



Royal College
of Nursing

RESTRAINT

RIGHTS

RISKS

RESPONSIBILITY

“Let’s talk about restraint”

Rights, risks and responsibility



Royal College
of Nursing

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“Let’s talk about restraint”

Rights, risks and responsibility

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Introduction

This guidance is applicable to all settings where nursing care is provided. It replaces *Restraint revisited – rights, risks and responsibility; guidance for nursing staff*. While again it has been written for all nursing staff, distinctions are made, where appropriate, between the roles and responsibilities of registered nurses, nursing students, and health care assistants. It also sets out what support and guidance nursing staff should expect their employing organisation to provide. In addition, it may be helpful to regulators and inspectors of health and social care.

This guidance is intended for nurses working with adults, with examples and case studies particularly geared towards the care of older people.

Whilst this guidance is directed at nurses, except in emergencies, decisions about restraint need to be made after discussion, wherever possible, with the older person, their relatives and friends, as partners in care. It is important to involve the whole care team, including other professionals and agencies that may be helping to support the older person. Whilst we have used the term 'clients' in this publication, it should be noted that this term is interchangeable with 'patients'.

Our aims

This guidance aims to help nursing staff to:

- ◆ Understand what restraint is
- ◆ Provide person-centred care that minimises the need for restraint
- ◆ Understand the legal and ethical frameworks relevant to restraint
- ◆ Know what to do if they suspect inappropriate or abusive use of restraint
- ◆ Understand the circumstances in which restraint may be legally or ethically appropriate
- ◆ Understand how to minimise the risks if restraint is used.

While this document cannot provide all the answers, its aim is to give nursing staff a framework for decision-making that helps them to provide the best possible care for every older person in their care.

What is restraint?

Whilst a basic definition of restraint might be 'restricting movement' or 'restricting liberty', many nursing interventions may restrict unintended movement – for example, plaster casts to stop a client accidentally displacing a fracture – or may unintentionally restrict movement – for example, a nursing home locked at night to protect residents and staff from intruders.

According to established international definitions, 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.' In this context, 'behaviour' means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is 'stopping a person doing something they appear to want to do.'

Types of restraint

- ◆ Physical restraint involves one or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.

- ◆ Mechanical restraint involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.
- ◆ Technological surveillance – such as tagging, pressure pads, closed circuit television, or door alarms – is often used to alert staff that the person is trying to leave or to monitor their movement. Whilst not restraint in themselves, they could be used to trigger restraint, for example through physically restraining a person who is trying to leave when the door alarm sounds. These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.
- ◆ Chemical restraint involves using medication to restrain. This could be regularly prescribed medication – including that to be used as required – over-the-counter medication, or illegal drugs.
- ◆ Psychological restraint can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

If an action fits the definition of restraint, it is not automatically unacceptable or wrong. Malicious and abusive use of restraint can occur, but even for the vast majority of caring and conscientious nurses, decisions about restraint are not easy or straightforward. A discussion of the ethical, legal, practical, and professional issues follows, to help nurses understand the difference between unacceptable or abusive restraint and the rare circumstances in which restraint may be justified or positively required, to help strike the right balance between independence and safety.

It is not possible to give a list of what kind of

equipment, physical holding, or medication constitutes restraint, as it depends upon the circumstances. A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.

Is it restraint or not? Some examples

Following treatment in hospital for a heart condition, a client develops dangerously high blood pressure levels. As part of her treatment, she is heavily sedated within a critical care environment. This does not fit the definition of restraint, as the sedation is being given to treat her illness, not to control her behaviour.

Following admission to hospital with a heart condition, a client who also has dementia is unable to settle, and constantly wanders. After two nights with little rest, his legs have become very oedematous, and there is a concern that his constant movement is exacerbating his heart condition. Sedation is prescribed. This may fit the definition of restraint, as the sedation is directed at controlling the client's behaviour. However, it is likely to be justified if the ethical and legal principles set out later in this guidance are met.

An older person has been admitted to a care home for a period of respite. He is very unsettled at night, finding it hard to sleep. He constantly walks around the home looking for his wife. Staff find it difficult to support this client and ask the GP to prescribe sedation. This could fit the definition of restraint, and is unlikely to be justified. Alternative ways of supporting the client to settle, such as conversation and reassurance, could be found.

