1 Introduction

This document provides information and guidance on restraint for staff employed by The Newcastle upon Tyne Hospitals NHS Foundation Trust.

The policy outlines the general principles that should be applied to practice with adults across the Trust, including the legal position where appropriate.

Decisions about restraint are not easy or straightforward. It is acknowledged that decisions on the use of restraint 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. 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.

The policy is in line with the Trust’s values, i.e. placing patients at the heart of everything we do, adhering to high professional standards and focusing on continuous improvement in the pursuit of excellence.

Appendix 1 is a Flow Chart to be used to guide decision making before using restraint.

Appendix 2 contains a Risk Assessment form to be completed when using restraint. For risk assessment in the use of bedrails see Policy For Safe And Effective Use Of Bedrails.

Appendices 3 provides guidance for clinical areas where restraint is used, this includes:
- Guidance in the use of restraint & Use of Restraint Flow Chart
- Daily Observation Record

An example would be where an arm restraint is being considered to prevent removal of a nasogastric tube. Bedrails can be construed as restraint, despite the fact that they are not used with intent to restrain.

For guidance on use of restraint in Critical Care see guideline:
Appendix 4 relates to additional advice relating to neurosciences

Appendix 5 relates specifically to challenging behaviour arising from drug and / or alcohol intoxication or mental health problems. These situations may require the use of restraint.

2 Policy scope

This policy applies to adult patients in hospital and community settings and also to visitors to hospital sites. It does not relate to the care of children. For the care of children, staff should refer to the Guidelines For The Restraint Of Children And Young People.

3 Aim of policy

The aim of this policy is to provide staff with the guidance needed to practise in accordance with the law, professional standards and Trust policy.

4 Duties (Roles and responsibilities)

<table>
<thead>
<tr>
<th>Trust Board</th>
<th>Ensuring that the appropriate Health and Safety and risk management arrangements are in place throughout the Trust.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate Managers, Clinical Directors and Heads of Department</td>
<td>Supporting staff in complying with the policy, including ensuring that the necessary systems, processes and equipment are in place to facilitate adherence to the policy.</td>
</tr>
<tr>
<td>All staff</td>
<td>Being aware of the policy and its content. Working in accordance with the policy at all times. Reporting any non adherence with policy to line manager.</td>
</tr>
</tbody>
</table>

5 Definition of Restraint and Deprivation of Liberty (DoL) Implications

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 or
- Restrict a person’s freedom of movement, whether they are resisting or not

Therefore restraint can include a whole range of measures / interventions such as holding someone to take blood, using bed rails to prevent a fall from bed, using a lap belt on a wheelchair to reduce the risk of a fall from the chair, administering sedative medication to reduce distress or agitation, locking a door to prevent someone from leaving a ward / department or their own home. See Section 9 below for more details on different types of restraint.
If an action fits the definition of restraint it is not automatically unacceptable or wrong. However this policy does not support the use of malicious or abusive restraint.

Restraint may or may not also amount to a deprivation of liberty. Deprivation of Liberty is part of the Mental Capacity Act framework for people who lack capacity and need to be deprived of their liberty in order to receive care and/or treatment.

The use of an Independent Mental Capacity Advocate (IMCA) must be considered if the patient is ‘un-befriended’ and is either in hospital for 28 days (in a care home for 8 weeks) or more serious medical treatment is proposed and a decision needs to be made. Information and contact numbers for the IMCA service can be accessed via the Trust Intranet: http://nuthvintranet1/cms/SupportServices/SafeguardingChildrenandAdults/MentalCapacityAct/IMCA.aspx

6 When is restraint within the law? (Mental Capacity Act 2005 and common law)

When taking action with the intention of restraining a person who lacks capacity the following two conditions must both be met: -

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- 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.

As long as these two conditions are met you will be acting within the legal framework of the Mental Capacity Act (2005) and you will therefore be protected against liability.


The Mental Capacity Act (2005) – although permitting the use of restraint under certain conditions, does not allow for actions that result in someone being deprived of their liberty (as defined by Article 5(1) of the European Convention on Human Rights (see below – section on Deprivation of Liberty).

The common law also imposes a duty on all health and social care staff. In relation to restraint this means that if a person who lacks capacity to consent, has challenging behaviour or is in the acute stages of illness causing them to act in a way which may cause harm (to self or others), staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, either to the person concerned and to anyone else. The common law does not provide grounds
for an action that would have the effect of depriving someone of their liberty, unless used in the prevention of crime or breach of the peace.

7 Detention under the Mental Health Act (MHA) 1983 (Code of Practice revised 2015)

Restraint and compulsory treatment can only be applied under the MHA for a physical disorder (rather than a mental disorder) in very specific situations where the physical condition is inextricably linked with the mental disorder. The specialist guidance of a psychiatrist should be sought on this matter.

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.

If treatment for a physical condition needs to be given against the patient’s wishes then the Mental Capacity Act (MCA) and Deprivation of Liberty provisions should be applied.

The Mental Capacity Act (MCA) applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

1. if someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person’s behalf
2. if somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat their mental disorder, or a very specific condition inextricably linked to their mental disorder, even if it goes against an advance decision to refuse that treatment. There are some specific exceptions to this under the MHA so specialist guidance of a psychiatrist should be sought in this matter.
3. if a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live.

