Document Control

Title

Restraint and Restrictive Practices Policy (including paediatrics)

Author	**Author's job title**
	Director of nursing, quality and workforce
Directorate	**Department**
Nursing	Nursing

Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	Apr 2011	Draft	Initial version for consultation
0.2	Sept 2014	Draft to / Final	To the task and finish for approval
0.3	Nov 2014	Final version 3	To Director of Nursing and Director of Finance
1.0	Jan 2015	Final	After executive meeting comments amendments made. Approval by Executive Directors Group and Published on Bob.
1.1	Jan 2016	Amend to final	Patient Safety Alert December 2015 resulted in the need to include this as formal guidance within the policy. NHS England Stage One: Warning *The importance of vital signs during and after restrictive interventions/manual restraint*.
2.0	Jan 2018	Final	Multiple refinements and updates expanded to include paediatrics. Reviewed and approved by the Health & Safety Committee 18 January 2018.

Main Contact	
Northern Devon Healthcare NHS Trust Raleigh park Barnstaple EX31 4JB	**Tel: Direct Dial** – **Tel: Internal** – **Email**:

Lead Director
Director of Nursing

Superseded Documents
Restraint and Restrictive Practices Policy V1.1

Issue Date	**Review Date**	**Review Cycle**
January 2018	January 2021	Three years

Consulted with the following stakeholders:

- Infection Control
- Medicines Management
- Clinical Staff, at NDDH, Community hospitals and in the Community.
- Safeguarding Adult lead
- Learning Disability lead
- Patient Safety Lead
- Governance Lead
- Compliance Manger (for NHSLA documents)
- Local Security Management Specialist

- Learning and Development lead
- Director of Nursing,
- Director of Finance
- Medicines Management
- Consultant Anaesthetist
- Moving and handling specialist
- Community Leads
- Clinical Site Manager
- Security Manager,
- Rapid Response Team Leader
- Specialty Registrar,
- Resuscitation Manager
- Ward Sister Capener Ward,
- Head of Therapies
- Clinical Development Facilitator
- Radiographer
- Senior Sister ICU,
- Consultant Physician
- Consultant Emergency Medicine,
- Matron Community Hospital
- Named Nurse for Safeguarding Children and Young People
- Health & Safety Manager

Approval and Review Process

- Clinical Governance Committee

Local Archive Reference

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Local Path

Community Nursing/Restraint Policy

Filename

Restraint and Restrictive Practice Policy V2.0 Oct2017

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
All staff	Physical intervention, Physical, Restraint, Restrictive, Practice

Contents

1. Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for restrictive practice use. It provides a robust framework to ensure a consistent approach across the whole organisation to safeguard and protect our patients, visitors and staff, and supports our statutory duties as set out in the NHS Constitution.

Restrictive practice may involve the physical containment of a patient by care staff or security, with or without the use of mechanical aids. It may include the use of equipment (for example door locks) to ensure that the patient cannot move out of a prescribed area.

More subtle forms of restrictive practices may also be used, for example removing a walking aid from the patients reach, not supporting an immobile patient if they wish to move or leave the use of electronic devices to alert staff to the movement of a patient, and chemical restraint.

While the emphasis should be on pre-emptive action, wherever possible, in order to prevent the need to restrain, there are some occasions in which the risks to the service user, or others, of inaction may outweigh those of taking action.

This version supersedes any previous versions of this document.

2. Background and Context

Restraint should only be used as a last resort and only when alternative methods of therapeutic behaviour management have failed. Its use should be proportional to the risk of the situation. The method used should be the least restrictive and be effective and safe.

Across the health and social care arena people who present with Behaviour that challenge are at a higher risk of being subjected to restrictive interventions.

Many restrictive interventions place people who use the services, and to a lesser degree staff and those who provide support, at the risk of physical and/or emotional harm (DOH 2014). It is therefore in everyone's best interests to minimise the use of restraint and restrictive practices to a minimum and when they are required use them sensitively and with skill, for the minimal amount of time. They become the last resort.

The government's positive and safe programme has this overarching aim and the Trusts clinically related Challenging behaviour strategy provides the framework for the delivery of safe and effective care (2014).

This policy sets out the best practice guidance for all staff working across Northern Devon Healthcare NHS Trust.

This policy applies to patients who require restrictive practice while receiving treatment; this would include those patients lacking the mental capacity to make specific decisions about their own health and personal safety needs.

3. Purpose

The purpose of this document is to describe good practice related to minimising restraint and restrictive practice, for both planned and emergency interventions, ensuring that were used, it is appropriate and complies with relevant legislation.

Implementation of this policy will ensure that:

- Restraint is well defined and understood. Always treated with the seriousness it requires and is well planned and followed up.
- Care and treatment offered is lawful, legitimate, proportionate, and the least restrictive reasonable option available.
- These issues are applied in line with the principles of the Dignity and Privacy Policy, and the broader principles of dignity, equality, respect, fairness and autonomy.
- People understand what is required of them both within and outside of clinical areas and therefore is applicable to all staff who are patient facing, and those who oversee security of the site and people. Publications from the department of health, clarify the desire for a positive and proactive approach to minimising restrictive practices. Therefore the policy covers this as well as what to do when Restraint is required.
- The policy also clarifies how the workforce will be prepared, through Training and Education to acquire the right skills and competencies to deliver preventative strategies and restraint in the kindest and most helpful way for all concerned
- The Trust's policy is to minimise the use of restraint and restrictive practice to ensure that staff actions and behaviours prior to the use of restraint de-escalate situations and reduce the need for its use. The Trusts challenging behaviour strategy outlines the framework for this.

This policy is designed to define restrictive practice and to allow the practitioner to ensure that the care or treatment that they are offering is lawful, necessary, proportionate, and the least restrictive option reasonably available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

4. Definitions

4.1. Restrictive practice

"Making someone do something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014)

4.2. Restrictive Interventions

"Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and

- Contain or limit the person's freedom for no longer is necessary"

(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

4.3. Physical Restraint

"Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person"

(Positive & Proactive Care: reducing the need for restrictive interventions. DoH. April 2014)

The use of Physical restraint must be reported on the DATIX incident reporting system when there is: direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

The Mental Capacity Act (2005) Section 6(4) of the Act states that someone is using restraint if they: use force - or threaten to use force - to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.

It adds 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.

4.4. Challenging behaviour

Any non-verbal, verbal or physical behaviour exhibited by a person which makes it difficult to deliver good care safely.

4.5. Mental Capacity

Lack of capacity means the inability of a person to make a specific decision (**including consenting to a particular act of healthcare or treatment**) at the time the decision has to be made.

4.6. Deprivation of Liberty

Following a Supreme Court Judgment in March 2014 it is now clear that if a person lacking capacity to consent to their care/treatment arrangements is subject **both to continuous supervision and control and not free to leave**, they are deprived of their liberty.