Following a series of strokes, an older person in a rehabilitation hospital needs help from nurses and a hoist to get out of bed. He is also unable to communicate his needs. He is restless at night, has muscle spasms, and is at risk of falling out of bed. Nurses decide bedrails would be in his best interest, to reduce the risk of an accidental fall. This does not fit the definition of restraint, as the bedrails are not controlling his behaviour or preventing him from doing something he wants to do.

An older person is admitted to a care home after treatment for a hip fracture that occurred in her own home. The older person is unsteady when mobilising, and often forgets to use her walking frame. Her relatives are very worried a second hip fracture could result in fatality. They ask nurses to put bedrails up to prevent her from getting out of bed alone to use the toilet at night. This could fit the definition of restraint, as the older person appears to want to get out of bed. It is unlikely to be justified as alternative methods of reducing the risk of further falls – and so reassuring her relatives – could be found.

When might restraint be used?

Adults who may be at risk can be justifiably restrained in some cases, in the following circumstances:

- ◆ Displaying behaviour that is putting themselves at risk of harm
- ◆ Displaying behaviour that is putting others at risk of harm
- ◆ Requiring treatment by a legal order, for example, under the Mental Health Act 2007
- ◆ Requiring urgent life-saving treatment
- ◆ Needing to be maintained in secure settings.

This applies to individuals being cared for by nurses working in all types of settings, including continuing care, mental health, forensic, critical care and care in the community.

While abuse or restraint can occur in institutions, it may also happen in people's own homes. Nurses working in hospitals, care homes, or the community who suspect restraint is being used abusively – whether through information a client or carer discloses to them, or by what they have observed – should report the information to their employer. If a nurse believes there is a risk of harm to a client, they are required to report poor practice as set out in the NMC Code of conduct.

Bear in mind that legislation and national guidance is always subject to change. Nurses have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

Next this guidance examines the ethical and legal frameworks that can help nurses to decide if restraint is unavoidable.

Restraint outside the UK

Vest, belt or cuff devices specifically designed to stop people getting out of beds or chairs are in relatively common use in hospital and care home settings in many countries outside the UK, including in Europe, the USA and Australia. These devices are not acceptable in the UK. Nurses employed in the UK should make sure they understand standards of acceptable practice. Employers should ensure that nursing staff are aware of this RCN guidance.

Restraint as a last resort

In most circumstances restraint can be avoided by positive changes to the provision of care and support for the older person. It should be noted that a person with capacity to consent might request items, such as lap belts or bedrails, to enhance their feeling of safety and/or security. Whilst this may not accord with a nurse's recommendation, an individual's choice should be acknowledged and included in a care plan and risk assessment.

When a client cannot give informed consent, nurses should always explain what they are doing, seeking their understanding and agreement. A study suggests that even clients who were delirious when restrained, later remembered and valued nurses' explanations of what was happening to them, particularly reassurances that nurses were trying to keep them safe (Minnick, Leipzig and Johnson, 2001).

An example of good practice

Recent design principles to help clients with dementia have led to the development of small family-orientated households that support 12 older people, with a ratio of one member of staff to five clients. Through a design that excludes corridors – which can often be confusing for people with memory impairment – these units help clients to live more independently, be involved in purposeful activity and have safe access to a secure garden.

Cues for behaviour, memory and reality are provided within the design, helping people with dementia to maximise their independence, reducing their reliance on others. An open plan environment enables staff to observe residents without high levels of intrusion. Meanwhile a 'no uniform' policy removes the constant reminder that staff are different from clients.

The creation of a comfortable, relaxed environment where individuals feel valued, confident and safe reduces incidences of older people trying to leave the building or presenting with challenging behaviour, which may often lead to restraint. In addition, staff who try to understand the underlying reasons for a person's behaviour, and what that person is attempting to communicate, are more likely to help clients in distress.

In essence, a combination of well-considered environmental features and a workforce that has developed person-centred care reduces the need for inappropriate restraint.

Appendix One provides links to good practice resources to help nurses avoid the need for restraint by providing positive care environments. Topics include:

- ◆ Person-centred care of older people with mental health needs
- ◆ Freedom and risk in care homes
- ◆ Prevention of violence and aggression
- ◆ Preventing suicide and self-harm
- ◆ Client experience in critical care settings
- ◆ Meeting the needs of older people with dementia in acute care
- ◆ Prevention and treatment of delirium
- ◆ Dignity in care
- ◆ Falls prevention.

