

Management of Physical Intervention (Restraint) for Adults in an Acute Hospital Setting Policy

Issue Date	Review Date	Version
June 2019	June 2022	4

Purpose

To offer a framework for University Hospitals Plymouth NHS Trust (UHPNT) staff with regard to the use of non-physical and physical interventions on adult patients.

Who should read this document?

All clinical staff working in adult services should read this document, which provides information and guidance on the use of physical intervention for adult patients in UHPNT Derriford Hospital.

Key Messages

This policy will direct the clinical team in the appropriate, legal and safe management of the patient presenting challenging behaviours when other alternative de-escalation interventions have been exhausted. It involves clinical risk assessment and decision-making tools for the use of physical interventions (restraint).

The policy provides guidance on the use of the Mental Capacity Act – including use and application of Deprivation of Liberty Safeguards (DoLS), and the legal framework around the use of physical interventions.

Core accountabilities

Owner	UHPNT Physical Interventions Training Lead Named Nurse Adult Safeguarding
Review	Safeguarding Steering Group
Ratification	Director of Nursing
Dissemination (Raising Awareness)	UHPNT Physical Interventions Training Lead Named Nurse Adult Safeguarding
Compliance	Named Nurse Adult Safeguarding

Links to other policies and procedures

UHPNT Policy for the consent to examination or Treatment
UHPNT Procedure 22b Guidance on the use of bedrails
UHPNT Policy and Procedure for individuals who are violent or aggressive
UHPNT Prevention of violence policy to staff at work
UHPNT Violence and aggression in the workplace
UHPNT Planning to prevent slips, trips and falls
UHPNT Alcohol Withdrawal Guideline
UHPNT Mental Capacity Act Policy 2005
UHPNT Process for application for DoLS
UHPNT Safeguarding Vulnerable Adults Policy
UHPNT Child Protection Policy/Supervision Policy
UHPNT Plymouth Hospitals NHS Trust (UHPNT) Paediatric Physical Intervention Policy
UHPNT Incident Management Policy
UHPNT Uniform and Dress Code Policy
UHPNT Workforce SOP for Staff with Health Restrictions
UHPNT Decontamination Guidelines & Procedures
UHPNT Moving & Handling People and objects
UHPNT Assessment of Capacity Checklist
UHPNT Record of Supportive Holding /Physical Intervention Document, Children & Young People
UHPNT Risk Assessment for Planned Restrictive Physical Intervention for Children & Young People
UHPNT Flowchart Guide to Decision Making Before Using Planned Physical Restrictive Intervention on a Child or Young Person
UHPNT Request to Self-Discharge Against Medical Advice-Adults and Young Person
UHPNT Procedure 22b Guidance on the use of bedrails
UHPNT Debriefing Patients & Family/Carers of Children & Young People Document
UHPNT Debriefing staff involved in a Physical Intervention Incident Document Children & Young People

Version History

1.1	07/12/2009	Approved by Clinical Governance Steering Group
2	11/04/2013	Approved by Safeguarding Committee
2.1	02/02/2016	Amended and approved in response to NHS England Patient Safety Alert
3	2016	Approved by Safeguarding Steering Group
4	July 2019	Updated & consultation

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

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1.0 Introduction

- 1.1 UHPNT is committed to ensuring the safety of patients, staff, carers and visitors. There may be occasions when it is lawful and necessary for UHPNT employees, to use physical intervention skills to protect themselves and others from imminent danger, should patients or visitors present with challenging behaviours that threaten the safety of themselves and others. It is essential that employees are aware of the legal framework and national guidelines with regard to the use of such interventions.
- 1.2 Restraint intervention should only be used to prevent harm from happening and in line with Department of Health (DOH) Guidelines 2014 be used for the least amount of time and the least amount of force possible to render a situation safe. Restraint intervention should only be used by staff who have attended and been deemed competent in physical interventions training. Staff must ensure that they keep their training up to date to ensure that they are competent.

2.0 Purpose

- 2.1 The Trust is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care. Patients can develop or present with some form of challenging behaviour which may endanger their own safety or the safety of others if not effectively managed. When using restraint interventions, a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining dignity, personal freedom and choice.
- 2.2 This document provides information and guidance on the use of restraint intervention for adult patients in UHPNT; Providing direction to the health care professional in the management of the challenging patient when other alternative de-escalation interventions have been exhausted.
- 2.3 Emphasises the recognition, prevention and de-escalation strategies as being the first line in the management of challenging behaviours.
- 2.4 Exclusions to this policy include the routine use of sedation within anaesthetics and critical care – local Standard Operating Procedures may apply to specific clinical areas.
- 2.5 **Restraint intervention should only be used as a last resort and only when alternative methods of non-restrictive physical intervention and behaviour management have failed.**
- 2.6 Ensures staff are aware of and working within the legal framework for the use of physical interventions, and by accessing UHPNT physical interventions training minimises the risk of legal challenge, by ensuring that Trust approved techniques are taught to reduce risk of patient and staff injury.

2.7 This policy does not apply to those under the age of 18. Please see UHPNT Paediatric Physical Intervention Policy.

Aims and Objectives

2.8

- To inform the Healthcare Professional of the legal and ethical issues related to physical and pharmacological/chemical restraint.
- To emphasise that only once the causes of agitation have been addressed where possible and all the relevant parties present are in agreement, should restraint intervention be adopted for planned restraint intervention.
- To de-brief the patient/ or close family members/patient representative post restraint at the earliest opportunity.
- To ensure staff are offered a de-brief by their line manager after being involved in a restraint episode or following on from an incident of violence and aggression at the earliest practicable opportunity.
- To ensure that the use of restraint is regularly reviewed so that the most appropriate restraint intervention necessary is used.
- To ensure monitoring of vital signs are undertaken, regularly reviewed and clearly documented. Frequency will need to be responsive to the therapy or intervention required (e.g. increased observation during and after physical restraint (National Patient Safety Alert 2015)).
- To ensure that all decision making processes are clearly documented and in medical/nursing notes including the Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention tool (Appendix C) which is to be reviewed eight hourly.
- To ensure that all staff receive appropriate training in the use of physical interventions, self-protection and restraint (if identified as requiring it, i.e. by working in a high risk area where these skills are likely to be required). To ensure that training is regularly updated to enable practitioners to retain skills, competence, knowledge and confidence in using physical interventions.
- To ensure that the process of restraint intervention is appropriate, safe and dignified and in line with that person's human rights.

3.0 Definitions

Best Interest

Any decisions made, or anything done for a person who lacks capacity to make specific decisions must be undertaken in that persons best interests. The consideration of best interests is set out in section 4 of the Mental Capacity Act 2005.

Breakaway

Is a physical technique used by an individual to limit injury and/or to breakaway from someone who is attempting to physically assault them. They do not involve the use of restraint.

Challenging Behaviour

Reducing Distress NHS Protect (2014) indicates that its definition of clinically related challenging behaviour is "any non-verbal, verbal or physical behaviour by a person which makes it difficult to deliver good care safely", to perform clinical tasks and/or poses a safety risk. It can describe actions, but can also include non-compliance, particularly if staff need to intervene to deliver treatment or care. Behaviour can also be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and / or the physical safety of the individual or others" (Royal College of Psychiatrists and others – A Unified Approach, 2007).

Consent

Consent is the legal means by which a person gives a valid, informed and voluntary authorisation, including a care plan or treatment. For consent to be legally valid: (i) the consent must be given by someone at a time when they were deemed to have capacity, (ii) sufficient information must be given to the person so that an informed decision can be made, including the options, benefits and associated risks. There is also a legal duty to ensure the patient is aware of the material risk involved in the recommended treatment or action and of any reasonable alternative or variant. (iii) The consent must be freely given without duress, undue influence, inappropriate pressure, coercion or bullying.

Containment

Is the action of keeping something harmful under control (English Oxford Dictionary). This is the physical restraint which prevents the patient leaving, harming themselves (or others), or causing serious damage to property (Royal College of Nursing 2003).

Deprivation of Liberty & Deprivation of Liberty Safeguards (DoLS)

Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away.

Deprivation of Liberty Safeguards (DOLs) is the framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent themselves.

Independent Mental Capacity Advocate (IMCA)

This is an individual who supports and represents a patient who lacks capacity to make a specific decision, where that person has no one else (other than a paid professional) who can support them. They make sure that major decisions for a patient who lacks capacity are made in accordance with the Mental Capacity Act 2005.

Least Forceful Aversive Intervention

Is the physical intervention with the least force and least potential to injure a patient.

Mechanical Restraint

Mechanical restraint is a form of restrictive intervention which involves the use of a device or equipment (for example 'Posey Control Mitts' to prevent, restrict or subdue movement of a person's body or part of the body).

Non-Restrictive Physical Intervention

This allows a greater degree of freedom where the individual can move away from the physical intervention if they wish to do so. This would include prompting and guiding a patient to assist them walking, also defensive interventions such as disengagement for protecting oneself or others from assault.

Rapid Tranquilisation

Is defined as the administration of sedative medication by injection (NICE Guidelines 2015 (Violence and aggression: short-term management in mental health, health and community settings (NG10)).

Restraint

The use or threat of force to help undertake an act which the person resists, or the restriction of the person's freedom of movement, whether or not they resist. Restraint may only be used where it is reasonably believed that it is **necessary** to protect the person from **harm** and is **proportionate** to the likelihood of that person suffering harm and the seriousness of that harm, or where it is believed to be necessary to prevent harm from happening to others.

Restraint Intervention

Defined in the Positive & Proactive Care (DoH 2014) guidance as: 'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary'.

The use of force to limit the movement and freedom of an individual can involve bodily contact, mechanical devices, chemical restraint (e.g. the use of medication to alter or change a persons' behaviour), or changes to a person's environment. Such interventions can be:

- Highly Restrictive – i.e. severely limit the movement and freedom of an individual

- Low Level Restrictive –i.e. limit or contain the movement and freedom of an individual who is less resistant with low levels of force

Pharmacological or Chemical Restraint

Pharmacological or chemical restraint is defined as: “A drug used as a restraint to control behaviour or to restrict the patient’s freedom of movement and is not standard treatment for the patients’ medical or psychological condition.” Any pharmacological or chemical drug used for restraint must be prescribed by a registered doctor who has started specialist training and administered by those who are trained and competent to do so.

Psychological Restraint

Can include the telling of someone not to do something, or a positive message to direct their actions, or depriving an individual of equipment or possessions which enable them to do what they want to do, or making a threat or indication that physical, chemical, or mechanical restraint will occur in the absence of compliance.

This may involve simple verbal directions to the patient in order to direct their behaviour and may be a positive message to direct their actions or a negative message to alert them to behaviour or action which is prohibited. Psychological restraint may also include the removal of equipment or possessions that would be required by a patient to undertake autonomous activity. For example the removal of walking aids, or glasses with the intention of reducing their freedom of movement.

