LINDSEY LODGE HOSPICE POLICY FOR THE RESTRAINT OF PATIENTS (Adults)

Contents

1.0 Policy Statement / Purpose

1.1 This policy seeks to reflect current best practice guidance as detailed in National Institute of Clinical Excellence (NICE) Guidelines on Violence (2005), and relevant Department of Health Guidance, whilst incorporating the Mental Capacity Act 2005 (the Act) and the accompanying Code of Practice (the Code) to detail the factors to be considered and actions which must be taken when assessing the use of any form of restraint for adult patients aged 18 years and over on Hospice premises.

The policy also seeks to ensure compliance with the relevant health and safety legislation, namely the Health & Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999.

1.2 The purpose of this policy document is:

- To provide Hospice health care professionals guidance on the making, documentation and review of decisions relating to the use of restraint (physical or otherwise) for adult patients aged 18 years or over
- To ensure that a consistent approach is taken by all members of the healthcare team handling patients who have aggressive or challenging behaviour or self-harm tendencies, which present as either a threat to themselves or others
- To ensure that all relevant healthcare professionals, are aware of the Hospice policy for the use of restraint, are implementing the policy appropriately and effectively, and are aware of their obligations under the relevant health & safety legislation, and the Mental Capacity Act 2005 (Act covers people who are 16+ if they lack capacity) and accompanying Code of Practice
- To provide a baseline of good practice for clinical audit; protection for staff in that they will have legal immunity from decisions made if they follow the MCA
- code of practice; ensure compliance with statutory guidance

1.3 Interpretation

1.3.1 For the purposes of the Mental Capacity Act and the Code, and this Policy, an act of ''restraint'' is as defined in section 6(4) of the 2005 Act, as being an act which occurs when any member of staff working in the hospice:
a) ''uses, or threatens to use, force to secure the doing of an act which resists
or
b) restricts the patient's liberty of movement, whether or not the patient resists"

1.3.2 For the purposes of this policy, deprivation of liberty has the meaning given in Article5(1) of the European Convention on Human Rights.

1.3.3 As well as the obvious method of physical restraint, methods of restraint (both legitimate and illegitimate) may include verbal, environmental or pharmacological interventions, including:

- bed rails (see separate Policy on Safe Use of Bed Rails)
- inappropriate bed heights (too high or too low)
- medication
- inappropriate use of wheelchair safety straps (see separate Policy for The Use of Wheelchairs)
- arranging furniture to impede movement
- chairs whose construction immobilises patients, including reclining chairs
- isolation in a room with restricted access (entrance and exit)
- removal of walking aidsuse of sensor mats
- withdrawal of sensory aids such as spectacles

2.0 Introduction

2.1 Every citizen who is not subject to lawful detention has the right to liberty. In a Hospice setting a person may be restrained against their will or, where a person lacks capacity, as necessary in their

'best interests' where it is necessary to protect them from harm to themselves or to others, or to prevent a crime being committed.

2.2 Anyone who applies any form of restraint should be prepared and able to justify why they have done it. The action is unlikely to be unlawful providing that it can be shown to be the only way of preventing harm to the individual or others; it is an appropriate restraint; is used for the shortest possible period of time only; is regularly reviewed with the patient and where appropriate their relatives/carers, and the multidisciplinary team. It may sometimes be necessary in an emergency situation to take a decision on the use of an appropriate restraint method without having time to consult fully with colleagues or others, in order to prevent harm to the patient or others in the vicinity, but in all scenarios, the method of restraint used must be proportionate to the risk posed, be the least restrictive means necessary and for the shortest possible period of time.

2.3 The 1998 Human Rights Act implements the provisions of the European Convention on Human Rights and the right to liberty under Article 5 and the right to personal and family life under Article 8. Any restraint used by a health professional on someone in their care has the potential to infringe that patient's human rights. Each situation must be carefully assessed, and a clear rationale put forward as to why the patient is a risk (either to themselves or others), before any form of restraint is used.

2.4 The common law imposes a duty of care on healthcare staff in respect of all persons for whom they provide services. If a person who has been assessed as lacking capacity presents with challenging behaviour which may cause harm to themselves or others, staff may take appropriate and necessary action to restrain or remove the person from their current setting in order to prevent harm to themselves or others. Healthcare staff must only use reasonable force to restrain a person, and must not carry out any act that would have the effect of depriving a person who lacks capacity of their liberty (see section 14).

2.5 Restraint should only be used as a last resort when all other methods of dealing with the situation by means of therapeutic behaviour management are either not suitable or have failed. The use of restraint should be proportionate to the risk of the situation, and the type of restraint used should be the least restrictive means necessary, and for the shortest possible period of time.

2.6 Restraint is defined as the use or threat of force where a person who lacks capacity resists and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. (MCA Act 2005 - Summary).

