Policy for Restraint
### Executive Summary:

This Policy is intended for managers, staff and security contractors in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration. This policy should be read in conjunction with the policy schedule.

### Supersedes:

Version 1

### Description of Amendment(s):

This policy will impact on: All Trust Staff

### Financial Implications:

None

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<tr>
<th>Policy Area</th>
<th>Adult Safeguarding</th>
<th>Document Reference:</th>
<th>Effective Date: 1&lt;sup&gt;st&lt;/sup&gt; October 2014</th>
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<tr>
<td>Version Number:</td>
<td>V0.2</td>
<td>Review Date:</td>
<td>September 2017</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Legal Services Manager</td>
<td>Impact Assessment Date:</td>
<td>October 2014</td>
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### APPROVAL RECORD

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<td>Consultation: Deputy Director of Corporate Affairs &amp; Governance Managers Local Security Management Specialists</td>
<td>October 2014</td>
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<tr>
<td>Approved by: Risk Management Sub Committee</td>
<td>October 2014</td>
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<td>Received for information:</td>
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1. Introduction

1.1. East Cheshire NHS Trust is committed to delivering the highest standards of healthcare, and ensuring the safety and welfare of its patients, visitors, and employees.

1.2. The Trust recognises that violence and aggressive behaviour can escalate to the point where restraint may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed.

1.3. Physical intervention should only be considered once de-escalation and other strategies have failed to calm the situation. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, the clinical need, safety of patients and others should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the person.

2. Scope of the Policy

2.1. This policy is intended to provide guidance in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration. For matters of chemical restraint please refer to the Trust’s Rapid Tranquilisation Policy.

2.2. The policy covers all staff and persons within East Cheshire NHS Trust, and others who are acting on behalf of the Trust.

2.3 Section 10 of this policy deals exclusively with restraint issues in the Intensive Care Unit (ICU), where issues of restraint differ from those in the rest of the hospitals within East Cheshire NHS Trust.

3. Definitions

3.1. Restraint
Restraint is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property.

3.2. Physical Restraint
Any manual method, physical or mechanical device, material, or equipment that immobilises or reduces the ability of a person to move his or her arms, legs, body, or head freely.

3.3. Imminent Danger
Any situation or practices in a place of employment which are such that a danger exists which could reasonably be expected to cause death or serious injury.

3.4. Person in Control
The most senior person in an area/ward, who takes responsibility for managing a threatening situation.

4. Policy Statement

The Trust

- Acknowledges that there will be occasions when an individual’s behaviour will necessitate the use of physical or chemical restraint and in extreme cases the withholding / withdrawing of treatment.
- 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 again the risk of harm to themselves, staff and members of the public.
- Pledges that restraint 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, 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 any restraint used is reasonable, proportionate and necessary.
- Will ensure that professional and legal support is made available to any member of staff acting lawfully and in good faith, in situations where aggression or violence (actual or threatened) have led to restraint being applied.

5. Roles & Responsibilities

5.1. Chief Executive
   The Chief Executive has overall responsibility for all Trust polices and ensuring an appropriate process for the production, management and monitoring of polices is in place.

5.2. Director of Nursing, Performance and Quality
   The Director of Nursing, Performance and Quality is the executive director responsible for ensuring that all appropriate polices and procedures are in place and actioned appropriately in relation to Adult Protection.. The Director of Nursing, performance and Quality is responsible for providing assurance to the Trust Board and identifying risk to the organisation in relation to this policy.

5.3. Director of Finance
   The Director of Finance is the executive director responsible for ensuring systems and processes are in place for the provision of Local Security Management (LSMS) services and contracted security services.

5.4. Deputy Director of Nursing and Quality
   The Deputy Director of Nursing and Quality is the senior nurse responsible for safeguarding adults and will ensure that this policy is implemented and used appropriately across the organisation, review key risks and incidents relating to this policy and ensure monitoring is completed and reported back to the Director of Nursing, Performance and Quality.

