Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

# Restrictive Interventions:
## Principles and Guidance

**This procedural document supersedes: PAT/PS 15 v.2 – Restrictive Practice Policy: Clinical holding, restraint and restriction.**

**This should be read in conjunction with the Mental Capacity Act & DoLs and Safeguarding Adults & Children Policies.**

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| Author/reviewer: (this version) | Deborah Oughtibridge – Head of Safeguarding |
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# Amendment Form

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| Version 3 amended | 1 March 2016 | • Following a national patient safety alert, additional bullet point added to section 4.4 - 'Decision making and assessment',<br>• Patient Safety Alert reference added. | Deborah Oughtibridge |
| Version 3 | 29 September 2015 | Title change<br>Updated in line with new national guidance and to reflect Trust changes. Changed to provide key principles and general guidance. | Deborah Oughtibridge |
| Version 2 | July 2013 | Change of focus of policy to restrictive practice<br>Change of title<br>Range of minor amendments to update policy following further review and consultation- please read in full. | Deborah Oughtibridge |
| Version 1 | January 2012 | This is a new procedural document, please read in full. | Deborah Oughtibridge |
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# Contents

## 1. INTRODUCTION

Doncaster and Bassetlaw Hospitals NHS Foundation Trust ("the Trust ") is committed to delivering the highest standards of health, safety and welfare to its patients, visitors, and employees.

The Trust recognises that a patient's behaviour can escalate to the point where restriction or 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. Any actions must be taken with an ethos of caring, safety and respect.

The Trust;

- Acknowledges there will be occasions when an individual's behaviour may necessitate the use of restraint and restriction.
- Believes that the management of difficult and challenging behaviour is an activity requiring decency, honesty, humanity and respect for the rights of the individual, balanced against the risk of harm to themselves, staff and members of the public. Restraining any aggressive behaviour **by any means should be proportionate** (i.e. least restrictive – which means the shortest time possible) and only be used when it is reasonable to do so and where there has been appropriate training.
- Pledges that restraint/restrictive practice will only be considered when all other practical means of managing the situation, such as de-escalation, verbal persuasion, voluntary 'time out', or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. The self-respect, dignity, privacy, religion, belief, cultural values, race, and any special needs of the patient should be considered in so far as is reasonably practicable.
- Has systems and processes to review all incidents where restraint is deployed, to ensure that the restraint used is **reasonable, proportionate and necessary.** The focus should be on prediction through risk assessment and prevention through de-escalation.

In addition, the Trust recognises that there will be circumstances where children and young people require restrictive physical intervention and therapeutic holding, managed in a safe controlled manner, for procedures, treatments or care delivery.

This policy relates to the restriction of patients by Trust staff.

## 2. PURPOSE

This policy is intended to provide guidance for managers and staff in relation to the nature, circumstances and use of restrictive practice with patients receiving care within the Trust. Its aim is to help all involved act appropriately in a safe manner to ensure effective responses in potential or actual difficult situations with a focus on using the least restrictive option available. It sets out a framework of good practice, ensuring legal, ethical and professional issues have been considered.

The policy covers all staff and persons within the Trust and others who are acting on behalf of the Trust.

The policy applies to patients who require restrictive practice while receiving care and treatment. This policy also includes a section specifically in relation to guidance on carrying out restrictive physical interventions or therapeutic holding of a child /young person in a safe manner which ensures minimal trauma and distress for the child/young person and their family.

The objective of any restrictive practice/restraint is to maintain the safety of staff, other persons present and the subject where practicable, by establishing an appropriate degree of control.

This policy is key to compliance with the Care Quality Commission Essential Standards. It should be read in conjunction with the Trust policies on Safeguarding, Mental Capacity Act and Deprivation of Liberties (see Appendix 5).

### 2.1 Individual Care Groups and clinical services

Care Group management teams need to undertake a risk assessment in relation to their clinical areas and restraint/restrictive practice. They should then consider drawing up specific supplementary guidance to address issues relevant to their wards/departments. This might include the provision of staff training on the care of patients with certain conditions (i.e. dementia or stroke) or where there is substance misuse (drugs or alcohol).

Care Group management teams need to ensure risk assessments are completed on known “at risk” patients and seek appropriate legal and professional advice and local guidance should be developed.

There are a range of clinical areas where there may be special circumstances in relation to restraint and restrictive practice.

These areas include:

- Accident and Emergency
- Critical Care and Anaesthetics
- Care of patients with delirium and/or dementia
- Care with the Medical Imaging Department

## 3. DUTIES AND RESPONSIBILITIES

### 3.1 Responsibilities of all staff

Individual members of staff are responsible for ensuring they implement this policy and that they report any concerns to their manager and they record any incident on the Trust’s Datix incident reporting system.

## 3.2 Responsibilities of Care Group Managers, Ward and Department Managers

Members of Care Group management teams, and ward and department Managers must familiarise themselves with this Policy, and ensure that this is brought to the attention of employees under their supervision.

Managers must ensure:

- Staff receive Conflict Resolution and other relevant Aggression, Violence and Harassment training as stated in section 7.
- Appropriate management plans are in place for all patients who have been assessed as posing a high risk of challenging behaviour. All such plans must be brought to the attention of all relevant staff.
- Staff involved in (or witness to) restraint incidents are offered support, either via their Line Manager or via the Occupational Health Department.

Managers are responsible for:

- Ensuring compliance with this policy within their work areas.
- Communicating its contents to their staff.
- Ensuring staff can access appropriate training.
- Ensuring staff are aware of the policy and that they are expected to act within it, taking all reasonable practicable measures to protect the safety and well-being of patients.
- Identifying any areas under their control where patients may be at particular risk.
- Ensuring risk assessments are undertaken.
- Ensuring staff are trained in the relevant preventative measures in the workplace and that facilities are available for use of alternative methods of intervention.

