

**The Use of Restraint: Alternatives and Considerations  
(Including Use of Bed Rails)**

Effective: March 2011

Review: March 2012

**1. Summary**

This document provides information and guidance on the use of restraint for adult patients in the Newcastle upon Tyne Hospitals NHS Foundation Trust. The policy outlines principles (contained within the appendices) and practice guidance.

**2. Individual Wards and Departments**

Individual wards and departments are encouraged to develop their own policies to address specific issues relevant to their ward/department. This might include the provision of training for staff on the care of certain patients, such as people with dementia or stroke, or people who abuse drugs or alcohol, and more in depth information on the types of restraint which might be used in specific circumstances. Any separate policy should be consistent with this policy and must be developed through consultation with the multi-disciplinary team, Safeguarding Adults Lead, Heads of Nursing and where necessary the Trust Solicitor.

**3. Exclusions**

This policy does not relate to the routine clinical use of sedation within anaesthetics and critical care or clinical treatment areas such as endoscopy or radiology when conscious sedation is required.

**4. Trust Statement**

It is acknowledged that decisions on the use of restraint methods to be applied to patients in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such restraint may lead to complaints by patients or their relatives. Unlawful restraint may give rise to criminal or civil liability (see Appendix 4). It is self-evident that staff may be required to account for their actions in such circumstances. However the Trust will always support employees who act in a way that is deemed reasonable and measured at the time of the incident and in accordance with professional standards and training.

**5. Definition**

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

- Use force - or threaten to use force - to make someone do something they are resisting.
- Restrict a person's freedom of movement, whether they are resisting or not

Restraint is the use of threat or force to help carry out an act which a person is resisting.

The Deprivation of Liberty provisions of the Mental Capacity framework are for people who need to be deprived of their liberty in a hospital or a care home in their best interests for care and treatment where they lack capacity to consent to the arrangement for their care and treatment.

## **6. Before Using Restraint**

Restraint or Deprivation of Liberty will only be used when the person using it reasonably believes it is necessary to prevent harm to the person and the restraint used will be proportionate to the likelihood and seriousness of harm.

This policy and others will be maintained to ensure that people who lack capacity will not be deprived of their liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

Before using restraint an individual assessment should be carried out which considers:

- The environment
- Patient's behaviour
- Patient's underlying condition and treatment
- Patient's mental capacity
- Duty of care
- Risk to patient and to others

Departments are responsible for ensuring that detailed care plans and risk assessments are carried out on the use of restraint in accordance with the Trust Health and Safety Policy and Procedure.

[http://intranet/Policies/healthsafety/HealthSafetyOperationalPolicyDecember2007\(2008\).pdf](http://intranet/Policies/healthsafety/HealthSafetyOperationalPolicyDecember2007(2008).pdf)

### **6.1 The Environment**

The care environment can have either a positive or a negative effect on patients. Every effort should be made to reduce the negative impact of the environment. Examples of environmental factors which can have a negative impact include: extreme staffing shortages impacting on quality of care or levels of supervision, restricted observation in patient areas, high levels of noise or disruption, boredom or the incorrect level of stimulation for patients and negative attitudes/poor communication skills of staff.

### **6.2 Behaviour and Underlying Condition**

Understanding a patient's behaviour and responding to individual needs should be at the centre of patient care. All patients should be assessed comprehensively in order to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying the underlying cause of the behaviour (agitation, wandering, absconding etc) and deciding whether the behaviour needs to be prevented. Possible causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel
- Pain or discomfort

- Electrolyte or metabolic imbalance
- Anxiety or distress
- Mental illness<sup>1</sup> – (organic eg, dementia and delirium or functional eg, mania or schizophrenia)
- Other form of memory impairment
- Drug dependency or withdrawal (including alcohol, nicotine, sleeping tablets and illicit drugs)
- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)

If a patient's mental health is an issue, the mental health services can be contacted for advice/support. Details of how to contact the mental health services are in Appendix 5.

<sup>1</sup> Other related factors might be: hallucinations, delusions, paranoia and personality issues 3.

Often behaviour such as wandering is problematic for staff. However this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.

Having identified the reason for the behaviour, the Clinical Team should then decide on the appropriate strategy for dealing with this in conjunction with other members of the multidisciplinary team (to include treatment of the underlying cause). This should be documented in the medical or nursing/multidisciplinary notes or on the "request for consultation" (as appropriate).

### 6.3 Mental Capacity (see Appendix 4)

It is necessary to consider the patient's mental capacity, as consent for the use of any type or method of restraint must be gained from patients, unless they lack mental capacity to make this decision. Patients should be "informed partners" in their health care. The Trust policy on Consent to Examination or Treatment should be referred to and adhered to. Assessment of capacity must be in accordance with the Mental Capacity Act.

A capacity issue is decision and time specific. Individual patients cannot simply be described as "lacking capacity". A patient's capacity may fluctuate.

All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests.

### 6.4 Duty of Care (see Appendix 4)

All health care staff have a duty of care for the patients in their care. This means acting in their "best interests". In relation to a patient who is at immediate risk of harm, the use of restraint may be part of fulfilling duty of care.

## 7. Using Restraint

The Trust is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care. Therefore when using restraint a balance must be achieved between

minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of the patient.

