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Children & Adults Safeguarding committee (version 3 is an update / review only)	Children & Adults Safeguarding committee	01/11/2018

Related Trust Policies (to be read in conjunction with) This policy is linked to the following policies/Guidance: • Policy for Management of a Vulnerable adult (CM-55) • Policy for Mental Capacity (CM-62) • Policy for Deprivation of liberty (CM-61) • Policy for documentation and record keeping (CM-56) • Policy for Violence and Aggression (RM-05) • Policy for bed rails (CM-66) • Policy for Dignity and Respect (CM-43) • SET Safeguarding Adults Guidelines – April 2008 • Risk Management Training Policy (CM-46). • Incident and near miss reporting policy (RM-10) • Policy for Learning Disabilities (CM-53) • Management and Prevention of inpatient Falls (CL 13) • Policy for Enhanced Observations (CM 51)	(Refer to the main body of the text)

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments:**	**Issue Date:**
1		New Policy	07/2014
2	Adult Safeguarding Manager	Review and update. Title change. Additions to purpose. Changes to duties and reporting structure. Managing Challenging behaviour and non-restraint interventions.	08/2016
3	Adult Safeguarding Manager	Inclusion of training for Security Staff. Inclusion of monitoring and review. Review and check of content and references.	10/2018

Contents

1 Introduction

Southend Hospital University NHS Foundation Trust is committed to delivering the highest standard of care that maintains the safety and welfare of its patients, visitors and employees. The trust accepts its legal and moral responsibility to reduce or eradicate risks wherever reasonably practicable.

There are occasions when patients in hospital are at risk of harm to themselves or other people. It is recognised that in certain situations, when all other methods have been tried and failed, the application of restraint or restrictive measures may need to be considered for the prevention of harm to an individual or others. It is imperative that if restraint is used to prevent harm, it is used as a last resort and must be conducted lawfully whilst ensuring that the patient's dignity and human rights are maintained at all times.

Restraint may only be considered when:

- the patient has given their informed consent;
- or where clinicians reasonably believe that the patient lacks the requisite capacity to make this decision, and that using restraint is in the patient's best interest, proportionate, and all other less restrictive options have been tried.

If the use of restraint is necessary to prevent harm, it must be proportionate to the likelihood of the person suffering harm (Mental Capacity Act, 2005). Regard must be given as to whether the required restraint is conducted in a way that is least restrictive of the person's rights and freedom of movement. Inappropriate use of restraint may be viewed as a form of abuse and result in further enquiry under adult safeguarding procedures or may even be considered as a criminal act. If restraint is necessary to prevent harm to the patient, it must be with the minimum amount of force, for the shortest time possible and only carried out by staff that are considered competent in the skill or intervention required.

Prior to using any method of restraint, a systemic and planned risk assessment approach should be taken. Where possible, decisions concerning the use of restraint should be discussed with the multi-professional team approaches agreed using a best interest process and the plan should be documented in the patient's clinical record. A risk assessment and care plan should be completed to ensure that the restraint used is appropriate and proportionate to the calculated risk of harm and is in the best interest of the individual. The plan must also include monitoring and review.

It is acknowledged that decisions on the use and method of restraint may need to be applied to patients in urgent and emergency situations when consultation with colleagues may not be possible due to the urgent need for intervention. All Southend University Hospital NHS Foundation Trust procedures and policies in relation to the application of restraint must then be referenced to ensure continuing safety and that application of restraint is in the patients best interests at all times.

The Trust will support employees who act in a way that is deemed reasonable and measured at the time of the incident and in accordance with professional standards. This policy outlines all definitions relating to restraint and is intended to give guidance on acceptable methods of restraint and application within a safe environment.

2 Scope

The purpose of this document is to:

- To assist staff to understand what restraint is in the context of their work.
- To assist staff to understand the diversity of restraint techniques.
- To assist staff in choosing a correct approach proportionate to the circumstances.
- To guide staff to provide person centred care that will minimise the need for restraint.
- To make it clear to staff that when there is no other option but to implement therapeutic restraint, ethical and legal issues are considered as outlined in this policy, to prevent unlawful restraint of a patient.
- To ensure patients are cared for in a safe environment and the risk of harm is minimised.
- To ensure appropriate multi-disciplinary assessments including Mental Capacity Act (MCA) assessment and Deprivation of Liberty Safeguard (DoLS) assessment is carried out as necessary in line with best practice (refer to Mental Capacity Act policy CM-62 and Deprivation of Liberty Safeguards Policy CM-61).
- Ensure the human rights of the patients are maintained in adherence with the Human Rights Act 1998.
- To ensure that consideration is given to maintain the dignity of patients at all times in adherence to the Dignity & Respect Policy CM-43).
- Ensure that therapeutic restraint is a considered intervention, is used as a last resort and that the least restrictive form of restraint is used only when alternative methods of therapeutic behaviour management have failed.
- To ensure that all decision making processes are clearly documented and in the patients clinical record and a best interest process can be evidenced.
- Ensure that the patient's family, and if appropriate the patient themselves, Advocate, Lasting Power of Attorney or Court Deputy are informed of the decision to use restraint.

3 Definitions

TERM	DEFINITION
MCA	Mental Capacity Act
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
NICE	National Institute of Clinical Excellence
CQC	Care Quality Commission
RCN	Royal College of Nursing
MDT	Multi-Disciplinary-Team
IMCA	Independent Mental Capacity Advocate
CPAP	Continuous Positive airway Pressure
NIV	Non-Invasive Ventilation
CVP	Central venous Pressure
PNMF	The Professional Nursing and Midwifery Forum
LSMS	Local Security Management Specialist
SIRS	Security Incident Reporting System

Restraint	'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 (Counsel and Care UK, 2002), An alternative plain English definition is 'stopping a person doing something they appear to want to do.' (RCN, 2008)

4 Roles and Responsibilities

4.1 Roles & Responsibilities within the Trust (Committees)

Duties Are:

Children & Adult Safeguarding Committee
The Southend University Hospital NHS Foundation Trust Children & Adult Safeguarding Committee meets quarterly to ensure compliance to processes and practice within the Trust related to all safeguarding activity, including restraint

4.2 Role & Responsibilities of Individuals within the Trust

Duties Are:

The Trust

- Undertakes to advise and support its staff in the event of legal proceedings by, or against, a patient, their family, or other members of the public, where the action by the member of staff concerned was reasonable under the circumstances and is consistent with agreed policies and procedures.
- Will advise and support staff in the event of criticism, where the action by the member of staff concerned was reasonable under the circumstances and is consistent with agreed policies and procedures.
- Provide guidance to its staff as to when it may be reasonable and proportionate to use interventions that may be deemed as restraint.

Managing Director
The managing Director has responsibility for ensuring the implementation and adherence of this policy within the Trust and for ensuring that:

- Arrangements exist for the identification, evaluation and management of risk associated with restraint.
- Arrangements exist for the monitoring of incidents related to restraint and for the planned periodical review of the effectiveness of this policy.

Chief Nurse

As the MSB Groups accountable officer and executive lead, the Chief Nurse has overall responsibility for ensuring the MSB Group, including Southend University Hospital NHS Foundation Trust has robust, complete and up to date procedures in place to govern and guide activities so that legal and national requirement are met.

The Chief Nurse is also responsible for the reporting of safeguarding / MCA issues to the Joint Executive Group.

The Director of Nursing / Lead for Safeguarding

The Director of Nursing Has the delegated authority from the managing Director for the operation of this policy and ensures that the Chief Nurse and Joint Executive Board are advised of the effectiveness of this policy and any shortfalls in meeting the standards set.

Security Management Director:
The Security Management Director is responsible for:

- Ensuring that full co-operation is given to the agencies, including the Local Authority and Police, including access to personnel, premises and records (electronic or otherwise) if considered relevant to security matters.
- Ensuring that details of incidents are recorded on the Trust's incident reporting system (Adverse Incident Report Form) to comply with Health and Safety legislation and appropriate incidents are reported on the Security Incident Reporting System (SIRS) in accordance with the Secretary of State's Directions for NHS Protect.
- Ensure all Security Staff have the required training, experience and competence relevant to the role.

Security Staff
Security Staff are responsible for:

- Ensuring that they are only involved in restraint when a patient is at risk of harming themselves or another patient or staff member and/or is likely to commit a crime.
- Ensuring that only the least restrictive form of restraint proportionate to the risk of harm to the patient or others.
- Utilise initial strategies to de-escalate the need for restraint as per Control & Restraint Training and Conflict Resolution Training.
- Ensure no method of restraint can be used that impacts on a patient's airway, breathing or circulation (note that the basket and prone techniques have been outlawed in the NHS due to methods involving potential asphyxiation).
- Attend relevant training as Physical intervention, restraint and breakaway course as approved by SUHFT or the MSB Group.