2.7 Restraint in the MCA is about the protection of the person who lacks capacity from harm. Restraint in the pursuit of protecting others is around common law i.e. if a staff member restrains a person who lacks capacity from hitting someone else with their walking stick they would be protecting someone else from harm and they are restraining under common law and as such do not have the same level of immunity.

3.0 Area

This policy applies to all adult patients (aged 18 years and over) being cared for on the In-patient Unit or Day Case area at Lindsey Lodge Hospice

4.0 Personnel / Duties

This policy outlines responsibilities for the following:
All Health Care Professionals employed by Lindsey Lodge Hospice.

5.0 Actions before Using Restraint

5.1 Non-emergency use of restraint

In non-emergency situations, prior to using restraint, the Registered Healthcare Professional (HCPs) should carry out and document assessment of the patient's condition and should consider:

- the environment that the patient is in
- the patient's behaviour
- the patient's underlying condition and treatment

- the patient's mental capacity

5.2 The HCPs should assess and record the patient's behaviour, and state why this behaviour is a challenge i.e. is it a danger to the patient or to others and if so, how? The HCPs should consider environmental factors: e.g. could the patient be moved to a more appropriate setting? Are there enough staff to ensure adequate and safe supervision? Are there high levels of noise/disruption, or lack of stimulation? The patient's underlying condition could be contributing to their behaviour e.g. due to hypoxia, pyrexia, pain, drug withdrawal, side effects of medication etc.

5.3 Prior to using restraint, consent should be sought from the person in question, if there is any doubt as to a person's capacity to consent to or refuse interventions or procedures, this should be assessed and documented. If the patient lacks capacity, they can be treated in their 'best interests', including the use of restraint, unless they have a proxy decision maker who is authorised to make personal welfare (including healthcare) decisions on their behalf (see section 12), and that person refuses the restraint. Any dispute about the use of restraint in 'best interests' should be resolved locally. If it is an emergency situation, restraint can be used if it is a necessary and proportionate response to the risk and seriousness of harm to the patient and others, and the minimum necessary force is used for the shortest period of time. If there is concern about the patient's mental health, a psychiatric assessment should be requested as soon as possible (see below).

5.4 Prior to using restraint on a patient, a range of solutions for dealing with the challenging behaviour should be considered.

6.0 Involving Relatives in Decisions

6.1 Patients and, where a person lacks capacity, if appropriate their relatives/carers, should be treated as partners in the patient's care. Whilst such an approach seeks to be inclusive, one of the key challenges for HCPs is balancing the needs and wants of the patient alongside those of the relatives/carers. Relatives/carers often have indepth knowledge that can help HCPs decide how to care for the patient if a challenging situation arises. However care must be taken to ensure that the concerns of relatives/carers are not given priority over the needs and wants of the patient. At all times, the HCP's duty of care is to the patient e.g. a relative may ask for cot sides to be put on a bed but this may not be in the 'best interests' of the patient. Neither a patient nor relative can require a healthcare professional to provide a particular treatment or intervention if the HCP does not believe it is clinically appropriate and in the patient's 'best interests'.

6.2 Best Interests – An act done or decision made for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a non exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. Also, people involved in caring for the person lacking capacity gain a right to be consulted concerning a person's best interests.

7.0 Situations when the use of restraint is NOT justified

7.1 Restraint is most commonly used to manage restless or agitated behaviour that, if unchecked, could be dangerous for the patient or others. However some examples of the **inappropriate** use of restraint are when:

- lack of staff places heavy demands on nurses at times when patients' needs are high, so that full attention cannot be given to every patient
- lack of registered staff puts nursing students or health care assistants in a position where they have to make decisions about restraining patients for which they have not been properly trained
- relatives expressly demand that a patient is prevented from wandering

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8.0 Alternatives to Restraint

It is sometimes possible to avoid using restraint by understanding and tackling the underlying causes of this behaviour, possible reasons for changes in behaviour may be:

- Physiological causes e.g. chest or urinary tract infection, dehydration, constipation, inadequate nutrition or metabolic changes caused by medication. In this case, HCPs should consider treating the underlying physical disease or disability as an alternative to restraint
- Patients who 'wander' may be looking for something – the toilet, a drink, a particular person – or they may just need exercise. If the patient appears to be lost, modifying the environment may stop them wandering
- Restlessness may be caused by physical discomfort
- Disorientation could be due to changes in the environment, lack of sleep or medication
- Aggression might be the result of a build-up of frustration when the patient
- feels their needs are not being met

9.0 When should restraint be used?

9.1 Restraint should only be used as a last resort when all other methods of managing the identified problem are not considered suitable or have failed and the risks of the patient's behaviour are considered to outweigh the risks of using restraint.

