# Policy Document Control Sheet

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## Final approval

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<td>Name &amp; Job title of Chairman or Executive Sponsor</td>
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Version Control Table

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<tr>
<td>October 2016</td>
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Contents

Policy Document Control Sheet................................................................. i
Version Control Table ........................................................................... ii
Table of Revisions ................................................................................... ii
Contents .................................................................................................... iii

1 Introduction .......................................................................................... 5
2 Purpose ................................................................................................... 5
3 Scope ....................................................................................................... 5
4 Definitions ............................................................................................. 6
5 Management .......................................................................................... 7
  5.1 Restraint in Emergency Situation .................................................... 7
  5.2 Before Using Restraint .................................................................... 7
    The Environment .................................................................................. 7
    Behavior & Underlying Condition ...................................................... 7
  5.3 Using Restraint ................................................................................ 9
  5.4 Methods of Restraint ...................................................................... 10
  5.5 Communication & Documentation .................................................. 14
  5.6 Evaluation and Review of Use of Restraint ...................................... 14
  5.7 Reporting of Injuries ...................................................................... 14
  5.8 Involvement of Security Staff in Restraint of Patients ....................... 14
  5.9 When to Contact the Police ............................................................. 15
  5.10 Training & Education .................................................................... 15
6 Monitoring ............................................................................................... 16
  6.1 Compliance and Effectiveness Monitoring ....................................... 16
  6.2 Compliance and Effectiveness Monitoring Table ................................ 16
7 Associated Documentation ..................................................................... 16
  7.1 References ....................................................................................... 16
  7.2 Associated Documents ..................................................................... 18
  7.3 Appendices ....................................................................................... 18

  Appendix 1 – Additional Information on Consent (Department of Health, 2001),
  Mental Capacity, Duty of Care and Other Legal Aspects of Restraint ........ 19

  Appendix 2 – Restraint Decision Support Tool ....................................... 23

  Appendix 3 – Challenging Behaviour in People with Cognitive Impairment –
  Think Delirium! ..................................................................................... 24
Appendix 4 – Challenging Behaviour in People with Cognitive Impairment – If Delirium Excluded. 25

Appendix 5 – Equality Impact Assessment 26
1 Introduction

Section 6(4) of the Mental Capacity Act 2005 states that someone is using restraint if they:

• Use force - or threaten to use force - to make someone do something they are resisting.
• Restrict a person's freedom of movement, whether they are resisting or not

Restraint is the use of threat or force to help carry out an act which a person is resisting.

The deprivation of liberty standards of the mental capacity framework are for people who need to be deprived of their liberty in a hospital or care home in their best interests for care and treatment where they lack capacity to consent to the arrangement for their care and treatment.

Staff within County Durham & Darlington NHS Foundation trust will, from time to time, encounter situations where restraint is indicated in order to protect the safety of patients or to deliver life sustaining medical treatment. Where restraint is applied it must be done with the patients best interests at the centre of any decision that is made and within the law and best practice guidelines described in this policy document.

2 Purpose

This document provides information and guidance on the use of restraint for adult patients in County Durham & Darlington NHS Foundation Trust. The policy outlines principles (contained within the appendices) and practice guidance.

This policy does not relate to the routine clinical use of sedation within anaesthetics and critical care or clinical treatment areas such as endoscopy or radiology when conscious sedation is required.

3 Scope

The guidance in this policy applies to all staff employed by CDDFT, including staff that are contracted on a temporary basis or who provide services as sub-contractors of the organisation (including PFI providers). Staff will ensure that they are aware of their responsibilities as described in this policy.

DUTIES

Executive Director of Nursing

The executive director of nursing is the executive lead for this policy and will receive assurance, via care group lead persons, of the application of this policy.

Associate Director of Nursing
The associate director of nursing is the policy owner and will ensure that the policy content reflects law and national best practice. The policy owner will be supported in this role by the clinical standards matron and the trust lead for mental capacity.

**Care Group Clinical Directors**

Care group clinical directors will ensure that staff across their care group are aware of the content of this policy and will assure themselves, via care group governance groups, that the policy is being applied consistently where restraint is being used in practice.

**Clinical Leads**

Clinical leads will provide medical leadership in the application of this policy and will ensure that medical teams are aware of their accountability in the assessment of patient capacity and involvement of patients in decisions about their care and treatment. Clinical leads will assure themselves that medical teams are aware of the prescribing limitations associated with restraint.

**Matrons**

Matrons will provide nursing leadership in the application of this policy and will ensure that nursing teams are aware of their accountability in the assessment of capacity and use of restraint in the clinical environment. Matrons will assure themselves that where restraint is being used in practice it is being undertaken within the principles outlined in this policy document.