Head of Estates
The Head of Estates is responsible for:

- Matters relating to the security of Trust property and premises and for the CCTV arrangements.
- Ensuring the Directorate fully participate in any review or investigation into the use of restraint.

Matron/Senior Matron/General Manager

Matron/Senior Matron/General Managers are responsible for:

- Ensuring Ward Managers make their staff aware of this policy and ensure they comply with their responsibilities.

- Ensuring that Managers review any incidents involving the use of restraint and that action plans are formed to prevent any further incidents from occurring.
- Ensuring that Ward Managers support their staff if an incident occurs involving restraint.
- Ensuring opportunities for staff are given to discuss restraint episodes and support staff when handling these situations.
- Ensuring staff have had training in Mental Capacity Assessment and Deprivation of Liberty Safeguards when using interventions that could be considered as restraint.
- Ensure co-operation with the Adult safeguarding when a review of an incident is required.

Ward and Department Managers

Ward / Department Managers are responsible for:

- Ensuring that all members of staff are aware of this policy and comply with the main responsibilities below.
- Ensuring that if an incident has occurred involving therapeutic restraint, the staff member is supported appropriately and reflective statements are written and kept by staff involved.
- Root cause analysis is undertaken in a timely manner and the results are communicated to matrons and senior managers.
- Datix forms are completed by those involved where appropriate.

All Clinical Staff

All clinical staff:

- Must be aware of, and understand the restraint policy and act in accordance with the stated requirements.
- Understand what restraint is and how to ensure that restraint is appropriately used in an emergency and as a planned intervention.

It is imperative that if any method of restraint is being considered the following processes must be applied:

- Provide person-centred care that minimises the need for restraint.
- Undertake risk assessment to establish if restraint could be used (Appendix 2).
- Complete decision tree for restraint if restraint is to be used and other forms of de-escalation have not been used (Appendix 3).
- If the form of restraint is hand control mittens then risk assessment in Appendix 5 must be used.
- Check the patient does not have a valid Advanced decision which may determine if restraint can be used for treatment given.
- In completing risk assessment utilise initial strategies to de-escalate the need for restraint (see Appendix 7 for environmental and communicational strategies).
- Falls risk assessment and care plan should be completed if appropriate (see falls policy CL 13).
- An individualised care plan must be completed and evaluated.
- Care planning should include assessing risks and set out appropriate actions to try to prevent possible risks of harm.
- Involve appropriate members of multi-professional team where relevant.
- Involve members of the patients' family, lasting power of attorney or court appointed deputy, friends or carers where appropriate.

- Consider 'best interests' where restraint is planned or on-going. Even if restraint is used as an emergency a MCA 3 form has to be completed. This is to ensure that the method of restraint is the most appropriate and to decide what method of restraint should be used if the situation occurred again.
- Contact and involve IMCAs where appropriate.
- Record Keeping must be accurate and detailed as per record keeping policy (CM-56)
- The least restrictive form of restraint must be used which is proportionate to the risk of harm to the patient or others.
- The member of staff using restraint should be trained in Mental Capacity and Deprivation of Liberty and of had conflict resolution training.
- Members of staff who care for patients requiring chemical restraint should be trained in Intermediate life Support.
- To understand the legal and ethical frameworks relevant to restraint.
- Know the process to follow if they suspect inappropriate or abusive use of restraint (refer to safeguarding guidance by Southend Essex and Thurrock SET and CM-55)
- All actions and agreements are documented within the clinical record and communicated to all members of the multi-professional team and next of kin/Lasting power of attorney/Advocate if appropriate.
- Completion of Deprivation of Liberty or enhanced observations, if required (Policy Enhanced Observations CM-51 and Dols CM-61).
- Review the need for restraint every shift or if patients capacity, condition or individual needs change as the use of restraint may become inappropriate
- Be aware of the need to de-escalate as soon as is safe for the patient.
- All staff involved must be aware of the need for a multi-professional approach.
- Inform Matron responsible for the ward of the use of restraint, on the same day or if out of hours inform the clinical site manager.
- The doctor in charge of the patient's care should ensure that the patient has a complete medical review at this time if out of hours the on-call doctor is to review patient.
- All members of the healthcare team responsible for the patient **must** be compliant with identified actions.
- The therapeutic restraint recording form is to be completed by staff involved in the therapeutic restraint used (Appendix 6).

Independent Mental Capacity Advocate (IMCA)

An IMCA is independent of the person making the decision. The IMCA:

- Provides support for the person who lacks capacity.
- Represents the person without capacity in discussions about any proposed treatment.
- Provides information to work out what is in a person's best interests.
- Questions or challenges decisions that they believe are not in the best interests of the person lacking capacity. Presents individuals' views and interests to the decision-maker.
- The IMCA is not the decision-maker but the lead decision maker has a duty to take into account the information and views expressed by the IMCA

5 Body of Policy

5.1 Inclusion Criteria for the consideration of restraint / restrictive interventions

Staff must be able to clearly evidence why any restraint interventions were required and used. The following are examples when restraint or restrictive measures *may* need to be considered (for guidance only):

Patients who lack capacity

- Patients with learning disabilities who lack capacity.
- Patients aged 16 and over who have been assessed as lacking capacity who are unable to maintain their own safety within the clinical environment including those at continued high risk of falls may be restrained for their own safety.
- Patients who are exhibiting self-harming behaviour, which may be considered involuntary (due to an assessed lack of capacity) or deliberate, and/or which may involve a risk to the safety of the patient or others in the clinical setting.
- Patients who have been assessed as lacking capacity to look after their own welfare who are threatening or intending to abscond from the clinical care setting.
- Please note that at all times full assessments of the patient's capacity must be undertaken and recorded.

Patients who are held under the Mental Health Act

- Patients detained under any holding "section" of the Mental Health Act 1983
- Adult patients suspected to be suffering from a mental health disorder (as defined within the Mental Health Act) who, pending formal psychiatric assessment, may be considered liable to be detained under the provisions of that Act (section 5(2) should be considered in this circumstance.
- Detention and treatment of patients held under the Mental Health Act can only be for the direct treatment of the mental disorder or physical causes or consequences of the mental disorder.
- Even if a patient is detained under the Mental Health Act, they may still have capacity to consent to treatment of other physical symptoms. This should be considered in line with the Mental Capacity Act Policy.

Patients who have capacity

- Patients who have capacity but consent to therapeutic interventions which may be viewed as a form of restraint to maintain their safety. The consent should be accurately documented in the patient's notes.

This inclusion list is not intended to be exhaustive but is for guidance. Each situation involving patient safety and the welfare of others must be considered on an individual basis.

5.2 Exclusion Criteria when proportionate restraint cannot be used

The following are examples when restraint or restrictive measures cannot be considered (for guidance only):

- Threats of violence or physical harm to others by patients or members of the public who have capacity (refer to the Violence and Aggression Policy RM-05).

- If healthcare staff has the evidence that an 'advance decision' form is valid and it applies to the proposed treatment, they are not protected by law if they then use restraint to give the treatment.
- People who have capacity and decline the use of restraint (unless restraint is used to protect others from harm under common law).

5.3 Considerations prior to using restraint

5.3.1 Consider the context

The document 'Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings' aims to assist staff in: recognising and assessing the factors which can contribute to a patient's distress and lead to challenging behaviour; anticipating the patient's needs; assessing the risks; and designing care accordingly. This document led to a review of management of clinically related challenging behaviour at Southend University Hospital NHS Foundation Trust.

When patients and service users are distressed, anxious, frightened, ignored, or unable to tell someone what they need, they may display challenging behaviour. This is particularly the case where their clinical condition is linked to some form of cognitive impairment and/or communication difficulty that may cause them to be predisposed to distress or unable to express themselves verbally.

Clinically related challenging behaviour is common yet under reported across healthcare settings. If not adequately addressed, challenging behaviour can impair the ability of staff to deliver high-quality, appropriate care. It can also lead to an over-reliance on restrictive physical and pharmacological interventions, psychological ill health and physical injuries among staff and patients. At an organisational level, a failure to adequately manage challenging behaviour can be harmful to the organisation's reputation and/or detrimental financially (e.g. through sickness absence).

