knife to cut vegetables
- to learn, adapt or perform activities as part of a therapy program such as physically holding on or physically guiding a person in a swimming pool because they are not able to swim independently, or implementing a physiotherapy program
- to ensure a person's safety when the person is engaged in certain stereotyped movements such as guiding a person who is fixated on finger flicking away from the road
- to comply with 'duty of care' expectations.

'Physical restraint' means the use, for the primary purpose of the behavioural control of a person with a disability, of **physical force** to prevent, restrict or subdue movement of that person's body or part of their body, and which is not physical assistance or physical guidance.

'Duty of care' is defined broadly in this direction as taking action, where reasonably required, to prevent or reduce foreseeable harm from occurring to a person. This requires that the least restrictive principle is applied in the circumstances. For example, to hold or physically guide a person away from wandering into busy traffic, or prevent a person from placing their hand on a hot stove, or prevent self-injury such as the person hitting their own body.

'Physical restraint – planned emergency response' means –

a) a planned response developed in accordance with the *Senior Practitioner's Physical Restraint Direction* and approved by the Senior Practitioner; and

b) where physical restraint is necessary in an emergency, and developed as a planned emergency response to a known potential emergency situation or known behaviour, to prevent or manage a serious risk of harm to the person or to any other person; and

c) forms an attachment to a behaviour support plan or treatment plan aimed at safely eliminating this restrictive intervention.

Introduction

A direction from the Senior Practitioner under s.150(2)(e) of the Disability Act 2006

Prohibition on the use of physical restraint on people with a disability who are receiving a disability service provided by a disability service provider.

The role of the Senior Practitioner was established by the *Disability Act 2006* to protect the rights of people with a disability who are subject to restrictive interventions and compulsory treatment, and to ensure that appropriate standards in relation to restrictive interventions and compulsory treatment are complied with. The Senior Practitioner is conferred with legislative powers, duties and functions to ensure compliance with the Act. This includes the power to prohibit and regulate other restrictive interventions as per s.150 of the Act.

The use of physical restraint is considered as 'other restrictive interventions' under s.150 of the Act. This direction was developed based on a comprehensive review, research and consultation process.

Physical restraint does not include physical assistance or physical guidance, which are defined at the beginning of this direction.

1. Intent of this direction and its application

Intent of direction

This is a direction issued by the Senior Practitioner under s.150(2)(e) of the Disability Act.

This direction:

- prohibits the use of specific types of physical restraint listed in this direction
- prohibits the use of other types of physical restraint by disability service providers on people with a disability, except as provided for under this direction
- specifies the process for obtaining the Senior Practitioner's approval for using physical restraint under this direction.

Who does this direction apply to?

This direction applies to all disability service providers defined in the Act when a disability service is being provided to a person. This includes children and young people with a disability in receipt of a service provided by a disability service provider.

As such, this direction applies to employers of disability services and their employees (such as management, support professionals, clinical practitioners and trainers) and includes volunteers.

What does this direction mean for disability service providers?

Disability service providers are required to comply with this direction.

This may also mean further development of a disability service provider's current practice manuals, policies and procedures where relevant.[1]

What is a restrictive intervention?

A restrictive intervention is defined in the Act as any intervention that is used to restrict the rights or freedom of movement of a person with a disability.

What is a physical restraint?

A physical restraint is a type of restrictive intervention under s.150 of the Act.

Physical restraint means the use, for the primary purpose of the behavioural control of a person with a disability, of **physical force** to prevent, restrict or subdue movement of that person's body or part of their body, and which is not physical assistance or physical guidance.

Physical restraints include, but are not limited to, interventions such as a prone restraint (face down), supine restraint (face up), pin down and basket hold.

What is physical assistance or physical guidance?

Physical assistance or physical guidance is ***not*** physical restraint as defined in this direction.

Physical assistance or physical guidance means the use, for the purpose of the wellbeing and support of a person with a disability, of **non-coercive** physical contact to enable activities of daily living or for therapeutic purposes.

Physical assistance or physical guidance include, but are not limited to:

- performing activities of daily living, such as physically assisting a person with dressing or shaving

1 Disability service providers are also reminded of their obligations under the *Occupational Health and Safety Act 2004* and related legislation.

