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RESTRICTION AND RESTRAINT IN ADULT CARE POLICY

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Document Manager (job title)	Mental Health Matron
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Related Procedural Documents	Rapid Tranquilisation Guideline, Mental Capacity Act and Deprivation of Liberty Safeguards Policy, Prevention and Management of Aggression and Violence, Restrictive Physical Intervention and therapeutic holding policy for Children and Young People. *This policy includes the Use of Mittens*
Key Words (to aid with searching)	Vulnerable adult, violence and aggression, mental capacity, Restraint

Summary

This policy aims to provide a framework for staff working in Portsmouth Hospital University NHS Trust to follow a consistent and safe approach to patient restriction and restraint. It aims to list the individuals and Trust responsibilities and highlight were restraint can and cannot be used within an acute hospital setting

Version tracking

Version	Date Ratified	Brief Summary of Changes	Author
4.1	04/04/2023	• Addition of Appendix G	Safeguarding Team
4	01.11.2022	• Updated to new Trust framework	Mental Health Matron
3.2	01.02.2021	• Extended review date due to Coronavirus pandemic	-
3.1	09.04.2020	• Alterations relating to Coronavirus Act 2020	Head of Legal Services

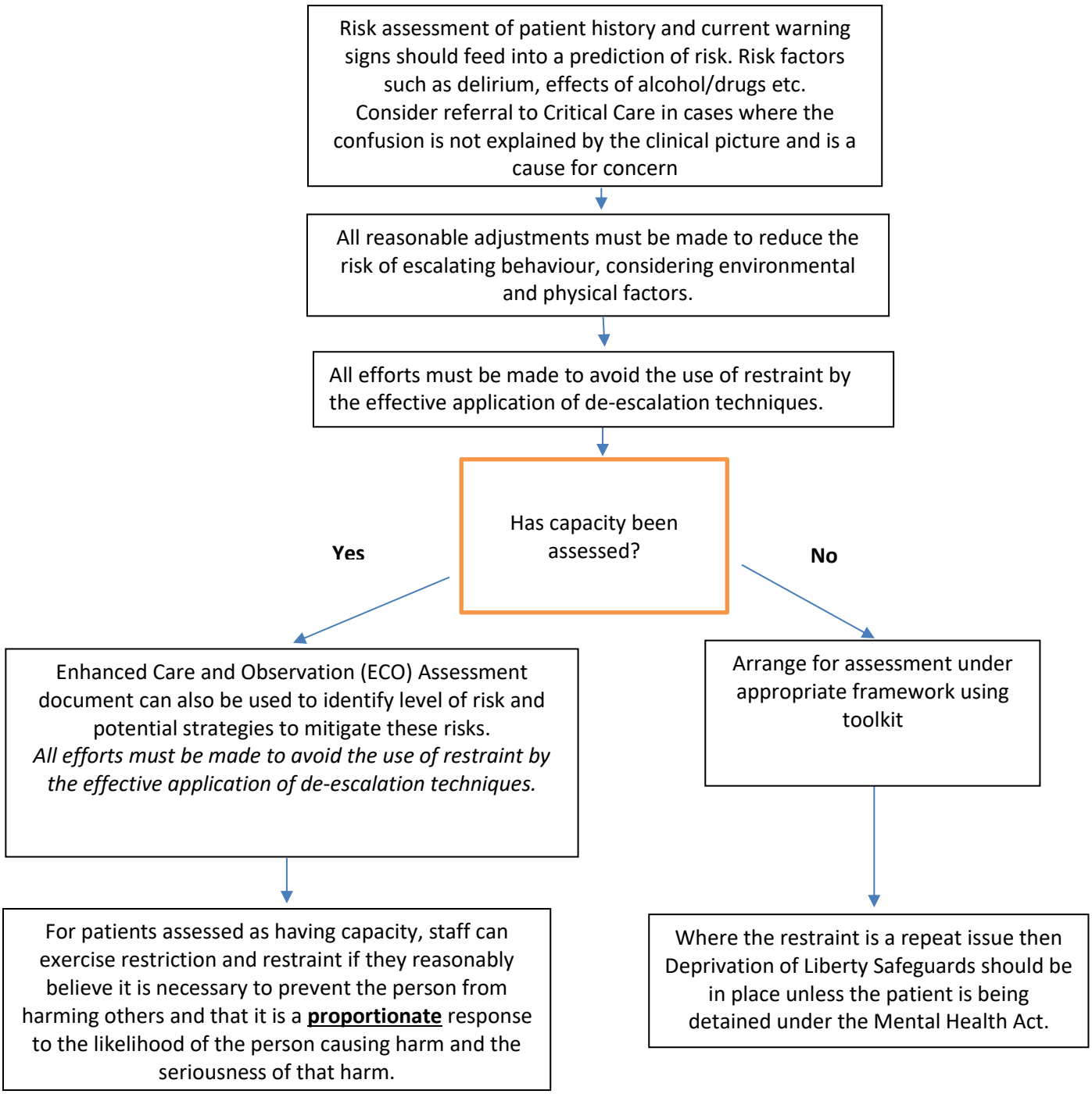
Version tracking			
Version	**Date Ratified**	**Brief Summary of Changes**	**Author**
4.1	04/04/2023	• Addition of Appendix G	Safeguarding Team
3	29.11.2019	Clarification re responsibilities in an episode of restraint, Removal of the use of speed-cuffs, Insertion of a SWARM template, Insertion of a RA Tool, Addition of MCA / BIA	Head of Safeguarding

