 **Promise Care Services Ltd**

#  RESTRAINT

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Policy Statement

This organisation takes seriously the safeguarding of its service users and staff. This policy clarifies where the use of restraint is considered and the steps that all staff need to take to comply with current advice and legislation.

Legal Definition

The most relevant legal definition of restraint for care homes in England is that found in the Mental Capacity Act (2005) and its amendments:

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

* Use force or threaten to use force to make someone do something that they are resisting, or
* Restrict a person’s freedom of movement, whether they are resisting or not.” (14 section 10.4)

The definition is deceptively short but is supported by extensive guidance to assist in its interpretation, and it is, or will be, ultimately interpreted through the decision of the courts in specific cases. The brief outline that follows is not intended as a substitute for the Mental Capacity Act 2005 Code of Practice but merely to indicate some of its salient features.

It is legal to use restraint only if certain conditions are satisfied:

In an emergency: 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 that may cause harm to others, staff may, under Common Law, take appropriate and necessary action to restrain or remove the person, to prevent harm, both to the person concerned and to anyone else.

Any action intended to restrain a person can be legal if the person consents (as long as there has been no coercion), but the restraint of a person who lacks the capacity to consent has to meet two conditions:

* The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity.
* The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm (Section 6.41; the terms in italics are further elaborated in the Mental Capacity Act 2005 Code of Practice).

In addition, the person´s lack of capacity cannot be assumed simply because they have some cognitive impairment or illness. The person who is considering undertaking restraint should take reasonable steps to establish whether the individual lacks capacity concerning the matter in question, and should reasonably believe that it will be in the best interests of the person to use restraint, bearing in mind possible benefits, risks and consequences. There is a process (that is, a set of indicative questions) outlined in the code of practice to establish whether someone has the capacity to make a particular decision.

The Policy

Implementation of this policy will help services to address important outcomes for service users’ choice, rights, independence and inclusion and will contribute to joint working with other agencies. The safety of staff during physical interventions is of equal importance to the best interests of service users, and both take priority over the care of the property, which can be replaced.

Defining Physical Intervention

In this document, the term 'physical intervention' refers to a range of physical actions used as techniques for responding to challenging behaviour, and which involve some degree of direct physical force to limit or restrict movement or mobility; this can include the removal of aid to mobility that is normally used by that person.

There are three main types of physical intervention:

* Direct physical contact between a member of staff and a service user. Examples include holding another person by the arm to stop self-harm; using manual guidance to stop a person from wandering into the road; or two people each holding a person and guiding him or her to a seat, if agitated.
* The use of barriers to limit freedom of movement, e.g. placing door catches beyond the reach of service users.
* Materials or equipment which restricts or prevents movement. Examples include using a splint to limit the movement of an arm or leg. (mechanical).

Physical intervention implies the restriction of a person's movement that involves resistance. It is therefore different from forms of physical contact such as manual prompting, physical guidance or simply support. Over time, the term 'restraint' has acquired a number of negative connotations. It is also a term that is closely linked with a particular kind of approach to the management of aggressive and violent behaviour, Control and Restraint, or C&R. For this reason, this document uses the more neutral term 'physical intervention', to indicate a continuum between touching, holding and restraint, and the link with other approaches of de-escalation to be used in conjunction with physical interventions at all times.

Hence the use of physical intervention needs to be consistent with the guidance, Positive and Proactive Care: Reducing the Need for Restrictive Interventions, issued by the Department of Health in April 2014. From this document, the following principles are defined.

Principles

[Paragraph 58] The safe and ethical use of all forms of restrictive interventions.

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded **on eight overarching principles:**

* Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
* There must be a real possibility of harm to the person or staff, the public or others if no action is undertaken.
* The nature of the techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
* Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need.
* Any restriction should be imposed no longer than necessary.
* What is done to people, why, and with what consequences must be subject to audit and monitoring and must be open and transparent.
* Restrictive interventions should only be used as a last resort.
* People who use services, carers, and advocate involvement is essential when reviewing plans and restrictive interventions.

Key principles

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| **Key principle** | **What it means** | **What it looks like in practice** |
| Participation | Enabling participation of all key people and stakeholders | Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights. |
| Accountability | Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach | Clearly outlining responsibilities under the Mental Health Act and the Mental Capacity Act (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards. |
| Non-discriminatory | Avoiding discrimination, paying attention to groups who are vulnerable to rights violations | Using person-centred planning approaches that do not discriminate based on religion or belief, race or culture, gender, sexual preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights. |
| Empowerment | Empowering staff and people who use services with the knowledge and skills to realise rights | Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions; |
| Legality | Complying with relevant legislation including human rights obligations, particularly the Human Rights Act | Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy. |

National Policy and Legal Context

The use of physical interventions involves important legal and ethical considerations, which need to be fully understood by the organisation. Any physical intervention must employ the minimum level of force, for the least amount of time needed. Furthermore, it cannot be used solely to force compliance with staff instructions.