- developing or acquiring new skills, such as physically assisting a person to prepare dinner where it may involve physically guiding the person's hand to use a kitchen knife to cut vegetables
- learning, adapting or performing activities as part of a therapy program, such as physically holding on or physically guiding a person in a swimming pool because they are not able to swim independently, or implementing a physiotherapy program
- ensuring a person's safety when the person is engaged in certain stereotyped movements, such as guiding a person who is fixated on finger flicking away from the road
- complying with 'duty of care'.[2]

It is important to consider (a) the extent of the use and (b) the reasonableness in the circumstances of physical force during physical assistance or physical guidance as this may constitute physical restraint.

Example 1: A person who is led into the bathroom for a shower (physical assistance) but the force applied to lead the person into the shower is excessive and the person's arm is bruised (physical restraint).[3]

Example 2: A person with a disability who is escorted or directed to another activity or a room (physical assistance) but the force applied is excessive (physical restraint), leading to a soft tissue injury, pain or psychological harm (physical restraint).

Careful consideration and planning must be given when escorting a person to a seclusion room if physical restraint is part of escorting the person. If physical restraint is being considered as part of the escort then this direction and its requirements apply.[4]

2 It is noted that the 'duty of care' definition may vary from one disability service provider to another. For departmental employees, please refer to the *Residential services practice manual* section 'Duty of care in residential services'.

3 These examples may also be considered as a possible physical assault. Disability service providers are reminded of their obligations under Disability Services' policy, *Responding to allegations of physical or sexual assault*.

4 Where physical restraint is not applied during the escort, disability service providers need to be aware of and caution staff of 'other restrictive practices' such as 'psychosocial restraint' or 'consequence-driven strategies' that may be inadvertently be used in lieu of physical restraint. See the *Senior Practitioner practice guide: Other restrictive interventions: locked doors, cupboards, other restrictions to liberty and practical ideas to move away from these practices, January 2010*.

2. Senior Practitioner's direction

Section 1. Direction under section 150(2)(e) of the Act

1.1 Disability service providers are prohibited from using physical restraint in the course of providing a disability service, except as permitted under this direction.

1.2 Without intending to be an exhaustive list, the following physical restraint types or interventions are specifically prohibited:

(a) the use of prone restraint (subduing a person by forcing them into a face-down position)

(b) the use of supine restraint (subduing a person by forcing them into a face-up position)

(c) pin downs (subduing a person by holding down their limbs or any part of the body, such as their arms or legs)

(d) basket holds (subduing a person by wrapping your arm/s around their upper and or lower body)

(e) takedown techniques (subduing a person by forcing them to free-fall to the floor or by forcing them to fall to the floor with support)

(f) any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning

(g) any physical restraint that has the effect of pushing the person's head forward onto their chest

(h) any physical restraint that has the purpose or effect of compelling a person's compliance through the infliction of pain, hyperextension of joints, or by applying pressure to the chest or joints.

Section 2. Exceptions

2.1 Disability service providers must not apply any physical restraint to a person with a disability, except as provided for under this direction where it is regulated under s.150(2)(e)(ii) and only in the following circumstances:

(a) where physical restraint is necessary in an unplanned[5] emergency or in a 'duty of care' exception,[6] or

(b) where physical restraint is necessary in an emergency, and developed as a planned response[7,8] to a known potential emergency situation or known behaviour, to prevent or manage a serious risk of harm to the person or to any other person

(c) where the use of physical restraint (other than in an emergency described above) is being sought for approval

5 An unplanned emergency applies to circumstances in which a behaviour displayed by a person is new, unpredicted or not known as part of the person's history or known repertoire of behaviours.

6 'Duty of care' may be broadly defined in this context as the need to take necessary action where reasonably required in a situation, to prevent and or reduce foreseeable harm from occurring to a person or people; the least restrictive principle is applied in the circumstances.

7 Physical restraint is not permitted as part of a support plan nor is it permitted as a standard response in a person's treatment or behaviour support plan. Where a planned response is required, the "physical restraint – planned emergency response" must be (a) documented, (b) referred to and (c) attached as part of the treatment or behaviour support plan.

8 Where behaviours that are known or can be predicted to occur in a potential known situation, and where physical restraint is considered as a last resort, a planned response to be used in an emergency situation only must be documented as a physical restraint – planned emergency response. Physical restraint is not to be used as part of a person's routine management. Disability service providers must also refer to *Attachment 3: Checklist on the use of physical restraints in an emergency and as a planned response.*

by a disability service provider to the Senior Practitioner.