Some situations are identified where steps taken amount to more than a restraint and may amount to a deprivation of liberty. Relevant factors may include:

- If restraint is used including sedation to admit a person to an institution where the person is resisting admission.
- Where staff need to exercise complete and effective control over care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others or permitted to live elsewhere unless staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

Further guidance is provided within the Mental Capacity Deprivation of Liberty Policy.  
<http://intranet/Policies/CorporateGov/MentalCapacityAct200909b.pdf>

Restraint should only be used as a last resort and only when alternative methods of therapeutic behaviour management have failed. Its use should be proportional to the risk of the situation. The method used should be the least restrictive and be effective and safe.

Inappropriate use of restraint may be viewed as a form of abuse and a safeguarding concern. (See Trust Policy on Safeguarding Adults and Children.) When restraint is used it should be considered in a systematic and planned way according to the individual needs of the patient. Where possible, decisions concerning the use of restraint should be discussed and agreed by the patient's medical consultant, the patient and the relatives and carers, and the multidisciplinary team.

Ideally decisions should be made which both those close to the person and the healthcare team caring for that person agree, are in the person's best interests. Family members cannot require clinicians to provide a particular treatment if the health care professionals involved do not believe that it is clinically appropriate. However as a matter of good practice you should explain to people close to the patient why you believe any treatment they may have suggested is inappropriate. An example of the latter might be a relative who requests that bed rails are used, when the multidisciplinary team consider this to be inappropriate.

Details of physical techniques to restrain patients are not included in this policy, as these techniques should only be used by staff who have had the appropriate training.

For situations involving violence and/or aggression, staff should refer to the Violence and Aggression Policy.

## 7.1 Methods of Restraint

### 7.1.1 Acceptable Methods of Restraint

The following methods of restraint are acceptable when used appropriately (ie, in accordance with the principles and guidance outlined in this Policy):

**Medication/chemical sedation.** There are certain situations in which patients may benefit from anti-psychotic medication, such as in cases of extreme restlessness or agitation or if a patient is very frightened. This situation may arise postoperatively. Prescribing advice should be sought as appropriate. All staff prescribing or administering benzodiazepines or anti-psychotic drugs must be familiar with the properties of these drugs.

**Chemical sedation, in the form of rapid tranquillisation.** This may be used to restrain patients who are acutely disturbed, the aim being to:

- Calm or lightly sedate the person.
- Reduce physical and psychological strain.
- Reduce the risk of violence.
- Reduce the risk of injury to self and others.

This should only be used only as a short term measure and in conjunction with treatment for the cause of the psychomotor agitation eg, psychiatric illness.

If a patient is acutely disturbed a doctor must be called to assess the patient. Non-psychiatric causes for disturbed behaviour must be explored and excluded.

Prior to using rapid tranquillisation there should be an assessment of risk. It should only be used when the risk of not using rapid tranquillisation is greater than the risk of the acute pharmacological treatment.

As with other forms of restraint, other interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical sedation.

The patient must be informed that he/she is to be given medication. Oral medication should be the first choice. If the patient is unable to give informed consent, then treatment within the Medicines Policy under Common Law should be given. Consideration must be given to the appropriateness of using powers under the Mental Health Act, utilising the Liaison Mental Health Service.

The minimum effective dose of medication should be used. The maximum BNF doses (for older patients this should be half of the recommended dose) should only be used in exceptional circumstances. Polypharmacy with same class medication should be avoided.

Review of current oral medication for co-existing medical illness and its impact on side effects should be reviewed/considered.

Any existing 'care plans' for preferable medication to be used in the event of acute psychomotor agitation, should be taken into consideration.

Oral medication should be offered before parenteral treatment is administered.

Specific details of medications and doses to be administered cannot be given specifically in this policy, as this will depend on a number of factors in relation to the individual patient, such as underlying and co-existing medical conditions.

Patients for whom rapid tranquillisation has been used, should be constantly observed (visually), until symptoms have reduced.

Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation (using pulse oximeter) and level of consciousness should be monitored every 15 minutes after intra muscular (IM) injections, and every 5 minutes after intravenous (IV) infusions for the first hour, then hourly for 4 hours and until the patient becomes active again. Measurements should be documented in the patient's notes. It is recognised in some circumstances this level of observation may not be practical and could fuel the challenging behaviour. A case by case decision is required and the reason behind any variances should be clearly documented.

Adequate physical restraint should be achieved before attempting parenteral administration in a struggling patient.

**Physical techniques.** If physical techniques are to be used as an acceptable means of intervention by a particular ward or department, this should be agreed by the Directorate and appropriate training provided for staff who are likely to be involved.

**Preventing patients from leaving the hospital site.** Decisions in relation to this should be made according to the individual circumstances and by considering the patient's best interests. Staff should refer to Section 5 above and to the flow chart in Appendix 3. Preventing a patient from leaving the hospital site will ordinarily be in response to an emergency situation and will therefore be a short term measure. This must be followed up by a full assessment and plan for ongoing intervention.

Staff safety and the safety of others in the immediate vicinity must be taken into consideration.

Where necessary advice should be sought from the Patient Services Co-ordinator. Staff should also refer to the Trust Missing Patients Procedure.

Consideration must be given to reporting instances to the police (see Section 7.6).

**Electronic tagging.** Electronic patient tagging systems can be beneficial for patients who are unable to maintain their own health and safety, should they wander off the ward without staff knowledge (for example acutely confused patients). However staff are reminded that tagging should be used to benefit individual patients and not as a convenience measure for staff.