## 3.3 Considerations prior to using Restrictive Practice/Restraint

**Before using restrictive practice/restraint an individual assessment* should be carried out**

Consider:

- **Patient's mental capacity**
- Environmental factors
- Patient's behaviour
  - Is the patient behaving in a way that threatens or causes harm to him/herself, others or to property?
  - Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour? (e.g. hypoxia, drug intoxication, encephalitis, psychosis)
- Patient's underlying condition and treatment
- Duty of care

Consider ***Is restrictive practice /restraint in the patient's best interests?***

* this assessment may be visual in an emergency situation as due to the very nature of an "emergency" situation staff may be required to implement a physical intervention as part of the use of "reasonable force" to prevent immediate harm.

Departments are responsible for ensuring that health and safety risk assessments are carried out on the use of restraint in accordance with the Trust Health and Safety Policies and Procedures CORP/HSFS 01.

By understanding what causes behaviour and reducing those causes, it is sometimes possible to avoid using restraint. Older people who show 'problem behaviour', particularly those who are confused and disorientated, are often attempting to communicate their needs (RCN 2008). It is important to look beyond the behaviour and attempt to understand the message behind it, and identify the unmet needs.

For example:

- A change in behaviour could arise from physiological causes e.g. chest or urinary tract infection, dehydration, constipation, inadequate nutrition, hypoxia, hypotension, pyrexia, drug dependency or withdrawal, brain injury, intoxication or metabolic changes as a result of medication.
- Changes of behaviour may be due to anxiety, stress or mental illness. If a patient's mental health is an issue, contact the Mental Health Services/adult crisis team/older peoples Mental Health Liaison for assistance.
- People who 'wander' might be looking for something (e.g. the toilet, a drink, food, a person) or could just need exercise – the challenge is to understand why the patient is walking about.
- Restlessness may be due to physical discomfort or pain.
- Disorientation could be due to changes in the environment, lack of sleep or medication.
- Aggression might be a result of a build-up of frustration when the patient feels their needs are not being met.

In relation to treatment/investigation it should be considered whether they are necessary at that time or altogether. It may be better to leave investigations/treatment unless clinically essential and try again later.

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

Understanding the patient's behaviour and responding to individual needs should be at the centre of patient care. All patients should be comprehensively assessed to establish which sort of therapeutic management might be of benefit. This involves identifying the underlying cause of the behaviour and deciding whether the behaviour needs to be prevented. Possible causes to consider are:

- Fear, phobia and irrational behaviour
- Medical conditions – hypoxia, hypoglycaemia
- Intoxication
- Agitated cerebral state

Once the reason for the behaviour is identified, appropriate strategies for dealing with this should be agreed by the MDT. This would include treatment of the underlying cause.

Restraint should only be used as a **last resort** and only when alternative methods of therapeutic behaviour management have failed. It should be least restrictive – which means for the shortest time possible

Restraint should be proportional to the risk of the situation. The method used should be the least restrictive, effective and safe. Inappropriate use of restraint may be viewed as a form of abuse. When restraint is used, it should be considered in a systematic and planned way according to the individual needs of the patient.

To use restraint appropriately, a risk assessment must be performed and the situation reviewed regularly as an integral part of the multidisciplinary team (MDT) care programme/MDT warning**.** Full records should be kept of the review process.

Having identified the reason for the behaviour, the multi-disciplinary team would decide on the most appropriate strategies for dealing with this (to include treatment of the underlying cause). This should be documented in the patient clinical records.

Ideally, decisions should be made which, both the person's carers/family members and the healthcare team agree, are in the person's best interests. Family members cannot require clinicians to provide a particular treatment if the healthcare professionals involved do not believe that it is clinically appropriate. However, as a matter of good practice explanation should be given to people close to the patient why you believe any treatment they may have suggested is inappropriate.

Whilst staff are expected to use restraint where they can see that the patient might harm themselves or others, staff cannot be expected to remove all risks from a patient's life. To provide an environment of care where a patient has a reasonable degree of freedom, some degree of risk must be considered acceptable. Each patient should be individually assessed so that his or her care maximises therapeutic benefits, and minimises dangers from risk.

Restraint, if overused, can lead to a cycle of dependence. Patients who have their personal liberty removed in this way can eventually become severely institutionalised. Restraint if inappropriately used may lead to patient injury and harm.

### 3.4 Communication and documentation

Clear communication with patients is essential in relation to the use of restrictive practice/restraint. If restraint is used, the reason should be explicit and clearly documented in the nursing/multidisciplinary notes.

A written care plan should include:

- Assessing/documenting if the patient has mental capacity.
- Risk assessment
- Rationale for the use of restraint/restrictive practice and evidence of multi- disciplinary discussion and approach
- The frequency of re-assessment of the need for restraint/restrictive practice. Review times should be specified in advance. There should be emphasis on ongoing review of the need to use restrictive practice /restraint
- All discussions that have taken place to allow patient to give valid consent and to assess best interests if the patient lacks capacity.
- Details about the use of any restraint/restrictive practice itself.

All documentation in relation to restrictive practice/ restraint should be clear and contemporaneous.

# 4. PROCEDURE

## 4.1 An overview of restraint/restrictive practice

Restraint can cause both physical and psychological harm to patients and staff. As a result the Government has published new guidance on "Positive and proactive care": reducing the need for restrictive measures. The aim is to make situations more manageable and less distressing for all concerned, in particular, to improve the care of vulnerable people.

The aim is to make situations more manageable and less distressing for all concerned, in particular, to improve the care of vulnerable people.
It is known that people who present with behaviour that challenges are at higher risk of being subjected to restrictive interventions.

Although it is sometimes necessary to use restraint to stop someone hurting themselves or others, the safety of patients must always come first.

It is acknowledged that decisions on the use of restraint methods to be applied to patients in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such restraint may lead to complaints by patients or their relatives.

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 measured at the time of the incident.

## 4.2 Principles to follow

If restrictive intervention has to be used it must always represent the least restrictive option to meet the immediate need. Individualised support plans must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions. Staff should dynamically assess the situation when things go wrong, minimise the risks and respond to an individual's anxiety and distress calmly, by non-confrontation and de-escalation.

