Policy on the Use of Restraint (Adults)

Alternatives and Considerations (includes use of Bed Rails)

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NHS Shetland

Policy on the Use of Restraint (Adults): Alternatives & Considerations (includes use of bed rails)

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NHS Shetland

Policy on the Use of Restraint (Adults): Alternatives & Considerations (includes use of bed rails)

1.0 Introduction

1.1 This policy provides relates to the use of restraint for older people with NHS Shetland. It should be used in conjunction with other relevant policies and procedures and guidelines for NHS Shetland. The policy relates to adults across the range of care settings, including people’s own homes, hospital wards and day units, both hospital and community clinics and care homes.

1.2 As a rule we all have the right to take risks in our lives. The use of restraint without consent of the individual should only be considered when the person has some degree of diminished capacity to understand the risk. The risk must be to a degree that justifies the interventions. Self determination and freedom of choice of movement should be paramount unless there are compelling reasons why this should not be so.

2.0 Individual services and teams

2.1 Individual services and teams are encouraged to develop their own Policies / protocols to address specific issues relevant to the service / team.

3.0 When to use this policy

3.1 Staff should use this policy when an intervention is being considered to prevent a person from behaving in a way that might threaten or cause harm to themselves, to others or to property. Restraint should not be used for any other purpose e.g. to compensate for inadequate staffing levels. Further example of a restraint policy can be found within Medical Imaging e.g. Radiological procedure for the use of immobilisation during Radiographic Examinations.

4.0 NHS Shetland statement

It is acknowledged that decisions on the use of restraint methods to be applied to patients in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such restraint may lead to complaints by patients or their relatives. Unlawful restraint may
give rise to criminal or civil liability. It is self-evident that staff may be required to account for their actions in such circumstances.

5.0 **Definition**

5.1 There is no precise legal definition of what constitutes restraint but in broad terms restraint means "restricting someone’s liberty, preventing them from doing something they want to do" (Barnett, 2002).

5.2 Restraint takes place when the planned or unplanned, conscious or unconscious actions of care staff prevent a person from doing what he/she wishes to do as a result places limits on his/her freedom.

5.3 Any definition of restraint must take into account the involuntary nature of the action with respect to the individual being restrained. The most obvious form is the prevention of movement by the use of physical force. This may include holding back, redirecting by force or immobilization by confinement or chair.

5.4 Restraint implies the restriction of freedom and choice of action of the person being restrained.

Examples of restraint include the following:
- Restraining chairs
- Inappropriate seating such as bucket chairs
- Limb restriction/harnesses
- Cot sides/ bed rails
- Secure sleeping bags
- Cocoon beds/hammocks
- Battles locks/locked doors/stair gates
- Inappropriate use of wheelchair straps
- Arranging furniture to impede movement
- Electronic tagging
- Inappropriate use of night clothes
- Restricted of food intake.

5.5 Other methods of restraint include:
- Verbal
- Psychological pressure
- Social exclusion
- Brusque or bullying attitudes
- Not providing a walking aid or removal of outdoor shoes
- Not providing assistance to use the stairs
- Doors that are difficult to open

5.6 Medication as restraint
Use of sedatives or tranquillizing medication purely for symptomatic treatment of restlessness or disturbed behavior.
5.7 Restraint by default
Patients movements being restricted by deliberately not providing with walking aid or wheelchair.

5.8 Restraint as a result of interpersonal control by staff
Verbal control by staff such as distracting someone who is trying to leave or being guided can be regarded as restraint when this is regularly used as a method of controlling the patients desired actions and as such must be fully assessed and discussed as part of the patients plan of care.

6.0 **Before using restraint**
The aim should be to avoid using restraint whenever possible. It should only be used to prevent or minimize harm to the individual or others and only when all other methods of intervention have failed.

6.1 The degree and type of restraint should always be the minimum which is reasonably necessary for the minimum time.

6.2 The use of restraint without consent of the individual concerned should only be considered where that person has a significant degree of diminished capacity to understand the risk that the individual is putting him/herself in.

