Nottinghamshire Hospice
adding life to days

POLICY/PROCEDURE INFORMATION (Policy no CS027)	
Subject	**Restraint Policy** *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs)*
Applicable to	All employees of Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	15 October 2024
Next review date	15 October 2027
Lead responsible for Policy	Director of Care
Policy reviewed by	Head of Community Services
Notified to (when)	Quality and Safety Committee 15 Oct 2024
Authorised by (when)	Quality and Safety Committee 15 Oct 2024
CQC Standard if applicable	Safe
Links to other Hospice Policies	Safeguarding Adults at Risk Policy and Procedures CS003 Mental Capacity Act Policy CSOO7
Links to external policies	Positive and Proactive Care: reducing the need for restrictive interventions (DH) NICE Guideline [NG31] Care of dying adults in the last days of life
Summary	This policy Is clear that restraint is a last option and details methods staff may use to avoid it. It outlines the types of restraint that may be used and those that may not. It details the principles of the Mental Capacity Act and the monitoring and checks that surround any restraint that takes place.
This policy replaces	Restraint Policy CS027 [2023-24]

IMPORTANT NOTICE

Staff should refer to the Hospice Intranet for the most up to date Policy. If the review date of this document has passed it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Review date**
Original policy written by Deputy Director of Care, Governance Lead	Aug 2023	
Policy notified to Quality and Safety Committee	26 Sept 2023	
Policy ratified by Quality and Safety Committee	26 Sept 2023	26 Sept 2024
Policy reviewed by Head of Community Services	Sept 2024	
Policy notified to Quality and Safety Committee	15 Oct 2024	
Policy authorised by Quality and Safety Committee	15 Oct 2024	15 Oct 2027
Updated control sheet and published on website	Oct 2023	Oct 2024

INDEX		
Section	**Contents Title**	**Page**

APPENDICES		
Appendix	**Appendix Title**	**Page**

1.	**Introduction** Nottinghamshire Hospice is committed to providing the highest standard of health, safety and welfare to its patients, employees and volunteers. Restraint **r**estricts a person's freedom of movement, whether they are resisting or not. The Mental Capacity Act 2005 states: *'Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.'* Restraint is a last resort intervention and will only be considered when all other practical means of managing the situation, such as de-escalation, involvement of family where appropriate, verbal persuasion, or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. A Best Interest decision should be considered if the Patient does not have capacity. Restraint should not cause injury, pain, distress or psychological trauma. It should not undermine dignity, humiliate or degrade the patient. Where it is thought that these things might occur, they should be openly acknowledged along with the steps to minimise this. The intensity of the restraint used should be proportionate to the risk – to both the patient and others.
2.	**Policy Statement/Aims** The use of restraint will be reasonable, proportionate and used only when necessary for the shortest period of time**.** This policy aims to reflect best practice and current legislation as well as providing staff with guidance on how to avoid the use of restraint and what their responsibilities are if it has to be used for the safety of the patient and others.
3.	**Scope** This policy includes all staff and persons working or volunteering for Nottinghamshire Hospice
4.	**Responsibilities** **Director of Care** The Director of Care is responsible for implementation of this policy to ensure

	that staff use restraint appropriately. **Heads of Service** Must ensure the staff both understand and implement this policy. **Staff** All staff must ensure adherence to the policy when working with those who use the service. **Accountability** Staff will be accountable at all times for their actions in relation to the use/non-use of restraint, and inappropriate use of restraint, force or acts that are deemed a deprivation of liberty and may result in: • Disciplinary action by Nottinghamshire Hospice • Disciplinary action by a professional body e.g. NMC • Civil liability for damages for assault, battery, false imprisonment or infringement of human rights • Criminal charges for assault, battery, false imprisonment, or the criminal act of 'ill treatment' or 'willful neglect' set out in the MCA 2005. On 1 April 2007 the criminal offence of ill treatment and willful neglect created by Section 44 MCA 2005 came into force. It applies to anyone caring for a person (of any age) who lacks capacity to make decisions for themselves due to an impairment of or a disturbance in the functioning of the mind or brain. Any deprivation of liberty, and in certain situations, acts of restraint, may constitute the offence where the act or omission amounts to ill treatment or willful neglect. If a person is found guilty of ill treatment or willful neglect, they will be liable for a fine, or a term of imprisonment of up to five years, or both. It is therefore important that any act of restraint used in the care or treatment of a person lacking capacity is carried out in accordance with the specific provisions of Section 6 of the Act, namely that the person carrying out the act has a reasonable belief that the act is necessary to prevent harm to the individual, and it is a proportionate response to the likelihood and seriousness of the

	harm. All factors considered, decisions taken, and actions carried out should be fully documented in the patient's healthcare records.