For further information, see Trust policy for ‘Patients Detained under the Mental Health Act 1983’:

8 Deprivation of Liberty

The Deprivation of Liberty safeguards provide extra legal protection for people who may be deprived of their liberty in a hospital or care home (public or private) and hospices. The safeguards comprise certain procedures that must be followed if deprivation of liberty is to be within the law.
It is therefore not within the law to restrain a person in a way that deprives them of their liberty unless the procedures set out in the Code of Practice relating to Deprivation of Liberty are followed. The Deprivation of Liberty Safeguards provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person’s own best interests.

The Supreme Court delivered its ruling on a Deprivation of Liberty Case in March 2014 and within this ruling the definition as to what constitutes a Deprivation of Liberty was stated by Lady Hale who termed the definition the ‘Acid Test’.

The acid test is applied to people who lack capacity to be able to give valid consent to care and treatment and…

- **Are not allowed to leave.** That is, it is the hospital’s intention that they are not allowed to leave to live/reside at another place even if that place does not exist or they are physically incapable of doing so.
- **The person is under continuous supervision and control.** This would include hospital care regimes.

In addition the following factors CANNOT be taken into account when considering if there is a Deprivation of Liberty occurring.

- the purpose (or reasons, motives) behind the placement
- whether the patient is objecting or compliant, or
- the ‘relative normality’ of the placement.

Lady Hale, in delivering the judgment, decided that if there was any question that a person was being deprived of their liberty then the hospital, care home or community staff dealing with a domestic situation, should ‘err on the side of caution’ and submit an application to the local council requesting an authorisation to detain the person. Lady Hale added, “A gilded cage is still a cage”.

The Trust [Policy on Deprivation of Liberty](#) should be referred to.

The Deprivation of Liberty Safeguards do not apply to people detained under the Mental Health Act 1983 (amended 2007).

### 9 Types of restraint

Types of restraint include (RCN, 2008):

- Physical restraint such as staff holding or moving the person, blocking their movement to stop them leaving (see Section 13.3 & 13.5 and Appendices 3, 4 & 5 for further guidance).

- Mechanical restraint using special equipment e.g. specially designed mittens (see Appendices 3, 4 & 5), using a belt or heavy table to stop a person getting out of a chair, using bed rails to stop a person getting out of bed (see [Safe and Effective use](#)).
of Bedrails Policy). Controls on freedom of movement e.g. keys, baffle locks or key pads, can also be a form of mechanical restraint.

- Technological surveillance such as tagging, pressure pads (bed and chair alarms), door alarms – whilst not restraint in themselves could be used to trigger restraint i.e. through physically restraining a person who is trying to leave when the alarm sounds

- Pharmacological restraint i.e. using medication with the intention of restraining someone (see Appendices 3, 4 & 5). Rapid Tranquillisation is a form of pharmacological restraint and additional guidance for staff using rapid tranquillisation is currently being developed by a Trust working group.

- Psychological restraint such as constantly telling a person not to do something or depriving a person of equipment or possessions they consider necessary to do what they want to do e.g. taking away walking aids or spectacles or keeping a person in nightwear with the intention of stopping them leaving. This would also include coercion or deception, for example: telling a patient they can go home the next day when in reality they cannot.

10 Isolation

Isolation should not be used, except in designated psychiatric treatment areas. It is important to note however that patients may be “isolated” for other clinical 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 if appropriate.

11 Before using restraint

As stated above, restraint may only be used where it is necessary to protect the person or others from harm and is proportionate to the risk of harm.

Refer to the flow chart in Appendix 1 before using restraint (unless in an emergency situation). This is a guide to decision making.

Before using restraint the following should be assessed by the clinical team:

- Patient’s behaviour
- Patient’s underlying condition and treatment
- Patient’s mental capacity in relation to making decisions about their behaviour which is leading staff to consider using restraint (in accordance with the Mental Capacity Act 2005 Code of practice) and completing Forms MCA 1 & 2 which can be found on the Mental Capacity Act intranet page or via this link [http://nuth-vintranet1/cms/SupportServices/SafeguardingChildrenandAdults/MentalCapacityAct/Forms.aspx](http://nuth-vintranet1/cms/SupportServices/SafeguardingChildrenandAdults/MentalCapacityAct/Forms.aspx)
11.1 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:

- Need to empty bladder or bowel
- Anxiety or distress
- Mental illness – (e.g. dementia, schizophrenia)
- Delirium (acute confusion) due to:
  - Infection/ Pyrexia
  - Hypoxia
  - Electrolyte or metabolic imbalance
  - Pain or discomfort
  - Constipation/dehydration
  - Hypotension
- 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)
- Pregnancy and postnatal conditions
- Communication; religious and cultural issues
- Impact of Disability, Learning Difficulties

Any new agitation or confusion in a patient must be flagged up and documented as a score of 3 by staff in the AVPU / GCS assessment section of the NEWS (National Early Warning System). This will trigger a NEWS Responder review within 30 minutes.

