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Restrictive

Intervention

Guidelines

Guidance on strategies used during

situations of risk to best support an individual

June 2020



# 1. Restrictive Intervention Guidelines

There are ongoing, potential risks, around restrictive practice, in ensuring that residents and staff within Services are supported within a positive culture and learn from experience. Health and Social Care often work together in Lancashire when undertaking safeguarding, quality assurance and contract monitoring within Care Homes. These guidelines are intended to provide support to health and social care settings when restrictive intervention is being used. This guidance should be read and used in conjunction with the LSAB Positive Behaviour Support guidelines document.

It is acknowledged that there may be occasions when more restrictive practices are required to protect the individual and those around them. These guidelines are intended to provide support to health and social care settings when restrictive interventions are being used and good practice guidance around such interventions.

**Purpose of Restrictive Intervention**

Restrictive interventions are strategies used in response to situations of risk and during situations to best support an individual to lead a fulfilled and meaningful life. They involve managing a challenging situation in order to minimise the immediate risk. These strategies are person centred and are used to manage an immediate risk and keep everyone safe. They do not aim to control the behaviour or deliver long term and lasting behavioural change.

Restrictive practice can include a range on interventions. These can range from environmental measures up to physical interventions. The following identifies the types of interventions used in care settings (Not an exhaustive list).

**Environmental**:

* 24 hour support/observations/1:1
* Key pad access
* Access to space
* Locked doors/drawers/medication cabinets
* Seclusion
* Segregation
* Assistive technology
* Non inclusive environments (access)

**Mechanical**:

* Bed rails
* Lap straps
* Arm cuffs/splints to reduce self-injury
* Grab belts
* Harnesses in vehicles
* Use of mittens

**Pharmaceutical**:

* Regular sedative medication
* PRN sedative medication
* Rapid tranquilisation (N.B this practice tends to be used in clinical settings and under very specific guidelines. NICE Guidance on the use of rapid tranquilisation can be found [here](https://www.nice.org.uk/guidance/NG10))
* Covert medication (LSAB guidance can be found [here](http://www.lancashiresafeguarding.org.uk/media/39265/LSAB-Covert-Medication-Guidance-FINAL-Feb-18-.pdf))

Any form of pharmaceutical intervention must be agreed within a multi-disciplinary meeting with minimum membership of GP, provider and pharmacist

**Physical**:

* Proactive working practices i.e. Manual guidance/assistance and ensuring staff are prepared for potential situations.
* Keeping safe techniques i.e. breakaway techniques.
* Person specific interventions i.e. Hair pull release.
* Restrictive person specific i.e. anything that would restrict the individual’s freedom of movement, such as 2 person escorts.
* Removal of mobility aids

Whilst it is recognised that de-escalation techniques and positive behavioural support is used throughout any intervention, when restrictive intervention is used, services must ensure that the techniques and methods used to restrict a service user:

* Are proportionate to the risk and potential seriousness of harm it is intended to prevent.
* Are the least restrictive option to meet the need. The level of force utilised matched the severity of the circumstances. (The more restrictive the intervention the more it will need to be justified that it was in the individual’s best interest).
* Are a last resort. It will need to be evidenced that there was no other way, in the circumstances to meet the need regarding ‘Duty of Care’.
* Are used for no longer than necessary and take account of the service user's preferences.It will need to be demonstrated that a less restrictive approach was utilised as soon as practicable.
* If known and it is possible to do so take account of the service user's physical health, degree of frailty and developmental age.This should be informed by the GP and multi-disciplinary team and be reflective of any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used.

[NICE violence and aggression](http://pathways.nice.org.uk/pathways/violence-and-aggression)

[NICE Learning Disabilities and behaviours that challenges services, design and delivery](https://www.nice.org.uk/guidance/ng93/resources/learning-disabilities-and-behaviour-that-challenges-service-design-and-delivery-pdf-1837753480645)

It is important to remember that many of the people who come to be in a position where they are restrained may already have a history of trauma and this experience can be re-traumatising. Sensitivity to this is crucial as, if not recognised, the situation could quickly escalate.

It is vital that aftercare arrangements are developed and implemented to maximise recovery and minimise any potential traumatising effects of any restraint.