6.3 Restraint should not be used to cover deficiencies of service, professional skill or deficits in the environment.

6.4 Assessment of risk should be part of care planning; this should include strategies to anticipate and manage future risk and should include:
   - The environment
   - Patient’s behaviour
   - Patient’s underlying condition and treatment
   - Patient’s mental capacity (including issues of consent)
   - Duty of care

6.5 If patient falls are an issue, the Cannard Risk Assessment should be completed and associated care pathways and falls prevention intervention plans followed.

6.6 Decisions to use restraint and the rationale for this should be documented in the multidisciplinary team records.

6.7 **The environment**

6.7.1 The care environment can have either a positive or a negative effect on patients. Every effort should be made to reduce the negative impact of the environment. Examples of environmental factors which can have a negative impact include: extreme staffing shortages (care settings) impacting on quality of care or levels of supervision, high levels of noise or disruption, boredom or
lack of stimulation for patients and negative attitudes / poor communication skills of staff.

6.8 Behaviour and underlying condition

6.8.1 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.

Possible causes to consider are:
- Hypoxia
- Hypotension
- Pyrexia
- Need to empty bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Mental illness – e.g. dementia
- Other form of memory impairment
- Drug dependency or withdrawal
- Brain insult / injury or cerebral irritation
- Reaction / side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse)

6.8.2 If a patient’s mental health is an issue, the mental health services can be contacted for advice / support. Details of how to contact the Mental Health services are in Appendix 3.

6.8.3 Often behaviour such as wandering is problematic for staff or for other family members; however this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.

6.8.4 Having identified the reason for the behaviour, you should then decide on appropriate strategies for dealing with this in conjunction with other members of the Multi disciplinary team (to include treatment of the underlying cause). This should be documented in the nursing / multidisciplinary notes.

6.9 Principles

6.9.1 If restraint is found to be necessary, staff must ensure that they are guided by the principles describes in the Adults with incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 which are:
- Any intervention must be of benefit to the individual
- Any intervention must be of the least restrictive in relation to personal freedom
- Any intervention should take into account past and present wishes of the adult
- Any intervention should take account of relevant other parties
- Any intervention should encourage the adult to use existing skills and to develop new ones
- Staff should consider the range of options available.

6.9.2 Patients should be involved in any discussions of restraint no matter how disabled they are.

6.9.3 It is highly undesirable to restrain patients in a way which causes greater distress than the original problem.

7.0 **Duty of Care**

7.0.1 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.

8.0 **Assessment**

8.1 All patients should have a documented assessment within 24 hours of admission to hospital; this should include the person’s ability to maintain a safe environment.

8.2 If restraint is being considered, the first step is to consider why the person is acting in a manner that is causing concern and this assessment should include:

- Potential distress and increased risk caused by restraint itself
- Possible benefits to the individual, who’s interest should be paramount
- Alternatives to restraint
- Full physical examination to look for causes of restlessness or poor mobility and identifying effective treatment where possible.
- Review of medication
- Environmental factors including temperature, noise levels, lighting, restrictive oppressive spaces or décor, overcrowding, ease of observation.
- Elimination – constipation, frequency
- Pain – if a person cannot express pain verbally this can manifest as restlessness or increased confusion.
- Boredom and loneliness
- Psychological needs – depression can lead to anxiety which can produce restlessness and inability to initiate meaningful activity.
- Fear
- Activity – The importance of activity should be taken into account and incorporated into the care plan.
8.3 In all cases, alternatives to restraint should be considered;
- Increased supervised exercise time
- Redeployment or increasing staff for observation and supervision
- Change in pattern of rest periods in bed
- Provision of engrossed seated activity
- Imaginative use of diversional or occupational therapy.

8.4 If no remediable cause if found, there should be an assessment of the degree of risk. Only if this is acceptable should further discussion proceed. Restraint should only be used as a last resort after alternative actions have been considered, tried, evaluated and found to be ineffective.

