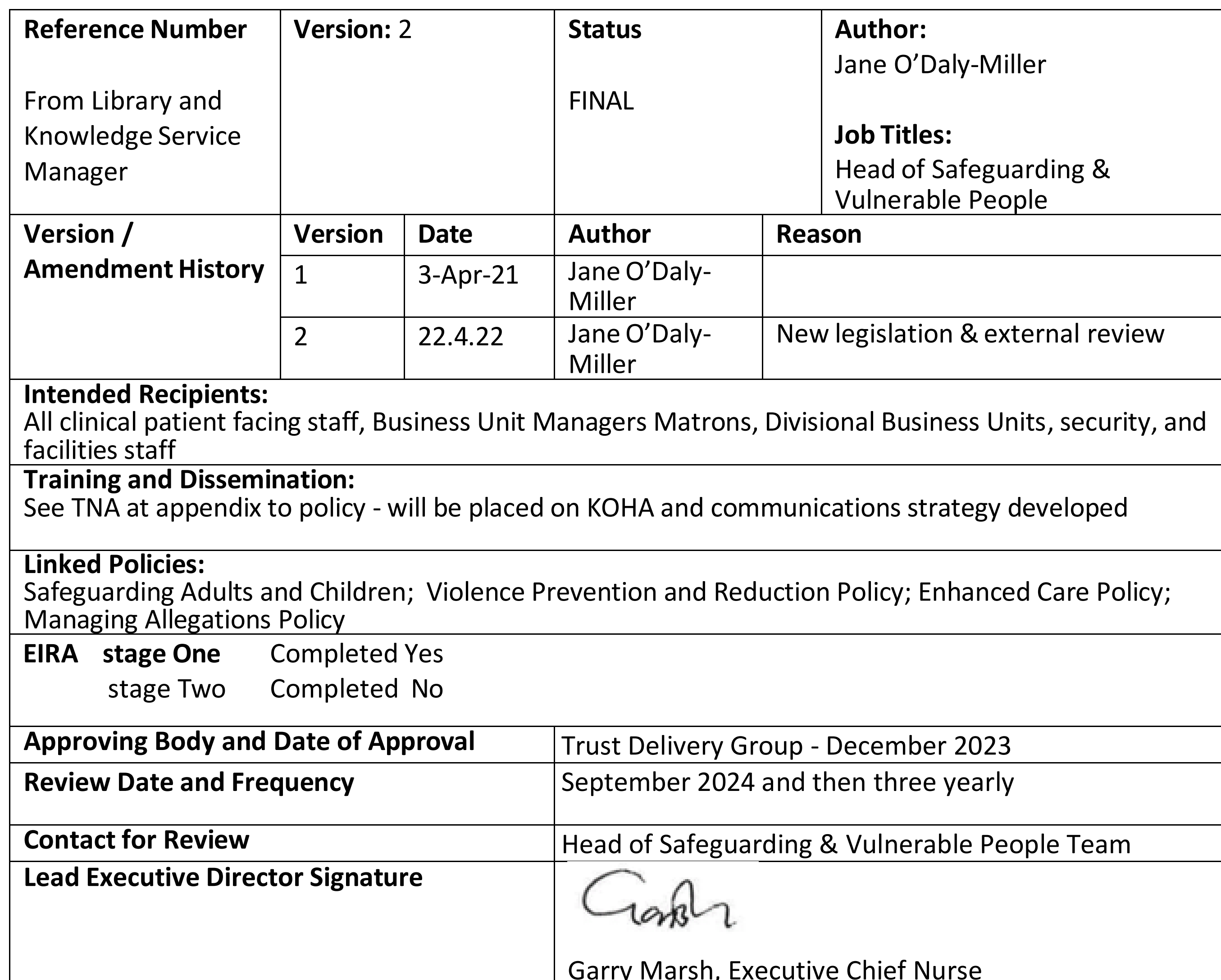
NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

**TRUST POLICY FOR LEAST RESTRICTIVE PRACTICES**



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| | 1 | 3-Apr-21 | Jane O'Daly-Miller | |
| | 2 | 22.4.22 | Jane O'Daly-Miller | New legislation & external review |
| **Intended Recipients:**<br>All clinical patient facing staff, Business Unit Managers Matrons, Divisional Business Units, security, and facilities staff | | | | |
| **Training and Dissemination:**<br>See TNA at appendix to policy - will be placed on KOHA and communications strategy developed | | | | |
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| **Contact for Review** | | | Head of Safeguarding & Vulnerable People Team | |
| **Lead Executive Director Signature** | | | Garry Marsh, Executive Chief Nurse | |

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## 1 Introduction

University Hospitals of Derby & Burton NHS Foundation Trust (UHDB/ The Trust) is committed to delivering the highest standards of healthcare, and ensuring the safety and welfare of its patients, visitors, and employees.

The Trust recognizes that effective and compassionate communication skills coupled with person centered care, understanding the needs of individual patients, skills in distraction and least restrictive practice all need to be at the forefront of care provided to our patients across the Trust. When difficulties and issues arise, it is vital that skilled and effective de-escalation strategies are used promptly to defuse the situation.

However, violence and aggressive and other challenging behaviours can escalate to the point where restraint may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed. The Trust also recognizes that at times there will be a need to implement restrictive interventions in the patient's best interests and this policy provides guidance relating to management in such cases or refers to relevant clinical guidance.

It must be reiterated that physical intervention must only be considered once de-escalation and other strategies have failed to calm the situation. Physical interventions are management strategies that are **not** to be regarded as primary treatment techniques. When determining which interventions to employ, the clinical need, safety of patients and others must be considered. The intervention selected must be necessary and proportionate response to the risk posed by the person to themselves or others.

Decisions about restrictive interventions or restraint are not easy or straightforward. It is acknowledged that decisions in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Managing risk and maintaining safety is paramount.

Unlawful restraint may give rise to criminal or civil liability. It is self-evident that staff may be required to account for their actions in such circumstances. However, the Trust will always support employees who act in a way that is deemed reasonable and proportionate at the time of the incident and in accordance with professional standards and training.

Following incidents of physical restraint, effective and compassionate debrief for staff, the patient concerned, and their family / carers, is vital to learn from the situation and to try to prevent physical intervention being necessitated in the future. The timing and manner of the debrief should be suited to their needs.

The policy covers all staff and persons within UHDB, and others who are acting on behalf of the Trust, including Trust contractors and sub-contractors. It covers interventions for adults, children, and young people.