Ethical issues

To help meet the needs of its members, the RCN is currently developing a comprehensive ethics strategy. This acknowledges that every nursing decision has an ethical dimension, and that ethics and ethical decision-making abilities are applicable to all aspects of nursing in all areas of practice.

Basic ethical concepts underpinning nursing practice include:

- ◆ **Obligations and duties** – identifying our moral obligations to other people can help us determine what we should do in a given situation
- ◆ **Avoiding harm** – perhaps the most essential ethical concept and the basis for good practice
- ◆ **Assessing the consequences of action** – the ethically appropriate action may be determined by calculating its potential benefits and harm
- ◆ **Autonomy and rights** – respect for the individual's rights to make their own decisions and respect for the rights of others
- ◆ **Best interests** – identifying and acting in the best interests of others is a commonly applied means of ethically justifying an action or decision
- ◆ **Values and beliefs** – from which we may formulate ethical principles.

Resolving an ethical problem is rarely straightforward

Making an ethical decision – a case study

Sarah works in a care home. Although one resident, Mrs Green, suffers from Alzheimer's disease, she usually appears very happy to live there. Mrs Green has a slight temperature and a visit from her GP has been requested. In the meantime, Mrs Green becomes very agitated, and attempts to leave the home, apparently believing it is many years ago and her small children are at home alone. Sarah has tried to reassure Mrs Green, telephoning her daughter to ask her to visit the nursing home, but in her anxiety Mrs Green is pushing past her to go out of the front door.

Sarah has professional, legal and ethical obligations towards Mrs Green. She foresees that, in these circumstances, it is unlikely she can avoid some degree of harm occurring. She is aware that either preventing Mrs Green from leaving the care home, or allowing her to go out alone, will result in harm. In assessing the consequences of her actions, Sarah concludes that, as Mrs Green is unable to look after her own safety and could come to serious harm if allowed to leave the home unaccompanied, restraining Mrs Green's movements, although distressing, is likely to be the least harmful action.

Preventing Mrs Green from leaving overrides her right to freedom. However, this must be balanced against her right to be free from physical harm. Mrs Green is currently unable to make an autonomous decision about whether she should leave; therefore it is acceptable that Sarah makes a carefully considered ethical decision on her behalf. Sarah can ethically justify her actions, as she is acting in Mrs Green's best interests.

In order to minimise Mrs Green's distress, Sarah calls another staff member to accompany Mrs Green on a walk outside to wait for her daughter's arrival, reassuring her that her family are safe and on their way to meet her at the home.

and can be challenging to all concerned. In terms of making decisions about physical restraint, it is often difficult to avoid harm, as both restraining or not restraining could bring about harm. Nurses have obligations to all those in their care and, if allowing one person freedom of action causes harm to others, decision-makers need to strike a balance between the consequences of applying or not applying restraint.

The use of restraint as a first line response is not

conducive to a positive social environment. If people feel enabled to do things, rather than prevented from following their desires, they are more likely to be in a better state of emotional well-being over time. Making decisions about the best course of action can be difficult. As part of their training and continuing professional development, nurses need to discuss real and theoretical dilemmas. Except in emergencies, individual decisions about restraint and policies or guidance should be discussed within multi-disciplinary teams, with the involvement of the older person and their carers, as far as possible.

Legal issues for nurses

While this guidance cannot give legal advice, it can outline broad requirements under law. Nurses have different obligations relating to their different roles – in other words, they have those belonging to any member of the public, and those relating to their professional or contractual duty of care.

The law that would cover restraint comes from both criminal and civil law. Different Acts of Parliament may apply in each UK country. Relevant Acts of Parliament that impact on the law relating to restraint include:

- ◆ Offences Against the Person Act 1861
- ◆ Mental Capacity Act 2005
- ◆ Adults with Incapacity (Scotland) Act 2000
- ◆ Human Rights Act 1998.

When is restraint justified in law?

Situations in which restraint can be justified include where the client gives informed and voluntary consent as part of a planned programme of care. In other cases, the nurse may have a professional duty of care to restrain a client to protect that client from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others. In a situation where a nurse or other person is being attacked or is at risk of physical harm, it is possible to justify the use of restraint as self defence.

