RESTRAINT

VERSION No	3
REVIEWED BY	Mariana Philipova
NUMBER OF PAGES	24

Policy Statement
This organisation takes seriously the safeguarding of its residents and staff. This policy clarifies where the use of restrain is considered and the steps that all staff need to take in order to comply with current advice and legislation.

INTRODUCTION TO RESTRAINT: ***related specifically to older people and people with dementia: rights risks and responsibilities***

This introduction aims to help staff to:

- ✓ ***Understand what restraint is***
- ✓ ***Provide person-centred care that minimises the need for restraint***
- ✓ ***Understand the legal and ethical frameworks relevant to restraint***
- ✓ ***Know what to do if they suspect inappropriate or abusive use of restraint***
- ✓ ***Understand the circumstances in which restraint may be legally or ethically appropriate***
- ✓ ***Understand how to minimise the risks if restraint is used.***

While this introduction cannot provide all the answers, its aim is to give staff a framework for decision-making that helps them to provide the best possible care for every older person in their care.

What is restraint?

Whilst a basic definition of restraint might be 'restricting movement' or 'restricting liberty', many interventions may restrict unintended movement, for example, plaster casts to stop a service user accidentally displacing a fracture, or may unintentionally restrict movement, or 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 and Care UK, 2002), ***restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.' 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.'***

Legal definition
The most relevant legal definition of restraint for care homes in England is that found in the Mental Capacity Act (2005) and its amendments:
Section 6 (4) of the Act states that "someone is using restraint if they:

- ✗ ***use force – <u>or threaten to use force</u> to make someone do something that they are resisting, or***
- ✗ ***restrict a person's freedom of movement, whether they are resisting or not." (14 Section 10.4)***

The definition is deceptively short, but is supported by extensive guidance to assist in its interpretation, and it is, or will be, ultimately interpreted through the decision of the courts in specific cases. The brief outline that follows is not intended as a substitute for the Code of Practice issued with the Mental Capacity Act 2005 but merely to indicate some of its salient features.

It is legal to use restraint only if certain conditions are satisfied:
In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in

the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

Any action intended to restrain a person can be legal if the person consents (as long as there has been no coercion), but restraint of a person who lacks capacity to consent has to meet two conditions:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm. (Section 6.41; the terms in italics are further elaborated in the Code of Practice, Mental Capacity Act 2005)
- In addition, the person´s lack of capacity cannot be assumed simply because they have some cognitive impairment or illness. The person who is considering undertaking restraint should take reasonable steps to establish whether the individual lacks capacity in relation to the matter in question, and should reasonably believe that is will be in the best interests of the person to use restraint, bearing in mind possible benefits, risks and consequences. There is a process (that is, a set of indicative questions) outlined in the Code of Practice to establish whether someone has capacity to make a particular decision.

Types of restraint

- ***PHYSICAL RESTRAINT*** *involves one or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.*
- ***MECHANICAL RESTRAINT*** *involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.*
- ***TECHNOLOGICAL SURVEILLANCE*** *such as tagging, pressure pads, infrared sensors, closed circuit television, or door alarms is often used to alert staff that the person is trying to leave or to monitor their movement. Whilst not restraint in themselves, they could be used to trigger restraint, for example through physically restraining a person who is trying to leave when the door alarm sounds. These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.*
- ***CHEMICAL RESTRAINT*** *involves using medication to restrain. This could be regularly prescribed medication, including that to be used as required, over-the-counter medication, or illegal drugs.*
- ***PSYCHOLOGICAL RESTRAINT*** *can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.*

If an action fits the definition of restraint, it is not automatically unacceptable or wrong. Malicious and abusive use of restraint can occur, but even for the vast majority of caring and conscientious staff, decisions about restraint are not easy or straightforward. A discussion of the ethical, legal, practical, and professional issues follows, to help staff understand the difference between unacceptable or abusive restraint and the rare ***circumstances in which restraint may be justified or positively required, to help strike the right balance between independence and safety. It is not possible to give a list of what kind of equipment, physical holding, or medication constitutes restraint, as it depends upon the circumstances. A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.***

Is it a restraint or not? Examples:

1. *Following treatment in hospital for a heart condition, a service user develops dangerously high blood pressure levels. As part of her treatment, she is heavily sedated within a critical care environment. This does not fit the definition of restraint, as the sedation is being given to treat her illness, not to control her behaviour.*

2. *Following admission to hospital with a heart condition, a service user who also has dementia is unable to settle, and constantly wanders. After two nights with little rest, his legs have become very oedematous, and there is a concern that his constant movement is exacerbating his heart condition. Sedation is prescribed. This may fit the definition of restraint, as the sedation is directed at controlling the service user's behaviour. However, it is likely to be justified if the ethical and legal principles set out later in this guidance are met.*

3. ***An older person has been admitted to a care home for a period of respite. He is very unsettled at night, finding it hard to sleep. He constantly walks around the home looking for his wife. Staff find it difficult to support this service user and ask the GP to prescribe sedation. This could fit the definition of restraint, and is unlikely to be justified. Alternative ways of supporting the service user to settle, such as conversation and reassurance, could be found.***

4. ***Following a series of strokes, an older person in a rehabilitation hospital needs help from nurses and a hoist to get out of bed. He is also unable to communicate his needs. He is restless at night, has muscle spasms, and is at risk of falling out of bed. Nurses decide bedrails would be in his best interest, to reduce the risk of an accidental fall. This does not fit the definition of restraint, as the bedrails are not controlling his behaviour or preventing him from doing something he wants to do.***

5. *An older person is admitted to a care home after treatment for a hip fracture that occurred in her own home. The older person is unsteady when mobilising, and often forgets to use her walking frame. Her relatives are very worried a second hip fracture could result in fatality. They ask staff to put bedrails up to prevent her from getting out of bed alone to use the toilet at night. This could fit the definition of restraint, as the older person appears to want to get out of bed. It is unlikely to be justified as alternative methods of reducing the risk of further falls, and so reassuring her relatives – could be found.*

When might restraint be used?

Adults who may be at risk can be justifiably restrained in some cases, in the following circumstances:

- Displaying behaviour that is putting themselves at risk of harm
- Displaying behaviour that is putting others at risk of harm
- Requiring treatment by a legal order, for example, under the Mental Health Act 2007
- Requiring urgent life-saving treatment
- Needing to be maintained in secure settings

This applies to individuals being cared for by staff working in all types of settings, including continuing care, mental health, critical care and care in the community. While abuse or restraint can occur in institutions, it may also happen in people's own homes. Staff working in hospitals, care homes, or the community who suspect restraint is being used abusively: whether through information a service user or carer discloses to them, or by what they have observed, should report the information to their employer. If staff believes there is a risk of harm to a service user, they are required to report poor practice.