Following the use of any restrictive intervention staff members must continue to monitor the individual for signs of emotional or physical distress for a significant period of time following the application of restraint. After the application of a restrictive practice the staff team should monitor the individual for a 24 hour period and ensure this is documented. For any physical interventions that may restrict the breathing mechanism such as a Two Person Escort it is advised that this monitoring period is increased to 48 hours. This timeframe should be discussed with the individual's GP, who should be part of the multidisciplinary team.

This is due to the higher risk of Positional Asphyxia. Positional Asphyxia can occur when the position of the human body interferes with respiration (breathing), resulting in suffocation. Restraint Related Positional Asphyxia occurs when an individual is placed in a position that prevents or impedes their breathing and they cannot escape their position. Unconsciousness or death can occur rapidly. If an individual shows signs of discomfort or distress Staff members should immediately cease the intervention.

**Case Study**

*Ethel is 82 years old and has a diagnosis of vascular dementia. She resides at Bluebird Lodge Care Home. Staff report she has been more confused in recent weeks, continually wanting to leave the care home, becoming physically and verbally abusive towards staff and residents. Recent blood tests returned normal and she has been screened for a UTI with no infection present. A referral has been made to mental health services for additional support given the changes to behaviour. A key pad is attached to all external doors to prevent Ethel from leaving the care home. She is observed during all waking hours by staff and by the use of assistive technology to track movements during the night. Ethel is prescribed regular sedative medication which is taken each evening to support a consistent sleep pattern. At times when Ethel is agitated, she is manually guided to her bedroom where staff attempt to engage her in specific activities whilst keeping other residents safe from harm. Ethel is therefore subject to environmental, pharmaceutical and physical interventions that would be described as restrictive practice.*

**Legal Requirements**

The Mental Capacity Act (2005) and its Code of Practice set out the most important legal information on restraint. The Mental Capacity Act's Code of Practice (2015) states when it might be necessary to use restraint as:

'Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.' s6.44

On a practical level the legal requirements that need to be satisfied prior to any restrictive physical intervention are:

* Capacity tests (for a specific decision relating to restraint) need to be completed by a competent and experienced individual, along with any other relevant professionals or people who know the service user well. In these capacity tests you would need to consider the following:
	+ Assume capacity. You would need to assess this by seeing if the individual can understand the decision to be made, can retain that information, can weigh up the information to formulate a decision and finally communicate the decision either verbally, via symbols, signs, or other means.
	+ That the individual has been given every opportunity, including all practicable help to understand the decision. This means that using the preferred method of communication and others if possible at different times of the day, different days of the week, presented by different people.
	+ That individuals are aware of their right to make unwise decisions.
	+ Any decision made has to be in the persons’ best interests.
	+ That the intervention is the least restrictive option and for the shortest time possible. This should form part of any Positive Behavioral Support Plan.

Once you have ascertained that the individual lacks capacity to consent to some or all of the restrictive practices, a best interest decision will need to be made in relation to each relevant restrictive practice. A best interests meeting may be convened to carry out this process (but is not essential so long as interested parties are consulted). A Best Interests meeting or consultation should include all relevant professionals (MDT) advocates, family and people who know the individual best. Wherever possible you should invite and support the individual to participate in the meeting/discussion. If they are unable to participate, try to obtain any wishes views or preferences of the person themselves.

At the meeting/discussion you should talk through the capacity assessments that you have completed so everyone is clear around these determinations. For each restrictive practice, options and alternatives should be gathered and explored so that the MDT can be satisfied that each is necessary and proportionate to the risk of harm to the person. This is done by discussing the benefits and burdens of all options. Each person involved should be able to contribute their view and no decision should be ratified without full agreement of all involved. The decision maker is responsible for the overall decisions, however, if there is a disagreement or objection (including from the person themselves) on a best interests determination that cannot be resolved, this will need to be referred to the Court of Protection. Finally the decision and supporting evidence should be documented and kept as evidence at site.

Where restrictive practices are in place or being proposed, you will need to consider whether these either collectively or individually, amount to a DOL. (**Reminder of Cheshire West)**. (A restriction in and of itself may not constitute a DOL).