9.0 Using restraint

9.1 NHS Shetland is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care. Therefore when using restraint a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining dignity, personal freedom and choice.

9.2 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, safe and for as short a time as possible.

9.3 Any restraint used must be considered part of the individual's care plan

9.4 People who should be consulted during development of this written care plan should include;
- The patient
- Staff delivering the care
- Multidisciplinary team
- Senior nurse
- Consultant
- Relatives, advocates, welfare guardians or other representatives.

9.5 A plan of care should be prescribed with an evaluation schedule. This should detail activities which investigate the cause and prevent any immediate danger from the restraint method.

9.6 Reassessment strategies should be formulated

9.7 Once the plan of intervention has been approved, the plan should be communicated to all relevant staff caring for the individual. Any identified training needs for the staff should be met.
9.8 The intervention plan should be subject to continuing and regular reviews arranged at predetermined intervals. Specific instances of implementation will be reported to the consultant and discussed at ward level and multidisciplinary team meetings.

9.9 Inappropriate use of restraint can be viewed as a form of abuse. More information may be found within the Mental Welfare Commission for Scotland, Rights, Risks and Limits to Freedom (2006), and Let’s talk about Restraint, Rights, Risks and Responsibilities - RCN

10.0 Methods of Restraint

10.1 Acceptable methods of restraint

The following methods of restraint are acceptable when used appropriately (i.e. in accordance with the principles and guidance outlined in this Policy). Some are used more frequently in care settings, such as on wards and in care homes, than in the community.

- **Netting / mesh bed sides / bed rails.** The RCN (2004) suggests alteration of the environment and meeting the comfort needs of the patient rather than using bed rails. Netting / mesh bed sides should be used where possible, as they are less likely to cause injury than bed rails.

  “The only appropriate use of bed rails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed”. (NPSA, 2007). A number of hazards associated with their use have been identified (see Appendix 6).

Before using bed rails you should consider alternatives, such as:

- A change to the position of the bed in relation to the care environment
- Asking relatives or carers if they can stay with the patient at certain times
- Allocating a nurse to stay with the patient
- Engaging 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.
- Nursing the patient on a bed that can be lowered to near floor level
- Nursing the patient on a mattress on the floor.
- Using netting / mesh bed sides.
- Reality orientation
- Reminiscence
- Diversional therapy

In deciding whether to use bed rails you should carry out a risk assessment (see flow chart - Appendix 6 and please refer to NHS Shetland patient
Admission Documentation over 72 hours Risk assessment part 2 Bed Rails
Risk Assessment

Individual areas may opt to use a more ‘in depth’ risk assessment form than
the one in Appendix 6, but it should as a minimum include the items in the
sample risk assessment form. You should also consider criteria both for and
against the use of bed rails, in relation to the individual patient, as well as the
likelihood of the patient falling out of bed.

Criteria supporting the use of bed rails:
- Patient is on a pressure redistributing mattress with which the use of
  bed rails is recommended
- Patient (in hospital) uses bed rails at home.
- In terms of manual handling, this is preferable to nursing a patient on a
  mattress on the floor.
- This would be as a result of a risk assessment and following
discussion with the multidisciplinary team and the patient’s relatives.
  Staff must adhere to moving and handling regulations. If a specialist
  bed or mattress is being used, with which the use of bed rails is
  recommended, this should be adhered to.
- Patient has osteoporosis and is more likely to suffer a
  fracture if he / she falls out of bed (use netting / mesh bed sides
  instead of bed rails).
- Patient has expressed a wish to have bed rails (encourage use of
  netting / mesh bed sides instead of bed rails).
- Patient known to have previously fallen out of bed, resulting in injury
  and / or distress (use netting / mesh bed sides instead of bedrails).

Criteria against use of bed rails:
- Patient has fragile skin and is therefore more likely to suffer a bruise or
  laceration when coming into contact with bed rails.
- Patient is known to ‘climb over’ bed rails.