CONTENTS

PROCESS

For quick reference the guide below is a summary of actions required. Additional details, by exception to cover any additional notes that supplement the quick reference guide can be found in Section 3 – Process.

Use of restraint will be reasonable, proportionate and used only when necessary for the shortest period possible



Emergency physical and/or chemical restraint carries risks to the patient and staff and can only be applied by trained and competent persons if there is evidence of the person behaving in a way that:

a. poses an imminent risk of danger to those in the immediate vicinity, e.g., other patients and/or members of staff.
b. means they are unable to receive urgent medical attention

Consider referral to Critical Care in cases where the confusion is not explained by the clinical picture and is a cause for concern.

For patients assessed as lacking capacity, staff can exercise restriction and restraint if they reasonably believe it is necessary to prevent the person coming to harm or harming others and that it is a **proportionate** response to the likelihood of the person suffering/causing harm and the seriousness of that harm.

1. INTRODUCTION

Portsmouth University Hospitals NHS Trust (the Trust) is committed to delivering the highest standards of health, safety and welfare to its patients, visitors and employees.

The Trust believes that the management of challenging behaviour is an activity requiring humanity and respect for the rights of the individual, balanced against the risk of harm to themselves, staff and members of the public. Restricting or restraining any behaviour should only be used when it is proportionate and reasonable to do so.

However, it is recognised that violent and aggressive behaviour can escalate to the point where physical or chemical restraint may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed.

Consider referral to Critical Care in cases where the confusion is not explained by the clinical picture and is a cause for concern.

Restraint is a last resort intervention and will only be considered when all other practical means of managing the situation, such as de-escalation, involvement of family where appropriate, verbal persuasion, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. The self-respect, dignity, privacy, cultural values, race and any special needs of the patient should be considered in so far as is reasonably practicable.

In the event of the application of physical or urgent chemical restraint an Incident Form must be completed by a member of the clinical staff and a Use of Force form completed by a member of the Security Team must be attached to the Form.

Used inappropriately, some restraint may be classed as a form of abuse or assault and if unreasonable may lead to investigation. If restraint of any kind is used it should be carefully recorded in the patient records and monitored.

The policy applies to adults (people aged 18 years and over). (For children and young people please refer to the Restrictive practice Policy for Children and Young People).

2. SCOPE

All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary), the Ministry of Defence Hospital Unit, Joint Hospitals Group South (Portsmouth) and Retention of Employment (ROE) staff must follow the policies agreed by the Trust. Breaches of adherence to Trust policy may have potential contractual consequences for the employee.