## 2 Aim of the Policy

This policy is intended to provide guidance in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its 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, recognizing the need to ensure that all legal, ethical, and professional issues have been taken into consideration. The aim of this policy is to provide staff with the guidance needed to practice in accordance with the law, professional standards, and Trust Policy.

The policy outlines the general principles that must be applied to practice across the Trust, including the legal position where appropriate.

The policy is in line with the Trust's values in that our services and care are patient centered; safe, are provided with respect and compassion and focus on continuous improvement in the pursuit of excellence.

## 3 Definitions/ Abbreviations

Definitions of the types of restraint are outlined below:

- **Physical restraint:** The MCA defines restraint as including the use or threat of force to do something that the person resists, or any restriction of liberty whether the person resists in the context of protecting the person or persons from harm. any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- **Prone restraint:** (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position (or not), is resistive (or not), and whether the person is face down, or has their face to the side.
- **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 or mental illness.
- **Mechanical restraint:** the use of a device (e.g., belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.
- **Psychological restraint:** can include constantly telling the person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

*Principles of Positive and Proactive Care* (DH April 2014) states that: "The legal and ethical basis for organizations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles".

These are:

- Restrictive interventions must never be used to punish or for the sole intention

of inflicting pain, suffering or humiliation.

- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction must be imposed for no longer than necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- Restrictive interventions must only ever be used as a last resort.
- People who use services, carers and advocate involvement is essential when reviewing plans for restrictive interventions.
- If a restriction is deemed appropriate the practice needs to have a legitimate aim. The following points must be considered.

    - It must be necessary to protect the health and wellbeing of the individual or to protect the safety or human rights of others (patients, staff, and visitors, public).
    - All individuals who may be affected by the practice must be involved in the decision- making process.
    - The practice that is implemented must be proportional, i.e., the least restrictive practice required to achieve the aim and be proportionate to the level of risk required.
    - Principles of dignity and respect must be observed during the implementation of any restrictive practice.
    - The effectiveness of the practice in meeting its aims must be continually reviewed and the practice must continue only for as long as it remains both necessary and effective.

## 4 Roles and Responsibilities

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| **Trust Board** | Strategic overview and final responsibility for setting the direction of this policy.<br>Ensure that it fulfils its statutory responsibilities |
| **Chief Executive** | The Chief Executive has overall responsibility for all Trust polices. and ensuring an appropriate process for the production, management and monitoring of polices is in place |
| **Executive Chief Nurse & Director of Patient Experience** | The Executive Chief Nurse is responsible for the Trust strategic direction for this policy and is the Responsible Person within The Mental Health Unit (Use of Force) Act 2018 & statutory Guidance. They will be responsible for updating the Trust Board regularly on issues relating to restraint. |
| **Executive Medical Director** | The Executive Medical Director is responsible for ensuring that there is an up to date-policy that meets both legal and best practice guidance and that professional conduct relating to consent is maintained. |

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| **Business Units** | Will be responsible for implementing this policy at local level. |
| **Matrons /ward Leaders** | The Matrons / ward leaders or managers across the Trust will support the Executive Chief Nurse in the operational implementation of this policy and support the process of training, risk management and incident reviews as required. They will ensure that any restraint is recorded via the DATIX process, that staff are undertaking MCA / DOLS assessments were indicated and that indicated cases have a DoLs completed. Additionally, risk assessments and care plans should be undertaken reviewed and updated as indicated. |
| **The Security Manager / Local Security Management Specialist (LSMS)/ Health and Safety Manager / Health & Well-being Specialists** | Ensure all security staff respond, support, and assist staff in a restraint.<br>Review all DATIX raised around restraint or restrictive interventions, provide overview and learning from all incidents involving restraint.<br>Liaise with relevant external agencies as appropriate.<br>Be involved in the de-brief and any subsequent follow up activity.<br>Provide regular updates to the Health & Safety Group. Ensure security involvement in planning the Trust response to an expected situation where the need for restraint is considered probable.<br>Advise the Trust and its employees on any change in security legislation or guidance around restraint. Identify training needs of security staff in relation to restraint.<br>Ensure all security staff apply a uniform approach to a request for restraint.<br>Ensure the Health & Safety Group are kept fully informed of any incidents, the outcome and any learning that needs to take place.<br>Identify from datix data and risk assessments all high-risk areas and support managers to implement appropriate arrangements. |
| **Appropriate person in control (of health of patient)** | A member of the clinical team who has responsibility for the patient's clinical condition throughout the process of restraint. This person is the designated communicator with the patient to reduce over-communication and interference by multiple sources. They are also to assess the person's level of distress providing a clinical judgement regarding their current mental state and status of situation.<br>They should not however become involved physically in the intervention – their purpose is to ensure that the restrained person's:<br>• Head and neck are appropriately supported and protected from potential accidental injury Airway and breathing are not compromised. During this time physical observations of patient's discomfort / pain, respiration and pulse must be recorded, and the observing nurse be fully aware of the possibility of restraint/positional asphyxia.<br>• Monitor the person's overall physical and psychological well-being throughout.<br>• For safety reasons, during a restraint it is only permissible to hold / apply pressure to the person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. |

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| | • Every effort must be made to use skills and techniques that do not use the deliberate application of pain.<br>• The level of force applied must be necessary and proportionate to a specific situation and be applied for the minimum possible amount of time.<br>• Any person subject to restraint must be physically monitored throughout the incident.<br>• Post-restraint, the person who has been restrained will be reviewed by the medical team and the level of required observations determined.<br>• Post-restraint, a recording of the restraint (to include; Reason force used, what type of force and description of how; Place, date and duration for which force used; Outcome of use of force ( particularly whether P died or suffered serious injury);- Name of Patient & their relevant characteristics such as age, race, sex religion etc.; Patient's mental disorder or condition if known, including learning disability or autism; Efforts made to avoid the use of force; trigger behaviours; who was involved in the restraint;) The record must be made in datix and datix number to be identified in in the patient record. |
| **Security Staff** | For a restraint situation a minimum of 2 personnel (3 in paediatrics) who have been trained in restraint are required to undertake restraint. Staff must be trained in restraint as per the level identified in Appendix 2.<br>• All individuals involved in physical intervention should be advised to remove anything from their person that may cause harm or damage to others or themselves.<br>• There must be liaison at the scene with the care team to agree restraint technique and agree who the Appropriate person in control (of health of patient) is.<br>• Security staff must restrain if it is the only option available to reduce the risk to themselves and others including medication to be administered.<br>• Security staff must inform patients and staff when body cameras are in use.<br>• Security staff may prevent a patient leaving the area/hospital in the following circumstances;<br>The patient is<br>• Subject to DoL, urgent DoL /MHA detention or detention authorised by court/police/other legal authority (e.g. under arrest in custody of accompanying police or prisoner in custody of prison officers)<br>• A Child under 16 - putting self at imminent risk/where child lacks capacity and under a care plan agreed by someone with Parental Responsibility<br>• Where the patient is likely to place self at imminent risk of significant harm & preventing them from leaving is reasonable and proportionate to protect them from imminent risk of significant harm. This is a common law power only available in exceptional situations where for |