A key guidance document that provides useful information is "Positive and proactive care". Key principles underpinning the guidance:

- Compliance with the relevant rights in the **European Convention of Human Rights** at all times.
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their **quality of life** to be enhanced.
- **Involvement and participation** of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's

wishes and confidentiality obligations.
- People must be treated with **compassion,** dignity and kindness.
- Health and social care services must support people to balance safety from harm and freedom of **choice**.
- Positive **relationships** between the people who deliver services and the people they support must be protected and preserved.

"Positive and proactive care" (DoH 2014).

"Positive and proactive care" gives further advice on:-
- Managing risk and assessing behaviours
- Care Strategies
- Medical assessment and management

**See Appendix 1 - Practical Guidance on Restraining Adults**
**See Appendix 2 - Principles for the Use of Restraint, Holding and Immobilisation – Children and Young People**
**See Appendix 3 - Quick Reference Guide – Holding of Children and Young People**
**See Appendix 4 - Stages for Clinical Holding of Children Undergoing Clinical Procedures**

## 4.3 Clinically Related Challenging Behaviour

It is known that people who present with behaviour that challenges are at higher risk of being subjected to restrictive intervention. Clinically related challenging behaviour by patients and service users makes it difficult for staff to deliver good care safely. It can take many forms from mildly uncooperative to highly disruptive and potentially dangerous behaviour. Such behaviour is often related to a clinical condition or treatment and may be a sign of distress and unmet needs rather that any intent to be challenging.

The aim is to prevent and manage clinically related challenging behaviour by minimising a patient's distress, meeting their needs and delivering high quality personalised care in an environment that is safe for staff, patients and visitors. Key to this is the importance of staff empathy, good communication skills and being compassionate to build trust with patients and service users and better understand what leads to distress. This will help ensure that appropriate care can be designed to prevent challenging behaviour.

A useful document is "Meeting needs and reducing distress guidance on the prevention and management of clinically related challenging behaviour in NHS settings (NHS Protect 2014)." This sets out:

1 Understanding challenging behaviour.
2 Managing risk and assessing behaviour.
3 Care Strategies.
4 Medical assessment and management.
5 Training.
6 Communication and information sharing.

It also includes references for a range of useful information and case studies.

**Chemical restraint**
This can often be used inappropriately for older people. Medications such as antipsychotics and strong benzodiazepines (e.g. midazolam) can be dangerous and are not always necessary. For example there may be a situation where a blood test could be left for the next day, or a patient could behave in socially inappropriate way so long as it isn't harming themselves or others. Intramuscular sedatives can be used too often and staff should be aware of the associated risks.

Antipsychotics should be carefully considered before using in older people. Steps such as calling relatives to talk with and calm the patient must be considered first.

## 4.4 Decision making and assessment

Individual assessment should be carried out that considers:

- The patient behaviours and underlying conditions and treatment understanding a patient's behaviour and responding to their individual needs should be at the centre of patient care. All patients should be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.

- The patient's mental capacity and/or mental health. It is necessary to consider a patient's mental capacity as consent must be gained from patient's to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Capacity Act or the Mental Health Act. Capacity is assumed unless there is reason to believe otherwise.

- Whilst the risk of death from positional asphyxia **during** restraint has been increasingly recognised, harm can also occur in the period **following** restraint from the effect of illicit substances, alcohol, prescribed medications (including any rapid tranquilisation) and co-existing medical conditions. **Vital signs must be reliably recorded and acted on during and after restraint** (Patient Safety Alert December 2015).

## 4.5 The environment

Every effort should be made to reduce the negative effects of the care environment e.g. high levels of noise or interruption, inappropriate temperature, inappropriate levels of stimulation, negative attitudes of care staff, poor communication skills.

A balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of patient.

The individual patient should be at the centre of the process, involving them and those who are important to them in their lives as is practical to do so. A person centred approach to assessment and planning must be taken.

## 4.6 Record Keeping

Staff who decide to restrain/restrict a patient should undertake a risk assessment and assess and record:

- The patient's behaviour.
- Why this behaviour is a challenge e.g. is it a danger to the patient or to others and if so how?
- The proposed solutions which includes restraint only as an option.
- Outcomes of other interventions and the effect on the patient.
- The reason why restraint is the chosen method of choice.
- How long it is intended to restrain the patient. Review times should be specified in advance, or as soon as possible after restraint is commenced.

**Restraint should be *time-limited* and for the *shortest period possible*.**

If it is decided to continue restraint for longer than first specified, a full review must take place with as many of the multi-disciplinary care team as possible.

Any restrictive practice must be documented in the clinical records with a Mental Capacity Act assessment, where appropriate. All documentation should be clear, detailed and contemporaneous. It should be of a factual basis and made clear where it is opinion. The documentation that follows the incident should record whether the patient has/lacks capacity, and the actions taken to respond to the situation.

## 4.7 Involvement of others in restraint/restrictive practice of patients

Situations may arise when additional support is required. In these cases assistance should be obtained via 2222 reporting a critical incident. Staff who know the patient have a greater knowledge as to what is in the patient's "best interests" and should instruct assisting staff accordingly. Clinical staff remain in charge of and responsible for patient care. Any assistance given by others, for example service assistants and security staff, is under the guidance and supervision of clinical staff. Clinical staff should remain with the patient at all times.

These incidents should be treated as adverse incidents and a review undertaken following the event including all those involved as part of the Care Group governance process.

***When to contact the police***

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

i) A violent situation where the safety of staff, patients or others is at risk (see Trust policy on Violence and Aggression CORP/HSFS 5).

ii) If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and there are **serious** concerns about the welfare or safety of that individual (e.g. the

effect of not taking important medication) or others. In these circumstances, the police may be able to check on the person by visiting them at home (see Trust Missing Patient Policy PAT/PS 1). In cases where the individual is threatening to commit suicide, the police have powers to take the person to a place of safety, which in most cases would mean bringing the person to the hospital, to be assessed.

Staff should also follow the normal procedure for discharge against medical advice.

