POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

CLINICAL HOLDING POLICY

Approved by:	**Trust Executive Committee**
On:	**30 January 2017**
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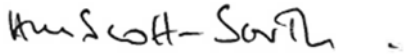
Signature:	
	Chief Executive
Date:	**30 January 2018**

Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

Title:	**Clinical Holding Policy**
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Linked Trust Policies:	**Adult Safeguarding Policy** **Mental Capacity Act Policy** **Rapid Tranquillisation** **Safeguarding Children** **Conflict Resolution** **Security Management Policy** **Safe and Secure Environment Policy**
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Responsible Committee / Group	**Health & Safety Group**
Consulted	**Clinical Staff** **Safeguarding Groups** **Director of Governance on behalf of Health and Safety Group** **Dementia Steering Group** **Chief Pharmacist** **Circulated via email**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
2	Reviewed in regard to Mental Health Act and MCA	12/09/14	Policy Review by Safeguarding and Health & Safety considering relevant legislation and guidance. Amendments in regard to MHA and MCA. Amendments in regard to Security Officers.
3	Policy Review	16/10/17	Policy reviewed by Safeguarding, amendments in regards changes to security and policies following consultation

CLINICAL HOLDING POLICY

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1. INTRODUCTION

1.1 Aggression and violence can take many forms – verbal abuse, threats and physical assault. A violent outburst with no warning signs is uncommon. It is more likely that aggression will gradually escalate through confrontation into violence. It is recognised that violent and aggressive behaviour may occur in clinical settings due to circumstances or conditions beyond the control of the perpetrator of such actions. Such conditions may include trauma, dementia, adverse reaction to medication, mental illnesses or disorders, learning disabilities etc. Whilst there may be no criminal intent and no prospect of bringing a prosecution, such an assault still poses a foreseeable risk of injury to staff and needs to be managed.

1.2 In some instances physical intervention may be necessary in order to restrain an individual who is posing a significant threat to him/herself and/or others. When this situation arises the methods engaged must be safe, effective and proportionate and only used as a last resort, when all other means have been exhausted unless the immediate circumstances dictate otherwise e.g. in order to preserve life.

1.3 The Trust recognises the need to minimise the risk of violence and aggression as part of its commitment to provide a safe and secure working environment for its staff and as part of providing a therapeutic environment of care for patients and visitors.

1.4 The guidelines laid down in this Policy will require the commitment of both management and staff, to put into place working practices and relevant training which will identify the correct procedure for the physical restraint of violent individuals or those individuals requiring restraint for the purposes of providing their health care.

1.5 Wherever practicable, physical restraint of patients should be avoided by making positive changes to the provision of care (e.g. Rapid Tranquilisation Policy available on Trust intranet on pharmacy site), considering alternatives to restrictive practices and support. The use of reasonable force should only be used as a last resort where all other preventive measures have failed. However, it is acknowledged that there may be times when in spite of all efforts to prevent it, the behavioural and clinical challenges presented by a small number of adults and children may mean that the use of some form of physical intervention may be unavoidable. Where physical restraint cannot be avoided it should be considered as a short-term solution.

1.6 Chemical restraint and the specific use of equipment for the purpose of restraint will be covered in approved Trust policies and procedures elsewhere. Furthermore, in most circumstance, it is likely that violence and aggression can be dealt with in accordance with the Trust's Conflict Resolution Policy which should be read in conjunction with this Policy.

2. OBJECTIVES

2.1 This Policy details the Trust's commitment to provide an adequate response where it is deemed necessary for a violent individual or other person who has committed, is about to commit, an arrestable offence to be physically restrained. It is the responsibility of all employees to safeguard themselves, patients, visitors, Trust property, assets and private property against malicious or criminal acts.

2.2 The Policy also aims to describe the requirements for the control and restraint of violent or confused individuals by means of physical or chemical restraint so as not to compromise the personal safety of any members of the public, patient or Trust employee and to prevent damage to Trust property. It aims to provide guidance and to identify when reasonable restraint may be required. It seeks to ensure that patients' rights to dignity, privacy, self-determination and safe treatment are not compromised and that any action taken to restrain patients does not breach the law.