9.2 Wherever possible, the decision to use restraint should be a multi-disciplinary one and should be part of the patient's agreed care plan. A full review must take place as soon as possible with as many of the multidisciplinary team as possible. If the continued use of restraint is supported, this should be reviewed regularly as an integral part of the nursing care programme. If physical restraint or pharmacological intervention is deemed necessary, this should only be carried out by HCPs specifically trained in these methods of restraint and appropriate life support techniques

9.3 The use of restraint should always be incident reported and the Department Manager should undertake a review of the incident and consider the need for a staff and patient debrief.

9.4 If a situation arises out of hours (e.g. patient's condition deteriorates) and the need for restraint is identified, the nurse in charge has to make a decision to use restraint. The nurse should document clearly why they have opted for restraint and how long they plan to use it for. The patient should be closely monitored throughout the period of restraint and review times should be set as early as possible. The Senior Manager on call is available for advice out of hours and should be informed depending upon the individual circumstances of the incident. Depending on the circumstances, advice may also be available from the on-call mental health team.

10.0 Acceptable Methods of Restraint

10.1 The methods of restraint which are acceptable when used appropriately in accordance with this policy are listed in this section.

10.1.1 Bed rails

These are appropriate as a preventative safety measure for those patients who have a tendency to roll out of bed. They should only be used after a full risk assessment and if they are considered the least restrictive option available to healthcare staff to ensure the safety of the patient and prevent harm. Staff should refer to the Hospices' policy on the ''Safe Use of Bed Rails for Adult Patients".

10.1.2 Hand bandaging / use of mittens

In certain specific situations, it may be appropriate to bandage a patient's hands or use mittens to prevent them pulling out a feeding tube (NG/PEG). Such a decision should be taken by the multi-disciplinary team after a full consideration of all risks and benefits of bandaging the patient's hands against the implications for the patient of their feeding tube coming out (such as potential difficulties in re-siting the tube, implications for their overall nutritional status, whether

alternative feeding methods are an option etc).

10.1.3 Physical restraint:

Physical restraint should be avoided if possible, and in the event that it is necessary, should only ever be carried out by staff specifically trained in physical restraint techniques and who are trained to the appropriate level in Basic Life Support (BSL). Please see Section 18 below for full policy guidance on physical restraint.

10.1.4 Medication / chemical sedation

The aim of pharmacological intervention is to reduce excitement and activity in order to facilitate other interventions. Any medication given must be prescribed by a doctor but can be administered without the patient's consent if it is an acute situation and is in the patient's best interests to do so. For example, in certain situations patients may benefit from anti-psychotic or sedative medication if they are extremely agitated post-operatively.

11.0 Patients who lack capacity

11.1 Capacity is the ability to make a decision, and the starting point must always be to assume that a person has capacity unless it is established that he lacks capacity. Difficulty communicating a decision is not the same as a lack of capacity to make the decision (see Section 30 'Definitions').

11.2 The Mental Capacity Act 2005 ('the Act') provides that healthcare professionals will not incur liability for any acts carried out in connection with the care or treatment of a person if, before doing the act, they have taken reasonable steps to establish that the person lacks capacity in relation to the matter in question, and it is in the person's best interests for the act to be done. ''Care or treatment'' is not defined within the Act, and these words should be given their normal meaning. It will include restraint (see Section 30 Definitions).

11.3 If a healthcare professional performs an act of restraint (whether physical, verbal, environmental or by administration of medication), they will need to take 2 further steps to ensure that they do not incur liability in relation to their actions. The member of staff must ensure that:

- They reasonably believe that it is necessary to use the chosen form of restraint in order to prevent harm to the person
  and
- That use of chosen form of restraint is a proportionate response to both the likelihood of the person suffering harm and the seriousness of that harm

11.3.1 The 2005 Act does not define ''harm'' because it will vary depending upon the patient and the situation but see Chapter 6.45 of the Code of Practice to the MCA 2005 for examples.

11.3.2 A ''proportionate response'' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity (see Section 30 definitions for further information and Chapter 6.47 of the Code of Practice).

11.3.3 For the purposes of the Act and this policy, a member of staff restrains an individual if he/she:

- uses, or threatens to use, force to secure the doing of an act which the individual resists
  or
- restricts the individual's liberty of movement, whether or not the individual resists

11.4 Unless it is an emergency situation, there should always be an assessment of the patient's capacity and a full risk assessment completed and documented in the patient's records before the use of any type of restraint is implemented (for further information on assessing capacity, see section 30 'Definitions'). There must also have been due consideration given to whether there are any less restrictive options which would prevent harm and ensure the safety of the patient and others. Where restraint techniques are employed, they should be in place for the shortest possible time period. This requires regular re-assessment of the patient's risk of harm and whether the use of restraint is a necessary and a proportionate response to the assessed risk.