Prone Position (patient lying on their stomach)

There must be no planned proning of patients in UHPNT, due to the risk of positional asphyxia. Positional/restraint asphyxia is defined as occurring when 'the position of the body interferes with respiration, resulting in asphyxia (suffocation). Positional/restraint asphyxia can occur extremely rapidly when a patient is in a position that interferes with inspiration and / or expiration and the individual cannot alter that position.

4.0 Duties

Chief Executive

4.1 The Chief Executive and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out in law, and of statutory and regulatory authorities such as the Department of Health, Commissioners and the Care Quality Commission. The Trust’s Chief Executive has overall responsibility to have processes in place to:

- Ensure that clinical staff are aware of this policy and adhere to its requirements
- Ensure that appropriate resources exist to meet the requirements of this policy

Executive and Non-Executive Directors

4.2 The Executive Directors are responsible for ensuring that all operational managers in their area are aware of this policy, understand its requirements and support its implementation.

Role of Non- executive and elected leads

4.3 The Non-Executive and elected leads are responsible for:

- Championing & maintaining focus on Mental Capacity
- Providing independent scrutiny
- Holding Executive Directors and the Board to account

Medical Directorate / Consultants

4.4 The Medical Director (delegate Mental Capacity Lead for the Trust) and Lead Consultants (Clinical Service Leads or equivalents) are responsible for ensuring legal frameworks and procedures detailed in this policy are understood and adhered to by medical staff.

4.5 Matrons, Line Managers, Team Leaders

Ensuring that all staff have access to and comply with this policy in relation to the use of appropriate physical interventions procedures to prevent self-harm, harm to others.

- Ensuring that their staff understand what physical interventions are.
- Ensuring that their staff understand the legal and ethical frameworks relevant to physical interventions.
- Ensuring that staff understand the circumstances in which restrictive interventions may be legally or ethically required.
- Ensuring that staff know what to do if they suspect inappropriate or abusive use of physical interventions
- Ensuring that person centred care is provided, that minimises the need for physical intervention.
- Ensuring staffing levels are appropriate to the potential risk of patient led violence and aggression.
- Ensuring that all incidents involving the use of physical interventions are reported in line with UHPNT Reporting of Incidents procedures.
- Providing appropriate and timely feedback for UHPNT staff involved in any incident involving physical intervention. De-brief should take place as soon as is practically possible following any incident involving physical intervention

both with the staff and the patients (and families/carers) involved. De-brief should take place in the first instance by the staff member's line manager.

- Reviewing each incident of physical intervention in order to learn lessons and improve practice.
- Carefully consider the impact of resource management on the use of physical intervention.
- Ensuring that staff are supported to attend training (including refresher training) as appropriate to the assessed needs of the work area and the role that the staff have within that area.
- Ensuring that staff that are not capable of physical intervention techniques in a work area where by it has been recognised that there may be a requirement for such techniques, are risk assessed and appropriate precautions taken.
- Ensuring that wherever appropriate learning incidents are fed back to UHPNT Physical Interventions Training Lead.

Clinical Educator

4.6 Ensuring that clinical area training needs analysis accurately reflects training requirements for staff in relation to physical intervention training.

Identifying physical intervention training needs from learning outcomes from Incidents.

Working with the Line Managers to ensure all appropriately identified staff attend physical intervention training, to include refresher training.

Ensuring that local records are kept to evidence that the training has taken place.

Working with UHPNT Physical Interventions Training Lead to ensure that the any physical intervention training accurately reflects the needs of both staff and patients with in clinical area.

Medics

4.7 Medics have responsibility to comply with the requirements of this and associated policies and have a legal duty to adhere to the Mental Capacity Act (MCA, 2005) when working with, or caring for, adults who may lack capacity to make decisions for themselves.

Quality, Safety and Compliance Team

4.8 The Quality, Safety and Compliance Team (Implementation Team) are responsible for informing the Care Quality Commission (CQC) of all Deprivation of Liberty Safeguard (DoLS) applications and outcomes. This is a statutory requirement.

Role of Safeguarding Adults and Medical/Nursing Leads with Safeguarding and Mental Capacity Act (MCA, 2005) responsibilities

4.9 The Safeguarding Adults and Medical/Nursing Leads are responsible for:

- Ensuring the process and procedures are consistent for recording mental capacity and applying restraints lawfully
- Providing systems and structures to support MCA implementation e.g. procedures, training.

4.10 The Safeguarding Adults Executive Lead is responsible for:

- Ensuring the Trust fulfills its responsibilities in protecting vulnerable adults within UHPNT.
- Ensuring that the Mental Capacity Act 2005, Deprivation of Liberty Safeguards 2007 and the use of restraint intervention are fully implemented within the Trust, to ensure that the rights of persons lacking capacity are respected.

4.11 The UHPNT Physical Interventions Training Lead

- Ensuring this policy updated, and in line with current guidelines and legal frameworks.
- Working with Matrons, Line Managers and Clinical Educators to ensure that staff identified as requiring physical interventions training can access it.
- Identifying training needs through review of UHPNT incidents.
- Ensuring all training records are kept in line with Information Governance recommendations.

4.12 Involvement of Security team in the restraint of patients

Sometimes situations may occur when additional support is required. The aim of this service is to assist nursing/health care professionals in maintaining the health and safety of patients, staff and visitors.

Staff may need to call Trust Security team for assistance regarding any threatening or violent physical behaviour from a patient or visitor, including serious attempt of self-harm. Security staff are not clinically trained, so it is important that in any such situation involving Security the Nurse, Health Care Assistant or Health Care Practitioner ensures the patient is safe. Staff who are familiar with the patient will have a far greater understanding of what is in the patient's "best interests", and must advise the security team accordingly.

It remains the responsibility of the nursing staff or health care professional responsible for the patient to ask security to desist in any restraint that they feel will cause harm to the patient.

In unplanned emergency situations where clinical staff feel unable to carry out a specific restrictive intervention without the support of security, and security are not available, then the Police should be contacted. Whenever there is Police or security involvement in a restrictive physical intervention it must be reported following Trust Incident Management Policy.

4.13 **Involvement of Bed Watch in the restraint of patients**

If Bed watch are involved in the restraint of a patient it is important that in any such situation the Nurse, Health Care Assistant or Health Care Practitioner ensures the patient is safe. Staff who are familiar with the patient will have a far greater understanding of what is in the patient's "best interests", and must advise the security team accordingly.

If there are any concerns about the type of restraint being employed by Bed Watch and the safety of the patient, UHPNT Nursing staff, or other Health Care Professionals must ask Bed Watch to stop the restraint hold. All such incidents must be reported following UHPNT Incident Management Policy, and the patient should be observed for any signs of injury or harm, for a period of time until there are no further concerns.

All Staff

4.14 All staff who carry out physical interventions techniques are responsible to:

- Identify training needs in respect of this policy document and informing their line manager.
- Attend the identified level of training, and engage in regular supervision when required.
- Ensure that the use of physical intervention is clearly documented and reported via UHPNT incident reporting procedure.
- Ensure that for any planned use of restraint the legal framework is in place e.g. DOLS/Mental Capacity Act.
- Take appropriate and proportionate actions only.
- Raise concerns with regard to the inappropriate use of restrictive interventions via Trust Incident Management Policy, Physical Interventions Lead, or Safeguarding.

5.0 Restriction and Restraint – Mental Capacity Act Standards and Practice

Core Principles

- 5.1 Any adult patient that has been identified to have potential for aggression, violence or unsafe behavior must be risk assessed and this must be fully documented in patient records. Any assessment must take into account known triggers, and the appropriate strategies to be implemented. Discussions should be captured on the patients care plan (Department of Health 2014). Any plan where possible should be written with the patient/family/carer/IMCA, or rationale provided as to why this has not occurred.
- 5.2 Restraint intervention must only be used as a last resort i.e. when all other measures (including de-escalation) have been unsuccessful or appropriately ruled out and the situation is deteriorating.
- 5.3 The intervention / physical intervention selected must be appropriate, justifiable, reasonable and proportionate to the specific situation and applied for the minimum possible time. It should take into account the person's physical disabilities, physical and mental health issues, and emotional state. Any lower level interventions which have been ruled out must be appropriately documented as well as the intervention which is selected and used. In accordance with these principles all efforts must be made to preserve the privacy and dignity of the patient during any restraint.
- 5.4 It is important that people who have the potential to be violent or exhibit aggression/unsafe behaviour are not treated less favorably on the basis of culture, gender, diagnosis, sexual orientation, disability, ethnicity, religious or spiritual beliefs.
- 5.5 Physical intervention should only be carried out by staff who have reached the required competency. Staff present at the time of an incident must agree to the need to implement the planned intervention at that time. Any dissent in the decision-making process should be recorded and should be addressed within the later debrief.
- 5.6 All staff involved in the physical intervention should be clear regarding their role within the team, including the techniques to be used. Staff must ensure that any restraint episode are a minimum two person approach to ensure their safety.
- 5.7 Consideration must be given to the overall context of care. Therefore, staff must take into account the detrimental effect the use of physical intervention may have to all involved, and have the ability to respond appropriately.
- 5.8 All incidents of physical intervention must be reported in accordance with UHPNT Incident Reporting Procedures. Additionally, any injury to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be considered a clinical accident / incident and reported according to Trust policy. Incidents should also be documented in the nursing / medical and multidisciplinary notes.
- 5.9 Restraint incidents should be followed by a staff "debrief" and this should be recorded on the incident form and, if appropriate, a summary captured in the

patient's records/care plan. The debriefing of the staff involved should be undertaken by the line manager within 24 hours or at the earliest opportunity.

Exclusion

- 5.10 This policy is concerned with the acute adult hospital setting and does not relate to the routine use of sedation within anaesthetics and critical care or psychiatric units. Please refer to the NICE NG10 guidelines, Violence and Aggression: Short-term management in mental health, health and community settings (2015). Employees have the right to request a security or Police presence in circumstances where they believe there is a potential for an act of violence to take place or the need for physical restraint in this circumstance may exist. Staff should refer to the UHPNT Violence and Aggression Policy, Violence and aggression in the workplace and the Policy and Procedure for people who are violent or aggressive and Prevention of violence to staff at work.
- 5.11 Details of physical holding techniques to restrain patients are not included in this policy; these techniques should only be used by staff that have the appropriate training.