5.3.2 Consideration of causes

All staff must consider and evidence that they have explored and acted on possible causes of challenging behaviour:

- Mental health issues
- Medical conditions eg. Delirium
- Dementia
- Lack of mental capacity
- Volatile personality
- Upsetting situations
- Substance misuse
- Socially unacceptable response to stress

5.3.4 Less restrictive options

All staff must consider less restrictive options before using any form of restraint and complete a risk assessment (Appendix 2). Consideration should be given to whether it is possible to delay the decision making process temporarily to a time where the patient's capacity may improve or return and restraint interventions may not be necessary. Where possible, the staff member or relative should be consulted to ascertain a possible reason

for the behaviour and how the behaviour is usually managed. All members of the multi-professional team should be consulted to discuss potential reasons for the behaviour and decide on an appropriate management plan to treat the behaviour and underlying cause. It may be appropriate to request that an advocate comes to see the patient to minimise the need for restraint.

5.3.5 Consideration of what the patient is trying to communicate

Older people who show 'problem behaviour', particularly those who are confused and disorientated, often attempt to communicate their needs (RCN 2008). They may become restless and wander. It is important to look beyond the types of behaviour and attempt to understand the message behind it to identify any unmet needs the patient may be experiencing.

Therapeutic approaches can be used to reduce confusion and agitation and include a positive environment with good communication skills. Every effort should be made to reduce the negative impact of the environment in which the patient is being cared for. Examples of environmental factors which have a negative impact include: staffing shortages (impacting the quality of care) or levels of supervision, restricted observation of patients, high levels of noise or disruption, boredom or lack of stimulation for patients.

See Appendix 7 for a list of Environmental and Communication strategies to promote a positive environment with good communication.

See Appendix 8 for considerations to psychological, pharmacological or physiological reasons for behaviour.

5.3.6 Non restraint intervention

It is important that all potential physical causes of the challenging behaviour have been ruled out in line with the suggested management of the challenging behaviour:

- Assess and treat for possible causes of delirium.
- Assess and treat any pain management issues for the patient.
- Assess the patients posture, position in bed if appropriate adjust position and make comfortable.
- Assess bowels and bladder, consider whether patient may need to pass urine or open bowels.

5.3.7 Good ccommunication to manage challenging situations

When dealing with challenging situations communication and approach should be considered. All staff should:

- Introduce themselves and explain all nursing and medical interventions at each episode of care.
- Explain all procedures, keep instructions simple and to a minimum.
- Use yes / no questions.
- Speak slowly.
- Communicate in a non-confrontational manner.
- Keep calm, even if the patient becomes aggressive.
- Adopt a firm but gentle tone.
- Repeat information as often as required.

- Avoid harsh or patronising tone to voice.
- Ignore angry outbursts, make no direct response, ***do not shout or argue back or become upset in front of the patient.***
- Attempt to distract or remove the patient from the situation that prompted the outburst. If you are unable to defuse the situation remove yourself from the situation.
- Documentation of these episodes may help to establish cause of agitation/aggression or patterns of behaviour, allowing a plan of care to be produced to minimise the re-occurrence of this behaviour.
- Avoid asking too many questions.
- Leave pauses and gaps in conversations to allow the patient time to respond.
- Use non-verbal communication e.g. exaggerated facial expressions, communication boards.

5.3.8 Involvement off family and visitors

In most situations family and visitors may be a valuable resource in the management of challenging behaviour:

- Visitors should be given advice on how to interact with the patient and what to expect.
- The family should receive written information relating to the patient's condition if appropriate.
- Visitors should be restricted to 2 people unless otherwise agreed within the plan of care.
- Length of visiting time should be considered in relation to the patient's clinical condition.
- If the patient is tired or agitated no visitors should be permitted unless staff feel it is helpful to do so.
- Information about delirium for carers should be offered.

5.3.9 Environmental considerations

- Consider moving the patient to an area of low stimulation as noise and excessive stimulation may be stressful, possibly single room if available.
- Try to avoid excessive bed moves.
- Remove any unnecessary equipment, lines, catheters etc.
- Make sure the patient is receiving sufficient food and fluid.
- Nurse on low level bed for patients assessed as having risk of falls.
- Encourage day/night routine. Keep bed area well lit during the day and dark and quiet at night if possible.
- Have structure to the day; try to keep to the same routine. Allow for adequate periods of rest and avoid abrupt changes in routine.
- Avoid clutter of bed space.
- Allow patient to move around the ward if appropriate and safe.
- Have reminders of date, time and location if appropriate.
- Have pictures / notes / cards from family friends and reminders when they will be visiting.

5.4 Criteria for the use of restraint

If non-restrictive interventions have failed and the patient is behaving in a way that threatens or causes harm to him/herself, other patients or property restraint or a restrictive interventions may need to be considered. For example Patient without capacity who is inadvertently removing life-saving medical devices such as: Naso gastric tube, tracheostomy, CPAP/NIV, arterial line, CVP line, high flow oxygen.

There is no definitive number of incidences which will trigger assessment for the use of restraint. Criteria for assessment should be based upon clinical judgement and in the best interests of the patient. Considerations *may* include:

- Organic causative factors for behaviour (e.g. hypoxia, pain, hypoglycaemia, psychiatric disorders, neuropathological conditions, alcohol withdrawal) have been identified and excluded or managed wherever possible before considering restraint.
- Less restrictive options must be considered such as distraction techniques prior to the application of restraint.
- A mental capacity assessment form has been completed and reveals the patient lacks capacity to make informed decisions.

Patients who have mental capacity and are able to make their own decisions can give informed consent to the use of restraint to prevent any harm (such as the use of cot sides for safety). Patient choice must clearly be documented in their medical notes. However, if a patient who has capacity refuses to allow the use of restraint then this refusal must be upheld.

It is important to consider that the use of an intervention could actually cause the individual more distress. Therefore monitoring and reassessment of any technique used is very important and most be included within the plan of care.

5.5 Forms of Restraint.

When any form of restraint is being considered the least restrictive restraint proportionate to the risk of harm must be used. Refer to Appendix 10 for acceptable forms of restraint and the nursing actions for these. Assessment must be carried out to act in the patient's Best Interest involving the multi-professional team and significant others involved.

5.5.1 Physical restraint

Physical restraint is the positive use of force in order to protect a person from harming themselves or others, or seriously damaging property (Department of Health 1993).

Physical restraint should avert danger by preventing and deflecting a person's action or by removing the physical object. The objective of any restraint is to maintain the safety of staff, other persons present and the individual, by establishing an appropriate degree of control.

- Physical restraint is only permitted to be used in circumstances to avert immediate danger or significant harm to the patient if they lack capacity or harm to another individual whether they have capacity or not.
- To avoid immediate serious damage to property where they lack capacity.
- Used to prevent the patient from absconding where they lack capacity.

Such restraint should always involve the least restrictive practice and only be carried out by those trained in the restraint technique being employed.

However it is recognised that emergency physical restraint is sometimes necessary to prevent harm to the individual or others. If this is the case, it is recommended that as soon as possible a multi-disciplinary meeting is convened to discuss the approach to the behaviour and for there to be consideration given to what is permitted in the vent of further incidents happening that necessitate restraint again.

5.5.2 Mechanical Restraint
Mechanical restraint involves the use of equipment for example to stop a person falling out the bed and may restrict freedom of movement (RCN 2008) e.g:

- Bed rails *
- Sensory devices that alert staff when a patient is out of bed

However, it is not acceptable to use equipment to restrain a patient unless it is used in their best interests.

5.5.3 Softsides/bed rails.
The RCN (2004) suggests alteration of the environment and meeting the comfort needs of the patient rather than using bed rails. Softsides should be used where possible, as they are less likely to cause injury than bed rails.

"The only appropriate use of bed rails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed." (NPSA, 2007). A number of hazards associated with their use have been identified. (Refer to bed rail policy CM-66)

5.5.4 Hand control mittens
Patients in the acute phase of their illness frequently become restless and inadvertently remove feeding tubes and other essential access lines. There are various treatment options which include forms of restraint, and as such, are ethically sensitive and fraught with emotion for the patient, their family and for staff. Such tensions have to be managed alongside the need to provide optimal treatment. Hand control mittens are only considered if patients have removed essential lines or tubes. There is no definitive number of incidences which will trigger assessment and the decision about need for assessment should be based upon clinical judgement and best interests of the patient.

The use of hand control mittens is recognised as a form of restraint. They are designed to restrict the movement of one or both hands, and are used for patients to prevent the removal of essential lines and tubes. The Trust does NOT condone the use of bandaging to restrict hand movement in patients who remove tubes/lines.