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| | some reason other powers such as DoL or MHA cannot immediately be used. They are only available for a short period to manage a crisis situation.<br>• Where the patient is of unsound mind and is a danger to himself or others – requirement to show presence of mental disorder/reasonable belief of this & the necessity of detention. |
| **All Clinical Staff** | All clinical staff will ensure that they have read and adhered to this policy as and when required. They will also ensure that they attend the right level of training as identified in appendix 2. All individuals involved in a physical intervention should be advised to remove anything on their person that may cause harm or damage to others. or themselves. The member of staff identifying the violent, aggressive, or other challenging behaviour or intent will:<br>Attempt to de-escalate using person centred communication, techniques, and skills. In the event of not knowing the person, generic de-escalation strategies to be utilized to assist in the reduction distress.<br>Security staff to be notified upon escalation of risks that cannot be safely managed by the clinical team.<br>Security Services to attend at once and take reasonable steps to ensure the safety of patients, visitors and staff, child and young persons is protected.<br>Implement restraint as able to do according to level of training.<br>Wherever possible and if it is safe do to so move other patients away from the vicinity.<br>Report the incident to the Person in Control of the area or Nurse in Charge.<br><br>Bank and Agency Staff are responsible for ensuring that they follow best practice and work always within the scope and authority under the Nurse in Charge. Bank and agency staff are responsible for ensuring that any changes in the patient's presentation are escalated to the nurse in care of the patients care and promoting therapeutic intervention as well as adhering to the expectations listed within the procedure section of this policy. |

## 5 Legal Frameworks

The legal framework underpinning the lawful use of restraint is complex and underpinned by the Human Rights Act 1998, with various statutes and the common law-making restraint lawful in certain situations.

i) In Common Law the doctrine of necessity provides a general power for all UHDB staff to take steps that are reasonably necessary and proportionate (including proportionate appropriate restraint in so far as this is necessary)

- to protect people from the immediate risk of significant harm to themselves or others, whether the patient lacks capacity to make decisions for himself / herself or
- to prevent a breach of the peace or

- Where reasonable in the circumstances in the prevention of a crime (such as assault or criminal damage)

These are common law powers only available in exceptional situations where for some reason the other legal powers below cannot immediately be used. These common law powers are only available for a short period to manage a crisis.

ii) The Mental Health Act 1983 (MHA) for those who fulfil the criteria for detention – largely sections 2, 3, 4 and 5(2).

iii) The Mental Capacity Act 2005 allows reasonable restrictions and restraint to be used in a person's support who lacks capacity to make decisions about their care, but only where there is a reasonable belief that it is necessary to restrain the person who lacks capacity in order to prevent them from coming to harm; and where any restraint to be used is reasonable and proportionate to the likelihood of harm and the seriousness of that harm.. The MCA applies to young people (from 16yrs of age) and adults.

iv)) Staff may do what is reasonable in all the circumstances of the case for the purposes of safeguarding or promoting the welfare of a child in the care of the Trust ( see s.3(5) Children Act 1989)

iv) Lastly, any confinement in hospital must be lawful. In other words
   - it should be consented to by the capacious patient,
   - or it should be under the Mental Health Act where that applies,
   - or it should be authorised under the Deprivation of Liberty Safeguards if the patient lacks capacity.

When a patient lacks capacity and they are required to be in the acute trust, a series of restrictions/restraints could cumulatively add up to a deprivation of liberty (eg regular use of sedation / increasing sedation / use of bridles / bed rails / 1:1 / physical restraint).

The restrictions placed on any individual should be considered regarding the following:
- the duration of the restrictions,
- the frequency with which the restrictions are applied,
- the force used to implement the restrictions and
- the frequency & intensity of distress in relation to the restrictions that is experienced by the patient (or opposition from the individual or from family / friends / carers).

If restrictions of a sufficient degree or intensity are placed on a patient that it amounts to a deprivation of liberty this must be in accordance with the Deprivation of Liberty Safeguards.

- Where the patient can be considered to be "in their ordinary circumstances of living" (ie they are not receiving lifesaving or life sustaining treatment or treatment to prevent a serious deterioration) they should always be assessed

for Deprivation of Liberty.

- If they are being considered for discharge into a care home or residential provision when they have been admitted from their own home a DOL must be sought.

- If they require 1:1 enhanced care a DOL must be sought.

- If there is a disagreement with the family carers regarding the plan of care

- Their 1:1 care or observation would not be provided to a capacious patient.

In the circumstances above, staff are advised to undertake the DoLS checklist (contained within the Nursing Care and Assessment Record) and when indicated by the checklist, discuss with the safeguarding team to ensure effective authorisation. Authorisation forms are available on Extramed at RDH & FNCH and downloaded from Neti MCA / DOLS pages and emailed to uhdb.safeguarding@nhs.net

Occasionally the High Court will authorize the deprivation of liberty of a child / young person or adult at risk of harm. In such cases the relevant court order will set out the circumstances in which the person may be deprived of their liberty

It is important to consider restriction and restraint as a continuum and to assess whether DoLs is required by use of the DoLS checklist in the Nursing Care and Assessment Document (RDH sites) and V6 (Burton, Lichfield, and Tamworth sites). A DoLs checklist is also available on neti.

**Regarding locked ward doors**: These are often a necessity for patient safety and to exclude. inappropriate visitors – particularly in paediatrics, maternity and NICU areas for example. On the occasion that doors are locked clear signage must be displayed informing patients and the public that doors are locked and who they must ask to have them unlocked to exit. the ward. If a patient is asking to leave and being prevented by the locked door, that patient is being restricted but is likely to be permissible under s6 of the MCA.

- Patients with decision-making capacity:

As with all health-care interventions, a patient is presumed to have the capacity to give or refuse consent to the use of a particular method of restraint, unless there is evidence that he/she is unable to understand, retain and weigh up information and then communicate a decision due to an ‘impairment of, or a disturbance in the functioning of, [his/her] mind or brain’.