Risk Assessment

- 5.12 "At risk" patients must be assessed in line with local and national guidelines. This must include assessment with regards to the patient's potential for aggressive and violent behaviour.
- 5.13 Aggressive or violent behaviour is not always predictable although certain factors can indicate an increased risk and must be considered when completing a risk assessment, such as;
- History of violent or aggressive behaviour
 - History of substance abuse
 - Family or carers reporting previous anger or violent behaviour
 - Previous expression of intent to harm self or others
 - Previous dangerous or impulsive acts
 - Denial of previous established dangerous or impulsive acts
 - Severity of previous acts
 - Anticipated reluctance or non-compliance to a prescribed treatment.
 - Evidence of recent severe stress
 - Known personal trigger and situational factors
 - Previous use of weapons to harm self/others
 - Verbal threat of violence to self or others

5.14 Clinical variables should also be taken into consideration when assessing risk. These could include but are not limited to the following by way of example:

- Misuse of substances and or alcohol
- Drug effects
- Active symptoms of psychiatric disorder for example, extreme paranoid ideation in a psychosis, experience of prominent hallucinations
- Poor compliance with suggested /prescribed treatments
- People with additional complex needs for example Autistic Spectrum conditions, Learning Disability
- Antisocial personality disorder, other personality disorders (such as emotionally unstable), or traits of personality disorders
- Brain injury (especially consider assessment as to whether a newly acquired adult brain injury, or due to preceding longer term injury)
- Post Pump Delirium

5.15 Situational variables should be taken in account when assessing the risk of aggressive or violent behaviour. These could include but are not limited to the following by way of example:

- Extent of family/social support/carer/involvement
- Immediate availability of potential weapons, particularly if self-harm or harm to others is strongly suspected
- Environmental factors
- Involvement of other services for example care co-ordinators from community mental health team e.g. CPNs or Harbour, especially if complex care pathway.
- It is important to note that episodes of challenging behaviour may be clinically or non-clinically driven (behaviour driven), but in either case an incident form should be completed if restraint or self-protection techniques were required to prevent harm to the patient, staff, visitors or other patients.

5.16 Any physical condition which may increase the risk of patient injury during physical intervention must be clearly documented in the risk assessment and care plan, and communicated to appropriate staff. This may include but are not limited to the following by way of example:

- Muscle and joint impairment (arthritis)
- Epilepsy
- Asthma
- Pregnancy
- Size of patient e.g. very frail or obese

- Substance misuse
- Learning Disability
- Increased sensitivity to pain or physical touch
- Sensory Difficulties
- Problems with cardio pulmonary function / heart disease

5.17 Potential risks of applying restraint intervention should also be considered as part of the risk assessment. The use of chemical, mechanical or physical restraint may potentially cause unintended adverse physical and psychological consequences. These could include but are not limited to the following by way of example:

Physical:

- Limb injury
- Aspiration
- Positional Asphyxia
- Acute Compartment Syndrome
- Tissue damage
- Strangulation
- Tachycardia

Psychological:

- Anxiety
- Agitation
- Depression
- Anger
- Confusion
- Distress
- Feelings of loss of control and dignity

5.18 If it is foreseeable that the person may need restraint intervention the risk assessment must show that the risk of employing the intervention is lower than the risk of not doing so (refer to Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint Intervention tool (Appendix C)). This should involve the named nurse caring for the patient and multi-disciplinary team. Rationale for all decisions made should be clearly documented within the care plan/records.

5.19 The components of risk are dynamic and may change according to circumstance; a risk assessment must be completed and reviewed at a maximum of 8 hourly intervals (use the Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint Intervention tool (Appendix C).

Care Planning

- 5.20 It is an essential first step in care planning to understand the reason behind the patient's behaviour. The patient's needs and social history must be assessed in order to establish what sort of behavioural management might help them.
- 5.21 Where possible all patients/their carers/advocates must be fully involved with their decisions regarding their care. Listening to a patient's views and taking them seriously is now regarded as an important factor in managing aggressive or violent behaviour.
- 5.22 Clear and effective communication is essential when developing a care plan (see communication strategies below), and is of even greater importance if an individual has a hearing, visual or cognitive impairment, or whose first language is not English. When necessary, staff must access interpreters or staff with other specific communication skills, such as Speech and Language Therapists. All available resources should be used to ensure effective collaboration between patients, carers, advocates and staff.
- 5.23 Care plans will describe the specific interventions that have been discussed and agreed for the patient. This should include:
- Strategies that prevent behaviours that precipitate violence;
 - Strategies for de-escalation and recovery;
 - Explicit indications as to the circumstances in which physical intervention may be used.
- 5.24 Any physical condition must be taken into account when formulating the intervention and management strategies to be utilised.
- 5.25 The risk assessment and care plan in which interventions are detailed must be agreed and endorsed by the multi-disciplinary team.
- 5.26 There will be occasions when unplanned or emergency physical intervention is necessary when a patient acts in an unexpected way. Staff retain their duty of care to that patient and any response must be necessary to protect the person/or persons from harm, and if any restrictive physical interventions are used, they must be proportionate to the likelihood of that person/persons

suffering harm and the seriousness of that harm (Mental Capacity Act 2005, section 6).

Prevention

5.27 It is important that staff recognise the early stages of a patient's sequence of behaviour that is likely to develop into violence or aggression; at this stage it may be possible to diffuse a potentially escalating situation using de-escalation techniques.

Additional Factors

Treat Underlying Condition

5.28 All patients should be assessed comprehensively in order to establish what behaviour management plan might be of benefit. This will involve identifying the underlying cause of the behaviour (agitation, wandering, absconding etc.) and deciding whether the behaviour needs to be prevented. Possible causes to consider include, but are not limited to the following by way of example:

- Hypoxia
- Hypotension
- Pyrexia
- Full bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Drug dependency or withdrawal
- Alcohol Withdrawal
- Brain insult / injury or cerebral irritation
- Reaction / side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)
- Mental Disorder and Mental Illness
- Hallucinations, delusions, paranoid ideation, personality issues (including personality disorder or difficulties)
- Infection
- Dehydration

- Malnutrition

Therapeutic Approaches and Management Strategies

5.29 Therapeutic approaches used to reduce confusion and agitation includes a positive environment and good communication skills. Every effort should be made to reduce the negative impact of the environment.

Environment Strategies

5.30 Environmental strategies include but are not limited to the following by way of example

- Provide a visible clock
- Minimise excessive noise and light
- Maintain a day-night routine
- Maintain a consistent unit temperature
- Facilitate rest periods and also periods of patient activity
- Use diversion therapy - provide television/radio
- Use reminiscence with familiar objects from the patient's home e.g.
- Pictures, photographs
- Reduce monitoring and invasive lines as far as is practically possible
- Cluster care to avoid repeated disturbances

Communication Strategies

5.31 Communication strategies include but are not limited to the following by way of example:

- Engage the patient in meaningful activity – ask the patient and/or relatives and carers what the patient likes to do, what they would be doing if they were at home etc.
- Orientate patient to time, person and place
- Reality orientation - use of diaries and memory aides
- Communicate clearly and concisely with the patient
- Provide repeated verbal reminders
- Identify and correct any sensory impairments i.e. glasses and hearing aid
- Maintain a patient's dignity
- Use empathetic communication and touch
- Consider use of alternative therapies – massage, acupuncture, music therapy

- Involve a patient's family and friends in care
- Ensure continuity of staff
- Where the patient has known mental health issues or learning disability issues, refer them to the appropriate health care teams
- Provide communication aids

Communication, Record keeping and Documentation

5.32 Clear communication is essential in relation to the use of restraint intervention. Written information should be used to supplement verbal information given where possible. Patients and carers should be provided with written information including, for example around the use of Posey Control Mitts. If a restraint intervention is used, the reason should be explicit and clearly documented in the nursing / multidisciplinary notes, which should include:

- A full assessment of capacity in line with the legal framework. It is crucial to be clear as to whether or not the patient has capacity to consent to the use of restraint. Document all discussions that have taken place to allow a patient to give informed consent and to assess best interests and their capacity or incapacity.
- Where the patient has capacity and is able to provide consent, details of the information provided to the patient to enable them to reach their decision, as well as clear documentation regarding the patient's decision. Where the patient has capacity and refuses restraint this should not be undertaken and should be documented.
- In an emergency, the rapid use of clues to support a possible determination of incapacity under the doctrine of necessity can be used and documented. Any decision made to undertake restraint on this basis, must be supported by a clear and reasoned explanation and rational in relation to why staff believed they needed to take action out of necessity to keep the patient or others safe from harm.
- Any member of staff who determines that there is a need to restrain a patient will need to document that the criteria to carry out the restraint were met, including that the patient did not have capacity (if applicable), that it was necessary to prevent harm and was a proportionate response, and that it was in the best interests of the patient. Staff must be able to demonstrate that on balance the patient will suffer harm unless a proportionate restraint is used.

5.33 A risk assessment –Planned restraint should only be considered following a risk assessment which includes an assessment of the risk to and posed by the patient from their behaviour. The risk assessment should be conducted to determine any areas where the patient is considered a risk to themselves or others without the use of any form of restraint. The level of risk involved should be identified. The risk assessment should then determine any risks to the

patient or others in implementing the restraint to be used. For unplanned emergency use of restraint the risk assessment will be dynamic, and the nature of the dynamic risk assessment carried out by the practitioner/s involved will need to be documented in the patient's notes. Before the application of planned restraint an individual assessment should be carried out to consider:

- The environment
- Patient's behaviour
- Patient's underlying condition and treatment
- Patient's mental capacity
- Duty of care
- Impact of family and friends on patients behaviour/mood

- Signatures of the health care professionals involved in making the decision. Rationale for the use of restraint intervention should be indicated, including why other lower level interventions were deemed to be unsuitable.

- Document any de-escalation techniques and other efforts used to try to avoid the use of restraint.

- Document the type of restraint used and any equipment or chemical interventions used. Outline the rationale for using this type of restraint. This should include:
 - Why the restraint is necessary to prevent harm to the patient;
 - What harm is being prevented or mitigated by the use of restraint;
 - Why the use of restraint is proportionate;
 - Document why the restraint to be used will be the minimum amount in the circumstances;
 - Document why the restraint used is in the patient's best interests.

- Document those involved in restraint.

- Document the period over which restraint is to be used (remember restraint should be used for the shortest time possible).

- Document review times as specified within care-plan and risk assessment tool to re-evaluate the restraint intervention.

- Document any concerns or adverse reaction to restraint;

- Document all clinical observations during the restraint process and post restraint.

5.34 The decision to continue with the restraint intervention should be considered by the nursing staff as a minimum at every eight hours, or more regularly where it

is felt appropriate, and should be discussed with the multi-disciplinary team if a change in the level of intervention is deemed necessary. This should also be communicated at wider MDT meetings if there is a change in the appropriate nursing and medical evaluation of care.

Discontinuation of restraint intervention

5.35 Having implemented restraint intervention, the healthcare team must continually monitor for physical and psychological adverse effects. If the risks outweigh the benefits, then restraint intervention must be stopped immediately. The restraint intervention should be discontinued at the earliest opportunity. This may be because the patient's behaviour no longer renders the need for restraint intervention or that the restraint intervention has worsened the patient's agitation. Reasons for discontinuation should be clearly documented. The effect of physical, mechanical or pharmacological restraint intervention should be evaluated throughout, utilising the specified care plan (Appendix D).