Mental Capacity Act 2005

The Act creates and clarifies the common law on consent in England and Wales. A similar Act exists in Scotland- Adults with Incapacity (Scotland) Act 2000 where the principles are similar. A short summary of the key

provisions of the Mental Capacity Act 2005 is set out in this document. A fuller set of materials on the application of each Act is given in the useful material section.

The Mental Capacity Act 2005 affects everyone aged 16 and over and provides a statutory framework to empower and protect people who may not be able to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries.

The Mental Capacity Act 2005 lays down five principles that relate to the protection of capacity and each must be respected in relation to the provision of healthcare:

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of actions.

The Mental Capacity Act 2005 sets out the legal definition of the status of an individual who lacks capacity. A person is unable to make a decision for himself if he is unable

- a) to understand the information relevant to the decision
- b) to retain that information
- c) to use or weigh that information as part of the process of making the decision, or
- d) to communicate his decision (whether by talking, using sign language or any other means).

The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as being competent and able to make the decision.

In a situation where restraint is being considered for a client who lacks capacity, the Mental Capacity Act 2005

does allow for treatment to be provided as long as this is in the best interests of the individual. The Act requires that the following factors must be considered before any action is taken for the person lacking capacity:

- a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
- b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- c) the other factors that he would be likely to consider if he were able to do so.

The Mental Capacity Act 2005 sets out the conditions in which an act may be planned that would constitute restraint of a client who lacks capacity. Restraint is defined in the Act as action that uses, or threatens to use, force to secure the doing of an act which the client resists, or restricts the client's liberty of movement, whether or not the client resists.

This legal authority to restrain a client is allowed only if the following three conditions are satisfied:

- ◆ The client lacks capacity in relation to the matter in question
- ◆ The nurse reasonably believes that it is necessary to do the act in order to prevent harm to the client
- ◆ The act is a proportionate response to a) the likelihood of the client's suffering harm and b) the seriousness of that harm.

A new Court of Protection has been created which can decide the lawfulness of any act done or yet to be done in relation to that person, including any omission or course of conduct. It is possible that where nurses are working in settings in which restraint is a real possibility for clients who lack capacity, that some challenge may be made to the Court of Protection about the potential for forms of restraint to be declared unlawful. Good record keeping and sound policy development will be considered by the Court of Protection in such cases to assess whether the three conditions have been met.

Consent

Consent is the legal means by which the person gives a valid authorisation for treatment or care. This could include giving consent to an agreed form of restraint. The legal basis of consent is identical to the professional requirement that consent is needed before carrying out any treatment. The case law on consent has established

Abuse of restraint – two case studies

1. An older people's specialist nurse visited a client in a care home. Although the home appeared to be very caring, she was concerned that staff seemed overly protective. She was surprised to see many residents in special chairs, which appeared to be restricting their freedom to move independently. The nurse contacted her employer's POVA lead to talk through her concerns. After discussions between agencies, the care home was provided with support to update its practices, enabling it to strike the right balance between safety and freedom for individual residents. More frequent unannounced inspections have also been introduced.

2. A community psychiatric nurse (CPN) made an assessment visit to a new client who had a diagnosis of Alzheimer's. The nurse was concerned to find that the client's daughter routinely locks him alone in his bedroom, while she attends a part-time job. The daughter is convinced that this is the best way to keep him safe, and is unwilling to consider alternatives. The CPN discussed the situation with the multi-disciplinary team and his employer's POVA lead. After an emergency case conference, an arrangement was made whereby the daughter accepts a day care place and carers for her father. This arrangement is closely monitored, with plans in place to intervene if the daughter returns to locking her father in his room.

three requirements which must all be satisfied before any consent given by a person can be sufficient:

- ◆ The consent should be given by someone with mental capacity
- ◆ Sufficient information should be given to the person
- ◆ The consent must be freely given.

Professionals who are personally regulated have professional accountability under their Code of Conduct to ensure that while caring for clients they are assured they have been given information about their condition and understand the risks and implications of any proposed restraint. A failure to obtain valid consent could also lead to professional misconduct as ensuring consent is valid is inherent to the regulatory codes of professional conduct.

Consent must be freely given and no threats or implied threats used. Coercion or manipulation of the client would tend to imply that consent has not been obtained voluntarily. In this situation, even where the client signs

a consent form, the consent will have been obtained in an unlawful manner and the consent will not be valid.