In the event of an infection outbreak, pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

The Trust is committed to promoting a culture founded on the values and behaviours which will bring us closer to achieving our vision of working together to drive excellence in care for our patients and communities. All staff are expected to uphold the Trust Values of **Working Together: For Patients, With Compassion, As One Team, Always Improving** and all leaders are expected to display, and role model the behaviours outlined in the Trusts **Leadership Behaviours Model**

This policy should be read and implemented with the Trust Values and Leadership Behaviours in mind at all times

3. PROCESS

Appendix E contains a risk assessment record & clinical decision making tool for use when considering the use of restraining therapies

3.1 Consent and capacity

It must be assumed that a person has capacity to give their informed consent unless assessed as otherwise. If the patient lacks capacity, care and treatment should be planned in their best interests in discussion with the multi-disciplinary team and those close to the patient (Mental Capacity Act 2005). All clinical documents must include information detailing the assessment process and how it was concluded that the patient lacks capacity. Where possible, patients should be given a choice as to the gender of the staff providing ECO, particularly at night.

3.2 Escalating Risk

Police and security to be called

The Person in Charge will:

- Ensure that wherever possible de-escalation techniques are used throughout a restraint process.

- To avoid prolonged physical intervention / immobilisation (no longer than 10 minutes), consider rapid tranquilisation (which may be safer where appropriate) as an alternative.

- Take responsibility for any restraint that takes place and conduct the risk assessment of the circumstances that will determine whether restraint is appropriate and justified – *see Appendix E – Risk Assessment.*

- If considered necessary request assistance from security in the first instance via 2222. If staff are in fear for their safety, the Police should be contacted stating '**We are in fear of our safety'**

- Have a sufficient understanding of restraint processes, of the law and of the policy to ensure a satisfactory outcome for all involved.

- He or she should ensure that the restrained person's
  - head and neck is appropriately supported and protected.
  - airway and breathing are not compromised.
  - vital signs (pulse, BP and RR) are monitored.

- For safety reasons, during a restraint it is only permissible to hold / apply pressure to the person's limbs. Avoid and direct pressure being applied to the neck, thorax, abdomen, back or pelvic area.

- Avoid restraining persons on the floor. If, however, the floor is used then this should be used for the shortest period of time and only for the purpose of gaining reasonable control. In the rare and exceptional situations where the restrained person needs to be held in a face down prone position, this should be for the shortest possible time to bring the situation under control.

- The level of force applied must be reasonable, necessary and proportionate to a specific situation, and be applied for the minimum possible amount of time (no longer than 10 minutes).

- Any person subject to restraint must be physically monitored throughout the incident. Post-restraint, the person who has been restrained will be reviewed for placement on the appropriate observations level, for a period of up to 24 hours. During this time physical observations must be recorded and the observing nurse be fully aware of the possibility of restraint/positional asphyxia.

- Where it is believed that we are depriving someone of their liberty completion of both an urgent and standard Deprivation of Liberty Safeguards DoLS authorisation should be completed and sent to PHT-Dols@porthosp.nhs.uk. See Mental Capacity Act (2005) Policy.

- Inform and involve appropriate medical staff with appropriate urgency.

- Ensure a care plan is in place whilst the patient is receiving restrictive practice and remember to regularly assess the need for continued clinical oversight.

- Arrange for family, friends or carer to be contacted / be involved if it is thought they may have a calming influence on the person.

- Ensure the incident is reported using the DCIQ system in accordance with Trust policy.

- Ensure the SWARM template (*see Appendix F*) is completed as part of a debrief within 24 hours. The patient involved in the incident should be offered the opportunity where appropriate to contribute to the immediate debrief and discuss the incident with a member of staff, an advocate or carer.

- Ensure the operational Security Team provide a Use of Force Form to attach to the SLE.

- Ensure Care Plan document is completed and filed in patient records (*Appendix F*).

Manual restraint considerations

Only as a last resort should Patients be restrained on the floor.

Do not use a manual restraint in a way that interferes with the patient's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen or obstructing the mouth or nose.

Do not use manual restraint in a way that interferes with the patient's ability to communicate for example by obstructing eyes, ears or mouth.

Undertake manual restraint with caution and extra care if the patient is physically unwell, disabled, pregnant or obese.

Aim to preserve the patient's dignity and safety as far as possible during manual restraint.

As a guideline restraint should be no longer than 10 minutes. If this is exceeded justifiable actions must be recorded.

Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable and proportionate to the situation and applied for the shortest amount of time possible.