Raising Concerns

5.36 Where staff have concerns regarding the use of, or the omission to use restraint, or where another member of staff, the patient or another individual raises concerns with a member of staff, this should be raised at the earliest opportunity with the ward manager. The alleged inappropriate use of restraint must be managed as an incident in accordance with the Trust Safeguarding Adults at Risk Policy (Vulnerable Adults) policy.

Reporting of injuries

5.37 Any injury to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be considered a clinical accident / incident and reported according to Trust policy. Incidents should also be documented in the nursing / multidisciplinary notes.

Evaluation, discontinuation and audit of use of restraint intervention

5.38 The use of restraint intervention should be evaluated in terms of its effectiveness and lesser alternatives must be considered. For planned use of restraint intervention this should involve a discussion at ward level. The factors, which led up to the use of restraint intervention and its appropriateness, should be discussed and reviewed by the ward team.

6 Legal Framework

6.1 The lawful use of restraint intervention in respect of people who lack capacity is based on the Mental Capacity Act 2005 which applies to all persons aged 16 years and over. It provides a statutory framework to assess capacity, and to

protect people who may not be able to make some decisions for themselves, so that any action which is undertaken in relation to an incapacitated individual is done in their best interests.

6.2 The Mental Capacity Act 2005 has core principles:

- A person must be assumed to have capacity unless it is established that he or she lacks capacity. A lack of capacity has to be clearly demonstrated by formally assessing and recording capacity at the time.
- A person is not to be treated as lacking capacity to take a decision unless all practicable steps to help him/her to do so have been undertaken without success.
- A person is not to be treated as lacking capacity to make a decision merely because he/she makes an unwise decision.
- Any act done or decision made, for or on behalf of a person who lacks capacity must be done or made in their best interests.
- Any decision should show that the least restrictive option or intervention is achieved.

What is a proportionate response?

- A proportionate response means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity;
- The level of restraint should diminish as the risk of harm diminishes;
- Staff must use the minimum amount of restraint for the shortest period necessary. When determining what type of restraint to use in order to minimise a particular risk of harm to a patient, you must be able to demonstrate that you have considered less restrictive options as alternatives;
- It will be necessary to consider the psychological impact upon the patient of being restrained. Where restraint is being considered, staff must consider the best interests of the patient recognising that in some circumstances to use restraint may cause more harm than the clinical benefits.

In summary –

6.3 Restraint may be appropriate when it is used to prevent harm to the patient or others (e.g. staff, other patients, visitors) and is a proportionate response to the likelihood of, and seriousness of harm. Any staff member who determines that there is a need to restrain a patient will need to document that the criteria to carry out the restraint were met as indicated in this document. This will include that the patient did not have capacity, that it was necessary to prevent harm and was a proportionate response, and that it was in the best interests of the patient. Staff must be able to demonstrate that on balance the patient will suffer harm unless a proportionate restraint is used.

- 6.4 If restraint is necessary to prevent harm to a patient (or others), it must be the minimum amount of force for the shortest time possible. The reason for the restraint, risk assessments and the evidence of continual assessment must be clearly documented.
- 6.5 In the event of an emergency response it will not be possible to conduct the UHPNT Risk Assessment Record & Clinical Decision Making Tool (Appendix C) prior to the restraining interventions proceeding, however if it is likely that there will be repeat restraining interventions, then this must be completed.
- 6.6 Remember, restraint can only be used if:
- The patient does not have capacity,
 - The staff members using it reasonably believe that it is necessary to prevent harm to the patient or others and,
 - Its use is proportionate both to the likelihood and seriousness of harm to the individual or others present,
 - The restraint is in the individual's best interests, and
 - The restraint is the least restrictive means necessary to prevent such harm.
 - Staff must not use restraint so that they can do something more easily.
- 6.7 If restraint is not undertaken in line with this legal framework actions could be determined to amount to a deprivation of liberty which is unlawful without relevant legal authority.

Deprivation of Liberty

- 6.8 Where the restriction of the person goes beyond restraint, it may amount to a deprivation of liberty. That is determined by considering whether the steps involved means that the person is not free to leave (the hospital or treatment center) AND will be under continuous supervision and control. Where this is the case the individual will be deprived of their liberty. All cases must be assessed on their own individual merits and circumstances.
- 6.9 Any deprivation of liberty must be authorised in accordance with a procedure prescribed by law where the person concerned is incapable or incompetent. Such authorisation can be secured via the Mental Health Act 1983, the Mental Capacity Act 2005 or the High Court. For further guidance, and the application process please refer to the Mental Capacity Act Policy and / or StaffNet Safeguarding Adults page.

Doctrine of Necessity

- 6.10 Where a patient is in immediate danger, the ability to undertake a full and thorough assessment of their mental capacity is not always possible. In such circumstances decisions must be made based on the evidence available at that time and based on the principle that on the balance of probabilities (i.e. being

more likely than not), it would suggest that in the circumstances the patient lacks capacity.

6.11 Any actions then undertaken on this basis must be considered immediately necessary to save life and / or prevent very serious deterioration in the patient's physical or mental wellbeing. The doctrine is a positive duty in law, which means that failure to act could be deemed to be negligent.

6.12 However the doctrine of necessity must not be used where there is sufficient time to assess the patient's capacity and implement the above restraint framework. This is important because if the doctrine of necessity is used inappropriately there is again a risk of civil trespass to the person which may amount to a crime depending on the severity and impact of the restraining measure.

6.13 Any decision made to undertake restraint on this basis must be supported with a clear and reasoned rationale in relation to the basis upon which staff believed that they needed to take action out of necessity as opposed to the wider legal framework. This must be documented. Essentially the doctrine of necessity enables immediate action in extreme emergency to immediately save life or prevent very serious harm or deterioration.

Patients with Capacity and Consent to the Use of Restraint

Consent

6.14 Consent is the legal means by which a patient gives a valid, informed and voluntary authorisation for assessment, treatment or care.

6.15 The legal basis of consent is identical to the professional requirement that consent is required before carrying out any assessment or treatment. Case law on consent has established the following requirements which must all be satisfied before consent given by any person can be deemed sufficient:

- The consent must be given by someone at a time when they were deemed to have capacity.
- Sufficient information must be given to the patient so that an informed decision can be made, including the options, benefits, and associated risks. There is also a legal duty to ensure that the patient is aware of the material risk involved in the recommended treatment or action and of any reasonable alternative or variant option.
- The consent must be freely given, without coercion or bullying.

6.16 Professionals are accountable under their Code of Conduct to ensure that whilst caring for patients they are assured they have been given information about their condition and understand the risks and implications of any proposed restraint. A failure to obtain valid consent could also lead to professional misconduct as ensuring consent is valid is inherent to the regulatory codes of

professional conduct. In certain emergency situations or if the patient lacks capacity it may not be possible to gain the consent of a patient prior to the restraint episode taking place.

Additional Legal Frameworks

Common Law

6.17 Under common law, anyone (including members of the public), as well as Trust staff can use reasonable force to prevent harm to themselves or others, which includes the patient. However, the individual will be accountable for the force that is used and actions taken and inappropriate use of force or restraint could constitute assault or battery which is a criminal offence. Likewise, the individual may be liable for negligence in civil law if persons are injured. Consequently, it is important that staff ensure that if they are using force or restraint under the common law it is reasonable, accountable and justifiable at all times. In this context, “reasonable force” is understood as the honest and genuine belief at the time by the person applying the force, that it is appropriate to prevent harm to themselves, and others including the patient.

6.18 **Criminal Law Act 1967** Section 3 makes provision for a person to use such force as is necessary in the circumstances in the prevention of a crime.

6.19 **The Human Rights Act 1998** requires that the use and extent of restraint should be justified by a clear rationale. This should explain why considerations are reasonably believed to override the individual's human rights under the European Convention on Human Rights.

- **Article 3 – No one shall be subjected to torture or inhuman or degrading treatment or punishment.** Forcible restraint of another can engage Article 3, however as a general rule, a measure which is a therapeutic necessity will not be regarded as inhuman or degrading. It is however essential to satisfy that there is a medical necessity. The key issue will be the proportionality of the restraint when set against the identified and documented risks,
- **Article 5 – Right to Liberty** – No one shall be deprived of their liberty save in specified circumstances. The nature and circumstances in which a person is restrained must not amount to a deprivation of liberty. A person can only be deprived of their liberty subject to strict legal frameworks prescribed by law
- **Article 8 – Everyone has the right to respect for his or her private and family life, home and correspondence.** Article 8 is broad ranging and is often closely connected with other rights such as freedom of expression. However this right is subject to proportionate and lawful restrictions where there is an appropriate legal framework applied.

Detention According to Mental Health Legislation (Mental Health Act 1983 as revised 2007)

- 6.20 **The Mental Health Act** permits treatment (including restraint) for mental disorder from which a detained patient is suffering, and this may include physical conditions arising from the mental disorder e.g. nutritional support or refeeding in anorexia nervosa.
- 6.21 However, the Mental Health Act cannot be applied to treat a physical illness (including the use of restraint) which does not directly relate to the patient's mental health condition for which he or she was detained. Instead the framework for restraint, in relation to a physical condition, should be in line with the Mental Capacity Act 2005.
- 6.22 There is a holding power which **doctors** can use under s.5(2) of the Mental Health Act where they believe that a patient is a danger to themselves or others and may require detention under the Mental Health Act pending assessment under that legislation by an approved clinician. The holding power can only be used for 72 hours and cannot be used beyond this. A mental health act assessment must be arranged as soon as possible, and in an event within the 72 hour timeframe. Please bear in mind that this part of the Mental Health Act cannot be used to force a physical or other treatment plan, it is a holding power to allow fuller assessment. Similar restrictions apply to section 5(4) as below.
- 6.23 A **section 5(4) Mental Health Act** is a nurse's holding power. Nurses must be of a 'prescribed class', which means that they should be registered in the area of mental health or learning disabilities nursing. This power can only be used when:
- A patient must be immediately stopped from leaving hospital for their own health or safety or for the protection of others
 - It is not possible to get a doctor to attend who can implement the holding power under s5 (2) MHA.
- 6.24 The specialist guidance of a psychiatrist should be sought on this matter. You must also refer to the Trust Policy entitled "Patients detained under the Mental Health Act 1983", which outlines the Trust policy, key roles and responsibilities and who to contact.

7 | Levels of Intervention

De-Escalation Techniques:

- 7.1 This relates to all staff coming into contact with people e.g. Medics, Nurses, Health Care Assistants, Allied Health Care Professionals, and Administration teams.
- 7.2 These are techniques aimed to reduce the level and intensity of a difficult situation. De-escalation means making a dynamic risk assessment of the

situation and using verbal and non- verbal communication skills in combination to diffuse the situation.

- 7.3 It may be appropriate to use a quiet room for de-escalation purposes if one is available. This is primarily a facility whereby the patient or aggrieved person may be taken to take time out to discuss their concerns in private. It can be provided within a safe and reduced stimulus environment thereby minimising the risk of significant physical or psychological harm to an individual or others. Please note however that if the individual is unable to leave the room should they wish to do so, this would amount to a greater restriction of movement and in the right circumstances, possibly a deprivation of liberty.