Departments are responsible for ensuring that detailed care plans and risk assessments are carried out.

### 4 Definitions

Whilst a basic definition of restraint might be ‘restricting movement’ or ‘restricting liberty’, many nursing interventions may restrict unintended movement, for example plaster casts to stop a client accidentally displacing a fracture, or may unintentionally restrict movement, for example a nursing home locked at night to protect residents and staff from intruders.

According to established international definitions, included within *Showing restraint: challenging the use of restraint in care homes* (Counsel & Care UK, 2002), restraint is defined as ‘the intentional restriction of a person’s voluntary movement or behavior’. In this context, ‘behaviour’ means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is ‘stopping a person doing something they appear to want to do.’

- ‘Let’s talk about restraint’: rights, risks and responsibility. RCN 2008
5  Management

5.1  Restraint in Emergency Situation

It is acknowledged that decisions on the use of restraint methods to be applied to patients in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such restraint may lead to complaints by patients or their relatives. Unlawful restraint may give rise to criminal or civil liability (see Appendix 1). It is self-evident that staff may be required to account for their actions in such circumstances. However the Trust will always support employees who act in a way that is deemed reasonable and measured at the time of the incident and in accordance with professional standards and training.

5.2  Before Using Restraint

Restraint will only be used when the trained person using it reasonably believes it is necessary to prevent harm to the person and the restraint used will be proportionate to the likelihood and seriousness of harm.

This policy and others will be maintained to ensure that people who lack capacity will not be deprived of their liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

Before using restraint an individual assessment should be carried out which considers:

- The environment
- Patient's behaviour
- Patient’s underlying condition and treatment
- Patient’s mental capacity
- Duty of care
- Risk to patient and to others

The Environment

The care environment can have either a positive or a negative effect on patients. Every effort should be made to reduce the negative impact of the environment. Examples of environmental factors which can have a negative impact include: extreme staffing shortages impacting on quality of care or levels of supervision, restricted observation in patient areas, high levels of noise or disruption, boredom or the incorrect level of stimulation for patients and negative attitudes/poor communication skills of staff.

Behavior & Underlying Condition

Understanding a patient’s behaviour and responding to individual needs should be at the centre of patient care. All patients should be assessed comprehensively in order to establish what sort of therapeutic behaviour management 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 are:

- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Mental health problems – (organic e.g., dementia and delirium or functional e.g., mania or schizophrenia)
- Other form of memory impairment
- Drug dependency or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)
- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)

If a patient’s mental health is an issue, the mental health liaison services can be contacted for advice/support.

Often behaviour such as wandering is problematic for staff. However this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.

Having identified the reason for the behaviour, the Clinical Team should then decide on the appropriate strategy for dealing with this in conjunction with other members of the multidisciplinary team (to include treatment of the underlying cause). This should be documented in the medical or nursing/multidisciplinary notes.

**Mental Capacity (see Appendix 1)**

It is necessary to consider the patient’s mental capacity, as consent for the use of any type or method of restraint must be gained from patients, unless they lack mental capacity to make this decision. Patients should be “informed partners” in their health care. The Trust policy on Consent to Examination or Treatment should be referred to and adhered to. Assessment of capacity must be in accordance with the Mental Capacity Act.
A capacity issue is decision and time specific. Individual patients cannot simply be described as “lacking capacity”. A patient’s capacity may fluctuate.

All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. All decisions must be recorded in the patient’s clinical record.

**Duty of Care (see Appendix 1)**

All health care staff has a duty of care for the patients in their care. This means acting in their “best interests”. In relation to a patient who is at immediate risk of harm, the use of restraint may be part of fulfilling duty of care.

**5.3 Using Restraint**

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. Therefore when using restraint a balance must be achieved between minimising risk of harm or injury to the patient and others and maintaining the dignity, personal freedom and choice of the patient.

Some situations are identified where steps taken amount to more than a restraint and may amount to deprivation of liberty. Relevant factors may include:

- If restraint is used including sedation to admit a person to an institution where the person is resisting admission.
- Where staff need to exercise complete and effective control over care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others or permitted to live elsewhere unless staff in the institution considers it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

Restraint should only be used as a last resort and only when alternative methods of therapeutic behaviour management have failed. Its use should be proportional to the risk of the situation. The method used should be the least restrictive and be effective and safe.

Inappropriate use of restraint may be viewed as a form of abuse and a safeguarding concern. (See Trust Policy on Safeguarding Adults policy) When restraint is used it should be considered
in a systematic and planned way according to the individual needs of the patient. Where possible, decisions concerning the use of restraint should be discussed and agreed by the patient’s medical consultant, the patient and the relatives and carers, and the multidisciplinary team.