11.5 Although 'restraint' of a person is permitted under certain conditions in order to prevent harm to a patient, there is no protection from liability for actions that result in a person being deprived of their liberty. It is therefore very important that when taking a decision as to whether the use of restraint is necessary and proportionate to prevent harm to a person, that the decision is never based upon a desire to prevent the person leaving the ward or hospital, a wish to exercise control over a person's movements or as a means of punishment. Restraint techniques must never be used as a means of controlling difficult patients, or as an alternative to adequate clinical and nursing observation and care. Restraint must only be used to prevent harm to the patient, and it must be a proportionate response to the likely seriousness of that harm. For example, a carer may need to hold a person's arm whilst they cross the road if the person does not understand the dangers of roads, but it is not a proportionate response to stop the person going outdoors at all.

12.0 Proxy Decision Makers

12.1 Although Section 5 MCA 2005 provides protection from liability for acts in connection with the care or treatment of a person in certain specified situations, this section of the Act does **not** provide protection for any actions that that go against the decision of someone who has been authorised as a proxy decision maker for the individual in question when the person is unable to make their own decision. Such persons may be an individual appointed as an attorney by the person to make healthcare decisions on their behalf, i.e. attorney acting under a registered personal welfare Lasting Power of Attorney (LPA), or a deputy appointed by the Court of Protection (see Section 30 Definitions).

12.2 Proxy decision makers must only make decision within the scope of their authority and in the person's best interests – be this the scope of the LPA, court order etc. If there is any disagreement as to whether the proxy decision maker is acting beyond their remit, or not in the person's best interests, the dispute should be resolved using the local dispute resolution procedure or, if necessary, an application can be made to the Court of Protection for a ruling if this cannot be resolved in any other way. If the dispute concerns provision of medical treatment, the 2005 Act authorises a HCP to provide life sustaining treatment or do any act reasonably believed to prevent a serious deterioration in the person's condition whilst a ruling is sought.

13.0 Advance Decisions

There will be no protection from liability under the MCA for any person who carries out an act in connection with the care or treatment of an individual lacking capacity if this act goes against a valid and applicable Advance Decision (AD). If a person has a valid and applicable Advance Decision in existence, its provisions must be followed by HCPs, and treatment in the patient's best interests does not feature (for further information on ADs see section 30 definitions). So for the purposes of this policy, if a person has a valid Advanced Decision to refuse treatment, there will be no protection from liability under the MCA for any person who uses restraint in order to carry out an act in connection with care or treatment that contravenes that advanced decision.

14.0 Deprivation of Liberty

14.1 Under the 2005 Act there is no protection from liability for actions which result in a person being deprived of their liberty (see section 28 Definitions for further information on what may constitute a deprivation of liberty and Chapter 6.49 onwards of the Code of Practice). This applies to anyone, including those who might otherwise have protection for acts of restraint performed in order to provide care or treatment for a person who lacks capacity. Further, no-one, including attorneys or court appointed deputies, can give permission or sanction an act that takes away a person's liberty.

14.2 In certain limited situations, it may be that the only way to provide care or treatment for an individual is by depriving them of their liberty, but this will only be a lawful act if formal authorisation is obtained first. For example, persons who meet the criteria for lawful detention in hospital under the provisions of the Mental Health Act 1983 may be lawfully detained and deprived of their liberty (see section 15 below for further information). The Court of Protection may also grant an order permitting the deprivation of a person's liberty if satisfied it is in their best interests. Alternatively, the Hospice can seek authorisation of a Deprivation of Liberty (DOL) in respect of an incapable adult who requires care and treatment in circumstances which amount to a deprivation of

liberty. The application is made to the relevant Local Authority Supervisory Body which must arrange a Best Interest Assessment in order to establish whether a deprivation of liberty should be authorised in the circumstances. Further guidance on the application process can be found via the Hospice Safeguarding Policies.

14.3 There is however an important distinction between the restriction of, and deprivation of a person's liberty. The difference is one of ''degree and intensity'', not of ''nature or substance''. This means there must be particular factors in the specific situation of the person concerned which provide the 'degree' or 'intensity' to result in a deprivation of liberty. This may relate to:

- the type of care being provided
- how long the situation lasts
- its effects, or
- the way the particular situation came about

14.4 For example, if HCPs are exercising 'complete and effective control' over the care and movements of an individual, such that the individual is effectively under continuous supervision and is not free to leave, then this is a deprivation rather than a restriction of liberty (for further information see section 28 Definitions and Chapter 6.52 of the Code of Practice).

15.0 Use of the Mental Health Act 1983

15.1 In some situations, HCPs may need to be alert to the possibility of the need to make an application under the Mental Health Act 1983 ('the 1983 Act') if, in their professional opinion, they cannot achieve their aims safely and effectively by relying on the MCA 2005 – for example, they may need to use a form of restraint in connection with the care and treatment of the person that is not permitted under the MCA 2005, (and so will not be afforded the protection from liability that Section 5 provides), or they may be at risk of depriving a person of their liberty in order to give the person the care and treatment they require.

15.2 A person can only be detained under the MHA 1983 if they fulfil the relevant criteria and are suffering from a serious mental disorder that puts themselves or others at risk. Whether the person lacks capacity or not is irrelevant to whether the MHA 1983 can be used, and it is based solely upon whether the person meets the Section 2 or 3 criteria in the 1983 Act for detention.