At the time of writing, an electronic tagging system is available on Ward 48 at the Royal Victoria Infirmary. Further details (including relevant

documentation) are available from Ward 48. Staff are also referred to Appendix A of the document “Restraint Revisited: Rights, Risk and Responsibility” (RCN, 2004).

**Bandaging hands/using mittens to prevent patients pulling out feeding tubes** (NG or PEG tubes). This may be acceptable in certain circumstances. As with other forms of restraint, the first consideration must be the patient’s best interests. Staff should be aware of the risks associated with patients pulling out their NG/ PEG tube.

**Softsides/bed rails.** The RCN (2004) suggests alteration of the environment and meeting the comfort needs of the patient rather than using bed rails. Softsides should be used where possible, as they are less likely to cause injury than bed rails. “The only appropriate use of bed rails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed.” (NPSA, 2007). A number of hazards associated with their use have been identified (see Appendix 7).

Before using bed rails you should consider alternatives, such as:

- A change to the position of the bed in relation to the ward environment.
- Asking relatives or carers if they can stay with the patient at certain times.
- Allocating a nurse to stay with the patient.
- Engaging the patient in “meaningful activity” – ask the patient and/or relatives and carers what the patient likes to do, what they would be doing if they were at home etc.
- Nursing the patient on a mattress on the floor<sup>2</sup>
- Using “Softsides™”<sup>3</sup> – see Appendix 7 for information on Softsides™
- Reality orientation.
- Reminiscence.
- Diversional therapy.

In deciding whether to use bed rails you should carry out a risk assessment (see flow chart and Risk Assessment Form – Appendix 7). This should consider criteria both for and against the use of bed rails, in relation to the individual patient, as well as the likelihood of the patient falling out of bed. Criteria supporting the use of bed rails:

<sup>2</sup> This would be as a result of a risk assessment and following discussion with the multidisciplinary team and the patient’s relatives. Staff must adhere to moving and handling regulations.

<sup>3</sup> Please note that Softsides™ cannot be used with profiling beds.

- Patient is on a pressure relieving mattresses with which the use of bed rails is recommended<sup>4</sup>.
- Patient uses bed rails at home.
- Patient has osteoporosis and is more likely to suffer a fracture if he / she falls out of bed
- Patient has expressed a wish to have bed rails
- Patient known to have previously fallen out of bed, resulting in injury and / or distress.
- Criteria against use of bed rails:

- Patient has fragile skin and is therefore more likely to suffer a bruise or laceration when coming into contact with bed rails.
- Patient is known to 'climb over' bed rails.

Examples of potential risks and benefits of using bed rails can be found in Appendix 7.

The decision to use bed rails should be a team decision where possible, following discussion with the patient and their relatives / carers.

If you decide to use bed rails you should ensure that the bed is kept at the lowest level possible, apart from when elevation is necessary to comply with good practice in manual handling.

If the patient is being transported on a bed it may be appropriate to use bed rails. Side rails should be used whenever a patient is transported on a **trolley**.

If bed rails are in use with thicker pressure relieving mattresses, staff should be aware that the height of the bed rails is effectively reduced. Alternative arrangements may be necessary, such as the hire of pressure relieving equipment with integral bed rails. Each situation should be assessed individually.

#### 7.1.2 Unacceptable Methods of Restraint

The following methods of restraint are generally unacceptable. However as stated above you must always act in the patient's best interests:

**Inappropriate bed height.** This is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed.

**Harnesses.** Harnesses should not be used, as they result in numerous risks to the person including pressure sores, chest infection.

**Cocoons/hammocks.** It may be appropriate to use cocoons for certain people in care homes, as part of their ongoing care. In general cocoons are not suitable for use in the hospital setting.

**Inappropriate use of wheelchair safety straps.** The safety straps on wheelchairs should always be used, when provided for the safety of the user.

<sup>4</sup> If a specialist bed or mattress is being used, the recommended bed rails must also be used.

However patients should only be seated in a wheelchair when this type of seating is required as part of ongoing care, not as a means of restraint.

**Using bean bags/inappropriately low chairs for seating.** Bean bags can provide comfortable seating for people who are physically frail and/disabled, but should not be used with the intention of restraining the person. Low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Both bean bags and low chairs also pose risks to staff in relation to manual handling.

**Chairs whose construction immobilises patients** eg, reclining chairs. Reclining chairs should be used for the comfort of the user or as an aid to manual handling, and not as a method of restraint.

**Baffle locks and locked doors.** Baffle locks may be used in psychiatric settings, but are unacceptable in an acute general hospital setting. Doors should not be locked without due attention to health and safety requirements in relation to fire.

**Arranging furniture to impede movement.** In general other methods of dealing with behaviour, such as wandering, should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended. This method of restraint is more likely to be used in a home situation, as opposed to a hospital, environment.

**Stair gates.** Stair gates may be appropriate in a domestic environment. It is important that any equipment is used for the purpose for which it is intended.

**Inappropriate use of night clothes during waking hours.** This is demeaning and should not be used as a way of restraining people in any care setting.

**Removal of outdoor shoes and other walking aids/withdrawal of sensory aids such as spectacles.** As with the above, these are not acceptable ways of restraining people in any care setting. Removal of sensory aids can cause confusion and disorientation.

**Isolation.** Isolation should not be used, except in designated psychiatric treatment areas. It is important to note however that patients may be “isolated” for infection control reasons and if a patient is cared for in a side room, when he or she wishes to be on the main ward, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.

## 7.2 Communication and Documentation

Clear communication with patients is essential in relation to the use of restraint. Written information should be used where possible to supplement verbal information given where possible.

