London Ambulance Service NHS
NHS Trust

Operational Procedure for the use of Restraint of Patients

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To provide guidance to staff regarding the use of restraint on people who lack capacity to consent to treatment and care, so that staff deal with restraint issues lawfully.

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Sponsor Department: Nursing and Quality Directorate

Author/Reviewer: Jason Challen – Practice Learning Manager PTS

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
01/10/15	1.1	IG Manager	Document Profile and Control update and minor changes
28/09/15	1.0	Peter Nicholson	Final version, EMT approval by proxy as Director assigned on 24/08/15. Policy wording previously agreed at EMT.
18/05/15	0.13	Jason Killens	Final amendments
14/05/15	0.12	Jason Challen & Jaqui Lindridge	Inclusion of feedback from Consultant Paramedic
28/05.15	0.10 & 0.11	Jason Challen	Inclusion of NRLS reporting and further feedback
13/04/15	0.9	Jason Challen	Feedback from directors & CEO
25/11/14	0.8	Jason Challen	Feedback from Service solicitors
27/08/14	0.7	Jason Challen	Final amendments from peer group
20/08/14	0.6	Jason Challen	Revision from peer group feedback
08/07/14	0.5	Jason Challen	Minor amendments following feedback
17/06/14	0.4	Jason Challen	Document type changed & reference number added
13/05/14	0.2 & 0.3	Jason Challen	First revision from peer group feedback
05/03/14	0.1	Jason Challen	Initial draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMT	10/06/15	1.0
Ratified by (If appropriate):		
EMT	24/08/15	1.0

Published on:	**Date**	**By**	**Dept**
The Pulse	01/10/15	Governance Administrator	GAT
LAS Website	01/10/15	Governance Administrator	GAT
Announced on:	**Date**	**By**	**Dept**
The RIB	06/10/15	IG Manager	GAT

Equality Analysis completed on	By
01/10/15	Practice Learning Manager PTS
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/003	Policy Statement of Duties to Patients	4.1
TP/004	Complaints and Feedback Policy and Procedure	2.4
TP/005	Risk Management Policy and Strategy	7.1
TP/006	Serious Incident Policy and Procedure	4.1
OP/045	Procedure for patients suspected of Alcohol and/or Drug intoxication	1.1
OP/014	Managing the Conveyance of Patients	TBC
OP/031	Policy for Consent to Examination or Treatment	3.1

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

1.1. The use of restraint is an emotive issue involving challenging and difficult decisions about care and treatment. If an action fits a definition of restraint contained in this procedure it is not necessarily unacceptable or wrong as the circumstances may, subject to the rationale being used, make the act of restraint both reasonable and necessary. This procedure outlines when restraint as a therapeutic intervention may be carried out in order to maintain the balance between independence and safety. It also outlines the procedure to follow when considering the use of restraint for patients receiving care and treatment and the procedure for raising concerns regarding possible abuse of restraint.

1.2. The most relevant legal definition of restraint in England is that found in the Mental Capacity Act (2005) and its amendments. Section 6(4) of the Act states that someone is using restraint if they:

- Use force, or threaten to use force, to secure the doing of an act which the person resists, or to

- Restrict a person's liberty of movement, whether they are resisting or not

2. Scope

2.1. This policy covers the use of restraint by Service staff when engaged in providing clinical care to patients and applies to all staff who are working on behalf of the Service; including agency workers, students and volunteers.

2.2. It does not cover the management of violence and aggression in bystanders or other individuals.

3. Objectives

3.1. To recognise that the Trust does not train staff in the use of physical restraint, as this is the province of the Police, but acknowledges that restraint can, on occasion be required to preserve life and protect staff and the public.

3.2. To ensure there is a consistent approach to the use of restraint within the Trust.

3.3. To ensure that the use of restraint is applied in line with current legislative frameworks and best practice guidelines.

3.4. To ensure that the use of restraint is appropriately applied, reassessed and documented.

4. Responsibilities

4.1. **All staff** providing clinical care to patients are responsible for adherence to this policy.

4.2. The **Medical Director** has responsibility for ensuring that guidelines for the use of chemical restraint are reviewed annually.

4.3. The **Director of Nursing and Quality** has responsibility for ensuring that this policy reflects current legislation and best practice.