Ideally decisions should be made with both those close to the person, and the healthcare team caring for that person, who agrees, are in the person’s best interests. Family members cannot require clinicians to provide a particular treatment if the health care professionals involved do not believe that it is clinically appropriate. However as a matter of good practice you should explain to people close to the patient why you believe any treatment they may have suggested is inappropriate. An example of the latter might be a relative who requests that bed rails are used, when the multidisciplinary team consider this to be inappropriate.

A decision support tool is available in appendix 2 of this policy that staff must use when considering restraint of any patient.

5.4 Methods of Restraint

Acceptable Methods of Restraint

The following methods of restraint are acceptable when used appropriately (i.e., in accordance with the principles and guidance outlined in this Policy):

Please refer to the algorithms in appendix 3 and 4 for guidance.

Medication/chemical sedation. There are certain situations in which patients may benefit from anti-psychotic medication, such as in cases of extreme restlessness or agitation or if a patient is very frightened. This situation may arise postoperatively. Prescribing advice should be sought as appropriate. All staff prescribing or administering benzodiazepines or anti-psychotic drugs must be familiar with the properties of these drugs.

Chemical sedation, in the form of rapid tranquilisation. This may be used to restrain patients who are acutely disturbed, the aim being to:

• Calm or lightly sedate the person.

• Reduce physical and psychological strain.

• Reduce the risk of violence.

• Reduce the risk of injury to self and others.

This should only be used only as a short term measure and in conjunction with treatment for the cause of the psychomotor agitation e.g., psychiatric illness.

If a patient is acutely disturbed a doctor must be called to assess the patient. Non-psychiatric causes for disturbed behaviour must be explored and excluded.

Prior to using rapid tranquilisation there should be an assessment of risk. It should only be used when the risk of not using rapid tranquilisation is greater than the risk of the acute pharmacological treatment.
As with other forms of restraint, other interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical sedation.

The patient must be informed that he/she is to be given medication. Oral medication should be the first choice. If the patient is unable to give informed consent, then treatment within the Medicines Policy under Common Law should be given. Consideration must be given to the appropriateness of using powers under the Mental Health Act, utilising the Liaison Mental Health Service.

The minimum effective dose of medication should be used. The maximum BNF doses (for older patients this should be half of the recommended dose) should only be used in exceptional circumstances. Polypharmacy with same class medication should be avoided.

Review of current oral medication for co-existing medical illness and its impact on side effects should be reviewed/considered.

Any existing 'care plans' for preferable medication to be used in the event of acute psychomotor agitation, should be taken into consideration.

Oral medication should be offered before parenteral treatment is administered.

Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation (using pulse oximeter) and level of consciousness should be monitored every 15 minutes after intra muscular (IM) injections, and every 5 minutes after intravenous (IV) infusions for the first hour, and then hourly for 4 hours and until the patient becomes active again. Measurements should be documented in the patient's notes. It is recognised in some circumstances this level of observation may not be practical and could fuel the challenging behaviour. A case by case decision is required and the reason behind any variances should be clearly documented.

Adequate physical restraint should be achieved before attempting parenteral administration in a struggling patient.

Please refer to appendix 3 and 4.

**Physical techniques.** If physical techniques are to be used as an acceptable means of intervention by a particular ward or department, this should be agreed by the Directorate and appropriate training provided for staff that are likely to be involved. Staff trained in Conflict Resolution training – managing violence and aggression.

Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation (using pulse oximeter) and level of consciousness should be monitored every 15 minutes during and after physical restraint is under taken for the first hour, and then hourly for 4 hours and until the patient becomes active again. Measurements should be documented in the patient’s notes. It is recognised in some circumstances this level of observation may not be practical and could fuel the challenging behaviour. A case by case decision is required and the reason behind any variances should be clearly documented.
Preventing patients from leaving the hospital site. Decisions in relation to this should be made according to the individual circumstances and by considering the patient's best interests. Staff should refer to Section 5 above. Preventing a patient from leaving the hospital site will ordinarily be in response to an emergency situation and will therefore be a short term measure. This must be followed up by a full assessment and plan for on-going intervention.

Staff safety and the safety of others in the immediate vicinity must be taken into consideration. Where necessary advice should be sought from the Patient flow manager. Consideration must be given to reporting instances to the police (see Section 7.7).

Please refer to the missing patients policy and consider an urgent authorization for a Deprivation of Liberty. (Refer to Deprivation of Liberty policy)

Soft sides/bed rails. The RCN (2004) suggests alteration of the environment and meeting the comfort needs of the patient rather than using bed rails. Soft sides should be used where possible, as they are less likely to cause injury than bed rails. “The only appropriate use of bed rails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed.” (NPSA, 2007).