Breakaway:

- 7.4 Breakaway is a physical technique used by an individual to limit injury and/or to escape from someone who is attempting to physically assault a member of staff.
- 7.5 Staff who have face to face patient and parent /carer contact should receive mandatory Breakaway training yearly unless risk assessed as not requiring it by their line manager (in partnership with the Trust Physical Interventions Training Lead).

Non-Restrictive Physical Intervention and Least Forceful Restraint Intervention:

- 7.6 In an unplanned emergency situation, staff that have not been trained in formal physical intervention techniques are entitled to, and indeed may have a duty of care to use non-restrictive and least forceful restraint intervention to the best of their ability when their safety or the safety of the patient or others is in jeopardy. All members of the Multi -Disciplinary Team regardless if they are trained in restraint intervention should offer assistance to staff, for example make sure that the area is clear of other people, reassurance to other patients if they find the situation stressful, calling for additional help, ensuring that the ward area remains safe. However, the use of untrained staff for planned restraint intervention should be avoided wherever possible.

Holding for Therapeutic Interventions:

- 7.7 This should be pre-planned wherever possible ensuring that the patient and Carer/NOK/IMCA is aware of the reasons for the supportive holding episode, and how this will be achieved. All staff involved in the procedure aligned with the therapeutic holding episode should be clear of their role prior to the intervention taking place, and this intervention must be recorded in the patient notes.

Restraint Intervention:

- 7.8 Before restraint intervention techniques are implemented it must be ascertained as far as possible whether the patient is in possession of anything that could be used as a weapon. If there is any doubt police assistance should be considered and efforts should be made to make the environment as safe as possible.
- 7.9 Anyone within the immediate area must be supervised throughout a physical intervention. If there are staff on duty that are not required, they should remain with other patients and visitors in the area, who are not involved in the physical intervention.
- 7.10 Once restraint intervention techniques have been initiated, the team involved has a duty of care to the individual and must ensure the restraint is discontinued as soon as the situation is considered to be safe.
- 7.11 The purpose of restraint intervention is to take control of a dangerous situation and secondly to limit the patient's freedom for no longer than necessary to end or reduce significantly the threat to themselves or others. Physical intervention must only be used when all other less intrusive methods have been explored and considered not suitable or have failed.
- 7.12 Throughout the situation staff must continue to employ de-escalation techniques, one member of staff must talk and explain the reason for actions to the patient, this is usually the lead person. Restraint intervention must be brought to an end at the earliest opportunity.
- 7.13 Staff not trained in restraint intervention techniques still have a duty of care for their patients and must act in a manner reasonable to the situation and in good faith, bearing in mind the principals within this guideline, e.g. the use of reasonable force, duty of care, best interests.

Implementation of Restraint Intervention Techniques:

- 7.14 Approved restraint intervention techniques should only be used when all other options are no longer practicable and restraint intervention is in the best interests of those involved.
- 7.15 Restraint intervention techniques should only be undertaken by staff that are appropriately trained and competent. It is recognised that in an emergency situation, staff who have not been trained but who still have a duty of care may become involved in an unplanned restraint intervention.
- 7.16 In a situation where a staff member finds themselves at risk, Trust approved Breakaway techniques may be used to protect from assault/injury.
- 7.17 Where restraint intervention is predicted to be required in advance refer to Appendix B for the Clinical Decision Making Tool for: Challenging Behaviours / the use of Restraint Intervention.
- 7.18 Staff should be allocated to calm and reassure other patients and visitors who witness the event if possible.

7.19 In circumstances where the patient who lacks capacity has left or attempts to leave the ward area, and de-escalation and non-restrictive and least forceful aversive intervention techniques have failed, staff should consider seeking the assistance of security and/or the police, and seek clinical advice and support from an available Line Manager.

7.20 If the nurse in charge believes that the incident is becoming beyond the control or expertise of nursing staff, they should consult with senior colleagues if available or call for security or police assistance.

7.21 It is important to remember that sometimes restraint intervention can cause the patient psychological and physical harm (Nice 2015), and therefore vital signs should be monitored during and for a period after restrictive interventions (Patient Safety Alert NHS/PSAW/2015/011, 2015).

Procedure for Restraint

- Restraint must be undertaken in line with the legal frameworks set out in this policy.
- Should only be considered following a risk assessment (dynamic risk assessment if an emergency restraint).
- Restraint should only be undertaken following multi-disciplinary team input, in pre-planned therapeutic interventions.
- Should only be undertaken in line with the restraint techniques approved by UHPNT.
- The patient's overall physical and psychological well-being must be monitored throughout.
- There must be a lead member of staff with primacy of care responsible for ensuring that;
 - i. the patient's airway and breathing is not compromised,
 - ii. ensuring vital signs are monitored, and
 - iii. Ensuring that any restraint is for the shortest possible time and in the least restrictive way.
 - iv. Reported via Datix
- No patient should be restrained in a prone position due to the risk of positional asphyxia. This cannot be used at any time. Restraint should be documented in line with this policy.
- Restraint should be monitored and reviewed in line with this policy, and UHPNT Management of Incidents policy.
- It is unacceptable for a member of staff to restrain a patient on their own. All restraint interventions require a *minimum* of two persons, to keep the patient and staff members safe.

7.22 It is imperative that if **any method of planned restraint** is being considered, the following processes should be applied:

- Refer to the Clinical Decision Making Tool for: Challenging Behaviour / The Use of Restraint Intervention if considering any form of restraint (Appendix B).
- Undertake a risk assessment using the Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint Intervention (Appendix C) for planned interventions.
- Record keeping must be comprehensive and accurate.
- Ensure all decisions are communicated within the multi-disciplinary team, with carers, and next of kin.
- Re-evaluate and reassess using the Restraint Intervention Care Plan (Appendix D)

Procedure for Pharmacological / Chemical Restraint (Refer to UHPNT Medicines Management Policy

Approved Forms of Physical Intervention for use with UHPNT

7.23 The following methods of restraint intervention are acceptable when used appropriately (i.e. in accordance with the principles and guidance outlined in this policy, and UHPNT Medicines Management Policy).

- Pharmacological/Chemical restraint, which includes management of delirium and agitated behaviour and managing alcohol withdrawal.
- Mechanical Restraint intervention, including in the form of Posey Control Mitts when used in conjunction with:
 - UHPNT Risk Assessment Record & Clinical Decision Making Tool when considering the use of restraint intervention (for the use of Posey Control Mitts and acceptable methods of restraint intervention (see Appendix C). Full guidance for the use of Posey Mitts can be found Appendix E.
 - UHPNT Restraint Intervention Care Plan (see Appendix D).
- Psychological / Verbal Restraint
- Physical Restraint using Trust approved restraining techniques which the healthcare professional reasonably believes is **necessary** in order to **prevent harm** to the person who lacks capacity; and is a **proportionate response** to the likelihood of the person/s suffering harm and the seriousness of that harm. The restraint must also be in the **best interests of the person**.

Unacceptable forms of restraint intervention

7.24 The following methods of restraint are generally considered as **unacceptable**.

(a) Inappropriate Bed Height

7.25 This is an unacceptable form of restraint intervention as it increases the risk of injury resulting from a fall out of bed, particularly if bed rails are in situ. However, low profile beds which are too low can also impede the movement of the elderly or frail.

(b) Inappropriate use of Bed rails

7.26 In some situations, bed rails may need to be used if this is deemed suitable for the patient. In all instances a risk assessment must be undertaken for the use of bed rails as indicated in this policy and the actions recorded. This is in addition to the consideration of the use of restraint in line with this policy. Patients with fragile skin are more likely to suffer a bruise or laceration when coming into contact with bed rails. Patients are known to 'climb over' bed rails (MHRA ref MDA/2007/009).

(c) Inappropriate use of Harnesses

7.27 Harnesses should not be used as a form of restraint intervention, as they result in numerous risks to the person including pressure sores, chest infection and so on.

(d) Inappropriate use of Wheelchair Safety Straps

7.28 The safety straps on wheelchairs should always be used, for the safety of the patient during its normal / routine use. However, patients should only be seated in a wheelchair when this type of seating is required as part of on-going care, not as a means of restraint intervention.

(e) Inappropriately Low Chairs

7.29 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 and also pose risks to staff in relation to manual handling.

(f) Inappropriate use of Chairs whose design immobilises Patients

7.30 Reclining chairs for example, should only be used for therapeutic purposes such as for the comfort of the user or as an aid to manual handling, positioning for postural control and not as a method of restraint.

(g) Inappropriate use of Locked Doors

7.31 Electronic tagging devices and electronic security doors may be acceptable as a restriction in order to keep a confused patient who is wandering safe and are applied in relation to the Trust's duty of care towards that patient. This may not amount to a deprivation of liberty depending on the individual circumstances of the individual's case – see deprivation of liberty above. Consideration must also be given to other patients, staff and members of the public in order to ensure easy access to and from the area. Doors should not be locked without due attention to health and safety requirements in relation to fire.

(h) Inappropriate arranging of furniture to impede movement

7.32 In general, other less restrictive methods of dealing with behaviour, such as wandering, should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended.

(i) Inappropriate use of night clothes during waking hours

7.33 This is demeaning and should not be used as a way of restraining people in any care setting. However, in exceptional circumstances where it is seen as the least restrictive option, measures must be taken to ensure the patients' dignity is maintained at all times.

(j) Removal of outdoor shoes and other walking aids / withdrawal of sensory aids such as spectacles

7.34 Removal of sensory aids such as hearing aids and other communication devices can cause confusion and disorientation and is never deemed acceptable.

(k) Inappropriate use of Isolation

7.35 Patients may be "isolated" for infection control reasons and if a patient is cared for in a side room, when he or she wishes to be on the main ward, 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. **However, some patients with brain injury may not be able to interpret their surroundings and become anxious or threatened if placed in an open ward. Therefore, being placed in a side room with chaperon or carer may be the best option for them.**

(L) Bandaged hands

7.36 The practice of bandaging hands to deter patients from pulling on invasive lines or therapeutic tubes is not acceptable practice. The "Posey Control Mitt" is designed to be a safer more acceptable option, used in conjunction with the UHPNT Risk Assessment Record & Clinical Decision Making Tool when

considering the use of Restraint Intervention and the Restraint Intervention Care Plan (Appendix C and D).

(M) Long term restraint

7.37 If restraint of the patient is required over a longer period, this may constitute a deprivation of liberty. For further guidance refer to the Mental Capacity Act Policy. If a restraint episode is likely to last for in excess of ten minutes without an obvious de-escalation in sight, alternatives should be considered for example sedation/rapid tranquilisation (NICE 2015).