15.3 Compulsory treatment under the MHA 1983 is not an option if the patient's mental disorder does not justify detention in hospital (for either assessment or treatment), or if the patient needs treatment only for a physical illness or disability and is not suffering from a serious mental disorder which puts either themselves or others at risk.

15.4 In emergency situations, where HCPs are needing to use force or restraint on a patient, or are at risk of depriving a person of their liberty in order to give the person what in their professional opinion is the care and treatment they require, it may be appropriate to detain a patient in hospital temporarily under the holding powers available to doctors under Section 5(2) of the MHA 1983. This will enable the patient to be detained for up to 72 hours in order for an application under the MHA to be made and a full mental health act assessment to be carried out. This course of action is only appropriate if HCPs consider that the person is suffering from a mental disorder of such severity that it requires assessment or treatment in hospital in accordance with Sections 2 or 3 of the MHA.

15.5 Use of the Mental Health Act is only appropriate where a person requires treatment for mental disorder. For other incapable patients who require care and treatment in circumstances which amount to a deprivation of liberty, it may be appropriate to seek authorisation of this through the Deprivation of Liberty Safeguards (DOLS) process. Further guidance on the application process can be found via Hospices' Safegurading Policies.

15.6 The overlap between the appropriate use of the Mental Health Act and the use of DOLS is complex and further guidance should be sought where necessary.

16.0 Use of restraint to manage emergency (e.g. disturbed / violent) Situations

16.1 In an emergency situation e.g. disturbed/violent situation, the HCP in charge of the area has to make a decision to use restraint. In the UK there are situations when it would be seen as lawful to use reasonable force to restrain a patient (Dimond 2002). These are:

- To prevent self-harm or risk of physical injury
- Where staff are at immediate risk of physical assault
- To prevent dangerous, threatening or destructive behaviour

16.2 However staff need to ensure that this is reasonable and proportionate to the circumstance and that other techniques, such as de-escalation (see next paragraph) have been considered first. In an emergency situation it may be necessary to involve other members of staff or the police if further assistance is required (see section 19), because Lindsey Lodge Hospice is geographically isolated and at certain times there are limited numbers of staff on duty.

16.3 In some emergency situations requiring the use of restraint or a possible deprivation of liberty, it may be appropriate to consider the use of the MHA 1983 – see section 15 above, or use the DOLS process.

16.4 If staff feel that they, or others (patients, visitors or volunteers etc) are at risk of injury or assault then the Police should be contacted by using the panic buttons or be dialling 9-999

17.0 De-escalation

De-escalation techniques should be used before other interventions so it is important to identify areas of potential conflict before they escalate. To do this, it is necessary to be aware of and spot early signs of agitation such as balled fists, fidgeting, shaking, 'eye-balling', head thrust forward or clenched jaw. Changes in voice, such as speech becoming more rapid or high-pitched, may also indicate aggression. Key principles are as follows: (NICE Guidelines 2005 – Clinical Guideline 25). One staff member should assume control of a potentially disturbed/violent situation. This staff member should:

- Consider which de-escalation techniques are appropriate for the situation
- Manage others in the environment (e.g. removing other patients from the area, getting colleagues to help and creating space) and move towards a safe place
- Explain to the patient and others nearby what they intend to do, giving clear, brief, assertive instructions. Consider their language – it may be useful to follow the rule of 5 (no more than 5 words in sentence, 5 letters in a word – e.g. "Would you like a chair?"). Also lower their voice and keep their tone even. It is hard to have an argument with someone who is not responding aggressively back to you
- Ask for facts about the problem and encourage reasoning (attempt to establish a rapport; offer and negotiate realistic options; avoid threats; ask open questions and ask about the reason for the patient's anger; show concern and attentiveness through verbal and non-verbal responses; listen carefully; do not patronise and do not minimise the patient's concerns)
- Ensure that their own non-verbal communication is non-threatening and not provocative
- Where there are potential weapons in the area, the patient should be relocated to a safer environment, where possible
- If the patient has a potential weapon, ask for it to be put in a neutral location rather than handed over
- Consider asking the patient to make use of a designated room (e.g. quiet room where this is available/appropriate) to help them calm down
- Consider ways to maintain the safety of both themself and others during situations of potential violence:
- For example:
    - Taking a position just outside the individual's personal reach (out of arm's reach) on the non-dominant side
    - Maintain an open posture
    - Keep the individual in visual range
    - Make certain the room's door is readily accessible; avoid letting the individual get between you and the door

18.0 Physical Restraint of Patients

18.1 There are real dangers with physical intervention in any position therefore physical intervention should be avoided if at all possible. If physical restraint is required for the safety of the patient, other patients', visitors, volunteers or staff then the HCP in charge may make the decision to call for assistance from the Police or Ambulance service to restrain and monitor the patient and potentially transfer to local Accident and Emergency Department.