3. SCOPE

3.1 This Policy applies to all Trust clinical staff in all locations including temporary employees, locums, agency staff, and visiting clinicians.

The aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure legal, ethical and professional issues have been taken into consideration.

4. DUTIES AND RESPONSIBILITIES

4.1 **Chief Executive** - The Chief Executive is ultimately responsible for ensuring the health and safety of all staff at risk from physical and non-physical assault and for ensuring that the Policy is effective. Where violent incidents are foreseeable the Trust has a duty under the Health and Safety at Work Act to ensure that the nature and risk of those incidents are identified and assessed and also to ensure that a safe system and place of work is devised as a result. This Policy and procedure is part of that safe system.

4.2 **Chief Nurse** - The Director of Nursing has responsibility for ensuring that all nursing staff adhere to highest levels of professional standards and practice to optimise patient care. The Director of Nursing has responsibility for ensuring that all nursing staff adhere to the requirements of this Policy.

4.3 **Security Management Director** - The Director of Governance undertakes the role of Security Management Director (SMD) and has responsibility for the management of violence and aggression in accordance with Secretary of State Directions and ensuring that the Local Security Management Specialist (LSMS) has the necessary resources and support available to carry out their role effectively.

4.4 **Managers / Clinicians / Ward Sisters / Nurse in Charge**

- To be fully conversant with this Policy, relevant associated policies and ensure that they are implemented within their area of responsibility.
- Identification of patients who may require physical intervention.
- Ensuring an inter-disciplinary assessment to identify appropriate means of physical intervention is undertaken and documented.
- Ensuring the patient and relatives are involved in the assessment.
- Ensuring that all episodes of physical intervention are recorded in patients' notes and through the Trust's Incident Reporting System ensuring that an explanation of why the restraint was required, the duration of the restraint, the method of the restraint, who it was undertaken by and who it was authorised by is included.
- Reviewing the necessity and effectiveness of using physical interventions.
- Identifying staff training needs and ensuring staff are trained to manage patients with challenging behaviour. In areas where there is a high incidence of violence and aggression, managers to assess and consider increased level of specialist training i.e. MAPPA.
- Debriefing and supporting staff following an incident.
- Ensuring that appropriate risk assessments are carried out on the use of restraint so that risks involved in using restraint can be anticipated and reduced in accordance with the Trust Health and Safety Policy and Procedure.
- Ensuring staff know how and when to call upon the police for assistance.

4.5 **Divisional Nurse Directors** / **Matrons**

- To support the process of assessing and controlling risks identified
- To ensure that the incident reporting process is executed, that the incident report is fully completed and that care plans fully reflect the requirements for restraint.
- To ensure that arrangements have been put in place to ensure that staff involved in an incident are being/have been fully supported as appropriate.

4.6 **Employees**

- To be fully conversant with this Policy and relevant associated policies.
- To assist in the identification of patients who may require physical intervention.
- To be competent to manage patients with challenging behaviour when required.
- To successfully complete challenging behaviour training as required.
- When carrying out physical interventions, to ensure that there is continuous communication and reassurance is maintained with the patient.
- To document all episodes of physical intervention in patients' notes and through the Trust's Incident Reporting System.
- As far as reasonably practicable, to ensure security staff and/or the Police are fully briefed on all risks associated with the patient before physical intervention takes place.

- To understand how and when to call upon security staff/Police to assist.

4.7 **Risk Management Specialists** – Are responsible for maintaining records relating to incidents and subsequent investigations and producing reports concerning the restraint of patients.

4.8 **Head of Health and Safety / Local Security Management Specialist (LSMS)**

- Ensures that all security staff are trained to carry out physical interventions of patients and non-patients in conjunction with clinical staff on instruction of a clinician
- Advises on the provision of physical intervention training for staff requiring such training.

