

Restraint Policy: Considerations and Alternatives

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Version: 2.1 Technical Update

Status: Approved

Date of Authorisation: May 2018

Date added to Intranet: May 2018

Authorised by: Policy Approval Group

Review Date: May 2019

Key Words: Restraint; Management of Aggression Team; Risk Assessment; Bedrails; Keypads; Duty of Care; Human Rights Act; Violence and Aggression

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Key Messages	<p>The aim of this policy is to provide direction for staff in relation to the use of restraint. The Policy aims to provide a decision making framework which will support staff in balancing their duty of care, with the rights of the patient and the rights of staff to protect themselves from harm.</p> <p>Care and treatment will be delivered in such a way that patient's rights are not compromised, and in situations in which this is unavoidable restraint will be used within the context of what is legally and ethically justifiable.</p> <p>Staff will be informed and supported in making decisions about restraint, the necessary considerations and potential alternatives.</p> <p>All incidents requiring restraint will be controlled by the implementation of this policy, risk assessment, and competently trained staff.</p> <p>If an intervention is being used with the primary aim of stopping a person from doing what they appear to want to do, then it can be defined as restraint.</p> <p>Whenever restraint is used, there are some universal principles that must always be adhered to:</p> <ul style="list-style-type: none"> • The behaviour must be causing or have the potential to cause harm to the individual, others or serious damage to property. • Any form of restraint used must be necessary and proportionate. • A risk assessment should be conducted balancing the risks of restraint with the risks of not using restraint. • All alternatives to restraint must have been considered and if appropriate implemented (except in emergency situations). • Restraint must not be used for retaliation, retribution, or 'teaching someone a lesson'
Minimum Implementation Standards	<p>This policy applies to all NHS Lothian staff in all locations where staff are involved in the care, treatment and provision of services to patients.</p> <p>All incidents requiring restraint will be controlled by the implementation of this policy, risk assessment, and competently trained staff.</p>

NHS Lothian
Restraint Policy – Considerations and Alternatives

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1. Aim of the Policy

1.1 The aim of this policy is to provide direction for staff in relation to the use of restraint. The Policy aims to provide a decision making framework which will support staff in balancing their duty of care, with the rights of the patient and the rights of staff to protect themselves from harm.

2. Objectives

2.1 Care and treatment will be delivered in such a way that patient's rights are not compromised, and in situations in which this is unavoidable restraint will be used within the context of what is legally and ethically justifiable.

2.2 Staff will be informed and supported in making decisions about restraint, the necessary considerations and potential alternatives.

2.3 All incidents requiring restraint will be controlled by the implementation of this policy, risk assessment, and competently trained staff.

3. Policy Scope

3.1 This policy applies to all NHS Lothian staff in all locations where staff are involved in the care, treatment and provision of services to patients.

4. Definitions

4.1 "Restraint is taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a patient from doing what he or she wishes to do and as a result places limits on his or her freedom"

Rights Risks and Limit to Freedom - Mental Welfare Commission

4.2 "Stopping a person doing something they appear to want to do"

Let's Talk About Restraint - RCN

5. Responsibilities

5.1 NHS Lothian is responsible for:

- Full and effective implementation of this policy
- Providing a safe working environment in line with Health and Safety legislation
- Providing safe and effective care to NHS Lothian patients
- Ensuring that there are arrangements for identifying, evaluating and managing the risks associated with the use of restraint
- Providing sufficient resources to train staff effectively
- Ensuring that incidents relating to restraint are monitored and investigated by Local Health and Safety Committees

- Ensuring that the Lothian Partnership Forum reviews the effectiveness of this policy every two years or as required.

5.2 Senior Managers are responsible for:

- Ensuring that all Service/Departmental Managers are aware of this policy and the requirements within it
- Supporting the completion of NHS Lothian Violence and Aggression Risk Assessment and Risk Reduction system and associated individual risk assessments/care plans for the use of restraint
- Ensuring the implementation of risk reduction strategies and ensuring that process are in place to monitor the effectiveness of such strategies
- Facilitating the mandatory training of all staff expected to undertake restraint to ensure that restraint is being carried out safely and effectively
- Ensuring that all aspects of NHS Lothian's Incident Management Policy are implemented
- Promoting the implementation of post incident support strategies for all individuals affected by a restraint