Before using bed rails you should consider alternatives, such as:

• A change to the position of the bed in relation to the ward environment.

• Asking relatives or carers if they can stay with the patient at certain times.

• Allocating a nurse to stay with the patient.

• Engaging 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.

• Reality orientation.

• Reminiscence.

• Diversional therapy.

In deciding whether to use bed rails you should carry out a risk assessment using the standard bed rails assessment form. This should consider criteria both for and against the use of bed rails, in relation to the individual patient, as well as the likelihood of the patient falling out of bed.

The decision to use bed rails should be a team decision where possible, following discussion with the patient and their relatives / carers.

If you decide to use bed rails you should ensure that the bed is kept at the lowest level possible, apart from when elevation is necessary to comply with good practice in manual handling.

If the patient is being transported on a bed it may be appropriate to use bed rails. Side rails should be used whenever a patient is transported on a trolley.
If bed rails are in use with thicker pressure relieving mattresses, staff should be aware that the height of the bed rails is effectively reduced. Alternative arrangements may be necessary, such as the hire of pressure relieving equipment with integral bed rails. Each situation should be assessed individually.

**Unacceptable Methods of Restraint**

The following methods of restraint are generally unacceptable. However as stated above you must always act in the patient’s best interests:

**Inappropriate bed height.** This is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed.

**Harnesses.** Harnesses should not be used, as they result in numerous risks to the person including pressure sores, chest infection.

**Inappropriate use of wheelchair safety straps.** The safety straps on wheelchairs should always be used, when provided for the safety of the user. 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.

**Using bean bags/inappropriately low chairs for seating.** Bean bags can provide comfortable seating for people who are physically frail and/disabled, but should not be used with the intention of restraining the person. 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. Both bean bags and low chairs also pose risks to staff in relation to manual handling.

**Chairs whose construction immobilises patients.** E.g. reclining chairs. Reclining chairs should be used for the comfort of the patient and not as a method of restraint.

**Baffle locks and locked doors.** Baffle locks may be used in psychiatric settings, but are unacceptable in an acute general hospital setting. Doors should not be locked without due attention to health and safety requirements in relation to fire.

**Arranging furniture to impede movement.** In general other 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.

**Stair gates.** Stair gates may be appropriate in a domestic environment. It is important that any equipment is used for the purpose for which it is intended.

**Inappropriate use of night clothes during waking hours.** This is demeaning and should not be used as a way of restraining people in any care setting.

**Removal of outdoor shoes and other walking aids/withdrawal of sensory aids such as spectacles.** As with the above, these are not acceptable ways of restraining people in any care setting. Removal of sensory aids can cause confusion and disorientation.

**Isolation.** Isolation should not be used, except in designated psychiatric treatment areas. It is important to note however that 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.

5.5 Communication & Documentation

Clear communication with patients is essential in relation to the use of restraint. Written information should be used where possible to supplement verbal information given where possible.

There should be a written care plan. A care plan should include:

- Rationale for the use of restraint.
- The frequency of re-assessment of the need for restraint. Review times should be specified in advance.
- All discussions that have taken place to allow patient to give informed consent and to assess best interests.
- Discussions with relatives, carers and others as to restraint.
- Details about the use of the restraint itself.

5.6 Evaluation and Review of Use of Restraint

The use of restraint should be evaluated in terms of its effectiveness and alternatives considered wherever possible. For planned use of restraint this should involve a discussion at ward level.

The use of restraint in an emergency situation (including the use of rapid tranquillisation) should be viewed as a critical incident and an Incident Form should be completed. The factors, which led up to the use of restraint and its appropriateness, should be discussed and reviewed by the ward team.

5.7 Reporting of Injuries

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.

5.8 Involvement of Security Staff in Restraint of Patients

Situations may arise when additional support is required (additional to that already available on the ward or department). In these cases security staff should be contacted. The aim of this service is to assist staff in maintaining the health and safety of patients, staff and visitors.

Situations in which the security staff are required to assist should be treated as critical incidents and a review undertaken following the event including all those involved. Such reviews should be co-ordinated by the Ward Manager, with the support of the Matron, out-of-hours – patient flow manager, security manager and should be multidisciplinary where possible.
In most instances security guards will not know the patient or the circumstances surrounding their care and treatment. Staff who know the patient will therefore have a greater knowledge as to what is in the patient’s “best interests” and should advise security guards accordingly. The usual issues in relation to patient confidentiality should be taken into consideration when sharing patient details with non-clinical staff.