Staff are required to consider the patient's capacity to be involved in the decision-making process and where at all possible gain the patient's consent. Patients and their relatives or carers should be involved in the decision making process and provided with appropriate information. The views of patients and relatives must be used in the decision making process and documented in the patients' health record.

A review must be made of the patient's mental capacity and the use of the mittens each time the condition changes or at least every 24 hours.

Please see Appendix 4 for the criteria, contraindications, application and removal of hand mittens. Appendix 5 is the risk assessment for the use of hand control mittens.

A multi-disciplinary best interests meeting must take place prior to the use of mittens to discuss the best interests of the patient when considering the use of the mittens. This meeting must involve the family, nurse looking after the patient, doctors involved in the care and any other medical professional deemed relevant to the discussion.

If the patient has no next of kin an IMCA should be considered to be present at the meeting. Conclusions of all discussions and decisions should be clearly documented in the medical notes.

5.5.5 Chemical Restraint

Mott *et al* (2005) say: 'Chemical restraint describes both deliberate and incidental use of pharmaceutical products to control behaviour and/or restrict freedom of movement, but which is not required to treat a medically identified condition.

Chemical restraint may be used to restrain patients who are acutely disturbed, the aim being to:

- Calm or lightly sedate the person.
- Reduce physical and psychological strain.
- Reduce the risk of violence.
- Reduce the risk of injury to themselves and others.

When considering the use of Chemical Restraint, also consider whether a Psychiatrist's input is required, when a patient is acutely disturbed a doctor must be called to assess the patient. If the doctor called is not a Psychiatrist, consider whether a second opinion from a Psychiatrist would be beneficial.

The following must be adhered to when chemically sedating a patient:

- Prescribing advice should be sought as appropriate. All staff prescribing or administering benzodiazepines or anti-psychotic drugs must be familiar with the properties of these drugs.
- These drugs must not be purposively administered to sedate a patient as a means of convenience.
- As with other forms of restraint, other interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical restraint.
- Frequent review should be carried out by nursing and medical staff to ensure the appropriate level of sedation is being achieved, with the minimum amount of medication and with the aim that chemical restraint is a short term measure in conjunction with treatment for the cause of the psychomotor agitation eg, psychiatric illness.
- While the patient is receiving chemical restraint they should be closely observed and have their physiological parameters assessed using the early warning score system

as frequently as decided by the nurse in charge to ensure that any complications of the medications are detected immediately.

Chemical restraint should only be used as a short-term measure and in conjunction with treatment for the cause of the psychomotor agitation e.g. psychiatric illness. Non-psychiatric causes for disturbed behaviour must be explored and excluded (Appendix 8). Prior to using chemical restraint there should be an assessment of risk where the need for sedation is greater than the risk of the pharmacological treatment. Alternative interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical sedation.

A crash bag should be available within 3 minutes in healthcare settings where these interventions might be used. This equipment should include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medications. The equipment should be maintained and checked regularly.

5.5.6 Psychological Restraint

This can involve staff advising patients not to do something, for example, not to leave the ward, or that doing what they want is not allowed (RCN, 2008). It may involve staff having to remove possessions belonging to patients if they are at risk of using these belongings to harm themselves and they lack capacity.

5.5.7 Technological surveillance

This can be the use of alarm pressure pads, closed circuit television, or door alarms. This is often used to alert staff that the patient is trying to leave or to monitor their movement (RCN, 2008). They could be used rather than having to use restraint.

5.5.8 Proportionate

'Proportionate restraint' means using the least intrusive type and minimum amount of restraint for the shortest possible time to achieve a specific outcome in the best interests of the patient (MCA, 2005).

5.5.9 General points for for the management.of challenging behaviour or restraint

Staff are advised to record and communicate any successful interventions and also those interventions that may agitate the patient further, in the clinical records. This will assist in providing a more person centred approach to managing individual behaviour.

If the patient has a history of presenting as challenging when unwell, staff are to complete Agitation scale (appendix 1) and proactive management pathway (appendix 2) on admission to provide staff with a baseline score which on review may highlight an increase or decrease in agitation levels. If the patient does not have a known history complete the agitation scale (appendix 1) following first episode.

Staff are advised to use this guideline in conjunction with the mental capacity act, enhanced observations policy and management of violence and aggression policy.

If the patient becomes so agitated that they are a danger to themselves or others in terms of violence and aggression, security are to be contacted via fast bleep to manage any physical violence. See urgent management pathway (appendix 3).

All episodes of violent and or aggressive behaviour should be reported through the DATIX system. Any interventions by the security team to be documented by the nurse in the medical notes.

All staff should be given the opportunity to discuss interventions for the management of challenging behaviour following any incident, in a supportive environment with their line manager or occupational health if relevant.

5.6 De-escalation

De-escalation (also referred to as 'defusing' or 'talk-down') involves the use of various psychosocial short-term techniques aimed at calming disruptive behaviour and preventing behaviour from occurring. Every effort should be made to avoid confrontation. This can include talking to the patient, often known as verbal de-escalation, or moving the patient to a less confrontational area.

According to NICE guidance (2005) staff when trying to de-escalate should :

- Ask for facts about the problem and encourage reasoning to attempt to establish a rapport;
- Offer and negotiate realistic options;
- Avoid threats;
- Ask open questions and ask about the reason for the service user's anger;
- show concern and attentiveness through non-verbal and verbal responses;
- Listen carefully;
- Do not patronise and do not minimise the service user's concerns.

5.7 The Mental Capacity Act (MCA) 2005

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Anyone caring for a person who may lack capacity to make specific decisions, must comply with this act when making decisions or acting for that person.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks capacity to make the decision or to act for themselves, is made in their best interests (refer to mental Capacity Act policy CM-62). The five principles of the Mental Capacity act which must be adhered to are:

The 5 Principles of the Mental Capacity Act

- There is a presumption of capacity. All adults have the right to make decisions for themselves, unless it can be shown that they are unable to make them.
- Everyone should be given all the help and support they need to make a decision before anyone concludes they cannot make their own decision.
- People are allowed to make what we might think is an unwise or eccentric decision – this doesn't mean they lack capacity to make a decision.
- Any actions made on behalf of someone who lacks capacity must be done in their best interests.

- If acting in a patient's best interests, due to their lack of capacity, the least restrictive course of action must be taken. People who lack capacity must not have their rights and freedoms restricted unnecessarily by the decisions made for them (MCA, 2005).

Anyone assessing someone's capacity to make their own decisions should use the two-stage test of capacity (MCA, 2005):

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? (MCA, 2005)

5.8 Deprivation of Liberty Safeguards

The deprivation of liberty safeguards were inserted into the Mental Capacity Act (2005) via the new Mental Health Act (2007) and came into effect on 1st April 2009. These safeguards are designed to prevent unlawful deprivations of liberty and to provide safeguards for those whose liberty is deprived to prevent them from coming to significant harm and to ensure all decisions made on their behalf are in their best interests (DOLS Policy CM-61).

There must therefore be particular factors in the specific situation of the person concerned which provide the 'degree' or 'intensity' to result in a deprivation of liberty. In practice, this can relate to:

- the type of care being provided
- how long the situation lasts
- its effects, or
- the way in a particular situation came about.

5.9 Enhanced observations

All patients being cared for in clinical areas are observed by staff in order to monitor their well-being. This is not usually intrusive to a patient's personal space for any prolonged period of time or restrictive. Some patients may need closer observation or supervision for reasons other than ones directly related to managing their physical clinical care/treatment, to ensure their own safety. It is important that appropriate levels of observation are provided for all patients which are non-discriminatory. (Enhanced Observation policy CM-51).

5.10 Best interests

'Best interests' is a method for making decisions which aims to be more objective than that of substituted judgement. It requires the decision maker to think what the 'best course of action' is for the person. It should not be the personal views of the decision-maker. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for the person (Joyce, 2009).

The Mental Capacity Act (2005) sets out guidance on how to determine someone's best interest's (see appendix 1). Health care staff, when considering someone's best interests should complete a MCA form which incorporates considering what is in their best interests.

In patients who may regain capacity, decisions regarding their care should be delayed until they regain capacity**.** Unless in an emergency situation, it may not be possible to wait for the patient to regain capacity and in this situation a decision has to be made in the patients best interests.

5.11 Duty of care

The law imposes a duty of care on practitioners, whether healthcare support workers, registered nurses, doctors or others, in circumstances where it is 'reasonably foreseeable' that they might cause harm to patients through their actions or their failure to act (Cox 2010). All health care staff have a duty of care for the patients in their care. This means acting in their "best interests". In relation to a patient who is at immediate risk of harm, restraint may be part of the duty of care.