## 4.8 Reporting of injuries

Any injury to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be considered an adverse incident and reported according to Trust Policy for the Reporting and Management of Incidents and Near Misses - CORP/RISK 13 and documented in the clinical records.

## 4.9 Evaluation and review of use of restrictive practice/restraint

The use of restrictive practice/restraint should be evaluated in terms of its effectiveness and alternatives considered wherever possible. Planned use of restraint should involve discussion at ward/department level. The use of restraint in an emergency should be viewed as an adverse incident (Datix) and an Adverse Incident Form must be completed. Clinical areas should put mechanisms in place to collect and review data about non-emergency uses of restraint.

A post-incident review should be undertaken within a maximum of 1 month to seek to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers (NICE 2005). Staff involved should be asked to record a clear description of what happened and their role in the event. A root cause analysis process should be used. Each care group should have a mechanism in place through their Governance arrangement to review.

A de-brief should take place as soon as practicably possible post-incident unless exceptional circumstances prevent this. Reflective reviews and root cause analysis are essential after restraint. The review should address:

- What happened during the incident?
- Any trigger factors
- Each person's role in the incident
- Their feelings at the time of the incident, at the review and how they may feel in the near future
- What can be done to address their concerns

All persons involved in the use of physical interventions must be offered post-incident support by the appropriate line manager, and be involved in any support or feedback process. Managers and team leaders ought to consider asking the Crest Team to debrief staff who have been involved in restraining a patient. The staff may have been emotionally distressed by the event.

# 5. SAFEGUARDING CONSIDERATIONS AND LEGAL ASPECTS OF RESTRAINT

## 5.1 Safeguarding Adults

In terms of legislation, staff should be aware of the Human Rights Act and in particular Articles 3 (Prohibition of Torture – included inhuman or degrading treatment) and 5 (Right to Liberty and Security).

Staff are also referred to the Mental Capacity Act 2005 and in particular Part I – Sections 1-6 inclusive. The Act can be found at the Department of Health
http://www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm
Trust staff should refer to the Trust's MCA & DoLs Policy PAT/PA 19.

**Mental Capacity**
Adults are always presumed to be capable of taking healthcare decisions unless the opposite has been demonstrated or is suspected.

If it is uncertain as to whether a patient lacks capacity to make a particular decision, an assessment of this should be made drawing on the assistance of specialist colleagues if necessary.

Mental capacity and the ability to communicate one's decisions are separate issues. Use all steps that are reasonable in the circumstances to ensure patients can communicate their decisions e.g. using interpreters and communication aids or involving specialist colleagues such as speech and language therapists.

**Duty of Care**
All healthcare staff have a duty of care for the patients in their care. This means acting in their "best interests" unless the patient has capacity to refuse advice. In relation to a patient who is at immediate risk of harm, restraint may form part of the duty of care.

In deciding what is in a patient's "best interests", decisions should not be limited to those that benefit them medically. Consideration should also be given to the views and beliefs of the patient (or previous views and beliefs if they are no longer able to articulate them), their general wellbeing, their relationships with those close to them and their cultural, spiritual and religious welfare (DoH, 2001).

Decisions about a patient's best interests should be agreed both with those close to them and with the healthcare team caring for them. However, if such an agreement cannot be reached in relation to a significant decision, the courts can be asked to determine what is in the patient's best interests.

**Deprivation of Liberty**
In situations where the patient has been assessed as lacking capacity to make a decision about his/her care or treatment, the degree of restraint required to manage that care or treatment may be such that he is (or may be) deprived of his liberty.

The Trust must ensure that all such actions are lawful. Therefore it is imperative that a deprivation of Liberty Authorisation is requested immediately, using due regard for the Deprivation of Liberty process. (Refer to The Deprivation of Liberty Code of practice, (DoH 2009) and the Trust MCA/Deprivation of Liberty policy.

## 5.2 Safeguarding Children

It is essential that where the use of holding or restraint is concerned, staff must consider the rights of the child and the legal framework surrounding children's rights, including the Human Rights Act (1998) and the European Conventions on the Rights of the Child, Consent and Capacity Assessment (RCN, 1989) A 'rights' led approach to children advocates that measures impinging on their health, well-being, treatment and care should involve consultation with the child. Within the limits of their understanding, the rights of the child should be respected in the same way as those of an adult. The United Nations Convention on the Rights of the Child (UN 1989) is endorsed in the National Service Framework for Children (2002). Listening, Hearing and Responding (DoH 2002) state that a child centred approach is advocated, listening to the needs of the child and family rather than a procedure focused 'get it over with' approach.

The Children's Act (DoH 2004) placed each child's/young person's welfare at the centre and changed the way that children's rights are viewed. The rights of the child have been further reinforced by Article 3 of the Human Rights Act (Power 2002). Children have the right to consent but not to refuse procedures e.g. administration of injections, taking of medicines, scans, x-rays. Their wishes can be overridden by those with parental responsibility and by doctors if the procedure is deemed to be in the child's best interests (Alderson 1993).

The Children Act (1989) stresses the importance of preventing children from what it terms 'significant harm' and, as the child's closest advocate, the family has a major part to play in decisions affecting the child. Families are given the freedom to exercise personal judgement as to what is deemed to be in the child's best interests.

**Absconding**

There are times when a sick child/young person may attempt to leave. Such situations can arise when: -

- A child/young person presents in the Emergency Department as a result of substance or alcohol abuse
- A child/young person has behavioural difficulties
- A child/young person becomes psychotic because of a medical condition
- A child/young person has attempted self-harm or suicide

Decisions relating to this should be made according to the individual circumstances and by considering the child or young person's best interest. In such situations reasonable measures need to be taken to contain and prevent them from leaving. In all situations the safety and well-being of all other patients and staff must also be considered. This may be in response to an emergency situation and will therefore be short term measure.