Examples of potential risks and benefits of using bed rails can be found in
Appendix 5.

The decision to use bed rails should be a team decision where possible,
following discussion with the patient and their relatives/carers. If you decide to
use bed rails you should ensure that the bed is kept at the lowest level
possible, apart from when elevation is necessary to comply with good practice
in manual handling. The use of bed rails must be reviewed at frequent
intervals and/or if the patient’s condition changes. If the patient is being
transported on a bed it may be appropriate to use bed rails. Side rails should
be used whenever a patient is transported on a trolley.

If bed rails are in use with thicker pressure redistributing mattresses, staff
should be aware that the height of the bed rails is effectively reduced.
Using ‘mittens’ to prevent patients pulling out feeding tubes (NG or PEG tubes). This may be acceptable in certain circumstances. As with other forms of restraint, the first consideration must be the patient’s best interests. Staff should be aware of the risks associated with patients pulling out their NG / PEG tube. As with all equipment, it should only be used for the purpose for which it is intended. Care of the ‘gloved’ hand should be attended to.

Medication / chemical sedation.
There are certain situations in which patients may benefit from anti-psychotic medication, such as in cases of extreme restlessness or agitation or if a patient is very frightened. Prescribing advice should be sought as appropriate. All staff prescribing or administering benzodiazepines or anti-psychotic drugs must be familiar with the properties of these drugs.

Physical techniques.
If physical techniques are to be used as an acceptable means of intervention by a particular service or team, this should be agreed by the Service and appropriate training provided for staff who are likely to be involved.

Chemical sedation, in the form of rapid tranquillisation.
This should only be used only as a short term measure and in conjunction with treatment for the cause of the psychomotor agitation, e.g. psychiatric illness. If used to restrain patients who are acutely disturbed, the aim should be to do one or more of the following:
- calm or lightly sedate the person
- reduce physical and psychological strain
- reduce the risk of violence
- reduce the risk of injury to self and others

If a patient is acutely disturbed a doctor must be called to assess the patient. Non-psychiatric causes for disturbed behaviour must be explored and excluded. Prior to using rapid tranquillisation there should be an assessment of risk. It should only be used when the risk of not using rapid tranquillisation is greater than the risk of the acute pharmacological treatment.

As with other forms of restraint (in care settings), other interventions such as increasing staffing levels, increasing levels of observation, should be considered before using chemical sedation.

The patient must be informed that he / she is to be given medication. Oral medication should be the first choice. If the patient is unable to give informed consent, then treatment under Common Law should be considered.

The minimum effective dose of medication should be used. The maximum BNF doses (for older patients this should be half of the recommended dose) should only be used in exceptional circumstances. Polypharmacy with same
class medication should be avoided, and synergistic potentiation should be considered.

Current oral medication for co-existing medical illness should be considered before prescribing. Potentiation of action and side effects of existing and added medicine is possible. Existing medication may therefore need to be reviewed at this time.

Review of all current medication for co-existing medical illness and its impact on side effects should be reviewed / considered.

Any existing ‘care plans’ for preferable medication to be used in the event of acute psychomotor agitation, should be taken into consideration.

Oral medication should be offered before parenteral treatment is administered.

Specific details of medications and doses to be administered cannot be given, as this will depend on a number of factors in relation to the individual patient, such as underlying and coexisting medical conditions.

Patients, for whom rapid tranquillisation has been used, should be constantly observed (visually), until symptoms have reduced.

Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation (using pulse oximeter) and level of consciousness should be monitored every 15 minutes after intramuscular (IM) injections, and every 5 minutes after intravenous (IV) infusions for the first hour, and then hourly for 4 hours and until the patient becomes active again. Measurements should be documented in the patient’s notes.

Adequate physical restraint should be achieved before attempting parenteral administration in a struggling patient.