Where there is a restraint of a patient by security staff clinical staff must maintain responsibility for the safety and wellbeing of the patient and will only act upon instruction by the clinical staff unless there is a spontaneous incident.

Security staff will only apply restraint if they are directed to do so by clinical staff following a clinical risk assessment. Unless there is a spontaneous incident where they would protect patients staff, and others from harm.

In terms of infection control, all staff including security staff should use universal precautions, as per the Trust Infection Control Policy, when intervening in a way that will or might involve contact with blood or body fluids.

5.9 When to Contact the Police

There are certain situations where the police may be able to provide help and support:

- A violent situation where the safety of staff, patients or others is at risk.
- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and is threatening to commit suicide or may come to harm or cause harm to others. In these cases the police have powers under the Mental Health Act to take the person to a place of safety, which in most cases would mean bringing the person to hospital, to be assessed.

Please refer to the trust missing patient policy for further information.

- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and you have serious concerns about the welfare or safety of that individual (e.g., the effect of not taking important medication) or others. In these circumstances the police may be able to check on the person by visiting them at home.

In the 2nd and 3rd situations above you should also follow the normal procedure for discharge against medical advice. Prior to contacting the police you should contact your manager and the patient flow manager.

5.10 Training & Education

It is a legal requirement that staff who restrain must be trained in the use of restraint techniques. Staff that require training will be identified within the trust training needs analysis and training will be available via people and organisational development.

Attendance at Essential Training is recorded by People & Organisational Development (P & OD) and entered onto the Trust Training Management System, OLM. Monitoring of non-attendance will be in line with the Training Needs Analysis, Monitoring and Evaluation Policy and carried out by P & OD. Please refer to this policy for detailed information.
6 Monitoring

6.1 Compliance and Effectiveness Monitoring
Performance will be measured on a regular basis as shown below.

6.2 Compliance and Effectiveness Monitoring Table

<table>
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<th>Response</th>
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<td>Who will perform the monitoring?</td>
<td>Security manager, Adult Safeguarding Lead, Patient Safety Manager</td>
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<tr>
<td>What are you monitoring?</td>
<td>Evidence that, where restraint has been used and reported via safeguard, that there is evidence of appropriate decision making.</td>
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<td>When will the monitoring be performed?</td>
<td>Annually</td>
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<td>How are you going to monitor?</td>
<td>An audit of case notes. The sample will be patients identified via the safeguard system that have been restrained in the last 12 months.</td>
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<tr>
<td>What will happen if any shortfalls are identified?</td>
<td>Action plans will be developed Individuals involved will receive feedback where appropriate</td>
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<td>Where will the results of the monitoring be reported?</td>
<td>Safety Committee</td>
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<tr>
<td>How will the resulting action plan be progressed and monitored?</td>
<td>Safety committee will receive action plans and seek assurance of there full implementation</td>
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<tr>
<td>How will learning take place?</td>
<td>Key themes will be communicated to staff via care group leadership teams.</td>
</tr>
</tbody>
</table>

7 Associated Documentation

7.1 References


Counsel and Care (2002) Showing restraint: challenging the use of restraint in care homes. London: Counsel and Care UK


MHRA “Atlantic Bed Rails” MDA/2010/080


National Patient Safety Agency (2007) “Resources for reviewing or developing a bedrail policy”


Royal College of Nursing (2008) “Let’s talk about restraint”

Watson R and Brunton M (1990) “Restrain Yourself” Nursing the Elderly May p 21-22

7.2 Associated Documents

This policy should be read in conjunction with the following policies:

- Adult Safeguarding Policy
- Child safeguarding
- Guidelines for restrictive physical intervention and therapeutic holding for children and young people
- Mental Capacity Act policy
- Management of violence & aggression and Lone worker Policy
- Being open policy
- Incident management policy
- CCTV Procedure
- Pharmacy and Medicines Management – Covert Medication
- Body Worn Camera Procedure

7.3 Appendices

Appendix 1 – Additional Information on Consent

Appendix 2 – Restraint Decision Support Tool

Appendix 3 – Challenging Behaviour in People with Cognitive Impairment – Think Delirium!

Appendix 4 – Challenging Behaviour in People with Cognitive Impairment - If Delirium Excluded

Appendix 5 – Equality Analysis/Impact Assessment
Appendix 1 – Additional Information on Consent (Department of Health, 2001), Mental Capacity, Duty of Care and Other Legal Aspects of Restraint

1. Consent

If a patient is not capable of giving or refusing consent, it is still possible for you to lawfully provide treatment and care, unless such care has been validly refused in advance (e.g. using an Advance Directive). However such treatment or care given without consent must be in the patient’s “best interests”.