2.2 The Senior Practitioner may only regulate and approve the use of physical restraint in the above circumstances outlined in paragraphs 2.1 (b) and 2.1 (c) where the disability service provider has demonstrated the following:

(a) evidence that positive behaviour support alternatives are being trialled or implemented over a period of time, such as more than a year

(b) evidence that a comprehensive review or assessment and analysis have been conducted to determine whether a behaviour(s) or an incident is foreseeable and the behaviour(s) or incident is more likely to re-occur

(c) evidence that a comprehensive treatment/behaviour support plan has been implemented and evaluated overtime, such as more than a year

(d) evidence that implementation of the treatment/behaviour support plan, and analysis of the plan yielded no significant gains or outcomes for the person

(e) other less restrictive options (under the circumstances) are considered and outlined in the person's treatment/ behaviour support plan

(f) appropriate arrangements are in place to ensure that the person's physical condition[9] is closely observed and documented during the period of the physical restraint[10] and for at least one hour after the application of the restraint

(g) that clear directions are in place to ensure that the proposed or administered physical restraint ceases immediately when the serious risk of harm to the person or to others is no longer present.

2.3 Disability service providers must apply for the Senior Practitioner's approval to any proposed use of physical restraints as in 2.1(b) and 2.1(c) and satisfy all the requirements in 2.2.

2.4 The Senior Practitioner may only permit use of physical restraint for periods of no longer than 12 months, after which any further use of physical restraint must be subject to further approval by the Senior Practitioner based on the same requirements in 2.2.

Section 3. Reporting of physical restraint

All episodes of physical restraint, whether approved or not approved under sections 1 or 2 of this direction, must be reported to the Senior Practitioner via the Restrictive Interventions Data System (RIDS) within seven days after the end of the month following the application of the physical restraint.

Section 4. When does this direction take effect?

4.1 Section 1 of this direction *(Directions under 150 (2) (e) of the Act)* takes effect from **1 January 2012**. Meanwhile, if a disability service provider is of the view that any of the prohibited list of physical restraints is still required for a person with a disability prior to this date, then the disability service provider must:

9 Observations of a person's physical condition include (but are not limited to): a person's breathing; skin colour; body temperature; any signs of distress or pain; any bleeding or bruising (such as nose bleeds or bruises); and signs of aspiration or choking. See also advice on when to cease physical restraint (footnote 10).

10 Physical restraint must cease immediately if the person demonstrates any of the following conditions: breathing difficulties; fits or seizures; choking; vomiting; blue colouration of the hands, feet, lips or other parts of the body; paleness or yellowing of the skin; bone fractures; or any other signs of distress or pain.

(a) apply for the Senior Practitioner's approval immediately

(b) satisfy all the conditions in section 2.2

(c) demonstrate the safe administration of the proposed physical restraint from the prohibited list of physical restraints (such as providing regular staff training and ensuring all training is documented)

(d) seek medical or allied health professional advice prior to seeking approval from the Senior Practitioner for the use of the physical restraint

(e) demonstrate how the proposed physical restraint will be eliminated safely.

4.2 Section 2 of this direction (*Exceptions*) takes effect from **1 January 2012**.[11]

4.3 Section 3 of this direction (*Reporting of physical restraint*) takes effect from **1 July 2011**.

11 For departmental employees, noncompliance with this direction will be dealt with under the department's Managing performance and conduct policy from 1 January 2012. Funded disability service providers should consider similar management of performance and conduct of their employees.

Attachment 1: Explanatory note

The Senior Practitioner has issued a direction to disability service providers prohibiting physical restraint.

Can a person's guardian authorise physical restraint?

No.

The direction applies to disability service providers (both department-provided and funded community service organisations) in all aspects of service provision, regardless of the environment or whether the service is being provided by a paid employee or volunteer. For example, it applies to a paid employee or volunteer respite worker supporting a person with a disability in their family home, or to a paid or volunteer disability support professional who is assisting a person to participate in the community.

The direction applies even if the person's guardian has, or would be prepared to, authorise a department-provided or funded disability service to use physical restraint. That is, physical restraint cannot be used except as regulated by this direction irrespective of the views of a person's guardian.

Why has this direction been given?

The Senior Practitioner has a responsibility under the Disability Act to protect the rights of people with a disability who are subject to restrictive interventions and compulsory treatment. As with all public authorities, the Senior Practitioner also has a responsibility under the *Victorian Charter of Human Rights and Responsibilities* to act compatibly with human rights and to take human rights into account in the office's decision making.

Physical restraint is a very serious form of restrictive practice that limits the human rights of people with a disability. It is associated with a high risk of injury and harm (including death) to those upon whom it is used. It is also associated with a high risk to the wellbeing of employees who administer physical restraint.