One clinical staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- Able to protect and support the patient's neck and head if needed.
- Able to check that the patient's airway and breathing are not compromised.
- Able to monitor vital signs.
- Supported throughout the process.
- Monitor the patient's physical and psychological health for as long as clinically necessary after using manual restraint.

3.3 Chemical Restraint

A drug or medication used to manage a patient's violent or aggressive behaviour. Administration if necessary may be given against the persons wishes if they lack capacity and it is deemed in the patient's best interests. Such drugs may of course be used with patients consent and may (with the persons consent) be used in circumstances in which treatment or harm is less immediate, for example, when caring for people with Dementia or other long term conditions

3.4 Imminent Danger

Any situation or practices in a place of employment which are such that a danger exists which could reasonably be expected to cause death or serious injury.

3.5 Person in Charge

The most senior or appropriate person in an area/ward who takes responsibility for managing a threatening situation.

3.6 De-brief/SWARM

Term used generically as a way of describing the need for the person, staff and others to take 'time out' to reflect on the situation that has occurred and learn from it, ideally within 24 hours following an incident.

3.7 Hand Mittens

These are a safe form of restraint which restrict movement after looking at all of the least restrictive options. These are sometimes utilised (following a formal process) to reduce the patients tactile ability, always used in conjunction with discussion with next of kin.

3.8 Bed Rails

Should only be used when a risk assessment within the Care Plan has been completed and their use is to maintain safety of the patient.

3.9 Unacceptable Methods of Restraint

- **Elevated bed height –** It increases the risk of injury resulting from a fall out of bed. Patients are occasionally nursed on low beds to reduce the risk of harm should they fall. A low bed is acceptable when appropriately risk assessed. This includes raising the patients legs above the patient hips which for some patients may stop them being able to get out of bed due to the position of the bed.

- **Wheelchair safety straps** The straps on wheelchairs should always be used. However these are used for patient safety and not as a means of restraint.

- **Reclining chairs** Reclining chairs should be used for the purpose of patient comfort and not as a method of restraint.

- **Locked doors** Doors should not be locked in an acute care setting. Coded locks and push button exits are excluded.

- **Arranging furniture to impede movement** Any equipment/furniture included is to be used for its intended purpose only. Using furniture to impede movement increases the risk of falls through trips.

- **Removal of walking aids, outdoor shoes and sensory aids such as spectacles/hearing aids** This can cause confusion and disorientation and increases the risk of patient harm from falls.

Further details regarding the potential effect of restraint can be found in *Appendix C*.

4. TRAINING REQUIREMENTS

PUHT does not recognize or support any other staff to provide restraint other than appropriately trained security staff and the police. **Only staff** provided by PFI provider and only those who have completed the necessary MAYBO training are allowed to restrain any patient. This also excludes RMN staff who may be working under the bank office who may have received training elsewhere.

All staff involved in the restraint and restriction process are required to complete an SLE after each event and attend a SWARM where appropriate.

In all circumstances, staff are encouraged to de brief the patient and attempt to record their experience of restraint.

All staff are expected to have up-to-date Mental Capacity Act and Deprivation of Liberty Safeguards training.

5. REFERENCES AND ASSOCIATED DOCUMENTATION

Mental Capacity Act 2005 Policy
Mental Health Act Policy for Patients of all ages
Staff Escalation Policy:

6. EQUALITY IMPACT SCREENING

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This procedural document has been assessed accordingly. The assessment document is held centrally and is available by contacting the Trust Policy Management Inbox.

7. MONITORING COMPLIANCE

This procedural document will be monitored to ensure it is effective and to provide assurance of compliance.

Element to be monitored	Lead	Tool	Frequency of Report	Reporting arrangements	Lead
Impact upon workforce	Workforce Lead	Safe staffing	Daily	Staffing Meeting	Head of Mental Health and Safeguarding.

Element to be monitored	Lead	Tool	Frequency of Report	Reporting arrangements	Lead
Number of restraints both physical and chemical	Head of Safeguarding and MHM	IPR report and annual MH report	Monthly	Mental Health Operational Group	Divisional Leads
Number of MCA and DOLS requests	Adult Safeguarding lead	Annual report	Annually	Monthly IPR	Divisional Leads

Appendix A: Roles and Responsibilities

The Chief Nurse is responsible for all Levels of this policy are completed and actions implemented, updated and monitored. Provide adequately documented plans for communication. Responsible for liaising with nursing staff regarding reassessments and current level of supervision.