5.3 Service and Departmental Managers are responsible for:

- Ensuring that all staff are aware of this policy and the requirements within it
- Completing the NHS Lothian Violence and Aggression Risk Assessment and Risk Reduction system and associated individual risk assessments/care plans for the use of restraint
- Implementing all risk reduction strategies identified as a result of risk assessments and ensuring that strategies are monitored and reviewed.
- Communicating the results of risk assessments to ensure that staff are fully aware of the potential risks
- Evaluating the level of mandatory training required for staff expected to undertake restraint and ensuring that all staff complete training
- Implementing all aspects of NHS Lothian's Incident Management Policy and ensuring that all incidents relating to restraint are reported using the Datix System.
- Accessing support and specialist advice from NHS Lothian Health and Safety Department, The Management of Aggression Team and Risk Management
- Facilitating post incident support strategies and ensuring that all staff and individuals affected by incidents of restraint are supported appropriately

5.4 All staff are responsible for:

- Taking reasonable care of themselves, and any other people whom may be affected by their actions.
- Following all policies and procedures designed to ensure safer ways of working and the delivery of safe and effective patient care

- Contributing to the risk assessment process, following individual restraint risk assessments and care plans and completing mandatory training to the appropriate level.
- Reporting all incidents and near misses that may affect the health and safety of themselves or others, using the Datix system in line with the incident management policy.
- Reporting any dangers they identify or any concerns they might have in relation to implementation of restraint.

6. What Constitutes Restraint?

6.1 Physical restraint

Physical restraint involves holding a person, moving them, or blocking their movement to stop them leaving an area.

6.2 Mechanical restraint

Mechanical restraint involves the use of equipment to restrict a person's movement, directly or indirectly. Examples include: bedrails, the use of furniture to restrict movement, chairs with belts, mittens to prevent removal of medical devices, locked doors, baffle locks, keypads, emergency response belts as well as other mechanical means.

6.3 Chemical restraint

Chemical restraint is the use of medicine purely to control or moderate an individual's behaviour. This includes covert medication administration, such as concealing medicine in food or drinks and administration of medication against someone's will.

Please refer to:

NHS Lothian Safe Use of Medicines Policy & Procedures

NMC Position Statement on the Covert Administration of Medicines

6.4 Psychological restraint

This involves telling people what they can and cannot do for example, what time to go to bed and get up in the morning, removing belongings such as outdoor shoes or walking aids to prevent people from leaving. Observation levels and staff escort may also be defined as psychological restraint.

6.5 Technological surveillance

This includes the use of closed circuit television, electronic tagging, and alarmed door to alert staff to an individual leaving the area.

7. What is potentially legally and ethically justifiable?

7.1 If an intervention is being used with the primary aim of stopping a person from doing what they appear to want to do, then it can be defined as restraint. Restraint can be an acceptable and useful component of care in some situations, and potentially the only option in an emergency situation.

7.2 Whenever restraint is used, there are some universal principles that must always be adhered to:

- The behaviour must be causing or have the potential to cause harm to the individual, others or serious damage to property.
- Any form of restraint used must be necessary and proportionate.
- A risk assessment should be conducted balancing the risks of restraint with the risks of not using restraint.
- All alternatives to restraint must have been considered and if appropriate implemented (except in emergency situations see paragraph 14).
- Restraint must not be used for retaliation, retribution, or 'teaching someone a lesson'

Restraint may also be justifiable when:

- An individual requires treatment and or the needs to be maintained in a secure environment by legal order, for example under the Mental Health Act or Home Office restrictions

8. Risk assessment for restraint

8.1 A risk assessment should be conducted, balancing the risks of restraint with the risks of not using restraint.

8.2 Restraint can present risks to the patient and any such risks must be considered before decisions about restraint are made. However not using restraint in a situation in which the patients is causing harm to themselves or to others, also presents a significant risk.

