

Clinical Holding and Restraint Policy

Version 3.0

Policy Statement:

The Trust is committed to delivering the highest standards of health, safety and welfare to its patients, visitors, and employees.

Key Points:

- This Policy provides guidance on the use of restraining patients within the clinical environment.

Key Changes:

- The inclusion of paediatrics within the policy
- DOH 6 Principles of Safeguarding
- Use of Mittens
- Seclusion

Paper Copies of This Document

- If you are reading a printed copy of this document you should check the Trust's Policy website (<http://sharepoint/policies>) to ensure that you are using the most current version.

Ratified Date: 8th October 2012

Ratified By: Chief Nurse

Review Date: January 2018

Accountable Directorate: Corporate Nursing

Corresponding Author: Lorraine Longstaff, Phil Chambers & Julie Taylor.

Meta Data

Document Title:	Clinical Holding (Restraint) Policy
Status	Final
Document Author:	Lorraine Longstaff, Phil Chambers & Julie Taylor Lorraine.longstaff@heartofengland.nhs.uk
Source Directorate:	Corporate Nursing
Date Of Release:	28 th June 2013
Approval Date:	20 th June 2013
Approved by:	Adult Safeguarding Steering Group
Ratification Date:	3 rd September 2015
Ratified by:	Adult Safeguarding Steering group
Review Date:	January 2018
Related documents	<ul style="list-style-type: none"> • Trust Management of Violence & Aggression Policy • Trust Violent Warning Marker Policy • Consent to Examination and Treatment Policy (HEFT 2011) • Conscious sedation policy • Psychiatric and self harm guidelines • Adult Safeguarding Policy • Therapeutic Nursing Observation Policy (including Specials) • Use of Mittens Guidance
Superseded documents	Adult Clinical Holding v3.0
Relevant External Standards/ Legislation	<ul style="list-style-type: none"> • National Institute for Clinical Excellence “Clinical Practice Guidelines for the Short-Term Management of Disturbed/Violent Behaviours in Adult Psychiatric In-patient settings and Accident and Emergency Settings, (NICE 25) March 2005. • Restrictive physical intervention and therapeutic holding for children and young people. Guidance for nursing staff. The Restraining, holding still and containing young children guidance was first published in 1999 and was updated in 2003, following consultation with RCN members. • The Resuscitation Council for the UK, “Intermediate Life Support Guidelines (2004)” • Health & Safety at Work etc Act 1974 • Management of health & Safety at Work Regulations 1999 • Secretary of State Directions 2005 • Counter Fraud and Security Management Services, 2003 • Mental Capacity Act • Corporate Manslaughter Act • CQC Regulation 13, Outcome 7.
Key Words	Physical Restraint. Holding patients therapeutic holding, containment.

Revision History

Version	Status	Date	Consulted	Comments	Action from Comment
0.1	Draft			Initial version	
0.2	Draft		Director of governance, Health and Safety team, Safety advisors, Chief Nurse, Deputy Chief Nurse, head Nurses, Corporate nursing, Matrons, Sisters. All clinical directors, consultants,	Comments regarding format noted and actioned.	Minor changes made to first draft.
0.3	Draft		Resuscitation Officer regarding chemical restraint	Comments/amendments added	Changes made in light of comments
0.4	Draft	06.01.12	Beachcroft Solicitors: Jessica Major	Comments added	Changes made in light of comments from solicitors
0.5	Draft	11.01.12	Sisters, Matrons, Head Nurses, Clinical Directors, Elderly Care Consultants. Clinical Governance team	Comments/amendments added	Minor changes made in light of comments
0.5	Draft	19.01.12	Solihull Community Team	Concerns raised between Acute & Community practice	Exclude Solihull Community Services from this policy.
1.0	Approved	14/06/2012			
1.1	Draft	28/09/2012	Safeguarding Lead for Adults & Paediatrics CQC Compliance Committee	To change from Adults only to incorporate Paediatrics as interim measure	Policy amended and version 2 to be approved.
2.0	Approved	08/10/2012	Approved by Chief Nurse		
2.1	Draft	7/06/2013	Sent to original authors L.Longstaff.and J.Taylor	Amend policy to add in HEFT's own paediatric guidance	
2.2	Final	20/06/13	Approved at Nursing Midwifery Board		
3.0	Draft	24/07/15	Chief Nurse, Deputy Chief Nurse, Head Nurses, Corporate nursing, Matrons, Operational Security	Amend policy to include 6 principles and use of mittens	

Table of Contents

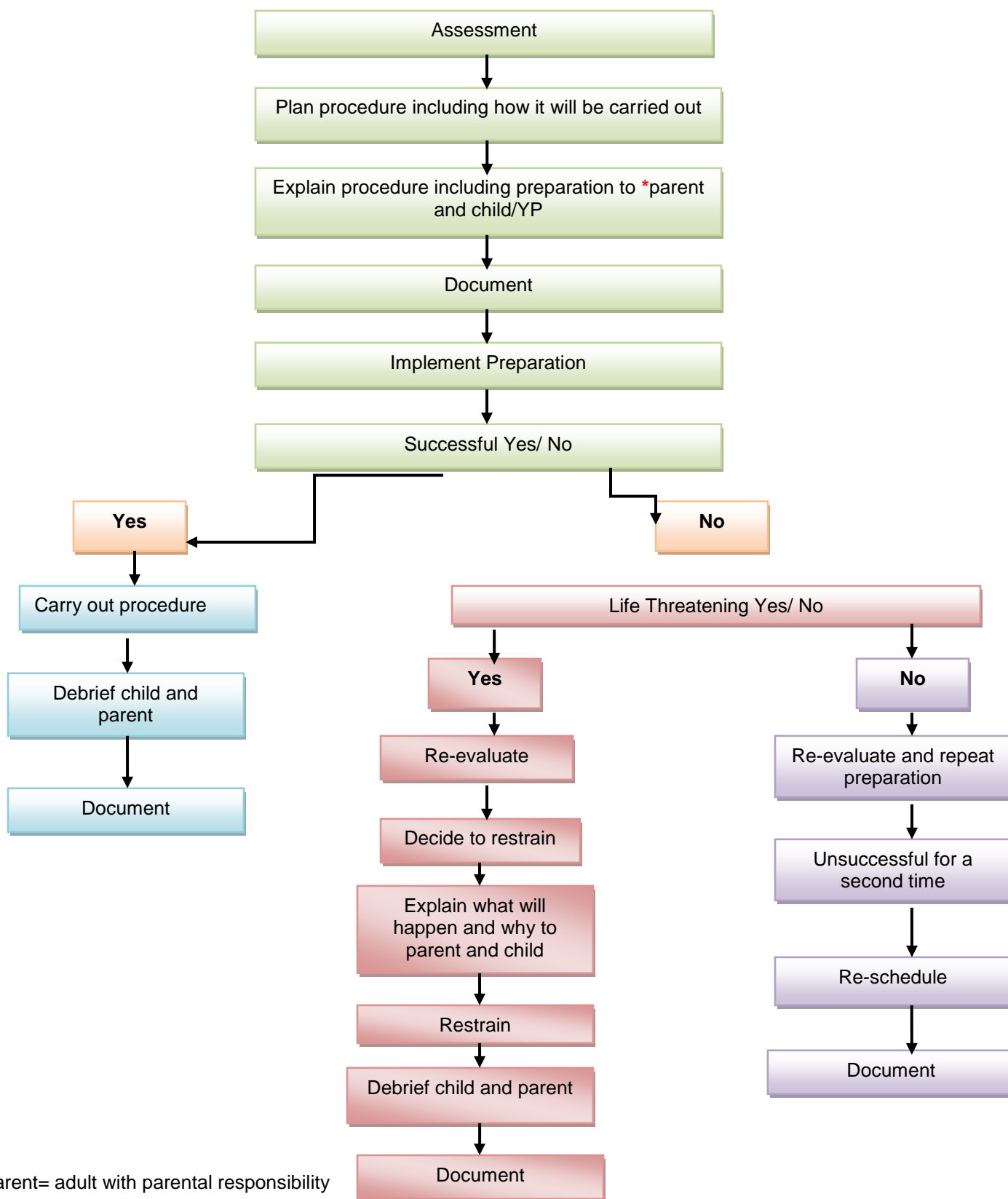
Quick reference Guides

- **Implementing clinical holding with Children and Young People.....6**
- **The use of physical restraint with patients who demonstrate violent/aggressive behaviour 7**
- **The use of physical restraint to prevent patients from leaving the clinical environment...8**
- **The use of chemical restraint with patients who demonstrate violent/aggressive behaviour.9**