Divisional Director Has a responsibility to ensure that the policy is implemented, by delegating duties to the Heads of Nursing & Quality, Clinical site management, Matrons and Ward/Line Managers, ensuring the policy is implemented with appropriate actions.

Clinical Site Manager/Matron To attend any incidents of restraint and have overall responsibility for the incident ensuring appropriate escalations to po9lice etc are made. Clinical Site managers are also responsible for providing support to staff, relatives involved and for the appropriate framework to be applied and processed including the acceptance of any MHA paperwork.

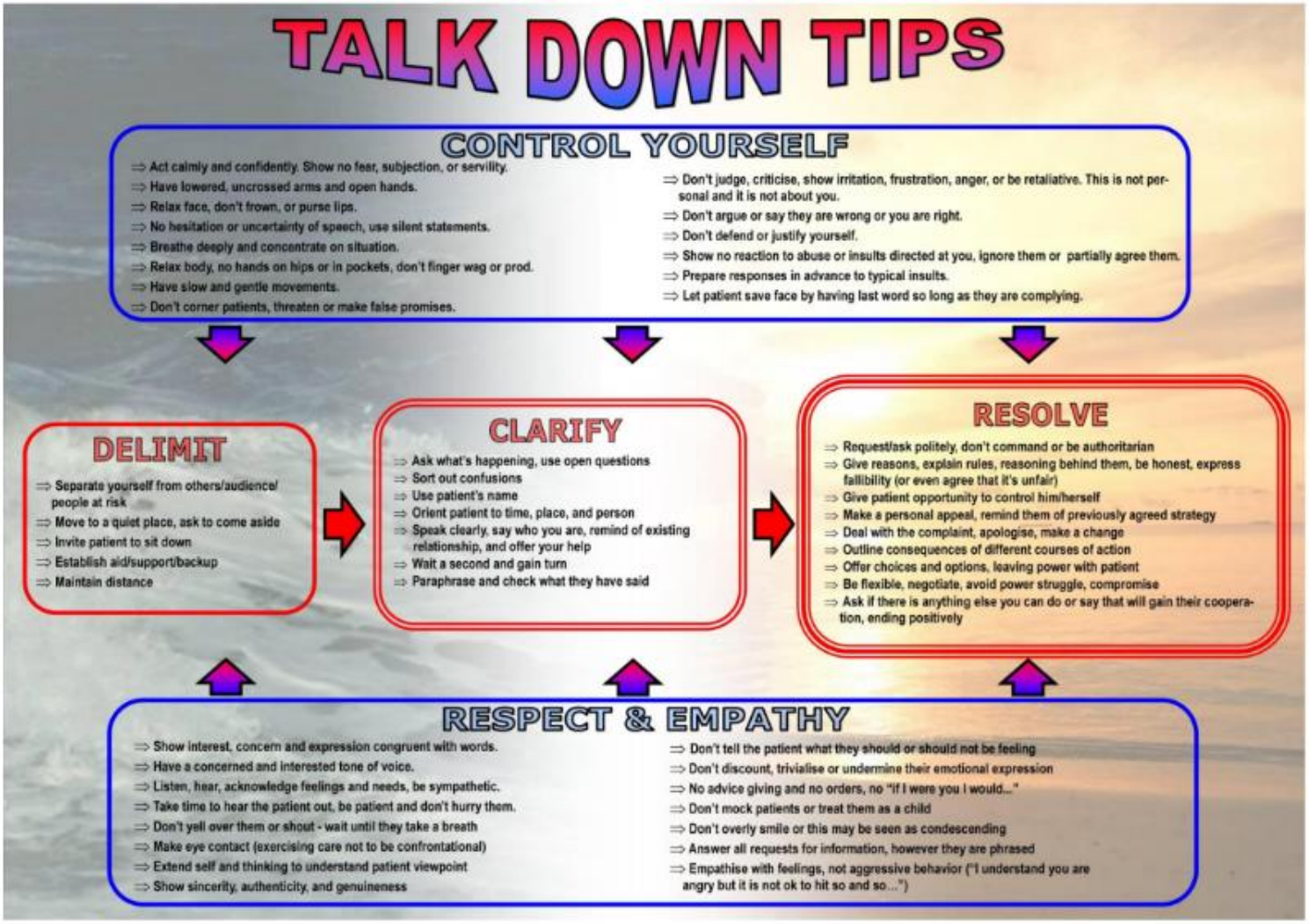
Ward/Line Managers Responsible for ensuring that staff have received the appropriate training to carry out MCA and follow the steps around gaining the right pathway. Ward Line managers recognition that if staff have not had the appropriate levels of training and are not competent then they are not to participate in supervision of the patient. Policy is to be adhered to and escalated to the Matron/Site Manager if any problems with regards to staffing for the ward or department. Ward managers are also responsible for arranging the SWARM as below.