4.4. The **Clinical Safety and Standards Committee** will monitor the implementation and compliance with this policy.

5. Duty to Patients

5.1. All staff are reminded of the requirements contained within TP/003 (Policy Statement of Duties to Patients), specially the responsibility of all LAS staff to:

- Strive to preserve life and alleviate suffering
- Care for each patient as an individual, with courtesy, respect and dignity
- Avoid any action that is detrimental to the interests of the patient or to those involved in the patients care

6. Definitions

6.1. There are a number of different types of restraint:

6.2. Psychological restraint

- Can include telling someone not to do something or depriving individuals of equipment or possessions which enable them to do what they want to do (e.g. glasses, hearing aids, mobility aids etc.), or making a threat or indication that physical, chemical or mechanical restraint will occur in the absence of compliance.

6.3. Chemical Restraint

- Is the use of medication for the purpose of alleviating or managing symptoms or behaviours associated with an underlying medical or mental health condition. In the LAS this will only be undertaken by staff who have been specifically authorised and trained to administer the requisite medication using guidance approved by the LAS Medical Director.

6.4. Mechanical Restraint

- Involves the use of equipment to restrict movement (e.g. arranging furniture to restrict movement, mechanical locks, straps, blanketing etc.).

6.5. Physical Restraint

- One or more members of staff holding the person, moving the person, or blocking their movement.

6.6. Restraint may be used either (a) reactively i.e. in response to violence or to prevent harm or (b) proactively to support necessary treatment or where an assessment has indicated that an individual is likely to pose a risk to themselves or others.

6.7. **There are a number of routine procedures such as the application of trolley bed or carry chair straps, splintage and blankets that are in principle are a form of mechanical restraint. However their use is applied for safety purposes rather than as a means of restraint and therefore do not require additional measures to be taken.**

6.8. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangement only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

7. The Legal Framework

7.1. Under common law, like any member of the public, staff can use reasonable force to prevent harm to themselves or others; this includes the patient and may extend to situations involving self-harm. However, inappropriate use of any form of restraint can constitute assault and/ or a battery under criminal law or negligence under civil law if patients are injured. Therefore it is important for staff to have an understanding of the legal framework.

7.2. The Human Rights Act 1998 requires that the use and extent of restraint should be justified by a clear rationale. This should explain why other considerations are reasonably believed to override the individual's freedom of action.

7.3. Restraint may be appropriate when it is used to prevent harm to the patient and it is a proportionate response to the likelihood of, and seriousness of harm (Mental Capacity Act 2005 s. 6 (2-3)). Any staff member who determines that there is a need to restrain a patient will need to document that the criteria to carry out the restraint were met (i.e. that is was necessary and proportionate) and that the restraint was in the best interests of the patient. They must be able to demonstrate that on balance the person being cared for is likely to suffer harm unless proportionate restraint is used. For example holding onto a patient who threatens to jump into the path of oncoming traffic or the use of blankets to prevent a confused patient from wandering off.

7.4. Where restraint is being considered; staff must consider the best interests of the patient recognising that in some circumstances harm may be done to the patient in the course of imposing treatment and such harm may outweigh its clinical benefits. Where uncertainty exists, staff should not make decisions in isolation and advice should be sought.

7.5. If restraint is necessary to prevent harm to the patient, it must be the **minimum amount of force** for the **shortest time possible**. The reason for the restraint, risk assessments and the evidence of continual reassessment must be clearly documented on the Patient Report Form (PRF), and where appropriate the LA5. Staff should also consider completing form LA066, Checklist for assessing best interests in patients aged 16 and above. Where the police are in attendance on scene, it must be emphasised that the most qualified member of LAS staff has overall responsibility for the patient's clinical management at all times.

7.6. Restraint can only be used if:

- The staff member using it reasonably believes that it is necessary to prevent harm to the patient and,
- The patient is deemed likely to have a condition that requires further assessment,
- Its use is proportionate both to the likelihood and seriousness of harm to the individual or others present and,
- The restraint must be in the patient's best interests and,
- The restraint is the least restrictive means necessary to prevent such harm.

7.7. A carer or professional must not use restraint just so they can do something more easily.

7.8. Patients with Capacity

- A person with capacity may consent, or withhold consent, to restraint being used. For example a patient may agree to the use of blankets and straps when being transported in the ambulance carry chair.

- Any action intended to restrain a person can be legal if the person consents (as long as there has been no coercion) though staff must act within the scope of their professional boundaries and the law which requires informed consent and avoidance, so far as possible, of foreseeable harm.