1. Circulation.....	10
2. Scope.....	10
3. Definitions.....	10
3.1 Restraint	10
3.2 Physical Restraint	10
3.3 Chemical Restraint.....	10
3.4 Immediate Danger	10
3.5 Person in Control	10
3.6 Containing.....	11
3.7 Therapeutic Holding for paediatrics.....	11
3.8 Purpose of restraint.....	11
3.9 Decision to restrain.....	11
4. DOH 6 Principles of safeguarding	11
5. Reason for Development.....	11
5.1 What is 'Reasonable' In Law	12
6.Aims and Objectives of the Policy.....	12
6.1 Key Principles for Clinical Holding or restraint.....	12
6.2 Patients lacking Mental Capacity.....	13
6.3 Diversion Therapy.....	14
6.4 Involving Relatives/Parents	14
6.5 Environment.....	15
6.6 Verbal/non-verbal communication.....	15
6.7 Use of Mechanical Restraint	15
6.7.1 Use of Mittens.....	15
6.8 Face down/Prone restraint.....	15
7. Management of Care	15
7.1 Physical Monitoring.....	16
7.2 Arrangements for Rapid Tranquillisation/Chemical Restraint.....	16
7.3 Post Chemical Restraint.....	16
7.4 Post incident Support	17
8. Roles and responsibilities.....	17
8.1 Chief Executive.....	17
8.2 Executive Directors.....	14
8.3 Head Nurses	14

8.4	Matrons	15
8.5	Senior Sister/Charge Nurse/Departmental Manager	15
8.6	The member of staff identifying the violent or aggressive behaviour or intent	16
8.7	The person in Control (Senior member of team) will:	18
8.8	The Head Of Facilities will:	18
8.9	The local Security Management Specialist will:	19
8.10	Resuscitation Officer will:	19
8.11	Adult Safeguarding Steering Group	19
9.	Training	19
10.	Monitoring and Compliance	20
11.	References and Supporting policies and Procedures	21
12.	Appendices	21
	Appendix 1 Positional Asphyxia and Excited delirium	22
	Appendix 2 Imminent Risk of Harm Algorithm	24
	Summary Flow Chart-Procedure when dealing with patients deemed not to have Capacity (Ref :(MCA/DOLS Section 6)	27
	Summary Flow chart for managing a patient demonstrating violent or Aggressive behaviour	28
	Appendix 3 Triggers to violent and aggressive behaviour	29
	Attachment 1: Consultation and Ratification Checklist	32
	Attachment 2: Equality and Diversity - Policy Screening Checklist	34
	Attachment 3: Equality Action Plan/Report	36
	Attachment 4: Launch and Implementation Plan	37

Quick Reference Guide for implementing clinical holding with Children and Young People



The use of physical restraint with patients who demonstrate violent/ aggressive behaviour

Attempt to de-escalate the situation by reassurance/diversion therapy. Try to establish the cause of the behaviour and treat accordingly. If appropriate involve family/*parents to support the patient/ child.

Achieved →

Continue with normal plan of care and continue to monitor patient. Document incident in patient's medical record.

Wherever possible and if it is safe to do so remove other patients from the immediate environment. Keep the number of Healthcare Professionals to the minimum number required to make the situation safe

Ensure the Senior Nurse on duty is informed and assumes responsibility for the situation. Ensure the medical team are contacted and either 1st On Sister/POD Lead/Lead Nurse for Site/ Night Practitioner are also contacted to provide additional support to clinical team.

If physical restraint is required, request rapid attendance of security team. If necessary consider contacting the Police for further assistance.

Use of security for physical restraint within paediatrics is considered a critical incident and can only be undertaken after a multi-disciplinary agreement.

Physical restraint can only be applied by staff that are deemed competent to do so. Security team should be informed of any pre-disposing medical condition which may impact on their health/well being or maybe contra-indicating to the patient if physical restraint is applied.

When physical restraint is being applied to a patient a member of the clinical team must remain present at all times and be identified as the lead of the patient being restrained. They must have sufficient knowledge and skills to monitor the patient throughout the period of restraint and intervene when the clinical needs of the patient may be compromised.

Physical restraint can only be applied to the patient's limbs If any marks are left on the patient post restraint this must be documented within the patient's medical record.

Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The clinical member of the team must ensure patient has a patent airway and this is not compromised at anytime during the period of restraint. There must be immediate access to Emergency Resuscitation Equipment.

Under no circumstances can mechanical restraints (use of handcuffs/ bed-sheets) be applied to a patient by any member of the healthcare team including the security team.

All incidents need to be recorded within the patient's medical records and reported via the Trust datix system.

All patients to receive appropriate after care (observed and monitored for 24hr period), if security to remain present without the use of physical restraint then the clinical team can resume their normal clinical duties.

*Parent = adult with parental responsibility

The use of physical restraint to prevent patients from leaving the clinical environment.

Adult Patients

At no time during the period of restraint will the adult patient be deprived of his/ her liberty.

The only exception to this is when a patient is detained under the Mental Health Act 1983 (for hospital treatment)

Any patients who have left the clinical area without being discharged refer to the Discharge Policy available on share-point

<http://sharepoint/policies/Office%20Documents/Discharge%20Practices%20Policy%20and%20Procedure%20v6.0.pdf>

Document in the patient's medical notes, the incident that has occurred; the actions that have been taken, including contacting next of kin/family members.

Children and Young Persons

There are times when a sick child/ young person may wish to leave the clinical area. For example:

- A child or young person presents in the Emergency Department as a result of alcohol or substance misuse.
- A child/ young person has behavioural difficulties.
- A child/ young person become psychotic due to their medical condition.

To use physical restraint to prevent child/ young person should be done in the persons best interest and wherever possible with the support of the *parents.

Contact the Police if:

- If a child or young person has left the clinical area alone
- If the child has left the clinical area either alone or with parents and there are child protection/ safeguarding concerns involved.

Life Threatening Situation

- In life threatening situations physical interventions of restraint are vital for the child's survival. **In these incidents d decision to restrain must be documented accordingly.**

*Parent= adult with parental responsibility

The use of chemical restraint with patients who demonstrate violent/ aggressive behaviour

All chemical restraint must involve a multi-disciplinary approach. Risk factors of patient pre-existing medical condition, interactions with any medication previously administered and any other substances the patient may have already taken. (E.g. excess alcohol. or patients with known drug dependencies.)

All medication must be administered in line with Trust Medicine Policy and the Manufactures guidelines. Patient's allergy status must be confirmed before any medication is administered.

Medication can only be administered by Registered Healthcare Practitioners who are qualified to administer via the stated route and to the identified patient group. (E.g. only paediatric nurses to administer to children)

If security team are to be involved in assisting to hold/restraint patients the team must be informed of any pre-disposing medical condition which may impact on their health/well being or maybe contra-indicating to the patient if physical restraint is applied.

A minimum standard for staff involved in the administration of chemical restraint must be trained to Intermediate Life Support. (ILS) No chemical restraint can be administered if there is no immediate access to Emergency Resuscitation Equipment.

Patients must be informed they are being given medication and what the desired outcome is expected.
Under no circumstances can covert administration be carried out

Were possible the patients' family or carers should be involved in the decision to use chemical restraint. If this is not possible the family/ next of kin must be informed as soon as possible.