The Protection of Vulnerable Adults (POVA)

POVA is a statutory system that requires employers to refer care workers directly to the Secretary of State who can impose a 10-year workforce ban on anyone who has been assessed as being unfit to work with adult or child service users. In addition to nurses, it applies to those employed in care homes, independent hospitals and domiciliary care agencies, as well as those who provide personal care in someone's own home. It requires health care providers and local authorities to have systems in place to act, when allegations are made that adults who

are defined as vulnerable, through their need for support or care, are at risk of physical, sexual, financial, verbal or psychological abuse. This includes systems to exclude care workers who have been identified as perpetrators of abuse, from further employment with vulnerable people.

The Government is repealing the POVA, and its equivalent system for children, POCA, and replacing it with the Safeguarding Vulnerable Groups Act 2006 in England and Wales, with similar legislation in other countries. This introduces a new vetting and barring scheme for those who work with children and vulnerable adults. The statutory duty on employers remains, but there is also a fine of £5,000 for failing to make the statutory referral. The new scheme covers health and social care services and is scheduled to be introduced from autumn 2008.

The law and restraint – a case study

Tom is an adult with significant learning difficulties and care needs, who lives in a group home. He has been unwell for several days and when his GP visits, he suspects Tom has developed type 1 diabetes. Tom is close to collapse, needing urgent hospital care and treatment for dehydration and ketoacidosis. While waiting for an ambulance to arrive, Tom's GP tries to establish intravenous access, but Tom dislikes needles and does not co-operate. Staff from the home who are familiar to Tom try to reassure him, explaining in simple language the importance of the treatment, but Tom is unable to grasp the seriousness of his illness. The GP asks staff at the care home to hold Tom's arms still, while he finds a vein, explaining this needs to be done as soon as possible, as delays in treatment will expose Tom to risk of death or significant brain damage.

This is likely to be legally justified. No assumption has been made that Tom lacks capacity simply because of his learning disability and, given the emergency, as much as possible has been done to help Tom understand the situation, however he appears to lack capacity, as he cannot understand that his illness is life-threatening. Members of staff present have discussed the issues as much as is reasonable in an emergency. Delaying while they consult relatives or an advocate would not be reasonable in these circumstances. The nurses and GP believe holding Tom whilst they establish intravenous access – even if this causes distress and is done against Tom's wishes – is justified in Tom's best interests, to reduce the risk of greater harm from treatment delays.

While abuse or restraint can occur in institutions, it may also happen in people's own homes. Nurses working in hospitals, care homes, or the community who suspect restraint is being used abusively - whether through information a client or carer discloses to them, or by what they have observed - should report the information to their employer. However there is no requirement for a nurse to make a POVA related referral; in fact the scheme does not allow this unless a nurse is also an employer. If a nurse believes there is a risk of harm to a client, they are required to report poor practice to the NMC, under clause 8.2 of the Code of Conduct.

Bear in mind that legislation and national guidance is always subject to change. Nurses have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

Human Rights Act and Mental Health Act

The Human Rights Act (1998) sets out clear guidance on the freedom of the individual. The use of restraint must be justified by a clear rationale. This should explain why other considerations are believed to override individual freedom of action.

Like any member of the public, under common law nurses can use reasonable force to prevent harm to themselves or others. This public duty is most likely to be used in response to violence and aggression from a client; as a justification for restraining a client to protect staff from harm; or to protect other clients or members of the public. The Human Rights Act 1998 does not

apply to care homes run by independent providers, but does apply to NHS settings.

You may find it helpful to consult *Human rights in healthcare: a framework for local action*, produced by the Department of Health in 2007. You can download this publication from the Department of Health's website:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/

The Mental Health Act 1983. At the time this guidance was being prepared, amendments to the Mental Health Act were still being debated. Nurses should ensure they are aware of the powers and responsibilities they hold under any updated legislation.

Civil Law

If a nurse restrains a client without a sound professional and legal basis, the client may bring a civil claim against the nurse in negligence and make a claim for compensation for any harm suffered as a result of the restraint. Where any client can show that he or she has suffered harm- which can be physical or psychological- which was directly caused by the restraint and which was foreseeable, the courts will have to assess any professional standards that existed at the time to see whether the restraint was reasonable. If the actions of the nurse fell below those standards it is possible that a claim in negligence will succeed. The facts of each case

will be important and a review will take place of the length of time that the restraint lasted and the amount of force used. Both factors will be need to be justified to show that they are both reasonable and professionally accepted.