A patient's capacity to make such a decision will depend on the nature of the decision and may fluctuate over time. If the patient has capacity to give valid consent and their agreement or consent can be gained without undue pressure from the person, then the restriction can

be put in place so long as it does not contravene the law. It must be remembered that the person has the right to withdraw their agreement or consent and they must be informed of this right at the outset.
Where it is believed that a patient lacks capacity, the team looking after the patient need to:

1. Assess capacity for the interventions required
2. Undertake a best interests' assessment (including taking account of P's views and views of other relevant individuals)
3. Develop an appropriately detailed and recorded care plan

If the person withdraws their consent but it is felt that the restriction must continue, this can only be achieved if the practice is sanctioned under law; examples include the Mental Capacity Act, Mental Health Act, Criminal Law, and Public Health Act. Patients whose decision-making capacity is **not** impaired, and who are refusing to give consent to a particular method of restraint being used, cannot be restrained against their will, even if their decision appears to be unwise. The only exemption to this general rule is in those situations in which the act of restraint prevents immediate and serious harm to themselves or to other people.

- Person's requiring interventions whilst on hospital sites:

There may be occasions where a person on the hospital site but not a patient becomes unwell or displays behaviours that lead staff to believe there may be a risk to themselves or other people within the facility. Decisions regarding interventions need to be made using the principles of common law. See application in practice flow chart Appendix 1 – to support decision making. In this situation security must ensure site manager / patient flow or the Hospital

out of Hours team is in attendance to ensure the role of Appropriate Person in Control is undertaken.

**5.1 Unacceptable Methods of Restriction**

The following methods of restriction are unacceptable; however, if the patient requests or is consenting to (or the patient lacks capacity and a best interest's decision is made using the appropriate MCA legal framework) any of the following it may be considered and applied as appropriate, but this must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern.
The following list is not exhaustive.

| Unacceptable method of restriction on movement | Potential risk and category of abuse |
|---|---|
| Inappropriate bed height | Increased falls risk. Potential neglect. |
| Use of bed rails | Increased falls risk and injury - never to be used with confused patients. |
| Inappropriate seating e.g., Reclining chairs / bucket seats / wheelchairs (and utilizing straps) / low | Seating should only be used for the comfort or transport of patients. Also leads to increased falls risk and manual handling issues. |

| chairs | Potential neglect. |
|---|---|
| Arranging furniture to impede movement | Any equipment, including furniture, must only be used for the purpose for which it is intended. Leads to increased falls risk. Potential neglect. |
| Inappropriate use of nightclothes during waking hours | Lack of dignity for patients. Potentially neglect. |
| Removal of outdoor shoes and other walking aids and/or the withdrawal of sensory aids such as spectacles | Removal of sensory aids can cause confusion and disorientation. Increased falls risk - Potentially neglect |
| Creating or fabricating a story which informs a person that they are physically or mentally unable to do something that they can in fact do. | Potential psychological / emotional abuse |

## 6.0 Behaviour

### 6.1 Managing Challenging Behaviour

Restraint should always be a last resort. Successful management of challenging behaviour is underpinned by understanding the reasons for the behaviour and the identification of appropriate interventions which staff can use when interacting with the patient. Staff should ensure that the person is properly understood e.g., obtaining support from SALT / interpreter / Basic sign Language (BSL) practitioner and utilize appropriate tools such as “all about me” to provide personalized care.

- Family or other regular carers must be encouraged to participate in care giving in the hospital and use made of carers rooms e.g., John’s Campaign / parent rooms in paediatrics and ensure that distraction is provided and appropriate to the person (e.g., use of the Enhanced Supervision Bundle or Paediatric Enhanced Supervision Bundle)
- The use of de-escalation techniques must be the first strategy when faced with an escalating situation. De-escalation or diffusion refers to talking with a distressed or agitated patient in such a way that violence is averted, and the person regains sense of calm (NICE 2015). The gradual resolution of a potentially violent and/or aggressive patient using verbal and physical expressions of empathy, alliance and non-confrontational limit setting based on respect is essential (RCN 2013). De-escalation is a two-way process that takes as long as it takes.
- All patients who have undergone an episode of restraint must be given patient and family leaflets regarding UHDB approach and a copy of the Trust policy on restraint.

### 6.2 Behaviour and Underlying Condition

Understanding a patient’s behaviour and responding to individual needs must be at the center of patient care. All patients must be assessed comprehensively 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, mental ill health etc.) and deciding whether the behaviour needs to be prevented. Individual assessment must be carried out that considers the following:

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| **The patient's behaviour and underlying condition and treatment** | Understanding a patient's behaviour and responding to their individual needs must be at the center of patient care. All patients must be thoroughly assessed to establish what therapeutic behaviour support interventions may be of benefit. |
| **The patient's mental capacity and/or mental health** | It is necessary to consider a patient's mental capacity and if relevant presence of mental disorder: as consent must be gained from patients to use any type of restriction unless<br><br>a) they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Capacity Act in their best interests, or<br>b) the Mental Health Act applies. |
| **The environment** | Every effort must be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation (lack of access to outdoors, lack of circular design that can help people with cognitive dysfunction), negative attitudes of care staff, poor communication skills. |
| **The risks to the patient and to others** | When using restrictive practice, a balance must be achieved between minimizing risk of harm or injury to the patient and others, and maintaining the dignity, personal. freedom and choice of the patient. |

Possible causes to consider are:

- Need to empty bladder or bowel.
- Anxiety or distress
- Background of emotional trauma / ACES
- Mental illness – (e.g., dementia, schizophrenia) / poorly treated symptoms of mental disorder or eating disorders.
- Delirium (acute confusion) due to:
- Infection/ Pyrexia
- Hypoxia
- Electrolyte or metabolic imbalance
- Pain or discomfort
- Constipation/dehydration
- Hypotension
- Other form of memory impairment
- Drug dependency, intoxication or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)

- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Pregnancy and postnatal conditions
- Communication; religious and cultural issues
- Impact of Disability, Learning Disability, and developmental disorders.
- Conduct Disorder/Antisocial behaviours.
- Unmet social, emotional or health needs
- Excessive stimulation, noise, and general disruption
- Excessive heating, overcrowding and restricted access to external space.
- Boredom, lack of constructive things to do, insufficient environmental stimulation.
- Lack of clear communication by staff with patients
- The excessive or unreasonable application of demands and rules
- Lack of positive social interaction
- Restricted or unpredictable access to preferred items and activities
- Patients feeling that others (whether staff, friends and/or families) are not.
- concerned with their subjective anxieties and concerns.
- Exposure to situations that mirror past traumatic experiences.
- A sense of personal disempowerment
- Emotional distress, e.g., following bereavement.
- Frustrations associated with being in a restricted and controlling environment.
- Antagonism, aggression, or provocation on the part of others
- Inconsistent care
- Difficulties with communication
- The influence of alcohol or drugs
- A state of confusion, and
- Physical illness.
- or disordered eating

It is important that any new agitation or confusion in a patient must be flagged up, documented, and discussed with the clinical team and / or Mental Health Liaison Team

**6.2.1 Mental health issues and impact on behaviour**

If a patient's mental health is an issue, the mental health liaison services must be contacted for advice and support. Often behaviour can be problematic for staff; however, this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned as it may serve some important and positive function for them. Staff should refer to and apply The Trust Enhanced Nursing Policy for guidance and ensure that information has been gained about the patients', likes and dislikes from the patient/ carers or families who know them well.

**6.2.2 Dementia**

For additional information on the assessment and management of behavioural problems and managing agitation in patients with dementia, referral should be made to the Dementia Specialist Team for advice and guidance on distraction. Staff should refer to and apply The Trust Enhanced Nursing Policy

**6.2.3 Children and Young People**

For support and advice regarding behaviour management, advice and guidance can be sought from the Child Psychology service, Complex Behaviour Team, and Positive Behaviour support

team.

### 6.2.4 Adults with Learning Disability

For support and advice staff can access the Learning Disability Liaison Nurses via the Trust Safeguarding Team

**Having identified the reason for the behaviour, the Clinical Team must then proactively agree on the appropriate approach for dealing with this in conjunction with other members of the multidisciplinary team (to include treatment of the underlying cause and development of positive behaviour support plans). This must be documented in the medical notes.**

## 7 Types of Restraint

Restraint is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property. Restraint can occur in several ways including:

- Physical restraint
- Mechanical Restraint
- Pharmacological or chemical restraint
- Rapid tranquilization

### 7.1 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" (Positive & Proactive Care: reducing the need for restrictive interventions. DoH – April 2014) **The use of Physical restraint must be reported on the DATIX incident reporting system.**

Careful deliberation must precede the application of this practice and an assessment of mental capacity must be undertaken where possible, but this must not impinge on the need to take urgent and emergency steps to prevent harm to patient or others. The use of physical restraints does not ensure safety and staff must be always aware of the need for vigilance and constant supervision of these patients.

Bedrails must only be used following assessment of need and to safeguard patients. Bedrails are not a form of restraint where restraint is defined as: 'the intentional restriction of a person's voluntary movement or behaviour'. Bedrails will not prevent a patient from leaving their bed or falling elsewhere and must not be used for this purpose.

If physical restraint becomes necessary, it must be ensured that one member of the clinical team maintains responsibility for the patient's clinical condition throughout the process (Appropriate person in control of health of patient).

They should not however become involved physically in the intervention – their purpose is to ensure that the restrained person's:

- Head and neck are appropriately supported and protected.
- Airway and breathing are not compromised.
- Monitor the person's overall physical and psychological well-being throughout.
- For safety reasons, during a restraint it is only permissible to hold / apply pressure to the

person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area.

- Every effort must be made to use skills and techniques that do not use the deliberate application of pain.
- The level of force applied must be necessary and proportionate to a specific situation and be applied for the minimum possible amount of time.
- Any person subject to restraint must be physically monitored throughout the incident.
- Post-restraint, the person who has been restrained will be reviewed for placement on the observations as identified by the appropriate person in control of health of patient.

  During this time physical observations of pulse and respiration must be recorded, and the observing nurse be fully aware of the possibility of restraint/positional asphyxia and any other conditions that the patient may experience eg epilepsy, arrhythmia.
- Post-restraint, a recording of the restraint (trigger behaviours / time commenced / restraint position / who involved in the restraint and at what position to the patient / clinical observation of patient) must be made in the patient health record and a datix completed by the appropriate person in control of health of patient.

**Episodes of physical restraint must be reported via the datix system.**

**7.2 Restraint on the ground:**

Face down/ prone restraint must generally be avoided but may be necessary e.g., where the patient / service user and or staff become destabilized. It should only be used for the shortest period and only for the purpose of gaining reasonable control and the restraint moved as quickly as possible to place the patient / service user in a standing or seated position to reduce distress and manage critical risk.

**7.3 Mechanical Restraint**

Mechanical restraint must be used as a last resort when all other less restrictive options have been tried and failed. In some circumstances e.g., threat to public order and safety / acts of assaults upon staff or other patients / threat to life of patient or others, it may be necessary to request assistance from the police for this purpose.

The Trust does not currently support any mechanical restraint to be used by Trust personnel. (For all issues relating to use of Mittens / Bridles / nasal retention devices see CG-T/2011/148 NG Tubes and Other Lines - Prevention of Removal (Adult) - Full Clinical Guideline) Inappropriate use of restrictions / restraints may be viewed as abuse and a safeguarding concern.

**7.4 Pharmacological or Chemical Restraint**

Chemical restraint refers to the use of medication prescribed and administered for the purpose of quickly controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. It must not be used routinely or as a first response, but only for a child, young person or adult who is highly aroused, agitated, overactive, aggressive, is making serious threats towards others, or is being destructive to their surroundings and when other therapeutic or restrictive interventions have failed to contain the behaviour. An antipsychotic, an antidepressant, or both must not be prescribed in response to challenging behaviour without an appropriate clinical reason.

Chemical restraint must be used only as part of an agreed support plan and must be delivered in accordance with evidence-based best practice guidelines and by staff with the relevant qualifications, skills, and experience to administer it. Prescribers must provide information, to those who provide care and support, about any physical monitoring that may be required in addition to information about the medication to be used and how it must be administered (the route of medication).

**Episodes of chemical restraint must be reported via the datix system.**

### 7.4.1 Rapid Tranquilization - Adults

Rapid tranquilization is defined by the NICE (DH 2005) as "the use of medication to control severe mental and behavioural disturbance, including aggression associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other less coercive techniques of calming a service user, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a time-limited period of 30-60 minutes, to produce a state of calm/light sedation".