4.9 **Security Officers** – The legal powers and role of Security Officers is no greater than any other member of Trust staff and any force used should always be reasonable and proportionate and as such should work in conjunction with clinical staff.

5. LEGISLATION

5.1 The legislation that covers restraint derives from both criminal and civil law.

5.2 The Mental Health Act 1983 provides the legal authority to restrain a person detained under the Act, providing that it is reasonable, justifiable and proportionate to the risk posed by the patient, and is used for only as long as is absolutely necessary.

5.3 The Mental Capacity Act 2005 provides protection from liability in situations where a patient lacks capacity and it can be established that it is clearly in their best interests for reasonable and proportionate restraint to be used in order to prevent them from coming to harm or provide urgent medical treatment.

5.4 An authorisation under the Deprivation of Liberty Safeguards (DoLS) provisions of the Mental Capacity Act allows reasonable and proportionate restraint to be used where a level of supervision and control required to safely manage a patient's care is likely to be ongoing.

6. DEALING WITH VIOLENCE AND AGGRESSION

6.1 All staff should be aware of and adhere to the contents of the Trust Policy for the Management of Violence and Aggression. These procedures should be applied wherever practicable to minimise the requirement for restraint, as this should be used as a last resort where there is potential danger to the aggressor or others.

7. DUTY OF CARE

7.1 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 patient's care and must therefore be overseen by Clinicians. If it is necessary to restrain a patient because of non-compliance

with treatment, to prevent self harm or where there is risk of physical injury by accident, it is important to consider whether the 'Duty of Care' to a patient outweighs the risk of action for potential unlawful detention/physical assault.

8. GUIDELINES FOR THE USE OF PHYSICAL INTERVENTION (RESTRAINT)

8.1 Physical Restraint – Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person. (DoH 2014). Refer to Appendix 1

8.2 Chemical Restraint – the use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical and mental illness. (DoH 2014).

Guidelines for use of Rapid Tranquilization

http://www.sssft.nhs.uk/working-here/clinical-policies-yellow/medicines-management/156-policy-for-the-pharmacological-management-of-severely-disturbed-or-violent-behaviour-by-psychiatric-inpatients

9. REPORTING OF VIOLENT INCIDENTS / RESTRAINT

9.1 If any member of Trust staff is concerned that an individual is displaying, or has the immediate potential to display, aggressive or violent behaviour and feel that their own or others personal safety is compromised, they should immediately contact the Police and Trust Security Officers by dialling 5678 on the telephone, stating the exact location at Queens Hospital Site. The Queens site has one trained and licensed Security Officer on site 24/7. For the Community Hospitals sites, contact the Police.

9.2 Where staff, a patient or any other person has been harmed as the result of a restraint this must be reported in accordance with the Trust's Incident and Serious Incident Management Policy and Process.

9.3 Where there are concerns about the possible misuse of restraint these should be reported to Management or via the Trust's Whistle Blowing Policy.

9.4 An electronic Incident Report Form should be completed for all incidents involving restraint of a patient, by the Ward Manager, nurse in charge or of a non-patient by Security Officers as appropriate.

10. ADVICE

10.1 If clinical staff are unsure of the legal implications of an intervention, then expert advice should be sought from the Trust's Legal Services Manager. Further direction is also available in the Trust's Mental Capacity Act 2005 Policy and on the Deprivation of Liberty (Adults) Safeguards. The Trust Adult Safeguarding Lead Nurse can also be contacted for advice.

11. SUPPORT TO STAFF

11.1 The Trust acknowledges that its staff may be affected physically or emotionally following an incident where restraint has occurred. Managers need to be aware therefore that individuals will need active support and counselling, especially after an incident involving violence and on resuming or returning to work. This is particularly important given the potential impact of stress on the employee's current or future health.

11.2 It is therefore essential that the Line Manager conducts a full debriefing of all staff especially where staff have been involved in a violent episode. This should include the arrangement of professional counselling for all those who wish to avail themselves of it.