5.5. Service Heads
   The Service Heads will be responsible for implementing this policy at local level.

5.6. Matrons
The Matrons across the Trust will support the Deputy Director of Nursing and Quality in the operational implementation of this policy and support the process of risk management and incident reviews as required.

5.7. The Person in Control

- If they consider restraint is likely, request (without delay) that Security and / or the Police attend.
- Assume the lead role for any restraint that does take place, which is informed by an assessment of risk and clinical judgement.
- Have a sufficient understanding of restraint processes, of the law, and of this policy to ensure a satisfactory outcome for all involved.
- Inform appropriate medical staff and the Duty Nurse Manager with appropriate urgency.
- Ensure that wherever possible de-escalation techniques are used throughout a restraint process
- Arrange for the family, friends or carer to be contacted / be involved if they may have a calming influence on the person.
- Arrange and lead the de-brief, and participate in any subsequent follow up and support.
- Ensure the incident is reported in accordance with Trust Policy on Datix.

5.8. Clinical Managers

- Familiarise themselves with this Policy and supporting procedures, and ensure that the contents of the documents are brought to the attention of employees within their sphere of responsibility.
- In all wards/ areas within hospitals where the use of restraint is foreseeable there should be access to Basic Life Support (BLS) equipment within 3 minutes (NICE, 2005)
- Ensure all staff undergo Conflict Resolution and other relevant training as set down by the Trust.
- Ensure appropriate Management Plans are in place for all Patients who have been assessed as posing a high risk of aggression, violence or harassment, and that these plans are communicated to appropriate staff.
- Ensure that staff involved, or witness to, restraint are offered support in line with the Supporting staff following stressful or traumatic events policy.
- Ensure that the Local Security Management Specialist (LSMS) is informed of the use of restraint or incident (even if restraint is avoided), and is copied in on any subsequent correspondence.

5.9. The Security Manager / Local Security Management Specialist (LSMS)

- Ensure contracted security staff respond, support and assist staff in a restraint.
- Liaise with relevant external agencies as appropriate.
- Be involved in the de-brief and any subsequent follow up activity.
- Provide regular updates to the Risk Management Group.
- Ensure security involvement in planning the Trust response to an expected situation where the need for restraint is considered probable.
- Advise the Trust and its employees on any change in security legislation or guidance around restraint.
- Identify training needs of security staff in relation to restraint
- Ensure all security staff apply a uniform approach to a request for restraint.
- Ensure the Risk management Group are kept fully informed of any incidents, the outcome and any learning that needs to take place.
• Identify from incident data and risk assessments all high risk areas and support managers to implement appropriate arrangements.

5.10. The Resuscitation Officer

• Liaise with Managers to ensure that where the use of restraint is foreseeable there should be access to Basic Life Support (BLS) equipment within 3 minutes (NICE, 2005).

5.11. All clinical staff

All clinical staff will ensure that they have read and adhere to this policy as and when required.

• The member of staff identifying the violent or aggressive behaviour or intent will:
  • Attempt to de-escalate by reassurance and other means. If de-escalation is failing then notify Security Services at once and take reasonable steps to ensure safety of patients, visitor and staff is protected
  • Wherever possible and if it is safe do so move other patients away from the vicinity
  • Report the incident to the Person in Control of the area

6.0 Legal Framework

The legal use of restraint has recently become somewhat complex with the introduction of the Mental Capacity Act 2005 (MCA), and particularly by the Deprivation of Liberty Safeguards (DOLS) which were added in 2009. The requirements of the legislation can pose challenges to the provision of patient care, support and treatment in a health care setting.

6.1 Legal distinctions

The MCA and the DOLS operate to differentiate patients into three categories:

1. Patients who have the capacity to consent to the use of a method of restraint;

2. Patients who lack the capacity to consent to the use of a method of restraint, and for whom the use of such restraint would constitute a restriction of their liberty; and

3. Patients who lack the capacity to consent to the use of a method of restraint, and for whom the use of such restraint would constitute a deprivation of their liberty.