- A member of staff should prevent a child from leaving the immediate vicinity of the clinical location when they have reasonable cause to believe that the child is attempting to abscond,

has a realistic chance of success and would be at risk of significant harm unless some sort of intervention is utilised.
- Pursuing a child is acceptable if there is a reasonable expectation that this can be resolved safely.
- A member of staff is expected to attempt to prevent a child from absconding whilst being escorted outside the clinical location provided, if they have good reason t believe the child is attempting to abscond and would be at the risk of significant harm if he/she should succeed. Staff should not put themselves or the child at risk.
- All intervention to prevent absconding must be preceded by an instruction to the child to stop.
- Staff should carry professional identification in order to support actions they may need to take.
- If a member of staff or group of staff cannot prevent a child or young person from absconding, this must be accepted. Under no circumstances should members of the public be asked to help.

The Missing Person Policy (PAT/PS 1) should be followed.

If a child or young person has left the ward with or without a parent and there are child protection/safeguarding issues refer to the Safeguarding and Promoting the Welfare of Children and Young People Policy (PAT/PS 10) in conjunction with the Missing Person Policy (PAT/PS 1).

***Consent***
The Trust policy on Consent to Examination or Treatment (PAT/PSA) should be adhered to.

Reference should be made to professional Codes of Practice.

## 6. HOLDING AND IMMOBILISATION - CHILDREN AND YOUNG PEOPLE

### 6.1 Procedure

On occasions children may need to be held in a safe and controlled manner for a variety of procedures. The Trust has a duty to protect and safeguard the welfare of children and supports the ethos of caring and respect for children's rights. Restrictive physical intervention and therapeutic holding or containing children without their consent is a last resort and not the first line of intervention. The use of 'restraint' is a clinical decision. Alternative methods of intervention e.g. distraction, play, local anaesthetic, sedation and analgesia should be routinely considered in order to minimise distress to the child and their parent /carer.

Children and young people who require restrictive physical intervention and therapeutic holding for procedures, treatments or care delivery should have this managed in a safe, controlled manner in which discomfort is minimised. In urgent and emergency situations decisions on the use of restraint methods may need to be made quickly and without consultation with colleagues.

The Royal College of Nursing "Restrictive physical intervention and therapeutic holding for children and young people" (2010), sets out guidance for nursing staff with a focus on a set of principles and key references.

An individual assessment should be carried out which considers the child's/young person:

- environment
- behaviour
- underlying condition and treatment
- age
- mental capacity

## 6.2 Techniques to reduce the level and intensity of a difficult situation

Restrictive physical intervention and therapeutic holding of children and young people within the healthcare setting may be required to prevent significant and greater harm to the child/young person themselves, practitioners or others. If restraint is required, the degree of force should be confined to that necessary to hold the child or young person whilst minimising injury to all involved.

Techniques such as relaxation and distraction, together with pharmacological strategies such as the use of local anaesthetic cream and analgesia should be used.

Clinical holding may be required for

- venepuncture
- cannulation
- lumbar puncture
- insertion of naso-gastric tube
- insertion of urinary catheter
- plastering
- administration of medication
- medical examination
- recording observations
- application of splints for treatments
- radiographic examinations

This list is not exhaustive.

The following should always be considered:

- preparation play
- distraction
- other alternative therapies
- assistance of other professionals

**The use of holding**

There are occasions when control needs to be exercised over a child but the force of physical restraint is not necessary. This can be achieved through the procedure of holding. This is a controlled technique that can be used for a variety of reasons such as:

- helping children, with their permission, to manage a painful procedure quickly and effectively
- diverting a child from destructive or disruptive behaviour by being led away by the hand, arm or by means of an arm around the shoulder
- separating, by guiding away and holding with little or no force, a child engaged in an argument or fight which in itself is not likely to cause serious harm but is nonetheless disruptive and detrimental to the well-being of others.

Collaborative preparation and planning involving healthcare professionals, the child and their parent's/carers is essential when a child requires holding for a clinical procedure. Due consideration should be given for the mature child, and to children who are judged to be able to consent to treatment.

Effective preparation, the use of local anaesthesia, sedation and analgesia together with distraction techniques successfully reduce the need for undue force in the use of proactive immobilisation (e.g. holding a child's arm to take blood or administer an injection to prevent withdrawal and subsequent unnecessary pain to the child). However, 'therapeutic holding' without the child's consent or assent may need to be undertaken against the child's wishes in order to perform an emergency or urgent intervention in a safe and controlled manner (e.g. a lumbar puncture).

Good preparation for procedures may prevent the need for holding.

If staff are aware in advance that they may have to hold a child for a procedure or therapeutic intervention (i.e. to pass a naso-gastric tube or take blood), this should form part of the care plan and the consent of a person with parental responsibility for the child should be sought.

Discuss and agree on the position to be maintained during the intervention period

Principles are set out in Appendix 2.

## 7. TRAINING/ SUPPORT

Training and education should emphasise dealing effectively with situations in order to obviate the need for restraint/restrictive practice. Training should be available for staff members to access that are regularly required to use restraint. It is the responsibility of managers to identify if training is required and for which staff.

Training in the Trust is currently available in the form of:

- Basic Conflict Resolution
- Advanced Conflict Resolution

Further details can be obtained from the Trust Training and Education Department.
E-Learning packages are also available on Conflict Resolution.

Information, awareness and training are also components of other training for example:

- Training to care of those with Dementia.
- Mental Health Act training.
- Training on the care of people with Learning disabilities.
- Training on MCA and DoLs.

A useful document is "A positive and proactive workforce." This guidance sets out a range of information in respect of workforce development and focuses on developing workers so they can work in a positive and proactive way to minimise all forms of restrictive practice.

Training should be available for staff members who care for children and young people and may be required to use restrictive physical intervention and therapeutic holding.

Staff within Children's Services, such as play staff, can act as a resource for other practitioners within the organisation particularly in respect of distraction techniques, support through play and communication with children and young people. Advice can be sought via the Children's Services Matron, bleep holder or from play staff directly.