The Senior Practitioner must therefore ensure that the use of physical restraint by disability services is prohibited as soon as possible, except in circumstances of emergency. Disability service providers and their staff should develop their capacity to provide alternative positive behaviour support strategies to people with a disability who engage in behaviours of concern.

Can physical restraint ever be used?

Yes. Where physical restraint is necessary:

- in an emergency or in a 'duty of care' exception, or
- where physical restraint is necessary in an emergency and is developed as a planned response[12] to a potential emergency situation or known behaviour to prevent or manage a serious risk of harm to the person or to others, or
- where the use of physical restraint is regulated by the Senior Practitioner under a direction issued under s.150(2)(e)(ii) of the Act.

The direction does not change a disability service provider's duty of care to protect the person or another person from harm in an emergency.

The Senior Practitioner may also issue an approval to use physical restraint where it is necessary to prevent or manage a serious risk of harm to the person or to another person or people (and where it meets all the requirements outlined in this direction).

12 Physical restraint is not permitted as part of a support plan nor is it permitted as a standard response in a person's treatment or behaviour support plan. Where a planned response is required, the "physical restraint – planned emergency response" must be (a) documented, (b) referred to and (c) attached as part of a treatment or behaviour support plan.

Physical restraint is not the same as physical assistance or physical guidance.

Does the use of physical restraint have to be reported?

Yes.

All incidents of physical restraint, including any emergency use of physical restraint, must be reported to the Senior Practitioner in RIDS.

When does this direction come into force?

The obligation to report the use of physical restraint will come into force on 1 July 2011.

The prohibition on the use of physical restraint (except as permitted by the direction) will come into force on 1 January 2012.

Why is there a delay between implementation of the reporting obligation and implementation of the prohibition on physical restraint?

The Senior Practitioner recognises that, for a variety of reasons, physical restraint is still used in Victorian disability services.

The implementation of the reporting obligation from 1 July 2011 will ensure that the Senior Practitioner and the Department of Human Services have accurate information about the type of physical restraints used by disability service providers in an emergency.

This will enable the Senior Practitioner to begin to positively engage with service providers that still use physical restraint and to build their capacity to provide alternative positive behaviour supports. This will ensure a safe transition from current practice to new support models, both for people with a disability who are subject to physical restraints and the staff who work with them.

Why isn't the Senior Practitioner ruling out physical restraint altogether?

The aim of the direction is to work towards the elimination of physical restraint over time.

However, the Senior Practitioner recognises that, for some individuals and in some environments, it will take time to institute alternative and safer behaviour support practices. In these exceptional situations, physical restraints may need to continue in the immediate future but will be subject to strict safeguards aimed at minimising potential harm and that positive behaviour support alternatives will be actively trialled and instituted.

Attachment 2: Summary of evidence-based positive alternatives to physical restraint

See: McVilly, K. 2008, *Physical restraint in disability services: Current practices, contemporary concerns and future directions*, The Office of the Senior Practitioner, Department of Human Services, Melbourne.

1. Multi-element systemic intervention, including person-centred planning, active support and positive behaviour support
2. Counterintuitive intervention strategies including:
    - providing high-density non-contingent reinforcement of the desired behaviour
    - early attention provided to behaviours of concern and avoiding ignoring behaviours that could escalate; avoiding natural consequences likely to escalate behaviour
    - avoiding punishment that can exacerbate behaviour and which is not an effective teaching method for people with cognitive impairment
3. Room-based interventions including:
    - sensory rooms
    - relaxation rooms
    - safe/comfort rooms
4. Sensory interventions, including the provision of preferred sensory stimulation and the elimination of non-preferred stimulation
5. Low-arousal techniques including minimising the complexity, frequency and duration of demands and expectations of the person and minimising the intensity of how these demands are delivered
6. Intensive interaction for people with severe, profound and multiple disabilities
7. Mindfulness techniques for both people with a disability and those providing support services

Attachment 3: Checklist on the use of physical restraints as a planned emergency response

This checklist is not intended to be an exhaustive guide, rather it is intended to act as a prompt for disability service providers to reduce the risks associated with the use of physical restraints when used as a planned emergency response.

Disability service providers should refer to local organisational or departmental policy and related legislative compliance (such as the *Occupational Health and Safety Act 2004*). In particular, disability service providers must give due consideration to the objectives and principles of the *Disability Act 2006* (ss. 4 and 5) and the *Charter of Human Rights and Responsibilities Act 2006*.