Distinguishing between the second and third category (i.e. between restriction and deprivation of liberty) is vital in determining whether the use of restraint is legally defensible, and this distinction is one of degree rather than the nature of the restraint.

In practice, a restraint technique may restrict a patient's liberty, or deprive a patient of his liberty, depending on both the extent of its use, and the degree to which it stops him doing something he would otherwise want to do. In other words, the same restraint technique may be used in different ways with the consequences of a restriction or deprivation of liberty.
If an appropriate scenario is identified in which it is believed that a patient will need to be deprived of his liberty in hospital, in his/her best interests and to prevent him/her from coming to harm, the Trust (the ‘managing body’) must review the case and apply to Cheshire East Council (the ‘supervisory body’) for a Deprivation of Liberty Safeguards (DOLS) authorisation. (Please see the Mental Capacity Act Policy for instructions on how to seek a DOLS authorisation. Staff may also contact the Trust’s Legal Services Department for advice in this matter).

Please see Appendix 5 ‘Legal issues of physical restraint on acute hospital wards’ for further background information.

6.2 There are exceptional circumstances where people with mental capacity might need restraining against their wishes in their best interests. This might occur when somebody sectioned to the Trust under the Mental Health Act is endangering their own life because the actions they are taking are a manifestation of their mental illness. This is a very grey area as not all those sectioned under the Mental Health Act are allowed to be restrained against their wishes – particularly if they retain mental capacity.

6.3 In the event of any ambiguity in a matter of this nature, i.e. the possible need to restrain an inpatient in the course of his/her treatment, a multi disciplinary team (MDT) meeting should be arranged without delay to examine the options, e.g. if the same result can be achieved in a less restrictive way than using restraint techniques. The Trust’s Legal Services Manager should be asked to provide/obtain legal advice on the matter of restraint. In extreme cases, i.e. where agreement cannot be reached, a decision on restraint may be sough from the Court of Protection - this can be facilitated via Legal Services. (Note: at 6.3 the Policy refers to in-patients where a decision needs to be made about future treatment, and the use of restraint in the course of that treatment. Clearly, arranging an MDT meeting would not be appropriate in the event of a violent incident where an immediate decision on restraint is required).

7.0 Exclusions

7.1 This policy does not relate to the routine use of sedation within Anaesthetics and Critical Care.

7.2 This policy does not relate to restraint of patients in their own homes.

8.0 Arrangements for Physical Restraint

8.1 Any staff using physical restraint should:

- Wherever possible use de-escalation techniques irrespective of the stage of the restraint.

- Ensure that one member of staff leads the team and assumes control of the person being restrained throughout the process. He or she should ensure that the restrained person’s:
  - head and neck is appropriately supported and protected
  - airway and breathing are not compromised
Monitor the person’s overall physical and psychological well-being throughout. (See Note 3 in Appendix 3).

For safety reasons, during a restraint it is only permissible to hold / apply pressure to the person’s limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area.

To avoid prolonged physical intervention / immobilisation, consider rapid tranquillisation or seclusion (which may be safer where appropriate) as alternatives – See Section 9.0

Every effort should be made to use skills and techniques that do not use the deliberate application of pain.

The level of force applied must be reasonable and necessary and proportionate to a specific situation, and be applied for the minimum possible amount of time.

Any person subject to restraint must be physically monitored throughout the incident. Post-restraint, the person who has been restrained will be reviewed for placement on the observations as identified by clinical staff. During this time physical observations must be recorded and the observing nurse be fully aware of the possibility of restraint/positional asphyxia.

8.2 Mechanical Restraint

The use of mechanical restraints at this Trust is prohibited by Trust Staff or any employed contractor – except in the Intensive Care Unit (ICU) where exceptional circumstances may arise necessitating the use of physical restraint in the patient’s best interests. Please see Section 10 of this policy which deals exclusively with restraint issues in the Intensive Care Unit.