18.2 Further the monitoring of vital signs (observations physical and psychological) both during and after restraint (12 Hours) should be undertaken by a duly qualified HCP. N.B. For inpatients this will occur as part of ongoing observations and hourly rounds. In addition we train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).

19.0 Contacting the Police

In some situations, it may become necessary to contact the police for further assistance. In the following scenarios, staff should immediately contact the police:

- If a violent situation arises which cannot be brought under control by Hospice staff, and where the safety of staff, patients or others is at risk
- If a patient has discharged against medical advice, and there are serious concerns about the welfare or safety of that person or others. In such circumstances the police may be able to check on the person. The Hospices' procedure for discharge against medical advice should also be followed
- If a patient has discharged against medical advice and is threatening to commit suicide. In such circumstances the police have powers to take the person to a place of safety (usually a hospital) to be assessed. The Hospices' procedure for discharge against medical advice should also be followed.

20.0 Communication and Documentation

20.1 Clear communication with patients and their families/carers is essential in relation to the use of restraint, and where possible, written information should be given to supplement verbal information.

20.2 If restraint is used, the reason(s) should be clearly documented in the healthcare records. :

- The 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 regarding the use of restraint should be documented, and any
- assessment of capacity should be recorded
- Details about the use of the restraint itself

21.0 Evaluation and review of the use of restraint

21.1 The use of any type of restraint should be evaluated and reviewed in terms of its effectiveness and alternative options considered wherever possible. The use of restraint in an emergency situation should be viewed as a critical incident and an Incident Form should be completed.

21.2 Any injuries to either the patient, a member of staff or a visitor which arise from an act of restraint should be considered a clinical incident and an Incident Form completed according to Hospice Policy.

21.3 Out of hours the Duty Manager should be informed of the incident without delay.

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22.0 Accountability

22.1 Staff will be accountable at all times for their actions in relation to the use/non-use of restraint, and inappropriate use of restraint, force or acts that result in a deprivation of liberty may result in:

- Disciplinary action by the Hospice
- Disciplinary action by a professional body e.g. GMC or NMC
- Civil liability for damages for assault, battery, false imprisonment or infringement of human rights
- Criminal charges for assault, battery, false imprisonment, or the new criminal act of 'ill treatment'' or ''wilful neglect'' set out in the MCA 2005 (see below)

22.2 On 1 April 2007 the new criminal offence of ill treatment and wilful neglect created by Section 44 MCA 2005 came into force. It applies to anyone caring for a person (of any age) who lacks capacity to make decisions for themselves due to an impairment of or a disturbance in the functioning of, the mind or brain. Any deprivation of liberty, and in certain situations, acts of restraint, may constitute the offence where the act or omission amounts to ill treatment or wilful neglect.

22.3 If a person is found guilty of ill treatment or wilful neglect, they will be liable for a fine, or a term of imprisonment of up to 5 years, or both. It is therefore important that any act of restraint used in the care or treatment of a person lacking capacity is carried out in accordance with the specific provisions of Section 6 of the Act, namely that the person carrying out the act has a reasonable belief that the act is necessary to prevent harm to the individual, and it is a proportionate response to the likelihood and
seriousness of the harm. All factors considered, decisions taken, and actions carried out should be fully documented in the healthcare records.

23.0 Monitoring Compliance and Effectiveness

23.1 Audit
Audit of the implementation and the application of the Hospice's Policy on the Restraint of Adult Patients will be undertaken through the clinical audit route. This will aim to identify any areas where improvement is required, for example ensuring that decisions made as to the use of restraint are appropriate, auditing the number and pattern of injuries arising from acts of restraint etc. Audit will be informed by the information collected from the nursing notes, namely the ongoing care plan documentation and risk assessment documentation, and completed Incident forms.

23.2 Review
This policy will be reviewed every 3 years or sooner should the need arise.

24.0 Staff Training
Risk management training, moving and handling and conflict resolution training is available and all relevant for all clinical staff to support this policy.

25.0 Complaints
In the event that a patient or family member/carer wishes to make a complaint about a restraint intervention performed by a member of staff working on hospice premises, theys hould be directed to the Hospice's Complaints' .

26.0 Associated Documents
There are a number of related policies and guidelines which should be read in conjunction with this policy. These are:

- Hospice Consent to Treatment Policy
- Hospice Risk Management Strategy Including Incident Reporting Policy and Procedure
- NMC Code of Professional Conduct
- Mental Health Guidelines on General Hospital Care
- Policy for the Management of Violent & Aggressive Behaviour
- Hospice Policy on the Management of Falls
- Hospice Policy on The Safe Use of Bed Rails (Adult Patients)
- Hospice Deprivation of Liberty Safeguards Policy
- Hospice Complaints Policy
- Policy for the Use of Wheelchairs
- NLaG Restraint of Patients in Hospital (Adults)

27.0 References

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27.2 Norman A (1982) Rights and risk: a discussion document on civil liberty in old age, London: Centre for Policy on Ageing.