The use of any degree of force is unlawful if the particular circumstances do not warrant it. Therefore, the physical force could not be justified to prevent a patient from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force. The degree of force employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. The degree of force and the duration of its application should always be the minimum needed to achieve the desired result; frequently the role of staff is to allow the patience and time required to achieve this minimum.

Justification also includes the right of every citizen to self-defence, which applies to all situations for all staff and service users. To be justifiable in court, the use of force must be appropriate to the circumstances.

It is an offence to lock an adult in a room without a court order (even if they are not aware that they are locked in). The exception is the use of a locked room as a temporary measure while seeking assistance, which would provide legal justification; however, there are instances where an adult could be at risk due to lack of awareness of danger, which could provide a reason for the restriction to a room or area. Such use needs to be part of a care plan and risk assessment, not an ad hoc solution. To the extent that seclusion involves restricting a person's freedom of movement, it can be considered a form of physical intervention.

Justification (as a legal defence) for using physical interventions needs to address these questions:

* Is there clarity about how the intervention helps the patient concerned?
* Are there any conflicts of interest where staff experience fewer demands or less stress when physical interventions are used?
* What steps have been taken to reduce the likelihood that the physical intervention will be used in the future?
* Is the justification for this service user specifically, or 'all' in the group?

Under health and safety legislation, employers are responsible for the health, safety and welfare of employees, in addition to the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of physical interventions. Employers need to establish and monitor safe systems of work, and to ensure that employees are suitably trained. Use of physical intervention may give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned, making proper training and use of physical interventions imperative.

Providers of health and social care services owe a duty of care towards service users, which requires that reasonable measures to prevent harm are taken. Hence, in some circumstances, it may be appropriate to employ certain kinds of physical intervention to prevent a significant risk of harm. Physical interventions ought only to be used when other strategies have been tried and found to be unsuccessful, or when the risks of not employing an emergency intervention are outweighed by the risks of using one. The physical intervention needs to use the minimum force to prevent injury or to avert serious property damage, and be applied for the minimum amount of time.

The use of physical interventions needs to be consistent with the Human Rights Act 1998 and its Articles. These are based on the presumption that every person is entitled to:

* Respect for his or her private life.
* The right not to be subjected to inhuman or degrading treatment.
* The right to liberty and security.
* The right not to be discriminated against in his or her enjoyment of those rights.

Physical interventions need to be specific to service users, integrated with other less intrusive approaches, and part of a person-centred plan of care reducing risk when needed; they must not become a standard way of coping, or as a substitute for training in people-related skills.

Chemical Restraint

Chemical restraint refers to, “the use of medication which is prescribed and administered to control or subdue disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness”.

Chemical restraint will be used only for a person who is highly aroused, agitated, interactive, and aggressive, is making serious threats or gesture towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour. Chemical restraint will only ever be delivered following acknowledged, evidence-based best practice guidance and prescribed by a medical professional for example GP, doctor or prescribing registered nurse or community psychiatric nurse. The prescribers will provide information to us regarding any physical monitoring that may be required as well as the medication to be used and the route of medication. The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term ‘rapid tranquillisation' refers to intramuscular injections and oral medication. Oral medication should always be considered first. Where rapid tranquillisation in the form of intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face-down restraint.

This organisations policy aim is to follow the summary of action laid out in the guidance: Positive and Proactive Care: Reducing the Need for Restrictive Interventions, issued by the Depart of Health in April 2014, to ensure that the quality of life of a patient is enhanced and that their needs are better met which will reduce the need for restrictive interventions, and that staff and those who provide support are protected:

