Lancashire Teaching Hospitals
NHS Foundation Trust

TRUST POLICY/PROCEDURE/STRATEGY AMENDMENT SHEET

DOCUMENT TITLE	Restraint Procedure
NEW VERSION	3.4
REPLACES EXISTING VERSION	3.3
DATE OF ISSUE	24 September 2013
AUTHOR	Karen Mahon, Physical Risk Manager

Date of Amendment	Page No.	Amendment details
24 Sep 13	12	Procedure now includes the use of the vulnerable patients monitoring device Trust wide (where fitted) to alert staff that the patient is attempting to leave the ward.
16 April 2019	All	Review date extended to 31 October 2019. Request to extend procedural document validity form number 182 dated 13 March 2019.
14/10/2019	All	Extension agreed, Nov 19 PDRG. Form No: 451
29/01/2020	All	Extension agreed, Feb 2020 PDRG. Form No: 481

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

RESTRAINT PROCEDURE

PROCEDURE FOR THE CONSIDERATION AND MANAGEMENT OF RESTRAINT IN THE CARE OF PATIENTS WHO ARE AGITATED AND CONFUSED AND WHO ARE IN DANGER OF SELF HARM DURING CARE
(PLEASE SEE ASSOCIATED TRUST PROCEDURE - Procedure for the Use of Bed Rails)

AUTHOR.	AUTHORISED BY	DATE AUTH	RISK MANAGEMENT PROCEDURE NUMBER
NAME **Karen Mahon**	NAME **Karen Partington**	24 September 13	**RMP-C-24**
SIGNATURE **CLINICAL RISK MANAGER**	SIGNATURE **CHIEF EXECUTIVE**	REVIEW DATE 31 March 2020	

RISK MANAGEMENT PROCEDURE
CLINICAL

RMP

Risk Management Procedures are enabled by the Trust Risk Management Policy and should be read in conjunction with the Trust Risk Management Strategy. They are designed to effect the procedural requirements of relevant, Trust Board approved Policies which themselves outline the overarching principles involved.

Risk Management Procedures are also instrumental in meeting the requirements of Clinical Governance and Controls Assurance in the NHS.

This Procedure is mandatory and is to be followed by all Trust employees. The content is based on the legal requirements imposed by both primary and secondary legislation, approved codes of practice and/or evidence based guidelines. They are published following consultation with relevant staff and management groups/committees, prior to final approval by the Risk Management Committee and the appending of the Chief Executives signature.

Source information and relevant legislative requirements are listed as an appendix to each of the procedures.

This Procedure was produced in consultation with:
Restraint Committee (Nutritional Nurse Specialist, Practice Educator Neurosurgery, Clinical Governance Nurse Lead, Clinical Risk Manager, Occupational Therapist, Modern Matron Orthopaedics, Educational Facilitator, Paediatrics), NAMAGS, Hempsons Solicitors.

Other Trust Policies/Procedures associated with this document include:
Mental Capacity Policy and Procedure (Joint)

The Trusts Risk Management, Clinical and Security and Environmental Governance committees and the Practical Ethics committee agreed agreement for the use of the vulnerable patient monitoring device

Lancashire Teaching Hospitals NHS Foundation Trust Impact Assessment Screening			
Policy Title: Restraint Procedure **Policy Author: Karen Mahon**			**Impact Assessment approved by:**
1.	**Does the policy/strategy affect one group more or less favourably than another on the basis of:**	**Yes/No**	**Evidence in support of either positive or negative impacts, including references to research and national documents must be provided for the sections below**
	1. Race	no	The procedure follows Department of Health national guidance, including Consent and the Mental Capacity Act 2005, and supports the legal position with regards to managing consent in the public's best interest
	2. Disability	no	
	3. Gender	no	
	4. Sexual Orientation	no	
	5. Religion or Belief	no	
	6. Age	no	
	7. Marriage and Civil Partnership	no	
	8. Gender reassignment	no	
	9. Pregnancy and Maternity	no	
2.	Is there any evidence some groups will be affected differently?	yes	This is covered within the procedure
3.	If potential discrimination has been identified is this justifiable (you must explain why)?	n/a	
4.	What methods of consultation have you used and with whom please describe?		Practical Ethics Group.
5(a)	Is the impact identified likely to have a negative impact on the Policy/Strategy?	no	It supports it
5(b)	Can the impact be avoided?	na	
5(c)	Are there alternative ways of achieving the aims of the Policy/Strategy to remove the impact?	no	
5(d)	Can measure be put in place to reduce the impact?	no	
Comments **na**			**Action to be taken (or not applicable)** n/a

