

Hospital Restraint Policies

AAGBI POSITION STATEMENT

SEPTEMBER 2013



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

AAGBI Position Statement on Hospital Restraint Policies

Council of the AAGBI has recently been made aware of the development of “restraint” policies in some hospitals in which trainees in anaesthesia form part of an emergency response team and may be asked to sedate agitated or aggressive patients.

The use of physical, mechanical or pharmacological restraint is a complex legal, ethical and clinical issue that requires careful consideration before the creation of teams that may be asked to provide restraint. Such restraints should only be employed under the strict control of written policies that have been developed, agreed and implemented after clinical, legal, and managerial input, and which must take account of relevant legislation such as the Mental Capacity Act 2005 and the Adults with Incapacity Act (Scotland) 2000. Decisions about the use of restraint must be taken in accordance with such policies and by a multidisciplinary team. The decision to use pharmacological restraint by an anaesthetist should be supported by a consultant anaesthetist, and the administration of sedative agents outside of controlled environments such as operating theatres, critical care units or emergency departments must only be performed by experienced anaesthetists who are aware of the risks inherent in such practice and who have assured themselves that a full range of appropriate equipment and monitoring, as well as trained assistance, is available.

Council of the AAGBI does not believe that trainees in anaesthesia should be involved in pharmacological restraint except in extraordinary circumstances and after consultation with a consultant anaesthetist, and should refer any requests for pharmacological restraint to a supervising consultant anaesthetist.

We attach with permission a sample Restraint Policy active in Imperial College Healthcare NHS Trust [1], which incorporates advice from NICE [2].

1. Imperial College Healthcare NHS Trust Restraint Policy
2. <http://www.nice.org.uk/nicemedia/pdf/cg025niceguideline.pdf>

RESTRAINT

Procedural Guidance



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2 INTRODUCTION

- 2.1 The use of restraint is an emotive issue involving challenging and difficult decisions about care and treatment. If an action fits the definition of restraint it is not necessarily unacceptable or wrong. This policy seeks to outline the circumstances in which restraint is justified and outlines the procedure for carrying out restraint as a therapeutic intervention, in order to maintain the balance between independence and safety. It also outlines the procedure to follow when considering the use of restraint for patients receiving care and treatment and the procedure for raising concerns regarding possible abuse of restraint.
- 2.2 The most relevant legal definition of restraint in England is that found in the Mental Capacity Act (2005) and its amendments. Section 6(4) of the Act states that someone is using restraint if they:
- use force – or threaten to use force – to make someone do something that they are resisting, or
 - restrict a person's freedom of movement, whether they are resisting or not
- 2.3 An alternative plain English definition is offered by the Royal College of Nursing (RCN) 'stopping a person doing what they appear to want to do'.

3 DEFINITIONS

There are a number of different types of restraint:

3.1 Physical Restraint

One or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving. Technological surveillance is used often to alert staff that a person is trying to leave or to monitor their movement. Whilst not restraint in itself, they could be used to trigger restraint.

3.2 Mechanical Restraint

Involves the use of equipment to restrict movement (e.g. arranging furniture to restrict movement, bed rails, mechanical locks, mittens etc.).

3.3 Chemical Restraint

Is the use of medication for the purpose of alleviating or managing symptoms or behaviours associated with an underlying psychological condition. This most commonly includes sedatives, anti-muscarinics, anxiolytics and anti-psychotic drugs. Chemical restraint may be achieved through **rapid tranquilisation** which is the ability to achieve fast and targeted control of the problem behavioural symptom without producing unnecessary sedation or impacting on the quality of care.

3.4 Psychological restraint

Can include constantly telling someone not to do something or depriving individuals of equipment or possessions which enable them to do what they want to do (e.g. glasses, hearing aids, keeping the person in nightwear etc.)

3.5 Restraint may be used either (a) reactively i.e. in response to violence or to prevent harm or (b) proactively to support necessary treatment or where an assessment has indicated that an individual is likely to pose a risk to self or others.

4 SCOPE

4.1 This policy only covers individuals receiving care or treatment in at Imperial College healthcare NHS Trust (“the Trust”).

4.2 It does not cover:

- The management of violence and aggression in visitors or other individuals found on Trust premises i.e. ‘non-therapeutic’ restraint. Please refer to the Trust Policy for the Management of Violence and Aggression
- The Management of Non-anaesthetic Procedural Sedation. Please refer to the Trust [Non-anaesthetic Procedural Sedation policy](#)
- The use of bed rails which are covered in the Trust [Falls Prevention](#) policy

4.3 This procedural guidance must be read in conjunction with the Trust policy for the Management of Violence and Aggression. Where appropriate, wards and departments should have locally agreed policies and procedures in place in support of this procedural guidance.

5 FULL GUIDELINE

5.1 The legal framework

Like any member of the public, under common law staff can use reasonable force to prevent harm to themselves or others. However, inappropriate use of any form of restraint can constitute assault under criminal law or negligence under civil law therefore it is important for staff to have an understanding of the legal framework.

5.1.1 **The Human Rights Act 1998** states that the use of restraint should be justified by a clear rationale. This should explain why other considerations are believed to override the individual freedom of action.

5.1.2 A person with capacity may consent to restraint being used. For example a patient might request bed rails for example. An individual’s choice should be included in a risk assessment and documented in the care plan.