(N) Prone Physical Restraint

7.38 The use of prone physical restraint should not be used in any circumstance.

7.39 **The Clinical Decision Making Tool for: Challenging Behaviour / The Use of Restraint Intervention and Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint intervention** (Appendix B & C) must be utilised when any form of restraint intervention is being considered. These tools include assessment, monitoring and evaluation of any patient who may require physical or chemical restraint in order to maintain the patient's own safety or to protect patients and staff from harm. However, restraint intervention **may be applied in the event of an emergency** in the first instance whereby there is a high risk of harm to patient, staff or members of the public. All UHPNT procedures and protocols must then be followed up to ensure continuing safety of all and in that the application of continuing restraint intervention is appropriate and in the best interests of the patient.

8.0 Reporting

8.1 It is important that the Trust capture information on all incidents requiring restraint intervention, so that these may be learnt from. Incident reports will inform the on-going risk assessment process and may also provide added protection for staff and the Trust in the event of any subsequent legal action.

8.2 Instances where an unplanned restraint in an emergency situation on a person takes place, it must be reported in accordance with Trust Incident Reporting Procedure, and completed within 24 hours of the incident taking place. The incident form must detail the following:

- Names of all the people involved
- Details of patient involved
- Reason for using the specific type on intervention
- Types of intervention used
- Date and duration of intervention
- Whether any injuries to the patient, staff or visitors were sustained, and actions taken as a result.

Debriefing Patients: (Patients/ NOK/Carer/IMCA)

8.3 There should be a planned “de-brief” for the patient/person with parental responsibility/carer. The debrief should not happen whilst the patient is still agitated, and should be undertaken at an appropriate time following the incident. The agenda for this debrief should include:

Who would the patient like to be present?

Would the patient like to talk to anyone else about it, for example a family member or ward manager?

Does the patient understand why it happened?

How did it feel for the patient?

Would the patient like it to be different?

How could we avoid having to do it again?

Ask the patient if they have sustained any injuries following on for the PI, these should be mapped on body maps, and appropriate treatment sought.

Does the patient wish to make a formal complaint about any aspect of the incident?

Consider if there is a specific need for emotional support in response to the potential for trauma during any incident.

Debriefing Staff:

8.4 Following all unplanned restraint intervention and any planned restraint where there may be concerns or issues, debrief and review should take place at the earliest opportunity, preferably within 24 hours. Every effort should be made to ensure that all members of staff involved in the incident are able to attend. The aim of the debrief should be to evaluate the impact of the intervention, identify needs, determine alternatives, recommend changes.

8.5 Debriefing will include a discussion about whether restraint intervention is still seen as an appropriate intervention for that person, and any doubts should be discussed as soon as possible with the multi-disciplinary team.

8.6 De-briefing should take place with Clinical Manager/Sister as soon as is practically possible.

9.0 Staff Education and Training

Staff Education and Training

9.1 The policy promotes on-going education, training and awareness of the issues

Surrounding management of agitation and the use of restraint intervention. The emphasis of training and education should be on dealing effectively with situations in order to minimise the need for restraint interventions. It is the responsibility of managers (working in conjunction with the UHPNT Physical Interventions Training Lead), to identify if this training is required and to undertake any risk assessments using the workforce standard operating procedure for staff with health restriction.

- 9.2 There is a professional responsibility to ensure training is up to date as well as an organisational responsibility. All frontline staff should receive a minimum of Level 1 Conflict De-escalation/Resolution, at least every 3 years. All frontline staff in high risk areas for the need for physical intervention, should have Breakaway training yearly, and if appropriate physical interventions (restraint training) yearly.
- 9.3 For staff to be deemed competent they must have attended and taken part and been assessed as competent in Physical Intervention /Breakaway training, and be in date.
- 9.4 A programme of training is available at different levels which ensure that all ward areas and staff groups as previously highlighted, receive the appropriate level of training which reflects their respective patient groups.
- 9.5 Please note that a Health declaration is required to be completed by staff before Breakaway, and Physical Intervention training, which may lead to a requirement for a risk assessment to be undertaken by the staff member and their line manager, in accordance with UHPNT Workforce SOP for staff with health restrictions. Any such risk assessment must be presented to the Physical Interventions trainer at the start of the session, prior to the commencement of training.
 - **Level 1 Conflict Resolution**– 3 hour class room session, once every 3 years
 - **Level 2 Conflict Resolution (Breakaway/Self Protection)** - 3 hour practical session, once every year (if the staff member is unable to undertake Breakaway training due to ill health, injury or pregnancy following on from a risk assessment with their line manager, the staff member will be enrolled onto the Trust eLearning Breakaway module, to ensure that they are not disadvantaged by not being physically able to undertake the training. The risk assessment will be reviewed by their line manager on a regular basis, and should the assessment change to show that Breakaway training may be undertaken, the staff member will be enrolled onto the course when practicable and available).
 - **Level 3 Conflict Resolution Training (Physical Intervention /Restraint)** – this is bespoke training tailored to suit each clinical area, thus timings may vary dependant on requirement. This should be undertaken on an annual basis.

- **Level 4 Conflict Resolution (Highly Restrictive Physical Intervention/Restraint Training)** – this is for identified staff with in the Trust.

10.0 Overall Responsibility of the Document

- 10.1 This is a Trust wide policy for all adults developed by healthcare professionals from across a range of directorates.
- 10.2 The processes within this policy will be monitored by the Safeguarding Steering Group assuring compliance and establishing a regular monitoring system.

11.0 Consultation and Ratification

- 11.1 The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.
- 11.2 The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.
- 11.3 This document will be approved by the Safeguarding Steering Group and ratified by the Chair of that group.
- 11.4 Non-significant amendments to this document may be made, under delegated authority from the Chair, and by the nominated author. These must be ratified by the Chair and should be reported, retrospectively, to the approving Safeguarding Steering Group.
- 11.5 Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

12.0 Dissemination and Implementation

- 12.1 Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.
- 12.2 Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.
- 12.3 The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Chair

of the Safeguarding Steering Group and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

13.0 Monitoring Compliance and Effectiveness

- 13.1 The monitoring and compliance of the policy will be undertaken by the Physical Interventions Governance Group, reporting to the Safeguarding Steering Group. Any risks and associated action plans will be discussed in these forums.
- 13.2 Compliance will be measured by CQC Regulation 13.
- 13.3 Compliance with NICE Guideline 10 (2015): Violence and aggression: short-term management in mental health, health and community settings
- 13.4 Working to National Occupational Standards (2013) the Prevention and Management of Violence in the Workplace.
- 13.5 Working to Department of Health Guidelines (2014) Positive and Proactive Care: reducing the need for restrictive interventions.

- 13.6 Compliance with UK Core Skills Framework Statutory/Mandatory Subject Guide Version 1.4.1 Subject 4.

14.0 References and Associated Documentation

Department of Health (1983; 2007): Mental Health Act. HMSO. London.

Department of Health (1983): Practical Guidance for managing patients under the Mental Health Act HMSO London

Department of Health (2001): Guidance on Consent. HMSO. London.

Department of Health (2005): Mental Capacity Act. HMSO. London.

Department of Health (2007): Mental Health Act. HMSO. London.

Department of Health (2014): Skills for Care. A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. HMSO. London.

Department of Health Guidelines (2014) Positive and Proactive Care: reducing the need for restrictive interventions. HMSO. London.

Deprivation of liberty safeguards (2008): Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. Issued by the Lord Chancellor on 26 August 2008 in accordance with sections 42 and 43 of the Act Ministry of Justice London: TSO Ministry of Justice.

<http://www.justice.gov.uk/whatwedo/mentalcapacity.htm> accessed 29.09.08

Human Rights Act (1998): London. HMSO.

National Health Service England (2015): Patient Safety Alert: The importance of vital signs during and after restrictive interventions and manual restraint. NHS England.

National Institute of Clinical Excellence (2015): *Guideline - Violence and aggression: Short-term management in mental health, health and community settings*. Department of Health. London.

Patient Safety Alert (2015) Stage One Warning: The importance of monitoring vital signs during and after restrictive interventions/manual restraint.

Royal College of Nursing (2008): *“Restraint Revisited – Rights, Risk and Responsibility: Guidance for Nursing Staff.”* RCN. London

UHPNT Incident Reporting Procedure <http://staffnet.plymouth.nhs.uk>

UHPNT Incident Management policy <http://staffnet.plymouth.nhs.uk>

UHPNT Medicines Management Policy <http://staffnet.plymouth.nhs.uk>

UHPNT Prevention of Violence Policy to Staff at Work <http://staffnet.plymouth.nhs.uk>

UK Core Skills Training Framework V.1.5 Subject 4

Appendix A – Record of Mental Capacity and Best Interest (MCA 2005)

Record of Mental Capacity and Best Interest (MCA 2005)

Part 2 – DETERMINING BEST INTERESTS

All steps and decisions taken for someone who lacks capacity must be taken in their best interests.

Name Of Decision Making Officer: Designation: Signed:		Surname: First Name: Hospital Number: NHS Number: DOB: <i>Affix patient label here</i>
Date process started:		
Ward:		
Who is Representing Patient (NOK, Friend, IMCA)	Include Level of Authority: (i.e. Power of Attorney)	

Please give the name and status of anyone who assisted with making this best interest decision:

Name	Status	Contact Details

Details of the decision to be made on behalf of person who lacks capacity: e.g. medical intervention / DoLS

PART 1 DETERMINING LACK OF CAPACITY

	Response		Comments
	Yes	No	
1. Is there an impairment of, or disturbance in the functioning of the Patient mind or brain?			
2. Do you consider the Patient able to understand the information?			
3. Do you consider the Patient able to retain the information?			
4. Do you consider the Patient able to use or weigh that information?			
5. Do you consider the Patient able to communicate their decision?			
6. Has the Service User been determined as lacking capacity to make this particular decision at this moment in time?			

If you have answered **NO** to Q1 and consistently yes to Q2 to Q5, there is no such impairment or disturbance of the mind/brain and thus **THE PATIENT HAS CAPACITY** within the meaning of the Mental Capacity Act 2005. Sign/date this form above, record the outcome within the patient's records. **Do not proceed any further.**

If you have answered **Yes** to Q1 and **No** consistently to Q2 to Q5, the Patient is considered on the balance of probability, **NOT to have the capacity to make this particular decision at this time.** Please complete **Part 2** with a least one other individual who knows the person/circumstances best (this may not necessarily be NOK).

The MCA (2005) applies to those 16 years and over - you must consider the need for an advocate to be present for all young people aged 16 and 17 years and particularly where children are known to have a neurodevelopmental or mental health disorder. Remember **the safety of the child is paramount** and irrespective of whether the young person does or does not have mental capacity appropriate measures should be taken to ensure the young person's safety.