11.3 Should any legal proceedings result from a situation where a member of Trust staff has been involved in the physical restraint of a violent or potentially violent individual, providing the Trust can satisfy itself that the member of staff was acting appropriately, in good faith and in accordance with the relevant training and instruction received, it shall actively and fully support the member of staff, where appropriately, legally, emotionally and in any other way possible. Relevant advice and support shall be offered to all staff that have been, directly or indirectly, adversely affected by a violent individual.

12. EQUALITY AND DIVERSITY

12.1 The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day to day operations and has produced an Equality Policy statement to reflect this. All policies are assessed in accordance with the Equality initial screening toolkit, the results for which are monitored centrally.

13. POLICY REVIEW

13.1 This Policy will be reviewed in 3 years from time of implementation. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation of guidance.

14. TRAINING AND AWARENESS

14.1 All newly appointed staff will be made aware of the Policy and Procedures, upon commencement of employment with the Trust.

14.2 The Policy and procedure and any changes to it will be brought to the attention of all existing Trust employees using Trust internal communication systems and a copy of the Policy will be available on the Trust intranet.

14.3 Managers will ensure that all necessary training is given to staff to ensure this Policy is implemented and adhered to at all times.

14.4 Attendance at Trust Conflict Resolution training is Mandatory for all Trust front line staff. Staff who are ordinarily likely to find themselves in situations where training in the management of actual or potential aggression might be necessary should attend Conflict Resolution training and Person First study day which incorporates half day theory and half day practical this includes dis-engagement and de-escalation.

15. DISCIPLINE

Breaches of this Policy will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure.

16. MONITORING

16.1 Monitoring of compliance against this Policy will be as follows:

- Review by Divisional Nurse Directors/Matrons/ Sisters and Managers on individual episodes of use of physical intervention.
- Quarterly review of Incident reports by Safeguarding Adult Operational Group.

17. REFERENCES

General Restraint

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

Hendrick, J. (2004) *Law and Ethics* Nelson Thornes, London

Royal College of Nursing (2008) *"Let's talk about restraint" Rights, Risks and Responsibility* RCN London

Tingle, J. and Cribb, A. (eds) (2002) *Nursing and Ethics* 2nd ed Blackwell Science, Oxford

Violence The short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments; NICE Guidelines 25; February 2005.

Elderly Care

Commission for Social Care Inspection (2007) *Rights, risks and restraints. An exploration into the use of restraint in the care of older people.*

Royal College of Physicians (2006) *The Prevention, diagnosis and management of delirium in older people: national guidelines* Royal College of Physicians London

American Journal of Nursing March 2008 Vol. 108, No. 3 *"Avoiding Restraints in Patients*
with Dementia"

Children & Young people

Royal College of Nursing (2003) *"Restraining, holding still and containing children and young people; guidance for nursing staff".*

Peter Barnett - Emergency Medicine 2002. *'Use of child restraint during procedures'*

Critical Care

British Association of Critical Care Nurses, Nurses in Critical Care 2004 Vol 9 No 5 *"Position statement on the use of restraint in adult critical care units.*

Neurosciences

Waterhouse, C. Development of a tool for risk assessment to facilitate safety and appropriate restraint *British Journal of Neuroscience Nursing (2007) 3:9,421 - 426*

Nursing Times Vol 101 issue 23 Page No 28: *"Guidelines on the use of restraint in neuroscience settings"*

'The use of control and restraint techniques in acute psychiatric units' L Duff, R Gray, F Bristow - Psychiatric Care, 1996.

18. FURTHER ENQUIRIES

Further information relating to this Policy can be obtained from the Trust Security Adviser / Lead Nurse Adult Safeguarding

Appendix 1

Guidelines for the Use of Clinical Holding

The Purpose of Restraint

The purpose of restraint should be:

- To take immediate control of a dangerous situation;
- To contain or limit the patient's freedom for no longer than is necessary;
- To end or reduce significantly the danger to the patients or others.