- **Security coded doors.**

Doors to wards and departments often require the use of a security code to enter and exit the building in order to protect the safety and security of patients, staff and property. People (patients and visitors) who wish to exit the building, need to seek the assistance of a member of staff. It is important to realise that using this system to keep a patient on a ward who wishes to leave amounts to using restraint. As with other types of restraint, consent must be obtained from the patient, or if the person lacks the mental capacity to make the decision to leave the ward, then staff must act in the patient’s best interests.
• **Preventing patients from leaving a hospital or other care setting site.**

Decisions in relation to this should be made according to the individual circumstances and by considering the patient’s best interests. Staff should refer to Section above and to the flow chart in Appendix 2. Preventing a patient from leaving a hospital or other care setting site will ordinarily be in response to an emergency situation and will therefore be a short term measure. This must be followed up by a full assessment and plan for ongoing intervention.

Staff safety and the safety of others in the immediate vicinity must be taken into consideration.

Where necessary advice should be sought from the Senior Nurse and/or Senior Manager. Consideration must be given to reporting such incidents to the police (see Section 13)

10.2 **Unacceptable methods of restraint**

The following methods of restraint are generally unacceptable. However, as stated above you must always act in the patient’s best interests:

• **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.

• **Harnesses.** Harnesses should not be used, as they result in numerous risks to the person including pressure sores, chest infection.

• **Cocoons / hammocks.** It may be appropriate to use cocoons for certain people in care homes, as part of their ongoing care. In general cocoons are not suitable for use in the hospital setting.

• **Inappropriate use of wheelchair or other seating safety straps.** The safety straps on wheelchairs and other seating 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 as part of ongoing care, not as a means of restraint.

• **Use of lap or other positioning belts.** The use of lap or other positioning belts fitted to chairs must only be used when the chair and patient have been appropriately assessed. The rational must be clearly documented with an evidenced based care plan in situ. The use of the lap or positioning belt must be recommended as part of the patients’ ongoing care. The lap or positioning belt must not be used as a means of restraint.

• **Using bean bags / inappropriately low chairs for seating.** Bean bags can provide comfortable seating for people who are physically
frail and / or disabled but should not be used with the intention of restraining the person. 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. Both bean bags and low chairs also pose risks to staff in relation to manual handling.

- **Chairs whose construction immobilises the patient**, e.g. reclining chairs. Reclining chairs should be used for the comfort of the user or as an aid to manual handling, and not as a method of restraint.

- **Arranging furniture to impede movement**. In general, 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. This method of restraint is more likely to be used in a home situation, as opposed to a hospital, environment.

- **Stair gates**. Stair gates may be appropriate in a domestic environment. It is important that any equipment is used for the purpose for which it is intended.

- **Inappropriate use of night clothes during waking hours**. This is demeaning and should not be used as a way of restraining people in any care setting.

- **Removal of outdoor shoes and other walking aids / 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.

- **Isolation**. Isolation should not be used, except in designated psychiatric treatment areas. It is important to note, however, that patients in the hospital setting may be “isolated” for infection control reasons and if a patient is cared for in a side room, when he or she wishes to be on the main ward, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.

### 11. Communication and Documentation

11.1 Clear communication with patients is essential in relation to the use of restraint. Written information should be used to supplement verbal information given where possible.

11.2 If restraint is used, the reason should be explicit and clearly documented in the nursing / multidisciplinary notes.

There should be a written care plan. A care plan should include:

- **Rationale for the use of restraint**.
The frequency of re-assessment of the need for restraint. Review times should be specified in advance.

- All discussions that have taken place to allow patient to give informed consent and to assess best interests.
- Details about the use of the restraint itself.

11.3 The use of restraint should be discussed with relatives and carers and a record of these discussions made as appropriate.

11.4 All documentation in relation to restraint should be clear and contemporaneous.

11.5 Patient information leaflet on the use of bed rails, can be found in Appendix 8.

12.0 Evaluation and review of use of restraint

12.1 The use of restraint should be evaluated in terms of it effectiveness and alternatives considered wherever possible by the multidisciplinary team.