Post administration of chemical restraint the patient should be nursed in the recovery position where possible. The patient should have the observations recorded on either MEWS/PEWS Chart. The need for Neurological Observations including GCS should be assessed on an individual patient need and recorded on the appropriate observation chart.

The patients need to be nursed in a high visibility of the ward if this not possible then specialing of the patient needs to be considered.
<http://sharepoint/policies/Office%20Documents/Therapeutic%20Nursing%20Observation%20and%20Specialin g%20Policy%20v1.0.pdf>

Record incident in patient medical records ensure medication is signed for on the medication chart. Complete incident form on Datix when physical restraint has been used

1. Circulation

The policy covers all staff and persons within Heart of England NHS Foundation Trust, and others who are acting on behalf of the Trust, including those on temporary or honorary contracts.

2. Scope

Includes:

This policy will apply to all patients in all Trust departments. For all other groups, e.g. visitors/relatives refer to the Prevention & Management of Violence & Aggression Policy.

Excludes:

- Those patients that access the Solihull Community Services.

3. Definitions

Adults

Anyone nursed within an adult in-patient setting

Children and Young People

Age group defined as 0-19years old nursed within a paediatric setting

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.” Restraint is by definition applied without the person’s consent.

3.2 Physical Restraint

Is direct physical contact between persons where reasonable force is positively applied against resistance to either restrict movement or mobility or to disengage from harmful behaviour displayed by an individual (Welsh Assembly Government 2005)
Physical Restraint should only be used to prevent serious harm.

3.3 Chemical Restraint

A drug or medication used to manage a patient’s extremely violent or aggressive behaviour which is administered, if necessary, against the patient’s wishes. Such drugs may of course also be used with the patients consent, and may (with the patients consent) be used in circumstances in which the threat or harm is less immediate.

3.4 Immediate Danger

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

3.5 Person in Control.

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

3.6 Containing

Physical restraint or barriers preventing the individual leaving, harming themselves or others, or causing serious damage to property.

3.7 Therapeutic Holding for Paediatrics

Immobilisation, which may involve using limited force or applying splints. It can be used with a child's permission to help to manage a painful procedure quickly and effectively for the child. **Holding is distinguished from restraint by the degree of force and the intention** (Royal College of Nursing 2003)

- 3.8 Purpose of restraint

To take immediate control of a dangerous situation;
To contain or limit the patient's freedom for no longer than is necessary;
To end or reduce significantly the danger to the patient or others.

3.9 Decision to Restrain

To prevent harm, to either the patient or to others who are within close proximity of the patient. A member of staff is expected to take action that would calm the situation rather than provoke further aggression, where all other methods of management/ de-escalation have failed.

4.0 DOH 6 Principles of Safeguarding

The Local Arrangements Embed the 6 Department of Health Principles of Safeguarding:-
**EMPOWERMENT, PROTECTION, PREVENTION
PROPORIONALITY, PARTNERSHIP, ACCOUNTABILITY**

5. Reason for Development

Heart of England NHS Foundation Trust is committed to delivering the highest standards of health, safety and welfare to its patients, visitors and employees. Increasing concerns about the inappropriate use of restrictive interventions across health and care settings led to this guidance; including Transforming Care: A national response to Winterbourne View Hospital (DH 2012), Mental Health Crisis Care: physical restraint in crisis in June 2013 by Mind, and a recent inspection of inpatient learning disability services by the Care Quality Commission (CQC).

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. In some instances it may be necessary to withhold / withdraw of treatment.

The management of difficult and challenging behaviour is an activity requiring decency, honesty, humanity and respect for the rights of the individual, balanced against the risk of harm to themselves, staff and members of the public. Restraining any aggressive behaviour by physical or chemical means should only be used when it is reasonable to do so.

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.

5.1 What is 'Reasonable' In Law

For the purposes of considering what may be construed as reasonable in law the Criminal Law Act 1967, Section 3 states: 'A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders, suspected offenders, or persons unlawfully at large'.

Using this example, it is not possible to set out comprehensively when it is reasonable to use force; not two threatening situations are ever identical. However, what constitutes 'reasonable' will require staff in each situation to consider the following points carefully:

- Where a technique is applied, it must be done in a manner that attempts to reduce rather than provoke a further aggressive reaction.
- The numbers of staff involved should be the minimum necessary to restrain the violent individual, whilst minimising injury to all parties.
- The force used must be proportionate to the risk and the minimum necessary to be able to contain the situation.
- To take no action could be seen as negligent where the outcome results in self-inflicted injury to the individual or in injury to others.
- To convict a person of using unreasonable force, a court must be satisfied that no reasonable person in a similar position would have considered the action of the use of such force justified.

6. Aims and Objectives of the Policy

This policy is intended to provide guidance for all Healthcare 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, this 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.

- Has systems and processes to review all incidents where restraint is deployed, to ensure that any restraint used is **reasonable, proportionate and necessary**.
- To provide staff training and education for all staff involved in managing patients with challenging behaviour.
- To ensure professional and legal support is made available to all staff when acting lawfully and in good faith when situations of actual or threatened violence or aggression has led to restraint being applied.

6.1 Key Principles for Clinical Holding or Restraint.

- All patients should have a comprehensive assessment to establish the appropriate clinical holding/restraint that needs to be applied.
- Healthcare Practitioners should establish if possible the cause of the challenging behaviour in the first instance and apply appropriate interventions to de-escalate the situation. Possible cause include:
 - Patients in pain or discomfort
 - Anxiety or distress fear of hospital including needle-phobia
 - Age of patient particularly with young children and adolescents
 - Patients requiring to use the toilet but unable to articulate this.

- Patients with acute/ chronic delirium or confusion.
- Acute/ Chronic Mental Health illness
- Electrolyte or metabolic imbalance (hypo/hyperglycaemia)
- Brain injury/ Cerebral irritation
- Substance dependency or withdrawal
- Intoxication (due to alcohol, drug overdose or drug abuse)
- Reaction / side effect of medication
- Hypoxia
- Hypotension

This list is not exhaustive.

- Where a patient's behaviour poses a significant risk to themselves or others, urgent medical (and if appropriate mental health) assessment must be sought. Restraint may be appropriate in this case.
- The decision to restrain a patient can only be made by clinical staff (i.e. a qualified member of the medical/nursing staff or allied health professionals caring for the patient concerned) in consultation with Security/Police as appropriate and the rationale for this should be documented in the patient medical records. The decision to restrain a patient cannot be delegated to non-clinical and non-professionally qualified staff (e.g. students, security, porters, support workers).
- Particular care must be taken to avoid more than minimum reasonable force to quell a disturbance. The use of excessive and dis-proportionate force may constitute a criminal act and may result in criminal charges being brought against the individuals concerned. It may also result in a complaint and/or claim against the Trust and/or individuals concerned.
- Physical restraint should only therefore be used as a last resort where there is a potential danger to the aggressor or others and when other methods have proved ineffective or have been considered and rejected. The restraint should last no longer than is necessary to deal with the immediate risk. Caution is always to be considered to before restraint techniques are used. The use of force to repel force is in law, perfectly acceptable, subject to one qualification, which is that it must only entail reasonable force. Restraint will not be applied directly by one person onto another (i.e. bodily restraint is to be avoided).
- **Physical restraint may also be used by security officers who have reason to believe that a crime may be being committed provided the force used is reasonable and proportionate. The decision to restrain a person other than a patient will be made by security officers.**
- Reasons for restrain include
 - Physical assault;
 - Dangerous or threatening or destructive behaviour;
 - Non-compliance with treatment – for non-capacitous patients;
 - Self harm or risk of physical injury either deliberately or by accident, to self or others – this could include risks associated with absconding, falls;
 - Extreme and prolonged over-activity likely to lead to physical exhaustion.
- The Senior Nurse on the ward will review the situation every two hours to assess whether the risk still exists and whether alternatives to restraint are now possible. This will be documented in the patient's notes each time the assessment is made. The nurse in charge must also complete an Incident Report Form (IR1) and copy to the Trust Security Management Specialist (LSMS) and the Adult Safeguarding Lead Nurse/Adult Safeguarding Nurse (Adults/ Children's)

6.2 Patients Lacking Mental Capacity

- If the patient is considered to lack capacity to a point in time and to a specific decision then a capacity assessment should be completed if reasonably possible.