This includes the use of handcuffs (by Security Teams) or the use of bed sheets etc, applied locally on wards or departments. Any use of mechanical restraints constitutes a deprivation of liberty and is therefore against the law (unless a Deprivation of Liberty Safeguards [DOLS] Authorisation is in place – even then restraint used must be the least restrictive; please refer to the policy on the Mental Capacity Act 2005 for further details regarding Deprivation of Liberty Safeguards [DOLS]).

This prohibition does not apply to the Police, Prison Service or other approved agency or body.

8.3 Face down/Prone Restraint

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.

8.4 Physical Monitoring

Physical Monitoring is important during and after restraint. This should be documented as part of the risk assessment and also in the Plan of Care. Monitoring must be undertaken by the Clinical Team in attendance and must include observations e.g. Pulse, Blood Pressure, Respiration, SPO2, GCS etc.

This is especially important:

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

9.1 To avoid prolonged physical intervention/immobilisation, consider rapid tranquilisation which may be safer where appropriate. When considering use of chemical restraint please refer to the Trust’s Rapid Tranquilisation Policy.

10.0 Post Restraint Arrangements

10.1 Post Incident Support

10.1.1 The aim of a post-incident review should be to seek to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers.

10.1.2 A de-brief should take place as soon as practically possible post-incident unless there are exceptional circumstances which preventing this.

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

10.1.3 As soon as practically possible following the use of physical interventions the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the LSMS.

10.1.4 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.

10.1.5 The person leading the team must ensure the Trust’s Incident Reporting process is completed.

11.0 Restraint in the Intensive Care Unit (ICU) at Macclesfield District General Hospital

11.1 There is a small population of critically ill adults who, once certain checks and balances have been completed, may benefit from the use of physical restraints in support of pharmacological measures in the management of their agitation / anxiety.

11.2 It is common for patients in critical care units to lack mental capacity, either temporarily or permanently. Many are sedated to help them tolerate their treatment. Particular problems can occur when sedation is being reduced during recovery, as patients may, for example, try to pull out their lines or disconnect themselves from
vital life-supporting devices. It is generally accepted that in these circumstances, where a real risk of self harm exists, restraint may be necessary.

11.3 Agitation and delirium are common in the intensive care environment and pose a significant risk to a patient’s well-being. Effective management involves a multidisciplinary risk assessment based on harm vs. benefit. Indications for implementation of the guidelines include:

   a. CAM –ICU assessment
   b. Acute agitation unresponsive to other therapies

Mutual agreement between medical and nursing is necessary as part of the package of care required ensuring that appropriate care is carried out in a safe environment.

11.4 The aim is to minimise risk to the vulnerable patient, attenuate suffering and preserve patient dignity. A physical restraint attached to the patient’s limbs will be implemented to minimise risk to the patient.

   - A physical restraint may be either soft “collar and cuff” material, tubigrip or “boxing gloves”, such as ‘Peek a Boo’ or ‘Posi Mitts’ (commercially available products).

11.5 GUIDELINES: (This section applies to ITU only)

   11.5.1 The senior nurse completes the risk assessment using the CAM –ICU reports the findings to the anaesthetic /medical staff and documents the same in patient’s notes.

   11.5.2 Exclude or manage any identifiable organic causative factors e.g. hypoxia, hypoglycaemia, psychological disorders, neurological pathology, alcohol or drug withdrawal.

   11.5.3 Remove all non-essential devices.

   11.5.4 Ensure adequate analgesia /anxiolysis is provided and that sedation management issues are addressed.

   11.5.5 Consider the possibility of using the ICU side room to promote privacy balancing need for privacy and observation.