## 8. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

It is the responsibility of the Care Group management teams to put systems and processes in place to achieve the above and monitor staff awareness and understanding and compliance with this policy. This should include:

- Roles and responsibilities,
- Risk assessment,
- Documentation e.g. case note reviews,
- Incident figures and review of any incidents recorded through the Datix Adverse Incident reporting system,
- Monitoring of training undertaken and its impact.

| What is being Monitored | Who will carry out the Monitoring | How often | How Reviewed/ Where Reported to |
|---|---|---|---|
| Adverse incidents reported on Datix | Care Group Management Teams | On an annual basis or more frequently if issues identified | Care Group Governance Group |
| Policy compliance | Care Group Management Teams | Annual Basis | Care Group Governance Group |
| Incidents where there is a safeguarding element | Safeguarding Team | Annual overview plus individual incident reviewed | Strategic Safeguarding People Board |

## 9. DEFINITIONS

Section 6 (4) of the Mental Capacity Act 2005 states that someone is using **restraint** if they:

- Use force or threaten to use force to make someone do something they are resisting
- Restrict a person's freedom of movement, whether they are resisting or not
- Restraint is the use of threat or force to help carry out an act which a person is resisting

**Best interests**
Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests, which are set out in section 4 of the act, and in the non-exhaustive checklist in 5.13 of the Mental Capacity Act 2005 Code of Practice.

**Containing**
Physical restraint or barriers to prevent a person leaving, harming themselves, or causing serious damage to property.

**De-escalation**
Involves making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems.

**Deprivation of liberty**
Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.

**Mental capacity**
The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the Mental Capacity Act 2005.

**Types of restriction/restraint**
Restrictive practice is not confined to physical restraint: it also refers to actions or inactions that contravene a person's rights. Listed below are some restrictive categories. It must be remembered that to apply any of these to an individual they must have a lawful and legitimate right and reason to do so. The following list is not exhaustive.

There is no precise legal definition of what constitutes restraint but in broad terms, restraint means restricting someone's liberty, preventing them from doing something they want to do. For the purposes of this document, restraint should be viewed as an intervention that prevents a person from behaving in ways that threaten or cause harm to themselves, to others or to property (Duff et al. 1996).

**Chemical restraint**
A drug or medication used to manage a patient's extremely violent or aggressive behaviour. Chemical restraint may be required in the situation of a sudden acute incident/aggressive

situation or to maintain patient safety on an ongoing basis. Pharmacy and expert/specialist advice should be sought.

**Physical restraint**
Physical restraint is the positive use of force in order to protect a person from harming themselves, or others or seriously damaging property. Physical restraint is **only** permissible in circumstances to avert an immediate danger or significant injury to the person or another individual, avoid immediate serious damage to property, when any other course of action would be likely to fail. Physical restraint should avert danger by preventing and deflecting a person's action or by removing the physical object. **Averting harm by causing or threatening hurt, pain or distress is always unacceptable.** The objective of any restraint is to maintain the safety of staff, other persons present and the subject where practicable, by establishing an appropriate degree of control of the aggressive or violent behaviour.

**Restrictive physical intervention**
Direct physical contact between persons where reasonable force is positively applied against resistance to either restrict movement or mobility or to disengage from harmful behaviour displayed by an individual (Welsh Assembly Government, 2005). It can encompass a range of approaches (Hart, Howell, 2004) and should only be used to prevent serious harm.

**Therapeutic Holding**
This means immobilisation, which may be splinting or by using limited force. It is a method of helping a person, with their permission, to manage a painful procedure quickly and effectively. Holding is distinguished from restraint by the degree of force and the intention (RCN, 2010). Within this policy there is a focus on children and young people, but principles can be applied to adults also.

## 10. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 5.

## 11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

| | |
|---|---|
| Equality Analysis Policy | CORP/EMP 27 |
| Health and Safety Policy | CORP/HSFS 01 |
| Mental Capacity Act 2005 Policy and Guidance including DoLS | PAT/PA 19 |
| Missing Patient Policy | PAT/PS 1 |
| Consent to Examination or Treatment Policy | PAT/PA 2 |
| Policy for the Reporting and Management of Incidents and Near Misses | CORP RISK 13 |

| | |
|---|---|
| Privacy and Dignity Policy | PAT/PA 28 |
| Risk Identification, Assessment and Management Policy | CORP/RISK 30 |
| Safeguarding Adults Policy | PAT/PS 8 |
| Safeguarding and Promoting the Welfare of Children | PAT/ PS 10 |
| The Safe Use of Safety Sides | PAT/PS 5 |
| Aggressive and violent behaviour toward staff policy | CORP/HSFS 5 |

## 12. REFERENCES AND FURTHER READING

Department of Health/Skills for Health/Skills for Care. (2014) *A positive and proactive workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.*

Department of Health. (2001) *Seeking consent: working with older people*. London: TSO

Department of Health. (2002) *Listening, Hearing and Responding*. London: TSO

Department of Health. (2003) *National Service Framework for Children, Young People and Maternity Services*. London: TSO

Department of Health. (2005) *The Mental Capacity Act 2005*. Retrieved Dec 2011 from http://www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm.

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

Department of Health. (2009) *Deprivation of Liberty Code of Practice*.

Duff, L, Gray, R, & Bristow, F. (1996) The use of control and restraint techniques in acute psychiatric units.
*Psychiatric Care, 3*(6), 230-234.

Great Britain. (2004) *The Children Act 2004*. London: TSO.

NICE. (2005) *CG 25 Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.* London: NICE

NHS Protect. (2014) *Meeting needs and reducing distress: guidance on the prevention and management of clinically related behaviour in NHS settings.*

Nursing & Midwifery Council. (2008) *Code, standards of conduct, performance and ethics for nurses and midwives*. London:

Power, KJ. (2002) Implications of the Human Rights Act 1998. *Paediatric Nursing, 14(4),* 14-19.