Name and designation of person completing this form Karen Mahon, Head of Clinical Case Management Date 5 July 2013 (If anyone reading this form identifies any potential discriminatory impact that has not been identified on this form, please contact the Policy Author named above, along with suggestions how the impact can be eliminated or reduced.)

CONTENTS:

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

PROCEDURE FOR THE CONSIDERATION AND MANAGEMENT OF RESTRAINT IN THE CARE OF PATIENTS WHO ARE AGITATED AND CONFUSED AND WHO ARE IN DANGER OF SELF HARM DURING CARE

1. Introduction

Patients who are delirious or agitated may require some form of restraint.

When patients become agitated or confused they may remove their life-saving equipment, become aggressive and present with socially unacceptable behaviour, which prevents their privacy and dignity being maintained, thus jeopardising their well-being. Preventing and protecting the patient from self-harm, is a central nursing and medical responsibility for those patients who are incapacitated.

2. Consent and Capacity

Restraint may amount to medical treatment. If so, a distinction must be made between patients who are **capable** of consenting to medical treatment and those who are **incapable** in that regard.

Capable patients may only be given medical treatment to which they consent. If treatment is given to them to which they have not consented, that treatment be an assault and might be the subject of civil or criminal legal proceedings. So, for example: a capable patient may not be restrained in order to prevent him/her from removing a feeding tube. Because s/he is capable, the patient may decide for him/herself whether to accept feeding by those means.

Many interventions used within the acute hospital setting can impair the patient's ability to make such decisions, i.e. medication, illness, emotional distress, language barriers or other issues may inhibit a patient's understanding and competency and all efforts to assist with communication should be explored to ensure that the patient is incapable of making a decision. All decisions made regarding capacity must be specific to a proposed intervention or treatment and the gravity of the outcome. For example, a patient may be capable of making a decision that they do not want to have bath but incapable of understanding the outcomes of refusing serious life sustaining treatment. This may be temporary or permanent. When consent cannot be obtained, it is recognised that a decision to act in the patient's best interest can be applied. This enables the professional to act in the best interests of the patient according to approved acceptable standards of care. It is reasonable to assume that a sensible person would wish to be treated for life threatening conditions when not able to give consent. It would therefore be lawful in an emergency situation to use restraint to protect him/her or others from immediate risk of harm, provided that restraint is the least restrictive effectively proportionate to that end. Examples of this are the use of vulnerable patient monitoring device, which alert staff to a vulnerable patient attempting to leave the ward.

3. Advice

However, if clinical staff are unsure of the legal implications of an intervention, then expert advice should be sought from the Trust's Legal Advisers, via the Head of Clinical Claims Management tel ext. 2449, pager 07623 621646) Where ethical advice is also required it would be appropriate to refer to the Trust Practical Ethics Group. This advice may also be sought by the Clinical Risk Manager or the Chairman of the Group. Further direction is also detailed within the Trust's Mental Capacity Act Policy and Procedure and the Deprivation of Liberty (DoLs) Procedure.