4.7. Pharmacological or Chemical Restraint

Pharmacological or chemical restraint is defined as…. "A medication used as a restraint to control behaviour or to restrict the patients freedom of movement and is not standard treatment for the patients' medical or psychological condition"

4.8. Rapid Tranquilisation

Rapid tranquilisation is defined by the NICE (DH 2005) as "the use of medication to control severe mental and behavioural disturbance, including aggression associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other less coercive techniques of calming a service user, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a time-limited period of 30-60 minutes, in order to produce a state of calm/light sedation".

Rapid Tranquilisation in children

A decision to initiate rapid tranquilisation in children should only be made by a consultant paediatrician.

5. Responsibilities

5.1. Role of Trust Board

In addition the positive and proactive Care DOH document (2014) suggests the following leadership, assurance and accountability actions.

- A board level, or equivalent, lead must be identified for increasing the use of recovery-based approaches including, where appropriate, positive behavioural support planning, and reducing restrictive interventions.
- Boards must maintain and be accountable for overarching restrictive intervention reduction programmes.
- Executive boards (or equivalent) must approve the increased behavioural support planning and restrictive intervention reduction to be taught to their staff. Governance structures and transparent polices around the use of restrictive interventions must be established by provider organisations.
- Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers.
- Providers must report on the use of restrictive interventions to service commissioners, who will monitor and act in the event of concerns.
- Boards must receive and develop actions plans in response to an annual audit of behaviour support plans.
- Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used.
- Ensuring that the policy is implemented with the appropriate training and monitors are in place for adherence to it ensuring the on-going safe guarding of patients within the Trust's services and the safety of the Trust's staff.
- Assuring itself and its non-executives that the policy is embedded in practice

5.3. Role of Director of Nursing

The Director of Nursing is responsible for:

- Acting as a lead in the implementation of the policy and the safeguarding of the patients in the care of Northern Devon Healthcare NHS Trusts Care
- Ensuring that the appropriate training and monitoring is in place for adherence to this policy

5.4. Role of the Operational Leads

The Operational Leads are responsible for:

- Acting as a lead in the implementation of the policy and the safeguarding of the patients in the care of Northern Devon Healthcare NHS Trusts Care, in their area of responsibility
- Ensuring that the appropriate training and monitoring is in place for adherence to the policy ensuring the on-going safe guarding of patients within NDDH Trusts services and the safety of the Trusts staff
- Reporting through the Trust incident reporting system and acting on incidents which involve restraint to add to the organisations learning and monitor the level of incidents and the learning for their teams.

5.5. Role of all staff

All Staff are responsible for:

- Working to the policy to safeguard patients in the care of the Trust
- All staff must co-operate with the Trust on matters relating to the use of restraint: ensuring they attend appropriate training as outlined in the training matrix available on the Trust's intranet and have read the policy to ensure the on-going safe guarding of patient's within Northern Devon Healthcare NHS Trust's services and the safety of themselves and their colleagues
- Reporting through the incident reporting system and acting on incidents which involve restraint to add to the organisations learning and monitor the level of incidents and the learning for their teams from them
- Working jointly with Social Services colleagues to consider Devon County Council polices and input of DCC DOLs team, this is particular to the clusters and community services, but may be relevant in other settings
- All staff should take reasonable care of themselves and consider their actions and omissions and how that might affect their safety and that of others

5.7. Duty of care, all staff

All health care staff have a **duty of care** for the patients in their care. This means acting in their "best interests". In relation to a patient who is at immediate risk of harm, restraint may be part of the duty of care. Legally there are no precise details as to what comes within one's duty of care.

Four main ethical principles should also be respected where possible when considering your duty of care, although it must be acknowledged that these principles may be in conflict with one another. You should always:

- 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)

The concept of "duty of care" has its origins in **common law** and is the decision of judges in individual cases which is different from the law that is set out in various Acts of Parliament, such as the Mental Health Act (Statute Law or Legislation). Common law changes over time according to the decisions of judges in various cases (Dimond1995) and is often referred to as case law

A Human Rights approach can be achieved by applying the PANEL principles; the table shows the five Panel principles (**See Appendix 1**). When thinking about care and support of people who present with behaviour that challenges the service.

5.8. The importance of vital signs during and after restrictive interventions / manual restraint

In the NHS England Alert (Dec 2015) the need to Identify if vital signs during and after restraint are undertaken appropriately in our organisation, is explicit.

The alert refers to restraint (used as a last resort) in terms of restrictive interventions, seclusion, rapid tranquillisation or manual restraint.

When undertaking restraint or restrictive interventions please ensure vital signs are reliably recorded and acted on during and after restraint (see section 7.4 concerning the frequency of observations).

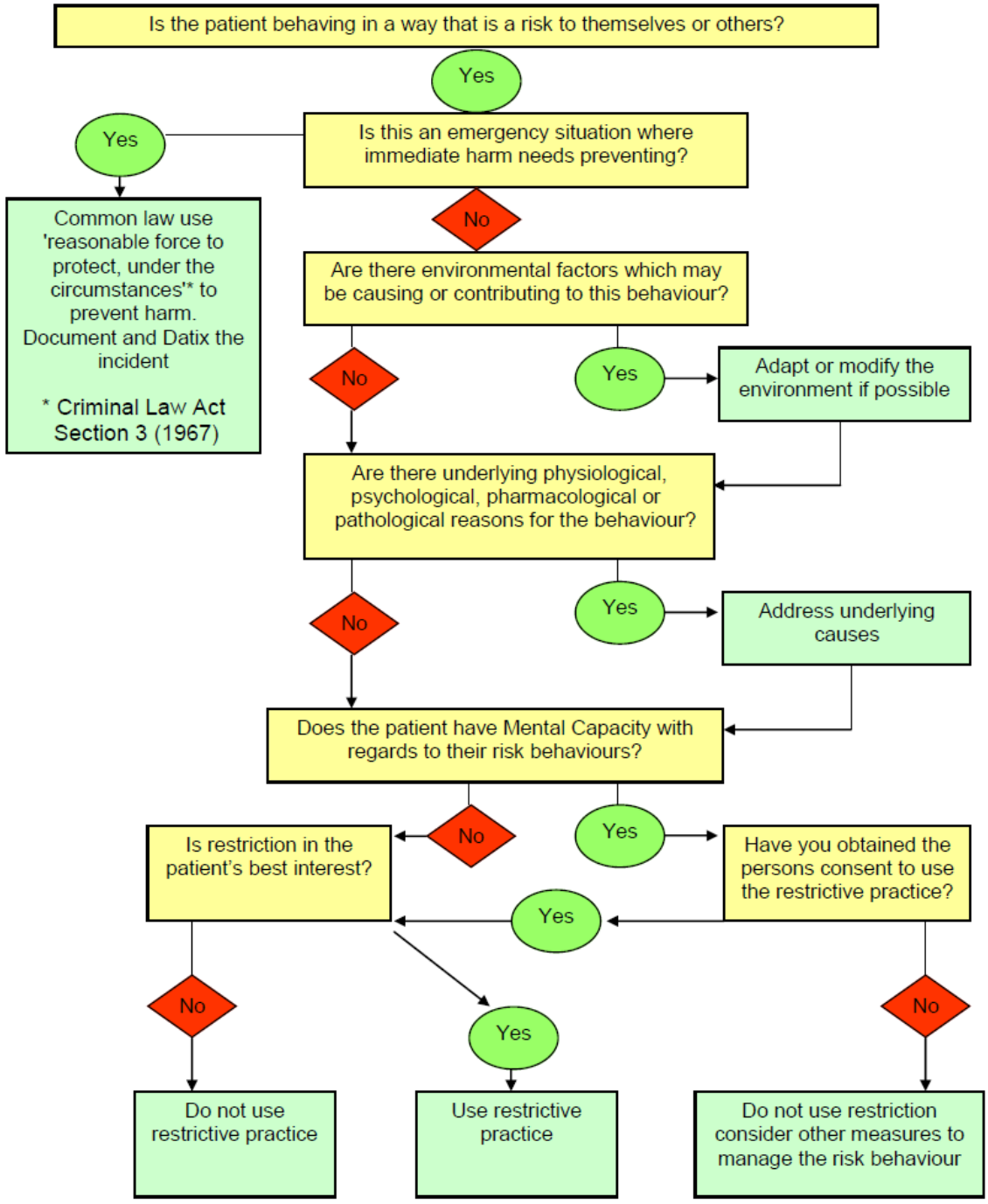
When restraint occurs and is recorded through DATIX (as per policy) please include feedback on the following