Nurse in Charge Responsible for completing the level of reporting including SLE, the process flow to call security and making the necessary steps to ensure the relevant legal framework is applied to the patient. The NIC is also responsible for administer and getting prescribed any medications or repaid tranquilization. The NIC will also escalate to their ward manager and matron who will arrange with eth Governance lead a SWARM.

Bank and Agency Staff are responsible for ensuring that they follow best practice and work always within the scope and authority under the Nurse in Charge. Bank and agency staff are responsible for ensuring that any changes in the patients presentation are escalated to the nurse in care of the patients care and promoting therapeutic intervention as well as adhering to the expectations listed within the procedure section of this policy.

Security leads are responsible for maintaining Engie staff training in MAYBO and completion of Use Of Force forms are of a good standard and made available to PUHT at request.

Appendix B: De-escalation Techniques



Appendix C: Definitions

Mental Capacity
(see Appendix A of the Hampshire Toolkit Mental Capacity Assessment below contained in appendix D of this document)
The Mental Capacity Act 2005 sets out the legal definition of the status of an individual who **lacks capacity.**

A person will lack capacity if they are unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain.

To make a decision the person must be able to:

- Understand the information relevant to the decision
- Remember that information
- Weigh up that information in making a decision
- Communicate their decision

The MCA permits the use of restraint if it is necessary to protect from harm and proportionate to the likelihood and seriousness of harm and it is the least restrictive option.

Deprivation of Liberty Safeguards (DoLS)
A deprivation of liberty occurs when the person is 'under continuous supervision and control and is not free to leave'. It should be applied for if the person is trying to leave, lacks capacity re accommodation and requires restraint.