It is important that any use of restraint should be reasonably anticipated and steps taken to record this fully in the clinical records. If the nature of the restraint is such that only named staff can undertake this, it would be advisable that their full names and job title are clearly recorded. If training is needed for a particular form of restraint, each healthcare professional should keep a clear record of that training.

Criminal Law

Restraining another person without their consent may be a criminal activity. The nurse who carries out an unlawful restraint may face criminal prosecution that could lead to a fine or imprisonment depending on the severity of the restraint. It is important that whenever restraint is used by a nurse, it is in accordance with accepted professional standards that are justified in the particular circumstance. Any prosecution under criminal law will consider whether the restraint amounted to an offence under an Act of Parliament that could include assault, unlawful detention, ill treatment or willful neglect.

Contracts of employment often set out the limits of a

If restraint is used – three case studies

New management took over a residential care home where some residents had confusion or dementia. Previous policy had been to keep all exits locked. After reviewing the residents' needs, and discussing the issues with all the care team, it was decided it would be much less restrictive if the garden gates could be secured, while doors into the garden could be fitted with new handles that were easier to open. The front door was fitted with a lock that could be opened from the inside, while technology was installed that rang a portable buzzer, carried by a nurse on duty, when the door was opened. This practice fulfils the requirement that if restraint is used, it should be the least restrictive option.

Managers of a unit providing intensive support for adults with significant mental health needs knew that, despite the skills of their staff, including their training in therapeutic care, occasions may arise when physical restraint would be needed to protect clients from

harming themselves or others. To ensure this would be done as safely as possible, they provided extensive theoretical and practical training, with clear roles and responsibilities, planning and debriefs. They also devised a process for continual revision and updating of plans for assessing and reducing the risks involved in using restraint. This practice fulfils the requirement that if restraint is used, it should be as safe as possible.

Although no longer needing sedation for therapeutic reasons, a client recovering from a head injury in intensive care became very agitated, attempting to remove equipment that his survival depended upon. Although the emergency was managed, with further sedation used as a chemical restraint, plans were made to gradually reduce this sedation as soon as possible, with staff attempting to manage his care through positive alternatives to restraint. This practice fulfils the requirement that if restraint is used, it should be for as short a time as possible.

nurse's practice, and require nurses to adhere to locally approved policies, procedures or protocols relevant to restraint. This might include detailing how decisions on restraint in different circumstances are to be made, who is responsible, and other requirements, such as having undertaken competency-based training, and the carrying out of risk assessment to reduce the possibility of unintended harm before using restraint. Requirements on documenting decision-making and actions taken are likely to be covered both by professional standards and contracts of employment.

Restraint of children and young people

Anyone working with children or young people is advised to consult the RCN's guidance on *Restraining, holding still and containing children and young people: guide for good practice* (2003) and the BMAs *Consent, Rights and Choices in Health Care for Children and Young People* (2001). This sets out the rights of the child, and the legal framework surrounding those rights, including the Human Rights Act 1998 and the European Convention on the Rights of the Child 1989.

Building exit controls

Units or homes providing support and care for adults may have a variety of controls on how people can enter or leave the building. These include:

- ◆ Buildings which are locked constantly – fire exits can be opened but are alarmed
- ◆ Buildings where a receptionist controls everyone going in and out
- ◆ Doors which require a number code before they can be opened
- ◆ Doors with 'baffle handles' that are difficult for a person with cognitive impairment to open
- ◆ Doors painted to resemble bookcases with the intention of distracting someone from recognising and using the door
- ◆ Stripes and pattern changes on flooring near doorways intended to direct the person away from this area
- ◆ Tagging systems that raise an alarm if a tagged person approaches the door
- ◆ 'Loop' building designs that encourage a person to walk in circles, never finding the front door
- ◆ CCTV installed to observe all exits.

Is this restraint?