A patient information leaflet on the use of bedrails can be found in Appendix 8.

If restraint is used, the reason should be explicit and clearly documented in the nursing/multidisciplinary notes. There should be a written care plan. A care plan should include:

- Rationale for the use of restraint.
- The frequency of re-assessment of the need for restraint. Review times should be specified in advance.
- All discussions that have taken place to allow patient to give informed consent and to assess best interests.
- Discussions with relatives, carers and others as to restraint.
- Details about the use of the restraint itself.

All documentation in relation to restraint should be clear, detailed and contemporaneous.

### 7.3 Evaluation and Review of Use of Restraint

The use of restraint should be evaluated in terms of its effectiveness and alternatives considered wherever possible. For planned use of restraint this should involve a discussion at ward level.

The use of restraint in an emergency situation (including the use of rapid tranquillisation) should be viewed as a critical incident and an Incident Form should be completed. The factors, which led up to the use of restraint and its appropriateness, should be discussed and reviewed by the ward team.

### 7.4 Reporting of Injuries

Any injury to a patient, member of staff or visitor to the Trust premises, involving the use of restraint, should be considered a clinical accident/incident and reported according to Trust policy. Incidents should also be documented in the nursing / multidisciplinary notes.

### 7.5 Involvement of Porters and Security Staff in Restraint of Patients

Situations may arise when additional support is required (additional to that already available on the ward or department). In these cases security staff/porters should be contacted. The aim of this service is to assist staff in maintaining the health and safety of patients, staff and visitors.

Situations in which the porters are required to assist should be treated as critical incidents and a review undertaken following the event including all those involved. Such reviews should be co-ordinated by the Ward Manager, with the support of the Matron, out-of-hours – PSC, and should be multidisciplinary where possible. In relation to violent and aggressive incidents staff are reminded that they must follow the “Protocol for Reporting of Violent and Aggressive Incidents to Hospital Staff”.

In most instances porters/security guards will not know the patient or the circumstances surrounding their care and treatment. Staff who know the patient will therefore have a greater knowledge as to what is in the patient’s “best interests” and should advise porters/security guards accordingly. The usual issues in relation to patient confidentiality should be taken into consideration when sharing patient details with non-clinical staff.

In terms of infection control, all staff including porters and security staff, should use universal precautions, as per the Trust Infection Control Policy, when intervening in a way that will or might involve contact with blood or body fluids.

### 7.6 When to Contact the Police

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

- A violent situation where the safety of staff, patients or others is at risk. (See Trust policy on Violence and Aggression.)

- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and is threatening to commit suicide or may come to harm or cause harm to others. In these cases the police have powers under the Mental Health Act to take the person to a place of safety, which in most cases would mean bringing the person to hospital, to be assessed.
- If a patient has left the ward or hospital site, contrary to the advice of medical or nursing staff and you have **serious** concerns about the welfare or safety of that individual (eg, the effect of not taking important medication) or others. In these circumstances the police may be able to check on the person by visiting them at home.

In the 2<sup>nd</sup> and 3<sup>rd</sup> situations above you should also follow the normal procedure for discharge against medical advice. Prior to contacting the police you should contact your manager and the Patient Services Co-ordinator.

## **8. Staff Education and Training**

The emphasis of training and education should be on dealing effectively with situations in order to obviate the need for restraint.

Training should be provided for staff members who are regularly required to use physical methods of restraint. It is the responsibility of managers to identify if this training is required. Specialist training is currently being developed nationally by the Counter Fraud and Security Management Service, aimed specifically at staff working in mental health, learning disabilities and other high risk NHS environments. This is with the intention of standardising training nationally. Further details can be obtained from the Trust Training and Education Department.

## **9. Monitoring and Review**

This policy will be reviewed every two years. Comments, queries and suggested amendments should be addressed to the Safeguarding Adults Lead.

Policy will be monitored within 12 months of the date of effectiveness through review of Datix incidents, and safeguarding causes for concern to identify any restraint related issues.

Author: Safeguarding Adult Lead and Heads of Nursing

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<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59815&p=3>

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## **Appendix 1**

### **Development of Policy**

This Policy has been developed by a Trust Working Group and following consultation with a wide range of experts and stakeholders including Northumbria Police, the Trust Solicitors, clinical colleagues and the Deputy Director of Nursing (now Director of Nursing) from the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, the Trust Heads of Nursing, the Hospital Manager (RVI/NGH), the Trust Health and Safety Advisors, the Trust Clinical Ethics Advisory Group and the Trust Clinical Risk Group.

### **Trust Working Group Members**

Clare Abley – Nurse Consultant (Chair)

Liz Hunter – Paediatric Radiographer

Karen Lapworth – Clinical Audit - RVI

Jon Lawler – Charge Nurse – Poisons Information Service - FH

Alan Shellard – Deputy Head Porter – Portering Services, RVI

Jackie Rees – Nurse Specialist - Continence

Gail Robinson – Nurse Practitioner – Orthopaedic Trauma

The Policy has been reviewed by the Safeguarding Adults Leads and Heads of Nursing following the enactment of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards, including advice from Trust Solicitor and the Mental Capacity Deprivation of Liberty Steering Group.