   11.5.6 Ensure comprehensive communication where possible with patient and relatives, as well as other appropriate healthcare professionals. Document this in notes and if indicated seek advice from Legal Services and the Trust’s solicitors.

   11.5.7 Ensure restraint is used for the shortest period possible. Reassess at timed intervals.

   11.5.8 Assess the use of restraint at the beginning of each shift and on each subsequent twice daily ward round. Document on risk assessment form.

   11.5.9 Ensure documentation is complete and filed in patients notes.

   11.5.10 Staff applying restraint should be trained in their application and follow the restraint algorithm. Company representatives will provide training for commercially available restraint device.

11.6 CONTRAINDICATIONS/CAUTIONS

   11.6.1 Radial renal fistulae.

   11.6.2 Un-plastered fractures of the arms.

   11.6.3 Severe arthritis of wrists / arms.

   11.6.4 Any operative sites on wrist / forearms in the vicinity of the restraint.
11.6.5 Fractured clavicle / shoulder dislocation.
11.6.6 Unstable spinal injury.

12 Monitoring and Audit

12.1 The effectiveness of this policy will be routinely monitored by the Risk Management Sub-committee through the following key performance indicators:

• Number of restraint incidents reported
• Number of patient or staff harm incidents as a result of restraint

This will be via the Quarterly Complaints Incidents Claims and Patient Experience Report

13 Review

This policy will be reviewed on a 3 yearly basis by the Legal Services Manager.
Appendix 1 – Restraint Algorithm (non-ICU)

Decision Taken to Restrain by Person in Charge of Area

Call security, Senior Manager and the Police via 5555 emergency number

If the Police haven’t arrived, Security/person in charge to undertake an assessment of the situation. If the Police are present they will lead.

If the Police are not present and an imminent risk exists, decide if the situation can be dealt with by ECT staff and security alone?

No

Wait for the Police

Whilst waiting, contain the situation (see Appendix 2)

Yes

Physical Restraint

Member(s) of the medical/nursing staff in attendance and security staff when appropriate

Agree action/technique

Security to lead

Once restrained monitor patient, avoid placing pressure on back of neck

Complete Incident Report Form

Yes

Control Achieved

No

Inform Family

Person in charge to arrange de-brief as soon as possible after event

Beware of positional asphyxia and excited delirium. Release or adjust restraint immediately if significant head or neck swelling observed. *Forceful prone position i.e. held face down with pressure placed on back, hips or abdomen must never be used.*
Appendix 2 - Containing the Situation

- The senior nurse in charge will have been informed at this stage. Security staff and members of medical/nursing staff should be present.
- If possible move other patients, visitors away from the vicinity.
- Security staff will liaise with the Police as necessary to ensure a swift response.
- If “Isolation” room available utilise this but ensure constant monitoring of aggressive person (ED ONLY).
- Wherever possible physical restraint should only be administered by trained staff.
- Wherever possible continue to use de-escalation techniques throughout.
- If family, friends have a calming influence gain their involvement.
- Maintain control until Police take over. Ensure de-brief as soon as possible after event.

Appendix 3 - Security staff’s Role

- Call received to respond to incident
- For such a situation a minimum of 2 security personnel are required to assist/lead the nursing team.
- The security staff should be trained in restraint as per National Standards.
- Liaison at the scene with medical/nursing staff to agree restraint technique and security will lead.
- Security staff can restrain if it is the only option available to reduce the risk to themselves and others including to allow medication to be administered - it is not always necessary to await medical staff as nurses may be competent in the administration of sedation, all nursing staff are trained in Basic Life Support techniques and one member of staff will be allocated this observation role (see Appendix 4).
- Security staff may prevent a patient leaving the area/hospital if they are advised by the senior nurse/manager present, that the patient has been assessed as lacking mental capacity, and must be prevented from leaving either in their best interests, or because a Deprivation of Liberty Safeguards authorisation is in place.
Appendix 4 - Monitoring & observation of restrained person during and after event

**DURING**

One member of staff should assume control throughout the process. He or she should be responsible for:

- Protecting and supporting the persons head and neck, where required
- Ensure the airway and breathing are not compromised
- Ensure vital signs are monitored
- Monitor the persons overall physical & psychological well being throughout.