4. Legal Aspects of Decision Making

When making such decisions, staff have a moral obligation to do no harm and to promote good. In order to do this they need to balance the risks and benefits associated with all forms of restraint. This is compounded with patients who lack the capacity to consent and rapid decisions are needed to ensure that patients do not harm themselves. Where patients are though to lack capacity, assessment should be undertaken using the Mental Capacity Assessment form found in the Trust's printable managed stationery folder. In such cases action needs to be justified and at a level of practice that is accepted as proper by a responsible body of opinion (Bolam Test). Decisions should therefore balance the best interest of the patient to ensure safety, and promote the patient's wellbeing and safeguard their interests. This is a difficult course to take, and the responsibility of the professionals involved must adhere to their professional codes of conduct. In the UK **when all other alternative therapies have failed, and as a last resort**, it is deemed that there are situations where it would be seen as lawful to use reasonable force to restrain a patient.

These are:

1. To prevent self-harm or risk of physical injury.
2. Where staff are in immediate risk of physical assault.
3. To prevent dangerous, threatening or destructive behaviour.

It is important that staff need to be sure that the agreed level of restraint is reasonable and proportionate to the circumstances, otherwise they may face allegations of assault.

It is unlawful to use the common law doctrine of necessity to "detain" an incapable patient (HL v United Kingdom 2004). Therefore it will often be necessary for clinicians to identify with some precision the point at which "restraint" becomes "detention". Please refer to the Deprivation of Liberty (Dols) Procedure. Advice from a member of the Clinical Case Management Team may be sought.

In the case of an incapable patient, it is likely to be necessary (a) to apply restraint to him/her for short but frequent periods or (b) to do so over a prolonged period of time and, if this is the case, it may be necessary to seek a DOL's assessment and approval or to ask the High Court to make a formal declaration that such treatment would be lawful.

5. Assessment and Application of making the Decision and Applying Restraint

Considering the physical, psychological and ethical aspects of physical restraint is very difficult and it is advocated that it is only used when all other methods of managing the problem have failed. It should be employed with caution and as a last resort and be proportionate to its requirement. It should also only be employed following consideration of any other pre-disposing factors for the agitated patient as listed in Appendix One (Checklist and Audit form).

Once all considerations have been taken into account, if it is felt that restraint is needed the following protocol should be used:

1. The decision to restrain an individual should, wherever possible, be made through a multi-disciplinary collaborative forum, the purpose of which is to ensure that a global professional perspective is sought. These decisions should be well documented defining clearly the circumstances where it may not be possible or in such circumstances where a patient may suddenly present with symptoms of aggression to themselves or others.

   Where possible the consent of the patient to restraint and the preferred choice for restraint should be gained. However, if this is not feasible a decision should be made by the consultant and MDT in the patient's best interests. Although information provided by relatives, friends and carers may be relevant to the decision as to a patient's best interests, unless there is a person with Lasting Power of Attorney or a Court Appointed Deputy, those people are not able to *direct* that a particular course be taken, nor should they be invited to "consent" to such a course. However, involvement of the family or interested party should take place as soon as possible and these discussions should be well documented in the case record and included on the sheet. A designated best interest form, found in the Trust's printable managed stationery folder, for complex decisions, or the checklist and audit form for restraint should be used. (Appendix 1).

   A mechanism for staff to voice concerns if they disagree with the decision should be available. **The decision to restrain should not be influenced in any way by the degree or lack of staffing levels within the ward areas.**

2. The documentation and discussion should address the method of restraint to be used, when it should be used and for how long and should incorporate a regular review. (See Checklist and Audit Form Appendix One). The form should be stored in the case notes. The decision to continue with the restraint should be considered by the nursing staff <u>as a minimum</u> at every shift change, or more regularly where it is felt to be appropriate, and should be communicated at other MDT meetings if there is a change in the appropriate nursing and medical evaluation of care. Consideration should also be given to periods of time where restraints may be removed for passive exercise.

3. A training programme for the staff involved should accompany the adoption of any restraint technique. This will be by delivery by the introduction of training to ward staff following the agreement of the procedure to staff by the Clinical Practice Educators within Directorates and included in the Trust-wide Violence and

Aggression programme. Physical restraint should never be used in a manner, which may be considered indecent or undignified, and limitations to the restraint should take this into consideration. The equipment used for physical restraint should be as per that listed in Appendix 2 and 3 of this document.