- Refer to the Safeguarding share-point site for further information.
<http://sharepoint/safeguardingadults/MCA%20%20DOLS/Forms/AllItems.aspx>
- Any action intended to restrain a patient who lacks capacity will not attract protection from liability unless the following conditions are met:
- Before doing the act, reasonable steps are taken to establish whether the individual lacks capacity in relation to the matter in question; and
- When doing the act it is reasonably believed that the person being cared for or treated lacks capacity in relation to the matter and it will be in the best interests of the person being cared for or treated for the act done.
- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity.
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.
- At no time during the restraint period will the act of restrain deprive the patient of his / her liberty. The only exception to this is when a patient is detained under the Mental Health Act 1983 (for hospital treatment) and where formal authorisation has been obtained.
- It is lawful under common law for a person to temporarily restrain a non-sectioned, mentally incapable patient where this is immediately necessary in their best interests (i.e. in order to give them medical treatment in their best interests or to prevent them harming themselves or others). Although this principle is not contained in any legislation it is the law established by the Courts and is often referred to as the “common law doctrine of necessity”.
- If the patient’s mental health is considered to be the primary driver for their behaviour advice should be sought from the appropriate mental health team (adult/ paediatrics). Before referring a patient to Mental Health Services the Trust’s Mental Health Screening Tool should be used. The Mental Health Act 1983 allows for a person suffering from a mental disorder to be detained against their wishes.
- The Human Rights Act 1998 also impacts on the Trust and staff must consider the individual’s right not to be deprived of their freedom except in certain circumstances, such as under the Mental Health Act 1983 or emergency situations. It does not automatically follow that because a patient has been detained under the Mental Health Act that the patient lacks capacity.

6.3 Diversion Therapy

- Intervention and de-escalation should be instigated early, if it becomes clear that an aggressive episode of behaviour is likely to occur, and this should be individualised to the person concerned.(e.g. play therapy for children) Maybe appropriate with children) These approaches will include the focus of negotiation, communication, use of staff body language, personal space etc.
- The overall aim will be to maintain safety at all times.
- In all services it must be decided where it is appropriate to deliver these distractions / diversion therapies as it may not be appropriate that the patient be taken out of the ward environment for safety reasons. If this is the case then these therapies should be provided on the ward so that the patient can be observed at all times by staff.

6.4 Involving Relatives/Parents

- Relatives and carers provide a known and reassuring face to the patient, and their presence can assist greatly in reducing their anxieties that may cause aggression and violence. Consider calling the relative or carer to sit with the patient if they are becoming agitated and becoming either verbally or physically aggressive.
- Ensure parental presence and involvement if they wish and are able to be present. Parents should not be made to feel guilty if they do not wish to be involved in clinical holding for interventional

procedures. Nursing staff are responsible for explaining the parent role in supporting the child and ensuring parents are offered support post procedures as parent are often very distressed at seeing their child upset.

6.5 Environment

- The patient's environment can include both the physical environment and the level and qualification of staff. Considerations must include how to manage the patient's environment or care setting to limit the potential for violent and / or aggressive behaviour. A noisy environment can cause increased anxiety and agitation in some patients. Similarly frequent changes of ward or bed space can increase these levels.

6.6 Verbal / non-verbal communication

- Your body language and tone of voice can often prevent an aggressive situation from escalating. Talk in a firm but quiet, calm voice and do not hurry the person. Do not stand over the patient or keep your arms crossed as these actions imply threat or dominance.
- Restraint should be an act of care and control, not punishment
- Physical restraint should NOT be used purely to force compliance with staff instruction when there is no immediate risk to themselves, other people or property

6.7 Use of Mechanical Restraint

- **The use of mechanical restraints at this Trust is prohibited by Trust staff or any employed contractor. This includes the use of handcuff's (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. Staff should consider the patient's mental capacity and best interests when considering any form of restraint; this should be clearly documented in the patient's medical notes (Consent to Treatment Policy, HEFT 2011). This prohibition does not apply to the Police, Prison Service or other approved agency or body.

6.7.1 Mittens

- Mittens can only be used within Critical Care and Stroke units and staff within these units must adhere to the Trust guidance and monitor the application. Outside of these units the decision to use mittens will only be made by the dietician, following discussion with the Adult Safeguarding Team.

6.8 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.

7. Management of Care

- An appropriate plan of care with a review date should be devised by the clinician in charge and the nursing staff which will include any special requirements the patient may have with one or more nurses providing the care. In deciding to use restraint, the nurse must assess and record within the nursing care plan:

- The problem behaviour
- Why this behaviour is a problem i.e. it a danger to the client or to others?
- The proposed solutions which may include restraint
- Document the reason why restraint and the particular method of restraint is the method of choice
- Members of staff involved in restraint including security staff.

7.1 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 be documented on a MEWS/PEWS chart. The need for Neurological observations including GCS must be assessed and documented on the appropriate chart.

This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilisation
- If the person is suspected to be under the influence of alcohol or illicit 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.

7.2. Arrangements for Rapid Tranquillisation / Chemical Restraint

- In carrying out rapid tranquillisation, the patient should be able to respond to communication throughout the period of rapid tranquillisation. The aim of the rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others (NICE 25). Medication for rapid tranquillisation, particularly in context of physical intervention, should be used with caution owing to the following risks:
 - Loss of consciousness instead of tranquillisation
 - 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 physical disorders
- Any decision to chemically restrain a person should be made by the multidisciplinary team. Any longer term chemical restraint should be risk assessed and agreed and documented following MDT discussions.
- All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK).
- All staff who engage with physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS – Resuscitation Council UK).

7.3 Post Chemical Restraint

- After rapid tranquillisation is administered, staff should recognise the importance of nursing the patient in the recovery position (where safely possible). Staff should monitor and document observations on a MEWS/PEWS chart. The need for Neurological observations including GCS must

be assessed and documented on the appropriate chart. Patient hydration status must also be assessed.

7.4 Post incident support

- 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 (NICE 25). The post incident review should be arranged and chaired by the most senior person involved in the incident.
- A de-brief should take place as soon as practicably possible post-incident, unless there are exceptional circumstances which prevent this. Reflective reviews and root cause analysis are essential after restraint.
- The review should address:
 - What happened during the incident
 - Any trigger factors (Appendix 3)
 - 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
- As soon as practicably 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. 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.
- The Matron /Senior Sister of the clinical area must ensure the incident is reported via the DATIX system and the review, root cause analysis and its outcome is documented and sent to the Safety and Governance and a copy to Adult Safeguarding Team/Lead Nurses for Children's Safeguarding.

8. Roles and Responsibilities

8.1. Chief Executive

The Chief Executive retains overall responsibility for policies within the Trust Operational responsibility for this policy it is delegated to the Chief Nurse.

8.2 Executive Directors

The Chief Nurse is responsible for the development and review and monitoring of this Policy. The Chief Nurse will delegate this operational responsibility to the Head Nurses.

8.3 Head Nurses

The Head Nurses will oversee the implementation of this Policy and supporting. The Head Nurses will be involved in any RCA's where patient has been physically or chemically restrained and harm has occurred due to the restraint being applied.

8.4 Matrons

Matrons are responsible for adhering to and implementing this policy. Matrons must be aware of any patients within their clinical areas that require physical or chemical restraint and to ensure the clinical area is managing the patient in line with this policy. Matron must ensure that appropriate risk assessments, care plans and actions are completed and clearly documented.