If a patient’s mental health is an issue, the mental health services should be contacted for advice/support.

Often behaviour can be problematic for staff. However this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.
For additional information on assessing the need for enhanced observation of patients with Mental Health Problem or acute behavioural disturbances see Trust **Enhanced Observation Policy**.

Core care plans are available and should be used when ‘Caring for patients with behavioural and psychological symptoms associated with cognitive impairment (Dementia/Delirium)’ and for ‘Promoting health and wellbeing/treating Delirium in frail older adults’ and are available on the Trust Dementia and Delirium page.

For additional information on the assessment and management of patients with Delirium see Trust **Delirium guidelines**:

For additional information on managing behavioural problems and agitation in patients with Dementia see Trust **guidelines**:

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).

### 11.2 Mental Capacity

It is necessary to assess 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.

Assessment of capacity must be in accordance with the Mental Capacity Act. See Trust policy on Mental Capacity Act 2005. You must complete Forms MCA 1 & 2 for each decision made and also ensure the decision is documented. MCA 1 & 2 are available on the Trust Intranet.

Assessment and documentation of capacity must be in accordance with the Mental Capacity Act. For additional information see Trust **guidance on Mental Capacity Act 2005** (including the Deprivation of Liberty Amendment 2009):

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.

### 11.3 The care environment

The care environment should also be considered and ways in which this can be optimised. The 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, negative
attitudes/poor communication skills of staff or lack of understanding of patients’
disability, communication, religious or cultural needs.

11.4 **Duty of care**
Staff should be aware of their duty of care – which will be different for patients
and others, i.e. visitors. In relation to a patient who is at immediate risk of harm,
the use of restraint may be part of fulfilling the duty of care.

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 if you are uncertain.

12 **Risk assessment**

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.

A risk assessment should be completed prior to use of restraint (see Restraint Risk
Assessment in Appendix 3) and restraint considered in a systematic and planned way.

Departmental managers are responsible for ensuring that detailed care plans and risk
assessments are carried out in accordance with the Trust [Health and Safety Policy and
Procedure](#).

13 **Using restraint**

13.1 **Use as a last resort**
Restraint should only be used as a last resort and only when alternative methods
of therapeutic behaviour management have been considered and are known to
be inadequate or have failed. The use of restraint should be proportionate to the
risk of the situation. The method used should be the least restrictive and be
effective, safe and in the patient’s best interest. Staff must take all reasonable
steps to ensure that they will not cause the person being restrained undue harm
or anxiety. Consultation with medical staff may be required to establish this.

13.2 **Involvement of relatives and carers**
Where possible, decisions concerning the use of restraint should be discussed
and agreed with relatives and carers. If a patient lacks capacity to make a
decision about the use of restraint then the decision as to whether to use
restraint must be made in the patient’s best interests. 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. The decision maker (Senior
Clinician/Consultant) has the final say in deciding what course of action to pursue. This must be in the patient’s best interests. However, the decision maker should only make their decision following consultation, if possible, with family, friends, etc., or with the IMCA service if one needs to be involved.

However the wishes of relatives do not override the responsibility of professionals to act in the patient’s best interests (where the patient lacks capacity). Family members cannot require clinicians to provide a particular treatment which would include restraint, 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.

Likewise restraint may be used contrary to relatives or carers’ wishes if the clinical team consider it to be in the patient’s best interests; i.e. relatives, friends etc. cannot give consent for the withholding of treatment such as restraint. The decision maker is the only person who can decide if the treatment is in the person’s best interests after consultation, unless there is an advance decision to refuse treatment (ADRT), an appropriate and valid Lasting Power of Attorney (LPA) or a court appointed deputy, and any of which indicates otherwise. A Lasting Power of Attorney or Court appointed Deputy can agree to restraint, however, if this amounts to a Deprivation of Liberty, the usual process will apply.

13.3 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. Patient Service Co-ordinators will also be in attendance in all cases where security staff have been requested and will contact and liaise with senior medical staff.

Situations in which the porters are required to assist should be reported on Datix and treated as critical incidents and a review undertaken following the event including all those involved.
Such reviews should be co-ordinated by the Ward Sister / Charge Nurse, with the support of the Matron, and should be multidisciplinary where possible.

In relation to managing and reporting violent and aggressive incidents, staff are reminded that they must follow the Management of Violent and Aggressive Incidents at Work Policy.

Consideration should also be given to the powers under Sections 119 and 120 of the Criminal Justice and Immigration Act 2008 which gives a legal framework for
removal of individuals from hospital premises if they are causing a nuisance or disturbance. Trust training in the exercise of these powers is very important.

In most instances porters/security staff will not know the patient or the circumstances surrounding their care and treatment. Staff that know the patient will have a greater knowledge as to what is in the patient’s “best interests”, and should advise porters/security staff 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 Prevention Control Policy, when intervening in a way that will or might involve contact with blood or body fluids.

13.4 Preventing patients from leaving the hospital site

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 Matron or Patient Services Co-ordinator (out of hours). Staff should also refer to the Trust Missing Patients Procedure and consider if a Deprivation of Liberty application is required.