* All services where restrictive interventions are used must have an identified person at the **board level** for increasing positive behaviour support planning and reducing restrictive interventions.
* All services where restrictive interventions may be used should have **restrictive intervention reduction programmes** in place. Such programmes must be based on the principles of effective leadership, data informed practice, workforce development, the use of specific restrictive intervention reduction tools, patient empowerment and a commitment to effective models of post incident review.
* In those services where people can reasonably be predicted to be at risk of being exposed to restrictive interventions, individualised support plans must incorporate the key elements of behaviour support plans. This will include how needs will be met and the environment structured to reduce the incidents of the behaviour of concern. They must also detail how early warning signs of behaviour escalation can be recognised and responded to together with plans for the safe application of restrictive interventions if a crisis develops.
* Plans for the use of physical or mechanical restraint must not include the deliberate application of pain in an attempt to force compliance with instructions, painful holds or stimuli cannot be justified unless there is an immediate threat to life.
* Where behaviour support plans, or equivalent, which incorporate the key components, are used, reviews of their quality of design and application should be included within a service provider’s internal audit programmes.
* Appropriate governance structures and transparent policies around the use of restrictive interventions must be established within a context of positive and proactive working.
* The choice of any restrictive intervention that has to be used must always represent the least restrictive option to meet the immediate need.
* Wherever possible, people who use services, family carers, advocates, and other relevant representatives should be engaged in all aspect of planning their care including how to respond to crises, post-incident debriefings, rigorous reporting arrangements for staff and collation of data regarding the use of restrictive interventions.
* Provider organisations must use a process whereby there is board-level (or equivalent) authorisation and approval of the restrictive interventions taught to their staff and used in practice.
* The organisation that provides care and support to people who are at risk of being exposed to restrictive interventions must have clear organisational policies which reflect current legislation, case law and evidence of best practice. Accessible versions of the policies should be available to those who use the services.
* Services must publish a public, annually updated, accessible report on the use of restrictive interventions which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.
* Service commissioners must be informed about restrictive interventions used for those for whom they have responsibility.
* There must be a clear and accurate recording of the use of restrictive interventions to evaluate services progress against their restrictive intervention reduction programmes.
* Service provides must ensure that post-incident reviews and debriefs are planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.
* All staff who may be required to use restrictive interventions must have high quality, specialised training.
* Service commissioners must assure themselves that the service has the necessary competencies to provide effective support for the people they are funding.

In addition to the above guidance, the Care Quality Commission (CQC) has issued brief guides for inspectors concerning restraint and inspections which providers will find useful. You will find this under “brief guides for inspection teams” on their website http://www.cqc.org.uk/content/brief-guides-inspection-teams. From this guidance, definitions of restraint are outlined below

**Physical restraint**: any direct physical contact where the person intervening intends to prevent, restrict, or subdue movement of the body, or part of the body of another person.

**Prone restraint** (a type of physical restraint): holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is faced down or has their face to the side. It includes being placed on a mattress faced down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.

**Chemical restraint** (this brief guide does not cover the use of chemical restraint. Refer to the brief guide on cycle active medicines for people with learning disabilities): The use of medication that is prescribed and administered to control or subdue disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness

**Mechanical restraint:** this is the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person’s body or part of the body, for the primary purpose of behavioural control.

A self-assessment tool, Reducing Restrictive Practices Checklist, has been published by Restraint Reduction Network in 2016 to help organisations ensure that the use of the coercive and restrictive practice is minimised and the misuse and abuse of restraint are prevented.

This organisation will always take advice and guidance from multi-agency partners to ensure a consistent and planned approach in any situation that requires physical intervention.

Related Policies

Adult Safeguarding

Assessment of Need and Eligibility

Care and Support Planning

Challenging Behaviour, Violence and Aggression

Deprivation of Liberty Safeguards

Dignity and Respect

Mental Capacity Act 2005

Moving and Handling

Positive Behavioural Support

Related Guidance

NICE Quality Standard [QS154], June 2017: Violent and Aggressive Behaviours in People with Mental Health Problems:

https://www.nice.org.uk/guidance/qs154

NICE Quality Standard [QS101], October 2015: Learning Disabilities: Challenging Behaviour:

https://www.nice.org.uk/guidance/qs101

The Challenging Behaviour Foundation:

https://www.challengingbehaviour.org.uk/

Restraint Reduction Network: Reducing Restrictive Practices Checklist, 2016:

http://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

NHS How to Deal with Challenging Behavior in Adults: https://www.nhs.uk/conditions/social-care-and-support-guide/practical-tips-if-you-care-for-someone/how-to-deal-with-challenging-behaviour-in-adults/

Bild: The Seven Key Questions about Positive Behavioural Support:

https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2016/07/bild-key-questions.pdf

Skills for Care: Positive Behavioural Support Framework:

https://www.skillsforcare.org.uk/

Bild: What Are the Five Signs of Good Positive Behavioural Support

http://www.bild.org.uk/

Training Statement

All staff, during induction, are made aware of the organisation’s policies and procedures, all of which are used for training updates. All policies and procedures are reviewed and amended where necessary, and staff are made aware of any changes. Observations are undertaken to check skills and competencies. Various methods of training are used, including one to one, online, workbook, group meetings, and individual supervisions.

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