	Response		Details of Actions
	Yes	No	
Q1. Avoid Discrimination – Guidance Have you avoided making assumptions merely on the basis of the Patient's age, appearance, condition or behaviour?			
Q2. Relevant Circumstances – Guidance: Have you identified all the things the Patient would have taken into account when making the decision for themselves?			
Q3. Regaining Capacity – Guidance: Have you considered if the Patient is likely to have capacity at some date in the future and if the decision can be delayed until that time?			
Q4. Encourage Participation – Guidance: Have you done whatever is possible to permit and encourage the Patient to take part in making the decision?			
Q5. Special Considerations – Guidance: Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death?			
Q6. The Persons Wishes – Guidance: Has consideration been given to the Patient past and present wishes and feelings, beliefs and values that would be likely to influence this decision including written statements?			
Q7. Consult Others – Guidance: Have you where practicable consulted and taken into account the views of others including those engaged in knowing or caring for the Patient, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection? In cases of serious medical treatment including DNR decisions or changes to accommodation and there is no one identified here you must consider instructing an Independent Mental Capacity Advocate.			
Q8. Avoid Restricting Rights – Guidance: Has consideration been given to the least restrictive option for the Patient?			
Q9. Other Considerations – Guidance: have you considered factors such as emotional ties, family obligations that the Patient would be likely to consider if they were making the decision?			
Q10. Having considered all the relevant circumstances, what decision/action do you intend to take whilst acting in the Best Interests of the Patient?			
Signature:			Date:

Appendix B – Clinical Decision Making Tool for: Challenging behaviours / The use of Restraint Intervention

CLINICAL DECISION MAKING TOOL FOR: CHALLENGING BEHAVIOURS / THE USE OF RESTRAINT INTERVENTION

REASON FOR USE

- Patient clinical issues i.e. patient removal of essential medical equipment.
- Patient's personal safety i.e. leaving ward, removal of lines.
- Safety of others i.e. staff, relatives, patients (e.g. aggressive behaviour).

➤ Can the patient understand the consequences of their proposed actions?

Yes

- Inform patient why their behaviour is unsafe and that the Doctors would prefer that they continue their care / treatment.
- Involve family members / NOK in above discussion re: challenging behaviour.
- Commence the **Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint Intervention (Appendix C)** and use strategies described in this to improve compliance.
- Inform the multidisciplinary team.
- Assess and record mental capacity (Appendix A) (N.B. this is on-going and should be repeated frequently in order to reflect changes / fluctuations in capacity).
- Record all of the above in the medical notes.

- Does the patient continue to present with challenging behaviour and have been assessed to **have** mental capacity
- Can the patient understand the consequences of their proposed actions?

Yes

- Does the patient continue to present with challenging behaviour and have been assessed to **NOT have** mental capacity?
- Does the patient understand the consequences of their proposed actions?

Yes

No

No

- Ensure that all strategies used to eliminate challenging behaviour are known to clinical staff
- Record in the patient's notes all interventions
- Datix and alerts on Trust systems (Salus & IPM)

WITH MENTAL CAPACITY

- Ensure that all strategies are used to eliminate challenging behaviour.
- Inform patient that this behaviour will jeopardise **their safety** and that the Doctors would rather they continue with their treatment.
- Inform Medical team and contact next of kin.
- Abide with patient wishes regarding care or discharge.
- If patient continues to be aggressive then refer to UHPNT Policy & Procedure for Individuals who are Violent or Aggressive.
- Instigate behaviour contract.
- If the patient wishes to leave the ward inform G.P and if appropriate make referral to local community services.
- Get patient to fill in appropriate Trust documentation, if they are compliant.
- **Record** in the patient's notes all interventions.

WITHOUT MENTAL CAPACITY

- Ensure that all strategies are used to eliminate challenging behaviour.
- Consider safety of the patient and others (staff/visitors, other patients).
- Complete risk assessment for in Appendix C.
- MDT and best interest decision regarding least restrictive type of restraint intervention if appropriate, (for planned/repetitive restraint).
- Consider use of Independent Mental Capacity Advocate (IMCA) – see Mental Capacity Act Policy for further details.
- If patient attempting to leave ward, use the strategies in the Risk Assessment Record.
- Review / utilise closed doors as part of risk assessment.
- Complete Datix form as necessary.
- Additional guidance may be found in the missing patient procedure.
- Considerations may be required for Deprivation of Liberty Safeguards.
- **Record** in patients notes all restraint intervention.

Appendix C – Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention

Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention.

Surname:
 First Name:
 Hospital Number:
 NHS Number:
 DOB:

This record must be used in the assessment, monitoring and evaluation of any patient who may require physical or chemical restraint intervention in order to maintain the patient’s own safety to protect patients and staff from harm. Restraint intervention must be applied in the event of an emergency in the first instance and always in the best interest of the patient.

Does the patient behaviour have potential to endanger (tick those that apply)?		
Self	Staff	Others

No



Restraint Inappropriate

Yes ↓

Describe this behaviour: (this may be a combination of factors)	Yes	No
Wandering and may decide to leave the ward		
Falling more than once		
Confused and / or disinhibited		
Agitated, Aggressive, Combative (may accidentally remove lines/tubes, climbing out of bed)		

OR

Repetitive removal of non-life threatening medical devices (tick all that apply)			
IVI Peripheral		Dressings (VAC)	
NGT / PEG / PEJ		O2 Mask	
Catheter		Epidural	
Drains			

Potential removal of any one of these life sustaining devices / treatments			
CPAP/NIPPV		Chest Drain	
Inotropes		Art Line	
CVP		ICP Monitoring	
EVD /Lumbar drain		Tracheostomy	



Identify any Reversible Causes and Treat
Pyrexia, Hypoxia, Pain
Withdrawal (nicotine, drugs, alcohol – [CIWA score])
Bowel / Bladder
Fear / Anxiety
Communication, Memory Impairment

Strategies to Consider	Yes	No
Review drug therapy		
Diffuse situation / use minimum of staff		
Utilise verbal de-escalation techniques		
Remove harmful objects		
Involve family or significant other		
Provide orientation stimuli (clock, newspaper, radio)		
Utilise direct observation (1:1 or video monitor room)		
Divisional activities (music, TV)		
Optimise environment		

Is the assessing nurse able to maintain patient safety through the above strategies?

NO ↓

PLEASE SEE OVER

YES ↓

Patient settled and outcome successful
 Document strategies used/ inform MDT

Patient remains unsettled

Inform medical team of potential need for form of restraint intervention and document

Has an assessment been documented of patients Mental Capacity and Best Interests by duty Medical Team / MDT / Patient wishes / Relatives / IMCA?	Date	Time
--	------	------

In view of above decisions and current management plan,
Is Restraint Intervention Appropriate?

Yes

No

Document clinical reasoning

Decision making by clinical staff involved in the care of the patient of **safest, least restrictive option** regarding type of restraint intervention to be selected in accordance to individual patient's condition and situation specific

Identify least restrictive restraint intervention to be used (tick all that apply)	
One to one supervision	
Appropriate use of Bed Rails	
Appropriate use of Seat Belt	
Appropriate use of Locked Doors	
Appropriate use of Posey Control Mitts	
Appropriate use of Pharmacological restraint	
Appropriate use of Physical Interventions (Restraint)	

ORAL or IM lorazepam 500 µg to 1mg STAT dose. Repeat after 30 minutes if necessary.
Max 3mg in 24 hours:
Sedation in 30-45 minutes, peak effect in 1-3 hours.
Lorazepam is to be used with CAUTION in patients with or at risk of respiratory depression (or if appropriate follow alcohol withdrawal protocol)
NB. Local procedures may apply for specific patient groups (e.g. Neurosurgery/ICU/ED) (Please also see Appendix F)

Patient's must be observed throughout – remember
CLINICAL OBSERVATIONS
Monitor RR, HR, BP, SATS every 15 minutes for 1st hour, if agitated continue every 15 minutes.
Once settled and when consider medically stable then every 4 hours

The Care Plan must now be implemented and a copy can be found with additional information in the UHPNT Restraint Intervention Policy or on StaffNet in Safeguarding Adults page

	Print Name	Date	Time
Commence Care Plan			
Date and time restrictive measures implemented			
Signature of risk assessor			
Signature of senior nurse in charge in clinical area			
Relative / Carer / IMCA informed regarding use of identified restraining therapy and provided with Patient Information Leaflet			

Repeat and review risk assessment every 8 hours to ensure that restraining measures remain the most appropriate least restrictive option

Appendix D – Restraint Intervention Care Plan

Restraint Intervention Care Plan

Complete the 'Risk Assessment Record & Clinical Decision Making when Considering the use of Restraint Intervention' tool prior to commencing this care plan.

Indicate type of restraining care required (Tick all which apply)

Posey Mittens		Supportive Observation		Medication		Other restraining care	
Follow manufacture's guidance	<input type="checkbox"/>	Ward level observation	<input type="checkbox"/>	Regular medication	<input type="checkbox"/>	Closed Doors (wards)	<input type="checkbox"/>
Keep leaflet with care plan	<input type="checkbox"/>	Continuous Bay (eyesight)	<input type="checkbox"/>	Evening medication	<input type="checkbox"/>	Low-profile bed	<input type="checkbox"/>
One Hand Mitt	<input type="checkbox"/>	Bedside (1:1)	<input type="checkbox"/>	As required medication	<input type="checkbox"/>	Specialist seating	<input type="checkbox"/>
Two Hand Mitts	<input type="checkbox"/>	Family involvement	<input type="checkbox"/>			Restraint	<input type="checkbox"/>
Frequency of check (hrs)	<input type="text"/>	Frequency of check (hrs)	<input type="text"/>	Frequency of check (hrs)	<input type="text"/>	Frequency of check (hrs)	<input type="text"/>

Frequencies determined by individual level of distress / risks

THE FREQUENCY OF CLINICAL OBSERVATIONS MUST BE DOCUMENTED. OBSERVATIONS MUST BE COMPLETED DURING AND AFTER ALL CHEMICAL/PHYSICAL RESTRAINT AND CONTINUED UNTIL THE PATIENT IS CONSIDERED STABLE BY CLINICIANS.

Mark with a ✓ or a ✗ or a code letter/number or N/A Care Plan commenced by: (Signature of Registered Nurse) Date

Regular care and Observations	Time Hrs & mins																						
Mental State*																							
Alertness*																							
Pain score*																							
Skin assessed (Posey Mitts)																							
Continence check/Toilet offered																							
Drink/food offered / assisted																							
Repositioning*																							
Clinical Observations satisfactory																							
Is patient accompanied?																							
Restraint effective																							
Initials of observer																							
Ongoing need for restraint?																							
Initials of assessor (RN)																							

Consider Deprivation of Liberty Safeguarding (DoLS) application if restraint is on-going, needs escalating, or continuing at day 3

* **Codes for mental state:** S=settled; R = Restless; W = Wandering; A= Agitated **Codes for Alertness:** AL= Alert; D= Drowsy; SL= Sleeping **Codes for pain:** 0 = none; 1=mild; 2=moderate; 3=severe **Codes for positioning:** B= In bed; C= In chair; W= wandering

Rationale, potential risks and process of using Posey Control Mitts as a (restraint) intervention

A Posey Control Mitt is a glove purposely designed to inhibit movement, with netted upper palm and padded underside. It aims to provide a safe form of restraint intervention to restrict movement and is for single patient use only. This form of restraint intervention can potentially constitute an infringement of the patient's right to autonomy but this is potentially outweighed by benefits to the patient, i.e. their use may constitute an act of beneficence. Posey Control Mitts should generally be used where the patient is NOT thought to be exercising a determined wish to have treatment terminated (i.e. is acting involuntarily) OR is not felt to have the capacity to exercise a decision regarding the continuation or otherwise of treatment, (Lothian Stroke Management Network 2009). Indications for use for patients at risk will include the prevention of pulling out of lines such as intravenous, venous and arterial lines and also tracheostomy tubes. In some circumstances and after discussion with patients' consultant and multi – disciplinary team, Posey Control Mitts may be used to prevent repeated accidental removal of NGT and PEGs in patients deemed to lack mental capacity. However, the application of Posey Control Mitts should always be considered on an individual basis and never as routine.