Some examples of potential risks are:

- The use of physical restraint is associated with risk of positional asphyxia; however physical restraint may be the only effective option where risk of imminent serious harm is presented.
- All staff implementing physical restraint must have completed Restraint training with NHS Lothian's Management of Aggression Team, which will include physical intervention skills and training regarding the risks of physical restraint and positional asphyxia. Please see section 13. Training for physical restraint.
- Use of bedrails to prevent falling from bed can result in a potentially increased risk of injury if the patient climbs over the rail and falls from a greater height, than they would have been if they had falling from bed. In some circumstances the use of bedrails maintains the patient's

safety and does not increase the risk of injury. Please refer to NHS Lothian Protocol for Using Bedrails Safely and Effectively:

- The use of medication to moderate a patient's behaviour can result in side effects which may make the behaviour more difficult to manage. However use of medication can also help disturbed patients manage anxiety in a positive way. Please refer to NHS Lothian Safe Use of Medicine Policy:

8.3 In areas/wards where restraint care plans are utilised, the care plan must incorporate the components highlighted in the restraint risk assessment, these include

- Type of behaviour and associated risks
- Assessment of underlying/contributing factors
- Alternatives that are to be considered/implemented
- Plan for intervention
- Potential risk to patient and/or others
- Resource requirements eg staff, equipment, training etc
- Consultation process eg patient, MDT, family
- Plan for review with timescales

9. Human Rights Act

9.1 The Human Rights Act (1998) ensures that individual's human rights are respected by public authorities (which includes NHS boards) and makes it unlawful to act against peoples human rights.

The articles of the human rights act that are relevant to restraint are:

9.2 Article 2 - Right to life.

A person has the right to have their life protected by law. Staff may use restraint and force to stop and prevent imminent threat to life or serious harm being caused.

9.3 Article 3 - Prohibition from torture including inhuman or degrading treatment.

This right is referred to as an 'absolute right' and should never be contravened. It is therefore unlawful for any person to use force with the intention of causing inhumane and degrading treatment and or punishment or for the purpose of torture.

9.4 Article 5 - Right to liberty and security.

This right is referred to as a limited right and in some circumstances it may be legitimately taken away, for example when people are arrested on criminal charges. Under Common Law staff may have to remove a person's liberty in order to prevent harm to the individual or others.

10. Duty of care

10.1 All staff have a duty of care for their patients. This means acting in their 'best interests'. In relation to a patient who is at imminent risk of harm, restraint may be part of the duty of care.

10.2 There are four main ethical principles which must be respected when considering duty of care:

- Intend to do the patient good (beneficence)
- Intend to do the patient no harm (non-maleficence)
- Treat all clients fairly and equally (justice)
- Aid and respect the patient's right of self determination (autonomy)

10.3 There may be situations in which the principles are in conflict with each other, for example, in order to do the patient good (prevent harm) you are required to compromise that person's self determination (by using restraint).

10.4 Duty of care is also set out in law to ensure that individuals owed a duty of care do not suffer any unreasonable harm or loss.

11. Adults with Incapacity

11.1 Before it can be decided what is in the 'best interests' of patients in our care, their autonomy in respect to mental capacity must be considered.

11.2 Adults are always presumed to be capable of making health related decisions unless the opposite has been demonstrated.

11.3 A person's capacity must not be confused with staff's assessment of the reasonableness of a patient's decision. Capacity must be formally assessed by the appropriately qualified professionals.

See: NHS Lothian Obtaining Informed Consent Policy/Procedure.

12. Alternatives to restraint

12.1 Where possible all alternatives to restraint must be considered, before any form of restraint is used. The exception to this is in an emergency situation where consideration of alternatives may result in a delay of action to prevent harm to the individual or others.

12.2 When a patient's behaviour is presenting a potential risk of harm to themselves or others there is a risk that staff focus on managing the behaviour rather than focusing on the underlying cause of the behaviour.

12.3 Before restraint is used an assessment should be conducted which includes consideration of the following factors:

- Aim of the patient's behaviour
- Patient's emotion and psychological presentation
- Patients underlying conditions and treatment
- Impact of the environment
- Patient's mental capacity
- Risks associated with restraint
- Cultural, gender, sexuality, and communication issues
- Duty of care

This assessment can be documented in appendix b –restraint risk assessment or in the patients care plan

12.4 Where possible the issues identified should be addressed using a therapeutic approach with the intention of having a positive impact on the individual's behaviour, therefore reducing or removing the need to implement restraint.

Further information on alternatives to restraint is available via the Learnpro e-learning module – Restraint the Considerations and Alternatives.