The most common reasons for restraint are:

- Physical assault;
- Dangerous or threatening or destructive behaviour;
- Non-compliance with treatment – for non-capacitous patients;
- Self harm or risk of physical injury either deliberately or by accident, to self or others – this could include risks associated with absconding, falls;
- Extreme and prolonged over-activity likely to lead to physical exhaustion.

Decision to Restrain

In general, restraint is used to prevent harm, either to the person who is being restrained or to other people. A member of staff is expected to take action that would calm the situation rather than provoke further aggression utilising de-escalation skills. De-escalation techniques to consider are:

- diversion therapy
- involving relatives
- environment
- verbal/non-verbal communication

In most circumstances restraint can be avoided by positive changes to the provision of care and support to the patient. Restraint is only to be used therefore where all other methods of management/de-escalation have failed. See paragraphs 13 and 14 for when and how to call for security or Police assistance respectively.

Physical restraint of violent individuals is not an option for most staff because of the difficulty in doing it successfully, the need for specialised training, the lack of clarity within the law and the degree of danger to everyone involved therefore this would be undertaken by hospital security staff or Police under supervision of a clinician. Under no circumstances must restraint be used as a means of reducing workload. If restraint is being considered the following options should be evaluated:

- What hazards are immediately apparent or could be expected?
- What is the risk to the safety of the patient, the staff or others?
- What is to be achieved and are the necessary skills available to achieve the Aim?
- What specialist help needs to be called upon?

Where a patient's behaviour poses a significant risk to themselves or others, urgent medical (and if appropriate mental health) assessment must be sought. Restraint may be appropriate in this case.

The decision to restrain a patient can only be made by clinical staff (i.e. a qualified member of the medical/nursing staff or allied health professionals caring for the patient concerned) in consultation with Security/Police as appropriate and the rationale for this should be documented in the patient medical records. The decision to restrain a patient cannot be delegated to non-clinical and non-professionally qualified staff (e.g. students, security, porters, and support workers).

Particular care must be taken to avoid using more than minimum reasonable force to quell a disturbance. The use of excessive and dis-proportionate force may constitute a criminal act and may result in criminal charges being brought against the individuals concerned. It may also result in a complaint and/or claim against the Trust and/or individuals concerned

Physical restraint should only therefore be used as a last resort where there is a potential danger to the aggressor or others and when other methods have proved ineffective or have been considered and rejected. The restraint should last no longer than is necessary to deal with the immediate risk. Caution is always to be considered before restraint techniques are used. The use of force to repel force is in law, perfectly acceptable, subject to one qualification, which is that it must only entail reasonable force. Restraint will not be applied directly by one person onto another (i.e. bodily restraint is to be avoided).

It is the responsibility of the relevant clinical / medical staff to advise Site/Security Services staff of any known medical history of a violent or potentially violent individual(s), or infectious disease or condition which may compromise their health or well being, before or during the application of physical restraint.

Where a patient is being restrained by Security Officers, a member of the clinical team should be present to ensure the continuing healthcare needs of the patient. However, a member of the clinical team would not need to be present to monitor a patient when a security officer is not physically holding a patient down but is standing by the patient either to prevent them from leaving or as a deterrent to prevent an act of violence. This would not preclude a member of the clinical team from carrying out the normal clinical care needed by the patient.

Physical restraint may also be used by Security Officers who have reason to believe that a crime may be being committed provided the force used is reasonable and proportionate. The decision to restrain a person other than a patient will be made by Security Officers.

What is 'Reasonable' in Law

For the purposes of considering what may be construed as reasonable in law the Criminal Law Act 1967, Section 3 states: 'A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders, suspected offenders, or persons unlawfully at large'.

Using this example, it is not possible to set out comprehensively when it is reasonable to use force; no two threatening situations are ever identical. However, what constitutes 'reasonable' will require staff in each situation to consider the following points carefully:

- Where a technique is applied, it must be done in a manner that attempts to reduce rather than provoke a further aggressive reaction.
- The numbers of staff involved should be the minimum necessary to restrain the violent individual, whilst minimising injury to all parties.
- The force used must be proportionate to the risk and the minimum necessary to be able to contain the situation.
- To take no action could be seen as negligent where the outcome results in self-inflicted injury to the individual or in injury to others.
- To convict a person of using unreasonable force, a court must be satisfied that no reasonable person in a similar position would have considered the action of the use of such force justified.