There are specific risks[13] associated with the use of physical restraint, which disability service providers must consider. These risks include:

- the physical health condition(s) of the person
- the weight of the person
- the particular syndrome of the person (as there are particular physical conditions that increase risks, such as people with Down and Turner syndromes who may have cervical spine instability or abnormality)
- current medication that may also increase risks (for example, medication such as chlorpromazine and carbamazepine, which may affect particular heart function)
- neurological or psychological factors.

Therefore, at a minimum, the regional or local behaviour intervention support team (such as specialist services) must be consulted if physical restraint is being considered as a planned emergency response. As outlined below it may also be essential to consult with a medical or allied health professional.

The use of physical restraint as a planned emergency response can only be approved by the Senior Practitioner.

Checklist on contraindications of physical restraints related to health[14,15]

1. **Seek medical or allied health professional advice** on the use of physical restraints being considered as a planned emergency response, if the person with a disability:
   a) has a known history of heart or vascular problems (such as a history of arrhythmias, high blood pressure or low blood pressure)
   b) has a known history of or has difficulty breathing, or a history of respiratory illness (such as asthma, sleep apnoea or chronic chest illness)
   c) has a known history of musculoskeletal problems (such as abnormal curvature of the spine [scoliosis and kyphosis], neck and or back problems, arthritis, recent fractures or history of dislocated joints or osteoporosis)
   d) has a known history of neurological conditions such as epilepsy or cerebral palsy
   e) has a known history of metabolic disorders[16]

13 Perry, D.W., White, G., Norman, G., Marston, G., Auchoybur, R. 2006, 'Risk assessment and the use of restrictive physical intervention in adults with a learning disability', *Learning Disability Practice, 9(6)*, 30–36. This article provides a comprehensive list of risks associated with physical restraints.

14 Harris, J., Cornick, M., Jefferson, A., Mills, R. 2008, *Physical interventions: A policy framework* (2nd edn), Worcestershire: BILD Publications.

15 Perry, D.W., White, G., Norman, G., Marston, G., Auchoybur, R. 2006, 'Risk assessment and the use of restrictive physical intervention in adults with a learning disability', *Learning Disability Practice*, *9(6)*, 30–36. This article provides a comprehensive list of risks associated with physical restraints.

f) has a syndrome that increase risks in any of the above factors (for example, people with Down syndrome often have unstable neck joints – known as atlantoaxial instability; people with Rett syndrome are prone to scoliosis; or a person with cerebral palsy may have impaired respiratory function)

g) has a sensory impairment (visual or hearing) because the person may experience further stress from not understanding what is occurring to them

h) has a communication impairment (ensure support staff know how the person communicates such as understanding if the person is showing visible distress and therefore is unable to respond appropriately)

i) is an older person

j) is obese, underweight or has other problems with weight that may increase risks

k) is a person with a known mental health condition (such as anxiety or depression) or a known history of posttraumatic stress disorder (such as a previous history of adverse experience relating to restraints that may further trigger stress symptoms).

l) is on current medication that increase risks in any of the above factors

16 Metabolism is the process the body uses to get or make energy from the food consumed, such as proteins, carbohydrates and fats. Chemicals in the digestive system break the food down into sugars and acids. The body uses the sugars and acids as fuel that can be stored or used immediately. The energy is stored in the body tissues, such as the liver, muscles and body fat. A metabolic disorder occurs when abnormal chemical reactions in the body disrupt this process. A common metabolic disorder is diabetes.

Checklist for other contextual and environmental factors that may be contraindications of physical restraints[17,18]

2. Consider the following factors **prior to** using physical restraints as a planned emergency response if the person with a disability:

   a) has been physically unwell recently (such as had a cold or flu, has undergone medical or dental treatment)

   b) has experienced recent bereavement or distress

   c) has experienced significant change in their daily routine and hence may be in a heightened state of anxiety (such as having been transferred to new or different accommodation or has had new people introduced to their environment)

   d) is having a meal or drink, or has just finished eating or drinking

   e) is in an environment that may increase risks to self or to staff (such as in traffic or by a road [this does not include duty of care expectations], in confined spaces such as a bathroom, or in a context that may contribute to suffocation or injury to the person and staff).

1. **Stop the physical restraint immediately** if the person with a disability show signs of any of the following conditions:

   a) breathing difficulties – very rapid or slow breathing

17 Harris, J., Cornick, M., Jefferson, A., Mills, R. 2008, *Physical interventions: A policy* framework (2nd edn), Worcestershire: BILD Publications.