12.2 The use of restraint in an emergency situation (including the use of rapid tranquillisation) should be viewed as a critical incident and an incident Form should be completed. The factors, which led up to the use of restraint and its appropriateness, should be discussed and reviewed by the multidisciplinary team.

13.0 Reporting of injuries

13.01.1 Any injury involving the use of restraint, to a patient, member of staff or visitor to Board premises is recorded as an incident using the incident reporting, investigation and management policy and procedures. If a patient is injured as a result of the use of a restraint technique this should also be clearly documented in the patient health record.

14.0 When to contact the police

14.1 There are certain situations where the police may be able to provide help and support:

- A violent situation where the safety of staff, patients or others is at risk
- If a patient has left a ward or hospital site, contrary to the advice of medical or nursing staff and is threatening to commit suicide. In these cases the police have powers to take the person to a place of safety, which in most cases would mean bringing the person to the hospital, to be assessed.
- If a patient has left a ward or hospital site, contrary to the advice of medical or nursing staff and you have serious concerns about the welfare or safety of that individual (e.g. the effect of not taking
important medication) or others. In these circumstances the police may be able to check on the person by visiting them at home.

14.2 In the 2nd and 3rd situations above you should also follow the normal procedure for discharge against medical advice.

14.3 Prior to contacting the police you should contact your line manager and or Senior Nurse.

15.0 Staff Education and Training

15.1 Introduction of this policy will have implications for staff training. A number of Board wide training sessions will be held for staff when the policy is launched.

15.2 The emphasis of training should be on dealing effectively with situations in order to obviate the need for restraint. Ongoing training will be built into the Staff Development Training Programme.

15.3 If staff are regularly required to use physical methods of restraint, they must receive training on this. It is the individuals responsibility to indentify the training requirement and to ensure that it is built into PDP and that managers ensure this is completed and approved.

15.4 Staff who make decisions about bed rails, purchase, store, attach or maintain bedrails, or care for patients using bed rails (NPSA, 2007), must demonstrate they have had training and understood the detail of this policy.

16.0 Monitoring

16.1 Use of the policy will be monitored via audit on an annual basis. Results will be cascaded to clinical teams, clinical governance groups and senior charge nurses to inform on current practice, compliance with the policy and further training requirements.

17.0 Review

17.1 The policy will be reviewed every 3 years and more frequently if changes to policy or legal frameworks necessitate update.
References


London


Mental Welfare Commission for Scotland , Rights, Risks and Limits to Freedom.

Watson R and Brunton M (1990) “Restrain Yourself” Nursing the Elderly May p 21-22
Appendix 1

Other Relevant Local and National Guidelines, Policies and Legislation

These policy should be read in conjunction with other relevant NHS Shetland Policies / Guidelines including:
- Clinical Policy on Consent to Examination or Treatment
- Policy on Accident and Incident Reporting
- Health and Safety Policy
- Risk assessment policy
- X ray guidelines on use of restraint

Management of Aggression and Violence in Mental Health In-patient Settings” (NIMHE, 2004).

Although the document is aimed at mental health in-patient settings it provides useful guidance, making specific reference to restraint and listing a number of positive practice standards on education and training, physical care and observation during restraint and post incident support, review and reconciliation.

The Department of Health booklet “Seeking Consent: working with older people” (2001) includes useful guidance on deciding whether or not an adult has “capacity” to make health care decisions.

Nurses are referred to the booklet entitled “Restraint Revisited - Rights, Risk and Responsibility: Guidance for Nursing Staff” (RCN, 2004) which provides additional guidance.

In terms of legislation, staff should be aware of the Human Rights Act and in particular Articles 3 (Prohibition of Torture – included inhuman or degrading treatment) and 5 (Right to Liberty and Security).