Legislation and national guidance is always subject to change. Staffs have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

Restraint outside the UK

Vest, belt or cuff devices specifically designed to stop people getting out of beds or chairs are in relatively common use in hospital and care home settings in many countries outside the UK, including in Europe, the USA and Australia. ***These devices are not acceptable in the UK. Staff employed in the UK should make sure they understand standards of acceptable practice****.*

Restraint as a last resort

In most circumstances restraint can be avoided by positive changes to the provision of care and support for the older person. It should be noted that a person with capacity to consent might request items, such as lap belts or bedrails, to enhance their feeling of safety and/or security. Whilst this may not be according to a recommendation, an individual's choice should be acknowledged and included in a care plan and risk assessment. When a service user cannot give informed consent, staff should always explain what they are doing, seeking their understanding and agreement. A study suggests that even service users who were delirious when restrained, later remembered and valued staff' explanations of what was happening to them, particularly reassurances that staff were trying to keep them safe (Minnick, Leipzig and Johnson, 2001).

An example of good practice of good practice

Recent design principles to help service users with dementia have led to the development of small family-orientated households that support 12 older people, with a ratio of one member of staff to five service users. Through a design that excludes corridors – which can often be confusing for people with memory impairment, these units help service users to live more independently, be involved in purposeful activity and have safe access to a secure garden. Cues, signs, pictures for behaviour, memory and reality are provided within the design, helping people with dementia to maximise their independence, reducing their reliance on others. An open plan environment enables staff to observe residents without high levels of intrusion. Meanwhile a 'no uniform' policy removes the constant reminder that staff are different from service users.

The creation of a comfortable, relaxed environment where individuals feel valued, confident and safe reduces incidences of older people trying to leave the building or presenting with challenging behaviour, which may often lead to restraint. In addition, staff who try to understand the underlying reasons for a person's behaviour, and what that person is attempting to communicate, are more likely to help service users in distress. In essence, a combination of well-considered environmental features and a workforce that has developed person-centred care reduces the need for inappropriate restraint.

Ethical issues

Basic ethical concepts underpinning every day practice include:

- ***Obligations and duties:*** identifying our moral obligations to other people can help us determine what we should do in a given situation
- ***Avoiding harm:*** perhaps the most essential ethical concept and the basis for good practice
- ***Assessing the consequences of action:*** the ethically appropriate action may be determined by calculating its potential benefits and harm
- ***Autonomy and rights:*** respect for the individual's rights to make their own decisions and respect for the rights of others
- ***Best interests:*** identifying and acting in the best interests of others is a commonly applied means of ethically justifying an action or decision
- ***Values and beliefs:*** from which we may formulate ethical principles. Resolving an ethical problem is rarely straightforward and can be challenging to all concerned. In terms of making decisions about physical restraint, it is often difficult to avoid harm, as both: restraining or not restraining could bring about harm.

Staff have obligations to all those in their care and, if allowing one person freedom of action causes harm to others, ***decision-makers need to strike a balance between the consequences of applying or not applying restraint.*** The use of restraint as a first line response is not conducive / favourable to a positive social environment. ***If people feel enabled to do things, rather than prevented from following their desires, they are more likely to be in a better state of emotional well-being over time.*** Making decisions about the best course of action can be difficult. As part of their training and continuing professional development, staff need to discuss real and theoretical dilemmas. Except in emergencies, individual decisions about restraint and policies or guidance should be discussed within multi-disciplinary teams, with the involvement of the older person and their carers, as far as possible.

Making an ethical decision - case study

Sarah works in a care home. Although one resident, Mrs Green, suffers from Alzheimer's disease, she usually appears very happy to live there. Mrs Green has a slight temperature and a visit from her GP has been requested. In the meantime, Mrs Green becomes very agitated, and attempts to leave the home, apparently believing it is many years ago and her small children are at home alone. Sarah has tried to reassure Mrs Green, telephoning her daughter to ask her to visit the nursing home, but in her anxiety Mrs Green is pushing past her to go out of the front door.

Sarah has professional, legal and ethical obligations towards Mrs Green. She foresees that, in these circumstances, it is unlikely she can avoid some degree of harm occurring. She is aware that either preventing Mrs Green from leaving the care home, or allowing her to go out alone, will result in harm. In assessing the consequences of her actions, Sarah concludes that, as Mrs Green is unable to look after her own safety and could come to serious harm if allowed to leave the home unaccompanied, restraining Mrs Green's movements, although distressing, is likely to be the least harmful action.

Preventing Mrs Green from leaving overrides her right to freedom. However, this must be balanced against her right to be free from physical harm. Mrs Green is currently unable to make an autonomous decision about whether she should leave; therefore it is acceptable that Sarah makes a carefully considered ethical decision on her behalf. Sarah can ethically justify her actions, as she is acting in Mrs Green's best interests. In order to minimise Mrs Green's distress, Sarah calls another staff member to accompany Mrs Green on a walk outside to wait for her daughter's arrival, reassuring her that her family are safe and on their way to meet her at the home.

Legal issues for staff

This is to outline the broad requirements under the law. Staff have different obligations relating to their different roles, in other words, they have those belonging to any member of the public, and those relating to their professional or contractual duty of care.

The law that would cover restraint comes from ***both criminal and civil law***. Different Acts of Parliament may apply in each UK country. Relevant Acts of Parliament that impact on the law relating to restraint include:

- Offences Against the Person Act 1861
- Mental Capacity Act 2005
- Adults with Incapacity (Scotland) Act 2000
- Human Rights Act 1998.

When is restraint justified in law?

Situations in which restraint can be justified include where the service user gives informed and voluntary consent as part of a planned programme of care. In other cases, the ***staff may have a professional duty of care to restrain a service user to protect that service user from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others. In a situation where a staff or other person is being attacked or is at risk of physical harm, it is possible to justify***

the use of restraint as self-defence.

Mental Capacity Act 2005

The Act creates and clarifies the common law on consent in England and Wales. A short summary of the key provisions of the Mental Capacity Act 2005 is set out in this introduction. A fuller set of materials on the application of each Act is given in the useful material section.

The Mental Capacity Act 2005 affects everyone aged 16 and over and provides a statutory framework to empower and protect people who may not be able to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries.