Royal College of Nursing (1989) European Conventions on the Rights of the Child, Consent and Capacity Assessment

Royal College of Nursing. (2008) *"Let's talk about restraint" Rights, risk and responsibilities*

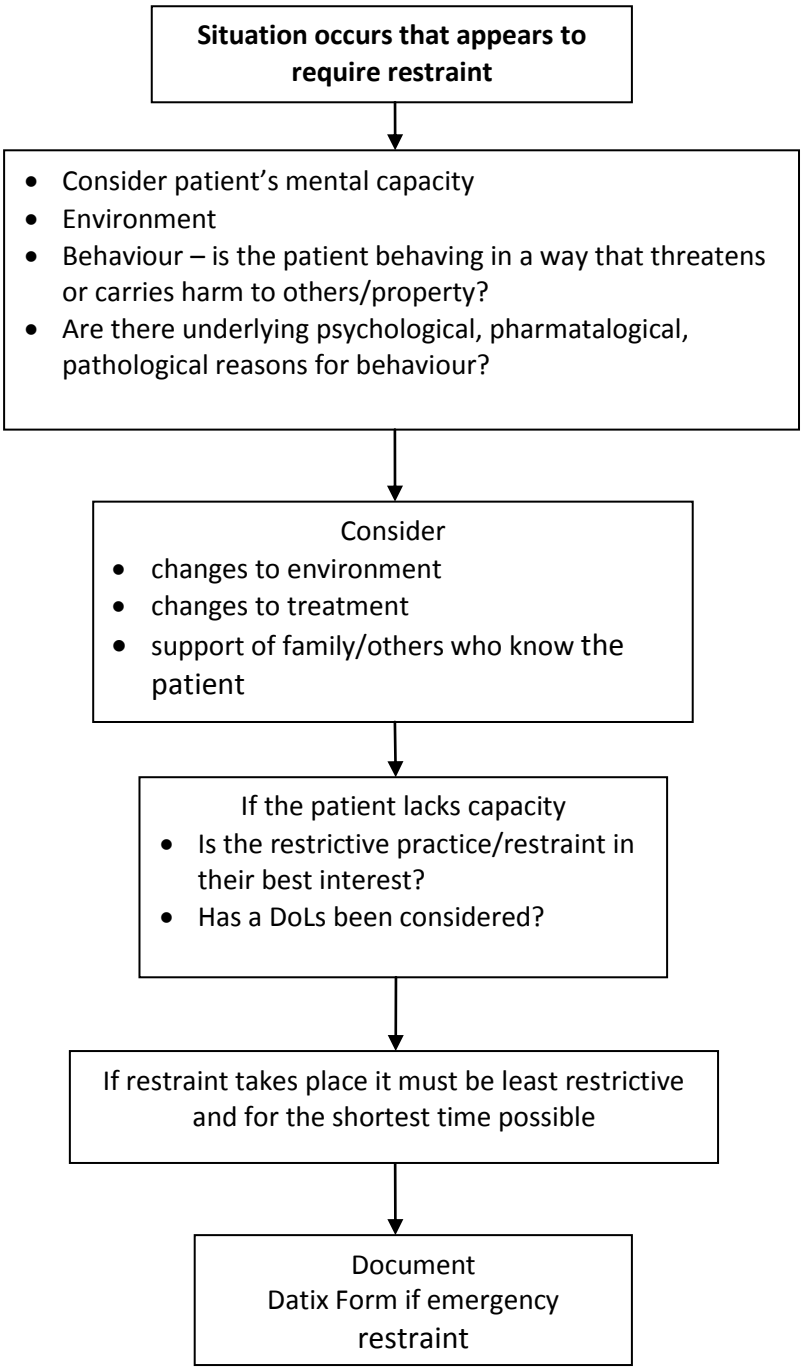
Royal College of Nursing. (2010). *Restrictive physical intervention and therapeutic holding for children and young people. Guidance for nursing staff*

***SCIE*** At a glance 16: Managing risk, minimising restraint (2009)
http://www.scie.org.uk/publications/ataglance/ataglance16.pdf

Patient Safety Alert: *The importance of vital signs during and after restrictive interventions/manual restraint*
Alert reference number: NHS/PSA/W/2015/011 3 December 2015

# APPENDIX 1

## Practical Guidance on restraining adults



# APPENDIX 2

**Principles for the Use of Restraint, Holding and Immobilisation - Children and Young People**

**The child's safety is of paramount importance**

Talking and listening should always be the first approach. Actions and decisions are clearly explained

Parental presence and involvement should be encouraged. Parental wishes should be sought as far as being present and what involvement they would want to have in the process.

Each patient should be individually assessed so that his or her care maximises therapeutic benefits, and minimises dangers from risk.

Staff should take steps in advance to avoid the need for physical restraint, through dialogue and diversion. The child should be warned verbally that physical restraint might be used if they resist.

Staff should have good grounds for believing that immediate action is necessary to prevent a child from significantly injuring themselves or others or causing significant damage to property.

Every effort should be made to secure the presence of other staff before applying restraint. These staff can act as assistants and witnesses.

Staff should be aware of the child's airways and breathing whilst being restrained. The restraint should be ceased immediately if concerns arise.

Staff must take into account how the incident is perceived by the other children and families in the vicinity.