8.5 Senior Sister / Charge Nurse /Departmental Manager

- Senior sisters, charge nurses and their deputies are responsible for local dissemination and implementation of this policy.
- Senior Sisters, Charge Nurses and their deputies must be aware of all high risk patients and have a ward based system to disseminate to their ward teams any patient that is requiring or has required physical or chemical restraint during their current hospital admission.
- Senior Sisters and Charge Nurses are responsible for ensuring that all their staff have the necessary skills and training to undertake the assessments and the observations. Familiarise themselves with this policy and support procedures, and ensure that the contents of the documents are brought to the attention of employees under their supervision.
- In all wards / areas where the use of restraint is foreseeable there must be a cardiac arrest trolley available to deliver a defibrillatory shock (if required) within 3 minutes. This must be stocked and checked according to Trust standard (HEFT Resuscitation Policy, NICE, 25)
- Ensure all staff undergoes Conflict Resolution Training.
- Ensure appropriate management plans are in place for all patients who have been assessed as posing a high risk of violence or aggression. All such plans must be brought to the attention of all relevant staff.
- Ensure staff involved in (or witness to) restraint are offered support, via the Occupational Health Department.
- Ensure that the Local Security Management Specialist (LSMS) and Adult Safeguarding Team is informed of the use of restraint or incident (even if restraint is avoided), and is copied in on any subsequent correspondence.

8.6 The member of staff identifying the violent or aggressive behaviour or intent will:

- Attempt to de-escalate by reassurance and other means.
- Wherever possible and if it is safe to do so move other patients away from the vicinity.
- Report the incident to the person in control of the area

8.7 The Person in control (the senior member of the team) will:

- 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, and conduct the risk assessment or the circumstances that will determine whether restraint is appropriate and justified
- 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 1st on Sister 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.

8.8 The Head of Facilities will:

- Ensure the Service Level Agreement between the Security Provider and the Trust is achievable, and report any deficiencies in the agreement to their line manager at the earliest opportunity
- Provide appropriately trained security staff to respond, support and assist HEFT 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 Security Sub Committee
- Ensure security involvement in planning the Trust response to an expected situation where the need for restraint is considered probable
- Ensure all security staff are fully aware of the Trust Policies and Procedures relating to violence and aggression
- Identify training needs of security staff in relation to restraint
- Ensure all security staff apply a uniform approach to a request for restraint

8.9 The Local Security Management Specialist will:

- Ensure the Security Sub Committee are kept fully abreast of any incidents, the outcome and any learning that needs to take place
- Advise the Trust and its employees on any change in security legislation or guidance around restraint
- Identify from incident data and risk assessment all high risk areas and support managers to implement appropriate arrangements
- Provide liaison and support to the Trust Solicitor, and Police & Crown Prosecution Service (CPS) as necessary
- Liaise with NHS Protect, Legal Protection Unit (LPU) and the Police in accordance with Secretary of State Directions
- Provide advice on care-planning in relation to potential violent and aggressive incidents
- Be part of the de-brief and any subsequent follow up

8.10 Resuscitation Officer will:

- Liaise with and support Managers of areas where the use of restraint is foreseeable in completing resuscitation risk assessment of their area. This will ensure that a cardiac arrest trolley is available to deliver a defibrillatory shock (if required) within 3 minutes (NICE 25)
- Work with the Trust's LSMS as required to review all incidents where the Restraint Policy has been used

8.11 Adult Safeguarding Steering Group

The Adult Safeguarding Steering Group will be responsible for ratification of this document and requesting review every 2 years or following any required material changes to the policy. The group should receive quarterly reports from the Safety Committee and the Challenging Behaviours Operational Group on the implementation of this policy.

9. Training

- Attendance at Trust Conflict Resolution is Mandatory for all Trust front line staff. Attendance at other conflict resolution training e.g. breakaway, management of actual or potential aggression will be determined by local risk assessment.
- All HEFT staff to receive as a minimum Level 1 Awareness Training for Safeguarding. All clinical staff receives a minimum of Level 2 Safeguarding.
- All clinical staff within the paediatric unit must receive training on the use distraction techniques, understanding the psychologically of children and be able to communicate with children and young people relevant to the child's own level of understanding.
Managers will ensure that all necessary training is given to staff to ensure this policy is implemented and adhered to at all times. Managers should identify through the appraisal process what the

individual /departments training needs are and will then source provision through the Faculty of Education.

- Staff within HEFT who is ordinarily likely to find themselves in situations where training in the management of actual or potential aggression might be necessary should attend an appropriate course taught by a qualified trainer. The trainer should have completed an appropriate course of preparation designed for health care settings and preferably validated by one of the health care bodies and processed for quality assurance through HEFT's Faculty of Education.

10. Monitoring & Compliance

<u>Requirement to be Monitored</u>	<u>Process for monitoring</u>	<u>Responsible group or individual</u>	<u>Frequency of monitoring</u>	<u>Responsible group or individual for review of results</u>	<u>Responsible committee, Group for development of action plan where required</u>
Our duties and local arrangements for management (a) through staff knowledge of this policy and procedures (b) policy compliance	Monitoring of incident trends will include monitoring of compliance with policy and knowledge and actions of staff.	The Local Security Management Specialist.	Monthly review of IR1s and quarterly reports to Safety Committee	Challenging behaviours operational group	Safeguarding Adults and Children's Steering Group. Challenging behaviours operational group
Duties and local arrangements through Number/themes trends and outcomes of those patients that require restraint Including feedback from families and carers	Datix reports, themes and trends reports	The Local Security Management Specialist	Monthly Review of IR1's & Quarterly report to committee	Challenging behaviours operational group	Safeguarding Adults and Children's Steering Group Challenging behaviours operational group
Our duties and local arrangements for management (a) through staff knowledge of this policy and procedures (b) policy compliance	Audit	The Local Security Management Specialist.	Annual	Challenging behaviours operational group	Safeguarding Adults and Children's Steering Group Challenging behaviours operational group
Expectations for staff training and compliance	Training Needs Analysis	Faculty of Education, Health and Safety team	Quarterly	Challenging behaviours operational group	Safeguarding Adults and Children's Steering Group Challenging behaviours operational group

11. References and Supporting Policies and Procedures

- BMA (2011), *Consent, Rights, and Choices in Health Care for Children and Young People*, BMJ London.
- Care Quality Commission Essential Standard (2010)
- Corporate Manslaughter Act
- Counter Fraud and Security Management Services, 2003
- Department of Health (1993). *The Guidance on Permissible Forms of Control in Children's Residential Care*. London HMSO.
- Department of Health (1997) *The Control of Children in Public Care: Interpretation of the Children's Act 1989* London HMSO.
- Guidance for nursing staff. *The Restraining, holding still and containing young children* guidance was first published in 1999, and was updated in 2003, following consultation with RCN members.
- Health and Safety at Work etc Act 1974
- HEFT Management of Violence and Aggression Policy
- HEFT Violent Warning Marker Policy
- Human Rights Act (1998), *European Convention on the Rights of the Child, Consent and Capacity cited in the UN convention on the Rights of The Child (1989)*
- Management of Health and Safety at Work Regulations 1999
- Mental Capacity Act
- National Institute for Clinical Excellence "Clinical Practice Guidelines for the Short-Term Management of Disturbed / Violent Behaviours in Adult Psychiatric In-Patient Settings and Accident and Emergency Settings, March 2005
- Physical Intervention : Reducing Risk
- RCN (2010) *Restrictive physical intervention and therapeutic holding for children and young people*.
- Secretary of State Directions 2005
- The Resuscitation Council for the UK, "Intermediate Life Support Guidelines (2004)"

12. Appendices

Appendix 1 Positional Asphyxia & Excited Delirium

Appendix 2 Imminent Risk of Harm Algorithm

Appendix 3 Triggers to violent and aggressive behaviour

Appendix 1 – Positional Asphyxia & Excited Delirium

Physical restraint can lead to harm and even death. The person being restrained must have close observation by a member of medical or nursing staff including A B C at all times

There are a number of potential adverse effects of the application of restraints. These include; being unable to breath, feeling sick or vomiting, developing swelling to the face and neck, and the development of petechiae (small blood-spots associated with asphyxiation) to the head, neck and chest.