## Appendix 2

### Other Relevant Local and National Guidelines and Policies and Legislation

These guidelines should be read in conjunction with other relevant Trust Policies/Guidelines including:

- Delirium Guidelines from British Geriatrics Society and NICE plus NICE Guidelines on Violence and Aggression  
[http://www.bgs.org.uk/Publications/Clinical%20Guidelines/clinical\\_1-2\\_fullDelirium.htm](http://www.bgs.org.uk/Publications/Clinical%20Guidelines/clinical_1-2_fullDelirium.htm)
- Mental Capacity Act Code of Practice Chapter 6 Use of Restraint 6.40-6.48  
<http://www.publicguardian.gov.uk/docs/mca-code-practice-0509.pdf>
- Deprivation of Liberty Safeguards 2008 Chapter 2 What is a deprivation 2.8-2.16.  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_087309.pdf11111](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf11111)
- Consent to Examination or Treatment
- Guidelines on the Prevention of Falls in Adult Inpatients
- Operational Policy and Procedure for Reporting and Management of Accidents and Incidents
- Health and Safety Policy entitled “Adverse Incident Reporting – Hospital Plant and Equipment”
- Management of Poisoning and Drug overdose at the Royal Victoria Infirmary – Operational Policy NUTH
- Management of Violence and Aggression at Work
- Missing Patients Procedure
- Patients Detained under the Mental Health Act 1983”
- Litigation and use of the Hospital Lawyer
- Withdrawal of Treatment from Violent and Abusive Patients – Policy and Procedure
- MCA Policy
- DOLs Policy

Staff working within the Directorate of Neurosciences should also refer to “Guidelines for the Use of Mechanical and Chemical Restraint in the Neurologically Compromised Patient” (September 2003).

The Radiology Department has “Guidelines for Immobilisation of Children During Radiographic Examinations” (effective from November 2001).

In terms of national policy, these guidelines should be applied in the light of “Essence of Care “ (Department of Health, 2001a) and the recent findings of the CHI Review on Rowan Ward (Commission for Health Improvement, 2003).

The National Institute for Mental Health in England (NIMHE) has recently published a document entitled: “Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings” (NIMHE, 2004). Although the document is aimed at mental health in-patient settings it provides useful guidance, making specific reference to restraint and listing a number of positive practice standards on education and training, physical care and observation during restraint and post incident support, review and reconciliation.

The Department of Health booklet “Seeking Consent: working with older people” (2001) includes useful guidance on deciding whether or not an adult has “capacity” to make

health care decisions. It is cross-referenced in the Trust Policy on “Consent to Examination or Treatment” and can be found at <http://www.dh.gov.uk> .

Nurses are referred to the booklet entitled “Restraint Revisited - Rights, Risk and Responsibility: Guidance for Nursing Staff” (RCN, 2004) which provides additional guidance.

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

The Mental Capacity Act 2005 should also be referred to. The following Sections are particularly pertinent to this policy:

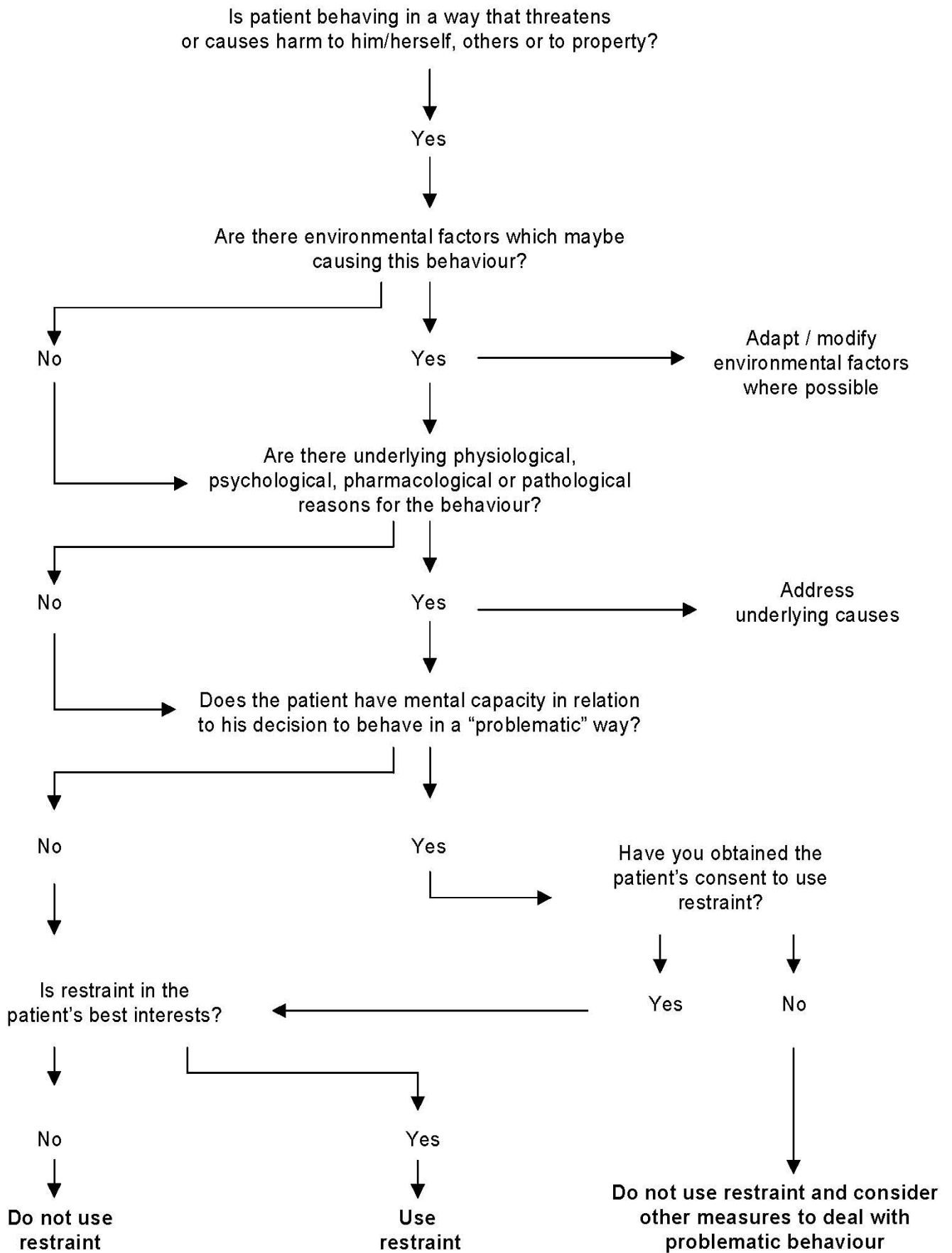
- Part 1 - Persons Who Lack Capacity
  - Section 1 The Principles
  - Section 2 People who lack capacity
  - Section 3 Inability to make decisions
  - Section 4 Best interests
  - Section 5 Acts in conjunction with care or treatment
  - Section 6 Section 5 Acts : limitations