5.	**Types of Restraint**
	These can be:
	Physical - 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person (1.)
	• Physical intervention
	  o Physical intervention should be avoided if possible, and in the event that it is necessary, should only ever be carried out by staff specifically trained in physical restraint techniques and who are trained to the appropriate level in Basic Life Support
	  o A suitable and sufficient risk assessment should be in place for all planned physical interventions.
	  o Physical Interventions will always involve minimum force and for the minimum amount of time
	  o They must never be for staff convenience
	• Hand bandaging/use of mittens
	In certain specific situations, it may be appropriate to bandage a patient's hands or use mittens to prevent them pulling out a feeding tube (NG/PEG). Such a decision should be taken only after discussion with the clinical on call after a full consideration of all risks and benefits
	Prone restraint: (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. **This should not be used**. If in the rare occasion it is used it should be for the shortest period of time and only for the purpose of gaining reasonable control **if necessary**.
	Mechanical - 'the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (1.)
	• Bed rails
	These are appropriate as a preventative safety measure for those patients who tend to roll out of bed. They should only be used after a full

	risk assessment and if they are considered the least restrictive option available to healthcare staff to ensure the safety of the patient and prevent harm. HSE Guidance on the safe use of bedrails Bed rail risk management **Chemical -** 'The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness' (1.) • Medication The aim of pharmacological intervention is to reduce excitement and activity in order to facilitate other interventions. Any medication given must be prescribed by a doctor but can be administered without the patient's consent if it is an acute situation and is in the patient's best interests to do so. This must be clearly recorded.
6.	**Unacceptable Methods of Restraint** **Elevated bed height** Raising the height of a bed so that a patient cannot get off, which increases the risk of a fall. **Wheelchair safety straps** Wheelchair straps should be used for safety and not for restraint **Reclining chairs** Reclining chairs should only ever be used for patient comfort and not as a method of restraint. **Locked doors** Doors can only be locked as a method of restraint if a Deprivation of Liberty Safeguard (DoLs) is in place. **Arranging furniture to impede movement** Using furniture or equipment to impede movement increases the risk of falls **Removal of walking aids, outdoor shoes and sensory aids (e.g., glasses/hearing aids)** This can cause confusion and disorientation and increase the risk of patient harm from falls. ***Inappropriate use of restraint will be considered a disciplinary issue.***

	If staff observe family members or staff from other agencies carrying out any of the above actions they should raise the matter if they feel comfortable in doing so or inform their line manager.
7.	**De-escalation** De-escalation techniques should be used before other interventions, so it is important to identify areas of potential conflict before they escalate. (Appendix 1)
8.	**Emergency** Whenever possible, risk assessments will mean that restraint will not be necessary. De-escalation techniques will always be the first option to resort to. If a patient's behaviour is escalating staff should inform the District Nurse and their Line Manager. Anyone who applies any form of restraint should be prepared and able to justify why they have done it. In some circumstances, behaviour can be unpredictable and there may be times when it is reasonable to use restraint if de-escalation hasn't been successful. In the UK there are situations when it would be seen as lawful to use reasonable force to restrain a patient providing that it can be shown to be the only way of preventing harm to the individual or others (2.). These are: • To prevent self-harm or risk of physical injury • Where staff are at immediate risk of physical assault • To prevent dangerous, threatening or destructive behaviour In all scenarios, the method of restraint used must be proportionate to the risk posed, be the least restrictive means necessary and for the shortest possible period of time. If staff feel they or others (patients, family, visitors or volunteers etc) are at risk of injury or assault then they must call the Police on 999.

9.	**Recording and Reporting** All incidents of restraint must be recorded in the patient's records and on a Vantage Incident Form. This will be reviewed by the Incident Review Group. It must be clearly documented that any mechanical or physical interventions were considered by a group wider than just the service to assess whether this was the least restrictive option, which was in the best interests of the person, and that there were no less restrictive alternatives which were appropriate and proportionate to the risks posed. (3.) Any injuries arising from the restraint to the patient, staff member or anyone else must be recorded on the Incident form.
10.	**Consent and the Mental Capacity Act** Wherever possible staff should seek the consent of the individual for all care and treatment, ensuring that everything is explained clearly to them in terms and ways that they can understand. If the patient's capacity to make a decision is in question under the Mental Capacity Act (4.) there are 5 statutory principles to be taken into account: 1. A person must be assumed to have capacity unless it is proved otherwise. 2. A person must not be treated as unable to make a decision unless all practicable steps to help have been taken without success. 3. A person is not to be treated as unable to make a decision merely because an unwise decision is made. 4. An act done, or decision made under the Act for, or on behalf of a person who lacks capacity, must be done in their best interests. 5. Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved in a less restrictive way. If it is believed they are unable to make a decision, then a formal capacity assessment should be carried out in relation to the specific intervention (see the Mental Capacity Act Policy).
11.	**Managing Anxiety, Delirium and Agitation** (5, 6)