The Mental Capacity Act 2005 lays down five principles that relate to the protection of capacity and each must be respected in relation to the provision of healthcare:

1. ***A person must be assumed to have capacity unless it is established that he lacks capacity***
2. ***A person is not to be treated as unable to make a decision unless all practicable steps to help him to do have been taken without success.***
3. ***A person is not to be treated as unable to make a decision merely because he makes an unwise decision.***
4. ***An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.***
5. ***Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of actions.***

The Mental Capacity Act 2005 sets out the legal definition of the status of an individual who lacks capacity. A person is unable to make a decision for himself if he is unable:

a) to understand the information relevant to the decision
b) to retain that information
c) to use or weigh that information as part of the process of making the decision, or
d) to communicate his decision (whether by talking, using sign language or any other means).

The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as being competent and able to make the decision. In a situation where restraint is being considered for a service user who lacks capacity, the Mental Capacity Act 2005 does allow for treatment to be provided as long as this is in the best interests of the individual. The Act requires that the following factors must be considered before any action is taken for the person lacking capacity:

a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
b) the beliefs and values that would be likely to influence his / her decision if he / she had capacity, and
c) the other factors that he would be likely to consider if he were able to do so.

The Mental Capacity Act 2005 sets out the conditions in which an act may be planned that would constitute restraint of a service user who lacks capacity. ***Restraint is defined in the Act as action that uses, or threatens to use, force to secure the doing of an act which the service user resists, or restricts the service user's liberty of movement, whether or not the service user resists. This legal authority to restrain a service user is allowed only if the following three conditions are satisfied:***

- ***The service user lacks capacity in relation to the matter in question***
- ***The staff reasonably believes that it is necessary to do the act in order to prevent harm to the service user***
- ***The act is a proportionate response to:***
  - ***a) the likelihood of the service user's suffering harm and***
  - b) ***the seriousness of that harm.***

The Court of Protection has been created which can decide the lawfulness of any act done or yet to be done in relation to that person, including any omission or course of conduct. It is possible that where staff are working in settings in which restraint is a real possibility for service users who lack capacity, that some challenge may be made to the Court of Protection about the potential for forms of restraint to be declared unlawful. Good record keeping and sound policy development will be considered by the Court of Protection in such cases to assess whether the three conditions have been met.

Consent

Consent is the legal means by which the person gives a valid authorisation for treatment or care. This could include giving consent to an agreed form of restraint. The legal basis of consent is identical to the professional requirement that consent is needed before carrying out any treatment. ***The case law on consent has established three requirements which must all be satisfied before any consent given by a person can be sufficient:***

- ☑ ***The consent should be given by someone with mental capacity***
- ☑ ***Sufficient information should be given to the person***
- ☑ ***The consent must be freely given.***

Professionals who are personally regulated have professional accountability under their Code of Conduct to ensure that while caring for service users 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.

Consent must be freely given and no threats or implied threats used. Coercion or manipulation of the service user would tend to imply that consent has not been obtained voluntarily. In this situation, even where the service user signs a consent form, the consent will have been obtained in an unlawful manner and the consent will not be valid.

Abuse of restraint – two case studies

1. *An older people's specialist nurse visited a service user in a care home. Although the home appeared to be very caring, she was concerned that staff seemed overly protective. She was surprised to see many residents in special chairs, which appeared to be restricting their freedom to move independently. The nurse contacted her manager to talk through her concerns. After discussions between agencies, the care home was provided with support to update its practices, enabling it to strike the right balance between safety and freedom for individual residents. More frequent unannounced inspections have also been introduced.*
2. *A community psychiatric nurse (CPN) made an assessment visit to a new service user who had a diagnosis of Alzheimer's. The nurse was concerned to find that the service user's daughter routinely locks him alone in his bedroom, while she attends a part-time job. The daughter is convinced that this is the best way to keep him safe, and is unwilling to consider alternatives. The CPN discussed the situation with the multi-disciplinary team. After an emergency case conference, an arrangement was made whereby the daughter accepts a day care place and carers for her father. This arrangement is closely monitored, with plans in place to intervene if the daughter returns to locking her father in his room.*

Safeguarding Adults at Risk (SAAR) DBS is a statutory system that requires employers to refer staff that works with adults at risk directly to the Secretary of State who can impose a 10-year workforce ban on anyone who has been assessed as being unfit to work with adult service users. In addition to staff, it applies to those employed in care homes, independent hospitals and domiciliary care agencies, as well as those who provide personal care in someone's own home. It requires health care providers and local authorities to have systems in place to act, when allegations are made that adults who are defined as vulnerable / at risk, through their need for support or care, are at risk of physical, sexual, financial, verbal or psychological abuse. This includes systems to exclude care workers who have been identified as perpetrators of abuse,

from further employment with people at risk.

While abuse or restraint can occur in institutions, it may also happen in people's own homes. Staff working in hospitals, care homes, or the community who suspect restraint is being used abusively, whether through information a service user or carer discloses to them, or by what they have observed, should report the information to their employer.

Legislation and national guidance is always subject to change. Staff have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

The law and restraint – a case study

Tom is an adult with significant learning difficulties and care needs, who lives in a group home. He has been unwell for several days and when his GP visits, he suspects Tom has developed type I diabetes. Tom is close to collapse, needing urgent hospital care and treatment for dehydration and ketoacidosis. While waiting for an ambulance to arrive, Tom's GP tries to establish intravenous access, but Tom dislikes needles and does not co-operate. Staff from the home who are familiar with Tom try to reassure him, explaining in simple language the importance of the treatment, but Tom is unable to grasp the seriousness of his illness. The GP asks staff at the care home to hold Tom's arms still, while he finds a vein, explaining this needs to be done as soon as possible, as delays in treatment will expose Tom to risk of death or significant brain damage.

This is likely to be legally justified. No assumption has been made that Tom lacks capacity simply because of his learning disability and, given the emergency, as much as possible has been done to help Tom understand the situation, however he appears to lack capacity, as he cannot understand that his illness is life-threatening. Members of staff present have discussed the issues as much as is reasonable in an emergency. Delaying while they consult relatives or an advocate would not be reasonable in these circumstances. The nurses and GP believe holding Tom whilst they establish intravenous access – even if this causes distress and is done against Tom's wishes – is justified in Tom's best interests, to reduce the risk of greater harm from treatment delays.

Mental Health Act

The Human Rights Act (1998) sets out clear guidance on the freedom of the individual. The use of restraint must be justified by a clear rationale. This should explain why other considerations are believed to override individual freedom of action.