No one, not even a spouse or others close to the person, can give consent on behalf of an adult who is not capable of giving consent for him or her self. It is important however that those close to the “incapacitated” person are consulted and involved in the decision making.

2. Mental Capacity

Adults are always presumed to be capable of taking healthcare decisions unless the opposite has been demonstrated or is suspected.

If you are unsure as to whether a patient lacks capacity to make a particular decision, you should make an assessment of this, by drawing on the assistance of specialist colleagues as necessary.

A patient who has the capacity to make a particular decision, will be able to:

• comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question , and

• use and weigh this information in the decision making process, and

• communicate their decision

In order to assess a patient’s comprehension and ability to use information to make a decision you should do the following:

• Explore the patient’s ability to paraphrase what has been said (repeating and rewording explanations as necessary).

• Explore whether the patient is able to compare alternatives or to express any thoughts on possible consequences other than those which you have disclosed.

• Explore whether the patient applies the information to his or her own case.

Patients should be assisted to make their own decisions if at all possible.

Capacity should not be confused with your assessment of the reasonableness of the patient’s decision. Consideration should be given as to whether a patient who does not have capacity will regain capacity and is so when.

Stereotyping should be avoided. It must not be assumed that a patient lacks capacity because of age or in view of the patient suffering from any particular illness, disease, injury or disability.
Mental capacity and ability to communicate one’s decisions are separate issues. You should take all steps that are reasonable in the circumstances, to ensure that patients can communicate their decisions. Examples of this include using interpreters and communication aids and involving specialist colleagues such as speech and language therapists.

If a patient lacks capacity in relation to a decision concerning the use of restraint, due regard should be given to any relevant prior expressed wishes, such as those contained within an Advanced Directive or to the views of a person appointed under a Lasting Power of Attorney.

Staff are also referred to the Mental Capacity Act 2005 and in particular Part I – Sections 1-6 inclusive The Act can be found at www.dh.gov.uk/publications.

Section 35-41 provide information on Independent Mental Capacity Advocates (IMCAs), which must be made available where “serious medical treatment” is proposed and the patient lacks capacity to consent to treatment and there is no other person available to advise on the patient’s best interests.

3. Duty of Care

In deciding what is in a patient’s “best interests” you should not just limit your decision only to things that will benefit the patient medically. You should also consider the views and beliefs of the patient (or their previous views and beliefs, if no longer able to articulate these), their general wellbeing, their relationships with those close to them and their cultural, spiritual and religious welfare (DOH, 2001b).

Decisions about what is in a patient’s best interests should if possible be agreed both with those close to the patient and with the healthcare team caring for the patient. However if such an agreement cannot be reached in relation to a significant decision, the Courts can be asked to determine what is in the patient’s best interests. The Trust Solicitor will advise as to the making of any necessary Court application.

You should decide what level of “duty of care” is required by measuring your practice against the standard of “an ordinary skilled nurse”, if you are a nurse, “an ordinary skilled porter”, if you are a porter, etc.

Legally there are no precise details as to what comes within one’s duty of care. Advice should be requested in all cases of uncertainty.

Four main ethical principles should also be respected where possible when considering your duty of care, although it must be acknowledged that these principles may be in conflict with one another. You should always:

• Intend to do the patient good (beneficence).

• Intend to do the patient no harm (non-maleficence).

• Treat all clients fairly and equally (justice).

• Aid and respect the patient’s right of self determination (autonomy).
4. Other Legal Aspects of Restraint

4.1 Duty of Care and Negligence

In relation to the law, the term “duty of care” is usually used in relation to negligence. For a negligence case to be established, the following three elements must be proved by the claimant:

• The defendant must owe a duty of care to the person who has suffered harm.

• There has been a breach of the duty of care by a failure to adhere to a reasonable standard of care.

• This breach has caused reasonable foreseeable harm.

4.2 Common Law

The common law is made up of the decisions of judges in individual cases and is different from the law that is set out in various Acts of Parliament, such as the Mental Health Act (Statute Law or Legislation) and rules and regulations made under those Acts. Common law changes over time according to the decisions of judges in various cases. (See Dimond, 1995 “Legal Aspects of Nursing” for more information on the law). Common Law is often referred to as case law. The concept of “duty of care” has its origins in common law.

4.3 Accountability

In terms of having to account for your actions in relation to the use/non use of restraint, there are four areas of accountability:

• Accountability to your employer i.e. the Trust (Trust policies and guidelines outline your responsibilities in relation to your employment).

• Professional liability to your regulatory body i.e. accountability to the NMC for nurses, GMC for medical staff.