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 various powers, including power 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 (e.g. 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 or elsewhere.
In the 2\textsuperscript{nd} and 3\textsuperscript{rd} situations above you should also follow the normal procedure for discharge against medical advice. Prior to contacting the police you should contact the Matron or the Patient Services Co-ordinator (out of hours).

13.5 **Inappropriate use of restraint**
Inappropriate use of restraint is a form of abuse and therefore a safeguarding concern (see Trust [Policy on Safeguarding Adults](#)). Anyone who has concerns about the protection of an adult in a care setting or in the community can make a referral via the adult safeguarding procedures. This includes members of staff, visitors, employees of another organisations and member of the public.

13.6 **Civil Law**
If a Trust employee, such as a porter, nurse or doctor, restrains a patient without a sound professional and legal basis, the patient may bring a civil claim against the member of staff for assault, battery, negligence or false imprisonment and make a claim for compensation for any harm suffered as a result of the restraint.

Where the patient can show that he or she suffered harm (physical or psychological) which was directly caused by the restraint and which was foreseeable, the courts will assess any professional standards that existed at the time to decide whether the restraint was reasonable and lawful.

13.7 **Criminal Law**
Restraining a person without their consent may amount to a criminal offence. Any prosecution under criminal law will consider whether the restraint amounted to an offence such as an assault, unlawful detention, ill treatment or wilful neglect. A Trust employee who unlawfully restrains a patient may face criminal prosecution that could lead to a fine or imprisonment depending on the severity of the restraint. Whenever restraint is used it should be in accordance with accepted professional standards.

14 **Communication and documentation**
Clear communication with patients is essential in relation to the use of restraint. Written information, including large print if necessary, should be used to supplement verbal information and the interpreter service used as appropriate. If interpreters are not used when necessary, patients may become more agitated and carers/relatives may become distressed.

If restraint is used, the reason should be explicit and clearly documented in the medical / 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 (or completed MCA1 & 2 forms)
• 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.

15 Evaluation and Review

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 frequency for review must be agreed and recorded on the Restraint Risk Assessment Form (see Appendix 2).

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

16 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. Patient incidents should also be documented in the nursing / multidisciplinary notes.

17 Training

The emphasis of training and education should be on dealing effectively with situations in order to obviate the need for restraint. An e-learning training package on Violence and Aggression is mandatory for all front line staff. This includes de-escalation. Face to face Conflict Resolution 1 day training is also mandatory for all front line staff.

Physical restraint must only be applied by staff members who are appropriately trained. 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 Manager and appropriate training provided for staff who are likely to be involved.

Face to face Control & Restraint training will be provided for staff members who are regularly required to use physical methods of restraint. Face to face Control & restraint training is mandatory for all Security Staff.
18  Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

19  Monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Use of restraint in Neuro Critical Care areas and Neurosciences (as higher use areas) as evidenced by completion of the following documentation: | Retrospective audit  
- Are both forms in use/in the notes?  
- Are both completed fully and correctly?  
If not, what is not completed or completed incorrectly? | Clinical educators in Neuro Critical Care and Neurosciences | Annually |
| All use of control & restraint by Security staff is reported and evidenced using Datix reporting system. | Datix electronic reporting system used by Security Staff for ALL incidents using control & restraint. Incidents signed off by Head of Security. | Head of Security in conjunction with Trust lead for Safeguarding Adults | Ongoing basis |

20  Consultation and review

This policy was reviewed and updated by the following people and groups:

**Trust Working Group Members**
Clare Abley, Nurse Consultant Vulnerable Older Adults
Louise Allen, Honorary Consultant Physician
Frances Blackburn, Head of Nursing, Freeman
Mick Brannen, Head of Portering and Security
Sarah Brown, Consultant Psychiatrist, Liaison Psychiatry, NTW Trust
This policy will be reviewed every two years. Comments, queries and suggested amendments should be addressed to the Nurse Consultant for Vulnerable Older Adults.

21 Implementation of policy (including raising awareness)

A single page briefing will be available for staff. An overview of the policy will be presented by the nurse consultant for vulnerable older adults at the Trust Matrons Forum and Clinical Leaders Forum. Presentations and awareness raising sessions will be run for clinical teams – on request (by nurse consultant vulnerable older adults)

22 References

23 Associated Trust Documents

This policy should be read in conjunction with other relevant Trust policies, national guidelines and legislation, including the following:

Trust policies
- Consent to Examination and Treatment (with reference to the Mental Capacity Act 2005)
- Delirium Assessment and Management
- Deprivation of Liberty Safeguards
- Enhanced Observation Policy: for patients with Mental Health problems and acute behavioural disturbances
- Guidelines for the use of Restraint in Critical Care
- Health & Safety Policy and procedure
- Management and Prevention of Patient Slips, Trips and Falls Policy
- Management and Reporting of Accidents and Incidents Policy
- Management of Poisoning and Drug overdose at the Royal Victoria Infirmary
- Management of Violence and Aggression at Work
- Managing Behavioural Problems and Agitation in Dementia
- Mental Capacity Act (2005) Including the Deprivation of Liberty Amendment 2009
- Missing Adult Patients Procedure
- Patients detained under the Mental Health Act 1983
- Safe & Effective use of Bedrails

National guidelines
- NICE Guidelines on Delirium http://guidance.nice.org.uk/CG103

Legislation
- Deprivation of Liberty Safeguards 2008 Chapter 2 What is a deprivation of liberty?
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).

  https://www.gov.uk/government/collections/mental-capacity-act-making-decisions
Appendix 1: Before Using Restraint – Flow Chart to Guide Decision Making

Is patient behaving in a way that threatens or causes harm to him/herself, others or to property?