Like any member of the public, under common law staff can use reasonable force to prevent harm to themselves or others. This public duty is most likely to be used in response to violence and aggression from a service user, as a justification for restraining a service user to protect staff from harm, or to protect other service users or members of the public. The Human Rights Act 1998 does not apply to care homes run by independent providers, but does apply to NHS settings.

You may find it helpful to consult *Human rights in healthcare: a framework for local action*, produced by the Department of Health in 2007. You can download this publication from the Department of Health's website: www.dh.gov.uk/en/Publicationsandstatistics/ Publications/

The Mental Health Act 1983 and in particular the 'Emergency Admission and Detention under the Act'

Civil Law

Under the Law of Tort, If staff restrain a service user without a sound professional and legal basis, the service user may bring a civil claim against the staff in negligence and make a claim for compensation for any harm suffered as a result of the restraint. Where any service user can show that he or she has suffered harm, which can be physical or psychological which was directly caused by the restraint and which was foreseeable, the courts will have to assess any professional standards that existed at the time to see whether the restraint was reasonable. If the

actions of the staff fell below those standards it is possible that a claim in negligence will succeed. The facts of each case will be important and a review will take place of the length of time that the restraint lasted and the amount of force used. Both factors will be justified to show that they are both reasonable and professionally accepted. It is important that any use of restraint should be reasonably anticipated and steps taken to record this fully in the clinical records. If the nature of the restraint is such that only named staff can undertake this, it would be advisable that their full names and job title are clearly recorded. If training is needed for a particular form of restraint, each healthcare professional should keep a clear record of that training.

Criminal Law

Restraining another person without their consent may be a criminal activity. The staff who carries out an unlawful restraint may face criminal prosecution that could lead to a fine or imprisonment depending on the severity of the restraint. It is important that whenever restraint is used by a staff, it is in accordance with accepted professional standards that are justified in the particular circumstance. Any prosecution under criminal law will consider whether the restraint amounted to an offence under an Act of Parliament that could include assault, unlawful detention, ill treatment or wilful neglect.

Contracts of employment often set out the limits of a staff practice, and require staff to adhere to locally approved policies, procedures or protocols relevant to restraint. This might include detailing how decisions on restraint in different circumstances are to be made, who is responsible, and other requirements, such as having undertaken competency-based training, and the carrying out of risk assessment to reduce the possibility of unintended harm before using restraint. Requirements on documenting decision-making and actions taken are likely to be covered both by professional standards and contracts of employment.

If restraint is used – three case studies

1. *New management took over a residential care home where some residents had confusion or dementia. Previous policy had been to keep all exits locked. After reviewing the residents' needs, and discussing the issues with all the care team, it was decided it would be much less restrictive if the garden gates could be secured, while doors into the garden could be fitted with new handles that were easier to open. The front door was fitted with a lock that could be opened from the inside, while technology was installed that rang a portable buzzer, carried by a nurse on duty, when the door was opened. This practice fulfils the requirement that if restraint is used, it should be the least restrictive option.*

2. *Managers of a unit providing intensive support for adults with significant mental health needs knew that, despite the skills of their staff, including their training in therapeutic care, occasions may arise when physical restraint would be needed to protect service users from harming themselves or others. To ensure this would be done as safely as possible, they provided extensive theoretical and practical training, with clear roles and responsibilities, planning and debriefs. They also devised a process for continual revision and updating of plans for assessing and reducing the risks involved in using restraint. This practice fulfils the requirement that if restraint is used, it should be as safe as possible.*

3. *Although no longer needing sedation for therapeutic reasons, a service user recovering from a head injury in intensive care became very agitated, attempting to remove equipment that his survival depended upon. Although the emergency was managed, with further sedation used as a chemical restraint, plans were made to gradually reduce this sedation as soon as possible, with staff attempting to manage his care through positive alternatives to restraint. This practice fulfils the requirement that if restraint is used, it should be for as short a time as possible.*

Building exit controls

Units or homes providing support and care for adults may have a variety of controls on how people can enter or leave the building. These include:

- ☑ Buildings which are locked constantly, fire exits can be opened but are alarmed
- ☑ Buildings where a receptionist controls everyone going in and out
- ☑ Doors which require a number code before they can be opened
- ☑ Doors with 'baffle handles' that are difficult for a person with cognitive impairment to open
- ☑ Doors painted to resemble bookcases with the intention of distracting someone from recognising and using the door
- ☑ Stripes and pattern changes on flooring near doorways intended to direct the person away from this area
- ☑ Tagging systems that raise an alarm if a tagged person approaches the door
- ☑ 'Loop' building designs that encourage a person to walk in circles, never finding the front door
- ☑ CCTV installed to observe all exits.

Is this a restraint?

Providers of buildings-based services have a responsibility to maintain safety for everyone who is visiting, staying, living or working there, including securing the building from intruders. However, there may also be an assessed need to prevent an older person who is a resident or service user from leaving, in order to protect their safety and well-being. This needs to be done in the most dignified way possible. Often subtle design changes in buildings, décor and doors can distract a person from leaving.

What support should employers provide?

Organisations, as well as the individual members of staff within them, have a duty of care. To help ensure restraint is not used abusively, and that staff and other staff are supported in making appropriate decisions about restraint, employers should provide:

- ☑ A policy or guidance for staff on the use of restraint
- ☑ A multi-disciplinary approach to individual care planning, including regular planned reviews of care
- ☑ A system for reporting incidents where service users or staff were harmed, or could have been harmed, and learning from them
- ☑ Clear channels for raising concerns about possible abuse of restraint
- ☑ Access to independent advocates for service users
- ☑ Risk assessment procedures, so that risks involved in using restraint can be anticipated and reduced
- ☑ Appropriate education, including clinical supervision, reflective practice, learning from best practice, and competency based training
- ☑ Regular audit related to restraint, including benchmarking against other comparable organisations
- ☑ Dementia care training and awareness for staff in all services.
- ☑ ***Employers should also ensure that: Staffs are not pressured to comply with a request from a person's relative to restrain them, when it is not in their service user's best interests***

Developing a policy on restraint in critical care – a case study

A service user who was being cared for in ICU had been sedated on a ventilator for some time. Their condition had improved and they were being weaned off both sedation and the ventilator. However, clearly the service user still had no capacity to consent and was manifesting behaviour that was likely to cause themselves harm – for example, by pulling out IV lines. Following organisational protocol, a second senior medical and nursing opinion was sought. This was explained to the service user's family. A decision to use mittens was taken to bridge the time between when the sedative drugs were wearing off and the service user regained their capacity and was no longer a danger to themselves. The decision was recorded in the service user's medical and nursing notes and reviewed at least twice daily.