A DoL will require appropriate authorisation through either DoLS, COPDOL or Welfare application dependent on the setting. It should also be noted that even where there is an LPA or Deputy (Personal welfare) they do not have scope of authority to authorise care arrangements which amount to a DoL, and these will still need appropriate legal authority.

For DoL’s, the provider must submit the correct documentation and evidence to csc.acscustomerservices@lancashire.gov.uk, which is the local DoLS team for individuals residing in Lancashire. A court of protection should be referred to the Responsible Body[[1]](#footnote-1)

The authorisation process then involves a number of professionals visiting, assessing and interviewing the person who is being deprived of liberty. These will include a doctor to make sure that the person has a diagnosis which allows one of the processes to be used (this means that they have what is described as a mental disorder). Another professional is called a ‘Best Interests Assessor’ (BIA) and they establish whether a DoL is occurring. If so, they will assess if it is in their best interests and that care and/or treatment cannot be done in a less restrictive way that is proportionate to the likelihood and seriousness of harm. Further to this, they will assess the arrangements for their care prevents them from coming to any harm. A BIA, Mental Health assessor, nurse assessor or GP will complete the assessment of capacity regarding the decision of where care and treatment takes place. From there a decision will be made whether to grant the appropriate authorisation either by the Local Authority (DoLs) or the Court of Protection (CoPDoL or Welfare Order). This can be done for a maximum of 12 months but may be less depending on the decision being made. Conditions may also be set out in the authorisation that the provider needs to adhere to.

In July 2018 the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS and COPDoLS) with a scheme known as the Liberty Protection Safeguards (LPS). The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation. The new standards mean that one scheme will apply in all settings (e.g. care homes, hospitals, supported living, people's own homes etc.) and will be available to anyone over the age of 16. The role of "Supervisory Body", which authorizes deprivations of liberty, will be abolished. It will be replaced by the "Responsible Body". There will be different Responsible Bodies in different settings. For some cases the Responsible Body will be the NHS Trust; in other cases the role will be filled by the Clinical Commissioning Group (or Local Health Board in Wales); and in other cases still it will be the local authority. There will only be 3 assessments:

The "Capacity" assessment, the "Medical" assessment and the "Necessary and Proportionate" assessment.

Documentation / information that the provider will need to hold are:

* Audit of need detailing prescribed interventions bespoke to each individual.
* Adequate Restrictive Physical Intervention model training that complies with Restraint Reduction Network training standards.
* Evidence of Physical assessment of all attending staff members booked on the physical intervention training.
* Evidence of Theory assessment of all attending training to ensure attending staff members have a clear understanding of the purpose and responsibilities relating to physical intervention.
* Certificates of completion to be accessed by local authorities, CCG’s and CQC.
* Training calendar or training matrix to ensure that all relevant staff are trained and have annual refreshers.
* Course feedback detailing the effectiveness of the training and understanding of the staff that have been trained.
* Evidence of that a high percentage of staff have completed first aid training.
* Evidence that all staff have completed relevant Safeguarding training.
* Copies of the Mental Capacity Assessments and Best Interest Decision for each restrictive practice being implemented (this must be reflected in the DoLS).
* Evidence of proactive and active working practices to best support the individual and reduce the need of restrictive practices being utilised.
* Evidence of incident analysis detailing slow triggers, fast triggers and outcomes, any potential common themes and these must be considered when updating or creating care and support plans and risk assessments. There must also be evidence that this is shared with the wider staff team.
* Evidence that all incidents are shared with all relevant parties i.e. MDT.
* Restrictive practice reduction plan for each individual to evidence that the provider is regularly reviewing restrictions with the aim to utilize less restrictive options.

When developing the laws and regulations regarding physical intervention there was a requirement to reference other legislation, including the Human Rights Act 1998, Care Act 2014 etc. It would be best practice to keep abreast of current law and changes in legislation to ensure that providers remain compliant in these areas.