Yes

Are there environmental factors which maybe causing this behaviour?

No

Yes

Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?

No

Yes

Adapt / modify environmental factors where possible

Does the patient have mental capacity in relation to his decision to behave in a “problematic” way?

No

Yes

Address underlying causes

Consider need for psychological or psychiatric input

Is a DoLs application or other legal action required?

No

Yes

Have you obtained the patient’s consent to use restraint?

Yes

No

Is restraint in the patient’s best interests?

No

Do not use restraint

Yes

Use restraint

Do not use restraint and consider other measures to deal with problematic behaviour

Consider obtaining legal advice
Appendix 2: Restraint Risk Assessment

The patient must be assessed by at least 2 qualified members of staff.

<table>
<thead>
<tr>
<th>Patient details</th>
<th>Qualified staff to sign, print name, date &amp; time.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Reason for use of restraint:

2. Other methods attempted:

3. Equipment and/or medication used:

4. Date and time restraint administered:

5. Frequency of review:

6. Discussed with relative/ Carer:

7. Management support:
   Consultant team informed: Y / N  Date: By whom:

8. Dates and times restraint reviewed with actions taken:

9. Date and time restraint discontinued:
Restraint Risk Assessment: Guidance for Completion

This form should not be completed for bed rail use where the intention is to prevent the patient falling out of bed. See Bedrails Policy for further information.

1. Reason for use of restraint – describe patient’s behaviour. Is the patient exhibiting behaviour that endangers their own or another’s safety?

2. Other methods attempted – describe less restrictive alternative(s) used which have failed.

3. Equipment and/or medication used – document which piece(s) of equipment where used and if attached to the patient say which limb/body part and whether any pieces of furniture were involved e.g. chair. If medication used document which one(s) and dosage.

4. Date and time restraint administered – document when restraint was commenced.

5. Record the frequency for review e.g. review hourly, review every 24 hours etc.

6. Discussed with relatives or carers– document which relatives informed, including date and time. Also document what information they were given regarding all of the above points and whether they agree with the decision and if they disagree, document reason.

7. Management support – If there is a problem with restraining a patient and/or the situation is potentially unsafe document who was informed, for example the line manager, including the date and time.

8. Dates and times restraint reviewed – record the dates and times when use of the restraint was reviewed. Record any action taken.

9. Date and time restraint discontinued – document date, time and reason for discontinuation of restraint, and any further action required.
Appendix 3  
Guidance in the Use of Restraint: Flow Chart

The algorithm below should be used to aid decision making regarding restraint.

**Reversible causes to consider:**
As per Delirium risk factors.

- Pain
- Anxiety
- Hypoxia
- Hypoglycaemia
- Urinary retention
- Constipation
- Drug/alcohol withdrawal
- Cerebral pathology
- Environmental
- Communication

Assess and document behaviour.

- Agitation
- Confusion
- Aggression
- Disinhibition
- Wandering
- Falls
- Disruptive

**Challenging behaviour**

Patient immediately at risk to themselves or others? Avoid restraint if possible.

Establish safety for patient, visitors and staff. Attempt re-orientation, discussion, persuasion.

Consider and treat reversible causes. Obtain medical opinion. Screen for Delirium (CAM or 4AT)


**Pulling out**

At risk if essential tubes pulled out eg NG / tracheostomy tube / IV access?

Options: 
- Mechanical restraint
- Upper limb gaiters
- "Boxing Gloves"

Pharmacological Restraint
- Consider medication options

**Rolling or falling out**

At risk of rolling out of bed or getting out of bed or chair and not weight-bearing?

Options: 
- Mechanical restraint
- Bedsides with bumpers (caution if pressure mattress in situ)
- Use a low level bed
- Mattress on floor

Pharmacological restraint
- Consider medication options

**Going out**

At risk of walking into unsafe areas, or leaving ward without informing staff?

Options: 
- Mechanical restraint
- Tagging- see Trust guidelines

Pharmacological Restraint
- Consider medication options

**Hitting out**

At risk to others through violence or aggressive behaviour?

Options: 
- Mechanical restraint
- See Trust Policy on violence 
- aggression

Pharmacological Restraint
- Consider medication options

**At risk if essential tubes pulled out eg NG / tracheostomy tube / IV access?**

Options: 
- Mechanical restraint

**At risk of rolling out of bed or getting out of bed or chair and not weight-bearing?**

Options: 
- Mechanical restraint

**At risk of walking into unsafe areas, or leaving ward without informing staff?**

Options: 
- Mechanical restraint

Restraint felt to be in patient's best interests.