In cases of acute behavioural disturbance (ABD), or 'excited delirium', describes the acute onset of agitated and aggressive behaviour and autonomic dysfunction, often in the setting of acute on chronic drug use or mental illness. There is not yet a common standardized definition. ABD is a medical emergency. It incorporates features of acute delirium and hyper-adrenergic autonomic dysfunction and is associated with sudden death in approximately 10% of cases. See Acute Behavioural Disturbance/Excited Delirium- ED - Management of Adults, including Rapid Tranquilization/Sedation - Clinical Guidelines Reference Number: CG-EMD/2021/017 – ED

### 7.4.2 Physical Health Monitoring During Restraint

The Appropriate Person in Control of health of patient direct monitoring must be undertaken by the Clinical Team in attendance and must include observations e.g. Pulse, Blood Pressure, Respiration, SPO2, GCS etc.

This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilization
- If the person is suspected to be under the influence of alcohol or elicit substances
- If the person has a known medical condition which may inhibit cardio-pulmonary function e.g., obesity (when face down), asthma, heart disease etc.

## 8 Post Restraint Arrangements

Debrief & Incident Review

- A de-brief with staff and patient separately must take place as soon as practicably possible post-incident or post discharge depending on the individual circumstances of the case. The de-brief should address any trigger factors, feelings at the time of the incident, at the review, how they may feel soon and what can be done to address their concerns.

- Incident Review must take place after every instance of security restraint of a patient. Attendees at the review should be the Trust Health and Safety lead, Head of security, Head of Safeguarding or Deputy, matron and clinical lead for the relevant area and the incident review must consider,
  - Bodycam footage:
  - Notes of incident in health care incident
  - Identification of any / avoidable triggers

## 9 Restraint in Intensive Therapy Unit (ITU) Only

There is a small population of critically ill adults who, once certain checks and balances have been completed, may benefit from the use of physical restraints in support of pharmacological measures in the management of their agitation / anxiety.
It is common for patients in critical care units to lack mental capacity, either temporarily or permanently. Many are sedated to help them tolerate their treatment. Particular problems can occur when sedation is being reduced during recovery, as patients may, for example, try to pull out their lines or disconnect themselves from vital life-supporting devices. It is generally accepted that in these circumstances, where a real risk of self-harm exists, restraint may be necessary.

Agitation and delirium are common in the intensive care environment and pose a significant risk to a patient's well-being. Effective management involves a multi-disciplinary risk assessment based on harm vs. benefit. Agreement between medical and nursing staff is necessary as part of the package of care required to ensure that appropriate care is carried out in a safe environment. All roles and responsibilities as outlined within the policy apply and particularly regarding the role of the appropriate person in control of the health of patient.

## 10 Therapeutic holding in the care of Children and Young People (including paediatric and non-paediatric areas)

**Overview**

This part of the policy applies to all staff undertaking Restrictive Physical Intervention or Therapeutic Holding in the care of children/young people and infants.

The purpose of this part of the policy is to

- Guide practitioners to enable them to carry out Restrictive Physical Intervention or Therapeutic Holding in a safe manner which ensures minimal trauma and distress for the child/ young person and their family.

- To highlight the necessity for the appropriate use of de-escalation technique, distraction, play therapy and alternative practice.

- To highlight the need for good communication, consent, training, and documentation.

Definition of Therapeutic Holding: This means immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children/young person, with their permission, to manage a painful procedure quickly or effectively.

Therapeutic Holding is a skill professionals use to carry out therapeutic interventions. It is not meant to be a quick alternative to carrying out care and must only be used as a last resort.

Therapeutic Holding is distinguished from restrictive physical intervention by the degree of force required and the intention.

Alternative terms for therapeutic holding include 'supportive holding' and 'clinical holding.'

### 10.1 Roles of Individual staff

| **All clinical staff members who have direct care of patients** | Are responsible for<br>• Ensuring they have up to date training into Positive Approaches to Challenging behaviour for example or other deemed appropriate by the Business Unit and this policy at appendix 2.<br>• Ensuring they have read and are complying with this policy and seeking advice if they are unsure of any aspect of their care.<br>• Ensuring they keep a record of events and plan of care for each patient.<br>• Ensuring they take all practical steps to comply with this policy when undertaking or assisting in interventions withchildren/young people. |
|---|---|

### 10.2 Standards and Practice

Effective preparation, the use of local anaesthetic, sedation, and analgesia, together with play specialist intervention and distraction techniques, successfully reduces the need for undue force in the use of proactive immobilisation. For example, when holding a child's/young person's arm from which blood is to be taken or when administering an injection, to prevent withdrawal and subsequent unnecessary pain to the child/young person.

However, therapeutic holding without the child's/young person's consent or assent may need to be undertaken against the child's/young person wishes to perform an emergency or urgent intervention in a safe and controlled manner – for example, to perform a lumbar puncture.

Good decision making about restrictive physical interventions and therapeutic holding requires that in all settings where children and young people receive care and treatment there is:

- An ethos of caring and respect for the child's /young person's rights, where the use

of restrictive physical interventions or therapeutic holding without the child's/young person's consent are used as a last resort and are not in the first line of intervention.

- A consideration of the legal implications of using restrictive physical intervention, where necessary, application must be made through the Family Courts for a specific issue order clearly outlining the appropriate restraint techniques to be used.
- Openness about who decides what is in the child's/young person's best interests – where possible, these decisions must be made with the full agreement and involvement of the parent or guardian.
- A clear mechanism for staff to be heard if they disagree with a decision.
- Enough staff available who are trained and confident in safe and appropriate techniques and in alternatives to restrictive physical interventions and therapeutic holding of children and young people.
- A record of events. This must include why the intervention was necessary, who held the child/young person, where the intervention took place, the method used, the length of time and any techniques needed to reduce the future need for restrictive physical interventions or therapeutic holding.
- Where any restrictive interventions are utilised as part of a behavioural support plan, a positive behavioural support approach is to be implemented. Here staff will utilise primary preventative strategies where possible, identify patterns of behaviour and secondary preventative strategies used to de-escalate situations, and review effectiveness of any interventions.
- Tertiary Strategies such as restrictive interventions must be reviewed and documented. (Guidance may be required by specialist nurses (e.g. Learning disabilities, paediatric specialist nurse i.e. autism nurse, and epilepsy specialist nurse).