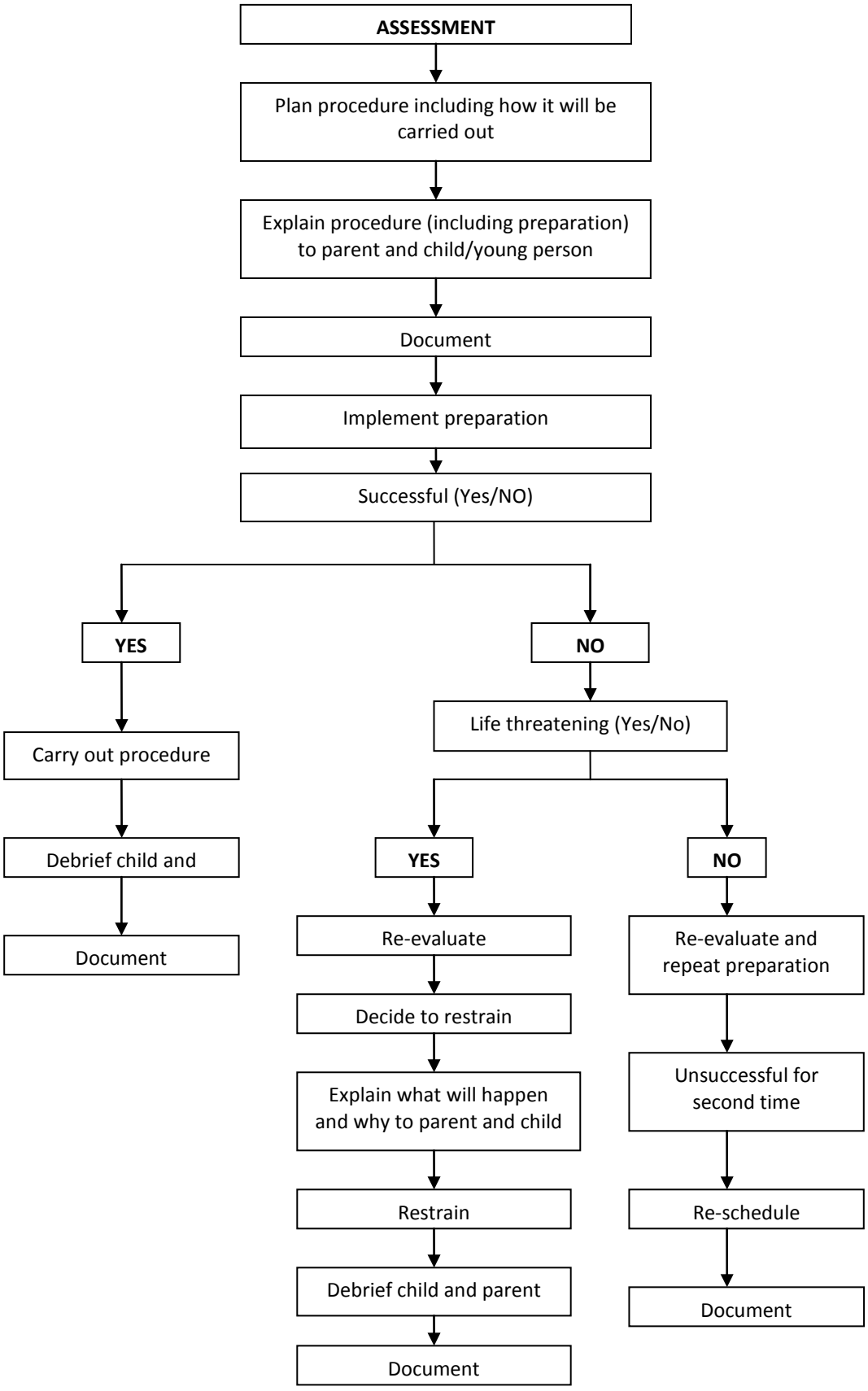
The level of restraint used should be proportionate to the risk of immediate danger or injury.

Restraint should be gradually relaxed, as soon as possible and safe to do so, to allow the child to regain self-control.

***IN A LIFE THREATENING SITUATION THE ABOVE MAY NOT APPLY - In some situations restrictive physical intervention is vital to the child's survival. In this instance, the decision to restrain must be documented accordingly.***

# APPENDIX 3

## Quick Reference Guide – Holding of Children and Young People



# APPENDIX 4

## Stages for Clinical Holding of Children Undergoing Clinical Procedures

**Stage 1: Assessment / explanation**

- Risk assessment to plan procedure, environment and equipment.
- Explain procedure, preparation and possibility of clinical holding to parent and child (Consider child's age and stage of development, use non-medical vocabulary, consider non-English speaking families).
- Children with special needs may need more time and preparation. Children with previous hospital / painful experiences need to have that taken into account.
- Ensure parent and child have a good understanding, have been shown equipment, and the child is comfortable with person performing procedure.
- Potential risk involved at each stage.

**Stage 2 – Have you considered?**

- Play
- Distraction
- Other alternative therapies e.g. distraction / guided imagery
- Analgesia
- Sedation

**Stage 3 – Is the child ready to proceed?**

- If not go back to stage 1
- If yes document what has been discussed and proceed

**Stage 4 – Clinical Holding – Is it necessary? Who requested this procedure and is it vital that it is carried out at this time?**

- Who is making the decision?
- Consent to be obtained if clinical holding to be carried out.
- Who is carrying it out?
- It requires two people to make the decision (this can include the carer)
- All health professionals need to feel competent and confident in carrying out the procedure.

# APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

| Service/Function/Policy/Project/ Strategy | CSU/Executive Directorate and Department | Assessor (s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| Restrictive Interventions | Safeguarding | Deborah Oughtibridge | Revised policy | 8-6-15 |

**1. Who is responsible for this policy?** Safeguarding

**Describe the purpose of the service / function / policy / project/ strategy?** Outlines principles and practice guidance for the use of restriction/restraint including guidance on holding and immobilisation.

**2. Are there any associated objectives?** Compliance with the Care Quality Commission Standards and safeguarding standards

**3. What factors contribute or detract from achieving intended outcomes?** – Prompt recognition and adherence to policy

**4. Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** No

- **If yes, please describe current or planned activities to address the impact**

**5. Is there any scope for new measures which would promote equality? No**

**6. Are any of the following groups adversely affected by the policy? No**

| Protected Characteristics | Affected? | Impact |
|---|---|---|
| a) Age | No | |
| b) Disability | No | |
| c) Gender | No | |
| d) Gender Reassignment | No | |
| e) Marriage/Civil Partnership | No | |
| f) Maternity/Pregnancy | No | |
| g) Race | No | |
| h) Religion/Belief | No | |
| i) Sexual Orientation | No | |

**7. Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box**

| Outcome 1 ✓ | Outcome 2 | Outcome 3 | Outcome 4 |
|---|---|---|---|

**Date for next review:** May 2018

**Checked by:** **Deborah Oughtibridge** **Date: 8/6/15**