In this case it was felt more beneficial to use mittens to prevent harm, rather than sedating the service user thereby increasing the risk of further harm. Providing purpose-made mittens was an important risk reduction, in comparison to improvised bandaging.

Restraint doesn't happen here' – what the National Patient Safety Agency (NPSA) says

"We were concerned to find occasional reports to the National Patient Safety Agency where nurses had let delirious or suicidal service users get into very risky situations, because they thought it was in all circumstances wrong to stop a service user doing what they wanted to do, or had been unsure whether to assist in life saving treatment because a service user – although clearly lacking capacity through head injury or delirium – was not co-operating.

"To find out more, we contacted lead nurses in a variety of health care settings to ask if they had policies on restraint. Many organisations shared thoughtful, practical and service user-centred policies, but some replied that they most certainly did not have policies on restraint, because they would not tolerate restraint in their organisation in any circumstances. One person even returned the questionnaire on restraint with a cover note saying 'in response to your questions on elder abuse…'

"It appeared that both some individual nurses and some organisations were working to the assumption that restraint was never justified in any circumstances, and autonomy was the only ethical principle they needed to follow. But if an organisation takes the position 'it doesn't happen here' any problems just get hidden. And if staff don't have a clear understanding of the circumstances where restraint is justified or positively required, they won't be able to recognise the circumstances where restraint is wrong or abusive." ***Martin Fletcher****, Chief Executive, NPSA*

The Policy

Implementation of this policy will help the home to address important outcomes for residents' choice, rights, independence and inclusion and will contribute to joint working with other agencies. The safety of staff during physical interventions is of equal importance to the best interests of residents, and both take priority over the care of property, which can be replaced.

Defining Physical Intervention

In this document, the term 'physical intervention' refers to a range of physical actions used as techniques for responding to challenging behaviour, and which involve some degree of direct physical force to limit or restrict movement or mobility; this can include the removal of an aid to mobility that is normally used by that person.

There are three main types of physical intervention:

- *Direct physical contact between a member of a staff and a resident. Examples include holding another person by the arm to stop self-harm; using manual guidance to stop a person*

wandering into the road; or two people each holding a person and guiding him or her to a seat, if agitated;

- *The use of barriers to limit freedom of movement, for example placing door catches beyond the reach of residents;*
- *Materials or equipment which restricts or prevents movement. Examples include using a splint to limit the movement of an arm or leg. (mechanical)*

Physical intervention implies the restriction of a person's movement that involves resistance. It is therefore different from forms of physical contact such as manual prompting, physical guidance or simply support. Over time, the term 'restraint' has acquired a number of negative connotations. It is also a term that is closely linked with a particular kind of approach to the management of aggressive and violent behaviour, 'Control and Restraint', or 'C and R'. For this reason, this document uses the more neutral term 'physical intervention', to indicate a continuum between touching, holding and restraint, and the link with other approaches of de-escalation to be used in conjunction with physical interventions at all times.

Hence the use of physical intervention needs to be consistent with the Guidance issued by the Department of Heath April 2014. Positive and Proactive Care: reducing the need for restrictive interventions. https://www.gov.uk/government/publications, from which the following principles are defined: **Principles:** *[Paragraph 58] The safe and ethical use of all forms of restrictive interventions.*

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded **on eight overarching principles:**

- Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of the techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions should only be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans and restrictive interventions.

Key principle	What it means	What it looks like in practice
Participation	Enabling participation of all key people and stakeholders	Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights.
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach	Clearly outlining responsibilities under the Mental Health Act and the Mental Capacity Act (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards.
Non-discriminatory	Avoiding discrimination, paying attention to groups who	Using person-centred planning approaches that do not discriminate on the basis of religion or belief, race or culture, gender, sexual

	are vulnerable to rights violations	preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights.
Empowerment	Empowering staff and people who use services with the knowledge and skills to realise rights	Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions;
Legality	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy.

National Policy and Legal Context

The use of physical interventions involves important legal and ethical considerations, which need to be fully understood by the organisation. Any physical intervention must employ the minimum level of force, for the least amount of time needed. Furthermore, it cannot be used solely to force compliance with staff instructions.

The use of any degree of force is unlawful if the particular circumstances do not warrant it.

Therefore, physical force could not be justified to prevent a resident from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force. The degree of force employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. The degree of force and the duration of its application should always be the minimum needed to achieve the desired result; frequently the role of staff is to allow the patience and time required to achieve this minimum.

Justification also includes the right of every citizen to 'self-defence', which applies for all situations for all staff and residents. In order to be justifiable in court, the use of force must be reasonable and appropriate to the circumstances.

It is an offence to lock an adult in a room without a court order (even if they are not aware that they are locked in). The exception is the use of a locked room as a temporary measure while seeking assistance, which would provide legal justification; however, there are instances where an adult could be at risk due to lack of awareness of danger, which could provide a reason for restriction to a room or area. Such use needs to be part of a care plan and risk assessment, not an *ad hoc* solution. To the extent that seclusion involves restricting a person's freedom of movement, it can be considered a form of physical intervention.

Justification (as a legal defence) for using physical interventions needs to address these questions:

- Is there clarity about how the intervention helps the resident concerned?
- Are there any conflicts of interest where staff experience fewer demands or less stress when physical interventions are used?
- What steps have been taken to reduce the likelihood that the physical intervention will be used in the future?
- Is the justification for this resident specifically, or for 'all' in the group?

Under Health and Safety legislation, employers are responsible for the health, safety and welfare of employees, in addition to the health and safety of persons not in employment, including residents and visitors. This requires employers to assess risks to both employees and residents arising from work activities, including the use of physical interventions. Employers need to establish and monitor safe systems of work, and to ensure that employees are suitably trained. Use of physical intervention may give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned, making proper training and use of physical interventions imperative.

Providers of health and social care services owe a duty of care towards residents, which requires that reasonable measures to prevent harm are taken. Hence, in some circumstances, it may be

appropriate to employ certain kinds of physical intervention to prevent a significant risk of harm. ***Physical interventions ought only to be used when other strategies have been tried and found to be unsuccessful, or when the risks of not employing an emergency intervention are outweighed by the risks of using one. The physical intervention needs to use the minimum force to prevent injury or to avert serious damage to property, and be applied for the minimum amount of time.***

Use of physical interventions needs to be consistent with the *Human Rights Act 1998* and its Articles. These are based on the presumption that every person is entitled to:

- ✓ ***Respect for his or her private life***
- ✓ ***The right not to be subjected to inhuman or degrading treatment***
- ✓ ***The right to liberty and security***
- ✓ ***The right not to be discriminated against in his or her enjoyment of those rights.***

Physical interventions need to be specific to residents, integrated with other less intrusive approaches, and clearly part of a person-centred plan of care reducing risk, when needed; they must not become a standard way of coping, or as a substitute for training in people- related skills.