12.5 There are some patient groups who may require further consideration and a more specialist approach than this policy can provide, although not exhaustive such groups include:

- Older people
- People with cognitive impairment
- Children and young people
- People with a brain injury
- Pregnant women
- People with a learning disability

If staff require advice regarding management of the above patient group, or advice related to issues of restraint please contact:

NHS Lothian Management of Aggression Team – contact details available via the HR Online:

References for further advice and guidance are also available: See Appendix A - Resources for further guidance

13. Training for physical restraint

13.1 All staff should complete NHS Lothian Management of Aggression training to the appropriate level.

13.2 In the event that individual staff members are unable to undertake training due to injury/illness or are awaiting a place on training, an

assessment of the risk should be taken by the responsible manager and arrangements put in place to manage the associated risks'

13.3 Management of aggression e-learning and theory is aimed at preventing situations escalating to a level where restraint may be necessary. Breakaway training equips staff with the skills required to protect themselves if required.

13.4 Restraint e-learning and restraint training is designed to assist staff in decision making in relation to restraint and to develop the physical skill to implement physical restraint safely. Training is available in low level techniques and high level techniques.

13.5 Staff should not be involved in restraint unless they have completed NHS Lothian Management of Aggression restraint training and the preceding Management of Aggression Theory & Breakaway courses .

13.6 The minimum number of competently trained staff required for a restraint is two. Three staff are required if the patient is to be restrained on the floor (four is best practice). If there are not sufficient numbers of competently trained staff available alternatives such as calling for back up and containing the individual should be considered. NHS Lothian Management of Aggression Team do not advocate one on one restraint.

13.7 In exceptional circumstances staff may use their judgement, skill and knowledge to engage in a situation on their own utilising reasonable force for the purpose of defending themselves or another person being assaulted.

14. Restraint in an emergency

14.1 In some situations staff may have to apply some form of restraint, such as mechanical means or physically restraining a person to prevent clear and imminent risk of harm to the patient or others.

14.2 Reasonable force may need to be used in such situations. The actions must be proportionate to the risk and staff must be able to justify that the actions taken were necessary to prevent harm.

14.3 If there is potential that the individual may require restraint in the future, the patient, their family or carers and the multidisciplinary team should discuss and document the options in a restraint risk assessment and adjust care plans accordingly.

15. Role of security staff in emergency restraint

15.1 Security staff may be required to assist clinical staff in restraint of patients. Before involvement in restraint, security staff must have received training in physical restraint.

15.2 Security staff will only assist in restraint under the direction of the clinical staff with responsibility for the patient. All clinical staff that may be required to

restrain patients and/or direct security staff should have also received the appropriate level of training.

15.3 Security staff should not be left alone to supervise or observe patients. Nursing and/or medical staff should undertake clinical observations of patients during and following restraint.

16. Communication and restraint

16.1 It is best practice to ensure clear communication with patients who require restraint. In some situations this may be foreseeable and the potential for restraint should be discussed with the patient prior to its implementation.

16.2 Simple, clear communication should be used during restraint, with one person taking the lead role in speaking to the patient to avoid confusion. Staff will need to make the decision as to the level and appropriateness of verbal communication in the given situation.

16.3 Following the use of restraint the patient should be de-briefed to explain the decisions that were made and why

16.4 Where there are communication issues due to sensory impairment or language barriers staff should access the appropriate support to enable effective communication as soon as possible. Please refer to NHS Lothian Policy for Translation and Interpreting

17. Restraint as a part of care

17.1 There are situations in which restraint is used to facilitate the delivery of care to an individual.

17.2 Consultative decision making should be used when considering the use restraint to facilitate the delivery of care. Decisions must be discussed with the individual, (irrespective of their ability to consent), family and carers and the multidisciplinary team.

17.3 The decision to use restraint must be fully documented, including:

- The assessment of the behaviour that is indicating the need for restraint,
- The alternatives that have been considered and implemented,
- Any risks associated with the method of restraint and actions in place to control these risks,
- How, when and why the restraint will be used
- Intervals for regular review.

See section 8.3 – restraint care plans

See Appendix B - Restraint Risk Assessment

See Appendix C - Risks of Physical Restraint and Positional Asphyxia guidance

17.4 Restraint should be used for the minimum time period necessary. It is therefore essential that the need for restraint is constantly reviewed and applied only when necessary as dictated by restraint risk assessment and in line with what has been discussed and decided through consultative decision making.