• Civil liability. This is your responsibility in relation to a case which goes to court (civil court) seeking the payment of damages. This may be a “negligence” case, an assault or battery or false imprisonment or a human rights case.

• Criminal liability. This is your responsibility not to commit a criminal act.

The four areas of accountability above are closely linked i.e. what is expected by your employer (the Trust) as acceptable practice in relation to restraint will be in line with one’s civil and criminal liabilities and will be based on the advice of a professional body, where such advice exists.

In addition to the above you are also accountable to patients, the public and society as a whole. The Trust will make legal advice available.

See “Legal Aspects of Nursing” (Dimond, 1995) for more information on the above.
4.4 Assault, battery and False Imprisonment – what are they?

Assault, battery and false imprisonment are referred to in legal terms as “trespasses to the person”. They are “torts”, or in layman’s terms, “civil wrongs”. Negligence is another type of tort.

**Battery** is the intentional application of force to another person in a hostile manner or against his will. It is not necessary to show the intention to injure.

**Assault** is an act by a person, which puts another person in fear of battery.

**False imprisonment** is the unlawful imposition of constraint on another’s freedom of movement from a particular place.

Battery and false imprisonment in particular, are important considerations when deciding whether or not to use restraint.

Assault is also a criminal act.
Appendix 2 – Restraint Decision Support Tool

Does the patient lack capacity to consent to the proposed restraint?

Yes

Has the patient made a valid and applicable advance decision refusing the type of restraint being proposed?

Yes

That particular restraint cannot be used

No

Is restraint necessary to prevent harm to the patient?

Yes

Is the patient have an attorney under a LPA or a court appointed deputy?

Yes

Restrain cannot be used unless it is to protect others from harm

No

Is the restraint proportionate to the likelihood and seriousness of harm?

Yes

Is the restraint in the patients best interests?

Yes

Complete risk assessment. Amend care plan. Inform patient & family/carer

No

Use prescribed restraint & Review.

No

Does the patient have an attorney under a LPA or a court appointed deputy?

No

Restraint cannot be used

Yes

Is the restraint the least restrictive means by which the patient can be kept safe from harm?

Notes

1. Refer to the mental capacity act 2005 for further guidance
2. Ensure that all decisions relating to restraint are clearly documented in the clinical record
3. Only trained staff may restrain patients

If the prescribed restraint is likely to be frequent, cumulative and on-going consider whether you need NOLS authorisation

No

Restraint cannot be used unless it is to protect others from harm

Can use restraint without the patients consent unless, under common law, it is used to protect others

Restraint cannot be used

Yes

That particular restraint cannot be used

If the attorney/deputy has authority does he/she consent to the use of restraint?

No

Restraint cannot be used

Yes

Is the restraint the least restrictive means by which the patient can be kept safe from harm?
 Appendix 3 – Challenging Behaviour in People with Cognitive Impairment – Think Delirium!

**Challenging Behaviour in People with Cognitive Impairment - Think Delirium!**

**START HERE**

“Delirium is characterised by disturbed consciousness and a change in cognitive function or perception that develops over a short period of time.” [WHO 2010]

**RECENT CHANGE IN MENTAL STATE?**

- Altered **cognitive function** (fluctuating orientation, impaired attention and memory).
- Altered **perceptions** (hallucinations).
- Altered **physical function** (reduced mobility, hyperactivity, altered sleep pattern, restlessness or agitation).
- Altered **social behaviour** (agitation, aggression, irritability, personality changes).

**Typically occurring over hours to days**

**HIGH RISK GROUPS**

- Age >65
- **Cognitive impairment or dementia**
- Recent hip fracture
- Severe illness e.g. cardiac/ hepatic/ renal failure
- Sensory impairment
- Previous history of delirium
- Urinary catheter
- On > 5 medications
- Dehydration, constipation, immobility
- Recent sleep disturbance or significant environmental changes

**MAKE DIAGNOSIS – CLINICAL SUSPICION OR POSITIVE TOOL e.g. CAM**

**IDENTIFY POSSIBLE CAUSES**

**COLLATERAL HISTORY EXAMINE / INVESTIGATE**

**TREAT URGENT CAUSES** e.g.

- **SEPSIS, HYPOXIA, HYPOGLYCEMIA**

**TREAT ALL IDENTIFIED CAUSES** (NB no specific cause can be identified in up to 30% of cases – if clinical picture is consistent with delirium then manage as such). **MULTIPLE CAUSES ARE THE NORM.**

**GENERAL MEASURES**

- Explain condition to patient and carers.
- Consider social care input.
- Review medication and stop high risk meds if possible (particularly anticholinergics, sedatives, opioids).
- Ensure glasses and hearing aids present and working.
- Promote calm and consistent environment.
- Provide aids to orientation – clock, calendar, appropriate lighting for time of day.