Chemical restraint

Chemical restraint refers to: "The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness".

Chemical restraint will be used only for person who is highly aroused, agitated, interactive, and aggressive, is making serious threats or gesture towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

Chemical restraint will only ever be delivered in accordance with acknowledged, evidence-based best practice guidance and prescribed by a medical professional for example GP, doctor or prescribing RN or CPN. The prescribers will provide information to us regarding any physical monitoring that may be required as well as the medication to be used and the route of medication. The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term "rapid tranquillisation" refers to intramuscular injections and oral medication. Oral medication should always be considering first. Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.

This organisations policy aim is to follow the summary of action laid out in Guidance issued by the Depart of Health April 2014. Positive and Proactive Care: reducing the need for restrictive interventions to ensure that the quality of life of a resident is enhanced and that their needs are better met which will reduce the need for restrictive interventions, and that staff and those who provide support are protected.

- All services where restrictive interventions are used must have an identified **board level** for increasing positive behaviour support planning and reducing restrictive interventions.
- All services where restrictive interventions may be used should have **restrictive intervention reduction programmes** in place. Such programmes must be based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, resident empowerment and a commitment to effective models of post incident review.
- In those services where people can reasonably be predicted to be at risk of being exposed to restrictive interventions, individualised support plans must incorporate the key elements of **behaviour support plans.** This will include how needs will be met and environment structured to reduce the incidents of behaviour of concern. They must also detail how early warning signs of behaviour escalation can be recognised and responded to together with plans for the safe application of restrictive interventions if a crisis develops.

- Plans for the use of physical or mechanical restraint **must not include the deliberate application of pain** in an attempt to force compliance with instructions, painful holds or stimuli cannot be justified unless there is an immediate threat to life.
- Where behaviour support plans, or equivalent which incorporate the key components, are used, reviews of their quality of design and application should be included within a service provider's **internal audit** programmes.
- Appropriate governance structures and transparent policies around the use of restrictive interventions must be established within a context of positive and proactive working.
- The choice of any restrictive intervention that has to be used must always represent the **least restrictive option** to meet the immediate need.
- Wherever possible, people who use services, family carers, advocates and other relevant representatives should be **engaged in all aspect** of planning their care including how to respond to crisis situations, post-incident debriefings, rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.
- Provider organisations must use a process whereby there **is board level (or equivalent) authorisation** and approval of the restrictive interventions taught to their staff and used in practice.
- Organisation that provide care and support to people who are at risk of being exposed to restrictive interventions must have clear organisational policies which reflect current legislation, case law and evidence of best practice. Accessible versions of the policies should be available to those who use the services,
- Services must publish **a public, annually updated, accessible report on the use of restrictive interventions** which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.
- Service **commissioners** must be informed about restrictive interventions used for those for whom they have responsibility.
- There must **be clear and accurate recording** of the use of restrictive interventions to evaluate services progress against their restrictive intervention reduction programmes.
- Service provides must ensure that **post-incident reviews and debriefs** are planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.
- All staff who may be required to use restrictive interventions must have high quality, specialised training.
- Service commissioners must assure themselves that the **service has the necessary competencies** to provide effective support for the people they are funding.

In addition to the above guidance CQC have issued brief guides for inspectors with regard to restraint and inspections which providers will find useful. You will find this under "brief guides for inspection teams" on their website http://www.cqc.org.uk/content/brief-guides-inspection-teams From the above guidance definitions of restraint are outlines below:

- **Physical restraint**: any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- **Prone restraint:** (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is faced down of has their face to the side. It includes being placed on a mattress faced down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.
- **Chemical restraint** (This brief guide does not cover the use of chemical restraint. Refer to brief guide on cycle active medicines for people with learning disabilities): The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness
- **Mechanical restraint:** this is the use of a device (e.g belt or cuff) to prevent, restrict or subdue movement of a person's body or part of the body, for the primary purpose of behavioural control.

A self-assessment tool "Reducing Restrictive Practices Checklist" has been published to help organisations ensure that the use of coercive and restrictive practice is minimised and the misuse and abuse of restraint is prevented. Published by Restraint Reduction Network in 2016 http://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

This organisation will always take advice and guidance from multi-agency partners to ensure a consistent and planned approach in any situation that requires physical intervention.

Before Using Restraint

Restraint or Deprivation of Liberty will only be used when the 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

a) 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 / lack of activities or the incorrect level of stimulation for patients and negative attitudes/poor communication skills of staff.

b) Behaviour and Underlying Condition

Understanding a resident's behaviour and responding to individual needs should be at the centre of individual care. All service users 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 illness (organic eg, dementia and delirium or functional eg, 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)
- Other related factors might be: hallucinations, delusions, paranoia and personality issues

- 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.

If a patient's mental health is an issue, the mental health services can be contacted for advice/support. Having identified the reason for the behaviour, staff 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 ADL 1 ('Communication, sensory aids, mental cognition and behaviour')

c) Mental Capacity

It is necessary to consider the resident's mental capacity, as consent for the use of any type or method of restraint must be gained from service users, unless they lack mental capacity to make this decision. Service users should be "informed partners" / involved in their health care. Assessment of capacity must be in accordance with the Mental Capacity Act. ***A capacity issue is decision and time specific. Individual residents cannot simply be described as "lacking capacity". A service user's capacity may fluctuate. All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests.***

d) Duty of Care

All health care staff have a duty of care for the residents in their care. This means acting in their "best interests". In relation to a service user who is at immediate risk of harm, the use of restraint may be part of fulfilling duty of care.

Using Restraint

The home is committed to providing a safe environment for its service users, 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 service user and others, and maintaining the dignity, personal freedom and choice of the service user.

Some situations are identified where steps taken amount to more than a restraint and may amount to a 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 consider 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. When restraint is used it should be considered in a systematic and planned way according to the individual needs of the service user. Where possible, decisions concerning the use of restraint should be discussed and agreed by the service user's medical consultant, the service user 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 agree, 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 service user 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.