The Mental Health Act and the Deprivation of Liberty Safeguards.

The Human Rights Act Article 5.

### Appendix 3

#### Before Using Restraint - Flow Chart to Guide Decision Making



## Appendix 4

### **Additional Information on Consent (Department of Health, 2001), Mental Capacity, Duty of Care and Other Legal Aspects of Restraint**

#### **1. Consent**

If a patient is not capable of giving or refusing consent, it is still possible for you to lawfully provide treatment and care, unless such care has been validly refused in advance (e.g. using an Advance Directive). However such treatment or care given without consent must be in the patient's "best interests".

No one, not even a spouse or others close to the person, can give consent on behalf of an adult who is not capable of giving consent for him or her self. It is important however that those close to the "incapacitated" person are consulted and involved in the decision making.

#### **2. Mental Capacity**

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

If you are unsure as to whether a patient lacks capacity to make a particular decision, you should make an assessment of this, by drawing on the assistance of specialist colleagues as necessary.

A patient who has the capacity to make a particular decision, will be able to:

- comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question , and
- use and weigh this information in the decision making process, and
- communicate their decision

In order to assess a patient's comprehension and ability to use information to make a decision you should do the following:

- Explore the patient's ability to paraphrase what has been said (repeating and rewording explanations as necessary).
- Explore whether the patient is able to compare alternatives or to express any thoughts on possible consequences other than those which you have disclosed.
- Explore whether the patient applies the information to his or her own case.

Patients should be assisted to make their own decisions if at all possible.

Capacity should not be confused with your assessment of the reasonableness of the patient's decision. Consideration should be given as to whether a patient who does not have capacity will regain capacity and is so when.

Stereotyping should be avoided. It must not be assumed that a patient lacks capacity because of age or in view of the patient suffering from any particular illness, disease, injury or disability.

Mental capacity and ability to communicate one's decisions are separate issues. You should take all steps that are reasonable in the circumstances, to ensure that patients can communicate their decisions. Examples of this include using interpreters and communication aids and involving specialist colleagues such as speech and language therapists.

If a patient lacks capacity in relation to a decision concerning the use of restraint, due regard should be given to any relevant prior expressed wishes, such as those contained

within an Advanced Directive or to the views of a person appointed under a Lasting Power of Attorney.

Staff are also referred to the Mental Capacity Act 2005 and in particular Part I – Sections 1-6 inclusive The Act can be found at [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications).

Section 35-41 provide information on Independent Mental Capacity Advocates (IMCAs), which must be made available where “serious medical treatment” is proposed **and** the patient lacks capacity to consent to treatment **and** there is no other person available to advise on the patient’s best interests.

### **3. Duty of Care**

In deciding what is in a patient’s “best interests” you should not just limit your decision only to things that will benefit the patient medically. You should also consider the views and beliefs of the patient (or their previous views and beliefs, if no longer able to articulate these), their general wellbeing, their relationships with those close to them and their cultural, spiritual and religious welfare (DOH, 2001b).

Decisions about what is in a patient’s best interests should if possible be agreed both with those close to the patient and with the healthcare team caring for the patient. However if such an agreement cannot be reached in relation to a significant decision, the Courts can be asked to determine what is in the patient’s best interests. The Trust Solicitor will advise as to the making of any necessary Court application.

You should decide what level of “duty of care” is required by measuring your practice against the standard of “an ordinary skilled nurse”, if you are a nurse, “an ordinary skilled porter”, if you are a porter, etc.

Legally there are no precise details as to what comes within one’s duty of care. Advice should be requested in all cases of uncertainty.

Four main ethical principles should also be respected where possible when considering your duty of care, although it must be acknowledged that these principles may be in conflict with one another. You should always:

- Intend to do the patient good (beneficence).
- Intend to do the patient no harm (non-maleficence).
- Treat all clients fairly and equally (justice).
- Aid and respect the patient’s right of self determination (autonomy).