5.12 Advanced decisions

Sometimes people will make an advance decision to refuse treatment while they still have capacity to do so and before they need that particular treatment. Healthcare staff must respect this decision if it is valid and applies to the proposed treatment. In this case restraint cannot be used to give medical treatment (MCA, 2005).

An advance decision is a decision made by an adult, who at the time of making the decision has capacity, that if at a later time and in specified circumstances, a specific treatment is proposed by a healthcare professional and at the time that these specific circumstances arise the patient lacks capacity to consent to the treatment.

Should, when the specified circumstances arise, the patient still has capacity to consent or to make a decision, this will override any valid advanced decision.

Rules for validity of an advanced decision:

1. Made by a person who is aged 18+ who, at the time, has capacity to make the decision;
2. The advanced decision has not subsequently been withdrawn;
3. There is no subsequent relevant Lasting Power of Attorney in place;
4. No other "clearly inconsistent act";

Please note that an advanced decision does not have to be in writing to be valid (except if it relate to life-sustaining treatment).

The treatment in question must be expressly specified in the advance decision.

An advanced decision may not be valid if at the time of the circumstances in question, there are reasonable grounds for believing such circumstances exist which the donor had not anticipated at the time of the decision.

Advance decisions which relate to life-sustaining treatment must be in writing, they must state that the decision is to apply even if the person's life is at risk and they must be witnessed.

5.13 Lasting Power of Attorney

If decisions concerning the treatment of the patient have been handed over to another person, under a Lasting Power of Attorney, then it is that person who must consent to or decline the restraint (MCA, 2005). Please note that a Lasting Power of Attorney only comes in to effect when the donor no longer has capacity. For as long as a person has capacity, the Lasting Power of Attorney will not take effect.

Patients can give authority to someone else to be able to make decisions on their behalf. A power of attorney is a legal document that allows them to do so. Under a power of attorney, the chosen person (the attorney or donee) can make decisions that are as valid as one made by the person (the donor) (MCA, 2005).

5.14 Court Appointed Deputy

If the patient has a Court Appointed Deputy who has been given authority to take decisions about the proposed restraint, then it is the deputy who must consent to or decline the restraint (MCA, 2005).

5.15 Risk of harm

It should be recognised that the use of restraint can cause significant harm. For example, patients forced to sit for long periods are subject to increased risk of pressure ulcer development. The use of bed rails may actually increase the risk of serious injury if the person attempts to climb over them. Restraint of patients must only be used after a detailed risk assessment (see appendix 5 for hand control mittens and appendix 2 and 3 for other methods of restraint) has been undertaken to ensure that the level of risk of using restraint is proportionate to the potential harm that could be caused to the patient to the patient if restraint methods were not to be used.

If restraint has been used that which is not proportionate to the risk of harm, the nurse in charge and Matron must be informed. If the restraint used has caused harm, then the patient must also be seen by a doctor as soon as possible and actions taken documented in patients clinical record by all members of the multi-professional team involved in the patients care. Any injury to a patient, member of staff or visitor on the Trust premises, involving the use of restraint, should be considered an adverse incident and reported according to Trust Policy for the Reporting and Management of Incidents and Near Misses (RM-10).

(Please see Appendix 9 for guidance for inappropriate forms of restraint and Appendix 10 for the appropriate forms of restraint with nursing actions).

5.16 The absconding patient.

Patients who have left the ward without staff's knowledge can cause anxiety and distress to staff and their family. However, many patients who leave ward areas/departments do so of their own free will and out of choice and are free to do so. Whilst most patients are able to leave the ward without causing any harm, some others may be at risk, either to themselves or others. A patient who may lack capacity regarding an element of medical treatment may have capacity to decide whether they want to leave a ward and this decision requires a separate Mental Capacity Assessment as in Section 3.3. A further and separate MCA assessment form should be completed regarding the patient's specific decision to leave the ward and a DoLs assessment as the patient will be deprived of their liberty if they cannot leave the ward.

The formation and maintenance of positive relationships is core to understanding the nature and extent to which a patient is at risk of absconding, and the risks created by their absconding. Accurate and on-going assessments are enhanced through the development of these relationships. 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 clients in distress (RCN, 2008).

It is expected that, in response to a patient intending or attempting to leave a ward without them being formally discharged, active and reasonable efforts should be made to encourage and persuade the patient to remain or return. If a patient has capacity and against advice, wishes to leave the hospital, then the nurse has to respect their wishes and advise them to fill out a self-discharge form. However, if a patient lacks capacity and it is decided that to let the patient leave the hospital could put them at significant risk of harm then the minimal level of restraint may have to be used to prevent the patient from leaving as this would be acting in their best interests. Preventing a patient from leaving overrides their right to freedom. However, this must be balanced against their right to be free from physical harm (RCN, 2008).

Decisions in relation to using restraint to prevent a patient from absconding should be made according to the individual circumstances and by considering the patient's best interests. Preventing a patient from leaving the hospital site will ordinarily be in response to an emergency and should be a short term measure. This must be followed up by a full assessment and plan for on-going intervention including filling out a form for best interests.

5.17 Incident report form

As soon as possible following an incident or near miss, incidents reports are to be completed by staff using the electronic incident reporting system which submits incident form information directly into the electronic Risk Management Information System (Datix).

- If restraint is used unlawfully it may be a form of abuse. It is the responsibility of **everyone** to recognise suspected or actual abuse and to take appropriate action in line with the procedures of safeguarding adults (SET Safeguarding Adults Guidelines – 2014).

5.18 When to contact the police

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

- A violent situation where the safety of staff, patients or others is at risk (see Trust policy on Violence and Aggression (RM-05)
- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and there are **serious** concerns about the welfare or safety of that Individual (e.g. the effect of not taking important medication) or if you have concerns that other people could be endangered by the patient who is absconding.

In these circumstances, the police may be able to check on the person by visiting them at home. In cases where the individual is threatening to commit suicide, the police have powers to take the patient to a place of safety, which in most cases would mean bringing

the person to the hospital for assessment. Staff should also follow the normal procedure for discharge against medical advice.

5.19 Ethical principles

Ethical principles should be adhered to where possible when considering duty of care. Basic ethical concepts underpinning nursing 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 (non-maleficence) – The most essential ethical concept and the basis for good practice. Using restraint may be to avoid harm.
- Assessing the consequences of action – The ethically appropriate action may be determined by calculating its potential benefits to the risk of harm.
- Autonomy and rights – respect for the individual's rights to make their own decisions and respect for the rights of others.
- Best interests (beneficence) – identifying and acting in the best interests of others is a commonly applied means of ethically justifying an action or decision to do the patient good.

5.20 Consent

The Nursing and Midwifery Council (NMC) (2008) states that: 'You must ensure that you gain consent before you begin any treatment or care'. Consent is necessary for all aspects of nursing care and therefore knowledge of the law in relation to consent is essential. Failure to gain consent may lead to a healthcare professional being prosecuted if the act performed was in the patient's best interest but was non-consensual.

For consent to be valid a patient must have the mental capacity to give consent, be supplied with relevant information to assist the decision to consent and the patient must come to a decision to consent free from any coercion or duress (Whitcher, 2008).

Patients who lack capacity should not be denied necessary treatment simply because they are unable to consent to it. The Mental Capacity Act 2005 has provisions allowing for the appointment of decision makers for incapacitated adults. This could be a Lasting Power of Attorney or a Court appointing Deputy.

In the absence of a Lasting Power of Attorney or Court Appointing Deputy, either because there isn't one or because they cannot be reached before emergency treatment is required, the principle of necessity justifies treatment of an incompetent patient without consent. In all these circumstances any decision that is taken on behalf of an incompetent patient must be taken in his or her best interests.

If the patient has a mental health disorder, you should refer to the Mental Health Act (MHA), 2003 with regards to their care. They allow compulsory treatment for patients with a mental health disorder in certain circumstances, without consent, even if the patient has capacity.

Section 5 of the Mental Capacity Act provides 'protection from liability'. The Act allows necessary caring acts or treatment to take place if the patient who lacks capacity to consent as long as it is in that person's best interests.

5.21 Civil Law and Criminal Offences

Section 44 of the MCA (2005) makes it clear that staff will be found guilty of an offence if they ill-treat or wilfully neglect patients who lack capacity.

If a patient is assessed as having mental capacity to consent and refuses restraint then its use would be unlawful and could constitute an assault. However, under common law which protects others from harm or the patient is detained under the Mental Health Act 1983 it may be justified to use restraint if the a person is about to harm another person. It is recognised under common law that reasonable steps can be taken where necessary and proportionate to protect others from immediate risk of significant harm. This applies whether or not the patient lacks the capacity to make decisions for her/himself. The common law does not protect an individual who uses reasonable force to stop someone who has capacity and is harming themselves or property.