**Case Study**

*George is 24 years old and has a diagnosis of Autism, learning difficulties and communication difficulties. He resides at Deer’s Leap Specialist Residential Home. George has a very limited ability to communicate verbally and uses PECS (Picture Exchange Communication Systems) to express his needs and wishes. George moved into his new home four months ago and has recently begun to present a variety of behaviours including self-injurious behaviours and behaviours towards others that some may consider “challenging”. There have been several incidents where George and staff members have been injured as a result of this. The following steps were taken as a result of this:*

1. *Full review and analysis of incidents to highlight any common themes and these findings shared with his MDT.*
2. *The service requested input from a PBS Practitioner to aid in the formulation of Proactive, Active and Reactive strategies.*
3. *Risk assessment and care plan updated and reviewed reflecting the current and potential risks.*
4. *MDT (Multi-Disciplinary Team) are contacted to discuss the change in presentation regarding George.*
5. *Mental capacity assessment completed by the service to ascertain if George has the ability to understand and retain the information given to him, retain that information long enough to be able to make the decision, weigh up the information available to make the decision, communicate his decision. The team at the service used staff that George appeared to like the most, at various times of the day and over a period of several days to ask George how he would like to be supported during times of increased anxiety. The staff team utilised a variety of communication methods such as spoken word supported by George’s favored means of communication (PECS), Talking Matts and simple yes/no cards.*
6. *Unfortunately, after completing the assessment it was felt that George was unable to understand the information being conveyed. This was shared with the MDT and a meeting with them was scheduled to discuss what action should be taken in George’s best interest to reduce the risk of harm to George and others.*
7. *During the Best interest meeting discussions were held and documented detailing what options were available, the benefits and burdens of each option and which option would be utilised that would be least restrictive in nature. The decision was made that keeping safe techniques/break away techniques should be utilised and a restrictive person specific intervention in the form of two-person arm support to reduce the possibility of George harming himself when engaging in self-injurious behaviors. This was then agreed by all present and documented within the best interest assessment form.*
8. *An amendment to George’s current DoLS authorization was requested and once the team had visited site and met with George this further authorisation was granted subject to review.*
9. *The staff team supporting George then completed appropriate training from a BILD accredited and approved training provided that complied with the Restraint Reduction Network Training Standards.*
10. *After 8 months it then became apparent that the Proactive and Active strategies that were implemented appear to have been successful. The service relayed this to the MDT and the decision was then made to contact the DoLS team and reduce some of the restriction that had been previously implemented.*

**Training**

Before any physical intervention techniques are used, staff must receive adequate training on positive behaviour support and approaches. Any training model that is utilised within services must comply with the Restrain Reduction Network Training Standards 2019. These Standards will be mandatory for all training with a restrictive intervention component that is being delivered. For each type of intervention being used, a tailored package of training needs to be provided: which is prescribed for each individual. Staff will need to be assessed as being competent in each intervention being used. The Restriction Reduction Standards state after initial training, staff must attend an annual refresher for the next three years. The following year would require a full course of training being completed. A copy of the restriction reduction standards can be [downloaded here](http://restraintreductionnetwork.org/know-the-standard-2/) these will become mandatory in 2020

All staff need to be trained and competent in the application of mental capacity assessment and best interests.

**Risk Assessments**

Each person must have an individual risk assessment for the use of each restrictive practice being used and there should be evidence of Multi-agency involvement and sign off.

**Case Study**

*Alex is 38 years old and has a diagnosis of Learning Disability and Autism. Alex lives in 24 hour supported accommodation and was admitted via the emergency department to the acute medical assessment unit at City Hospital, with a perished gastrostomy tube. Alex was accompanied with 2 support carers, who report that a previous change of PEG tube was poorly managed and caused Alex great distress.*

*Following a 2 stage capacity assessment it was determined that Alex lacked capacity to consent for the replacement of his PEG tube, it was therefore deemed in his best interest to proceed with a gastroscopy and tube change under general anaesthetic. A DoLS application was completed.*

*Co-ordination commenced with the Gastro consultant, safeguarding team, emergency theatres, anaesthetics, theatre staff, security and support carers. A meeting was held to discuss reasonable adjustments for Alex and to develop a care plan to support this procedure.*

*Alex was placed first on the list the next morning, carers were orientated around the hospital to ascertain best route to accompany Alex to theatre and the theatre room was also adjusted following risk assessments.*