Providers of buildings-based services have a responsibility to maintain safety for everyone who is visiting, staying, living or working there, including securing the building from intruders. However, there may also be an assessed need to prevent an older person who is a resident or client from leaving, in order to protect their safety and well-being. This needs to be done in the most dignified way possible. Often subtle design changes in buildings, décor and doors can distract a person from leaving. Nurses need to ensure that they sit on planning committees for new buildings and security design, ensuring that research-based design methods are used.

What support should employers provide?

Organisations, as well as the individual members of staff within them, have a duty of care. To help ensure restraint is not used abusively, and that nurses and other staff are supported in making appropriate decisions about restraint, employers should provide:

- ◆ A policy or guidance for staff on the use of restraint
- ◆ A multi-disciplinary approach to individual care

Developing a policy on restraint in critical care – a case study

A client who was being cared for in ICU had been sedated on a ventilator for some time. Their condition had improved and they were being weaned off both sedation and the ventilator. However, clearly the client still had no capacity to consent and was manifesting behaviour that was likely to cause themselves harm – for example, by pulling out IV lines. Following organisational protocol, a second senior medical and nursing opinion was sought. This was explained to the client's family. A decision to use mittens was taken to bridge the time between when the sedative drugs were wearing off and the client regained their capacity and was no longer a danger to themselves. The decision was recorded in the client's medical and nursing notes and reviewed at least twice daily.

In this case it was felt more beneficial to use mittens to prevent harm, rather than sedating the client thereby increasing the risk of further harm. Providing purpose-made mittens was an important risk reduction, in comparison to improvised bandaging.

planning, including regular planned reviews of care

- ◆ A system for reporting incidents where clients or staff were harmed, or could have been harmed, and learning from them
- ◆ Clear channels for raising concerns about possible abuse of restraint
- ◆ Access to independent advocates for clients
- ◆ Risk assessment procedures, so that risks involved in using restraint can be anticipated and reduced
- ◆ Appropriate education, including clinical supervision, reflective practice, learning from best practice, and competency based training
- ◆ Regular audit related to restraint, including benchmarking against other comparable

‘Restraint doesn’t happen here’

– what the National Patient Safety Agency (NPSA) says

“We were concerned to find occasional reports to the National Patient Safety Agency where nurses had let delirious or suicidal clients get into very risky situations, because they thought it was in all circumstances wrong to stop a client doing what they wanted to do, or had been unsure whether to assist in life saving treatment because a client – although clearly lacking capacity through head injury or delirium – was not co-operating.

“To find out more, we contacted lead nurses in a variety of health care settings to ask if they had policies on restraint. Many organisations shared thoughtful, practical and client-centred policies, but some replied that they most certainly did not have policies on restraint, because they would not tolerate restraint in their organisation in any circumstances. One person even returned the questionnaire on restraint with a cover note saying ‘in response to your questions on elder abuse...’

“It appeared that both some individual nurses and some organisations were working to the assumption that restraint was never justified in any circumstances, and autonomy was the only ethical principle they needed to follow. But if an organisation takes the position ‘it doesn’t happen here’ any problems just get hidden. And if staff don’t have a clear understanding of the circumstances where restraint is justified or positively required, they won’t be able to recognise the circumstances where restraint is wrong or abusive.”

Martin Fletcher, Chief Executive, NPSA

organisations

- ◆ Dementia care training and awareness for staff in all services.

Employers should also ensure that:

- ◆ Nursing students or health care assistants are not put in the position of making decisions about restraint because of a lack of qualified nurses.
- ◆ Nurses are not pressured to comply with a request from a person’s relative to restrain them, when it is not in their client’s best interests.

Restraint should never be used solely to reduce workload. Employers should never put nurses in a position where they resort to restraint because there are too few staff or resources to provide safe care.

Employers in different environments may have specific responsibilities, for example the National Minimum Standards for care homes require the registered person to ensure restraint is used solely when it is the only practicable method of ensuring a resident’s welfare – Regulation 13(7) – and that use of restraint is recorded – Regulation 13(8).

Individual responsibilities

With the help of their employers, colleagues, and managers, and the advice and resources within this guidance, nursing staff should ensure that they:

- ◆ Understand what restraint is
- ◆ Provide person-centred care that minimises the need for restraint
- ◆ Understand the legal and ethical frameworks relevant to restraint
- ◆ Know what to do if they suspect inappropriate or abusive use of restraint
- ◆ Understand the circumstances in which restraint may be legally or ethically required
- ◆ Understand how to minimise the risks if restraint is used.