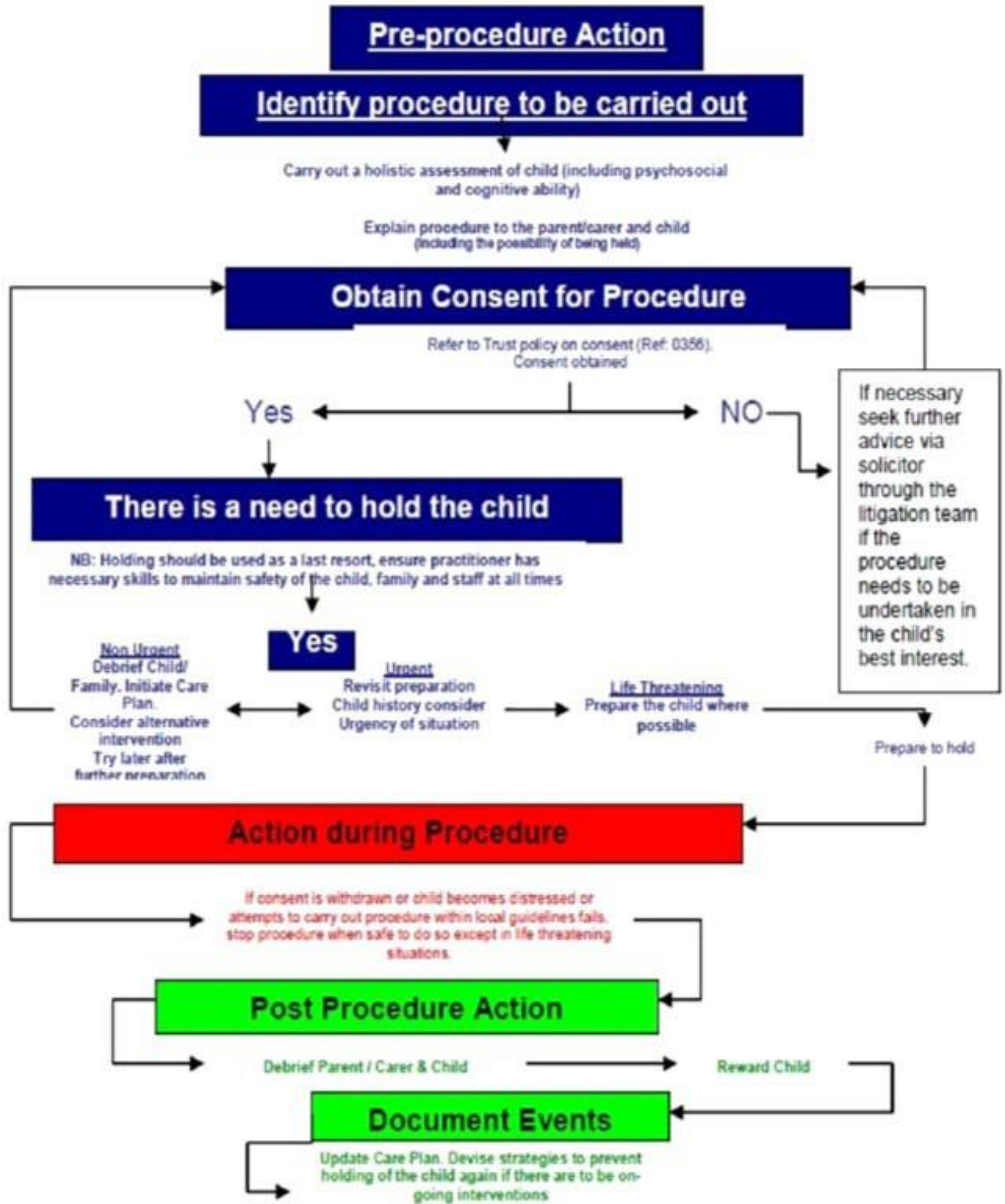
Therapeutic holding for a particular clinical procedure also requires practitioners to:

- Give careful consideration of whether the procedure is necessary, and whether urgency in an emergency prohibits the exploration of alternatives.
- Anticipate and prevent the need for holding, by giving the child/young person information, encouragement, distraction and if necessary, using sedation. In considering the use of sedation, one must recognise that the risks associated with sedation need to be outweighed by the harm caused by therapeutic holding in the absence of sedation. Involve the play specialist from an early stage. Introduce to the child/young person and family/carers as soon as possible and liaise with play specialist re appropriate techniques following their assessment of the child/young person. .
- An attempt must be made to obtain consent/assent from all but the youngest of children/young person for any situation which is not a real emergency seek the parent/carer's consent, or the consent of an independent advocate.
- Make an agreement prior with the parents/ guardians/carers and the child/young person about what methods will be used, when they will be used and for how long. This agreement must be clearly documented in the plan of care and any event fully documented.
- Ensure parental presence and involvement – if they wish to be present and involved. Parents/guardians must not be made to feel guilty if they do not wish to be present during procedures. Nurses must explain parents' roles in supporting their child

/young person and provide support for them during and after the procedure.

- Make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining, and preparing the child/parents beforehand as to what will happen.
- Comfort the child or young person where it hasn't been possible to obtain their consent and explain clearly to them why immobilisation is necessary.

Child Holding Algorithm



### 10.3 General Principles

- All staff that carry out Therapeutic holding must be trained in accordance with Appendix 2 of this policy.
- Follow the child/young person holding algorithm in point to ensure appropriate preparation and debrief.
- A lead person must be identified to coordinate the process. Identify a person to communicate and reassure the child/young person and family/carer/guardian throughout.
- Consider the child/young person's age and adapt procedure in accordance with training received.
- Supportively hold the limb or body in a natural position. Avoid pressure over the face, neck, chest, abdomen, genitalia, and soft tissue. Use the whole hand to support around a limb.
- Physical restraint must never be used in a way that might be considered indecent, be misconstrued as having sexual connotations or that could arouse sexual feelings.
- Apply a firm but even pressure when holding ensuring circulation and breathing is not compromised.
- Other than exceptional circumstances e.g., due to medical procedure, a child/young person must not to be restrained / held face down.
- Where incidents require Trust Security to support the individual, officers are to be in constant supervision by care / nursing staff on or from the unit. They will seek guidance from staff in terms of physical and emotional care needs.
- A record must be made of methods used and the circumstances in which they are used. This must be agreed with the parent's child/young person and clearly documented in the child/young person's individual care plan. For example, two unsuccessful attempts at bloods/cannulation must be followed by a rest and change in practitioner.

