CR17 - Restraint Policy and Procedure

Purpose

- To manage Service Users who may harm themselves or maybe vulnerable to harm and for whom restraint may be a care option.
- To give guidance to staff in relation to legal protection offered by Mental Capacity Act 2005.

Scope

- All Service Users.

Policy

- Respecting people's rights to dignity, freedom and respect underpin good quality social care. People may need support in managing their care and making decisions but they have the right to make choices about their lives and to take risks. Decisions regarding restraint need to be taken as part of the process of managing risk.
- People using care services are free to do what they want, and go where they want unless limited by law.
- Where people in care services have capacity, restraint may only take place with their consent or in an emergency to prevent harm to themselves or others, or to prevent a crime being committed.
- The following guidelines should be adhered to when it can be demonstrated that, for an individual in particular circumstances, not being restrained would conflict with the duty of care of the service and that the outcome for the individual would be harm to themselves or to others otherwise restraint may not be used and any acts of restraint could be unlawful.
- Staff will receive basic training and certification on restraint techniques, which will be re-certified on an annual basis.

Definitions

- Restraint is the act of restraining a person's liberty, preventing them from doing something they wish to do. The definition included within *Showing restraint: challenging the use of restraint in care homes* (Counsel and Care UK, 2002), restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.'
- The Mental Capacity Act 2005 describes restraint as the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm. This policy should be read in conjunction with Mental Capacity Act 2005 Policy and Procedure.
- Restraint that amounts to a deprivation of liberty contravenes Article 5 of the Human Rights Act 1998 and would only be lawful where a Deprivation of Liberty Safeguards authorisation had been sought and obtained. Therefore anyone who applies any form of restraint must be prepared to justify the restraint. This policy should be read in conjunction with Deprivation of Liberty Safeguards Policy and Procedure.
- The following definitions should guide you to thinking whether any of the interventions you use could be considered a constraint, whether any of their use could be avoided, whether there is a less restrictive alternative, or whether the continued use of one or more of these constitutes a deprivation of the person's liberty:
- **Physical restraint:**
  - **Physical restraint** can be defined as stopping an individual's movement by the use of equipment that is not specifically designed for that purpose. This could be through the use of bed restraints, belts, tables or chairs etc.
  - **Mechanical restraint** is the use of belts, arm cuffs, splints or helmets to limit movement to prevent self-

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injurious behaviour (SIB) or harm to others.

- **Physical intervention** is direct action by one or more members of staff holding or moving the person, or blocking their movement to stop them going where they wish. This should not be confused with interventions such as guiding and prompting that are intended to support the person.

- **Environmental restraint** is designing the environment to limit people's ability to move as they might wish. This could be through locking doors, using coded electronic keypads, complicated door handles, narrow doorways, not providing corridor rails, steps or stairs, poor lighting or heating etc.

- **Chemical restraint** is the use of drugs and prescriptions to change or moderate people's behaviour. This is also known as covert medication.

- **Forced care** is the act of 'forcing' someone to receive care. This could be food, medication, clothing etc.

- **Threatening or verbal intimidation** could be used to make a person subservient or scared of doing what they want to do. It may also be acts calculated to lead people to believe that they have no option but to remain in a particular care setting, or make them fear repercussions should they choose to resist or leave.

- **Electronic surveillance** – examples include the use of electronic tags, exit alarms, CCTV and pressure pads to monitor or restrict movement.

- **Cultural restraint** can be the result of constantly telling people not to do something, or that doing what they want to do is not allowed, is illegal, or is too dangerous. It could also include being got up or put to bed at unwanted times, or having meals at a time to suit the staff. It could also be seclusion in bedrooms because of their behaviour resulting in deprivation of activities and other stimulation.

- **Medical restraint** is the fixing of medical interventions such as catheters in order to deliberately restrict movement or being positioned to prevent their removal.