**AFTER**

Any person subject to physical interventions will need to be reviewed for placement on the appropriate observations level by clinical staff. During this time physical observations must be recorded and observing nurse be fully aware of the possibility of restraint/positional asphyxia.

The check will include:

- Care in the recovery position where appropriate
- Pulse
- Blood Pressure
- Respiration
- Temperature
- Fluid & food intake and output
Appendix 5 - Legal issues of physical restraint on acute hospital wards:

Patients with decision-making capacity

As with all health-care interventions, a patient is presumed to have the capacity to give or refuse consent to the use of a particular method of restraint, unless there is evidence that he/she is unable to understand, retain and weigh up information and then communicate a decision due to an ‘impairment of, or a disturbance in the functioning of, [his/her] mind or brain’. A patient's capacity to make such a decision will depend on the nature of the decision, and may fluctuate over time. Patients whose decision-making capacity is not impaired, and who are refusing to give consent to a particular method of restraint being used, cannot be restrained against their will, even if their decision appears to be unwise. The only exemption to this general rule is in those situations in which the act of restraint prevents immediate and serious harm to themselves or to other people, for example, dragging a person out of the path of an oncoming vehicle.

Patients who lack decision-making capacity and whose liberty is being restricted

Some patients admitted to hospital will be physically unwell and suffering a disorder of the mind (such as delirium or dementia), which means they may lack the capacity to make certain decisions about their care. If incapacity is established using the test from the MCA (see Mental Capacity Act Policy), then such a patient should be treated in his/her best interests, a judgment made after examining, among other things, the patient's known beliefs and values, and consulting people involved in his care. If restraint is used, it must not only be in the patient's best interests and the least restrictive alternative, but also (a) act to prevent him/her from coming to harm and (b) be of a type and degree that is proportionate to the risk of him/her suffering harm.

Patients who lack decision-making capacity and who are being deprived of their liberty

The introduction of the DOLS as an amendment to the MCA, acknowledges that, in some cases, patients who lack decision-making capacity will require care to be provided in ways that deprive them of their liberty, in order to act in their ‘best interests’, and to prevent them from coming to harm. The DOLS introduce new regulatory procedures that provide for the lawful basis for necessary deprivations of liberty, in order to ensure that health and social care practice is consistent with the requirements of the Human Rights Act 1998. DOLS are relevant to acute medical settings in circumstances, such as the management of behavioural changes after head injury or cerebrovascular accident, where patients may be kept in hospital for a long period under close supervision, and restrained if they attempt to leave the ward or engage in repeated episodes of self-harm. The DOLS are not, however, an appropriate way of managing short-term mental disorder (e.g. delirium), or behavioural problems, caused by physical illness when the treatment of the physical illness is likely to lead to a rapid resolution of the mental disorder or behavioural problems.
## Appendix 6 - Physical Restraint Risk Assessment Form (ITU Only)

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### Guidance for Risk Assessment

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<td>Removal of essential cannulae</td>
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<td>Risk of physical violence towards self or others</td>
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<td>Risk of removal of NG / NJ / PEG feeding tubes and subsequent malnutrition or aspiration</td>
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<td>Risk of removal of essential drains</td>
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<td>Risk of damage / contamination to major wound sites</td>
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<td>Risk of falling out of bed with cot sides in situ</td>
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<td>Serious risk to patient's limbs</td>
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<tr>
<th>Medium Risk</th>
<th>Date &amp; Time</th>
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</thead>
<tbody>
<tr>
<td>Risk of damage / contamination of minor wound</td>
<td></td>
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<tr>
<td>Risk of laceration or bruising</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Date &amp; Time</th>
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<tbody>
<tr>
<td>Risk of increased discomfort</td>
<td></td>
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<tr>
<td>Risk to patient dignity</td>
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</table>

### Implementation

(Must include any one of the following)

- Patient at high or medium risk may benefit from physical restraints as part of package of care.
- Patients scoring in the low category may require alternate therapy management.
Appendix 7 - Risk Management Plan (ITU Only)

Each patient will require to be re-assessed for the necessity of use of restraints frequently. Ideally these should be done with a risk assessment carried out by a senior nurse /doctor.