Restraint or restrictions on an individual who lacks capacity can be justified under the Mental Capacity Act 2005 provided:

- The staff member using restraint reasonably believes that it is necessary to prevent harm to the patient and its use is proportionate both to the likelihood and seriousness of harm.
- The restraint must be in the patient's best interests.
- The restraint is the least restrictive means by which to keep the patient safe from harm.

The unnecessary and disproportionate use of restraint may also amount to a breach of the patient's human rights under the European Convention on Human Rights (1998).

6 Training Requirements

Restraint, Mental Capacity and Deprivation of Liberty Safeguards are all included with the Adult Safeguarding Training. Conflict Resolution training is also provided. Staff are mapped according to role.

7 Monitoring and Audit

Aspect of compliance or effectiveness being monitored	Monitoring Method	Individual department responsible for the monitoring	Frequency of the monitoring activity	Group/ Committee/ forum which will receive the findings/monitoring report	Committee / individual responsible for ensuring the actions are completed
Use of restraint	Quarterly review and reporting of all incidents that involve the use of restraint. Incidents involving	Adult Safeguarding Manager	Quarterly	Children & Adults Safeguarding Committee	Clinical Governance Group

	moderate harm progress onto RCA				

8 Approval and Implementation

This document is a review and will be agreed and approved by the Integrated Children and Adults Committee.

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10 Quality Impact Assessment

This document has been approved by the Integrated Children & Adults Safeguarding Committee.

11 Equality Impact Assessment

This policy has been the subject of an Equality Impact Assessment. The output of the assessment demonstrates that no one as a consequence of this policy is placed at a disadvantaged over others.

Appendix 1 How do you determine what is in a person's "best interests"?

Section 4 of the Mental Capacity Act sets out how to determine the best interests of a person who lacks capacity to make a decision at the time it needs to be made. Section 4 sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. The following is a summary of what the decision maker should do to determine "best interests" under Section 4:

- encourage the person to participate or improve their ability to take part in making the decision;
- identify all the relevant circumstances;
- find out the person's views;
- avoid discrimination - not simply make assumptions about someone's best interests on the basis of their age, appearance, condition or behaviour;
- assess whether the person might regain capacity;
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death;
- consult others for their views about the person's best interests;
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights;
- weigh up all of the above factors in order to determine best interests.
- If a person's incapacity is likely to be temporary, it may be possible for the decision to be postponed until capacity is regained.

A person trying to work out the best interests of a person who lacks capacity to make a particular decision ('lacks capacity') should:

- Encourage participation
  do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

- Identify all relevant circumstances
  try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

- Find out the person's views
  try to find out the views of the person who lacks capacity, including:
  – the person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
  – any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
  – any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

- Avoid discrimination
  Not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.

- Assess whether the person might regain capacity:
  Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

- If the decision concerns life-sustaining treatment:
  not be motivated in any way by a desire to bring about the person's death.

- They should not make assumptions about the person's quality of life.
  If it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.

  In particular, try to consult:
- Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
- Anyone engaged in caring for the person
- Close relatives, friends or others who take an interest in the person's welfare
- Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
- Any deputy appointed by the Court of Protection to make decisions for the person.

For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted. When consulting, remember that the person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private so it would not be right to share every piece of information with everyone. (Mental Capacity Act, 2005).

Appendix 2 Risk assessment tool prior to considering the use of Restraint

Does the patient behaviour have the potential to endanger themselves, staff or others?

No → Restraint inappropriate

Do not need to complete this form.

Yes

Describe This Behaviour: It can be a combination of factors.	*YES*	*NO*
Wandering and may try to abscond from the ward?		
Falling more than once?		
Confused, agitated or inhibiting some form of aggressive behaviour?		
Inhibiting behaviour which shows concern to self-harm or harm others?		
Any other behaviour which may endanger patient or others?		
Repetitive removal of non-life threatening medical devices;		
For example O2 mask or cannula. Attempted removal of any life sustaining devices		
For example CPAP or Tracheostomy		

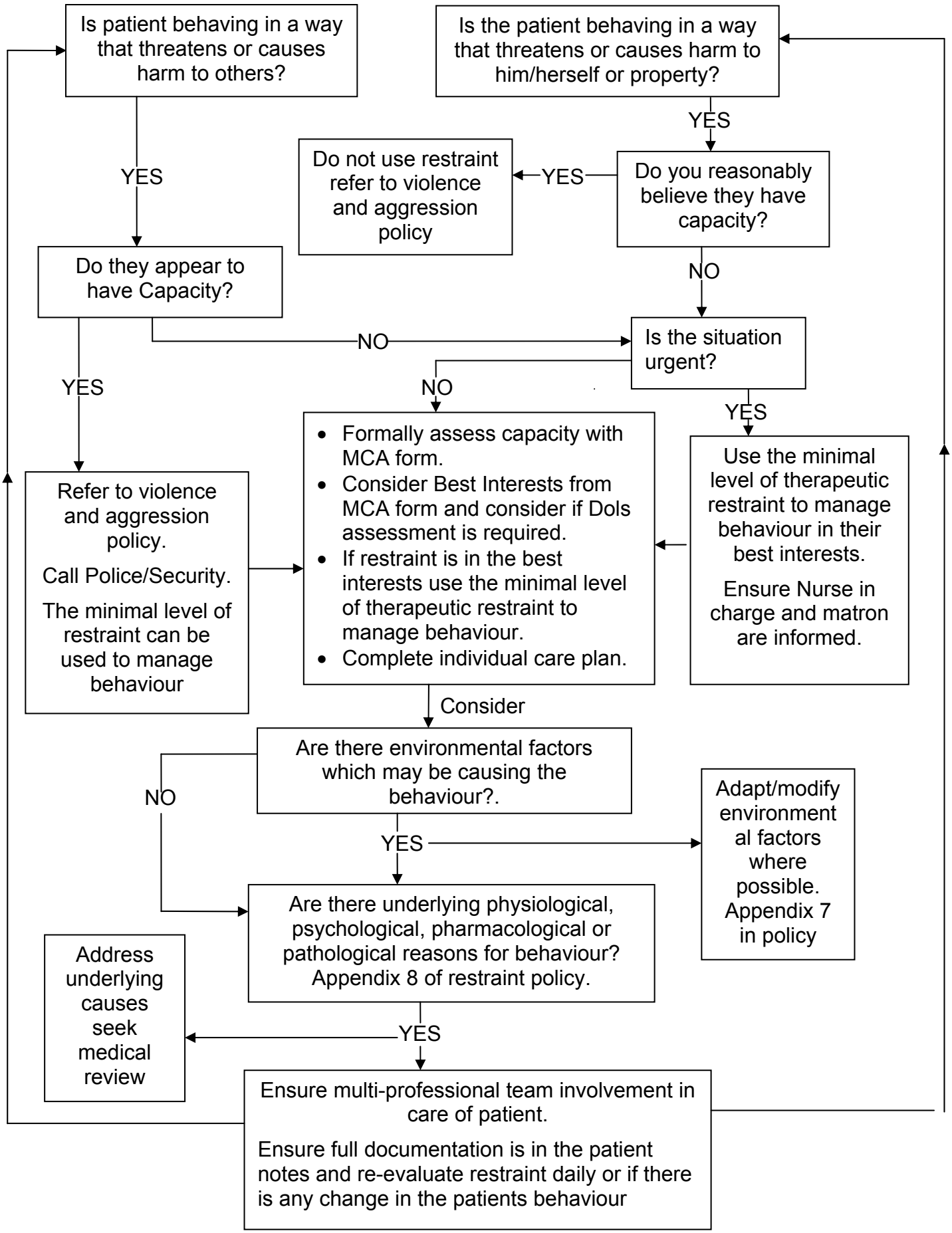
Yes

Initial strategies to consider and to act upon where necessary.

Utilise verbal de-escalation techniques.		Review drug therapy.	
Diffuse any situation with minimum staff.		Check observations.	
Remove harmful objects if appropriate.		Involve Family or a familiar person.	
Diversion techniques e.g. music, T.V.		Optimise Environment.	
Inform Nurse in Charge and Doctor.		Document in notes.	
Optimise Environment.		Consider observation	

Is the assessing nurse able to maintain patient safety through the above strategies? If NO please see Decision Tree for using therapeutic Restraint (Appendix 3). If yes continue with successful strategy to maintain patient safety.