- Section 5 of the Mental Capacity Act 2005 offers protection for staff against civil or criminal actions, where decisions about care and treatment are made in the best interest of someone who lacks the capacity to make those decisions themselves. In addition there is similar legal protection for staff, who in the process of making best interests decisions, restrain someone, as long as two further conditions are met, namely,

  - It is reasonable to believe that it is necessary to restrain the person to prevent harm to them; and

  - Any restraint is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.

- This policy should be read and applied in conjunction with Mental Capacity Act 2005 Policy and Procedure. In addition the following good practice should be borne in mind in the context of restraint:

  - Anyone can make decisions on behalf of someone who lacks the capacity to do so. You should consider who is the decision maker in each context, for example: *A Care assistant can legitimately decide what clothes a person should wear if they do not have the capacity to make the decision themselves.*

  - The more complicated or serious the implications regarding the capacity issue, the more safeguards there should be put in place to prevent abuse of the decision-making process.

  - The fact that someone does not have capacity does not mean that restraint or other practices to limit a person's freedom can be freely used.

  - If someone does not have capacity then the Mental Capacity Act (and its Code of Practice) defines a clear process that care services should follow in order to assess and record decisions that are being made on a person's behalf.

  - If it has been agreed that someone lacks capacity then the decisions made on their behalf must be clearly

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defined. This is because it is important that services do not assume someone lacks capacity in all situations as this could result in people being unnecessarily restrained.

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Procedure

- Restraint, in all cases, should very much be seen as the 'last resort', with other techniques and strategies always being employed before restraint is considered as an option.
- Staff should consider what is acceptable restraint, unacceptable restraint (where less restrictive alternatives are not considered) and unintentional (where staff do not realize their interventions constitute restraint).
- The Registered Manager, in consultation with staff members, must assess and record in the Service User Care Plan:
  - The problem behaviour which is causing restraint to be considered – does it affect any other persons;
  - Evidence of consent of a person to their own restraint, where they have the capacity to make the decision;
  - Note – a person who does not have capacity (see notes regarding the Mental Capacity Act 2005) cannot give consent.
- Restraint must be time limited and noted as such.
- Families must be aware of the restraint and in full agreement, and that agreement noted. The family consent does not replace the requirement for the restraint subject's consent to their own restraint.
- Restraint must be reviewed as per the stated time limit and certainly at no greater than weekly intervals. The review must be noted.
- Pre-printed "Restraint Register" forms are available from the office and must be used to ensure compliance with this policy.
- All "LIVE" restraint sheets must be kept in the register, and be available for inspection.
- Sheets no longer in use must be filed in the Service User's individual wallet file accompanying the Service User Care Plan.

FOR FURTHER GUIDANCE, SEE "ADVICE ON THE SAFE USE OF BED RAILS" BULLETIN, MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AGENCY, REF DB2006 (UPDATED 2012):

- Relevant documents, including a poster, are located in "Useful Documents" – see under "Bed Restraints".

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Restraint Assessment and Register

Service User name:		
Reasons for consideration of restraint (behaviour problem):		
Types of restraint considered:		
Restraint to be used, with reasons:		
Consultation with family (note name, date, time and brief summary of discussion):		
Family signature:		
	Date and any comments on changes:	**Signature:**
Restraint first instituted:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
Review date:		
If review requires change, use and complete a new form, including family consent.		

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Bed Restraint Assessment

Service User's name:	
First assessment date:	Age:
Aim: An assessment of the risk of falling and the Service User's ability to maintain their own safety. The frequency of assessment is based on professional judgement. The assessment will be discussed with the Service User and/or carer and reviewed.	
All Service Users must have a documented care assessment made within 24 hours of admission which includes maintaining a safe environment.	
Indications for use	**Indications for non-use**
ı Service User has capacity to consent. ı History of falls from bed. ı Fluctuating consciousness level. ı Sensory loss/confusional state (only where the Service User is completely immobile – see indications for non-use). ı Lack of awareness/physical limitations of ability. ı Service User/carer request. ı Location of bed.	ı Service User does not have the capacity to consent. ı Sensory loss/confusional state, where the Service User is mobile and may become entangled in the rails, or climb over them. ı Aware of limitations. ı Non-active movement when in bed. ı Independent in movement. ı No history of falls. ı Extreme distress when bed restraints are in place.