### **4. Other Legal Aspects of Restraint**

#### **4.1 Duty of Care and Negligence**

In relation to the law, the term “duty of care” is usually used in relation to negligence. For a negligence case to be established, the following three elements must be proved by the claimant:

- The defendant must owe a duty of care to the person who has suffered harm.
- There has been a breach of the duty of care by a failure to adhere to a reasonable standard of care.
- This breach has caused reasonable foreseeable harm.

#### **4.2 Common Law**

The common law is made up of the decisions of judges in individual cases and is different from the law that is set out in various Acts of Parliament, such as the Mental Health Act (Statute Law or Legislation) and rules and regulations made under those Acts. Common law changes over time according to the decisions of judges in various cases. (See Dimond, 1995 “Legal Aspects of Nursing” for more information on the law). Common Law is often referred to as case law. The concept of “duty of care” has its origins in common law.

### 4.3 Accountability

In terms of having to account for your actions in relation to the use/non use of restraint, there are four areas of accountability:

- Accountability to your employer i.e. the Trust (Trust policies and guidelines outline your responsibilities in relation to your employment).
- Professional liability to your regulatory body i.e. accountability to the NMC for nurses, GMC for medical staff.
- Civil liability. This is your responsibility in relation to a case which goes to court (civil court) seeking the payment of damages. This may be a “negligence” case, an assault or battery or false imprisonment or a human rights case.
- Criminal liability. This is your responsibility not to commit a criminal act.

The four areas of accountability above are closely linked i.e. what is expected by your employer (the Trust) as acceptable practice in relation to restraint will be in line with one’s civil and criminal liabilities and will be based on the advice of a professional body, where such advice exists.

In addition to the above you are also accountable to patients, the public and society as a whole.

The Trust will make legal advice available.

See “Legal Aspects of Nursing” (Dimond, 1995) for more information on the above.

### 4.4 Assault, battery and False Imprisonment – what are they?

Assault, battery and false imprisonment are referred to in legal terms as “trespasses to the person”. They are “torts”, or in layman’s terms, “civil wrongs”. Negligence is another type of tort.

**Battery** is the intentional application of force to another person in a hostile manner or against his will. It is not necessary to show the intention to injure.

**Assault** is an act by a person, which puts another person in fear of battery.

**False imprisonment** is the unlawful imposition of constraint on another’s freedom of movement from a particular place.

Battery and false imprisonment in particular, are important considerations when deciding whether or not to use restraint.

Assault is also a criminal act.

## **Appendix 5**

### **Contacting the Mental Health Service**

Mental health services for both adults and older people are provided in Newcastle (by the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust).

Please note that in most cases mental health services are not provided on the Trust's four hospital sites. The exception to this is Ward 3a at the RVI which is a specialist regional eating disorder and affective disorder service.

Colleagues from mental health services can provide advice and support however there is no dedicated service as such, and clinicians cannot be expected to attend and assess patients in emergency situations.

### **The Adult Psychiatry Service**

For adults under 65 or over 65 who are still current to adult mental health services contact the Liaison Psychiatry Team.

**Tel. 0191 282 4842**

### **Referrals to the Old Age Psychiatrists**

For patients at Freeman and Walkergate Hospitals, fax a referral to the Gibside Offices at NGH

**Fax: 0191 219 5080**

For patients at the RVI, fax a referral to the Akenside Offices at NGH

**Fax: 0191 219 5019**

For patients at NGH, fax a referral to the Castleside Offices at NGH

**Fax: 0191 219 5483**

**Outside of normal working hours**, the referral should be made to the duty on call team by contacting the switchboard at NGH.

### **The Psychiatric Liaison Nursing Service (Older People)**

The Psychiatric Nursing Liaison Service (for older people) provides advice on the care of older patients in the acute setting, who have a mental health problem that is affecting their physical care or recovery. It is available for patients as follows:

- Wards 1, 2, 3 at Walkergate Hospital and Ward 15 at the Freeman Hospital
- Lanercost and Wallington Wards, Wards 20, 21 and 35 at NGH and Wards 15 and 40 (Bellingham) at the RVI
- Wards 14, 15, 18, 22 and 23 at the RVI

Referrals for all Psychiatric Liaison Nurses should be faxed to Gibside Offices, NGH

**Fax: 0191 219 5080**

## Appendix 6

### Supplementary Information on Detention According to Mental Health Legislation (Mental Health Act, 1983)

The specialist guidance of a psychiatrist should be sought on this matter. You must also refer to the Trust Policy entitled “Patients detained under the Mental Health Act 1983”, which outlines the Trust policy, key roles and responsibilities and who to contact.

The Mental Health Act (MHA) allows for legal detention in order to assess or treat a person for a psychiatric condition where admission is considered necessary in the interests of the person’s health and safety, or for the protection of others, **and** where the person concerned does not consent to such an admission.

Restraint and compulsory treatment can only be applied under the MHA for a physical disorder in very specific situations where the physical condition is inextricably linked with the mental disorder.

## Appendix 7

### **Supplementary Information on the Use of Bed Rails (including Softsides)**

Deciding whether or not to use bed rails is often complex. Arguments against their use include the fact that bed rails can promote dependence on carers (including nurses), leading to a number of identifiable problems e.g. increased risk of incontinence and dehydration (Watson and Brunton, 1990). However there are also those (carers and relatives) who view bed rails as an acceptable form of restraint for patients at risk of wandering (Watson and Brunton, 1990).