17.5 In some service areas seclusion may be used to manage the risk of harm to self and/or others. In such situations local protocols and procedures must be developed with reference to the Mental Welfare Commissions Guidance and Good practice Document – The Use of Seclusion.

18. Actions following incidents requiring restraint

18.1 Health & Safety legislation requires the reporting of all incidents of workplace aggression & violence, NHS Lothian Incident Management Policy states that these incidents will be reported through the Datix System. The Datix System contains a restraint monitoring section for physical restraint which requires information regarding techniques used and staff involved, documentation of this information is mandatory.

18.2 The use of restraint can cause significant emotional impacts for all involved. Following restraint an incident review should be completed by the staff involved. Consideration should be given to discussing the incident with the patient and anyone else affected, this can be done using a de-brief format.

Guidance on incident review and de-brief is available on HR Online

Appendix A: Evidence Base and Further Guidance

- Mental Welfare Commission - Rights Risks and Limits to Freedom
- Royal College of Nursing “Let’s Talk About Restraint”
- Royal College of Nursing Restrictive Physical Intervention and therapeutic holding for children and young people
- Adults with Incapacity (Scotland) Act
- Human Rights Act
- Mental Welfare Commission – The Use of Seclusion Guidance on Good Practice
- Independent inquiry into the death of David Bennett
- NHS Scotland CRAG Engaging people observation of people with acute mental health problems, a good practice statement
- National Care Standards
- Alzheimer Scotland
- Nursing and Midwifery Council Code of Conduct
- Age Concern Rights for Real: Older People, Human Rights and the CEHR
- Care Commission and Mental Welfare Commission Remember I’m still me

NHS Lothian Management of Aggression Team can also give advice and guidance regarding training, risk assessment and any other aspects of incident management.

This policy should be read in conjunction with:

- NHS Lothian Management of Violence and Aggression Policy
- NHS Lothian Safe Use of Medicine Policy
- NHS Lothian Obtaining Informed Consent Policy/Procedure

- NHS Lothian Protocol for Using Bedrails Safely and Effectively - Adult inpatients
- NHS Lothian Protocol for Using Bedrails Safely and Effectively - Adults patients in the community
- NHS Lothian Policy for Translation and Interpreting

Appendix B: Restraint Risk Assessment



Management of Aggression Team

Restraint Risk Assessment	
Patient Name:	
CHI :	
Describe the behaviour the patient is displaying and the risks it presents:	
Please detail assessment of underlying and contributing factors:	
Alternatives to restraint that have been considered and/or implemented:	
Plan for intervention using restraint:	

What are the potential risks for the patient or others associated with the above plan?

Are there any resource requirements associated with this plan?

Staffing:

Equipment :

Training:

Other:

Who had been involved in the consultation regarding this plan?

When will this plan be reviewed, who will be involved?

Signed:

Print:

Date:

Appendix C Risks of Physical Restraint and Positional Asphyxia – Guidance

In some circumstances physical restraint is the only option available to staff to protect the patient or others from serious harm. However physical restraint is not without risks and staff working in areas in which restraint may be required must make an assessment of these risks balanced against the risks of not implementing physical restraint.

Over the past 30 years there have been more than 15 restraint related deaths in health and social care settings in the UK. Some of these deaths have been attributed to positional asphyxia or this had been cited as a contributory factor (asphyxiation due to the position and individual is left or held in). The aim of this guidance document is to ensure that staff are aware of the risks of physical restraint and informed to make risk assessments where restraint may be necessary. NHS Lothian's Restraint the alternatives and considerations policy should also be accessed for direction and guidance.

Of the 15 cases of restraint related death there were common themes that emerged:

- Method of restraint – neck holds, hog tying, basket holds and prone restraint (face down)
- Multiple staff restraining a patient (more than 4) resulting in pressure on the back and neck of the patient. Staff applying restraint incorrectly or with poor technique resulting in pressure on the neck and back of the patient
- Restraints on beds and sofas face down
- Clinical issues – Obesity, illicit drug use, and mental illness
- Prolonged struggles (between a few minutes and 90 minutes of full exertion)
- Excited or agitated delirium

Each of the above issues will be discussed in further detail in this guidance

NHS Lothian use physical intervention techniques specifically for use in health care that do not use deliberate infliction of pain to gain compliance, ensures that the patient is able to breathe effectively during restraint and have been medically risk assessed for safety.