Date	Time	Bed restraints required	Rationale	Signature

NB: Ensure that the rails in use comply with the measurements given in "Advice on the safe use of bed rails" bulletin, Ref MDA DB2001, Medicines and Healthcare products Regulatory agency.

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Bed restraint Fitting Assessment and Check

Name:	Date of birth:	GP:
Safe Fitting	Yes	No
Mandatory – Is the maximum gap between rail bars less than 120mm?		Do not use – replace with suitable equipment
Has the bed restraint been fitted to the bed correctly?		
Is there a gap between the lower bar of the bed and the top of the mattress, which could cause entrapment?		
Does the mattress compress easily at its edge, creating an entrapment hazard?		
Will the gap between the bed restraint and the headboard allow entrapment?		
Is there a gap between the bed restraint and the side of the mattress that will allow the occupant's body to pass through or trap their head?		
Is the bed restraint secure – does it seem likely that it will move away from the side of the bed and mattress in use, or fall off one end, creating an entrapment hazard?		
Do the dimensions and the overall height of the mattress compromise the safety of the bed restraint – is an extra height bed restraint needed?		
Is there any extra work needed to ensure the safe fitting of the bed restraints?		
Comments:		
Bed Occupant		
Are their head, body or limbs small enough to pass between the bed restraint bars?		
Are their head, body or limbs small enough to pass through the gap between the lower bed restraint bar and mattress (allowing for compression of the mattress at its edge)?		
Are their head, body or limbs small enough to pass between the bed restraint bars?		
Are they agitated or confused?		
Will they need to get out of bed during the night?		
Will a bed restraint bumper reduce the risk of entrapment of the occupant?		
As a result of the answers to Section 4, is it necessary to review the type of bed restraint fitted?		
Comments:		
If the bed, mattress, occupant or bed restraint is changed, or the condition of the occupant changes, the risk assessment must be carried out again.		
Name of assessor:		Date:
Signature:		Review date:

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Bed Restraint Consent Form

Dear

Following a thorough assessment, we have formed the professional opinion that your safety and wellbeing would be enhanced by the use of bed restraints in order to reduce the risk of you falling out of bed and injuring yourself.

Please be assured that we have also carried out an assessment of your detailed needs, physical condition and physical size, and will use a bed restraint system which that assessment indicates as appropriate.

We will reassess your needs and physical condition at regular intervals, as indicated in your Care Plan, and should you cease to require the bed restraint(s) they will be withdrawn from use.

You will be shown how the bed restraints work as they are installed, and at any time you can request more information from a member of staff.

If you agree to the use of bed restraint(s) under these conditions, please sign and date this form below where indicated and return a copy to the Manager.

If you are not able to consider the content of this letter and sign to indicate your agreement, we may ask a family member or independent advocate acting in your interests to consider the matter and sign on your behalf if they consider that use of bed restraints is in your best interests.

Yours sincerely

Registered Manager

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I give my consent to the use of appropriate bed restraints to my bed.	
Signed (Service User):	Date:
OR I give my consent to the use of appropriate bed restraints to the bed of:	
Name of Service User:	
My signature:	
My name and address:	
My relationship to the Service User date:	

Key Lines of Enquiry Table

Key Line of Enquiry	Primary	Supporting	Mandatory
R.S1 - How are people protected from bullying, harassment, avoidable harm and abuse that may breach their human rights?	✓		✓
R.E2 - Is consent to care and treatment always sought in line with legislation and guidance?	✓		✓
R.C1 - How are positive, caring relationships developed with people using the service?		✓	✓
R.W1 - How does the service promote a positive culture that is person centred, open, inclusive and empowering?		✓	✓

Note: All QCS Policies are reviewed annually, more frequently, or as necessary.