Restraint-related positional asphyxia

The physical status of a person should be checked regularly by a member of the clinical team while that person is being restrained. Restraint-related positional asphyxia occurs when a person being restrained is placed in a position in which he cannot breathe properly and is not able to take in enough oxygen. This can include pressing on the neck, chest, abdomen, back or pelvic area during physical intervention. This lack of oxygen can lead to disturbances in the rhythm of the heart and death can result immediately or some time after the restraint is released. Especially dangerous positions include facedown floor restraints or any position in which a person is bent over in such a way that it is difficult to breathe. This includes a seated or kneeling position in which a person being restrained is bent over at the waist and it also includes any facedown position on a bed or mat.

Procedure for Emergency Intervention - Restraint of a Patient

This is where use of force or medication is used in response to unforeseen events. Emergency intervention may be necessary when a patient behaves in an unexpected way. Even in an emergency, members of staff remain under a duty of care to act responsibly and any response must be reasonable and proportionate to the circumstances.

It is accepted that due to the urgency of the situation it may not always be possible to undertake a risk assessment or a mental capacity test. Where there is a threat of violence or where an assault has occurred Site/Security Services should be called for assistance immediately. If Site/Security Services are unable to respond immediately the Police should be called.

Before using restraint on a patient an individual assessment should be carried out wherever possible from a multi-disciplinary approach that will consider the impact on the following:

- The environment
- Patient's behaviour, underlying condition and treatment
- Patient's mental capacity
- Patient's mental health

- Duty of care
- Patient safety
- Staff safety
- Care planning
- Record keeping

The Environment

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

The Patient's Behaviour, Underlying Condition and Treatment

Understanding a patient's behaviour and responding to individual needs should be at the centre of patient care. All patients should be assessed comprehensively in order to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying the underlying cause of the behaviour (agitation, wandering, absconding, etc.) and deciding whether the behaviour needs to be prevented. Possible causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Mental illness
  – e.g. dementia
- Other form of memory impairment
- Drug dependency or withdrawal
- Brain insult / injury or cerebral irritation
- Reaction / side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)

The Patient's Mental Health

If a patient's mental health is an issue, consider contacting Mental Health Services for advice / support. Mental health services however, may not be able to meaningfully assess anyone who is acutely intoxicated through the use of alcohol and/or drugs; Any decision to undertake an informal mental health assessment or a formal Mental Health Act assessment should be based on the patient's capacity to engage in that assessment

and to make informed decisions about their care and treatment as a result. At such times it will be necessary to contact Mental Health Services and inform them of the condition of the patient so that they can plan to attend when the patient is sober and/or stabilised. The Mental Health Act 1983 allows for a person suffering from a mental disorder to be detained against their wishes. If requested to restrain a violent or aggressive patient within a ward or department, this must only be carried out under the instruction of a senior clinical person who is present.

The Patient's Mental Capacity

It is necessary to consider the patient's mental capacity. Patients should be "informed partners" in their health care. The Trust policy on 'Consent to Examination or Treatment' should be adhered to. A capacity issue relates to a single point in time and to a specific decision. Individual patients cannot simply be described as "lacking capacity". A patient's capacity may fluctuate from time to time. Refer to Mental Capacity Act Policy.

Any action intended to restrain a patient who lacks capacity will not attract protection from liability unless the following conditions are met:

- Before doing the act, reasonable steps are taken to establish whether the individual lacks capacity in relation to the matter in question: and
- When doing the act it is reasonably believed that the person being cared for or treated lacks capacity in relation to the matter and it will be in the best interests of the person being cared for or treated for the act done.
- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

At no time during the restraint period will the act of restraint deprive the patient of his/her liberty. The only exception to this is when a patient is detained under the Mental Health Act 1983 (for hospital treatment) and where formal authorisation has been obtained or an authorisation has been granted under the Deprivation of Liberty Safeguards process of the Mental Capacity Act 2005.