(a) If vital signs were recorded and did they require acting upon?

(b) If vital signs were not recorded why was this case? And how else was the safety of the patient maintained.

6. Standards and Practice (Adults)

6.1. Restrictive Practice Flow Chart (Adults)


Is the patient behaving in a way that is a risk to themselves or others?
Yes
Is this an emergency situation where immediate harm needs preventing?
Yes
Common law use 'reasonable force to protect, under the circumstances'* to prevent harm. Document and Datix the incident
* Criminal Law Act Section 3 (1967)
No
Are there environmental factors which may be causing or contributing to this behaviour?
No
Yes
Adapt or modify the environment if possible
Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?
No
Yes
Address underlying causes
Does the patient have Mental Capacity with regards to their risk behaviours?
No
Yes
Is restriction in the patient's best interest?
Have you obtained the persons consent to use the restrictive practice?
Yes
No
Yes
No
Do not use restrictive practice
Use restrictive practice
Do not use restriction consider other measures to manage the risk behaviour

6.3. Types of Restrictions

Restrictive practice is not confined to physical restraint; it also refers to actions or inactions that contravene a person's rights. Listed below are some restrictive categories. It must be remembered that to apply any of these to an individual there must have a lawful and legitimate right and reason to do so. The following list is not exhaustive.

6.3.1. Mechanical restraint

A device used on a person to restrict free movement such as placing a person in a chair which they are unable to get up from.

6.3.2. Environmental restriction

The design of the environment to limit people's ability to move as they might wish, such as locking doors or sections of a building, using electronic key pads with numbers to open doors, complicated locking mechanisms and door handles.

6.3.3. Chemical restraint

The use of drugs and prescriptions to modify a person's behaviour. Medication that is prescribed to be taken 'as and when required' can be used as a form of restraint unless applied responsibly. For more information please refer to: Guideline for 'Guidelines for Rapid Tranquillisation'

6.3.4. Forced care

Actions to coerce a person into acting against their will, for example having to be restrained in order to comply with the instruction or request.

6.3.5. Cultural restriction

Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group.

6.3.6. Decision making

Making a decision on the person's behalf or not accepting or acting on a decision the person has made.

6.3.7. Contact with community

Preventing the person from participating in community activities, including work, education, sports groups, community events or from spending time in the community such as parks, leisure centres, shopping centres

6.3.8. Contact with family and friends

Preventing or limiting contact with the person's friends and family, for example not allowing the person to receive visitors, make phones calls or not allowing contact with a specific friend or family member.

6.5. Unacceptable Methods of Restriction

The following methods of restriction are unacceptable, however if the patient requests or is consenting to any of the following it may be considered and applied as appropriate. This must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following list is not exhaustive.

6.5.1. Inappropriate bed height

This is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed.

6.5.2. Inappropriate use of wheelchair safety straps

The safety straps on wheelchairs should always be used, when provided for the safety of the user. However patients should only be seated in a wheelchair when this type of seating is required, not as a means of restraint.

6.5.3. Using low chairs for seating

Low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

6.5.4. Chairs whose construction immobilises patients

Reclining chairs, bucket seats. Reclining chairs should be used for the comfort of the user and not as a method of restraint.

6.5.5. Locked doors

On the occasion that doors are locked clear signage should be displayed informing patients and the public that doors are locked and who they should ask to have them unlocked to exit the ward. If a patient is asking to leave and being prevented by the locked door that patient is being restricted.

6.5.6. Arranging furniture to impede movement

Other methods of dealing with behaviour such as wandering should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended.

6.5.7. Inappropriate use of night clothes during waking hours

This is demeaning and should not be used as a way of restraining people.

6.5.8. Removal of outdoor shoes and other walking aids and/or the withdrawal of sensory aids such as spectacles

As with the above, these are not acceptable ways of restraining people in any care setting. Removal of sensory aids can cause confusion and disorientation.

6.5.9. Planned prone physical restraint

The utilisation of a planned prone restraint should not be used other than exceptional circumstances e.g. medical reason. Utilisation of seated, supine or release of person to be considered as alternatives.

6.6. Decision making and Assessment

Individual assessment should be carried out that considers:

6.6.1. The patient's behaviour and underlying condition and treatment

Understanding a patient's behaviour and responding to their individual needs should be at the centre of patient care. All patients should be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.

6.6.2. The patient's mental capacity and/or mental health

It is necessary to consider a patient's mental capacity as consent must be gained from patients to use any type of restriction unless they lack capacity to make this decision and the restrictive practice is sanctioned under the Mental Capacity Act or the Mental Health Act.

6.6.3. The environment

Every effort should be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation, negative attitudes of care staff, poor communication skills.

6.6.4. The risks to the patient and to others

When using restrictive practice a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of the patient.

6.7. Assessment should always place the individual at the centre of the process, involving them and those who are important to them in their lives, as is practical to do so. Evidence of a person centred approach to assessment and planning must be recorded.

6.8. If a restriction is deemed appropriate the following points must be considered; the practice needs to have a legitimate aim. It must be necessary in order to protect the health and wellbeing of the individual or to protect the safety or human rights of others (patients, staff, and visitors, public).

All individuals who may be affected by the practice must be involved in the decision making process to the fullest possible extent of their understanding.