	Patients who are receiving palliative care or end of life care may experience episodes of anxiety or delirium (7.), with or without agitation. It is important to explore the possible causes for this with the person who is dying and if possible, those who are important to them. Some of the causes may be related to unrelieved symptoms or bodily needs such as unrelieved pain, a full bladder or rectum. • Consider non-pharmacological management of agitation, anxiety and delirium in a person in their last days of life • Treat any reversible causes such as psychological causes or certain metabolic disorders (for example renal failure, hypercalcaemia or hyponatraemia) **Pharmacological Management** • Consider a trial of a benzodiazepine to manage anxiety or agitation • Consider a trial of an antipsychotic medicine to manage delirium or agitation • Seek specialist advice if the diagnosis of agitation or delirium is uncertain, if the agitation or delirium does not respond to antipsychotic treatment or if treatment causes unwanted sedation.
12.	**Training** Staff are trained in the following areas to enable them to support patients and avoid the use of restraint: • Non-pharmacological symptom management • Dementia awareness • Learning Disability Awareness • Conflict Resolution • Safeguarding Adults

13.	**Monitoring Oversight** Restraints data and details will be reported by exception to the bi-monthly Quality and Safety Committee and to the Quarterly Hospice Board by the Director of Care. Any death that occurs following a period of restraint needs to be highlighted in the notification of death process to the Care Quality Commission (CQC).
14.	**Equality Impact Assessment** An Equality Impact Assessment (EIA) screening has been completed.

15.	**References** 1. Positive and Proactive Care: reducing the need for restrictive interventions 2. Legal aspects of Nursing, 8th edn. Dimond B. London: Pearson. (2019) 3. Brief guide: restraint (physical and mechanical) CQC 4. Mental Capacity Act 2005 5. Delirium: prevention, diagnosis and management in hospital and long-term care NICE Clinical guideline [CG103] 6. Violence and aggression: short-term management in community settings NICE 2015 [Ng10] 7. Care of dying adults in the last days of life NICE guideline [NG31] December 2015

Appendix 1

De-escalation Guidelines

Be aware of and spot early signs of agitation such as balled fists, fidgeting, shaking, ‘eyeballing’, head thrust forward or clenched jaw. Changes in voice, such as speech becoming more rapid or high-pitched, may also indicate aggression.

Key principles are as follows:

One staff member should assume control of a potentially disturbed/violent situation. This staff member should:

- Consider which de-escalation techniques are appropriate for the situation
- Manage others in the environment (e.g., removing other patients from the area, getting colleagues to help and creating space) and move towards a safe place
- Explain to the patient and others nearby what they intend to do, giving clear, brief, assertive instructions. Consider their language – it may be useful to follow the rule of 5 (no more than 5 words in sentence, 5 letters in a word – e.g., "Would you like a chair?"). Also lower their voice and keep their tone even. It is hard to have an argument with someone who is not responding aggressively back to
- Ask for facts about the problem and encourage reasoning (attempt to establish a rapport; offer and negotiate realistic options; avoid threats; ask open questions and ask about the reason for the patient’s anger; show concern and attentiveness through verbal and non-verbal responses; listen carefully; do not patronise and do not minimise the patient’s concerns)
- Ensure that their own non-verbal communication is non-threatening and not provocative
- Where there are potential weapons in the area, the patient should be relocated to a safer environment, where possible
- If the patient has a potential weapon, ask for it to be put in a neutral location rather than handed over

- Consider asking the patient to make use of a designated room (e.g., quiet room where this is available/appropriate) to help them calm down
- Consider ways to maintain the safety of both them and others during situations of potential violence for example:
    - Taking a position just outside the individual's personal reach on the non-dominant side
    - Maintain an open posture
    - Keep the individual in visual range
    - Make certain the room's door is readily accessible; avoid letting the individual get between you and the door

(Adapted from NICE Guidelines [NG10] 28 May 2015)