18 Perry, D.W., White, G., Norman, G., Marston, G., Auchoybur, R. 2006, 'Risk assessment and the use of restrictive physical intervention in adults with a learning disability', *Learning Disability Practice, 9(6)*, 30–36. This article provides a comprehensive list of risks associated with physical restraints.

b) fits or seizures

c) choking[19]

d) vomiting

e) blue colouration of the hands, feet, lips or other parts of the body (indicates reduced oxygen circulation in the blood)

f) mottling (paleness/yellowing of skin due to restricted blood circulation)

g) bone factures

h) any other signs of distress or pain.

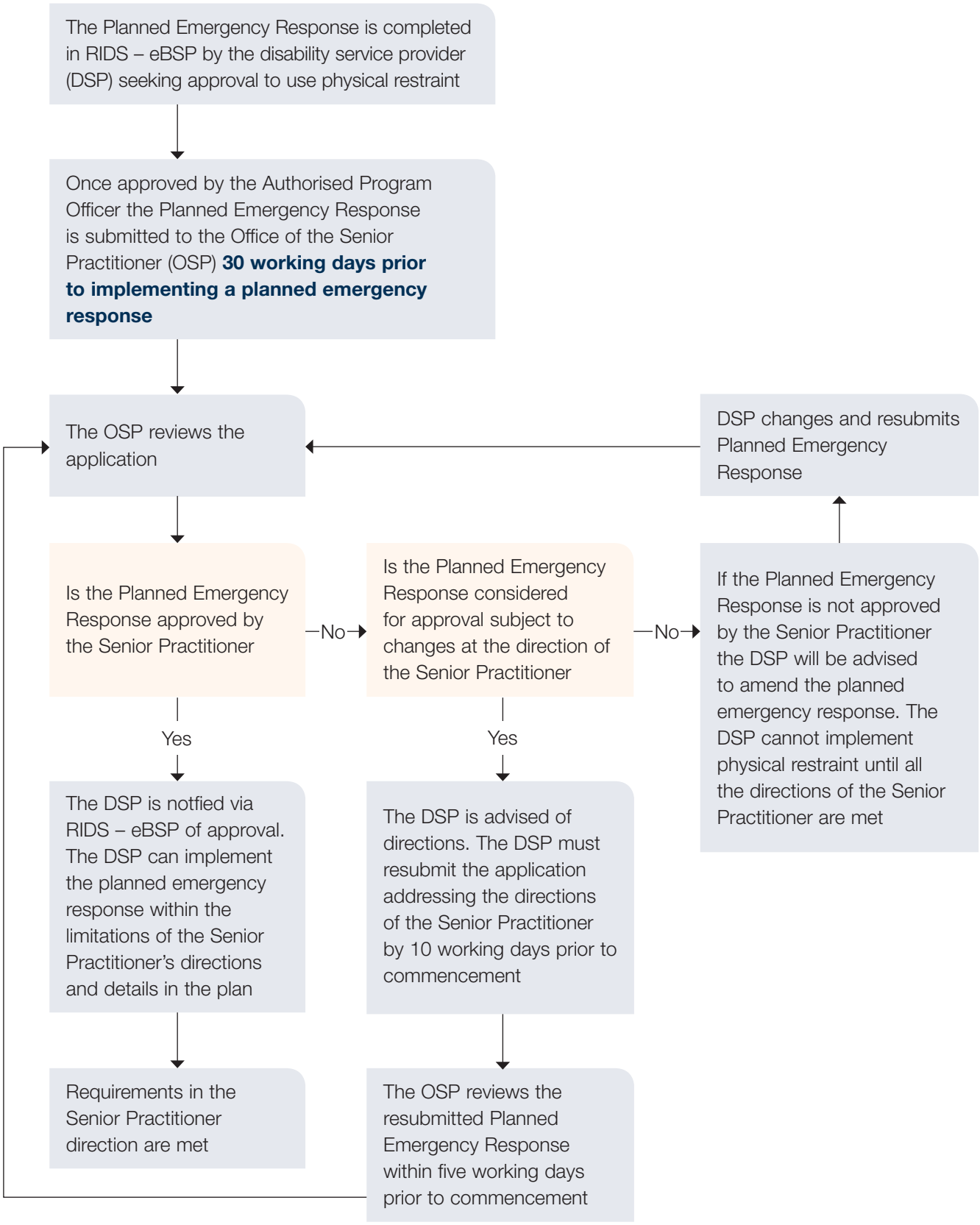
The role of senior management following the use of physical restraint on a person