Adults Lacking Mental Capacity

It is lawful under the Mental Capacity Act 2005 for a person to temporarily restrain a non-sectioned, mentally incapable patient where this is immediately necessary in their best interests (i.e. in order to give them medical treatment in their best interests or to prevent them harming themselves or others). If the level of supervision and control required to safely manage the patient's care is likely to be ongoing and constitute a deprivation of liberty, then an authorisation under the Mental Capacity Act DoLS process would be needed in order to be lawful.

The Human Rights Act 1998 also impacts on the Trust and staff must consider the individual's right not to be deprived of their freedom except in certain circumstances, such as under the Mental Health Act 1983 or emergency situations. It does not automatically follow that because a patient has been detained under the Mental Health Act that the patient lacks capacity.

Adults with Mental Capacity

If a patient is able to fully understand the consequences of refusing treatment or remaining in hospital and has had those consequences explained, they should be permitted to leave even if this places them at risk of significant harm. A senior Clinician should assess this patient. However, where someone is at immediate risk of harming themselves or others and staff are in a position to intervene, restraining the patient to avert the risk may be justified.

Care Plan

An appropriate care plan should be devised by the clinician in charge and the nursing staff which will include any special requirements the patient may have with one or more nurses providing this care. The care plan should be reviewed regularly. In deciding to use restraint, the nurse must assess and record within the nursing care plan:

- The problem behaviour
- Why this behaviour is a problem i.e. is it a danger to the client or to others?
- The proposed solutions which may include restraint
- Document the reason why restraint and the particular method of restraint is the method of choice

Record Keeping

The Senior Nurse or senior clinician on the ward will review the situation every two hours to assess whether the risk still exists and whether alternatives to restraint are now possible. This will be documented in the patient's notes each time the assessment is made.

Appendix 2

Approved Method of Restraint of Children

General Considerations

Children of 16 or 17 years of age are presumed to have the capacity to give their own consent to treatment. Under 16's may also have the capacity to give their own consent if they are sufficiently mature and able to understand what is being proposed. Someone with parental responsibility for the child can also give consent to their treatment and can override a child's refusal.

In all cases the overriding principle is that a child's welfare is paramount. Under common law restraining a child in their best interests to protect them from immediate risk of harming themselves will be lawful (subject to the provisos of using reasonable force). However, the law relating to children is complex and in individual cases advice should be sought from the Risk Management Department to consider the steps needed to minimise any legal risks. Out of hours advice should be sought from the on-call solicitor via the On Call Executive. In all cases:

- The healthcare practitioner should take into account the age of the child, the Child's understanding and the circumstances before deciding whether to:
  Restrain or remove a violent child from a situation and/ or engage the child's parents
- The healthcare team should seek the advice of and liaise with the paediatric team
- Obtain specific legal advice if necessary
- Refer to the appropriate policies regarding the management of children where appropriate

Circumstances of Restraint

If a child is detained under a Court Order or is subject to detention under the Mental Health Act 1983, the expectation is that the 'staff intervene positively' if that child attempts to leave without authority.

In other circumstances, staff should only intervene where immediate action is necessary to prevent a child from significantly injuring themselves or others or causing significant serious damage to property. Injury in this context is taken to mean ''significant injury'' and would include actual bodily harm or grievous bodily harm, physical or sexual abuse, risking the lives of, or injury of, or injury to self or to others by wilful or reckless behaviour and self poisoning. The law requires that force should only be used when every other approach has been tried and that all practical methods to de-escalate the situation have been employed.

Principles in the Use of Restraint of a Child

As soon as it is safe, restraint should gradually be relaxed to allow the child to regain self control.