When considering the use of Posey Control Mitts as a form of restraint:

- Refer to the Clinical Decision Making Tool for: Challenging Behaviour / The Use of Restraint Intervention, when considering the use of restraint intervention (Appendix B). It will assist in the decision making process and includes prompts for reconsideration of all alternative methods of calming an agitated patient.
- Undertake a risk assessment using the Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention (Appendix C).
- Treat underlying cause.
- Apply therapeutic approaches first.
- Consider legal and ethical aspects which include:
 - Mental capacity.
 - Deprivation of Liberty.
 - Patient's best interests.
 - Consent.
- Record keeping must be comprehensive and accurate.
- Communicate with multi-disciplinary team and carers.
- Re-evaluate and reassess.

A Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention (Appendix C) has been devised to assist in the decision making

process. It is designed to be used in conjunction with this policy and in line with all relevant UHPNT policies and current evidence. The Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention (Appendix C) **must be utilised** when restraint intervention of a patient is being considered. The tool includes assessment, monitoring and evaluation of any patient who may require restraint intervention in order to maintain the patient's own safety or to protect patients and staff from harm (Sheffield Teaching Hospital Trust 2007).

Application of Posey Control Mitts and interventions to minimise risks of application:

- Utilise Clinical Decision Making Tool for: Challenging Behaviour / The Use of Restraint Intervention (Appendix B).
- Risk assess using the Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention (Appendix C).
- Provide family and patient with reassurance and explanation, including the patient/Carer Information leaflet (information can be found on StaffNet under Safeguarding Adults).
- Keep family and patient involved in the on-going discussions regarding patient restraint.
- Ensure the application of the mittens allows free movement of wrists.
- Utilise Restraint Intervention Care Plan (Appendix D) which ensures that once the decision has been made to utilise a Posey Control Mitts as restraint intervention that the healthcare team continually monitor for physical and psychological adverse effects.
- Observe pressure areas for deterioration and document.
- Assess readiness for removal of restraint at least every 8 hours.
- Review every 15 minutes for the first hour after application or if the patient continues to be agitated.
- Hourly in the calm patient
- Remove mitts every 8 hours so as to monitor skin condition.
- Education for all on the use of restraint intervention.
- Report and adverse effects following Trust Clinical Incident Reporting Policy
- A completed copy of the Risk Assessment Record & Clinical Decision Making Tool when considering the use of Restraint Intervention.

Advice for Nurse for Clinical Area/Caring for Patient

It is important to ensure whoever is requesting a Posey Control Mitts follows UHPNT procedure on the application of restraint intervention and the following relevant documents utilised:

- Clinical Decision Making Tool for: Challenging Behaviour / The Use of Restraint Intervention (Appendix B).

- Risk Assessment Record & Clinical Decision Making Tool when Considering the use of Restraint Intervention (Appendix C).
- Restraint Intervention Care Plan (Appendix D).
- Any adverse effects caused by the use of Posey Control Mitts must be reported following Trust Clinical Incident Reporting policy.

SOP for Low Level Wrist Restraint within ICU

1. Introduction

In serious ill patients who require Critical Care, up to 80% become agitated or confused during their stay. A small number of patients become combative and may injure themselves, their family or their carers. “Chemical Restraint” is employed in the majority of cases, but is not without risk and in the long term sedative agents may be relatively ineffective at controlling agitation and may actually provoke or prolong confusion.

The use of patient safeguarding mitts (Posey Mitt or “boxing glove”) is already sanctioned by the PHNT policy “Restraining Therapies within the Acute Hospital Setting for Adults”. These gloves remove the use of the fingers and as such the patient’s dexterity and ability to hold objects whilst not reducing the mobility of the arms. The intention is that the patient has freedom of movement but will be unable to hold or grasp objects such as central lines, catheters or airways and pull them out. However despite their use a number of staff have been injured whilst providing care to combative patients.

2. Aim

To provide an escalated method of restraining patients beyond that currently described in PHNT policies when caring for confused, agitated, combative patients who represent a risk to staff.

3. Scope

All adult patients in Critical Care. This guideline does not supersede any UHPNT policies but is additional to them.

4. Inclusion Criteria

- Adult patient over the age of 16 being cared for within Critical Care.
- The patient is delirious as assessed by the CAM-ICU and/or the patient lacks capacity as described by the Mental Capacity Act.
- The patient exhibits violent behaviour.
- The patient is a potential risk to staff if unrestrained.
- The patient would require boluses or infusions of sedatives or psychoactive medication to ensure they are not a risk to themselves or others if physical restraints are not utilised.

5. Exclusion Criteria

Physical restraints should not be used if:

- The patient is autonomous and refusing treatment.
- The patient has physical injuries which may be aggravated by the application of restraints.

6. Method of Escalated Physical Restraint

For patients meeting the inclusion criteria above it will be appropriate to use wrist restraints to limit the patient's movement.

The wrist restraint is attached to the patient's wrist whilst the strap is attached to the patient's bedframe. Care should be taken to ensure that the cuff is not too tight. Restraints should not be placed over access devices such as arterial lines or peripheral cannula. These wrist restraints should be used in combination with Posey Mitts.

7. Assessment

Proper placement of restraint, skin integrity, pulses, temp, colour and sensation of the restrained limb should be assessed and recorded at least every hour. This prevents complications, skin breakdown and impaired circulation.

Reassess the patients need for continued use of escalated restraint each hour with the intention of discontinuing restraint as soon as patient's condition improves.

8. Links to Other Guidelines/SOP etc.

UHPNT Management of Physical Intervention (Restraint) for Adults in an Acute Hospital Setting Policy

Authors:	Reviewed By (Group):	Approved By (Lead):	
CN P Branfield	Critical Care Protocol Group	Dr Sam Waddy CD Critical Care	
Implementation Date:	November 2017	Review Date:	November 2019

Core Information				
Document Title	Management of Physical (Restraint) Intervention for Adults in an Acute Hospital Setting Policy			
Date Finalised	Reviewed and updated existing 2010-2012 policy finalised Dec 2013			
Dissemination Lead	Safeguarding Steering Group			
Previous Documents				
Previous document in use?	Yes			
Action to retrieve old copies.	Vital Signs, Matrons meetings ,Nursing and Midwifery meeting			
Dissemination Plan				
Recipient(s)	When	How	Responsibility	Progress update
All staff	Sept 2016	Email	Document Control	
All staff	August 2019	Email	Document Control	

Review		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination &	Is there an outline/plan to identify how this will be done?	Yes

Implementation	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment

Appendix 2

Core Information	
Manager	Named Nurse Adult Safeguarding
Directorate	Safeguarding
Date	July 2016
Title	Management of Physical and Non-Physical Restraint Intervention for Adults in an Acute Hospital Setting Policy
What are the aims, objectives & projected outcomes?	<p>To inform the Healthcare Professional of the legal and ethical issues related to physical and pharmacological restraint intervention.</p> <p>To emphasise that only once the causes of agitation have been addressed and all the relevant parties are in agreement, should restraint intervention be adopted.</p>
Scope of the assessment	

All protected characteristics have been considered when developing this policy. Workforce and Service User monitoring, analysis and publication will be undertaken to ensure compliance with legislative requirements, current guidelines and to meet CQC requirements.

Collecting data

<p>Race</p>	<p>Consideration has been made for patients whose first language isn't English for the restraint process.</p> <p>Consideration has been made if information provided to patients/carers is required in a different language.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>
<p>Religion</p>	<p>There is no evidence to suggest that there is an impact on religion or belief and non-belief regarding this policy.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored</p>
<p>Disability</p>	<p>Consideration will be made if information about the restraint intervention process is required in different formats for people with disabilities/learning disabilities.</p> <p>Consideration is made for those patients lacking capacity to give consent.</p> <p>Patients with a disability have been considered throughout the restraint process.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>

Sex	<p>There is no evidence to suggest that there is an impact on sex regarding this policy for patients.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>
Gender Identity	<p>There is no evidence to suggest that there is an impact on gender identity regarding this policy.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>
Sexual Orientation	<p>There is no evidence to suggest that there is an impact on sexual orientation regarding this policy.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>
Age	<p>Reference to the Mental Capacity Act in this policy only applies to people over the age of 16.</p> <p>Data collected from Datix incident reporting and complaints will ensure this is monitored.</p>
Socio-Economic	<p>There is no evidence to suggest that there is negative impact on socio-economic regarding this policy.</p>
Human Rights	<p>Consideration have been made for "deprivation of liberty" when caring or treating individuals who lack mental capacity.</p>
What are the overall trends/patterns in the above data?	<p>No comparative data has been used to date which means that no trends or patterns have been identified</p>
Specific issues and data gaps that may need to be addressed through consultation or further research	<p>No gaps have been identified at this stage but this will be monitored via data collected from datix incident reporting and complaints.</p>
Involving and consulting stakeholders	
Internal involvement and consultation	<p>Safeguarding Adult's Matron, Consultant Therapist, Matron for Neurosciences, Clinical Educator, Consultant Nurse Hepatology, Health Care of the Elderly Matron, Consultant Anaesthetist, Consultant Physician, Infection Control, Deprivation of Liberty Officer, Mental Health Team, UHPNT Physical Interventions Training lead</p>
External involvement and consultation	<p>Bevan and Brittan Glenborne Community Team</p>

Impact Assessment

Overall assessment and analysis of the evidence	<p>Consideration has been made for patients whose first language isn't English for the restraint process.</p> <p>Consideration has been made if information provided to patients/carers is required in a different language</p> <p>Consideration will be made if information about the restraint process is required in different formats for people with disabilities/learning disabilities.</p> <p>Consideration is made for those patients lacking capacity to give consent.</p> <p>Patients with a disability have been considered throughout the restraint process.</p> <p>Reference to the Mental Capacity Act in this policy only applies to people over the age of 16.</p> <p>Consideration have been made for "deprivation of liberty" when caring or treating individuals who lack mental capacity.</p>
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Action Plan

Action	Owner	Risks	Completion Date	Progress update
Collect and monitor data collected from Datix on incidents and complaints				