*Alex required a Safe hold in order to insert a cannula as detailed within the care plan.*

*Post procedure Alex was able to remain in theatre recovery for a period of observation with his carers and was discharged later that day.*

**Review**

Where PI is in place there is an expectation this is reviewed on a monthly basis and this review should contain the following:

* Number of incidents requiring PI and a breakdown of techniques used (e.g. breakaways, guided support, seated restraint).
* Number of incidents not requiring PI (possibly evidencing benefits of positive support plans in place).
* Brief thematic analysis of incidents requiring PI and those not requiring PI (what can be learnt from this to inform the person’s PBS plan going forward).
* Incident analysis of the perceived functions of the behaviour- for known functions focus should be on how these situations/ triggers can be managed better if possible (or highlight the residual risk of factors that it is not possible to control); where the function is not known this should be a prompt to review the service users’ functional assessment.

It would also be useful that other care plans for the service user are reviewed so that assurance can be given so that the foundations of good support are in place for the person. Documents that it would be beneficial to review would be as follows:

* Service user care and support plans.
* Risk assessments.
* Health action plans.
* Person centred plans.
* Communication passport/ care plans.

**Debrief**

Review of incidents etc.

All uses of restricted intervention should be recorded within a 24hour period and reviewed by the services management team. During this process it should provide the management team the opportunity to undertake the following:

* Ensure appropriate action was taken immediately after the event i.e. contacting GP, 111 service, police etc.
* Quality check the report, inform relevant individuals and key stakeholders etc.
* Make the relevant referrals and notifications if required i.e. safeguarding, CQC etc.
* Triage reports based on priority and risk.
* Facilitate debriefs with staff members and service users if required.
* Ascertain if any further action is required such as, review of risk assessments and support plans, if a strategy meeting is required etc.

As described above in the review section, review and analysis of incidents should take place on a monthly basis as well as after a significant event. This analysis should take into account a wide variety of aspects such as activities and scheduling, what went well and what didn’t go well, functional assessment to try to understand what purpose the behaviour served for the individual, skill building (supporting the individual to have this purpose met without the need to present behaviours that some may deem as challenging) and analyse of near misses as well as possible areas of de-escalation and best practice that can be shared with the wider team.

Functional assessment should take the form of the examination of antecedents (slow triggers and fast triggers). Slow triggers are the events which sensitise an individual to his/her environment. Fast triggers are the events that immediately precede the presentation of behaviours. It should also analysis any consequences following the behaviour. Once this data is gathered staff teams will then be able to identify any common themes and implement strategies regarding how best to support the individual to have this need met without the need to present behaviours that may be perceived as challenging.

Whilst the use of any kind of restrictive intervention may occasionally be necessary to keep people safe in certain situations, it is also traumatic for those involved. As such a fully embedded debrief process is vital to ensure support is provided for all involved where possible:

* Debriefing should take place as soon as possible after an incident has occurred.
* Debriefing should not be forced upon the individual and/or staff member and should be led by the person to be debriefed.
* It should allow ventilation of feelings in a controlled, safe environment and should offer the opportunity for staff to express themselves without fear of reprisal or accusations of unprofessional behaviour.
* It is vital that where possible accessible debriefs are utilised to meet the individual communication needs for service users and if required staff members.

Debriefs should also provide an opportunity to reflect in the practices and interventions being used as well as the opportunity for further functional analysis and the identification of precursor behaviours signifying an escalation in presentation.

## Appendix 1 - Mental Capacity Assessment Template

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| **Name** |  |
| **Date of Birth** |  |
| **Person completing the assessment** |  |
| **Role** |  |
| **Date of completion** |  |

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| **What prompted this capacity assessment? (I.e. summary of relevant history)** |
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| **What is the specific decision to be taken?** |
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| **Is there a Lasting Power of Attorney (LPA) Health and Welfare / financial, Enduring Power of Attorney (EPA), Court Appointed Deputy (CPD), Advocate (IMCA, IMHA)?** |
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**Determination of Capacity**