**Essential:** Regular supervision, documentation, regular review.
Guidance in the use of Restraint:

**Mechanical (physical) restraint**
Careful deliberation should precede the application of this practice and an assessment of mental capacity should be undertaken. The use of physical restraints does not ensure safety and staff should be aware of the need for vigilance and constant supervision of these patients at all times.

In some circumstances specially designed ‘mittens’ / ‘boxing gloves’ or ‘gaiters’ may be used to protect the patient from the risks associated with patient-initiated removal of indwelling devices such as endotracheal tubes.

Bedrails should only be used following assessment of need and to safeguard patients. Bedrails are not a form of restraint where restraint is defined as: ‘the intentional restriction of a person’s voluntary movement or behaviour’. Bedrails will not prevent a patient from leaving their bed or falling elsewhere and should not be used for this purpose.

For further information see policy for the [Safe and Effective Use of Bedrails](#) policy:

**Pharmacological (chemical) restraint**
Careful deliberation should precede the use of pharmacological restraint. In critical care pharmacological restraint may be advocated in the first instance according to the Guideline for the Assessment and Management of Delirium in Critical Care. All pharmacological interventions which may impact on a patient’s mental capacity should be reviewed and any altered physiology such as electrolyte levels, corrected.

When the decision has been made to use Mechanical or Pharmacological restraint the ‘Restraint Risk Assessment’ (Appendix 5) should be completed prior to use and the ‘Mechanical & Pharmacological Restraint: Daily Observation Record’ should be used to monitor the patient throughout the ongoing use of such restraint (see below, Appendix 1).

There is current work ongoing in the Trust to develop guidance for staff on the use of Rapid Tranquillisation that will link in with this policy.

**Restraint Risk Assessment and Care Plan**

The Restraint Risk Assessment in Appendix 2 should be used. Once restraint is in use care should be taken to ensure that the patient suffers no harm as a result. A care plan should be used together with a daily observation record form (see below).

The following is an example of a nursing care plan for use of an arm restraint device:
Nursing Care Plan

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

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

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

The Daily Observation Record referred to in the care plan above (Action 11) can be found below, together with guidance for completion.
# Mechanical and Pharmacological Restraint: Daily Observation Record

**Date**…

**Start Time**…

(Until midnight)

**Specify Restraint used:**

---

1. **TIME** (use 24 hour clock)

2. **MECHANICAL RESTRAINT USED**

3. **MEDICATION GIVEN**

4. **CHECKED**

   (used correctly √)

5.1 **CAM or 4AT score**

5.2 **BEHAVIOUR**

   - Violent
   - Restless
   - Calm
   - Drowsy
   - Sleeping

6. **COMA SCALE:**

   - Eyes open (1-4)
   - Best verbal response (1-5)
   - Best motor response (1-6)

   GCS Total:

7. **Resp. rate** (per min):

8. **PRESSURE AREAS / TISSUE VIABILITY CHECKED** – back of head, shoulder blades, elbows, sacrum, heels, restraint site)

9. **MOVEMENT RANGE OF RESTRICTED LIMB**

10. **ELIMINATION NEEDS MET**

    (routine & equip.)

11. **HYDRATION / NUTRITION NEEDS MET**

    (refer to fluid & food charts and feeding instructions)

---

INITIAL EACH RELEVANT BOX TO INDICATE OBSERVATION COMPLETED & SIGN ACCOUNTABILITY

<table>
<thead>
<tr>
<th>ON DUTY</th>
<th>PRINT NAME</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EARLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LATE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NIGHT</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Daily Observation Record: Guidance for Completion

The patients details, today’s date, time at start of restraint use and type of restraint in use must be documented.

The actual brand name of the product should be documented.

In the case of a patient who is wandering, a HCA may complete the Observation Record. For every other situation, a Registered Nurse must complete the Observation Record.

1. Time
   The actual time that the observations are recorded must be documented.

2. Mechanical restraint used
   Only initial each box if there is a restraint in use, otherwise leave blank.

3. Medication administered
   Only initial each box when medication is given, otherwise leave blank.

4. Checked
   Each box should be initialled and have a tick or a cross to indicate whether the restraint is applied correctly (if the restraint has not been applied correctly then it must be documented and reapplied).

5. Behaviour
   Assess using CAM or 4AT scores as per Delirium guidelines. The box must be initialled to indicate the state of the patient and action must be taken, if necessary, to rectify that state.

6. Coma Scale
   Assessing using the Glasgow Coma Scale:
   - Eye Opening: 4 = spontaneously, 3 = to speech, 2 = to pain, 1 = none
   - Best Verbal response: 5 = orientated, 4 = confused, 3 = inappropriate words, 2 = incomprehensible sounds, 1 = none
   - Best Motor Response: 6 = obeys commands, 5 = localises to pain, 4 = flexion to pain, 3 = abnormal flexion, 2 = extension to pain, 1 = none

Any deterioration must be reported to the nurse in charge and the medical staff.

7. Respiratory Status
   The patient’s respirations over a one minute period must be documented and the box initialled.
   This only needs to be completed when the patient is being chemically restrained, and action taken if the patient has a repressed respiratory status.

8. Pressures / tissue viability checked
   The areas listed must be checked and any redness or breakdown of the skin must be documented and action taken to rectify the problem.