In addition to departmental or local organisational policy and procedures, and the reporting requirements set out in this direction, disability service providers may wish to consider the following good practice:

1. Provide regular training updates on the safe application of physical restraint where it has been identified for use as a planned response in an emergency. Training should include current first aid competency, positive behaviour support strategies and standard defusing or de-escalation techniques when a person is showing behaviours of concern.
2. Ensure that the person who has been physically restrained is safe and supported, and has had a medical or allied health review where indicated (for example, the person might have had a nosebleed during the administration of emergency physical restraint, or the person complains of pain after the administration of emergency physical restraint that might indicate bone fractures or muscle pain).
3. Establish a restraint review committee to provide:
   - debriefing to disability support professionals involved in the development and application of the use of physical restraint, and use the debriefing as a reflective learning opportunity to find alternative and positive options
   - a review of each application of physical restraint to ascertain whether its use was warranted or not
   - assurance that legislative requirements are met
   - a strategic plan to work towards eliminating physical restraint use on a person
   - a report on the findings of the Restraint Review Committee to the senior management and Senior Practitioner (if such a committee is established).

19 Choking, or when someone is aspirating, may indicate constriction of the windpipe, or that a person may have food or fluid stuck in the throat. There may be 'gurgling', 'raspy' or bubbling type sounds or vocalisations produced by the person being physically restrained, indicating difficulty in breathing.

Attachment 4: Process for application/ approval of a 'physical restraint – planned emergency response'



Physical restraint – planned emergency response

Note: Behaviours that are known or can be predicted to occur in a potentially known situation, and where physical restraint is considered as a last resort, and a planned response to be used in an emergency situation only, must be documented as a physical restraint – planned emergency response. Physical restraint is not to be used as part of a person's routine behaviour support.

A 'physical restraint – planned emergency response' for the person must be developed and submitted for approval on RIDS eBSP

1. In developing a physical restraint – planned emergency response, disability service providers must consider all aspects outlined in *Attachment 3: Checklist on the use of physical restraints in an emergency and as a planned response* which are included in RIDS eBSP and document relevant information within the plan including:

   - ❒ the specific risks associated with using physical restraint
   - ❒ a checklist on contraindications of physical restraints related to health
   - ❒ a checklist for other contextual and environmental factors that may be contraindications of physical restraints
   - ❒ consideration of the factors outlined in Attachment 3 prior to using physical restraints as a planned emergency response
   - ❒ stopping the physical restraint immediately if the person with a disability show signs of any of the conditions outlined in Attachment 3.

2. The physical restraint – planned emergency response must provide details of:

   - ❒ the behaviour(s) of concern that is necessitating this application
     (Describe each in detail, including the impact of the behaviour of concern on the person and others, the predictors for the behaviour(s) and the frequency, intensity and duration of the behaviour(s) and why physical restraint is viewed as an intervention necessary in an emergency situation)
   - ❒ evidence that a comprehensive review or assessment and analysis have been conducted to determine whether a behaviour(s) or an incident is foreseeable and the behaviour(s) or incident is likely to re-occur
   - ❒ how often physical restraint has been used with this person during the last year
     (include the number of episodes, the location of each episode and the duration of each episode of physical restraint)
   - ❒ how the proposed emergency physical restraint will be applied
     (only include the process of the hands-on restraint, how exactly the person will be restrained, how many staff will be involved in the restraint and how the restraint will be concluded)

- ❒ appropriate arrangements to ensure the person's physical condition is closely observed and documented during the period of the physical restraint and for at least one hour after the application of restraint
- ❒ evidence that directions are in place to ensure that the proposed or administered physical restraint ceases immediately when the serious risk of harm to the person or to other people is no longer present
- ❒ the consultation report from the regional behaviour intervention support team (BIST), specialist services or equivalent that provides an opinion regarding the use of planned emergency physical restraint (attach a copy).

Behaviour support plan or treatment plan

Note: Physical restraint is not permitted as part of a routine support plan. Where a planned response is required, the "physical restraint – planned emergency response" must be (a) documented, (b) referred to and (c) attached as part of the treatment or behaviour support plan.