**NURSING MANAGEMENT**

- Treat pain if needed (consider Abbey Pain Scale).
- Encourage mobilisation.
- Identify and manage constipation.
- Ensure adequate hydration.
- Ensure adequate nutrition.
- Avoid / remove urinary catheter if possible.
- Review risk factors regularly.

**SYMPTOMATIC TREATMENT**

- Consider medication if patient is severely distressed or symptoms threaten their safety or that of others.
- First line medication **HALOPERIDOL** e.g. 0.5mg regular od / bd.
- Start low and go slow.
- Stick to ONE sedative medication & titrate cautiously.
- Avoid HALOPERIDOL in those with diagnosis of Lewy body dementia – alternative is **LOKAZEPAM** e.g. 0.5mg od / bd.
- Review medication after 72 hours and reduce / stop if possible.

**REVIEW DIAGNOSIS AND CAUSES REGULARLY**

Symptoms can persist for days or weeks even after precipitating cause has been resolved.

**CONSIDER SPECIALIST REFERRAL IF:**

Symptoms persisting or worsening after 5-7 days.
Potential need for hospital admission is identified.
Risk to patient or others is difficult to manage.

**SUGGESTED FIRST LINE INVESTIGATIONS:**

- Urea & Electrolytes, FBC, CRP, Glucose, Calcium.
- Urine dipstick & MSU. Other cultures if clinical suspicion of possible infection.
Appendix 4 – Challenging Behaviour in People with Cognitive Impairment – If Delirium Excluded.

Challenging Behaviour in People with Cognitive Impairment
If Delirium Has Been Excluded

Chronic or Gradually Deteriorating Behavioural or Psychiatric Symptoms
Or Acute Behavioural Change is Not Due to Delirium
Challenging behaviour is usually an expression of an unmet need or cause for distress. Successful management involves trying to identify and address the need.

- Consider using a behaviour chart with family or carers to identify:
  - Antecedents
  - Behaviour
  - Consequences
- Identify the nature of the behaviour:
  - Is this physical aggression, verbal hostility, restlessness, hallucinations/delusions, mood changes, sleep problems, other?
- Identify and remove/modify any immediate causes or triggers:
  - Changes in environment – noise, light, overstimulation, new people.
  - Changes in patient – physical disease or symptoms, depression.

Assess and manage pain – consider using the Abbreviated Pain Scale.
- Consider prescribing analgesia even if patient is not overtly complaining of pain – RCT evidence that this can reduce agitated behaviour in dementia.
- Regular Paracetamol as first line, follow WHO analgesic ladder as required.

Non-pharmacological interventions are first line management. These must be based on the unmet needs which have been identified, and take account of the person’s life history and preferences.

- Identity: Life story work
  - Develop a patient’s life story with them and family, use this to engage them in reminiscence conversations.
- Attachment: Promote contact with close relationships.
  - Use doll therapy cautiously and seek advice e.g. has the person ever lost a child?
- Occupation: Identify the person’s level of function/ability and engage them in what is meaningful to them (consider their interests and occupation).
- Comfort: Consider sensory interventions e.g. textures, smells...
  - Try to where possible promote the person having control of personal care.
- Inclusion: Modify physical environment to ensure that the person is included in things which are meaningful to them.

Pharmacological interventions have a limited role, and usually for short term management. Consider when non-pharmacological measures are ineffective, symptoms are severe and distressing and/or risk is severe. Use of antipsychotics in dementia is associated with increased mortality and risk of stroke.

- Physical aggression – consider RISPERIDONE e.g. 0.5mg od (AVOID in Lewy body dementia)
- Agitation/restlessness – consider SSRI (e.g. SERTRALINE 50mg od) or TRAZODONE e.g. 50mg od (unlicensed)
- Hallucinations/delusions – consider RISPERIDONE or HALOPERIDOL e.g. 0.3mg od (AVOID in Lewy body dementia)

An anti-dementia medication may be the most appropriate choice for longer term use – seek specialist advice.

Review medication regularly – do not continue antipsychotic for longer than six weeks.

Consider Specialist Referral if:
- Symptoms persisting or worsening.
- Potential need for hospital admission identified.
- Potential for care arrangements to break down.
- Risk to patient or others is difficult to manage.
- Comorbid depression / anxiety disorder is suspected.

Consider Caregiver Interventions:
- Social Services referral (Rapid Response if urgent need)
- Peer Support agencies.
- Counselling / psychological support.