1. Methods of Restraint

Acceptable Methods of Restraint: The following methods of restraint are acceptable when used appropriately (ie, in accordance with the principles and guidance outlined in this Policy):

a) **Medication/chemical sedation**. There are certain situations in which service users may benefit from anti-psychotic medication, such as in cases of extreme restlessness or agitation or if a service user is very frightened. 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.

b) **Chemical sedation, in the form of rapid tranquillisation.** This may be used to restrain service users 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 eg, psychiatric illness. If a service user is acutely disturbed a doctor must be called to assess the service user. Non-psychiatric causes for disturbed behaviour must be explored and excluded. Prior to using rapid tranquillisation there should be an assessment of risk. It should only be used when the risk of not using rapid tranquillisation is greater than the risk of the acute pharmacological treatment. The service user must be informed that he/she is to be given medication. Oral medication should be the first choice. If the service user 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.

c) **Physical techniques**. If physical restraint is required, staff should call the police. However, the home is not registered to provide service for people who suffer from any form of mental illness, though some of our service user may have some form of Dementia without being aggressive.

d) **Preventing service users from leaving the home.** Decisions in relation to this should be made according to the individual circumstances and by considering the service user's best interests. Preventing a service user from leaving the home will ordinarily be in response to an emergency situation and will therefore be a short term measure and DoLS policy and procedure should be followed by the home manager. The home has not had any incident to prevent somebody from leaving the home so far.

e) **Electronic tagging**. Electronic service user tagging systems can be beneficial for service users who are unable to maintain their own health and safety, should they wander off the ward without staff knowledge (for example acutely confused service users). However staff are reminded that tagging should be used to benefit individual service users and not as a convenience measure for staff.

f) **Sensor pads (bed or chair), infrared sensors (which this home has) and other monitoring devices**. Such equipment designed to monitor the movements of service users can be regarded as a form of restraint to free movement of people. Any use of those should be made in the best interest of the service user foe example to prevent falls.

g) **Bandaging hands / using mittens to prevent service users pulling out feeding tubes** (NG or PEG tubes). This may be acceptable in certain circumstances. As with other forms of restraint, the first consideration must be the service user's best interests. Staff should be aware of the risks associated with service users pulling out their NG/ PEG tube.

h) **Bedside Wedges / Bed Rails**. Other alternative options and alteration of the environment to meeting the comfort needs of the service user should be considered rather than using bed rails. Bedside wedges 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 service users accidentally slipping, sliding, falling or rolling out of bed." (NPSA, 2007). A number of hazards associated with their use have been identified.

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

- A change to the position of the bed.
- Engaging the service user in "meaningful activity" – ask the service user and/or relatives and carers what the service user likes to do, what they would be doing if they were at home etc.
- Using bedside wedges (cannot be used with profiling bed such as electrical bed)
- Reality orientation.
- Reminiscence.
- Diversional / recreational therapy by engaging the service user in activities such as gardening, yoga, etc.

In deciding whether to use bed rails you should carry out a risk assessment which in the home's care plan is form G/CP4d. This should consider criteria both for and against the use of bed rails, in relation to the individual service user, as well as the likelihood of the service user falling out of bed. Refer to the following policy No A15 which is bed rail specific.

Criteria supporting the use of bed rails:

- *Service user is on a pressure relieving mattresses with which the use of bed rails is recommended.*
- *Service user has osteoporosis and is more likely to suffer a fracture if he / she falls out of bed*
- *Service user has expressed a wish to have bed rails*
- *Service user known to have previously fallen out of bed, resulting in injury and / or distress*.

Criteria against use of bed rails:

- *Service user has fragile skin and is therefore more likely to suffer a bruise or laceration when coming into contact with bed rails.*
- *Service user is known to 'climb over' bed rails.*

When using bed rails:

- ☑ *The decision to use bed rails should be a team decision where possible, following discussion with the service user 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 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 service user's best interests:

a) **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.

b) **Inappropriate use of wheelchair safety straps**. The safety straps on wheelchairs should always be used, when provided for the safety of the user. However service users should only be seated in a wheelchair when this type of seating is required as part of ongoing care, not as a means of restraint.

c) **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 as many older people have difficulty getting up from low chair, bed, etc. Both bean bags and low chairs also pose risks to staff in relation to manual handling.

d) **Chairs whose construction immobilises service users** eg, reclining chairs. Reclining chairs should be used for the comfort of the user or as an aid to manual handling, and not as a method of restraint.

e) **Locked doors.** Doors should not be locked without due attention to health and safety requirements in relation to fire. Only front door should be locked during the day and night to prevent intruders from coming in but it is easy to open from the inside. All doors and windows should closed and locked except for fire exits during the night.

f) **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 otherwise it may be the cause of injury.

g) **Stair gates (similar to those used for toddlers)**. Stair gates should not be used to restrict freedom of movement.

h) **Inappropriate use of night clothes during waking hours**. This is demeaning and should not be used as a way of restraining people in this home.

i) **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 this home. Removal of sensory aids can cause confusion and disorientation and even harm.