## 11 Monitoring Compliance and Effectiveness

| | |
|---|---|
| Monitoring Requirement: | Review and debrief after each incident.<br><br>Data to be collected and submitted to national MH dataset |
| Monitoring Method: | Review Datix, post-incident recording in health record, body camera recordings |
| Report Prepared by: | Divisional clinical governance facilitator, Trust H&S lead, Head of Security, Matron and Clinical Lead for relevant area |
| Monitoring Report presented to: | Health and Safety Group<br><br>National MH dataset |
| Frequency of Report | Internal groups Quarterly / national dataset monthly |

## 12 Training and Implementation

Whilst the Security Teams need specific and regular refresher training in physical restraint approaches, the Trust emphasis of training and education will be on dealing effectively with situations in order to obviate the need for restraint eg distraction techniques; dementia training and conflict resolution training (mandatory for all front-line staff every 3 years as face-to-face training.) This training focuses on the basic reasons on why and how individuals become more challenging and looks at the possible causes for this and how to deescalate and diffuse situations.

- Positive Approaches to Challenging Behaviour training (PACB)
- Conflict Resolution Plus (includes de-escalation, personal safety & breakaway)
- Enhanced Nursing and Distraction
- Physical restraint
- Clinical holding

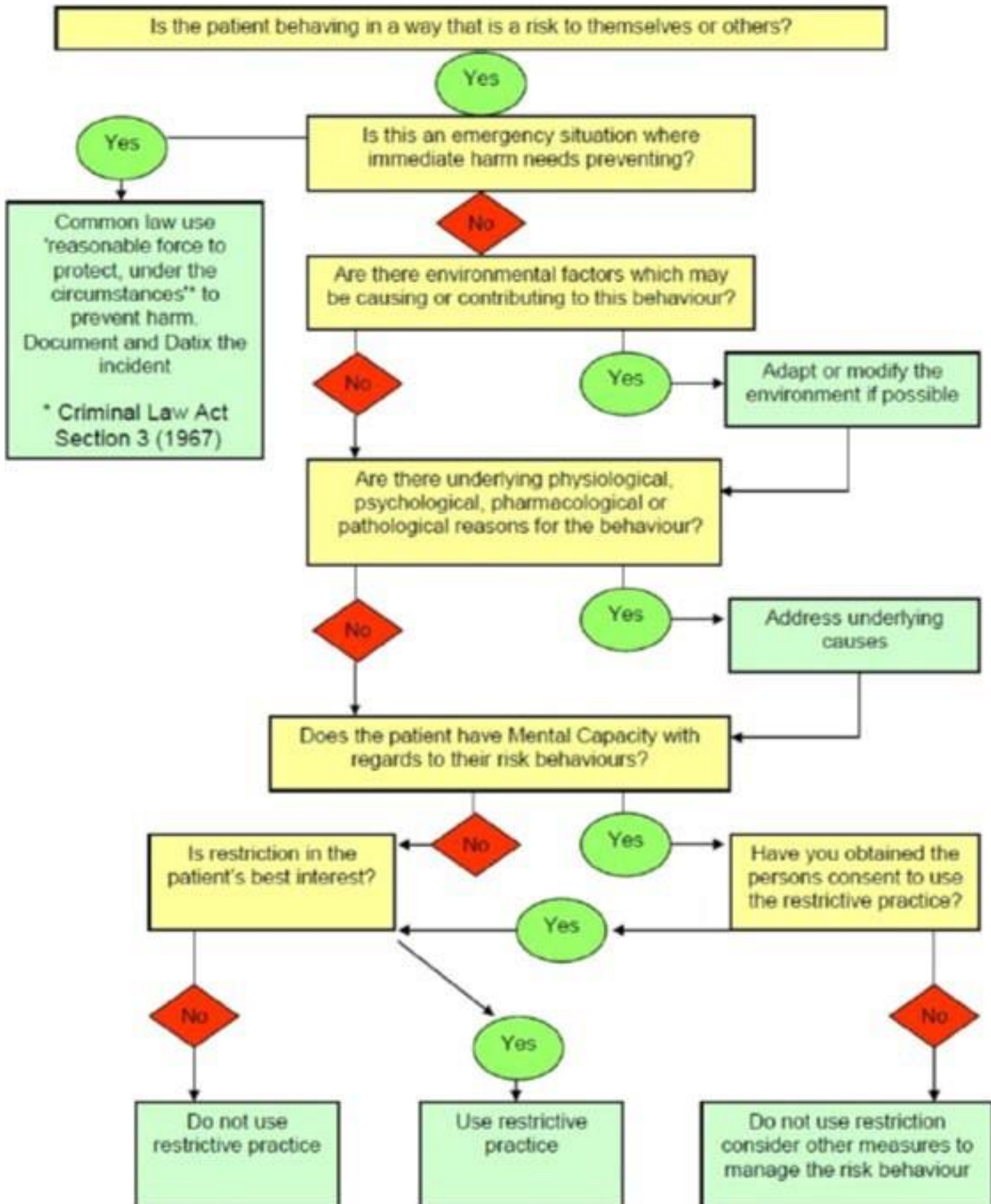
Physical restraint can be used as per common law (see para 5 above) but the Trusts training needs analysis should be referred to for training requirements of staff in any area. See Appendix 2

## 12 Related UHDB Documents

**Related UHDB Documents**:
This policy must also be read in conjunction with / considered alongside a range of documents which are referenced throughout along with links to the relevant intranet page; the most significant being:

- Safeguarding Adults Policy
- Safeguarding Children Policy
- Treatment with Lawful Consent (Mental Capacity Act (MCA)) Policy
- Mental Health Act (MHA) Policy
- Enhanced Nursing Care Policy

**Appendix 1 – Application in practice flow chart**



**Appendix 2 - Draft TNA**

| Staff Group | Conflict resolution (delivered by elearning) | Conflict Resolution Plus (Face to Face) | Positive Approaches to Managing Challenging Behaviour | Restraint | Therapeutic holding |
|---|---|---|---|---|---|
| All non-patient facing or non-clinical staff | ■ | | | | |
| All clinical, patient facing staff working on adult in-patient / out-patient / ED wards & Departments | ■ | ■ | | | |
| **All Paediatric clinical, patient facing staff** - working on in-patient areas | ■ | ■ | ■ | ■ | ■ |
| **All paediatric clinical, patient facing staff** - working in out-patient areas | ■ | ■ | ■ | ■ | ■ |
| All **Band 6 & 7** working on adult in-patient / out-patient / ED / wards & Departments | ■ | ■ | | ■ | |
| All clinical, patient facing staff working on **ICU & Step-down** | ■ | ■ | | ■ | ■ |