27.3 Royal College of Nursing (2004) 'Restraint revisited – rights, risk and responsibility'.RCN.

27.4 NICE (2005) Clinical Guideline 25. Violence. The short-term management ofdisturbed/violent behaviour in psychiatric in-patient settings and emergency departments.

27.5 Department of Health Guidance ''Good Practice in Consent Implementation Guide: Consent to examination or treatment''.

27.6 Health & Safety at Work etc Act 1974 (Sections 2 & 3).

27.7 SI 1999/3242 - Management of Health & Safety at Work Regulations 1999 (Regulation3).

27.8 The Human Rights Act 1998.

27.9 Mental Capacity Act 2005 and Code of Practice.

27.10 The Mental Health Act 1983 and Code of Practice.

28.0 Definitions

28.1 Battery
The intentional application of force to another in a hostile manner or against his/her will. It is not necessary to show intention to injure to prove 'battery'.

28.2 Assault
An act by a person which puts another in fear of battery.

28.3 False imprisonment
The unlawful imposition of constraint on another's freedom of movement from a particular place.

28.4 Capacity
This is the ability to make a decision, and the starting point must always be to assume that an individual has capacity unless it is established that he lacks capacity. Difficulty communicating a decision is not the same as a lack of capacity to make the decision.

28.5 The test for capacity

28.5.1 This is set out in the Mental Capacity Act, and is a 2 stage test which is decision specific. The test is:

- Does the patient have an impairment of, or a disturbance in the functioning of, their mind or brain?
- If yes, does this mean that the patient is unable to make a specific decision when they need to?

28.5.2 A person is unable to make a decision if they are unable:

- understand the information relevant to the decision to retain that information
- to use or weigh that information as part of the process of making the decision balancing risks and benefits
- to communicate the decision

28.6 Lack of capacity

A person lacks capacity in relation to the matter if at the material time he is unable to make a particular decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. This is a decision specific test, and so a person may lack capacity to make some decisions for themselves but may have capacity to make other decisions.

28.7 Best Interests
Anyone who is assessed as lacking capacity should be treated by healthcare professionals in their 'best interests' (unless there is a valid and applicable Advance Decision in existence, in which case this must be followed). The Mental Capacity Act does not actually define 'best interests' but is clear that in deciding what is in the best interests of a person lacking capacity, decision makers must take into account all relevant factors it would be reasonable to consider. As a starting point the Mental Capacity Act sets out a checklist of common factors that should always be considered, and these include:

- whether the person will regain capacity to make the decision and whether the decision can be delayed until then
- Considering all relevant circumstances, and making every effort to encourage and enable the person lacking capacity to take part in making the decision
- Taking into account any evidence of the patient's current and previously expressed wishes and feelings, including any written statements made by the patient when he had capacity
- Considering the beliefs and values that would be likely to influence the individual's decision if he had capacity, and any other factors he would be likely to consider if able to do so
- If practicable and appropriate, taking into account the views of anyone named by the individual as someone to be consulted on matters of this kind, any carers or other people interested in the individual's welfare, any donee of a LPA appointed by the individual or any Deputy appointed by the Court, as to what would be in the individual's best interests

28.8 Advance Decision
This is a decision made by a person after he has reached the age of 18 years and when he has capacity to do so, that if:

- at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing healthcare for him,
  and
- at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued

28.9 Proxy Decision Maker
This can be the done under a Lasting Power of Attorney who is authorised by the person under the LPA to make the decision for them when they lack capacity, or can be a deputy appointed by the court to make treatment decisions for the person when the person is unable to make decisions for themselves.

28.10 Proxy Decision Maker
Care or treatment
For the purposes of the 2005 Act and this Policy, these terms have their normal meaning. Actions that might be covered by the phrase 'care or treatment' includes aspects of personal care (such as helping with mobility, eating and drinking, washing, dressing and personal hygiene) and of healthcare and treatment, including:

- carrying out diagnostic examinations and tests
- giving medication
- providing professional medical, dental and similar treatment▫taking someone to hospital for assessment or treatment
- providing nursing care
- carrying out any other necessary medical procedures or therapies
- providing care in an emergency

28.11 "Proportionate Response":
▫▫For the purposes of the 2005 Act and this Policy, a ''proportionate response'' to the likelihood and seriousness of harm means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of a person who lacks capacity ▫▫On occasions where a 'proportionate response' involves the use of force this should be the minimum amount of force for the

shortest possible time.