The use of restraint is always an emotive issue, involving challenging and difficult decisions about care. Nurses need to discuss and debate the issues, and work with colleagues to develop caring, practical solutions that suit individual clients.

Appendix One

Resources for good practice that will help avoid the need for restraint

| TOPICS | SUGGESTED RESOURCES |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Freedom and risk in care homes | <i>Residents taking risks, minimising the use of restraint: a guide for care homes</i> (2001) and <i>Showing restraint: challenging the use of restraint in care homes</i> (2002). Both produced by the charity, Counsel and Care UK, these are excellent plain English discussions of ethical, practical and legal issues of risk and restraint that are useful in all settings, not just care homes. Visit: www.counselandcare.org.uk |
| Meeting the needs of older people with dementia in acute care | <i>Let's respect toolkit</i> . Primarily for health care staff who care for older people with mental health needs in acute hospitals. Priced at £25, to order visit: www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html <i>Who cares wins: improving the outcome for older people admitted to the general hospital: guidelines for developing liaison mental health services for older people</i> (2005). Produced by the Royal College of Psychiatrists and endorsed by the Alzheimer's Society, British Geriatrics Society and the RCN. Available at: www.alzheimers.org.uk/Working_with_people_with_dementia/PDF/WhoCaresWins.pdf A resource for caring for people with memory problems on medical and surgical wards. Available at: www.changeagentteam.org.uk/index.cfm?pid=250 |
| Guidance on ethics and freedom for family and friends of people with dementia | <i>Making difficult decisions</i> , published by the Alzheimer's Society www.alzheimers.org.uk Priced at £7, to order contact: 01753 535751. |
| Prevention and treatment of delirium | <i>Prevention, diagnosis and management of delirium in older people. National guidelines. Concise guidance to good practice number 6</i> (2006) published by Royal College of Physicians. Priced at £7 and available at www.rcplondon.ac.uk/pubs/brochure.aspx?e=142 |
| Dignity in care | The Government's <i>Dignity in care</i> campaign, launched in February 2007. This sets out a 10-point challenge for high quality services. Access at: www.dh.gov.uk |
| Falls prevention | National Institute for Health and Clinical Excellence (NICE) guidance on <i>The assessment and prevention of falls in older people</i> , published in 2004. Access at: www.nice.org.uk National Service Framework for Older People. Access at the Department of Health's website: www.dh.gov.uk <i>Slips, trips and falls in hospital</i> – the third report from the Patient Safety Observatory, published in 2007 by the NHS National Patient Safety Agency. Access at: www.npsa.nhs.uk/pso |
| Prevention of elder abuse | Protection of vulnerable adults – a wealth of guidance and information is available at the Department of Health's website: www.dh.gov.uk Action on Elder Abuse (AEA) is a charity working to protect, and prevent the abuse of vulnerable older adults. Visit: www.elderabuse.org.uk <i>Enough is enough</i> campaign, run by charity, Help the Aged. Find out more at: www.helptheaged.org.uk |
| Safe use of bedrails | <i>Using bedrails safely and effectively</i> , issued February 2007. NHS National Patient Safety Agency: www.npsa.nhs.uk/alerts |

Appendix Two

Restraint guidance in specialised settings

These are other sources of guidance. Please note that listing here does not imply the RCN endorses all content. These documents also include substantial information on strategies to avoid the use of restraint.

| SETTING | GUIDANCE |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Children and young people | <i>Restraining, holding still and containing children and young people; guidance for nursing staff</i> . Updated in 2003 and available at www.rcn.org.uk |
| Critical Care | British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units, <i>Nursing in Critical Care</i> , 2004, vol 9 No 5, pages 199-211. |
| Neuroscience | Guidelines on use of restraint in neuroscience settings, <i>Nursing Times</i> , June 2005 Vol 101 No 23, pages 28-29. |

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Counsel and Care UK (2002) *Showing restraint: challenging the use of restraint in care homes*. London: Counsel and Care UK.

Minnick A, Leipzig, RM, Johnson ME (2001) Elderly patients' report of physical restraint devices in intensive care units. *American Journal of Critical Care* 10 168-171.

Royal College of Nursing (2003) *Restraining, holding still and containing children and young people; guidance for nursing staff*. London: RCN.



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