The physical restraint methods of neck holds, hog tying and basket holds should not be used in NHS Lothian due to the risks they present.

Neck holds – Pressure exerted on the wind pipe and/or on the carotid arteries can rapidly induce unconsciousness and death.



Hog tying – Patients legs and arms are both held or tied behind their back with the patient in a face down position. This position results in hyper-expansion of the chest wall which makes effective breathing difficult. If the patient is carrying excess abdominal weight, this weight is pushed upwards into the diaphragm further restricting breathing. If the patient is been held and downwards pressure is exerted through the back this may result in severely limited respiration.



Basket holds – in this position a patients arms are cross across the front of their body and secured by a member of staff from behind. This can be done in a seated or standing position by one or two staff. Again the inwards and upwards pressure exerted across the patients abdomen pushes up towards the diaphragm limiting the lung capacity. If the patient is bent over (seated or standing) lung capacity is reduced even more.



Multiple Staff restraining a patient

In NHS Lothian this means more than 4 people in a take down to a floor restraint (one restraining each arm, one restraining the legs and one person leading the restraint, protecting the head and monitoring breathing). For a take down to the floor four members of staff is best practice, for face up trolley and bed restraint three staff are required and for standing holds and seated restraint two members of staff are required.

In extreme circumstances further staff may be brought in to reinforce existing restraints however there must not be any pressure on the neck or back area of the patient. If staff are struggling to maintain restraint, technique should be checked and the option of another member of staff taking over the restraint should be considered before using additional staff in the restraint.

When staff are not trained or apply restraint incorrectly there is a risk that in order to maintain control they get more and more staff involved. When staff are not trained and do not understand the risks there is potential that they control the patient by using their body weight to restrict movement. This results in compromised breathing ability and the risk of fatality.

Restraints on sofa's and beds face down

There is no safe technique to get a patient face down onto a bed for restraint, neither is there a safe technique to get them from a sitting position on the side of a bed to a face down position. When patients are restrained on beds or sofas it is very difficult for staff to gauge the amount of pressure being applied. A far greater pressure can be applied to a patient on a bed or sofa than can be applied to a patient on the floor without causing discomfort. As the bed or sofa yield under the weight of the patient and prevents the patient from being able to lift their chest and shoulder to enable them to fill their lungs effectively. There have also been deaths during restraint in which the patient has been able to bite down onto pillows, bed clothes or towels placed under the heads which has limited breathing due to the restriction of airway.

Clinical Issues

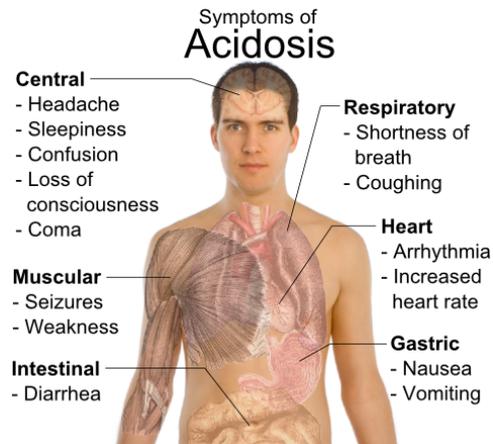
There is a range of clinical issues that can have an impact on the safety of physical restraint for patients:

- **Obesity**
As mentioned earlier, for patients who are obese or carrying excess abdominal weight, face down restraint carries the risks of weight being displaced upwards into the diaphragm limiting lung capacity.
- **Mental illness**
The delusional ideas that a mentally ill patient may be experiencing can result in extreme fear, this leads to catecholamine stress on the heart and this fight or flight response may drive prolonged struggles.
- **Medication and drugs**
CNS depressants such as alcohol, benzodiazepines, barbiturates, GHB and opiates can all cause respiratory depression.
Neuroleptics have been linked to sudden death in psychiatric patients due to cardiac arrhythmia and respiratory failure.
Administration of neuroleptic medication particularly during restraint may pose a risk by impairing the patient's ability to swallow and expectorate effectively.
Neuroleptic malignant syndrome (NMS) is rare however there are concerns that if its symptoms are not recognised then there is potential that it is managed using restraint and additional neuroleptic medication.
Cocaine and other stimulant recreational drugs have been linked to agitated and excited delirium (see below).
- **Physical conditions**
Medical conditions that effect cardio-respiratory function ranging from the common cold to chronic obstructive pulmonary disease will have an impact on a person's ability to breathe during a restraint.
Sickle cell anaemia causes blood cells to stick together which can block blood vessels and reduce oxygen and blood flow.