The practice that is implemented must be proportional, i.e. the least restrictive practice required to achieve the aim.

Principles of dignity and respect should be observed during the implementation of any restrictive practice.

The effectiveness of the practice in meeting its aims should be continually reviewed and the practice should continue only for as long as it remains both necessary and effective.

If the patient has capacity to give valid consent and their agreement or consent can be gained, without undue pressure, from the person then the restriction can be put in place so long as it does not contravene the law. It must be remembered that the person has the right to withdraw their agreement or consent and they should be informed of this right at the outset.

If the person withdraws their consent but it is felt that the restriction should continue, this can only be achieved if the practice is sanctioned under law; examples include the Mental Capacity Act, Mental Health Act, Criminal Law, and Public Health Act.

6.9. The Deprivation of Liberty Safeguards (DoLS) 2007 (came into force 2009) and the DoLS are an amendment to the Mental Capacity Act (2005). DOLS provide a legal framework to protect those who may lack the capacity to consent to the arrangements for their treatment or care where levels of restriction or restraint used in delivering that care are so extensive as to be depriving the person of their liberty.

6.9.1. Safeguards in England and Wales

The safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. A large number of these people will be those with significant learning disabilities, or older people who have dementia or some similar disability, but they can also include those who have certain other neurological conditions (for example as a result of a brain injury).

6.9.2. Mental Capacity and Deprivation of Liberty

For more information please see Mental Capacity Act Policy and Deprivation of Liberty Safeguards (DoLS) Policy

7. Planned Intervention

If restraint is planned the following points must be considered please also refer to (**Appendix 2** – Restrictive Practices – what should be considered):

- Any proposed restraint should either have the patients consent or if they lack mental capacity to provide consent then the intervention should be in the patient's best interest.
- The restraint needs to have a legitimate aim. It must be necessary in order to protect the health and wellbeing of the individual or to protect the safety and human rights of others (patients, staff, visitors and the public).
- All individuals who may be affected by the restraint must be involved in the decision making process to the fullest possible extent.
- The restraint that is implemented must be proportional, i.e. the least restrictive option available to achieve the outcome required.

- In the case of non-clinical staff implementing the use of restraint, they do not carry medical responsibility for a patient and therefore nursing or medical staff should be in attendance throughout the implementation of a physical restraint intervention for monitoring the patient after the intervention.
- Principles of dignity and respect should be observed during the implementation of any restraint, even on the rare and unavoidable occasions in which restraint has to be used in a public area.
- The effectiveness of the practice in meeting the aims should be continually reviewed and the practice should continue only as long as it remains both effective and necessary.
- Post a restraint event people need to be monitored for 24hrs, and this needs to be clearly documented.

All plans, discussions and subsequent actions should be documented in keeping with professional standards and policy.

7.1. Care Planning

It is essential that any restraint is identified and justified in the care plan. This should include recording which legislative framework is being used to support the restriction.

Any person affected by restriction needs to be involved in the decision making to the fullest possible extent.

Restrictions where possible must be a multi-disciplinary decision, consulting family. Un-befriended patients may require an Independent Mental Capacity Advocate (IMCA).

In cases where it is not possible to establish the persons view, e.g. due to mental incapacity, or urgency of the situation staff will need to consider if the restriction is likely to cause more harm than good.

The proactive approach whenever possible is the best and is about, good initial assessment and an understanding of the antecedents which may result in the behaviour and consequences of restraint.

If we understand what we can do to minimise distress or the likelihood to become aggressive this can avoid the need for restraint (**Appendix 3** – Managing Challenging Behaviour)

7.2. Community Based working

Community teams are frequently lone working, (supported under the lone working policy) in peoples own homes and require equally robust arrangements, to safeguard the patients and themselves as the need for restraint is applied. Strong working relationships and communications with partners, in South West Ambulance Trust, Devon doctors and other providers, is required to assist community teams to risk assess the situations they are walking into.

Teams should work with their partners to be clear this is required at point of referral and why.

7.3. Children and Young People

Details are contained in section 9.

7.4. Physical care and observations during restraint

Any person subject to restraint such as restrictive interventions, seclusion, rapid tranquillisation or manual restraint should have vital signs monitored during restraint and at least every 2 hours post restraint for a period of up to 24 hours. If an approach to the patient might result in harm to themselves or others, at the minimum a visual respiratory rate and a radial pulse can be recorded.

If the patient accepting of more intimate care the check should include:

- Care in the recovery position where appropriate
- Pulse
- Blood pressure
- Respiration rate and pulse oximetry
- Temperature
- Fluid and food intake and output

7.5. Reporting and Recording Restraint

Some departments will have systems and processes for recording the consistent use of restraint when it is part of the clinical planned interventions, for example intensive care units, using chemical restraint during periods of induced sedation.

Radiology departments for the correct positioning, governed by the need to produce a diagnostic image. These instances can be recorded in care plans, medical notes or on information systems as required. This generally acknowledges that the practitioners are aware of the need to use restraint, have included the patient/family in the conversation, and work within the principles of this policy. A separate incident form is not required on all occasion in these incidences.

All incidents of restraint outside of these circumstances or where harm is reported should be recorded and reported using the Trust incident reporting system; this should be a concise report of the type of restraint used, where and why. Care plans and other documents can be attached to the DATIX report for ease of reporting.

Staff should record the following

1. That restraint was used
2. Its duration
3. Who was involved?
4. The outcome/re-evaluation of the potential to need restraint again
5. If vital signs were recorded and did they require acting upon?

6. If vital signs were not recorded, why was this the case and how was the safety of the patient maintained.

The DATIX incident record should be informed by the documentation in the medical notes, with consent and capacity assessment and a core care plan where appropriate. Please ensure the restraint care plan is also completed and kept in the nursing notes.

Through implementation of the being open policy in all instances when restraint is used the relatives or significant others will be made aware and this will be documented. And if the patient is not cognisant at the time about the need for restraint of restrictive practice this must be explained to them as soon as they are. For vulnerable people, all methods must be sought to help them understand what is happening.

Teams should refer to the duty of candour policy in these situations

7.6. Physical and Non-Physical Assault

All incidents (including near misses) of physical assault and non–physical assault, intentional or due to clinically challenging behaviour should be reported on the Trust's incident reporting system in accordance with the Violence & Aggression Policy (follow link for further guidance).

The Local Security Management Specialist will review reported violence and aggression incidents and provide support, advice and guidance to staff. Where appropriate, warning markers may be placed against a patient's healthcare record in accordance with the Trusts Violence and Aggression Warning Marker SOP

8. Emergency Intervention

The legislation surrounding restraint still stands as previously set out. However, due to the very nature of an 'emergency' situation, e.g. to prevent immediate harm to a patient, staff may be required to implement a physical restraint as part of 'use of reasonable force' Section 3 Criminal Law Act Sec.3 1967.

Appropriate action to restrain or remove a person, in order to prevent harm to self or others may be conducted under this basis or under 'common law'.

This should be to resolve emergency situations only, for repeated or prolonged incidents of restraint other authority should be considered, or removal of the individual where appropriate by Security Officers or the police.

8.1. Emergency Response

North Devon District Hospital (Security Officer Emergency Response)

If any member of staff at NDDH feels that a situation is such, that it is beyond their control and there is a threat to their own safety or that of others, the Security staff should be summoned immediately via the Switchboard Operator by dialling 2333 requesting security.

Switchboard will make an immediate response concerning Security attending and incident. The operator will also bleep 500 Clinical Site Manager where the caller requests Site Management support. Clearly state the ward or area requiring assistance and the nature of the incident.

Security Staff are available at NDDH 24/7

The circumstances surrounding any physical intervention must be evaluated as to the appropriate level of attendance required by clinical staff for monitoring where Security Officer is contacted for support. For example:

- **Low Level Physical Intervention:** A security officer escorting a calm patient and returning them to a ward using a low level physical restraint technique such as light holding of the patients arm. Clinical attendance not necessarily required, unless specifically requested by the security officer and / or other staff in attendance.

- **Medium Level Physical Intervention:** A security officer responding to a verbal violence and aggression incident may need to quickly use physical restraint techniques such as a standing hold to prevent an agitated patient from assaulting others. If not already present then clinical staff are required to be in attendance as soon as possible to monitor and assess the person being restrained.

- **High level Physical Intervention:** A physically violent and aggressive patient being unavoidably held on the floor for their safety or the safety of others (Police contacted for assistance). Clinical attendance, support and input essential.

Concerning the use of physical restraint as outlined in the above scenarios, observations and monitoring of vital signs by clinical staff (see section 5.6) is essential and must be undertaken by clinical staff during high level interventions.

An assessment and judgement has to be taken by clinical staff as to if this may also be appropriate for circumstances such as the low or medium level scenarios outlined above. Judgements must be made by clinical staff as to the appropriateness for monitoring of vital signs giving due consideration to the following Patient Safety Alert:

- The Importance of vital signs during and after restrictive interventions / manual restraint. NHS/PSA/W/2015/011.

In non-emergency situations, security officers can be contacted via the Sodexho Helpdesk (ext. 5900) or via the Switchboard Operator by dialling 0.

Trust Wide (Police Emergency Response)

Trust Wide inclusive of North Devon District Hospital and the Community Hospitals where Police assistance is considered necessary, staff must be satisfied that at least one of the following criteria have been met:

- There is a risk of immediate and significant harm to patients or others;
- There is an identifiable and immediate risk to life or property;
- It is reasonably believed that a crime has been committed or is about to be committed; and / or
- Police attendance is necessary to prevent a breach of the peace

EMERGENCY: Dial 9 (internal) followed by 999

8.2. Advice on Restrictive Practice

For further support and advice on the use of restrictive practice please contact:

- Safeguarding Nurse for Adults
- Learning Disability Team
- Psychiatric Liaison Service

9. Restrictive practice in paediatrics

9.1. This section of the policy is designed to define Therapeutic Holding and Restrictive physical intervention and allow the practitioner to ensure the care or treatment that they are offering is lawful, legitimate, and the least restrictive reasonable option available. Where the use of restraint, holding still and containing children and young people is concerned, practitioners must consider the rights of the child and the legal framework surrounding children's rights.

9.2. The purpose of this part of the policy is to guide practitioners to enable them to carry out Restrictive Physical Intervention or Therapeutic Holding in a safe manner which ensures minimal trauma and distress for the child/ young person and their family.

9.2.1. To highlight the necessity for the appropriate use of de-escalation technique, distraction, play therapy and alternative practice.

9.2.2. To highlight the need for good communication, consent, training and documentation.

9.3. Scope

9.3.1. This part of the policy applies to all staff undertaking Restrictive physical intervention or therapeutic Holding in the care of children/young people and infants.

9.4. Specific Definitions to Paediatrics

9.4.1. Restrictive physical intervention: "Deliberate acts on the part of another person(s) that restrict an individual's movement, liberty and/ or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary"

9.4.2. Therapeutic Holding: This means immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively.

9.5. Holding is a skill professionals use to carry out therapeutic interventions. It is not meant to be a quick alternative to carrying out care and should only be used as a last resort.

9.6. Therapeutic Holding is distinguished from restrictive physical intervention by the degree of force required and the intention.

9.7. Alternative terms for therapeutic holding include 'supportive holding' and 'clinical holding.'

9.8. Role of Individual Staff

9.8.1. All staff members are responsible for:

- Ensuring they have up to date training.

- Ensuring they have read and are complying with this policy and seeking advice if they are unsure of any aspect of their care.
- Ensuring they keep a record of events and plan of care for each patient.
- Ensuring they take all practical steps to comply with this policy when undertaking or assisting in interventions with children/young people.

9.9. Standards and Practice

9.9.1. The Principles of good practice.

9.9.2. Effective preparation, the use of local anaesthetic, sedation and analgesia, together with play specialist intervention and distraction techniques, successfully reduces the need for undue force in the use of proactive immobilisation - for example when holding a child's arm from which blood is to be taken or when administering an injection, in order to prevent withdrawal and subsequent unnecessary pain to the child.

9.9.3. However, therapeutic holding without the child's consent or assent may need to be undertaken against the child's wishes in order to perform an emergency or urgent intervention in a safe and controlled manner – for example, in order to perform a lumbar puncture. When considering the use of sedation please refer to the RCHT Guidelines for the sedation of paediatric patients and young people.

9.10. General Principles.

9.10.1. Good decision making about restrictive physical interventions and therapeutic holding requires that in all settings where children and young people receive care and treatment there is:

9.10.2. An ethos of caring and respect for the child's rights, where the use of restrictive physical interventions or therapeutic holding without the child's/young person's consent are used as a last resort and are not in the first line of intervention.

9.10.3. A consideration of the legal implications of using restrictive physical intervention, where necessary, application should be made through the Family Courts for a specific issue order outlining clearly the appropriate restraint techniques to be used.

9.10.4. Openness about who decides what is in the child's best interests – where possible, these decisions should be made with the full agreement and involvement of the parent or guardian.

9.10.5. A clear mechanism for staff to be heard if they disagree with a decision.

9.10.6. A sufficient number of staff available who are trained and confident in safe and appropriate techniques and in alternatives to restrictive physical interventions and therapeutic holding of children and young people.

9.10.7. A record of events. This should include why the intervention was necessary, who held the child, where the intervention took place, the method used, the length of time and any techniques needed to reduce the future need for restrictive physical interventions or therapeutic holding.

9.11. Where any restrictive interventions are utilised as part of a behavioural management plan, a positive behavioural support approach is to be implemented. Here staff will utilise primary preventative strategies where possible, identify patterns of behaviour and secondary preventative strategies used to de-escalate situations, and review effectiveness of any interventions. Tertiary strategies such as restrictive interventions must be reviewed and documented. (Guidance may be required by specialist nurses (e.g. Learning disabilities, paediatric specialists).

9.12. Therapeutic Holding

9.12.1. Therapeutic holding for a particular clinical procedure also requires practitioners to:

9.12.2. Give careful consideration of whether the procedure is really necessary, and whether urgency in an emergency situation prohibits the exploration of alternatives.

9.12.3. Anticipate and prevent the need for holding, by giving the child information, encouragement, distraction and if necessary, using sedation. Involve the play specialist from an early stage. Introduce to the child and family as soon as possible and liaise with play specialist re appropriate techniques following their assessment of the child.

9.12.4. In all but the very youngest children, obtain the child's consent or assent (expressed agreement) and for any situation which is not a real emergency seek the parent/carer's consent, or the consent of an independent advocate.

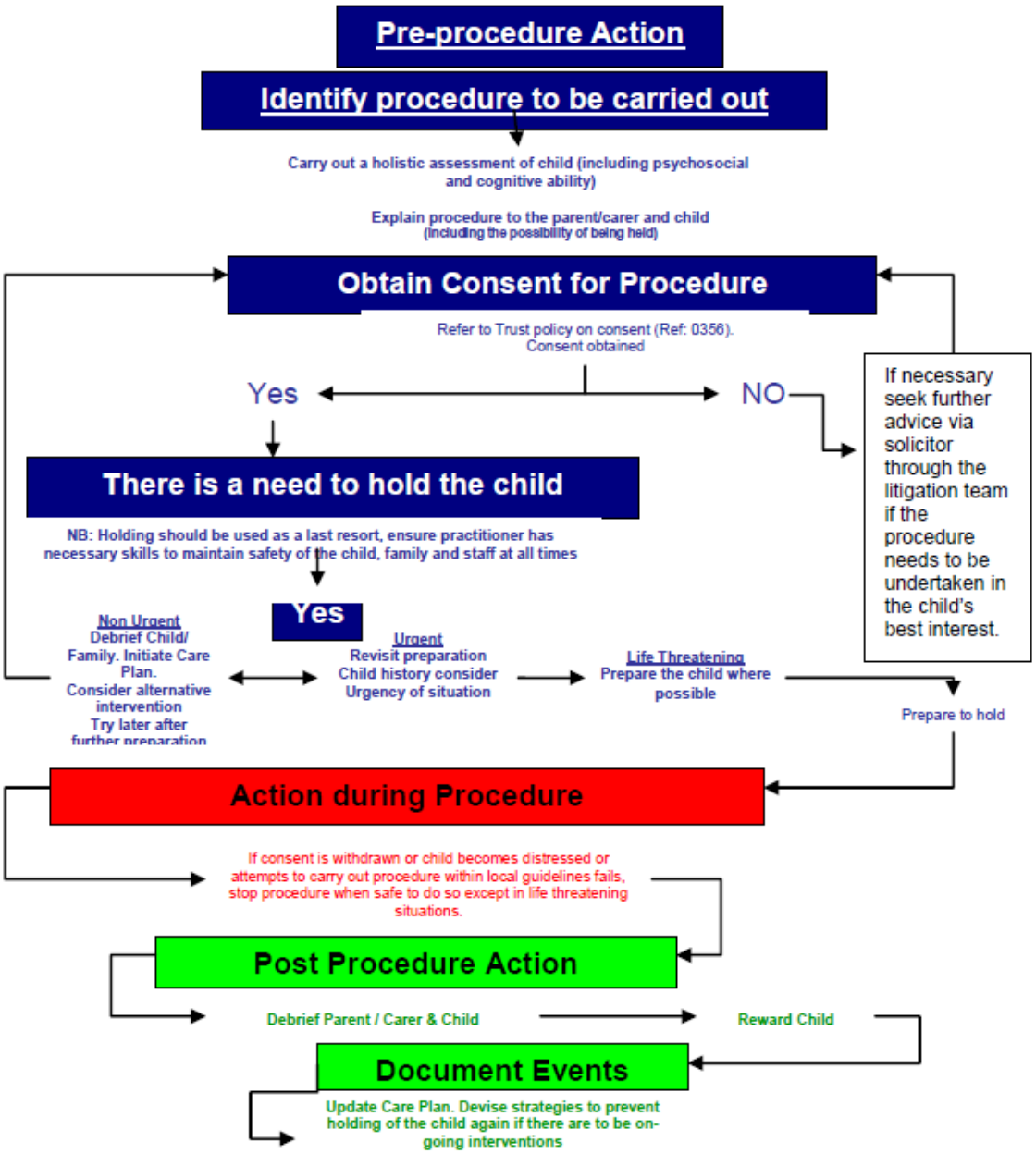
9.12.5. Make an agreement before hand with the parents/ guardians and the child about what methods will be used, when they will be used and for how long. This agreement should be clearly documented in the plan of care and any event fully documented.

9.12.6. Ensure parental presence and involvement – if they wish to be present and involved. Parents/guardians should not be made to feel guilty if they do not wish to be present during procedures. Nurses should explain parents' roles in supporting their child, and provide support for them during and after the procedure.

9.12.7. Make skilled use of minimum pressure and other age appropriate techniques, such as wrapping and splinting, explaining and preparing the child/parents beforehand as to what will happen.

9.12.8. Comfort the child or young person where it hasn't been possible to obtain their consent, and explain clearly to them why immobilisation is necessary.

9.13. Child Holding Algorithm


Pre-procedure Action
Identify procedure to be carried out
Carry out a holistic assessment of child (including psychosocial and cognitive ability)
Explain procedure to the parent/carer and child (including the possibility of being held)
Obtain Consent for Procedure
Refer to Trust policy on consent (Ref: 0356). Consent obtained
Yes
NO
If necessary seek further advice via solicitor through the litigation team if the procedure needs to be undertaken in the child's best interest.
There is a need to hold the child
NB: Holding should be used as a last resort, ensure practitioner has necessary skills to maintain safety of the child, family and staff at all times
Yes
Non Urgent
Debrief Child/ Family. Initiate Care Plan.
Consider alternative intervention
Try later after
Urgent
Revisit preparation
Child history consider
Urgency of situation
Life Threatening
Prepare the child where possible
Prepare to hold
Action during Procedure
If consent is withdrawn or child becomes distressed or attempts to carry out procedure within local guidelines fails, stop procedure when safe to do so except in life threatening situations.
Post Procedure Action
Debrief Parent / Carer & Child
Reward Child
Document Events
Update Care Plan. Devise strategies to prevent holding of the child again if there are to be on-going interventions

9.15. Action During Procedure.

9.15.1. All staff that carries out Restrictive physical intervention or Therapeutic holding must be trained by the nominated trust trainers.

9.15.2. Follow the algorithm in point 11.13 to ensure appropriate preparation and debrief.

9.15.3. A lead person should be identified to coordinate the process. Identify a person to communicate and reassure the child/young person and family throughout.

9.15.4. Consider the child/young person's age and adapt procedure in accordance with training received.

9.15.5. Supportively hold the limb or body in a natural position. Avoid pressure over the face, neck, chest, abdomen, genitalia and soft tissue. Use the whole hand to support around a limb.

9.15.6. Physical restraint must never be used in a way that might be considered indecent, or that could arouse sexual feelings or expectations.

9.15.7. Apply a firm but even pressure when holding ensuring circulation and breathing is not compromised.

9.15.8. Other than exceptional circumstances e.g. due to medical procedure, a person is not to be restrained / held face down. Should a child / young person require physical interventions they are to be turned if required to be held face up (supine) or seated position.

9.15.9. Where incidents require Trust Security to support the individual, officers are to be in constant supervision by care / nursing staff on or from the unit. They will seek guidance from staff in terms of physical and emotional care needs.

9.15.10. Restrictive physical intervention and therapeutic holding Care Plan to be commenced as per algorithm. Methods used and the circumstances in which they are used should be agreed with the parents child/young person and clearly documented in the care plan. For example two unsuccessful attempts at bloods/cannulation should be followed by a rest and change in practitioner.

9.15.11. Incidents resulting from the use of Restrictive physical intervention and therapeutic holding are to be reported on the Trust incident reporting system (Datix). This should be reported by those working in the area where the incident occurred.

9.16. Training.

9.16.1. All staff carrying out Restrictive physical intervention and therapeutic holding will be asked to read and sign to confirm they have read this policy. Restrictive Physical Intervention and therapeutic holding training is provided by those identified within the trust, as qualified to do so, to all staff involved with this practice.

9.16.2. Training must be up to date, relevant, purposeful, evidence based and given by experts. Detailed records of training and proof of competency are essential as well as a system of monitoring competency and regularly updating skills.

9.16.3. Datix incident reports identifying physical intervention activity will be reviewed by the Trust specialist violence and aggression trainers, to monitor activity and provide support and guidance to staff involved, along with quality assured training in terms of appropriateness.

10. A Learning Organisation around Restraint

Monitoring, reporting and learning

- All occasions in which restraint is used must be incident reported afterwards so the Trust can monitor the level of restraint being used and learn from each incident.

10.1. Debriefs following challenging behaviour/incident requiring restrictive practice

This policy recommends a debriefing methodology as a key way of learning from occasions when challenging behaviour has resulted in the need for restraint, here is a description of how this might happen.

Debriefs are distinct from post incident reviews such as 72 hour reports or significant event audits (SEAs). Post incident reviews analyse the incident, to identify weaknesses and learning to prevent it from reoccurring. Debriefs are part of the essential support offered to staff following an incident of challenging behaviour and sufficient time should be allocated for them to take place.

Debriefs should be conducted as a conversation among peers, allowing staff a forum to:

- Reflect on the incident and identify any on-going support or learning
- Share their reactions and feelings in a supportive environment with a 'no blame' attitude
- Consider what might be learned from the experience.

A debrief can be arranged at the discretion of the team leader, but a good knowledge of staff members, their attitudes and normal workplace dynamics will assist in determining whether one is needed. A formal debrief is especially beneficial where the incident was serious enough to cause stress, trauma or distress to those who were involved and should be led by the needs of the worker.

Further information regarding support that can be provided following traumatic incidents can be found in the Supporting Staff Involved in an Incident, Complaint or Claim Policy

Alternatively, for low-level, less serious incidents, staff may request the opportunity to have an open conversation about the incident, or arrange one informally among themselves or discuss at a team meeting.

Debriefs are invaluable for reflecting on an incident and refining practice. This process, known as 'reflective practice', is an important source of personal professional development, enabling individuals to learn from their own experiences. All of the above forms of support should feedback into individual and team learning and development plans, restrictive practice reductions plans and reviews of policies and procedures.

11. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age	X			The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's ability to consent and participate in decision making. Lack of mental capacity is often present in acutely ill older people and this guidance will ensure they are cared for appropriately
Disability	X			The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's ability to consent and participate in decision making.
Gender	X			The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's ability to consent and participate in decision making. There may be an issue here with only being able to restrain patients in an area where patients are of the opposite sex for e.g.? Considerate of this.
Gender Reassignment			X	There may be an issue here with only being able to restrain patients in an area where patients are of the opposite sex for e.g.? Considerate of this.
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment)	X			Article 3 of the Human Rights Act prohibits torture, and "inhuman or degrading treatment or punishment" Disproportionate restraint could breach the right not to be treated in an inhuman or degrading way. Restraining a patient in such a way as to cause physical

				pain and mental anguish could breach the right not to be treated in an inhuman or Degrading way even if it was done for their protection. The key is to be proportionate and to weigh up the clinical need against the degree of restraint. You need to show how you have done that and the evidence you have taken and from whom. Article 5 of the Human Rights Act – The right to liberty. The right to liberty is a right not to be deprived of liberty in an arbitrary fashion. Staff not being protected from violent or abusive patients could breach their Human Rights under this article. Equally, restraining a patient in such a way as to cause physical pain and mental anguish could breach the right not to be treated in an inhuman or degrading way even if it was done for their protection. The key is to be proportionate and to weigh up the clinical need against the degree of restraint. You need to show how you have done that and the evidence you have taken. The sections on DOL give an undertaking to work through the MCA and DOL's legislation to protect these rights
Marriage and civil partnership			X	Civil partners should be treated in the same way as married partners and so the decision to restrain and communication of that should be dealt with in the same way and the policy should reflect that.
Pregnancy			X	The consideration here is as to the suitability of the restraint not only for the patient but the unborn baby or where the baby has been born how the care of the baby may be affected due to the

				restraint e.g. the mothers ability to breastfeed etc.
Maternity and Breastfeeding			X	The consideration here is as to the suitability of the restraint not only for the patient but the unborn baby or where the baby has been born how the care of the baby may be affected due to the restraint e.g. the mothers ability to breastfeed etc.
Race (ethnic origin)	X			The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's specific cultural issues that may prevent restraint. Planning with the patient and/or next of kin and consideration of how the need for restraint can be balanced with the necessity to provide restraint.
Religion (or belief)	X			The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's specific cultural issues that may prevent restraint. Planning whenever possible with the patient and/or next of kin and consider how they can be balanced with the necessity to provide restrain
Sexual Orientation	X		X	The aim is to ensure that restraint when required occurs in a considered way, mindful of the individual's ability to consent and participate in decision making.

12. References

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- “Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff” (2010) https://www.rcn.org.uk/
- A positive and proactive workforce, a guide to workforce development for commissioner’s and employers seeking to minimise the use of restrictive practices in social and health care. (April 2014) DOH, Skills for health and skills for care.
- Positive and proactive care: reducing the need for restrictive interventions. Guidance for those working in health and social care settings; commissioners of services, executive directors, frontline staff and those who care for and support people. (April 2014) Department of Health.
- Transforming care: a national response to Winterbourne View Hospital (2012 Department of Health)
- Mental Health Crisis Care: physical restraint in crisis (June 2013 MIND)
- NHS Protect: Meeting Needs and Reducing Distress. Guidance on the prevention and management of clinically related challenging behaviour in NHS settings.
- Patient Safety Alert. The Importance of vital signs during and after restrictive interventions / manual restraint. NHS/PSA/W/2015/011. NHS England. 03 December 2015.

13. Associated Documentation

Being Open Policy
Consent Policy
Deprivation of Liberty Safeguards (DoLS) Policy
Dignity and Privacy Policy
Duty of candour guidance
Enhanced Observation Policy
Incident Reporting and Management Policy
Lone worker policy
Maintaining patients privacy and dignity policy
Mental Capacity Act Policy
Missing Patient Policy
Nice Rapid Tranquilisation policy
Police Welfare Checks Standard Operating Procedure
Rapid Tranquilisation Procedure
Safeguarding Adults Policy
Search of Persons and Property Standard Operating Procedure
Secure Environment Policy
Supporting Staff Involved in an Incident, Complaint or Claim Policy
Violence & Aggression policy
Violence and Aggression Warning Marker Standard Operating Procedure

APPENDIX 1 – Five Panel principles

TABLE 1

Key principle	What it means	What it looks like in practice
Participation	Enabling participation of all key people and stakeholders.	Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and behaviour support plans where possible; using advance statements where appropriate; identifying and reducing barriers to the person exercising their rights.
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights based approach	Clearly outlining responsibilities under the Mental Health Act[18] and the Mental Capacity Act[14] (where relevant); ensuring staff are aware of their obligations to respect human rights and are measuring outcomes, including quality of life, against agreed standards.
Non-discriminatory	Avoiding discrimination, paying attention to groups who are vulnerable to rights violations	Using person-centred planning approaches that do not discriminate on the basis of religion or belief, race or culture, gender, sexual preference, disability, mental health; making sure staff are sensitive to culture and diversity and how interventions may affect rights.
Empowerment	Empowering staff and people who use services with the knowledge and skills to realise rights	Raising awareness of rights for people who use services, carers and staff through education and use of accessible resources; explaining how human rights are engaged by restrictive interventions; empowering people through appropriate interventions.
Legality	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying the human rights implications in both the challenges a person presents and responses to those challenges; considering the principles of fairness, respect, equality, dignity and autonomy[19].

APPENDIX 2 – Managing Challenging Behaviour

Managing Challenging Behaviour

Planned Interventions

Treating the underlying condition, having good communication and environmental strategies will greatly assist people in managing proactively and hopefully preventing the need for restraint whenever possible.

Treat Underlying Condition

Understanding a patient's behaviour and responding to individual needs should be at the centre of patient care. All patients should be assessed comprehensively in order to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying the underlying cause of the behaviour (agitation, wandering, absconding etc.) and deciding whether the behaviour needs to be prevented. Although this is not an exhaustive list, possible causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Full bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Drug dependency or withdrawal
- Alcohol Withdrawal
- Brain insult / injury or cerebral irritation
- Reaction / side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)
- Hallucinations, delusions, paranoia and personality issues
- Infection
- Dehydration
- Malnutrition
- Mental illness

If a patient's mental health is an issue, the Mental Health Services can be contacted for advice / support.

Therapeutic Approaches and Management Strategies

Therapeutic approaches used to reduce confusion and agitation includes a positive environment and good communication skills. Every effort should be made to reduce the negative impact of the environment and poor attitudes or poor communication skills of staff. Examples of environmental factors which can have a negative impact include: extreme staffing shortages impacting on quality of care or levels of supervision, restricted observation in patient areas, high levels of noise or disruption, boredom or lack of stimulation for patients.

Teams should be cautious when considering pharmacological interventions, before all other approaches have been tried.

Environment Strategies

- Provide a visible clock
- Minimise excessive noise and light
- Maintain a day-night routine
- Maintain a consistent unit temperature
- Facilitate rest periods and also periods of patient activity
- Use diversion therapy - provide television/radio
- Use reminiscence with familiar objects from the patient's home e.g.
- pictures, photographs
- Reduce monitoring and lines as far as is practically possible
- Cluster care to avoid repeated disturbances

Communication Strategies

- Engage the patient in meaningful activity – ask the patient and/or relatives and carers what the patient likes to do, what they would be doing if they were at home etc.
- Orientate patient to time, person and place
- Reality orientation - use of diaries and memory aides
- Communicate clearly and concisely with the patient
- Provide repeated verbal reminders
- Identify and correct any sensory impairments i.e. glasses and hearing aid
- Maintain a patient's dignity
- Use empathetic communication and touch
- Consider use of alternative therapies – massage, acupuncture, music therapy
- Involve a patient's family and friends in care
- Ensure continuity of staff
- Where the patient has known mental health issues or learning disability issues, refer them to the appropriate health care teams
- Provide communication aids

APPENDIX 3 – Checklist of assumptions and helpful actions

Assumption	Helpful Actions
Am I anxious as a practitioner about my lack of required knowledge, might it lead me to make a decision which could be better informed?	Recognise that this is OK. We all need to learn new things sometimes. Seek help by talking to a mental health practitioner or someone with the knowledge you need, even if it means calling a neighbouring unit, another ward or home.
Do I fear the unknown and what will happen?	The person will be fearful of the unknown too. Stay focused on clear assessment based on facts and what you observe. Begin to use essential communication skills to build a relationship which will help you both with a therapeutic connection.
Has the person been labelled, do they come to our service or my shift with a 'Bad Press'	Look to the here and now. How does the person appear to you at this moment? Sometimes, behaviour may have been erratic some time ago and has calmed now or have been exaggerated by colleagues who need to build their own understanding.
Am I measuring this situation using past experience that did not go well?	If a past experience has left us feeling anxious about dealing with unusual behaviour, this may require some additional reflection to learn what we can do differently Remembering that all experiences have their worth use the past to inform this occasion with an open mind, this is a different person and circumstances the outcome will be different

Source: Tina Naldrett in Dilemmas in Mental Health (2007).

Having reviewed their assumptions, clinicians need to identify the issues relating to the decision or dilemma through a series of key questions which all relate to ethical decision making;

- What is causing concern and to whom?
- What are the risks and to whom?
- What are the desired and realistic outcomes?
- What are the alternatives?
- Who feels obligations and what are they?
- What beliefs and principles underpin what the older person thinks and what others think and believe about the situation?
- Who can and needs to make decisions?
- What has worked before?
- What has not worked before?

Once we have worked through some of the key questions we can look to the therapeutic approaches to see what might be helpful.