5.1.3 **The Mental Capacity Act 2005** provides the statutory framework when working with those people who may lack capacity to make certain decisions. For further detailed guidance on the Act, including it’s key principles and making an assessment of capacity, please refer to the main Code of Practice (2007) and the Trust MCA 2005 Interim Procedural Guidance and the Trust [Consent policy](#).

5.1.4 The Act sets out the conditions in which an act may be planned that would constitute restraint of a person who lacks capacity. Any action intended to restrain a person can be



legal if the person consents (as long as there has been no coercion) though staff must act within the scope of their professional boundaries and the law.

5.1.5 Restraint in the absence of consent is necessary when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm. The decision to restrain, should wherever possible, be multidisciplinary, and involve senior clinicians. Any staff carrying out restraint will need to demonstrate with evidence that the criteria to carry out restraint were met (i.e. necessity and proportionality). They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible (Code of Practice Mental Capacity Act 2005 (2007)). The reason for the restraint, risk assessments and the evidence of regular review must be clearly documented.

5.1.6 Where restriction or restraint on freedom of movement is frequent, cumulative and on-going this may be considered as a deprivation of liberty. There are separate provisions in the Act to safeguard individuals deprived of their liberty (see Code of Practice (2008) and Trust DOLS policy and procedure). However, appropriate use of restraint usually falls short of deprivation of liberty.

5.1.7 **The Mental Health Act (MHA) 1983 amended by the MHA 2007** provides the authority to detain individuals for assessment and or treatment of a mental disorder. The authority to restrain a client is allowed if the following conditions are satisfied:

- the patient lacks capacity in relation to the matter in question
- the member of staff reasonably believes that it is necessary to restrain in order to prevent harm to the client

5.1.8 Therefore restraint may be considered in the following circumstances, where the patient is:

- Displaying behaviour that is putting themselves at risk of harm
- Displaying behaviour that is putting others at a risk of harm
- Requiring treatment by legal order (e.g. MHA 1983 amended 2007)
- Requiring life saving or urgent treatment
- Needing to be maintained in secure settings

5.2 Principles of risk assessment

5.2.1 Research studies indicate that the use of restraint carries with it risks to both patients and staff. For example physical restraint in acute settings increases the risk to staff of adverse outcomes which includes direct and indirect injuries, as well as significant negative psychological effects (Evans et al, 2002; Huffman, 1998). For example:

- Patients will fall further if they have to climb over bedrails to get out of bed
- The risk of developing pressure ulcers, infection, malnutrition and decreased muscle mass is increased in people who are immobilised for long periods

- If patients are unable to use the toilet because of being restrained in a chair or in a bed, incontinence is inevitable
- The use of restraint may also give rise to behavioural changes such as violence or alternatively an apathetic withdrawn state

5.2.2 Restraint should only be considered following a thorough clinical assessment which includes an assessment of the risk to and posed by the patient from their behaviour, except in an emergency.

5.2.3 In most circumstances restraint can be avoided by positive changes to the provision of care and support. Plans should be in place to correct any identifiable physical or psychological causes of confusion, delirium or agitation (**see Appendix 1** and the [Trust Guidelines for the Management of Delirium in the Elderly](#)). The use of restraint should only be considered as a last resort and be in proportion to the risk of harm presented by the person to either themselves or others. Suggestions for strategies to use as an alternative to restraint are included in **Appendix 2**.

5.2.4 Except in emergencies, individual decisions regarding restraint should be discussed within the multi-disciplinary teams, with the involvement of the individual and carers as far as possible.

5.2.5 Each clinical assessment should include an assessment of capacity (see the trust MCA interim procedural guidance for further details of assessment of capacity). Where an individual lacks capacity staff should always attempt to improve the person's ability to make decisions and explain what they are doing and attempt to seek understanding and agreement. On making an initial assessment of capacity, where staff suspect a mental health problem they should make a referral to a relevant mental health professional.

5.2.6 The use of restraint can only be justified in the best interests of the patient or to prevent harm to others. If any form of restraint is used as a medical intervention as part of a patient's care or treatment for a prolonged period of time, then the consultant in charge of the care and treatment must assess the case to decide whether this constitutes a deprivation of liberty under the Mental Capacity Act 2005. For further details please refer to the DOLS Code of Practice (2008) and the Trust's DOLS policy and procedure.

5.2.7 Mittens may be applied by nursing staff where their use are in the best interest of the patient. This assessment needs to be clearly documented in the notes. Vest, belt or cuff devices specifically designed to stop people getting out of beds or chairs are in relatively common use in hospital in many countries outside the UK, including in Europe, the USA and Australia. In accordance with RCN guidance (2008), staff must be aware that devices are not acceptable for use in the Trust.

5.3 General considerations for vulnerable patients

5.3.1 The following guidance may be useful to assist decision-making in relation to managing aggression in vulnerable patient groups or using restraint (holding) to facilitate investigation or treatment. Patients who are confused or have impairments affecting the mind are likely to require careful assessment to identify particular triggers or ways of working proactively to

avoid the need for restraint. It is likely that working with professionals and carers who are familiar with the patient will be essential in achieving good outcomes for patients. An Independent Mental Capacity Advocate (IMCA) must be engaged where patients are 'unbefriended'. A person is unbefriended if they do not have any friends, family or anyone else to support them other than paid professionals. An IMCA must be appointed to assist an unbefriended person in two specific situations (1) when a decision is being made by the NHS about providing 'serious medical treatment' or (2) when certain changes in the person's living arrangements are being considered by the agencies supporting the person. Some treatment decisions in patients lacking capacity may require a decision from the Court of Protection. Please refer to the Trust MCA interim procedural guidance and Deprivation of Liberty Safeguards policy for further details.