9. Movement range of restrained limb
   Once the restraint is applied the patient must still be able to move that limb, but not so much as to render the restraint useless.

10. Elimination needs met
    This box must be initialled to indicate that the patient is not further distressed by their need to urinate / defecate. Action must be taken to ensure that this is met by whichever means is appropriate.

11. Hydration / nutrition needs met
    This box must be initialled to indicate the patient is receiving adequate fluids and nutrition by which ever means is appropriate, and is not suffering from dehydration or malnutrition as a result of being restrained.
Appendix 4: Additional Guidance Relating to Neurosciences

Cognitive impairment and challenging behaviour present one of many challenges to neuroscience staff, mainly because of the threat it poses to the safety of the patient, staff, other patients and visitors.

Patients with an acquired brain injury can experience acute agitation and can lack insight into their own condition. Patients are often confused, disorientated and lack the ability to make new memory. In this situation there is a place for restraint, to maintain a safe environment for the patient and in order to deliver the treatment which the clinicians have assessed to be in their best interests.

Managing this group of patients in environments with minimal stimulus (cubicles), away from excessive environmental noise and other patients is beneficial and can reduce agitation. Providing a clear explanation for relatives/carers of the need to reduce the ‘amount’ of visitors and time spent visiting, along with concise, relevant information about the Trusts use of restraint policy, helps to reduce anxiety on their part.

In Neurology and Neurosurgery settings both physical and / or chemical restraint may be used to achieve adherence with treatment regimes/best interest decisions and to achieve patient safety. Restraint within the ward environment is effectively managed by ward medical and nursing teams and additional advice can be sought from the Nurse Specialist (Head injury) on an individual patient basis when required.

In some instances ‘one to one’ nursing, to prevent falls, enable safe/appropriate wandering is deemed a best interests decision. The guidelines below should be followed. This method of restraint is preferred in the Neurological / Neurosurgical setting, but in some instances of extreme behaviours other forms of mechanical and / or chemical restraint can be used in conjunction with ‘one to one nursing’.
Guidelines for Nurses Specialising Individual Patients in the Neuroscience Department:

The patient you are looking after today has been identified as someone who needs **CONSTANT** supervision. If this situation is ongoing, then it is likely to be a Deprivation of Liberty and Deprivation of Liberty Safeguards should be applied.

Your patient could be at risk of:
- Leaving the ward without consent due to confusion.
- Getting lost on the ward.
- Being a danger to themselves due to a lack of insight and awareness.
- Falling.
- Pulling out tubes.

You need to be aware of who the named nurse for your patient(s) is during your shift, so that if you have any concerns you know who to talk to. You also need to make yourself aware of whom the nurse in charge of the ward is during your shift.

Following discussion with your patients named nurse, you share the responsibility for your patient’s safety and daily needs e.g.
- Washing/dressing/shaving/combing hair.
- Offering and supervising drinks/oral hygiene.
- Offering and supervising meals/assisting with feeding.
- Toileting and emptying commode/catheter.
- Liaise with the named nurse to complete documentation
- Complete fluid/food charts accurately.

You need to stay with your patient **AT ALL TIMES**. If you need to go to the bathroom or on a break you must not leave your patient without informing the named nurse or the nurse in charge. If you require assistance use the nurse call to summon help, do not leave the patient unsupervised at any point.

The named nurse will advise you as to the level of supervision required for example the patient may require constant visual supervision within the area of their bed space or they may require closer supervision of being in touching distance to maintain their safety.

As the patient has been assessed as requiring one to one nursing you must ensure that they receive your full attention during the period of supervision. Constant supervision is paramount and you should not attempt to read books or magazines or consume any food or drink at any period during the supervision period, breaks will be provided in line with policy. The use of mobile phones is strictly prohibited please refer to Trust policy: Use of Mobile Telephone and Personal Computing Devices Within Trust Premises Policy.

Finally, should you have **ANY** concerns during the specialising of your allocated patient please inform the nurse in charge.

**Thankyou for your support**

Compiled by Helen Hastie, Clinical Nurse Specialist - Head Injury
(Updated May 2015)
Appendix 5: Challenging behaviour arising from drug and alcohol intoxication or mental health problems

Certain wards and departments in the Trust have a significant number of patients with drug and / or alcohol problems or mental health problems that may result in challenging behaviour e.g. A&E, Burns and Plastics, Ward 30 (RVI), Ward 16 (Freeman Hospital).

As well as adhering to the general principles of the Mental Capacity Act 2005 the following is suggested to assist staff in dealing with challenging behaviour arising from drug and / or alcohol intoxication or mental health problems:

- Use de-escalation techniques to diffuse the situation where possible
- Only use safe holding / physical restraint techniques when you have received training to do so
- Contact porters/ security staff for assistance

Administration of sedative medication intramuscularly / intravenously (pharmacological restraint) is a possible option in a minority of cases e.g. extreme restlessness or agitation. Oral medication should be given as the first choice where possible. Delirium Guidelines should also be referred to. Considerations are the same as for other types of restraint, namely:
  - assess mental capacity
  - if lacking in capacity act in the person’s best interests
  - you must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
  - the administration of sedation must be a proportionate response to the likelihood and seriousness of the harm
  - the underlying reasons for the challenging behaviour should be assessed and treated where possible
  - A restraint risk assessment form should be completed such as the one in Appendix 5

When pharmacological restraint is used to restrain patients who are acutely disturbed, the aim should be 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 e.g., 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.
Remember that the symptoms of drug or alcohol use can be an example of an impairment of the brain or mind – and therefore the first stage of the mental capacity test may be met.