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| **Is there an impairment of or disturbance in the functioning of the person's mind or brain (diagnostic test i.e. dementia, learning disability, stroke etc.)?** |
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| **What reasonable steps were taken to maximise the person's capacity to make the decision?** |
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**Functional Assessment**

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| **Understanding** |
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| **Retention** |
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| **Balancing/weighing up** |
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| **Communication** |
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| **Can the decision be delayed because the person is likely to regain capacity in the near future?** |
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| **Views of interested others** *(e.g. family, friends, carers, LPA, IMCA, CPD etc. give names and roles. If no-one justify)* |
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| **Views of professionals involved** |
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| **Outcome of assessment** |
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## Appendix 2 - Best Interests checklist & Balance Chart Template

Decision Maker:

The named decision maker should consider all relevant circumstances of which he/she is aware, and which it is reasonable to regard as relevant in making the decision on behalf of a person who lacks capacity. This should include medical, social, welfare, emotional and ethical matters. Under no circumstances must a best interest decision be made by the desire to bring about a person’s death.

Decision to be made:

How the decision is phrased here becomes important in helping to maintain a focus on the decision to be made and the extent of the boundaries of the best interests’ process (should be the same wording as decision on the capacity assessment).

Attendees/ Consulted parties:

What are the views of family, friends, anyone engaged in caring for the person, anyone interested in the person’s welfare, anyone named by the person to be consulted? Please give details of each person consulted and their views. Identify and maintain a copy of any additional information given

**Assessment**

1.Has the person been permitted and encouraged to participate as fully as possible in the decision making process?

E.g. by simplifying information, using pictorial aids, having trusted family/friends involved to assist with communication. Please state what has been done to aid participation

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2Have you considered the person’s past and present wishes, feelings, beliefs and values that would have been likely to influence his/her decision if he/she had capacity?

Include any relevant written statements made when competent or any religious, cultural, moral and political beliefs and values. Please state any that are relevant to the decision to be made:

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3 Have you identified the relevant circumstances that he/she would take into account if they were making the decision themselves? List these below:

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Options available are:

1.

2.

3.

|  |  |
| --- | --- |
| **Benefits of**  | **Burdens of**  |
|  |  |
| **Benefits of**  | **Burdens of**   |
|  |  |

Weighting Tool Key

Options agreed to be in best interests of NAME are**:**

Magnetic Significance \*\*\*

Highly Significant \*\*

Significant \*

## Appendix 3 - Post Physical Intervention Monitoring Record

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| Post Physical Intervention Monitoring Record |
| **Service User Name** |  | **Date of Birth** |  |
| Are there any additional risk factors associated with this person? *e.g. brittle bones, diabetes, heart disease, alcohol abuse, drug abuse, asthma, etc. (seek additional medical advice)* |  |
| **Date of the Intervention** |  | **Approximate duration of the intervention** |  | **Approximate duration of the intervention** |  |
| **What Physical Intervention was used?** |  | **Was it a planned or unplanned response?** |  |
| **Guide to Monitoring Intervals:**0-12 hours following the intervention: Monitoring intervals will be 15 minutes between each observation12-24 hours following the intervention: Monitoring intervals will be 30 minutes between each observationAfter 24 hours – Observations will be hourlyAfter 36 -48 hours – Observations will be two-hourlyNB: The times given may vary according to the individual’s risk assessment and the answers you give in the first part of this form. | **KEY:****BC** = Behaviour change (Describe in comments box)**A** = Alert**N** = Non-Responsive**BFS** = Breathing fast and shallow**NB** = Noisy Breathing**L** = Lethargy |
| **Time****(24 hr)** | **Observation (use key)** | **Activity/Comments****What are they doing? What is the Schedule?** | **Initials** |
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| **Signature of Site/Service Manager on completion of period of observation** |  |

## Appendix 4 - PINCH ME (Checklist for delirium symptoms)

Pain

Infection

Nutrition

Constipation

Hydration (Dehydration)

Medication

Environment, e.g. changes to environment causing disorientation

Also watch out for sensory impairment, sleep disturbance and immobility.

Another common cause is withdrawal – (e.g. from alcohol, or from prescribed drugs if stopped too quickly)

1. The Responsible Body is the funding organisation responsible for the care package [↑](#footnote-ref-1)