28.12 Deprivation of liberty:
Under Article 5(1) of The European Convention on Human Rights, every person has the right to liberty and security of person, and may only be derived of their liberty in the prescribed situations outlined in Article 5(1), and in accordance with a procedure prescribed by law
The European Court of Human Rights has identified the following as factors which could be said to contribute to a deprivation of someone's liberty:

- Restraint being used, including sedation, to admit a person who was resisting
- Professionals exercising complete and effective control over a person's care and movement for a significant period
- Professionals exercising control over a person's assessments, treatment, contacts and residence
- Preventing a person from leaving if they made a meaningful attempt to do so
- Refusing a request by carers for the person to be discharged into their Care
- Keeping a person under continuous supervision and control such that they lose autonomy

29.0 Consultation

29.1 Senior Management team.

29.2 Board of Governors
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30.0 Dissemination

30.1 A copy of the Policy on the Restraint of Adult Patients will be made available to all new medical/nursing staff and a controlled copy will be available on the L drive, Staff will be informed following each policy review.

30.2 Copies of this policy will be made available for patients/carers/relatives on request.

31.0 Equality Act (2010)

31.1 In accordance with the Equality Act (2010), the Hospice will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Hospice will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

31.2 The Hospice will, wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Hospice's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).

Lead Author of Policy Karen Wright **Responsible Sub-group Quality Assurance** **RATIFICATION DATE BY TRUSTEES 13th April 2017** Review interval 3 year				
To Be reviewed	Review completed	By	Approved By	Circulation
April 2020				

Appendix A
2 part best interest forms

Two stage test of capacity under the Mental Capacity Act (2005)

Patient name:	NHS number	DoB

Stage 1

(a) Does the patient have an impairment of, or a disturbance in the functioning of, their mind or brain?	Yes	No
(b) Relevant diagnosis: **and/or** Is the patient orientated to time, person or place ? *(Able to state correctly own name, date of birth, address and present location)*		
Does (a) and (b) affect the patient's ability to consent or decline therapy at this time ?	Yes	No

Stage 2

Is the patient able to **understand** the information provided about the proposed therapy intervention ?	Yes	No
Is the patient able to **retain** the information provided about the proposed therapy intervention ?	Yes	No
Is the patient able to **weigh up** the information offered as part of the process of making a decision to consent to a therapy intervention ?	Yes	No
Is the patient able to **communicate** a decision to consent to a therapy intervention using any means available ? I	Yes	No
Can the treatment be delayed until the patient regains capacity ?	Yes	No
Is the therapeutic intervention urgently required ? *(for example: suctioning; chest physiotherapy; assessment to facilitate discharge; passive range of movement; repositioning for pressure relief, chest health, eating & drinking).*	Yes	No

Treatment provided by name & signature (named decision maker): Supported by (relevant members of MDT): Date:

OR is a formal best interests meeting required in order to involve the patient, family members, IMCA and MDT in a review of the best interests checklist ? *(For example; restraint to prevent self harm; risks associated with discharge planning; falls risk; swallowing risk; consent issues involving relatives)*	Yes	No

Appendix B

Consent Care Plan

IN PATIENT UNIT

CARE PLAN FOR CONSENT TO NURSING CARE

Patient Name:..... Date of birth:..... Room/bed number:.....Care plan number:.....

PROBLEM:	OUTCOME:	ACTION:
..... has possible vulnerability due to hospital admission or medical condition that may disrupt the patient's thought process and capacity to give consent.	1.To support ..... to make decisions about care once they have been given appropriate information regarding nursing care. 2. To maintain .....'s safety.	1. Assess the patient's mental capacity to consent to receive nursing care. 2. Re-assess the patient's ability to consent to care delivery, at each nursing intervention or if there is a change/deterioration in the patient's condition. 3. Gain informed consent from the patient for all care given and document in the relevant care plan. 4. Explain all care/management to the patient/relatives - at the level that is understood 5. Discuss with Medical staff and consider repeating the Abbreviated Mental Test Score (AMTS) which is done on admission. 6. Complete Refusal of Treatment form to document patients' decisions.

Appendix C
Best interests Decision Tool (Social Services)

Mental Capacity Assessment and Best Interest Decision

Date of Assessment:
Person's Name:
Person's PID:
Name of person completing this assessment: **Role:**
Contact Details:
IMPORTANT: PLEASE CONSIDER WHETHER THERE IS A LASTING POWER OF ATTORNEY OR A COURT APPOINTED DEPUTY WHO HAS THE LEGAL AUTHORITY TO MAKE THIS DECISION AND EVIDENCE THIS. If so, your role is to participate and record the outcome.

PLEASE NOTE: You must answer all the questions on this statutory checklist, If the question is not applicable please state why

What is the decision?
Background history – what has led to the need for a decision? Please record a recent history to show your reasons for undertaking this assessment:
What available options are being considered? Any decision must have options:

In carrying out this assessment I have met or consulted with the following people		
Name	**Address**	**Relationship to person**

If there is no one with whom to consult (e.g. family, friends, significant other) you must instruct an Advocate or IMCA to support the person

Date of Referral:
IMCA Service Referral has been sent to: