

## **Therapeutic Restrictions – Guidance for staff**

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**This guidance may evoke concerns addressing the following policies/guidance:**

- **Safeguarding Adults**
- **Mental Capacity Act**
- **Deprivation of Liberty Safeguards**

Please refer to the relevant guidance or contact the Trust  
Safeguarding Adults team for advice

In delivering care there may be some cases where what is perceived as restraint is necessary as an element of care planning/delivery. This is termed as Therapeutic Restrictions as the therapeutic restrictions involved follow guidance from the Mental Capacity Act and adhere to the 5 principles to support a patient who is assessed at that time to lack capacity and clinicians are requested to act in their best interests proportionately to the risk of harm and in the least restrictive, regularly evaluated method.

The multi disciplinary team needs caring but practical solutions, which are responsive to patients' individual circumstances.

Therapeutic restrictions are sometimes the only option in some circumstances, but it should only be used when other interventions have failed.

**Therapeutic restrictions are a last resort and its inappropriate use is a form of abuse and could lead to civil or criminal proceedings.**

If therapeutic restrictions are used, it should be carefully monitored.

All staff working for York Teaching Hospital NHS Foundation Trust in community and hospital settings are required to have an understanding of this guidance and how it affects their role.

Only a small proportion of staff (chiefly security) are trained to undertake the sort of physical intervention that would be required to hold an individual with reasonable force in an emergency situation.

This guidance aims to raise awareness in relation to the different forms of therapeutic restrictions (see definitions below)

**The policy does not cover the use of therapeutic restrictions in relation to caring for children. The paediatric department follow the RCN Guidance – Restrictive Physical Intervention and therapeutic holding of children found at:**

[http://www.rcn.org.uk/\\_data/assets/pdf\\_file/0016/312613/003573.pdf](http://www.rcn.org.uk/_data/assets/pdf_file/0016/312613/003573.pdf)

## Definitions

### Therapeutic restrictions

The Mental Capacity Act (2005) describes therapeutic restrictions as:

- “The use, or threat of use, of force to secure the doing of an act which the person resists”
- “The restriction of a person’s liberty of movement, whether or not they resist”

**Physical Therapeutic restrictions** - are the positive application of force for the purpose of overcoming another person’s resistance. It may involve one or more members of staff holding the person, moving the person, or blocking their movement to stop them from leaving.

**Physical Intervention** – is the direct action by staff holding or moving a person or blocking movement to go where the person wishes.

**Mechanical** – use of belts, cuffs, splints or helmets to limit movement

**Chemical** – the use of drugs to moderate people’s behaviour. This can include rapid tranquilisation and also includes the use of covert medication and its implications.

**Medical** – is the fixing of medical interventions such as catheters, drips to deliberately restrict movement or such equipment being positioned to prevent removal.

**Environmental** – is designing the environment to limit people’s ability to move as they wish. Examples are:

- Locked doors
- Complicated door handles
- Poor lighting/heating
- Electronic keypads

**Minimum Force** - To use the smallest amount, extent, size or degree of necessary control.

**Reasonable Force** - Such force as is reasonable and proportionate under the circumstances in order to prevent or repel the act.

**Common Law** – Is law developed through the courts and tribunals rather than through legislation and executive action.

**Consent** – Is the legal means by which a person gives a valid authorisation for treatment or care. This could include giving consent to an agreed form of therapeutic restrictions.

**Deprivation of Liberty** - The European Court of Human Rights has identified the following as factors contributing to the deprivation of liberty:

- Using therapeutic restrictions, including sedation, to admit a patient that is resisting
- Exercising complete and effective control over care and movement for a significant period
- Exercising control over assessments, treatment, contracts and residence
- The person would be prevented from leaving if they made a meaningful attempt to do so
- A request by carers for the person to be discharged was refused
- The patient was unable to maintain social contacts because of restrictions placed on access to other people
- The patient loses autonomy due to continuous supervision and control.

**Please refer to the Trust’s Deprivation of Liberty Safeguards and Mental Capacity Act guidance in conjunction with the Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice**

Clinical staff have a duty of care to ensure that an individual's care is;

- Person centred
- In their best interests (where they lack capacity)

And,

Where therapeutic restrictions are used it is;

- Reasonable and proportionate to the presenting circumstances
- Therapeutic restrictions follows the least restrictive pathway
- Applied for the minimum period necessary
- Appropriately risk assessed, planned, implemented and evaluated

The most common reasons for therapeutic restrictions are;

- Threat or actual Physical assault
- Dangerous, threatening or destructive behaviour
- Non-compliance with treatment (for patients lacking capacity)
- Self-harm or risk of physical injury either deliberately or by accident, to self or others – this could include risks associated with absconding, falls
- Extreme and prolonged over-activity likely to lead to physical exhaustion

The flowchart at Appendix 1 covers the decision making process in relation to therapeutic restrictions and appendix 2 provides a “10 step guide” to minimising therapeutic restrictions.

This policy includes guidance on the use of therapeutic restrictions in;

### **Accountability and responsibility**

The Chief Nurse has Board level responsibility for safeguarding adults (this includes MCA, DOLs and therapeutic restrictions)

The Trusts Safeguarding Adults team are available for advice in relation to this guidance

The Trusts Safeguarding Adults Governance Group is responsible for ensuring safeguarding adult procedures and processes are in place and operating effectively across the organisation.

All employees of the Trust have a contractual responsibility to adhere to the policies and procedures of the Trust and should therefore;

- Be aware of the Therapeutic Restrictions guidance and how it affects their practice
- Ensure they are trained to the appropriate level as their role requires and to seek the relevant training (as identified in the training needs analysis and their individual mandatory training profiles)

### **Assurance**

#### Care Quality Commission Outcome Regulation 7

Where any form of control or therapeutic restrictions is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or therapeutic restrictions being;

- (a) Unlawful; or
- (b) Otherwise excessive.

#### Clinical Commissioning Groups and Safeguarding Adults Board

As a minimum Clinical Commissioning Group expect the following;

Availability of copies of Mental Capacity Act Codes of Practice in all relevant wards/units within the organisation which will include guidance on restraint (therapeutic restrictions) on page 105.

Guidance in place, for staff reference re the Mental Capacity Act

Ensure processes are in place asking about and recording if a person has an advance decision on receiving medical treatment, or record if people have a LPA (Lasting Power of Attorney, IMCA (Independent Mental Capacity Advocate) or RPR (Relevant Person's Representative)

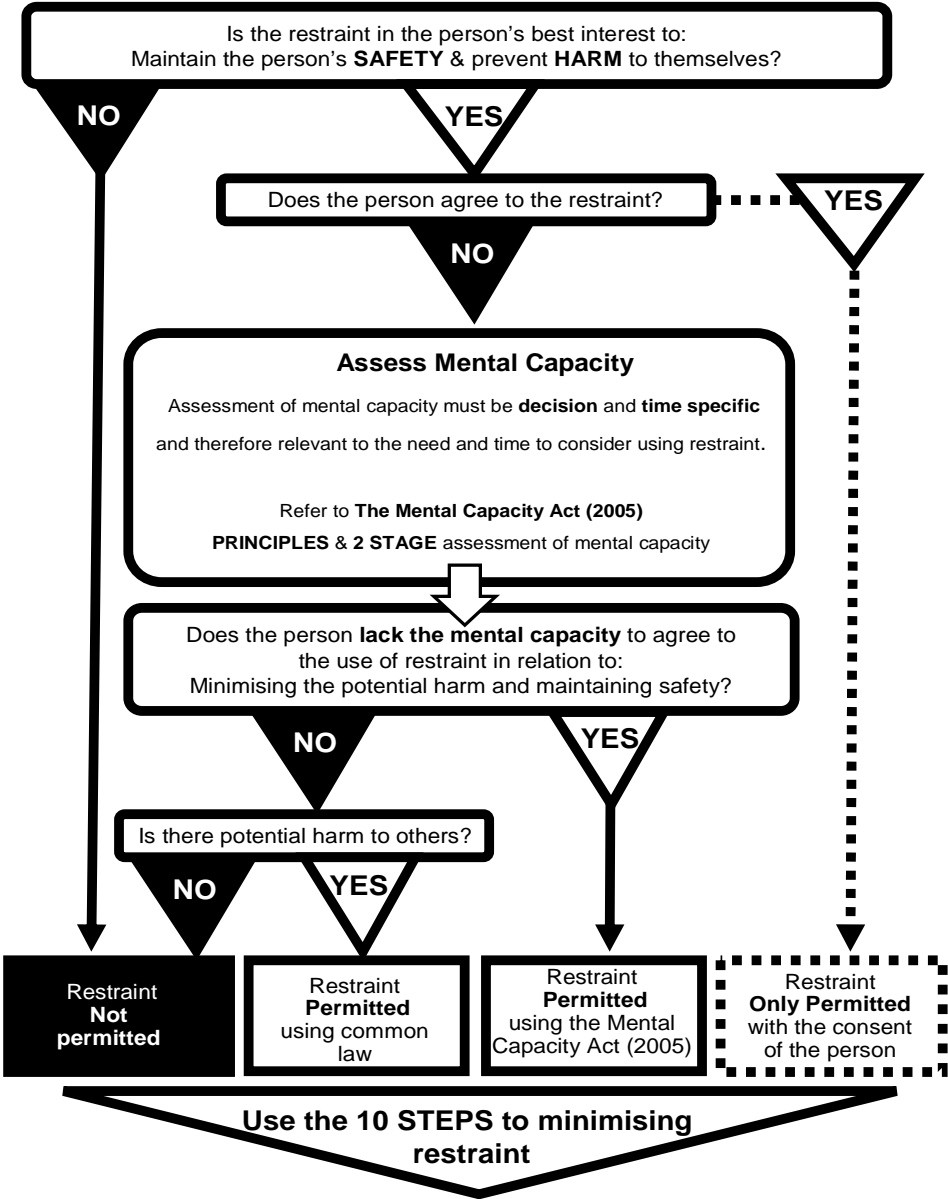
That staff are trained and understand when and how to use the Mental Capacity Act; including induction training where this is relevant to their role

## **14 Appendices**

Appendix 1	Decision making flowchart
Appendix 2	10 steps to minimising therapeutic restrictions
Appendix 3	The use of therapeutic restrictions in emergency situations
Appendix 4	The use of therapeutic restrictions as part of care planning/delivery
Appendix 5	Care Plan for one-off Therapeutic Restrictions
Appendix 6	Documentation requirements (planned therapeutic restrictions intervention)
Appendix 7	Documentation requirements (emergency therapeutic restrictions intervention)
Appendix 8	Rapid Tranquilisation (Extract from Emergency Department Doctors Handbook)

# Therapeutic restrictions Decision Making Flowchart

## Restraint Flow Chart





# 10 steps to minimising Therapeutic Restrictions

### Restraint Guidance Summary: 10 STEPS

## 10 STEPS to minimise the use of restraint

#### 1. Use A Person Centred Care Approach

Understand the individual's history, needs and preferences and underlying reasons for their behaviour. Considered the patients race, beliefs, age, size, gender and health status

#### 2. Is it in the person's best interests?

Is the restraint necessary to maintain the individual's safety and to prevent harm to themselves and / or others?

#### 3. Involve others in decision making

Where possible, discuss with the patient, The Multidisciplinary Team (MDT), other staff, relatives, friends, partners and carers

#### 4. Assessment of mental capacity

**Does the person lack the mental capacity to make a decision in relation to the need to consider restraint?**

Assessment of mental capacity must be both decision and time specific and therefore be relevant to the need and time to consider using restraint.  
Refer to The Mental Capacity Act (2005) **PRINCIPLES & 2 STAGE** assessment of mental capacity

#### 5. Review all alternative options

Are there other less restrictive options available?

#### 6. Consider the least restrictive option available and which can be employed for the minimum amount of time.

Does it maximise a person's independence and choices?

#### 7. Is the restraint proportional to the potential harm?

#### 8. Care plan: Record actions and outcomes

**5 QUESTIONS:** Why? Who? When? What? Where? How?  
Have the relevant people been informed?

#### 9. Support and communicate with the patient and others involved

Share knowledge and skills and debrief if appropriate.

#### 10. Review and evaluate

Aim to minimise the use of restraint and move towards and less restrictive option.

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Refer to: **RCN (2008) "Let's talk about restraint" Rights, risks and responsibility**  
**Mental Capacity Act (2005) Code of Practice**

## Appendix 3

### **The use of therapeutic restrictions in emergency situations**

In general, therapeutic restrictions are used to prevent harm, either to the person who is being restrained or to other people. A member of staff is expected to take action that would calm the situation rather than provoke further aggression (de escalation). In most circumstances therapeutic restrictions can be avoided by positive changes to the provision of care and support to the patient. Therapeutic restrictions are only to be used, therefore, where all other methods of management/de-escalation have failed.

Under no circumstances must therapeutic restrictions be used as a means of reducing workload. If therapeutic restrictions are being considered the following options should be evaluated;

- What hazards are immediately apparent or could be expected
- What is the risk to the safety of the patient, other patients, the staff or others
- What is to be achieved and are the necessary skills available to achieve the aim
- What specialist help needs to be called upon?

Where a patient's behaviour poses an immediate significant risk to themselves or others, urgent medical, and if appropriate mental health assessment must be sought. Therapeutic restrictions may be appropriate in this case. In some instances the use of rapid tranquilisation may be necessary. Guidance on the use of rapid tranquilisation is shown at Appendix 8.

The decision to use therapeutic restrictions to deliver care to a patient can only be made by clinical staff (i.e. a qualified member of the medical/ nursing staff or allied health professionals caring for the patient concerned) in consultation with security services as appropriate.

**The rationale for this should be documented in the patient medical records.**

Particular care must be taken to avoid using more than reasonable force to quell a disturbance, therefore only use the minimum force genuinely believed to be necessary to prevent harm. The use of

excessive and disproportionate force may constitute a criminal act and may result in criminal charges being brought against the individuals concerned. It may also result in a complaint and/ or claim against the Trust and/ or individuals concerned.

Physical therapeutic restrictions should only, therefore, be used as a last resort where there is a potential danger to the patient or others and when other methods have proved ineffective or have been considered and rejected. Therapeutic restrictions should last no longer than is necessary to deal with the immediate risk.

**Staff should NOT physically restrain a patient. In these circumstances security staff must be called, if security services are unable to respond immediately the police should be called**

It is accepted that owing to the urgency of the situation it may not always be possible to undertake a risk assessment or a mental capacity test.

To summon support from Security in an emergency contact switchboard via 6666 and they will fast bleep for assistance in less urgent circumstances security can be contacted via bleep 995.

Clinical staff will be expected to provide the attending personnel with any applicable Mental Capacity Act or Deprivation of Liberty status information. When a person is being restrained by security staff or the police a member of the clinical team should remain present to ensure the continuing health care needs of the patient are being met.

For detailed information refer to the Trust Security Policy.

### **Preventing Patients from leaving the hospital site**

Decisions in relation to this should be made according to individual circumstances and by considering the patient's best interests. If a patient has capacity (See Mental Capacity Act Guidance or Code of Practice) then staff should follow the Trust self-discharge procedure.

Under the Mental Capacity Act if a patient has capacity the Trust cannot prevent them from leaving even if it is viewed an “unwise” decision.

If a patient lacks capacity and is being prevented from leaving the hospital site then consideration should be given to whether a DOLs application is required (See Deprivation of Liberty Policy).

Preventing a patient from leaving hospital site will ordinarily be in response to an emergency situation and as such attract the support of security.

## Appendix 4

### **The use of therapeutic restrictions as part of care planning/delivery**

In some instances therapeutic restriction is a necessary element of care planning/delivery providing it is appropriately risk assessed, planned, delivered and regularly reviewed.

Guiding principles to planning care which may involve therapeutic restrictions are;

- To use the least limiting process
- The intervention must be in the patient's best interest
- To constantly re-assess to ensure the response remains proportionate
- To ensure that the Mental Capacity Act implications are considered and that the treatment remains in the best interest of the patient
- Any treatment must be justified and documented (see appendix 5)

The following list provides some examples of therapeutic restrictions that may be acceptable as part of care planning/delivery (the list is not intended to be exhaustive);

- Use of cot sides/bedrails - See Trust Policy
- Use of mittens to prevent removal of essential equipment
- Use of cuffs to prevent removal of invasive devices
- Sedation

One-off Therapeutic Restriction Care Plan

York Teaching Hospital   
NHS Foundation Trust



Safeguarding Adults

CARE PLAN FOR ONE OFF THERAPEUTIC RESTRICTIONS

<b>Patient Details (label)</b>	<b>Date</b>	
	<b>Ward</b>	
<b>Method of Therapeutic Restriction</b>		
<b>Medical Rationale</b>		
<b>Checklist</b>	<b>Date/time</b>	<b>Name (print) and signature</b>
<b>Capacity Assessed</b>		
<b>Assessment in notes</b>		
<b>Best Interests discussion with NOK (document discussion in notes)</b>		
<b>If no NOK refer to Safeguarding Adults team (01904 726296/4526 or 01723 236217) for Independent Mental Capacity Advocate</b>		
<b>This method is least restrictive</b>		

<b>method (Document in nursing notes alternatives explored)</b>			
<b>This method is proportionate to risk of harm</b>			
<b>Method evaluation</b> <i>Eg: Regularity of observation/evaluation, method remains appropriate to deliver care/treatment plan</i>	<b>Comments</b> <i>Eg: tolerating well. Skin not jeopardised? No evidence of harm. Note any improvement and recommendations to withdraw method of restriction</i>	<b>Date/time</b>	<b>Name (Print) and signature</b>
<input type="checkbox"/> <b>PLEASE INFORM SAFEGUARDING ADULTS TEAM WHEN THIS PLAN IS COMMENCED.</b> <input type="checkbox"/> <b>IF THIS METHOD CONTINUES FOR LONGER THAN 72HOURS PLEASE CONSIDER APPLICATION FOR AUTHORISATION OF DEPRIVATION OF LIBERTY SAFEGUARDS – contact the Safeguarding Adults Team for paperwork and support.</b>			

## Appendix 6

### Documentation Requirements - Planned therapeutic restrictions intervention

In some instances therapeutic restrictions is an acceptable element of care planning/delivery providing it is appropriately risk assessed, planned, delivered and regularly reviewed.

#### What documentation should be completed?

- **Risk assessments that:**
  - Recognise the wider scope of therapeutic restrictions including possible environmental, chemical and cultural therapeutic restrictions.
  - Are relevant for the risk assessment of identified route care delivery which may involve therapeutic restrictions.
  - Are individualised.
  - Are relevant for specific situations, and not generic.
  - Use information included within the person's care plan.
  - Balance the activity with potential for the risk of harm occurring to the patient, staff or others, if either therapeutic restriction is not used or from the therapeutic restrictions itself.
  - Involve the person using services and / or others people important to the person using services.
  - Use a multi disciplinary approach.
  - Explore alternatives to therapeutic restrictions
  - Focus on prevention and/or minimisation
  
- **Evidence of monitoring**
  - Any planned therapeutic restrictions should be **monitored** and regularly reviewed to ensure that they are still appropriate to meet the need and are part of a more proactive approach to reducing the impact care delivery.
  
- **Mental Capacity Act**

Recording should show evidence of consultation with any legally appointed representatives and Mental Capacity Act documentation such as:

  - Assessment of Capacity
  - Best Interest discussions



- Consideration of Deprivation of Liberty Safeguards
- Involvement of an Independent Mental Capacity Advocate where a patient is “unbefriended”, i.e. no appropriate next of kin.

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**Information for family/carers**

Where therapeutic restrictions may be used to carry out routine delivery of care and treatment on a regular basis consideration should be given to the production of information leaflets for family/carers.

## Appendix 7

### **Documentation requirements in unplanned (emergency) therapeutic restrictions intervention (events using reasonable force and effective control to reduce harm to the individual and others);**

When therapeutic restrictions have taken place in an emergency, staff **must** record the actions and decisions taken. The recording should be:

- Clear and consistent
- Completed as soon after the event as possible
- Used to identify why the therapeutic restrictions took place
- Used to detail what happened including;
  - When
  - Who involved
  - How long
  - What form did the therapeutic restrictions take
  - Any injuries
  - Impact of therapeutic restrictions on patient and others

Consider what has been learnt including;

- What did not work well?
- What did work well?
- Any training needs identified
- Any supervision needed for staff involved

## Appendix 8

### **Extract from Emergency Department Doctors Handbook. Rapid Tranquillisation**

Medication is not the first approach to managing disturbed or violent behaviour. The management of the disturbed behaviour is determined by the severity of the disturbance and the risks to the person and others. If the risks are high and imminent, and particularly if other methods have failed, the use of short-acting medication may be indicated.

Assessment of proportionate response to therapeutic restrictions should be applied.

Strategies for managing disturbed behaviour include:

- Engagement
- Distraction
- Low stimulus environment
- Therapeutic restrictions
- Some situations can be managed by administering oral medication.

**Rapid tranquillisation should be considered if:**

- **There is a high and imminent risk of dangerous behaviour,**
- **The patient is severely distressed or at risk of exhaustion,**
- **If other strategies to calm the patient have failed.**

One clinician should take responsibility for co-ordinating the episode. Medical and nursing staff should jointly weigh the risks of administering medication against the risks of not proceeding with rapid tranquillisation.

As far as is possible, the patient's medical condition, working diagnosis, recent substance misuse, current medication (including

all recent PRN), and previous responses or adverse effects to medication should be reviewed.

Information on previous exposure to antipsychotics is particularly important, as this may determine whether, and which, antipsychotic might be administered.

Resuscitation and monitoring equipment must be readily available.

Fully trained staff should be assembled and briefed.

As far as possible, staff should endeavour to preserve the patient's dignity and privacy. Non-pharmacological strategies to calm the patient's should continue throughout.

### **After Rapid Tranquillisation**

After rapid tranquillisation the patient should be physically monitored. The episode and the follow-up review must be fully documented.

The staff involved should review the episode to discuss what happened, any trigger factors, each person's role in the episode and how they feel about it.

Ongoing support should be available

Datix should be completed.