Appendix 3 Decision Tree for using Therapeutic Restraint



Appendix 4 Criteria for the use of Hand Control Mittens, Application and Removal

1. Patient is inadvertently removing life-saving medical devices such as:
    - Nasal Gastric tube
    - Tracheostomy
    - CPAP/NIV
    - Arterial line
    - CVP line
    - High flow oxygen.
    - PEG insertion

    There is no definitive number of incidences which will trigger assessment for the use of hand control mittens. Criteria for assessment should be based upon clinical judgement and in the best interests of the patient.

    If the patient has no next of kin an IMCA should be considered to be present at the meeting. Conclusions of all discussions and decisions should be clearly documented in the medical notes.

    Contraindications to the use of Hand Control Mittens

    Hand control mittens should not be used on patients who:

    - are Highly aggressive and likely to be violent.
    - are suicidal.
    - has a wound site or abrasions on both or either hands.
    - has severe arthritis of the wrist or hand.
    - has a radial renal fistula.
    - has a dislocation or fracture to either hand.
    - has an intravenous cannula inserted to the back of either hand or forearm.

    Application of Hand Control Mittens

    Prior to the application of the hand control mitten the medical professional must check for the following:

An MCA 3 form has been completed and a best interests meeting has taken place with the decision made that the use of hand control mittens is appropriate to prevent the removal of the lifesaving tube/medical device when a patient lacks capacity.

If the patient has capacity there is documentation that they have given informed consent to the use of the hand control mittens.

The Risk assessment form has been completed (Appendix). The risk assessment has to be completed every 24 hours or if there is a change in the patients capacity or medical condition.

The Care plan (Appendix) has been initiated and must be reviewed daily for the duration that the mittens are in use.

The Daily hand control mitten evaluation sheet (Appendix) must be completed every fifteen minutes for the first hour of use and then four hourly.

The medical professional must consider a DOLs application and document appropriately.

Removal of the Hand Mittens

If any of the following occur the use of hand mittens has to be reassessed and documented in the medical notes.

The patient's medical condition changes

The patient becomes more agitated/distressed when wearing the mittens

Consent by the patient is withdrawn and the patient has capacity to make informed decisions.

The patient regains capacity when they previously did not have capacity to make informed decisions.

The life-saving tube/medical device is removed as it is longer required.

Any deterioration of the skin or impaired circulation is noted.

Patient Identification label

Appendix 5: Daily Hand Control Mittens Risk Assessment Tool/ Record

PATIENT	YES	NO	Please Specify Supporting Information and Actions
1. Has the patient attempted to or removed essential tubes/medical devices that are still required and the necessity of the tubes /device is required and has been reviewed /documented daily?			
2. Have other less restrictive methods been tried? (Distraction techniques).			**Identify type(s) of technique to be used:**
3. Does the patient have a MCA 3 form completed? Or has the patient given informed consent if they have capacity for the use of hand mittens?			
4. Have any reversible causes of the patients lack in capacity been identified and consideration given to reverse these causes?			
5. Has the nominated next of kin (NOK)/ carer /IMCA (Independent Mental Capacity Advocate) been involved in the decision making process and been provided with adequate information and a MDT best interests meeting taken place and documented?			
6. If the patient has no next of kin, is there documented evidence that the clinical team agree to the use of hand mittens being in the patient's best interests?			
7. The patient has been assessed and found not to have any contraindications (listed in 3.4 of MCA policy)			**(if no contraindications then the answer is yes)**
8. Has the plan of care been discussed (patient, NOK/carer, team) and documented in medical notes?			
9. Is the patient being nursed in a high dependency setting or is the patient being cohort nursed so the patient is never out of vision from a member of staff.			

Please note if any questions above are answered with a NO then the hand mittens are not to be used on the patient.

Why have hand control mittens been issued for this patient?

……

……

Signature ..... date..... Signature ..... date.....

Signature ..... date..... Signature ..... date.....

Signature ..... date..... Signature ..... date.....

NB: Reassess every 24 hours or as soon as the patient's condition changes.

Appendix 6: Therapeutic Restraint Recording Form (To be used if further enquiry required and also as guidance for documentation within the patients notes)

Patients Name?	
Date and Time?	
Nurse completing form?	
Location of restraint used?	
Witnesses? Please name.	
What restraint method was used?	
Has a Datix report been completed? If not why?	
Was a risk assessment form completed?	
What initial strategies were used to de-escalate the need for restraint?	
Was restraint planned or used in an emergency?	
Why was restraint necessary?	
Please tick in which situation restraint was used:	The patient had capacity and consents to the use of restraint? The patient had capacity but restraint was used to provide protection to others? The patient lacked capacity and restraint was used for their best interests?
Who made the decision to use	

therapeutic restraint? Was a capacity assessment MCA completed either before or after event, If appropriate?	
If restraint is on going or planned has a best wishes form been completed?	
If restraint on going or planned has an individualised care plan been completed?	
If restraint on going or planned was a decision been made involving all relevant members of a multi-disciplinary team?	
Why was the method of restraint in the patients best interests?	
How long was the method of restraint used for?	
Did the patient suffer any injuries as a result of the incident? Injury, location and description?	
If so has a body map of injuries been completed and the patient had a medical review with doctor?	
Has the patient's Next of Kin been informed of the incident?	
Did staff or others suffer any injuries in the incident? Injury, location and description?	
Will Witness statements to be required by relevant staff? Ask line manager if unsure.	

Appendix 7 Environmental Strategies

- Provide an accurate visible clock.
- Minimise excessive noise at night.
- Maintain a day/night routine.
- Maintain a consistent temperature on the ward.
- Facilitate rest periods and also rest periods of patient activity.
- Use diversional therapy for example television or tiptree box.
- Use reminiscence with familiar belongings to the patient for example photos.
- Reduce monitoring where possible to reduce distress caused to the patient.

Communication Strategies.

- Engage the patient in meaningful activity.
- Ask relatives or carers what the patient likes to do, and what they would be doing if they were at home.
- Orientate patient to time, person and place.
- Communicate clearly and concisely with the patient.
- Provide repeated verbal reminders.
- Identify and correct any sensory impairments i.e. glasses and hearing aid.
- Use empathetic communication and touch when appropriate but with considering the patient's own need for personal space.
- Involve a patient's family and friends in care.
- Where a patient has known mental health issues or a learning disability refer to appropriate members of the multi-professional team.
- Provide communication aids.

Appendix 8 Considerations with psychological, pharmacological or physiological reasons for behaviour

- A change in behaviour could arise from physiological causes e.g. chest or urinary tract infection, dehydration, constipation, inadequate nutrition, hypoxia, hypotension, pyrexia, drug dependency or withdrawal, brain injury, delirium, intoxication or metabolic changes as a result of medication.

- Changes of behaviour may be due to anxiety, stress or mental illness. If a patient's mental health is an issue, then the relevant Mental Health Services need to be contacted.

- People who 'wander' might be looking for something (e.g. the toilet, a drink, food, a person) or could just need exercise – the challenge is to understand why the patient is walking about.

- Restlessness may be due to physical discomfort or pain.

- Disorientation could be due to changes in the environment, lack of sleep or medication.

- Aggression might be a result of a build-up of frustration when the patient feels their needs are not being met.

- When the cause of agitation or restlessness is identified and resolved, there may be no need for restraint.

- Fear, phobia and irrational behaviour

- Medical conditions – hypoxia, hypoglycaemia

- Intoxication

- Agitated cerebral state

Appendix 9 Unacceptable Methods of Restraint

Inappropriate Bed Height.

This is an unacceptable form of restraint as it increases the risk of injury resulting from a possible fall out the bed.

Inappropriate use of Bed rails.

There are circumstances in which bed rails are appropriate to be used (see bed rail policy CM 66)) However, using bed rails to restrain a patient who lacks capacity when they are at risk of climbing out of the bed could cause them to harm themselves either by climbing over the rails and falling or injuring themselves by getting caught between the bed rail and the mattress. Therefore, unless a patient has capacity and consents to the use of bed rails or if they lack capacity but they are not at risk of harming themselves as a result of the bed rails they should not be used as a method of restraint. Bed rails must not be used if a patient has capacity and the bed rails are used to stop the patient from getting out of the bed on their own.

Belts, cuff devices

Belts 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.

Inappropriate chairs.

Any chairs that are the wrong height for the patient must not be used. Sitting someone in a chair where they can't stand is an inappropriate form of restraint. Also a recliner chair should only be used for comfort. If inappropriate use of chairs is used then this could be a risk to the patient if they try to climb out the chair.