- Restraint should be an act of care and control, not punishment
- Physical restraint should NOT be used purely to force compliance with staff instruction when there is no immediate risk to themselves, other people or property

Forms of Restraint of a Child

In all circumstances where intervention is necessary, dialogue and discussions should be the first response. If necessary, staff may reinforce the dialogue with actions, such as standing in the way of a child wishing to leave, placing a hand on the child's arm or holding the child if he/she is very distressed. This type of intervention is acceptable, as long as it is persuasive rather than coercive.

The use of an adult's physical presence is the simplest method of intervention. The effect of this may restrict a child's movement. However, this is only acceptable for a short time, not extending into hours. The following principles apply to the use of an adult's presence:

- It must be likely to be effective by virtue of the overall authority carried by the staff member and not simply their physical presence.
- It must not be used in the context of trying to engage the child in discussion about the significance and implications of their behaviour.
- It should not persist if the child physically resists. In this case a decision will need to be made about whether another form of intervention is justified.

Holding is distinct from physical restraint, by the degree of force used. Holding a child's hand or arm or putting an arm around a child's shoulder may be used to discourage or deflect a child. This is permissible to prevent a situation escalating but staff should be aware of the interpretation a child may put on being touched, particularly in circumstances where the child may have been physically or sexually abused. Wherever possible the staff member should have an established relationship with a child and should explain what is being done and why.

Physical restraint should only be used as a last resort and it is at the discretion of the staff member involved in the degree of force necessary to prevent the child causing injury to themselves or to others or to property.

Physical Restraint of a Child

Clothing rather than limbs should be held when applying restraint. Care should be taken that the child does not get twisted up inside their clothing as this can restrict circulation. Painful or dangerous procedures such as joint locking must not be used. If limbs have to be grasped, a hold near the joint reduces the danger of fracture or dislocation, but care must be taken as these are points where children experience most pain.

Total restraint - Children are held in such a way that prevents them from moving. If used, the child's vital signs should be checked and on de-escalating the restraint must be managed carefully and gradually.

Partial Restraint – This includes a wide range of techniques, such as holding a child's upper arm or facing him/her into a corner to isolate them.

Appendix 3

When and How to call the Police

The Police will only attend the Trust when a crime has been committed or is about to be committed. Security should always be called for assistance in the first instance. However, if any individual should display a level of violence or behaviour that is deemed uncontrollable and likely to lead to an act of violence then Clinical staff or Security officers should take the decision to call the Police to the scene. In any emergency where the safety of staff or others is at immediate risk the Police should be called on 999 by the person with the most knowledge of the incident. The Police should be given clear details of the location and/ or be met by a member of staff to enable them to get to the incident as soon as possible.

Once the Police have been called every attempt should be made to contain the situation before their arrival and, if necessary, make arrangements to evacuate all other people who are unconnected with the incident from the area concerned.

When the police arrive at the scene all relevant information, including the capacity of the patient at the time of the incident should be provided to them so that they can determine a course of action e.g. arrest. Police will not effect an arrest if a patient did not have capacity at the time of the incident.

In cases where a clinician determines that a patient requires urgent medical attention but is incapable of informed choice, the clinician may administer the appropriate treatment. Police Officers requested to restrain an individual for the purposes of such treatment to prevent death or serious injury, may lawfully apply proportionate and necessary force in order to assist: in such cases the Mental Capacity Act 2005 and the common law defence of necessity apply (R v Cairns 1999). Police will only restrain a patient when informed by a clinician that the individual is in need of urgent medical attention and is incapable of informed choice.

Ensure details of the attending Police Officer/s, i.e. their name, collar number, the police station at which they are based and the action that they have taken is recorded and added to the Incident Report Form.

Legislation

The legislation that covers restraint derives from both criminal and civil law. Relevant Acts of Parliament that impact on the law relating to restraint include:

- Mental Health Act 1983.
- Human Rights Act 1998.
- Mental Capacity Act 2005.
- The Children Act 1989.

- Offences Against the Person Act 1861.
- Health and Safety at Work Act 1974.
- Human Rights Act October 2000.
- Criminal Law Act 1967.