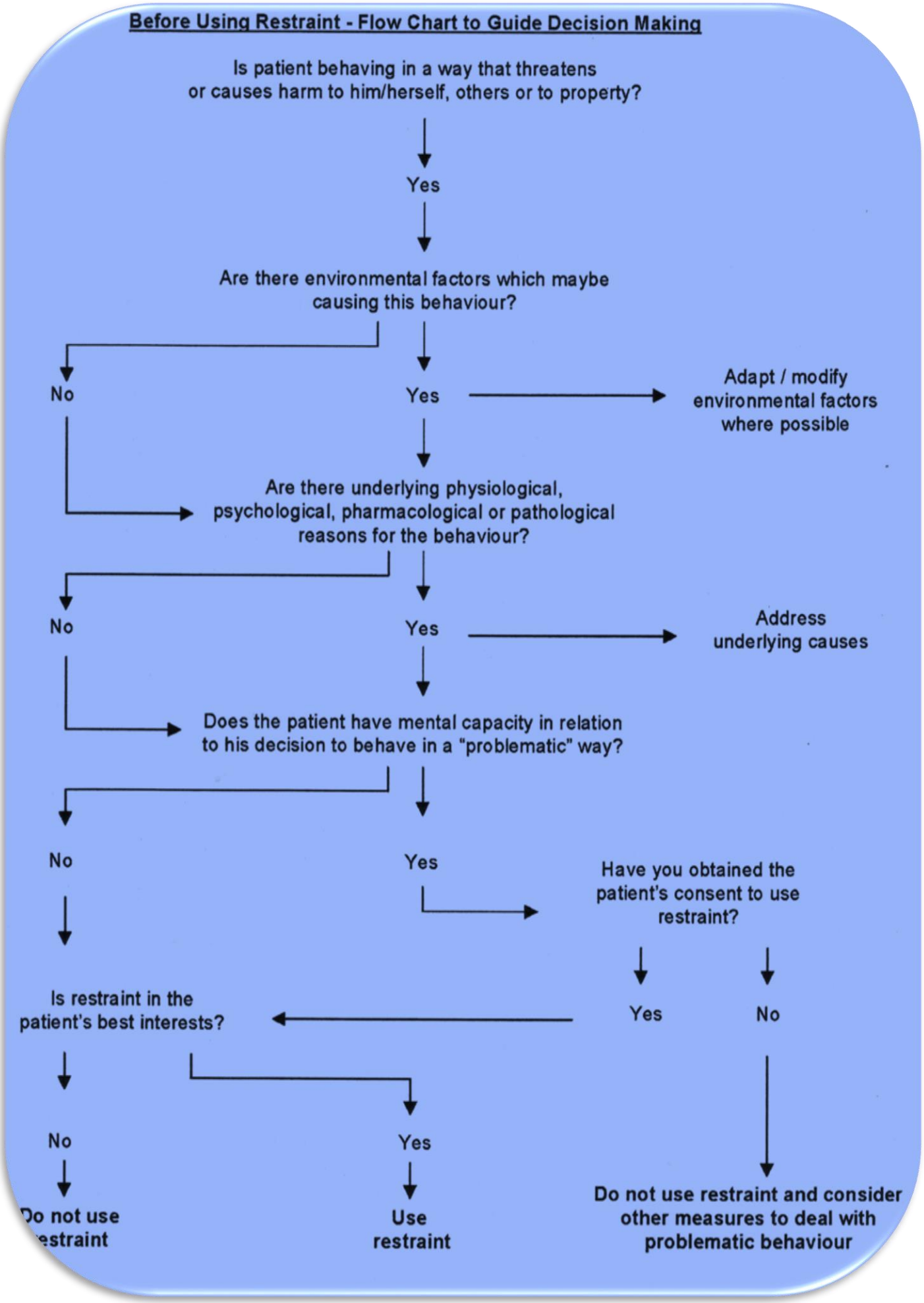
j) **Isolation**. It is important to note that service users may be "isolated" for infection control reasons and if a service user is cared for in a single room, when he or she wishes to be in the communal areas, this may be construed as restraint though the reason may be is prevent spreading an infection to other service user and hence, to protect other people. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.

Communication and Documentation

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

If restraint is used, the reason should be explicit and clearly documented in the 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 service user 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.***
- ☑ ***All documentation in relation to restraint should be clear, detailed and time specific.***


Before Using Restraint - Flow Chart to Guide Decision Making
Is patient behaving in a way that threatens or causes harm to him/herself, others or to property?
Yes
Are there environmental factors which maybe causing this behaviour?
No
Yes
Adapt / modify environmental factors where possible
Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?
No
Yes
Address underlying causes
Does the patient have mental capacity in relation to his decision to behave in a "problematic" way?
No
Yes
Have you obtained the patient's consent to use restraint?
Yes
No
Is restraint in the patient's best interests?
No
Yes
Do not use restraint
Use restraint
Do not use restraint and consider other measures to deal with problematic behaviour

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 with the service user, family / representative and if needed multi-disciplinary team. The use of restraint in an emergency situation should be viewed as a critical incident. The factors, which led up to the use of restraint and its appropriateness, should be discussed, reviewed and recorded.

Reporting of Injuries

Any injury to a service user, member of staff or visitor to the home's premises, involving the use of restraint, should be considered a clinical accident/incident and reported according to home's policy. Incidents should also be documented in the care plans.

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, service users or others is at risk. (Refer to policy No B11 on Physical and verbal Aggression.)
- ☑ If a service user has left the home, contrary to the advice of 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.
- ☑ If a service user has left the home, contrary to the advice of medical or nursing staff and you have **serious** concerns about the welfare or safety of that individual (eg, 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.
- ☑ Prior to contacting the police you should contact your manager and the service user's family / representative.

Staff Education and Training

The emphasis of training and education should be on dealing effectively with situations in order to prevent the need for restraint.

Training should be provided for staff members who are regularly required to use physical methods of restraint for physically aggressive people. It is the responsibility of managers to identify if this training is required. Currently this home is registered for activities that do not require such specific training, however, police officers have that training. Specialist training is currently being developed nationally by the Counter Fraud and Security Management Service, aimed specifically at staff working in mental health, learning disabilities and other high risk environments. This is with the intention of standardising training nationally.

Monitoring and Review

This policy will be reviewed annually or sooner if it is needed when for example new legislation, guidance or best practice has been validated.

OTHER: LEGAL ASPECTS OF RESTRAINT

1. Duty of Care (Law of Tort)

In deciding what is in a service user's "best interests" staff should not just limit their decision only to things that will benefit the service user. Staff should also consider the views and beliefs of the service user (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.

Decisions about what is in a service user's best interests should if possible be agreed both with those close to the service user and with the healthcare team caring for the service user. 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 service user's best interests.

Staff and more specifically nurses should decide what level of ***"duty of care"*** is required by measuring their experience against the standard of "an ordinary skilled nurse", if you are a nurse, "an ordinary skilled care assistant", if you are a care assistant against the standard of

"an ordinary reasonable person" 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 staff duty of care, although it must be acknowledged that these principles may be in conflict with one another. ***Staff should always:***

- ✓ ***Intend to do the service user good (beneficence).***
- ✓ ***Intend to do the service user no harm (non-maleficence).***
- ✓ ***Treat all residents fairly and equally (justice).***
- ✓ ***Aid and respect the service user's right of self-determination (autonomy).***

2. 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.***

3. 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. Common Law is often referred to as case or precedence law. The concept of "duty of care" has its origins in common law.

4. Accountability

In terms of having to account for your actions in relation to the use or not use restraint, ***there are four areas of accountability:***

a) **Accountability to your employer** i.e. the home (company's policies and guidelines outline your responsibilities in relation to your employment).
b) **Professional liability** to your regulatory body i.e. accountability to the NMC for nurses
c) **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.
d) ***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 home) as acceptable practice in relation to restraint will be in line with one's civil and criminal liabilities. In addition to the above you are also accountable to service users, the public and society as a whole.

5. 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". Duty of care and negligence is another type of tort.

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

Related Policies
Adult Safeguarding
Care and Support Planning
Challenging Behaviour, Violence and Aggression
Deprivation of liberty Safeguards
Mental Capacity Act 2005
Moving and Handling