7.9. Patients without Capacity

- The Mental Capacity Act 2005 provides the statutory framework when working with those people who may lack capacity to make certain decisions. The Act sets out the conditions in which an act may be planned that would constitute restraint of a person who lacks capacity.

- For further detailed guidance on the Act, including its key principles and making an assessment of capacity, please refer to the Mental Capacity Act 2005 Code of Practice and the LAS policy on consent and capacity contained within OP/031 (Policy for Consent to Examination or Treatment).

- Further statutory guidance exists for patients who lack capacity and are subject to lasting measures in hospitals and care homes, this is contained within the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS). The Deprivation of Liberty Safeguards Code of Practice 2008 states transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty. In almost all cases, it is likely that a person can be lawfully taken to a hospital or care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.

8. Procedure

8.1. Restraint should only be considered following a dynamic risk assessment which includes an assessment of the risk to and posed by the patient from their behaviour, or their non-compliance with treatment and/ or conveyance.

8.2. If possible move other patients, relatives and bystanders out of harm's way.

8.3. If the police are required they should be requested as soon as possible.

8.4. Continue to employ de-escalation techniques throughout, if applicable to the situation.

8.5. The patient's overall physical and psychological well-being must be monitored throughout. The member of LAS staff with primacy of care is responsible for:

- Ensuring the patient's airway and breathing are not compromised
- Ensuring vital signs are monitored where possible
- Ensuring any physical restraint is for the shortest possible time and in the least restrictive way

8.6. **No patient should be restrained in a prone position, due to the risk of positional asphyxia. Positional/restraint asphyxia is defined as occurring when 'the position of the body interferes with respiration, resulting in asphyxia (suffocation)'. Positional/restraint asphyxia can occur extremely rapidly when a patient is in a position that interferes with inspiration and/or expiration and cannot alter that position.**

8.7. Owing to the risks of positional/restraint asphyxia, the prone position must not be used during transportation.

8.8. If restrained, the patient must receive close and continuous monitoring. As a minimum, level of consciousness (AVPU, heart rate, end-tidal CO2, effort of breathing, SpO2, ECG and blood pressure must be monitored. If it is not possible to monitor any of the vital signs listed, the reason must be clearly documented on the PRF.

8.9. Following restraint, the person who has been restrained will need to be assessed and monitored and therefore every effort should be made to convey the patient to an Emergency Department or other place of safety or care.

8.10. Where the Police are present, they should take the lead in the application of restraint.

8.11. **Where the police are in attendance on scene, it must be emphasised that the most qualified member of LAS staff has overall responsibility for the patient's clinical management at all times. This remains the case even in circumstances where the police are required to provide force and restraint in dealing with a specific patient.**

8.12. In the event of a patient requiring restraint, there is an absolute need for close liaison and teamwork between the LAS and the police, as well as any other agencies on scene. This would generally take the form of a dynamic risk assessment, where the care and continuing welfare of the patient remains the key priority throughout

8.13. Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the patient understands why this has happened. This should be documented in the patient record.

9. Chemical Restraint

9.1. The aim of paramedic led, pre-hospital chemical restraint is to achieve a state of calm, sufficient to minimise the risk posed to the patient and others. Administering chemical restraint will often require initial physical restraint, therefore, in addition to the points above:

9.2. Procedure

- Chemical restraint must only be used by specifically authorised and trained paramedics (currently only LAS Consultant Paramedics, Advanced Paramedic Practitioners and other named senior clinicians within the Trust), using only those drugs specifically authorised by the LAS Medical Director for chemical restraint

- Where appropriate and possible the patient must be kept informed during the procedure and should be able to respond to communication throughout

- The procedure must be appropriately documented

- The patient must be regularly monitored. This is especially important following a prolonged or violent struggle where the person has been

subject to chemical restraint or if the person is suspected to be under the influence of alcohol or illicit substances or if the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity (when face down), asthma, heart disease etc.

- Medication for chemical restraint, particularly in the context of physical intervention, should be used with caution owing to the following risks (NICE, 2005):
    - loss of consciousness instead of tranquilisation
    - sedation with loss of alertness
    - loss of airway
    - cardiovascular and respiratory arrest
    - interaction with medicines already prescribed or illicit substances taken
    - possible damage to patient-staff relationship
    - underlying coincidental physical disorders

9.3. Staff should monitor and record pulse, level of consciousness (AVPU, heart rate, end-tidal CO2, effort of breathing, SpO2, ECG and blood pressure. Observations should be conducted continuously where possible and at a minimum, every 15 minutes until the patient becomes more active again. More frequent monitoring may be instigated dependent on the on-going clinical assessment which must be clearly documented in the patient record.