Restraining an individual in a position that compromises the airway or expansion of the lungs (i.e. in the prone position) may seriously impair an individual's ability to breathe and can lead to asphyxiation. This includes pressure to the neck region, restriction of the chest wall and impairments of the diaphragm. When the head is forced below the level of the heart, draining of the blood from the head is reduced and brain swelling can result. Swelling to the head and neck and bloodspots (petechial) are signs of reduced drainage of blood from the head and neck. They are warning signs of actual or impending brain injury.

Pressure should not be placed on the neck, especially around the angle of the jaw or the windpipe. Pressure on the neck, particularly in the region below the angle of the jaw (carotid sinus) can disturb the nervous controls to the heart and lead to a sudden slowing or even stoppage of the heart.

The effect is most likely in persons:

- (i) Who have had a heart attack or have angina
- (ii) With high blood pressure
- (iii) With diabetes
- (iv) Who are aged over 60

A degree of positional asphyxia can result from any restraint position in which there is restriction of the neck, chest wall or diaphragm.

The risk is increased where:

- The head is forced downwards towards the knees
- The subject is immobilised seated (the angle between the chest wall and the low limbs is already decreased)
- The torso is compressed against or towards the thighs (restricts the diaphragm and compromises the lung inflation)
- In prone restraints the body weight of the restrained person acts to restrict movement of the chest wall and the abdomen (restricting diaphragm movement)

Factors that predispose a person to positional asphyxia and sudden death under restraint include:

- Drug / alcohol intoxication (because sedative drugs and alcohol act to depress breathing so reducing oxygen taken into the body)
- Physical exhaustion (or any factors that increase the body's oxygen requirements, for example a physical struggle or anxiety)
- Obesity

Warning signs related to positional asphyxia:

- An individual struggling to breathe
- Complaining of being unable to breathe
- Evidence or report of an individual feeling sick or vomiting
- Swelling, redness or bloodspots to the face or neck
- Marked expansion of the veins in the neck
- Individual becoming limp or unresponsive
- Sudden changes in behaviour (both escalated and de-escalated)
- Loss of, or reduced levels of, consciousness
- Respiratory or cardiac arrest

Where warning signs are present the restrainers must immediately release or modify the restraint as far as practicable to reduce body wall restriction, and summon the Crash Team.

No person should be restrained face down (or in the case of a pregnant person, on her side) for longer than is absolutely necessary to gain control. There must be continuous observation of a person following relocation in the prone position until such time as the person is no longer lying face down (or in the case of a pregnant person, on her side).

There is a common misconception that if an individual can talk then they are able to breathe, this is NOT the case. An individual dying from positional asphyxia may well be able to speak or shout prior to collapse.

Excited Delirium

Excited Delirium is both a mental state and physiological arousal

Excited Delirium can be caused by drug intoxication (including alcohol) or psychiatric illness or a combination of both

Differentiating someone in excited delirium from someone who is simply violent is often difficult. People suffering from excited delirium may:

- Have unexpected strength and endurance, apparently without fatigue
- Show an abnormal tolerance of pain
- Feel hot to touch
- Be agitated
- Sweat profusely
- Be hostile
- Exhibit bizarre behaviour and speech

It may only become apparent that a person is suffering from excited delirium when they suddenly collapse: beware of sudden tranquillity after frenzied activity which may be caused by severe exhaustion, asphyxia or drug related cardiopulmonary problems (problems with the heart and lungs)

Appendix 2 – Imminent Risk of Harm Algorithm

Note 1 Containing the Situation

- First on and Matron for the clinical area will have been informed at this stage. Security and members of medical / nursing staff will be present
- If possible move other patients, visitors away from the vicinity
- Security 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 or security take over. Ensure de-brief as soon as possible after event

Note 2 Security Officer Role

- Call received to respond to incident
- Security will liaise with the Police as necessary to ensure a swift response
- For such a situation a minimum of 2 officers are required to assist the clinical team
- Wherever possible the respondent(s) should be trained in restraint as per National Standards. If NOT trained inform the Person in Control & Head of Technical Services as soon as possible. A swift response is paramount in order to contain the situation
- Liaison at the scene with medical / nursing staff to agree restraint techniques and security will lead
- Security officers can restrain if it is the only option available to reduce the risk to themselves and others including if the patient has multiple attachments, to allow medication to be administered. All nursing staff are trained in Basic Life Support techniques and one member of staff will be allocated this observation role (See Note 3).

Note 3 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 and psychological wellbeing throughout

AFTER

Any person subject to physical interventions will need to be reviewed for placement on the appropriate observations level, for a period of up to 24 hours. 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 and food intake and output

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.

When and How to call the Police

The Police will only attend the Trust when a crime has been committed or is about to be committed. Trust security staff should always be called for assistance in the first instance out of hours. However, if any individual should display a level of violence or behaviour that is deemed uncontrollable and likely to lead to an act of violence then clinical staff and security offices should take the decision to call the Police to the scene. In an emergency where the safety of staff or others is at immediate risk the Police should be called via 2222.

Once the Police have been called every attempt should be made to contain the situation before their arrival and, if necessary, make arrangements to evacuate all other people who are unconnected with the incident from the area concerned.

When the police arrive at the scene all relevant information, including the capacity of the patient at the time of the incident should be provided to them so that they can determine a course of action e.g. arrest. Police will not affect an arrest if a patient did not have capacity at the time of the incident.

In cases where a clinician determines that a patient requires urgent medical attention but is incapable of informed choice, the clinician may administer the appropriate treatment. Police Officers requested to restrain an individual for the purposes of such treatment to prevent death or serious injury, may lawfully apply proportionate and necessary force in order to assist: in such cases the Mental Capacity Act 1005 and the common law defence of necessity apply (R v Cairns 1999). Police will only restrain a patient when informed by a clinician that the individual is in need of urgent medical attention and is incapable of informed choice.

Appropriate details of the attending Police Officers, i.e. their name, collar number, the police station at which they are based and the action that they have taken, must be recorded and added to the Incident Report Form.

Police use of CS Spray in Hospitals

If officers are deployed to hospital wards to deal with inpatients then information should be obtained on the clinical condition of such persons and of those patients likely to be affected by any action taken by officers.

This is of particular importance where the use of CS spray is to be considered as a tactical option.

Legislation

The legislation that covers restraint derives from both criminal and civil law. Relevant Acts of Parliament that impact on the law relating to restraint include:

- Mental Health Act 1983
- Human Rights Act 1998
- Mental Capacity Act 2005
- Offences Against the Person Act 1861
- Health and Safety at Work Act 1974

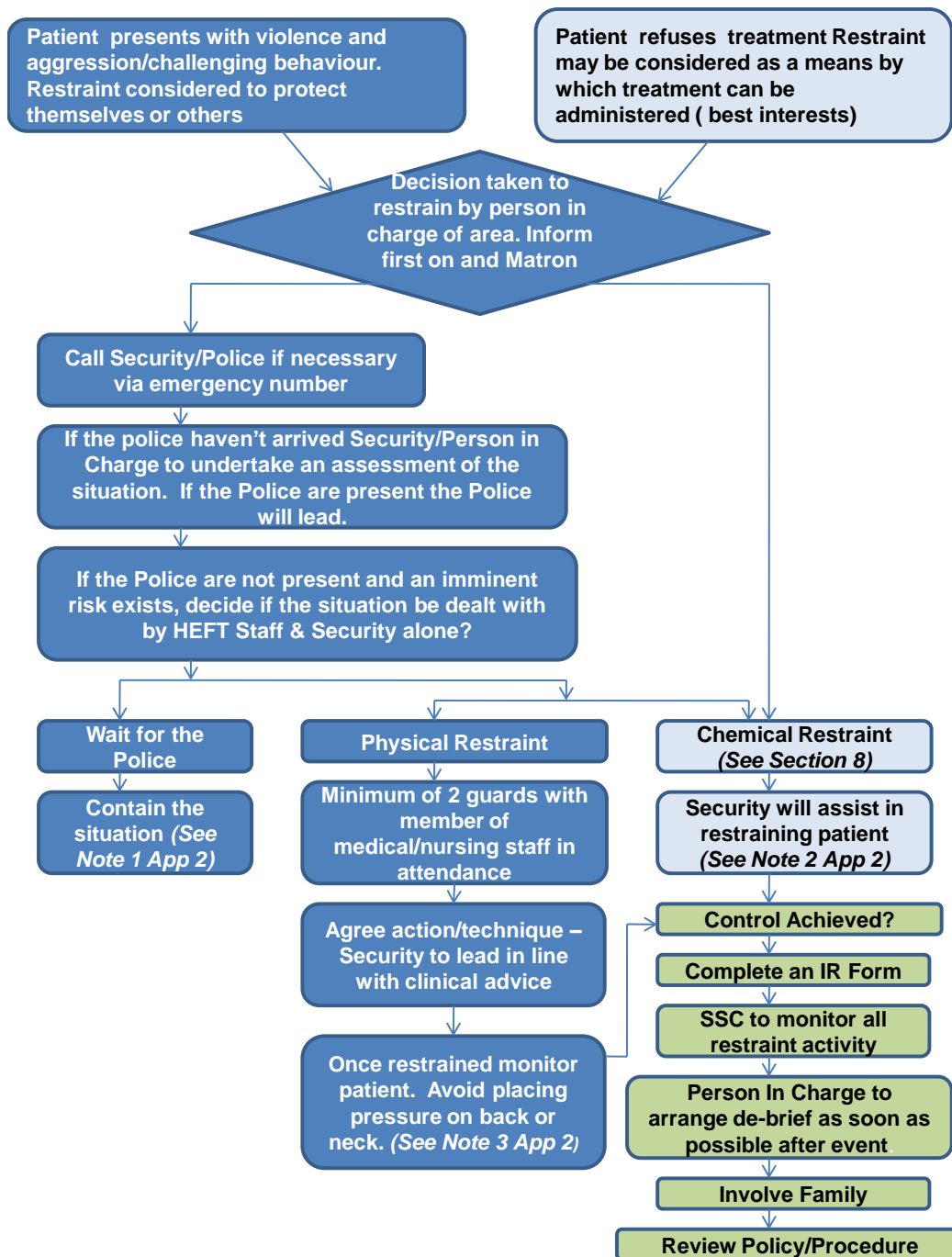
Clinical Holding (Restraint) Policy

Version 3.0



- Human Rights Act October 2000
- Criminal Law Act 1967

This flow chart refers to the procedure when dealing with patients deemed not to have capacity (ref. MCA and DOLS section 6.)



Beware of positional asphyxia and excited delirium. Patient could be in imminent danger of collapse but still may be able to talk or shout. Release or adjust 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.

Summary flowchart for managing a patient demonstrating violent or aggressive behaviour

If there is an **immediate risk of danger to self or others:**

- Contact security, first on sister and on call matron for assistance and describe patient as category red, amber or green as below.

RED	AMBER	GREEN
<ul style="list-style-type: none"> • Violent behaviour • Possession of weapon (requires urgent police attendance) • Extreme agitation/restless • Physical/verbally aggressive • Confused/unable to co-operate 	<ul style="list-style-type: none"> • Agitated/ restless • Intrusive behaviour • Bizarre/ disordered behaviour • Confused/ withdrawn/ uncommunicative • Ambivalence about treatment 	<ul style="list-style-type: none"> • No agitation/restlessness • Irritable without aggression • Co-operative • Gives coherent history • Communicative • Compliant with instructions

Call security and consider need for police

- De-escalate and use reasonable restraint to protect patients' and others' safety. (*Restraint policy HEFT 2011*)
- Close observation and RMN special required.
- Document incident and complete IR1

Request urgent assessment by senior medical staff

- Close observation with HCA / RGN special.

- Assess physical and mental health to determine cause of aggression.
- Do full psychiatric assessment (SAD tool) (*Policy for the management of psychiatric/ deliberate self harm patients, HEFT 2011*)
- Assess mental capacity using mental capacity assessment tool (*Consent to treatment policy, HEFT 2011*).

Does the patient have capacity?

i.e. understand the impact of their actions and the implications / sanctions that could follow?

No

Restraint can be used to protect patient or others from harm and/or to medically treat them if in patients best interest.

Patient can be prevented from leaving the ward if there is deemed a risk to them or others.

Consider application for DOLS (*Safeguarding adults policy HEFT 2010*).

Yes

Attempt to de-escalate and persuade to stop behaving aggressively.

Contact security for advice/support. (*Violence and aggression policy HEFT 2011*).

Patients with capacity have a right to leave the ward / self discharge.

Any consequences should be explained and documented.

Is patient displaying psychiatric symptoms and/or is detained under the mental health act or awaiting a sectioning assessment?

- Ensure referral to psychiatry

For detailed flowchart see policies and procedures on intranet

HEFT Version 1

Appendix 3 - Triggers to violent and aggressive behaviour

Violent or aggressive behaviour can be an attempt at communicating an unmet need. This behaviour is usually 'triggered' by something and it is important if you do recognise a trigger – that agitates or calms a person that you communicated it to all staff caring for that person. There may not be any rational explanation for these triggers but if they are recognised they can help you manage and prevent violent and aggressive behaviour.

Understanding aggression

Aggression may be a defensive reaction to a threatening invasion of personal space. Aggressive resistance to care may result if the purpose is poorly communicated or understood and staff are not recognised

- *An elderly lady would only let one particular nurse attend to her personal needs. The member of staff kept the lady calm by singing to her*

Resistance may be an expression of need to assert choice and remain independent. Giving instructions to 'stop it' or act differently may provoke an aggressive response

- *An elderly gentleman with dementia was quite happy when fed tea and toast and was allowed to sit next to the nursing station having previously been aggressive and found wandering at all times of the day and night.*

Night time can be very traumatic, with shadows, loud noises and no recall of where the person is. It is important to try to manage triggers at all times if possible and acknowledge feelings of disorientation may be heightened at night.

Abrupt or sudden approaches towards a person who is poorly sighted /hard of hearing as well as confused/frightened, may result in a hostile act of self protection. Make sure you are in full view and give the patient a chance to recognize you. If something can be done later when the patient is more settled then defer

Aggression may be linked to delusions – fixed false beliefs which cannot be reasoned with eg - staff are trying to poison them/ other patients are out to kill them

Blaming others may be the means by which the frightening implications of a deteriorating memory are denied.

An unexpected change of routine, a misplaced article or a name that cannot be recalled may result in an uncontrolled outburst of temper. Not knowing where you are, why you are there and the faces around you cause distress. The person may respond by wanting to go home.

Wandering

Some people may repeatedly walk the same route. Their actions are not under voluntary control. Some may be looking for 'landmarks' that make sense. Agitated wandering occurring at dusk may be a desire to leave the ward; the person thinks it is time to 'go home' from work/school

Curiosity and exploration may result in behaviours such as collecting items, fiddling with things and wandering. Trying to stop the person may result in frustration. Problems with perception, memory and understanding cause the once familiar to become mysterious.

'Pottering with purpose' may actually be a sign of contentment and may be reminiscent of work/hobbies. The person may feel isolated and alone walking around looking for a friendly, familiar face.

Noise making can be:

- A communication of pain or physical discomfort
- A response to unpleasant conditions e.g. being cold or uncomfortable
- A vocal confirmation of unmet needs – toilet, hunger, thirst 'help me'.
- A stress reaction
- A response to hallucinations
- A result of under stimulation

Adopting a safe environment.

- Calm, well organized and familiar.
- Adequate lighting to enable elderly patients to orientate themselves.
- Family members should be invited to assist in the care.
- Patient's belongings such as photos, and other objects around them.
- Regular and repeated visible and verbal clues to orientation (eg time, calendars)
- Reassurance and explanation to the patient and carer of any procedures or treatment, using short simple sentences
- Sensory aids should be available if possible. Some case studies mention toys, music etc. Inactivity can cause frustration and sensory deprivation may be compounded by poor vision/hearing
- Avoidance of inter and intra-ward transfers
- Continuity of care from caring staff
- Maintenance or restoration of normal sleep patterns
- Approach and handle gently
- Eliminate unexpected and irritating noise (e.g. pump alarms)
- Ensure fluid balance and meeting nutritional needs
- Attend to bowel and bladder elimination
- Encouraging visits from familiar friends and relatives may help to calm an agitated patient.

Communication with the relative regarding the nature of the confusion is essential. Where relatives are asked to assist in the care of a disturbed or agitated patient, an explanation of why their involvement is necessary and how they can help should be given.

Wandering and Agitation

Patients who wander require close observation within a safe and reasonably closed environment. It is often preferable to try distracting the agitated wandering patient rather than using restraints or sedation. Relatives could be encouraged to assist in this kind of management. Attempts should be made to identify and remedy possible cause of agitation - e.g. pain, thirst, need for the toilet.

If serious agitation/ aggression is displayed that may threaten the safety of other patients removal to a side room may be necessary if possible.

Management of the patient presenting challenging behaviour is crucial in creating a safe environment. It is essential to:

- Know the patient
- Obtain information – past history/anecdotes from other carers
- Ensure information is disseminated - handover
- Recognise triggers

- Try different approaches to care – can something be done differently according to the individuals needs.

Ref: Promoting Therapeutic Services Training book – Security management service of the NHS
Understanding and Responding to Challenging Behaviour – Cardiff and Vale NHS Trust. -2005
Clinical guideline for the care of Older people with Dementia in a General Hospital Setting - Isle of Wight
Healthcare NHS Trust – 2005

http://www.rcn.org.uk/_data/assets/pdf_file/0016/312613/003573.pdf

Attachment 1: Consultation and Ratification Checklist

Title	Clinical Holding (Restraint) Policy
--------------	--

	Ratification checklist	Details
1	Is this a: Policy	
2	Is this: New	
3*	Format matches Policies and Procedures Template (Organisation-wide)	Yes
4*	Consultation with range of internal /external groups/ individuals	Yes
5*	Equality Impact Assessment completed	Yes
6	Are there any governance or risk implications? (e.g. patient safety, clinical effectiveness, compliance with or deviation from National guidance or legislation etc)	No
7	Are there any operational implications?	Yes
8	Are there any educational or training implications?	Yes
9	Are there any clinical implications?	Yes
10	Are there any nursing implications?	Yes
11	Does the document have financial implications?	No
12	Does the document have HR implications?	No
13*	Is there a launch/communication/implementation plan within the document?	Yes
14*	Is there a monitoring plan within the document?	Yes
15*	Does the document have a review date in line with the Policies and Procedures Framework?	Yes
16*	Is there a named Director responsible for review of the document?	Yes
17*	Is there a named committee with clearly stated responsibility for approval monitoring and review of the document?	Yes

Clinical Holding (Restraint) Policy

Version 3.0



Document Author / Sponsor -

Signed -

Title -

Date -

Ratified by (Chair of Trust Committee or Executive Lead)

Signed -

Title -

Date -

Attachment 2: Equality and Diversity - Policy Screening Checklist

Policy/Service Title: Clinical Holding (restraint) Policy		Directorate: Corporate Nursing					
Name of person/s developing policy; Phil Chambers & Lorraine Longstaff							
Aims/Objectives of policy: This policy is intended to provide guidance for managers, staff and security contractors in relation to the nature, circumstances and use of approved restraint techniques currently adopted by the Trust							
Policy Content:							
<ul style="list-style-type: none"> For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation? The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation. 							
1. Check for DIRECT discrimination against any group of SERVICE USERS:							
Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
1.1	Age?		✓		✓		✓
1.2	Gender re-assignment?		✓		✓		✓
1.3	Disability?		✓		✓		✓
1.4	Race or Ethnicity?		✓		✓		✓
1.5	Religion or belief (including lack of belief)?		✓		✓		✓
1.6	Sex?		✓		✓		✓
1.7	Sexual Orientation?		✓		✓		✓
1.8	Marriage & Civil partnership?		✓		✓		✓
1.9	Pregnancy & Maternity?		✓		✓		✓
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
2. Check for INDIRECT discrimination against any group of SERVICE USERS:							
Question: Does your policy/service contain any statements/functions which may exclude people from using the services under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
2.1	Age?		✓		✓		✓
2.2	Gender re-assignment?		✓		✓		✓
2.3	Disability?		✓		✓		✓
2.4	Race or Ethnicity?		✓		✓		✓
2.5	Religion or belief (including lack of belief)?		✓		✓		✓
2.6	Sex?		✓		✓		✓
2.7	Sexual Orientation?		✓		✓		✓
2.8	Marriage & Civil partnership?		✓		✓		✓
2.9	Pregnancy & Maternity?		✓		✓		✓

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION =

3. Check for DIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any statements which may exclude employees from implementing the service/policy under the grounds of:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
3.1	Age?		✓		✓		✓
3.2	Gender re-assignment?		✓		✓		✓
3.3	Disability?		✓		✓		✓
3.4	Race or Ethnicity?		✓		✓		✓
3.5	Religion or belief (including lack of belief)?		✓		✓		✓
3.6	Sex?		✓		✓		✓
3.7	Sexual Orientation?		✓		✓		✓
3.8	Marriage & Civil partnership?		✓		✓		✓
3.9	Pregnancy & Maternity?		✓		✓		✓

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		Response		Action required		Resource implication	
		Yes	No	Yes	No	Yes	No
4.1	Age?		✓		✓		✓
4.2	Gender re-assignment?		✓		✓		✓
4.3	Disability?		✓		✓		✓
4.4	Race or Ethnicity?		✓		✓		✓
4.5	Religion or belief (including lack of belief)?		✓		✓		✓
4.6	Sex?		✓		✓		✓
4.7	Sexual Orientation?		✓		✓		✓
4.8	Marriage & Civil partnership?		✓		✓		✓
4.9	Pregnancy & Maternity?		✓		✓		✓

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION =

Signatures of authors / auditors: Lorraine Longstaff

Date of signing: 2.02.2012

Attachment 3: Equality Action Plan/Report

Directorate: Corporate Nursing

Service/Policy: Adult Clinical Holding (Restraint) Policy v1.0

Responsible Manager: Sam Foster

Name of Person Developing the Action Plan: Lorraine Longstaff

Consultation Group(s): Safeguarding Adults steering group, challenging behaviours operational group

Review Date:

The above service/policy has been reviewed and the following actions identified and prioritised.
All identified actions must be completed by: _____

Action:	Lead:	Timescale:

When completed please return this action plan to the Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey. The plan will form part of the quarterly Governance Performance Reviews.

Signed by Responsible Manager:

Date:

Attachment 4: Launch and Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Action	Who	When	How
Identify key users / policy writers	Safeguarding adults Matron/Governance and Safety Lead	When Ratified	Through matrons Groups & communications process
Present Policy to key user groups	Safeguarding Matron/Governance and safety Lead	When Ratified	Launch & awareness sessions
Add to Policies and Procedures intranet page / document management system.	Safety and governance Matron safeguarding adults	When ratified	Upload onto sharepoint
Offer awareness training / incorporate within existing training programmes	Safeguarding adults Matron/governance and safety lead. Nursing & Faculty of Education	When Ratified	Launch & include on safeguarding website and other relevant training
Circulation of document(electronic)	Safeguarding adults matron	When ratified	Via Corporate Nursing gatekeeper