4. Audit of restraining techniques should be by completion of the form Appendix One to this document as part of the audit of case note documentation.

PHYSIOLOGICAL CONSIDERATION FOR THE CONFUSED PATIENT

Are any of the following conditions present?	Yes/No	Action
Alcohol/nicotine addition Substance abuse	Yes/No	Determine amount, frequency, type of consumption and administer appropriate alternative drug therapies
Central Nervous System disorders Psychological or emotional disturbances Personality type	Yes/No	Investigate previous history of such and potential treatment to alleviate problem
Chronic renal, hepatic, cardiac, pulmonary dysfunction	Yes/No	Monitor condition, address alterations in blood chemistry
Advances age (i.e. over 65 years)	Yes/No	Be aware of multiple aetiologies and medications
Reduced hydration	Yes/No	Check electrolytes/fluid balance
Vitamin deficiency	Yes/No	Vitamin and mineral screen, trace elements
Reduced nutrition	Yes/No	Involve dietician
Brain trauma	Yes/No	Monitor and report changes in conscious level (re Glasgow coma scale)
Possible drug reaction/interactions	Yes/No	Review drug prescription chart Check for side effects, interactions, and incompatibilities
Hypoxia/dyspnoea	Yes/No	Check arterial blood gas, oxygen saturation, ventilator settings and function, and adjust to optimise patient's condition
Pain	Yes/No	Assess and monitor pain levels, and ensure adequate analgesia is administered (see acute pain guidelines)
General discomfort	Yes/No	Change of position/malposition of ET tube/NG tube (see guidelines) Check for urinary retention Bowel/incontinence evaluation
Anxiety/fear/stress	Yes/No	Reassurance and explanation of procedures
Communication difficulties	Yes/No	Re-orientation Provision of appropriate communication aids Minimise isolation as far as possible Allow participation of family/friends Consider alternative/diversional therapies Consider anxiolytics
Under sedation	Yes/No	Utilise sedation scales, titrate to desired effect Daily sedation holds
Environmental factors	Yes/No	Reduce noise levels to promote comfort
Sleep deprivation	Yes/No	Maximise sleep/minimise interventions Encourage day/night lighting and rest periods. Assess environmental conditions e.g. temperature and adjust accordingly.
Electrolyte imbalance	Yes/No	Commence treatment for imbalance

Consideration of other causes:

Lancashire Teaching Hospitals NHS
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AUDIT FORM FOR USE OF PHYSICAL RESTRAINT

Patient Name:			
Hospital Number:		**Date of Birth:**	
Ward:		**Consultant:**	
REASON FOR RESTRAINT:			
HAS THE MENTAL CAPACITY ASSESSMENT BEEN UNDERTAKEN? YES ☐ NO ☐ **OUTCOME OF MENTAL CAPACITY**			
THOSE INVOLVED IN THE DECISION MAKING PROCESS (include relatives informed):			
METHOD OF RESTRAINT USED:			
DETAIL WHERE APPROPRIATE PERIODS OF REST FROM RESTRAINT			
Date of commencement of restraint		**Time**	
Date of decision to discontinue restraint		**Time**	
Reason for discontinuation of restraint			
Please detail any problems associated with restraint			
Restraint reviewed (Please detail how often)			

THIS FORM SHOULD BE FILED IN THE NURSING KARDEX.

Version 2.2
Produced: 1 March 2011
Review: Feb 2012

METHODS OF PHYSICAL RESTRAINT

Peek-a-Boo Mitts

Leeder Rest

Wrist splints from the OT Dept As available

Chemical restraint must only be considered as a last option

Safety rails See Trust Procedure for the Use of Bed Rails

Vulnerable patient monitoring device (arm bands or clip for clothing) – for Trust wide application (where fitted) to alert staff to vulnerable patients attempting to leave the ward area.

Each Directorate is responsible for the provision and storage arrangements for all their areas of restraint equipment.