9.4. The physical fitness of older adults must be considered. Older adults may have poor muscle perfusion producing erratic absorption of intra-muscular drugs into the bloodstream. Particular care should be taken to establish co-existing medical problems and prescribed medicines, the risk of accumulation of drugs and the possibility of delirium. Older patients will also be more likely to experience adverse effects from drugs.

10. Documentation

10.1. Ensure that the PRF contains a comprehensive record of any intervention necessary to manage an individual's disturbed/violent behaviour, including full documentation of the reason for any clinical decision.

10.2. The LAS Capacity Tool (LA5) must be fully completed for all patients who lack capacity and are actively restrained. It is good practice to complete LA066, checklist for assessing best interests in patients aged 16 or above.

10.3. In all cases where active physical restraint is used an LA52 (incident form) must be completed and consideration given to completing a safeguarding referral.

- It is recognised that physical restraint occupies a spectrum which ranges from very low force restraint with very low risk of harm (such as gentle control techniques), to restraint requiring greater levels of force and thus a higher risk of harm, and a risk of a greater level of harm.

- In all cases where higher risk physical restraint is used an LA52 (incident form) must be completed and consideration given to completing a safeguarding referral. It is not possible to provide a definition of reportable restraint nor to provide an exhaustive list of examples. Many cases of reportable restraint will be obvious, however examples include:

    - Physical restraint requiring the physical intervention of the police
    - Physical restraint against active and meaningful resistance
    - Physical restraint involving children, frailty or known co-morbidities which may increase the risk of injury (in terms of severity and/ or likelihood)
    - Physical restraint where it would be reasonably clear to any 'restrainee' that physical restraint has taken place

- **It is important to recognise that reporting physical restraint as an incident in no way indicates that the physical restraint was inappropriate. All cases of restraint must be documented on the PRF and/ or LA5, as is most appropriate, regardless of any additional incident forms completed.**

10.4. If restraint is used, and physical harm occurs to a patient (as documented on the LA52 Incident Report Form) the appropriate National Reporting & Learning System (NRLS) incident report will be recorded by the Safety & Risk Department.

11. Raising Concerns

11.1. Where staff have concerns regarding the use of, or the omission to use restraint, or where another member of staff, patient or another individual raises concerns with a member of staff, this should be raised at the earliest opportunity with their line manager. The alleged inappropriate use of restraint must be managed in accordance with the appropriate Trust safeguarding

policy (adult or children). In situations involving allegations against a member of staff, the Director of Nursing & Quality or Head of Safeguarding must be informed and the Trust Whistle blowing policy applied.

12. Summary

12.1. The LAS does not provide training on physical restraint.

12.2. The Police are trained in restraint and should be involved at an early stage wherever the possibility of physical or chemical restraint is considered.

12.3. Should restraint be required to protect the patient, or members of staff, it should be proportionate and applied for the shortest possible period of time possible.

12.4. Attention to documentation;

- For all patients a PRF must be completed to record observations and rationale;
- A capacity assessment and LA5 must be completed for all patients who lack capacity;
- Consideration given to the completion of an LA066 for all patients 16 or over;
- If restraint is used to prevent harm to a patient or others a clear rationale (recorded on the PRF), why restraint under Common Law was justified must be recorded;
- An LA52 must be completed for all patients where active physical restraint was used;
- A safeguarding referral must be made for all patients where appropriate;

IMPLEMENTATION PLAN				
Intended Audience	Operational clinical staff			
Dissemination	Available to all staff on the Pulse			
Communications	Procedure to be announced in the RIB and a link provided to the document			
Training	*TBC*			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Incident Reports (LA52)	Quarterly review of local risk registers	ADO's report to each Area Quality Committee	Clinical Safety and Standards	Dissemination of learning in accordance with source of risk i.e. learning from risk highlighted via serious incident through SI Action Plan
Complaints	Quarterly PED activity reports and emerging themes	The patient Experiences Department reports to the Learning from Experiences Group	Quality committee	
Serious Incidents (SI)	All SI's involving the application of restraint will be investigated within the SI process	The 'Serious Incident Group' will monitor all SI's for the potential use of restraint	The 'Learning from Experience Group' will monitor the implication of any action plans	