5.4 Patients with Learning Disabilities

- 5.4.1 Patients with learning disabilities may present as confused or become aggressive in response to new situations or experiences that they do not understand; this may be complicated further if the patient has impairments with regards to communication. A sensitive assessment may therefore assist to identify those situations where a patient may be under stress and more likely to respond adversely. It would be useful for example to understand if a patient is able to wait for prolonged periods or to fast prior to a procedure. Reasonable adjustments may be necessary to ensure that patients receive care and treatment that is appropriate to their needs. It is usually helpful to involve their family members and / or carers in de-escalating the situation.
- 5.4.2 It may be appropriate to use restraint or holding to facilitate treatment or investigation where a patient with learning disabilities lacks capacity to make a decision regarding a planned intervention and that the intervention has been assessed in the patient's best interests. The same conditions apply as with any patient who may fall under the scope of the Mental Capacity Act 2005.

5.5 Patients with mental health problems

- 5.5.1 The National Institute of Clinical Excellence (NICE) (2005) provides specific recommendations for the [short-term management of disturbed /violent behaviour in in-patient psychiatric settings and emergency departments](#).

5.6 Dementia

- 5.6.1 In its Dementia guidance, NICE (2006) provides specific [non-pharmacological and pharmacological recommendations on interventions for non-cognitive symptoms and behaviour that challenges in people with dementia](#). However, restraint is rarely required in patients with dementia.
- 5.6.2 Anti-psychotics should be avoided in patients with Lewy Body dementia (LBD). Patients with LBD (characterised by fluctuating cognition, Parkinsonian features and visual hallucinations) are susceptible to severe and sometimes irreversible side effects from traditional anti-psychotics.



5.6.3 Newer anti-psychotics have been associated with an increased risk of stroke when used in dementia.

5.7 Confused patients

5.7.1 The majority of confused patients in an acute setting have delirium. Please refer to the Trust [Guidelines for the Diagnosis and Management of Delirium in the Elderly](#) for further guidance.

5.8 Children

Nursing staff working with children or young people should consult the RCN's '[Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff](#)' (2010) and the BMA's 'Consent, Rights and Choices in Health Care for Children and Young People' (2001). This sets out the rights of the child and the legal framework surrounding these rights including the Human Rights Act 1998 and the European Convention on Human Rights of the Child 1989.

5.9 Urgent Challenging Behaviour: physical restraint and rapid tranquilisation – overarching considerations

5.9.1 Physical restraint and rapid tranquilisation are management strategies for those displaying challenging behaviour and are not regarded as primary treatment techniques. (Seclusion is not employed in the Trust). These interventions must not be attempted unless an individual has been locally trained and deemed as competent in the use of these interventions. Where appropriate, these guidelines will be supported by a local policy.

5.9.2 Co-existing medical conditions and prescribed medications, as well as the use of illicit substances, must be considered as part of an overall assessment. Particular care should be taken in those with an underlying respiratory condition since sedation risks exacerbating / causing respiratory failure or respiratory arrest. Use of sedation in patients with chronic obstructive pulmonary disease (COPD) without plans for total ventilatory support must be the exception. In those exceptional circumstances, when such medication is used, close monitoring of the patient in the setting of a high dependency unit is mandatory.

5.9.3 They should only be considered once de-escalation and other strategies have failed. Clinical need, the safety of service users and others and, where possible, advance directives should be taken into account when making decisions on which interventions to use. The intervention selected must be a reasonable and proportionate response to the risk posed by the patient. Furthermore:

- **Equipment**
Resuscitation equipment must be available within 3 minutes in any clinical setting in the Trust where these interventions might be used, and
- **Personnel**
At all times, a doctor should be available to quickly attend an alert by staff members when these interventions are implemented.

5.10 Physical restraint

5.10.1 In addition to the points above:

- There are real dangers with physical intervention.
- Physical intervention should be avoided if at all possible.
- Physical intervention should not be used for prolonged periods, and should be brought to an end as soon as possible.
- The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation, and applied for the shortest possible time.

5.10.2 Procedure

- If possible move other patients and visitors away
- Clinical staff should alert security staff, who will inform the Police as appropriate, as soon as they require assistance. Where the Police are present, they should take the lead.
- Physical restraint should only be administered by at least two trained staff (ideally security staff) with the assistance of the nursing and medical team as appropriate. A senior clinician must be able to assure security staff that they are prepared to take responsibility for the request to restrain.
- Continue to employ de-escalation techniques throughout
- One member of staff trained in managing aggression/violence and assessed as competent to use physical interventions must assume control throughout the process. He or she should be responsible for:
 - protecting and supporting the patient's head and neck, where required
 - leading the team through the process
- The patient's overall physical and psychological well-being must be monitored throughout. The member of staff assuming control must identify a designated clinical (senior nurse or doctor) who is responsible for:
 - ensuring the patient's airway and breathing are not compromised
 - ensuring vital signs are monitored
- Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area.
- To avoid prolonged physical intervention, consider rapid tranquillisation (where available) as alternatives.
- Every effort should be made to use skills and techniques that do not use the deliberate application of pain.
- The application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, other service users or others.

5.10.3 Wherever possible, restraining persons on the floor should be avoided. If, however, the floor is used then this should be used for the shortest period of time and only for the purpose of gaining reasonable control. **In exceptional situations where the restrained person needs to be held in a face down position, this should be for the shortest possible time to bring the situation under control.**

5.10.4 Post-restraint, the person who has been restrained will be reviewed for placement on the appropriate level of observation (see Trust's Observation policy), for a period of up to twenty-four hours.

5.10.5 During this time physical observations must be recorded (consciousness, pulse, blood pressure, respirations, temperature and oxygen saturations as a minimum) and the observing nurse be fully aware of the possibility of restraint/positional asphyxia. If consent and co-operation for these observations is not forthcoming from the person subject to this process, then it should be clearly documented in their records why certain checks could not be performed and what alternatives have taken place.

5.11 Rapid tranquilisation

5.11.1 The aim of rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to the patient and others. Administering rapid tranquilisation will often require initial physical restraint, therefore, in addition to the points above:

5.11.2 Procedure

- Rapid tranquilisation (chemical restraint) must only be used under medical supervision.
- Appropriate specialist staff should be contacted immediately after the administration of rapid tranquillisation.
- The individual must be kept informed during the procedure and should be able to respond to communication throughout.
- The procedure must be appropriately documented.
- The person should be regularly monitored. This is especially important following a prolonged or violent struggle where the person has been subject to enforced medication or rapid tranquilisation or if the person is suspected to be under the influence of alcohol or illicit substances or if the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity (when face down), asthma, heart disease etc.
- The patient should be able to respond to communication throughout the period of rapid tranquilisation. The aim of the rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others.
- Medication for rapid tranquilisation, particularly in the context of physical intervention, should be used with caution owing to the following risks (NICE, 2005):
 - Loss of consciousness instead of tranquilisation
 - Sedation with loss of alertness
 - Loss of airway
 - Cardiovascular and respiratory arrest
 - Interaction with medicines already prescribed or illicit substances taken
 - Possible damage to patient-staff relationship
 - Underlying coincidental physical disorders

- 5.11.3 After rapid tranquilisation is administered, the patient must be nursed in the recovery position (where safely possible). Staff should monitor and record pulse, blood pressure, respirations, hydration, Glasgow Coma Scale (GCS) score and oxygen saturations using pulse oximeters where possible (NICE, 2005). At a minimum, observations must be conducted every 15 minutes for the first hour, then hourly for four hours or until the patient becomes more active again. More frequent monitoring may be instigated dependent on the on-going clinical assessment which must be clearly documented in the patient record.
- 5.11.4 Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the patient understands why this has happened. Where possible, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the patient record. **If verbal consciousness is lost a doctor must be called and the emergency life support procedure followed.**
- 5.11.5 If staff are aware that a patient has an infectious or contagious diseases, the advice of the Infection Control should be sought.

5.12 Rapid tranquilisation algorithms (18 years to 64 years)

It is recognised that rapid tranquilisation is principally undertaken in the Emergency Department (ED). If rapid tranquillisation in adults is thought necessary, consider oral lorazepam as the first-line drug of choice especially when prior to formal diagnosis or where there is any uncertainty about previous medical history (including history of cardiovascular disease, respiratory, dementia or uncertainty regarding current medication / the possibility of current illicit drug/alcohol intoxication). The minimum effective dose of medication should be used as higher doses increase the risk of extrapyramidal side effects (EPSEs). BNF maximum doses should only be exceeded in extreme circumstances and when doses are used outside of the BNF (i.e. the manufacturers summary of product characteristics) this is unlicensed. If there is a confirmed history of previous significant psychotropic exposure caution must be exercised in the administration of further anti-psychotics to ensure the maximum doses are not exceeded. The risk of QTc prolongation and associated arrhythmias is also significantly increased with high dose anti-psychotics and cardiac monitoring should be considered as appropriate, especially with haloperidol. Drugs should not be mixed in the same syringe for IM administration. The PO and IM routes are preferable and the IV route should only be used in very exceptional circumstances. The oral and IM doses must be prescribed separately as the doses via different routes may not be bioequivalent.

- 5.12.1 Please refer to **Appendix 3** for a detailed treatment algorithm. IV flumazaniil (benzodiazepine antagonist) and anticholinergics (IM or IV procyclidine) must also be readily available as appropriate.

5.13 Considerations for older adults (65 years and over)

The physical fitness of older adults must be considered. Older adults may have poor muscle perfusion producing erratic absorption of intra-muscular drugs into the bloodstream. Particular care should be taken to establish co-existing medical problems and prescribed medicines, the risk of accumulation of drugs and the possibility of delirium (see **section 5.2.3**). Elderly patients will also be more likely to experience adverse effects from drugs.

5.13.1 Please refer to **Appendix 4** for a detailed treatment algorithm.

5.14 Considerations for children (those under 18 years)

A decision to initiate rapid tranquilisation in children should only be made by a Consultant Paediatrician.

5.15 Third party requesting restraint

5.15.1 Occasionally family or carers may request that restraint is used for example to prevent falls, where staff have undertaken a risk assessment and agreed alternative strategies. Where a person is able to give consent to restraint being applied then it is their decision. Where a person is assessed as lacking capacity to give consent, the application of the restraint has to be in their best interests and the best interests decision maker is the person that will be carrying out the act and not the family. By involving family in all stages of risk assessment and planning on how to reduce the need for restraint this should be avoided, but ultimately the clinical team will make the decision in their best interests. If restraint is applied on the say so of the family but it is deemed illegal then it will be the hospital that is challenged in court and not the family.

5.16 Covert administration of medicine

5.16.1 Members of staff able to administer medicines are outlined in the Trust [Administration of Medicines policy](#). The Nursing and Midwifery Council (NMC) position statement regarding [the Covert administration of medicines: Disguising medicine in food and drink](#) should be adhered to by Registered Nursing and Midwifery staff when considering the covert administration of medicines. In summary, disguising medication in the absence of informed consent may be regarded as deception. However, a clear distinction should always be made between those patients who have the capacity to refuse medication, and those who lack this capacity. Where adult patients are capable of giving or withholding consent to treatment, no medication should be given without their agreement. Among those who lack this capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication and others who would be aware if they were not deceived into thinking otherwise. The Registered Nurse or Midwife must be sure that what they are doing is in the best interests of the patient, and be accountable for this decision. The Registered Nurse or Midwife will need to ascertain whether they have the support, or otherwise, of the rest of the multi-professional team, and make their own views clear. Even with completed risk assessments and guidelines, and following the involvement of all relevant parties, it is imperative that good record keeping should support duty of care arguments.

5.17 Documentation

5.17.1 Ensure that a comprehensive record is made of any intervention necessary to manage an individual's disturbed/violent behaviour, including full documentation of the reason for any clinical decision. This must include completing an online incident report via Datix.

5.18 Raising Concerns

5.18.1 Where staff have concerns regarding the use of restraint, or where another member of staff, patient or another individual raises concerns with a member of staff, this should be raised at the earliest opportunity with the ward manager, matron or lead nurse for that ward or department or an individual's line manager or professional lead as appropriate. A Datix incident report should be made in accordance with the Trust [incident reporting procedure](#). The inappropriate use of restraint must be managed in accordance with the appropriate Trust safeguarding policy ([adult](#) or [children](#)). In situations involving allegations against a member of staff, the Trust [Whistle blowing policy](#) may apply.

5.19 Debriefing and Training

5.19.1 A debriefing must be held within twenty-four hours on any event requiring physical or chemical restraint, which should include all staff involved in the event. Where possible and appropriate, a separate debrief should be offered to the patient concerned and any other individuals involved who are not employed by the Trust. The debriefing should be led by the senior clinician responsible for the area and provide staff and the patient the opportunity to discuss the circumstances resulting in the use of restraint and to identify strategies that could prevent further use of restraints or minimise other potentially adverse outcomes. Documentation of the debriefing should be made in the appropriate record.

5.19.2 The Trust currently provides the following training (for all staff clinical and non-clinical):

- Training in De-escalation and Conflict Resolution as part of mandatory induction which covers the eight key objectives of the NHS Security Management Service. This includes a three hour taught session and the completion of a workbook
- De-escalation and Conflict Resolution as part of statutory / mandatory update

5.19.3 As stated, Physical restraint and rapid tranquilisation must not be attempted unless an individual has been locally trained and deemed as competent in the use of these interventions. The training programme and competency assessment will be outlined in a local policy. All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, will receive ongoing competency training to a minimum of Immediate Life Support (ILS) (as recognised by the Resuscitation Council UK) (which covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators), (NICE, 2005).

5.19.4 Training, competency and the assessment of staff in the use of physical restraint in the management of individuals who are not receiving care and or treatment as a patient in the Trust are beyond the scope of this policy. Further details may be obtained in the Trust Policy for the Management of Violence and Aggression.

The following sections are compulsory and must be completed

6 IMPLEMENTATION

Training required for staff	Yes
If yes, who will provide training	Please give name/post As 5.19
When will training be provided?	Please give date(s) As 5.19
Date for implementation of guideline	Upon ratification

7 MONITORING / AUDIT

All instances where physical or chemical restraint have been identified as needing to be used either a part of a patients care plan (or in an emergency) must be entered as a Datix clinical incident. Clinical incidents will be reviewed on a regular basis as part of CPG governance processes. Where the use of restraint results in a serious untoward incident (SUI) the Trust [SUI policy](#) must be followed.

Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State Directives November 2003.

When will this guideline be audited?	March 2012
Who will be responsible for auditing this guideline?	Please give name/post William Gage, Lead Nurse for Practice Development & Innovation
Are there any other specific recommendations for audit?	no

8 REVIEW

When will this guideline be reviewed?	Please give person/post William Gage, Lead Nurse for Practice Development & Innovation
Please indicate frequency of review: As a guide: <ul style="list-style-type: none"> • Drug related guidance should be reviewed every 2 years • Therapy related guidance should be reviewed every 5 years • Clinical treatment guidance should be reviewed every 3 – 5 years 	2016
Date of next review	Please give month/year January 2016

9 REFERENCES

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[NICE \(2006\) Dementia: Supporting people with dementia and their carers in health and social care London: NICE](#) (last accessed 10.01.2011)

[Nursing and Midwifery Council \(NMC\) \(2007\) Covert administration of medicines: Disguising medicine in food and drink](#) (last accessed 10.01.2011)

[Royal College of Nursing \(2008\) Let's Talk About Restraint: rights, risks and responsibilities London: RCN](#) (last accesses 10.01.2011)

[RCN \(2010\) Restrictive physical intervention and therapeutic holding for children and young people Guidance for nursing staff available London: RCN](#) (last accessed 10.01.2011)

10 GUIDELINE DETAIL

Start Date: (date of final approval by CPG)	Upon ratification	
	Drugs and Therapeutics Committee (Rapid tranquillisation algorithms only)	April 2011, reviewed June 2011, V14 approved by Chair's action 5 September 2012
	Quality and Safety Committee	Ratified as interim policy October 2011; Chairs action taken to fully ratify on 17 th May 2012; V14 ratified 1 st October 2012
Have all relevant stakeholders (Trust sites, CPGs and departments) been included in the development of this guideline?	Please give names/depts <ul style="list-style-type: none"> • Members of the DOLS policy working group • Members of the Mental Health/Mental Capacity Forum • Circulated to CPG Quality and Safety leads for CPG comment • Pharmacy (Anna Pryor) 	
Related documents:	This guideline is to be read in conjunction with the following policy documents: <ul style="list-style-type: none"> • Consent policy • Mental Health Act policy • Mental Capacity Act interim procedural guidance • Falls policy • DOLS policy • Delirium in the Elderly guidelines • Emergency Oxygen in Adults: Administration and prescription 	
Author/further information:	William Gage, Lead Nurse for Practice Development & Innovation	
Document review history:	If applicable – version number; dates of previous reviews V1 first draft V2 (21.1.2011) incorporating comments from DOLS working group V3, V4, V5 (27.1.2011) minor re-drafts V6 and V7 incorporating comments from Pharmacy V7 (31.03.2011) Incorporating comments from Mental Health/Mental Capacity Forum V8 (08.04.2011) incorporating final comments	

	from CPGs V9, 10, 11 and 12 (20.05.2011) incorporating comments from D&TC and Consultant Nurse Critical care; V13 extra information added to section 5.18.1 at the request of Anne Mottram V13.1 minor amendment to single reference V13.2 footer amended to reflect that the document is substantive procedural guidance V.14 amendment to drugs algorithm to reflect withdrawal of olanzipine 10mg for injection	
Next review due	2016	
THIS GUIDELINE REPLACES:	Not applicable	

11 INTRANET HOUSEKEEPING

Key words	Restraint
Which CPG does this belong to?	Nursing Directorate
Which subdivision of the guidelines spine should this belong to?	Nursing: Policies and Procedures
Title for the intranet if different from the document (<i>please note that documents sit alphabetically so should not start with "guideline for..."</i>)	Restraint Procedural Guidance

Appendix 1: Possible physical or psychological causes of confusion, delirium or agitation

The commonest cause of delirium is infection

Alcohol/nicotine addiction Substance abuse	Determine amount, frequency, type of consumption and administer appropriate alternative drug therapies
Central nervous system disorders Psychological or emotional disturbances Personality type	Investigate previous history of such and potential treatment to alleviate problem
Chronic renal, hepatic, cardiac, pulmonary dysfunction	Examine patient Monitor condition, address alterations in blood chemistry
Advanced age (i.e. >65 years) Age is a risk factor for, but does NOT cause delirium	Be aware of multiple aetiologies and medications
Reduced nutrition	Involve Dietician
Vitamin deficiency	Vitamin and mineral screen, trace elements
Dehydration	Examine patient Check electrolytes/fluid balance
Brain trauma and stroke	Examine patient Monitor and report changes in conscious level
Possible drug reaction/interactions	Review drug prescription chart Check for side effects interactions, and incompatibilities & polypharmacy Ask about alcohol intake
Hypoxia/dyspnoea	Check arterial blood gas, oxygen saturation, ventilator settings and function, and adjust to optimise patient's condition
Pain	Assess and monitor pain levels, and ensure adequate analgesia is administered
General discomfort e.g. urinary retention, urinary or faecal incontinence, faecal impaction	Examine patient Change of position Continence assessment
Anxiety/fear/stress	Reassurance and explanation of procedures
Communication difficulties	Re-orientation Provision of appropriate communication aids Minimise isolation as far as possible Ensure participation of family/friends Involve interpreters
Under sedation	Utilise sedation scales, titrate to desired effect Daily sedation holds
Environmental factors	Reduce noise levels to promote comfort
Sleep deprivation	Maximise sleep/minimise interventions Encourage day/night lighting and rest periods. Assess environmental conditions e.g. temperature and adjust accordingly

(adapted from: British Association of Critical Care Nurses Position Statement on the Use of Restraint in Adult Critical Care Units, 2004)

Environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges

<ul style="list-style-type: none"> • Overcrowding • Lack of privacy • Lack of activities • Inadequate staff attention 	<ul style="list-style-type: none"> • Conflicts between staff and carers • Weak clinical leadership • Poor communication between the person with dementia and staff
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(source: NICE Dementia: Supporting people with dementia and their carers in health and social care, 2006)

Appendix 2: Restraint Alternatives (not all alternatives will be suitable in every clinical area or for every patient group. They should be considered as part of an overall risk assessment)

Environment

- Improved lighting & access to natural light
- Easy access to safe outdoor areas
- Non-slip strips on floors & stairs and ensuring a pathway clear of furniture (as an obstruction and a weapon)
- 'Open' care setting which facilitates appropriate observation whilst maintaining privacy
- Appropriately secured with safe exits in the event of an emergency
- Access to a 'day room' (both day and night)
- Stable & consistent team and appropriate bed occupancy

Altering the environment

- If climbing over bedrails at night is a problem, assess and investigate the cause of the restlessness or agitation. The lighting level in the area around the bed can be lowered to reduce disorientation, and the nurse can settle the patient by sitting and talking to them at the bedside for a while. Utilising relatives and friends may also help to calm the restless patient at night.
- A lower height setting for the bed or mattress on the floor may be an alternative solution. (ensure a risk assessment is carried out prior to this being implemented and / or seek the advice of the manual handling trainer)
- Diverting the patient's attention can improve the situation.
- If falling is a risk, walking aids, transfer aids and safety devices might be of use. Advice should be sought from Therapies.
- Comfortable chairs, rather than those incorporating lockable tables or tilting mechanisms should be used.
- Removing wheels from furniture
- If it is felt that the patient cannot be contained within the existing environment, advice should be sought from other departments i.e. it may be more appropriate for the patient to be managed in a psychiatric or neurological rehabilitation setting, or on a quieter environment such as a side room

Care

- Appropriate risk assessment & care planning
- Additional supervision / observation
- Individualised structured daily routines and activities (group and individual)
- Staff known to patients
- Call bell within easy reach
- Change 'bothersome' treatments (e.g. IV to oral, urinary catheters as soon as possible)
- Facilitate napping and encourage time spent in bed as time asleep
- Restlessness may occur because the patient is wet, constipated, or needs to go to the toilet
- Thirst, hunger and warmth are all causes of restlessness
- Medication review and identification and treatment of underlying causes if present
- Permitting wandering

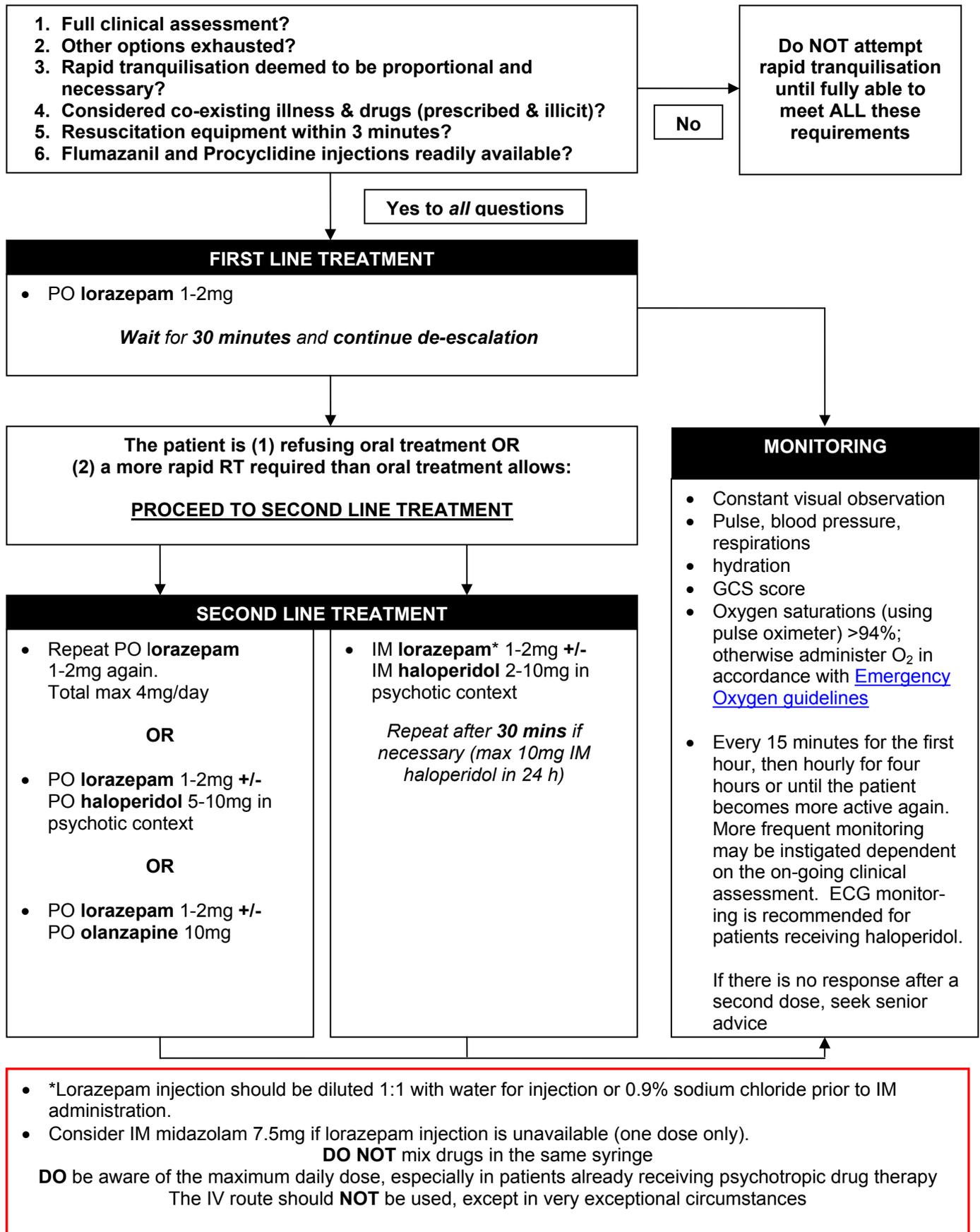
Reorienting to reality

- The healthcare practitioner should identify him / herself each time there is contact with the patient
- The healthcare practitioner must take care to talk with, and not at, the patient, taking account of any degree of deafness

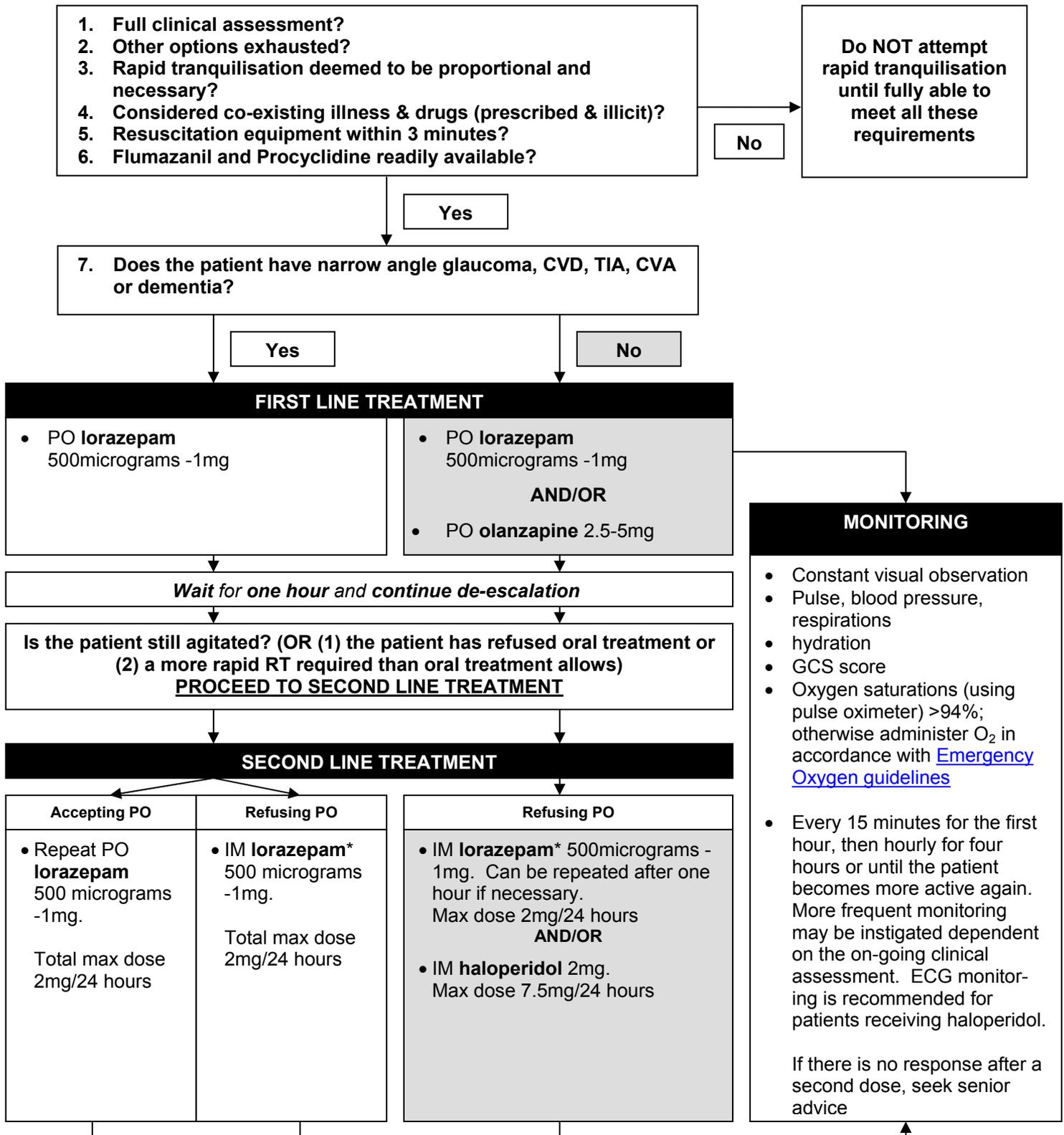
- Familiar objects and people, using the clock, television, radio, a watch, looking at newspapers and dressing appropriately for the time of day or night can all help to orientate the patient
- The healthcare practitioner should encourage the patient to express their true feelings in order to release the frustration and anxiety of being in unfamiliar surroundings with people they do not know

(Source: Joanna Briggs Institute (2002) Best Practice Evidence Based Practice Information Sheets for Health Professionals Physical Restraint – Part 2: Minimisation in Acute and Residential Care Facilities 6(4) pp.1-6)

Appendix 3 Rapid tranquilisation (RT) algorithm (18 years to 64 years)



Appendix 4 Rapid tranquilisation algorithm (over 64 years)



- *Lorazepam injection should be diluted 1:1 with water for injection or 0.9% sodium chloride prior to IM administration.
 - Consider IM midazolam 2.5-7.5mg if lorazepam injection is unavailable.
- DO NOT** mix drugs in the same syringe **DO NOT** prescribe anti-psychotics in Lewy Body dementia.
DO be aware of the maximum daily dose, especially in patients already receiving psychotropic drug therapy. The IV route should **NOT** be used, except in very exceptional circumstances