The minimum time span for re-assessment should be 4 hourly.

<table>
<thead>
<tr>
<th>Re-assessment – restraint remains necessary</th>
<th>Type of restraint used</th>
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<tbody>
<tr>
<td>Date &amp; Time</td>
<td>Signature</td>
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<td>Date &amp; Time</td>
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<table>
<thead>
<tr>
<th>Restraint is no longer required / of benefit</th>
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<tbody>
<tr>
<td>Date &amp; Time</td>
<td>Signature</td>
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<table>
<thead>
<tr>
<th>Repeat Assessment following review</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Date &amp; Time</td>
<td>Signature</td>
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</tbody>
</table>
Appendix 8 - Physical Restraint Algorithm (ITU Only)

Assess Patient CAM - ICU

Patient is agitated and in danger of self harm

Yes

Inform nurse in charge

No

Observe patient and remove restraint

Is the patient on appropriate prescribed medication for contributory / underlying condition?

Yes

Risk assess. Complete documentation

No

Refer to restraint protocol. Inform patient / relatives and apply appropriate restraint

Medical review for appropriate therapy


Hourly assess limbs. Complications?

Yes

Continue restraint if necessary

No
Appendix 9 - Nursing Care Plan (ITU Only)

Aim:

To maintain essential prescribed treatment / equipment during periods of disorientation / acute agitation unresponsive to other therapies.

Actions:

1. Choose the least restricting arm restraint device available.
2. Reassess patient’s response every hour.
3. Remove the restraints every two hours.
4. Review policy / orders every 4 hours.
5. Change patient’s position frequently and check skin integrity.
6. Provide adequate range of motion by passive exercises.
7. Assist with activities of daily living.
8. Assess pain management.
9. Assess hypoxia, hypoglycaemia, drug and alcohol withdrawal, and other causes of agitation, and treat accordingly.
10. Inform relatives of need for restraint.

Outcome:

Essential treatment and usage of necessary equipment to maintain patient’s safety is not compromised.
Appendix 10

CONFUSION ASSESSMENT METHOD (ITU Only)

The CAM-ICU assessment method is the approved assessment tool to be deployed on the Adult ICU.

CAM-ICU Method

In the CAM-ICU method, delirium is diagnosed when there has been:

A) an acute onset of mental status change (or a fluctuation in mental change)
B) inattention and, either:
   C) disorganised thinking
   or
   D) altered level of consciousness.

A) Acute onset of mental status change (or a fluctuation in mental change)

Is there evidence of an acute change in the patient’s mental status from the recorded baseline?
Has the patient’s (abnormal) behaviour fluctuated over the past 24 hours?

The sedation score would be the best place from which to find supporting evidence for this as we record this hourly. A score of +2 or +3 could be used to indicate agitation.

B) Inattention

Does the patient have difficulty focusing attention?
Does the patient have a reduced ability to maintain and shift attention?

Use the Vigilance A Random Letter Test.

Vigilance A Random Letter Test

Tell the patient: “I am going to read you a long series of letters. Whenever you hear the letter A, indicate this by squeezing my hand.” Read the following letter list in a normal tone at a rate of one letter per second.

SAVEAHAART
LTPEAOAICTDALAA
ANIABFSAMRZEOAD
PAKLAUCJTOEABAA
ZYFMUSAHEVAARAT

C) Disorganised Thinking

Is there evidence of disorganised or incoherent thinking, for example rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
Is the patient able to follow questions and commands throughout the assessment?