Pregnant woman cannot be restrained in a face down position and should not be restrained in a face up position as lying flat on the back cause's compression of the anterior vena cava restricting blood flow in the mother and baby. Pregnant woman should be restrained in a seated or semi-recumbent position (using specially designed furniture).

Prolonged or intense struggles

Prolonged or intense struggles were a factor in many of the restraint related deaths in the UK. The time factor in cases of restraint related death varies from a few minutes to 90 minutes of intense struggle. Intense struggling increases the body's requirement for oxygen if the patient in being restrained breathing may already be compromised. Excessive and continuous muscle metabolism resulting from an intense struggle leads to severe acidosis (see below):



When patients are admitted following contact with the police staff should find out what has happened to the patient whilst in police custody as this will have an impact on the risk factors once the patient is receiving care and treatment.

Excited or agitated delirium

Excited or agitated delirium can result in death due to exhaustion from mental excitement. This condition can occur due to mania, psychosis and stimulant use. The symptoms commonly exhibited are:

- Sustained mental and motor excitement
- Confusion
- Agitation
- Hyperthermia and clammy perspiration (Patients often strip off clothing)
- Hyperactivity (involving potentially extreme exertion)
- Falling blood pressure
- Delirium and death

Patients experiencing excited delirium often need to be restrained as their behaviour may cause risk of harm to themselves or others. Altered pain perception combined with extreme fear may them result in intense and prolonged struggle until the patient collapses or dies.

Prevention of restraint related death

- NHS Lothian's restraint policy gives staff direction in relation to the decision making process around restraint intervention.
- This policy makes it clear that all staff who may be expected to restrain patients should be competently trained to implement physical restraint. The Management of Aggression Team provides training for staff in both high and low level restraint techniques according to the needs of the clinical area.
- The Management of Aggression Team also run Advisor training courses for staff so that expertise can be developed and applied in the clinical area.

- The NHS Lothian Restraint policy dictates that risk assessments should be undertaken and documented in relation to individual patients restraint needs. This should be done via consultative decision making involving the multi-disciplinary team, the patient and their family or carers.
- This guidance document aims to explain the risks to staff who may be required to restrain patients so that they make an informed assessment of the potential risks.
- Restraint should be avoided where possible as there is no type of physical restraint that is 'safe' or risk free. Prone (face down) restraint has been cited as a factor in restraint related deaths however prone only refers to the face down position of the patient and not the type of restraint applied.
- Prone restraint is the most secure physical restraint intervention option, and is often the only option when managing extreme aggression. Lower level options such as seated restraint are encouraged when the risks can be safely managed in this way. There may be patients who due to physical conditions, drugs (prescribed and illicit) and mental state it would present too great a risk to place in a prone restraint.
- When implemented as taught by the Management of Aggression Team prone restraint is secure, there is no pressure placed on the patients back or neck and every opportunity for the patient to breathe freely is promoted. Observation of the patient's airway, breathing and circulation is reinforced during training as an essential component of restraint.

Evidence base and further reading:

- Paterson B, Stark C, Saddler D, Leadbetter D, Allan D, **Deaths associated with restraint use in health and social care in the UK. The results of a preliminary Survey**, Journal of Psychiatric Mental Health Nursing, 10, 3-15, 2003
- Morrison A, Sadler D, **Death of a psychiatric patient during physical restraint. Excited Delirium – a case report**, Medical Science Law, 41 (1), 46- 50, 2001
- **The lethal hazard of prone restraint: positional asphyxiation**, Protection and Advocacy INC Investigations Unit California, Publication number 7018.01, 2002
- NHS South Central, Board Paper HA06/037, **Report into the Treatment and Care of Geoffrey Hodgkins**, South Central Strategic Health Authority 2006

- Royal College of Nursing **“Let’s Talk About Restraint”**