### **Bed Rails and Patient Safety**

The recent Medicines and Healthcare Products Regulatory Agency's document, "Safe Use of Bed Rails" provides the most up to date guidance on their use and **should be referred to**. (MHRA, 2006). Key points include:

- Bed rails used following an individual risk assessment can be very beneficial for some bed occupants.
- A full risk assessment of the suitability of the bed rail, bed and bed base in combination for the bed occupant, is required.
- Potential risks exist associated with the use of different types of bed rail.
- How to reduce the risk of entrapment.
- Bed rails must be regularly maintained.

Miles et al (1997) found that between 1993 and 1996 there were 74 deaths reported which were as a direct result of bed rail use. 70% of these were due to entrapment between the mattress and the bed rail.

### **Bed Rails and Patient Falls**

Ball, Hanger and Wood (1999) and Jehan (1999) all agree that although the commonly cited reason given by nursing staff for the use of bed rails is falls prevention, and that their use for this reason is widespread in hospital, there is in fact no evidence that their use reduces the risk of patients' falling. Miles and Parker (1997) noted that in most documented falls from bed, bed rails were in place. In fact, it has been suggested that bed rails actually cause patients who fall to sustain more serious injuries', mainly due to the fact that they add an average of 18 inches to the height of the bed. Therefore if patients climb over bed rails they fall from a much greater height. This has been found to cause more head injuries than would be sustained without the bed rails in place (Bridel-Nixon and Everitt 1997 and Jehan 1999).

In February 2007 the MHRA issued a Medical Device Alert (MDA) on bed rails and grab handles. This stated that: "bed rails can successfully prevent falls, but their incorrect use has resulted in the deaths of bed occupants by asphyxiation due to entrapment." This Device Alert was aimed particularly at staff working in community settings.

### **Information on Softsides™ (netting/mesh bed sides)**

Softsides are manufactured by Westholme:

Westholme Ltd.

Newcombe St.

Elland

West Yorkshire

HX5 0EG

Tel. 01422 260011

<http://www.westholme.co.uk>

Email: [info@westholme.co.uk](mailto:info@westholme.co.uk)

For catalogue no. and price please refer to the Trust Intranet page for the Moving and Handling Team (see equipment – miscellaneous patient handling equipment).

“Softsides consist of 4 padded posts and a continuous length of netting which fits underneath the mattress. They provide gap-free support at either side of the bed, which eliminates the risk of the patient becoming trapped between the mattress and side support” (Westholme)

For the latest product information contact Westholme.

Netting / mesh bed sides may be considered as an alternative to bed rails (MHRA 2006)

<b>Examples of Potential Risks and Benefits of “Using Bed Rails” and “Not Using Bed Rails”</b>	
<b>Using Bed Rails</b>	
<b>Potential Risks</b>	<b>Potential Benefits</b>
<ol style="list-style-type: none"> <li>1. Limb entrapment and subsequent injury</li> <li>2. Patient climbs over bed rails, falls and sustains injury</li> <li>3. Psychological distress and/or increased confusion/disorientation/agitation</li> <li>4. Infringement of human rights</li> <li>5. Less physical contact with carers (including nurses) and relatives</li> <li>6. Patient feels isolated, trapped or imprisoned, which in turn leads to reduced self esteem and dignity, and hinders rehabilitation</li> </ol>	<ol style="list-style-type: none"> <li>1. Prevention of injury resulting from a fall out of bed e.g. head injury, fracture neck of femur, bruises/lacerations</li> <li>2. Reassurance for patients’ relatives<sup>5</sup></li> <li>3. Reassurance for other ward patients and visitors</li> </ol>
<b>Not Using Bed Rails</b>	
<b>Potential Risks</b>	<b>Potential Benefits</b>
<ol style="list-style-type: none"> <li>1. Physical pain/injury resulting from a fall out of bed</li> <li>2. Psychological distress caused by falling out of bed</li> </ol>	<ol style="list-style-type: none"> <li>1. Able to get up out of bed “freely”.</li> <li>2. Preparation for discharge from hospital to an environment where bed rails will not be provided</li> </ol>

<sup>5</sup> Although reassurance for relatives is an important consideration (and for other patients and visitors), you must always act in the best interests of the individual patient concerned.

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Use of Restraint: Alternatives and Considerations (Included Use of Bed Rails)	Policy Author:	FRANCES BLACKBURN / MAY BURNS
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (*denotes protected characteristics under the Equality Act 2010)	NO	This Policy does not discriminate against any individual or group based on any of the characteristics below.
	• Race*	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Nationality	NO	
	• Gender*	NO	
	• Culture	NO	
	• Religion or belief*	NO	
	• Sexual orientation including lesbian, gay and bisexual people*	NO	
	• Age*	YES	Policy only applies to Adults.
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems*	NO	The Policy ensures that patients who lack capacity are protected in line with Statutory Guidance.
	• Gender reassignment*	NO	
	• Marriage and civil partnership*	NO	
2.	Is there any evidence that some groups are affected differently?	NO	
3.	If you have identified potential discrimination which can include associative discrimination ie, direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	NO	
4(a).	Is the impact of the policy/guidance likely to be negative? (If "yes", please answer sections 4(b) to 4(d)).	NO	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d).	Can we reduce the impact by taking different action?	N/A	
<b>Comments:</b>			<b>Action Plan due (or Not Applicable):</b>

Name and Designation of Person responsible for completion of this form: **FRANCES BLACKBURN, HEAD OF NURSING FH & WGH**

Date: 11 FEBRUARY 2011

Names & Designations of those involved in the impact assessment screening process: FRANCES BLACKBURN, HEAD OF NURSING FH & WGH