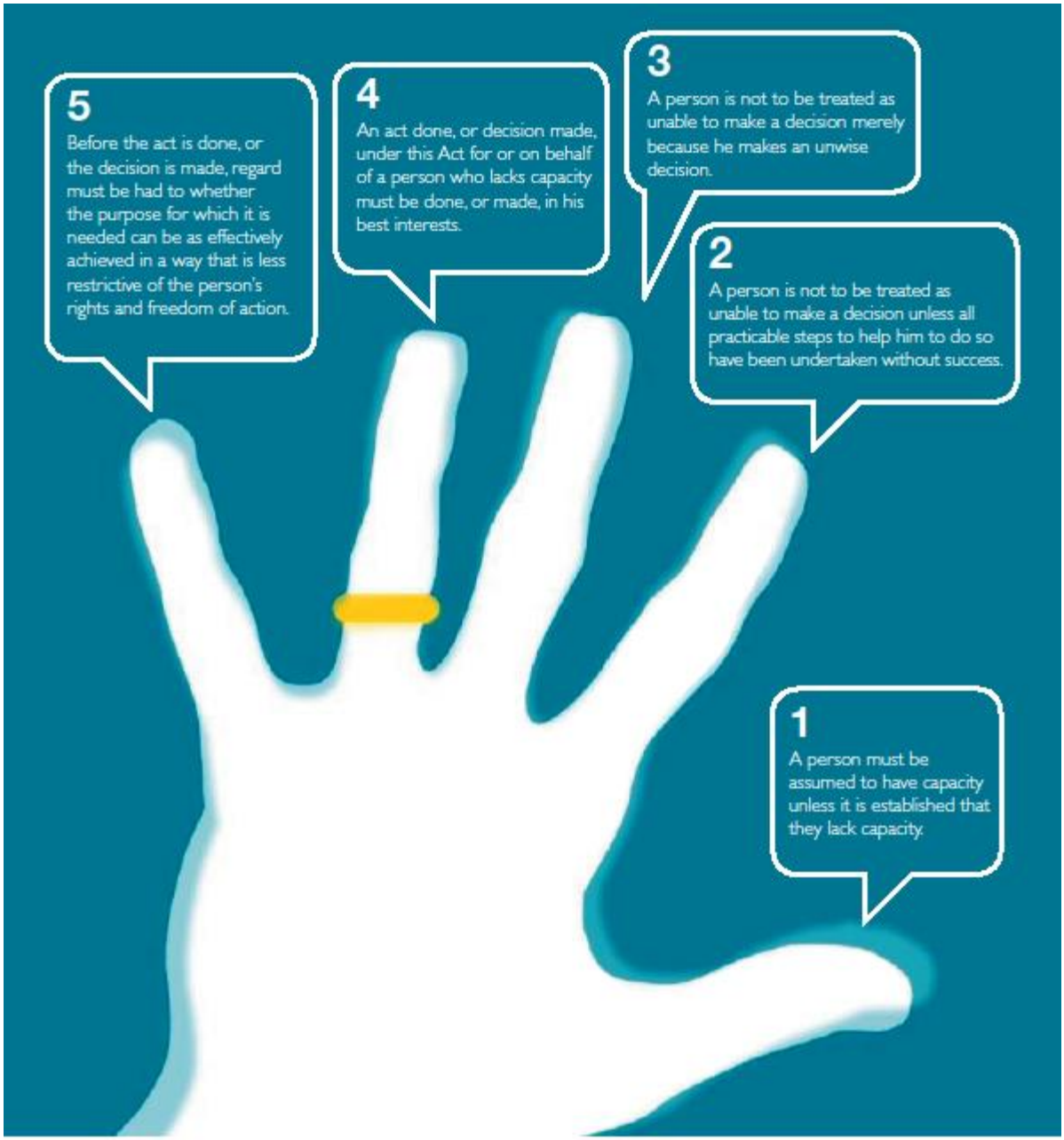
Best Interests
(see Appendix B of the Hampshire Toolkit Best Interests Decision Making below)
Any action carried out on behalf of someone who lacks capacity must be in their best interest. In deciding best interest consider:

- Past and present wishes.
- Any beliefs and values that influence how they would make their decisions themselves.
- The views of the family and friends.
- The views of the professionals involved.
- How the decision will affect the person, their health and welfare, their comfort and pleasure and their future experience.
- Any restrictions on the persons freedom that may be necessary to carry out the decision.

Restraint
"Restraint is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property."

Manual Restraint
"Any manual method such as guiding, hands on etc. that immobilises or reduces the ability of a person to move his or her arms, legs, body or head freely."

Appendix D: Hampshire Toolkit – Mental Capacity Assessment



Hampshire Mental Capacity Toolkit

Part A – Assessment of Capacity

January 2014

Hampshire County Council

Appendix E: Risk Assessment

RISK ASSESSMENT RECORD & CLINICAL DECISION MAKING TOOL WHEN CONSIDERING THE USE OF RESTRAINING THERAPIES

Name……

Hospital No……

NHS No……

Consultant……

Date……..

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

Does the patient behaviour have potential to endanger? (please tick, may be more than one)		
Staff	**Self**	**Others**

No → Restraint Inappropriate

Yes ↓

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

OR

Repetitive removal of non-life-threatening medical devices (please tick, may be more than one)			
IVI Peripheral		Dressings	
NGT		O2 Mask	
Catheter		PEG	
Drains		Epidural	

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

↓

Identify any Reversible Causes and Treat
Pyrexia, Hypoxia, Pain
Withdrawal (nicotine, drugs, alcohol – CIWA score)
Bowel/Bladder
Fear, anxiety
Communication, memory impairment

Strategies to consider	**Yes**	**No**
Review drug therapy		
Diffuse situation/use of minimum of staff		
Utilise verbal de-escalation techniques		
Remove harmful objects		
Involve family or significant others		
Provide orientating stimuli (clock, newspaper, radio)		
Utilise enhanced care (1:1)		
Diversional activities (music, T.V.)		
Optimise environment		

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

No

Yes

Patient settled and outcome successful.
Document strategies used / inform MDT

Patient remains unsettled

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

Has assessment been documented of patient's Mental Capacity and Best Interests by duty Medical Team / MDT? Patient wishes / relatives?	Date	Time

In view of above decisions and current management plan **is restraint appropriate?**

Yes

No

Document clinical reasoning

Decision making by Duty Medical/Senior Nursing or Therapy staff of safest, **least restrictive option** regarding type of clinical holding to be selected in accordance to individual patient's condition and situation specific.