Directorates that regularly see patients with challenging behaviour arising from drug and/or alcohol intoxication or mental health problems must ensure that staff members have adequate preparation to deal with this. Specific training could include:

- De-escalation techniques
- Safe holding / physical restraint techniques
- Knowledge of drug and alcohol problems

For further advice and information on alcohol withdrawal, please also refer to the Trust guidelines for the management of alcohol withdrawal: and withdrawal assessment tool:

**Fluctuating Capacity**

**The Mental Capacity act 2005 states that a patient may have fluctuating capacity.**

Some patients are intermittently or temporarily unable to make a decision for themselves. It may be possible to wait until the patient has capacity or, where this is not the case, patients must be treated in accordance with their best interests.

Events such a bereavement or sudden shock may have an impact on the individual's ability to make a decision, therefore rendering them temporarily incapacitated. It is important therefore to assess the capacity of an individual at the time a decision is to be made.

Where a person suffers from a disorder such as bi-polar disorder and is prone to fluctuating capacity, it is possible to plan in advance.

In very complex cases, for example where the individual's decision-making capacity is border-line, appears to fluctuate rapidly or is - by reason of mental disorder - particularly difficult to assess, it may be necessary to obtain the opinion of a psychiatrist. In these cases, it is good practice for the psychiatrist to assess capacity jointly with the responsible professional who can explain more fully the care decision to be made and the implications of a decision in either direction.
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

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

PART 1

1. **Assessment Date:** 26.05.2015

2. **Name of policy / strategy / service:**
   - Policy on Restraint (Adults)

3. **Name and designation of Author:**
   - Jo Ledger

4. **Names & designations of those involved in the impact analysis screening process:**
   - Jo Ledger, Clare Abley, Lucy Hall

5. **Is this a:**
   - Policy [√]
   - Strategy [ ]
   - Service [ ]

   **Is this:**
   - New [ ]
   - Revised [√]

   **Who is affected:**
   - Employees [√]
   - Service Users [√]
   - Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
   
   This policy provides information and guidance on restraint of patients by staff employed by The Newcastle upon Tyne Hospitals NHS Foundation Trust. It outlines the general principles that should be applied to practice with adults across the Trust, including the legal position where appropriate. The aim of this policy is to provide staff with the guidance needed to practise in accordance with the law, professional standards and Trust policy.

7. **Does this policy, strategy, or service have any equality implications?**
   - Yes [√]
   - No [ ]

   These implications have been considered and addressed in the policy review.

   **If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:**
### Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <em>(by whom, completion date and review date)</em></th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <em>(by whom, completion date and review date)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Interpreting service available. Reference made in policy to using interpreter service as appropriate Mental Capacity patient &amp; carer information leaflets are available in many different languages on Trust Intranet</td>
<td>If interpreters not used, patients may become more agitated and carers/relatives may become distressed. This is incorporated into the policy. Behaviour relating to lack of communication and cultural issues is highlighted in the policy with reference to also Critical care areas &amp; neurosciences Communication; religious and cultural issues and the impact of disability or Learning Difficulties has been added to the understanding behaviour and underlying condition section</td>
<td>No</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Chaplaincy service available</td>
<td>The environment can have either a positive or a negative effect on patients. Lack of understanding of disability, communication, religious and cultural needs can have a negative effect. Reference to this has been added to the policy</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>Forget me Not initiative, including information for staff &amp; carers Delirium &amp; Dementia Screening Independent Mental Capacity Advocates Core Care plans for the care of patients with Dementia</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Section</td>
<td>Details</td>
<td>Notes</td>
<td></td>
</tr>
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<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health.</td>
<td>ACE hospital passports &amp; ACE carer information Learning disability Liaison nurse support &amp; Care Pathways including in critical care &amp; ED. Disability Distress Assessment Tool. Psychology and Mental Health Services Independent Mental Capacity Advocates Large print written information is available</td>
<td>The environment can have either a positive or a negative effect on patients. Lack of understanding of disability, and communication needs, can have a negative effect. Reference to this has been added to the policy. Involvement of family &amp; carers has been highlighted in this policy.</td>
<td></td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>None relevant to this policy</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>None relevant to this policy</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>Maternity Services expertise</td>
<td>Conditions related to pregnancy such as puerperal psychosis can affect behaviour. Pregnancy and postnatal conditions has been added to this policy as potential underlying condition when assessing individual needs.</td>
<td></td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes [ ] No [√]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)
Yes - The right to liberty for patients when restraint used in patients' best interest. This has been considered in the policy and measures put in place to ensure restraint is only used in the patients’ best interests. Mental capacity and the Mental Health Act is also included in the policy.

PART 2

Name:
Jo Ledger

Date of completion:
26.05.2015

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)