For example, “Hold up this many fingers” whilst the examiner holds up two fingers. Then “Now, do the same with the other hand”, whilst the examiner refrains from repeating the number of fingers.

D) Altered Level of Consciousness

Any other level of consciousness from this list, other than “alert.”

Alert - normal, spontaneously fully aware of environment and interacts appropriately.

Vigilant – hyperalert

Lethargic – drowsy but easily roused, unaware of some elements of the environment, or not spontaneously interacting appropriately with the examiner; becomes fully aware and appropriately interactive when prodded minimally.

Stupor – difficult to arouse, unaware of some or all elements in the environment, or not spontaneously interacting with the examiner; becomes incompletely aware and inappropriately interactive when prodded strongly.

Comatose – unrousable, unaware of all elements in the environment, with no spontaneous interaction or awareness of the examiner, so that the interview is difficult or impossible even with maximal prodding.

Documentation

To avoid the introduction of any further paperwork, please record the result of the CAM-ICU method in the nursing notes, EACH SHIFT, as follows:

08:00 hrs: CAM-ICU test conducted; the patient has failed on points A, B, C, and D (as appropriate), therefore the use of physical restraints conforms with the unit’s Clinical Guidelines.

CAM – tive = Fail

CAM + tive = Pass

This will ensure that you are covered legally in your use of restraints.
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Policy for Restraint

Details of person responsible for completing the assessment:

• **Name**: John Glynn
• **Position**: Legal Services Manager
• **Team/service**: Governance

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This Policy is intended for managers, staff and security contractors in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust. Its aim is to help all involved act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration.

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

This Policy is intended for managers, staff and security contractors in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust.

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age**: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race**:
• In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
• 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
• 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.
• Gypsies & travellers – estimated 18,600 in England in 2011.

**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

**Sexual Orientation:**
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (*The Lesbian & Gay Foundation*).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

**Religion/Belief:**
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None
2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes ☐ No X

Explain your response:
Where a patient’s first language is not English, the Trust Interpretation and Translation policy will be followed. Where carers need to be informed the same applies.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes ☐ No X

Explain your response:
If a person requires restraint, staff will act in such a manner as to preserve the modesty and dignity of the patient as far as is possible. Other patients and visitors will be removed from the area or screened.

DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes ☐ No X

Explain your response:
The policy takes into account the issues around mental capacity, anxiety and agitation and special needs and the possible requirements for restraint for patients with disabilities.

AGE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes ☐ No X

Explain your response:
Issues around capacity are taken into account within the policy, and this would relate to dementia to possible requirements for restraint due to agitated/disturbed behaviour.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No X

Explain your response:
All staff have access to training in equality and human rights and same sex partners would be informed and involved in the same way as heterosexual partners.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☐ No X

Explain your response:
Restraint might impinge on a person's ability to pray at required times and this should be taken into account as to stop a person carrying out their prayer time could result in a worsening of the agitation.

**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes ☐ No X

**Explain your response:**
This Policy clearly states that carers will be informed and involved and recognises that there may well be opportunity to look for ways of calming the patient using the knowledge and experience of carers. Same sex partners will be involved in the same way as heterosexual partners.

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No X

**Explain your response:**
The policy identifies issues around privacy, dignity, respect and human rights, which are to be taken into account by staff and a patient's dignity preserved as far as possible.

4. **Safeguarding Assessment - CHILDREN**

| a. Is there a direct or indirect impact upon children? | Yes ☐ No X |
| b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people: | |
| c. If no please describe why there is considered to be no impact / significant impact on children | It is not envisaged that any child will be restrained by reference to this Policy. |

5. **Relevant consultation**

_Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?_


6. **Date completed:** October 2014  
**Review Date:** September 2017

7. **Any actions identified:** Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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8. **Approval**  
- At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 22.10.14