Identify least restrictive restraint to be used (please tick, may be more than one)	
One to one supervision	
Appropriate use of Bed Rails	
Appropriate use of clinical holding	
Appropriate use of Hand Mittens	
Appropriate use of Pharmacological Restraint	

See Medical Guidelines

- Aggressive and violent patients
- Acute confusional state
- Ensure maximum daily dose is specified

The Care plan must now be implemented

Continue overleaf

	Print Name	Date	Time
Commence Care Plan			
Date and time restrictive measures implemented			
Date and time restrictive measures ceased			
Signature of risk assessor			
Signature of senior nurse in charge			
Relative/carer informed regarding use of identified			

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

To be filed in the Nursing Records

Appendix F: SWARM

Restraint Interventions and Challenging Behaviour Events

General Information:		
Datix ID Number:		**Care Group:**
Date of Incident:		**Name of Patient/NHS Number:**
Date of SWARM:		**Chaired By:** **Signature of Chair:**
Attendees:		
Event Details:		
Brief description of incident and actions taken		
Harm or injury to the patient, staff or member of the public involved		
Other relevant factors • Mental health condition • Person with Learning Disabilities & Challenging behaviours • Dementia/Neurological impairment • Previous episodes of challenging behaviours or restraint interventions (known mental health problem/learning disability with challenging behaviour/previous violence and Aggression or restraint incident/known dementia/neurological impairment)		
What de-escalation or behavioural management techniques were employed? Were these timely?		
▪ Mental Capacity assessed ▪ Mental Health review , designation and time ▪ Any Sections applied ▪ Deprivation of Liberty Safeguard Authorisation applied		
Was restraint used? ▪ Purpose and type of Restraint e.g mechanical, prone, chemical(safety of patient/other patients/staff/property		

▪ Was the restraint applied proportionate response to the level of risk? (type / duration) ▪ If medication was used were they within PHT Rapid tranquilisation guideline? ▪ Did the patient receive post chemical sedation monitoring as per PHT rapid tranquilisation Policy?		
Immediate Post Incident Actions: ▪ Nursing / Medical Care plan review		
▪ Medication review		
▪ ECO Booked/ECO Charts		
▪ Mental Health review / Section applied		
▪ DOLS		
Was the staffing adequate on the ward at the time of the event?		
Have you requested a Use of Force form from the Operational Security Team?		
Exacerbating Factors		
Duty of candour -Patient / relatives aware? Was the patient/relative involved in agreeing a care plan for future reoccurrences		
Actions from the SWARM/Learning identified/Support to team		
1. 2. 3. 4. 5. 6.		
Recorded in the medical notes		
Datix Update:		
Who will be responsible for updating the SLE on Datix:		

Appendix G: Care Plan for the Use of Restraining Therapy

Name……Hospital No……
NHS No……
Consultant……
Date……

Type of restraint applied:
(e.g. mittens or sedation)

Undertake the following interventions	**Recommended Time Intervals**	**Date/time Initial**	**Date/time Initial**	**Date/time Initial**	**Date/Time Initial**
Monitor respirations, pulse, BP & oximetry	15 minutes for 1st hour				
Check skin integrity & circulation	If agitated continue every 15 minutes				
Offer hygiene and toileting	If settled every 4 hours				
Offer food & fluids					
If mittens are applied wash, dry hands thoroughly, check fingernails	At least once every 8 hours				
Consider removal of invasive lines etc	At least once every 8 hours				
Assess ongoing need for restraint	At least once every 8 hours				
Document in the nursing notes	At least once every 8 hours				

TO BE FILED IN THE NURSING RECORDS