Inappropriate use of locked doors

Wards outer doors being locked in order to restrict a patient who lacks capacity from wandering out of the ward is inappropriate. However, it is also not acceptable for a patient to be locked in any room of the hospital. Consideration must be given to patients that they are not being deprived of their liberty.

Inappropriate arranging of furniture to impede movement.

Furniture used to restrain a patient could result in the patient being at risk of harm. Any furniture and equipment should only be used for the purpose in which it is intended.

Removal of shoes or sensory aids

This is unacceptable practice unless any items are removed to prevent a patient from harming themselves or others.

Inappropriate use of isolation

Patients may be isolated if they have an infection, however, each patient nursed in a side room must have their care individually discussed and planned with the multi-professsional team. Steps must be taken to ensure that patients nursed in a side room do not feel isolated. Staff must not use seclusion as a means of restraint other than for people detained under the Mental health Act (1983).

Inappropriate use of holding or grabbing.

Unless an emergency whereby to save a life of someone it is necessary to grab someone or try to hold them it is inappropriate for staff to grab someone or hold someone down. When the situation is not an emergency and the patient lacks capacity a decision should be made as part of a multi-professional team to decide the least restrictive method of restraint to manage behaviour which is in the patients best interests. Staff must not restrain someone in a way that impacts on their airway, breathing or circulation such as face down on the floor.

Inappropriate use of sedation

A patient wandering should not have sedation just to stop them wandering. This could fit with the definition of restraint, but is unlikely to be justified. Alternative ways of supporting the client to settle, such as conversation and reassurance, could be found.

Relatives requesting restraint

Nurses should not feel pressured to comply with a request from a person's relative to restrain them, when it is not in the patients best interests.

Advanced Decisions and decision made by the court of protection

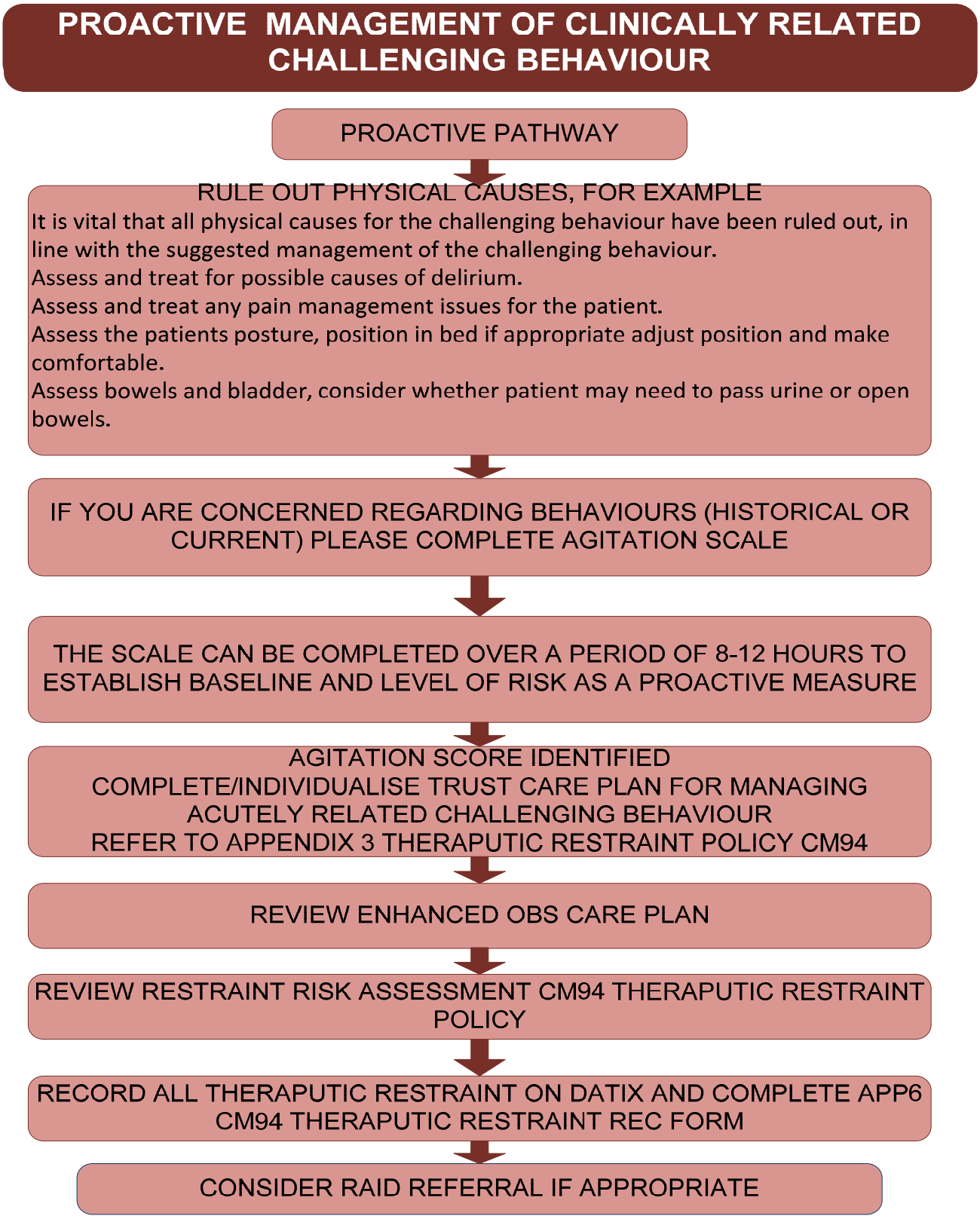
Restraint should not be used if this act would go against a valid advanced decision or by a decision made by the court of protection.

Appendix 10 Acceptable forms of Restraint

Restraint method	Situation where restraint method used.	Nursing Actions
Mechanical Restraint- bed rails Patients must lack capacity or appear to lack mental capacity. These patients should not be agile enough to climb over bed rails.	Patients at risk of falling out the bed. Patients being transferred to other departments in a bed. Patients trying to remove life saving devices.	Review daily (every 24hours) or if patients condition changes and affects capacity to consent. Ensure falls risk assessment is completed when using bed rails and hand mitten risk assessment completed when considering hand mittens.. Refer to Bed rails policy (CM-66). Clearly document in notes and have care plan in place.
Physical restraint - gentle coercion Patients must lack capacity or appear to lack mental capacity. Gentle encouragement with touch to persuade a patient not to leave the hospital or to do something they should not do, or holding of their arm to enable insertion of a cannula.	Patient trying to abscond from the ward or/and hospital. Patient trying to damage property. Patients attempting to harm themselves or others. Patients trying to stop staff giving treatment necessary to sustain their life.	De-escalation techniques with communication and environment strategies tried first before restraint used. The least restrictive form of restraint must be used which is proportionate to the risk of harm for the shortest time needed to prevent the patient from absconding, damaging property or from harming themselves. Ensure MCA 3 form confirms the patient lacks capacity or complete one after the incident if one has not been completed. Complete MCA 2 (Best interests) form where appropriate. Complete Dols assessment form Complete Datix incident form. Medical review required. Inform Matron or if out of hours Clinical Site Manager. Staff to write their own witness statements and hold on to them until they have obtained professional advice. Consider enhanced observations refer to policy (CM51).

Physical restraint The person attempting to harm another person or staff member and has capacity to know what they are doing.	A person who is attempting to harm others.	De-escalation techniques with communication and environment strategies tried first before restraint used. The least restrictive form of restraint must be used which is proportionate to the risk of harm for the shortest time needed to prevent the person from harming others or until police arrive. Ensure Police and security is called. Refer to violence and aggression policy (RM-05). Complete Datix incident form. Medical review required. Inform Matron or if out of hours Clinical Site Manager. Staff to write their own witness statements and hold on to them until they have obtained professional advice.
Psychological restraint. Patients must lack capacity or appear to lack capacity to be able to appropriately make decisions.	Repetitive removal of non-life threatening medical devices. Patients trying to stop staff giving treatment where the treatment is not urgent and not necessary to sustain life.	Ensure MCA 3 form confirms the patient lacks capacity or complete one after the incident if one has not been completed. Complete MCA 2 (Best interests) form where appropriate. Complete appropriate risk assessment for method of restraint. Consider enhanced observations refer to policy (CM51). Medical review required. Ensure multi-professional involvement and clearly document in medical notes.

Appendix 11 Proactive Management of Clinically Related Challenging Behaviour



Appendix 12 Immediate Assistance for Management of Clinically Related Challenging Behaviour