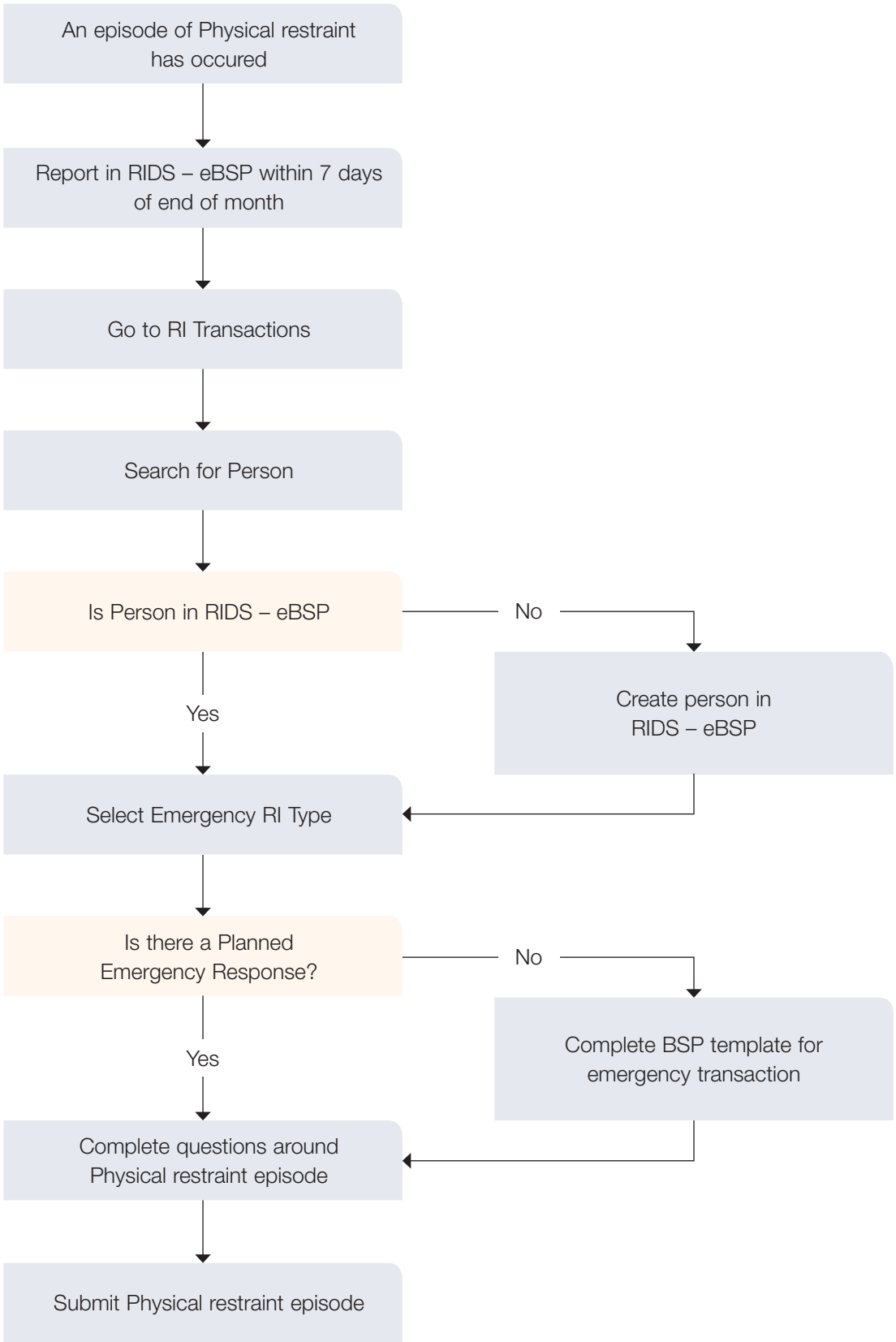
1. This application must be accompanied by:

   - ❒ a copy of the current and approved behaviour support plan or treatment plan
   - ❒ a copy of any associated assessment reports conducted in the past two years
   - ❒ a copy of any associated reviews or implementation reports completed in the past two years.

2. The behaviour support plan or treatment plan and any associated assessments and reviews must provide evidence that:

   - ❒ positive behaviour support alternatives are being trialled or implemented as alternatives to using physical restraints over a period of time, such as more than a year
   - ❒ a comprehensive treatment/behaviour support plan has been implemented and evaluated overtime, such as more than a year
   - ❒ implementation of the treatment/behaviour support plan and analysis of the plan yielded no significant gains or outcomes for the person
   - ❒ other less restrictive options in the circumstances are considered and outlined in the person's treatment/behaviour support plan.

Attachment 5: Process for entering a Physical restraint episode in RIDS – eBSP



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State Government Victoria
Department of Human Services