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Portering/Security Department Local Procedure Document

Use of Leg Restraints

Aim
To ensure the safe and lawful use of approved leg restraints

Procedure

- The use of leg restraints on a patient or any other person is restricted to the approved leg restraint system 'FASTSTRAP'.
- Only dedicated security staff will be authorised to carry and use the restraints and must have completed a 1-day training course with Lancashire Police.
- Leg restraints will never be used as the sole method of restraint and will only be used in conjunction with approved upper body restraint by trained staff.
- In every case, leg restraints will only be used as a last resort.
- Leg restraints may only be used on patients in circumstances where a patient is violent and there is an immediate requirement to restrain them for the purposes of preventing the patient from injuring themselves or any other person. Restraints will only be used in response to violent behaviour and not as a preventative measure.
- Leg restraints may only be used on a patient after consultation with the most senior nursing staff present at the time, unless there is an immediate requirement to prevent injury. The decision to use the restraints must then be confirmed as soon as practicable. The site manager/bleep holder/ matron must be informed that leg restraints have been used as soon as practicable during/after the incident.
- Leg restraints on a patient should not remain in place for longer than 10 minutes and be assessed after 5 minutes use by the senior nursing staff on duty at the time. They may be re-applied if appropriate or it is obvious that removing the restraint would put the patient or staff at immediate risk of injury.
- In circumstances where the restraints have been in place on a patient for a period exceeding 30 minutes the site manager/bleep holder/ matron must contact:
    - A senior clinician and
    - On-call executive team

- Any use of leg restraints on a patient or any other person must be reported on Incident Form IR1/2. The form will be completed by the member of staff applying the restraints and countersigned by the authorising person (if applicable). This form must be completed immediately after the restraints have been removed or as soon as practicable afterwards.

- Every incident involving the use of leg restraints on a patient will be alerted to the Head of Clinical Case Management and the Physical Risk Officer (Security)

- All incidents will be reported to and reviewed by the Practical Ethics Committee.

- The responsibility for the use of leg restraints remains with the individual applying the restraint and that person must be satisfied that the use was both necessary and proportionate.

- There is no requirement for nursing staff to authorise the use of leg restraints on a person who is not a patient.

Applicability

All Portering / Security staff

Responsibility

Security Supervisor
On duty Supervisor
On duty Security Officer
On duty Portering / Security staff

Reviewed by

Physical Risk /Clinical Risk Department
Practical Ethics Committee
Clinical Governance Sub Committee

References:

Kate Bray et al
British Association of Critical Care Nurses
Position statement on the use of restraint in adult Critical Care Units 2004 Volume 9 No 5

The Mental Capacity Act 2005
Hempsons Solicitors

M Nirmalan, P M Dark, P Nightingale, J Harris
British Journal of Anaeasthesia – London June 2004
Volume 92, Issue 6

UTNB Nursing Practice Standard Policy 7.3
Safe Practice Standard Initiating and Monitoring Restraint

Chubb Speciality Insurance publication focus on using restraint – a Risk Management Dilemma
http./2cber.chubb.com/publications/stat/stat-restraints.asp

October 16th 2001 Gerald A et al
Clinical Practice Guidelines for the maintenance of patients
Physical safety in the Intensive Care Unit: Use of Restraining Therapies

American College of Critical Care Medicine Taskforce 2001 –2002

Critical Care Medicine 2003 Volume 31 No 11 page 2665

Ruth Johnson – Reducing Patient Restraint Use
Nursing Management No 32 September 1998

The Board of Management and Trustees of the British Journal of Anaesthesia.

Editorial 1B Physical and Pharmalogical Restraint of Critically ill patients: Clinical Facts and Ethical considerations

Chevron et al
Unplanned Extubation: Risk factors of development and predictive Criteria for re-intubation

Critical Care Medicine: Volume 26 (6) June 1998 page 1049 – 1053

Carrion et al
Accidental removal of endotracheal and nasogastric tubes and intra-Vascular catheters
Critical Care medicine: Volume 28 (1) January 2000 page 63 - 66

Mental Capacity Act 2005.