Adults with Incapacity (Scotland) 2000
Appendix 2

Before Using Restraint – Flow Chart to Guide Decision Making

Is patient behaving in a way that threatens or causes harm to him/herself, others or to property?

Yes

Are there environmental Factors which maybe causing this behaviour?

Yes

Adapt / modify environmental factors where possible

No

Are there underlying physiological, psychological, pharmacological or pathological reasons for the behaviour?

Yes

Address underlying causes

No

Does the patient have mental capacity in relation to his decision to behave in a “problematic” way?

Yes

Have you obtained the patient’s consent to use restraint?

Yes

Use restraint

No

Do not use restraint

No

Is restraint in the patient’s best interests?

Yes

Do not use restraint and consider other measures to deal with problematic behaviour

No

Use restraint
Appendix 3

Contacting Mental Health Services
Specialist mental health services for both adults (working age) and older people are provided by the Mental Health team in NHS Shetland

Advice in relation to working age adults and the Older Person can be obtained by contacting the Mental Health Service Manager NHS Shetland
Appendix 4

Supplementary Information on the Use of Bed Rails (including netting / mesh bed sides)

Deciding whether or not to use bed rails is often complex. Arguments against their use include the fact that bed rails can promote dependence in carers (including nurses), leading to a number of identifiable problems e.g. increased risk of incontinence and dehydration (Watson and Brunton, 1990). However there are also those (carers and relatives) who view bed rails as an acceptable form of restraint for patients at risk of wandering (Watson and Brunton, 1990).

Bed Rails and Patient Safety
The recent Medicines and Healthcare Products Regulatory Agency’s document, “Safe Use of Bed Rails” provides the most up to date guidance on their use and should be referred to (MHRA, 2006). Key points include:
- Bed rails used following an individual risk assessment can be very beneficial for some occupants
- A full risk assessment of the suitability of the bed rail, bed and bed base in combination for the bed occupant, is required.
- Potential risks exist associated with the use of different types of bed rail.
- How to reduce the risk of entrapment.
- Bed rails must be regularly maintained.

Miles et al (1997) found that between 1993 and 1996 there were 74 deaths reported which were as a direct result of bed rail use. 70% of these were due to entrapment between the mattress and the bed rail.

Bed Rails and Patient Falls
Ball, Hanger and Wood (1999) and Jehan (1999) all agree that although the commonly cited reason given by nursing staff for the use of bed rails is falls prevention, and that their use for this reason is widespread in hospital, there is in fact no evidence that their use reduces the risk of patients’ falling. Miles and Parker (1997) noted that in most documented falls from bed, bed rails were in place. In fact, it has been suggested that bed rails actually cause patients who fall to sustain more serious injuries, mainly due to the fact that they add an average of 18 inches to the height of the bed. Therefore if patients climb over bed rails they fall from a much greater height. This has been found to cause more head injuries than would be sustained without the bed rails in place (Bridel-Nixon and Everitt 1997 and Jehan 1999).

In February 2007 the MHRA issued a Medical Device Alert (MDA) on bed rails and grab handles. This stated that: "bed rails can successfully prevent falls, but their incorrect use has resulted in the deaths of bed occupants by asphyxiation due to entrapment". This Device Alert was aimed particularly at staff working in community settings. Again the need for risk assessment was emphasised and the importance of compatibility between the bed, bed rail and occupant. Proper fitting and maintenance are also imperative.
Further information on the use of bed rails can be obtained from the Health and Safety Executive (HSE) Website:
www.hse.gov.uk
Netting/mesh bed sides may be considered as an alternative to bed rails (MHRA 2006).
Appendix 5

Examples of Potential Risks and Benefits of “Using Bed Rails” and “Not Using Bed Rails”

Using Bed Rails

Potential Risks Potential Benefits
- Limb entrapment and subsequent injury
- Patient climbs over bed rails, falls and sustains injury
- Psychological distress and/or increased confusion disorientation/agitation
- Infringement of human rights
- Less physical contact with carers (including nurses) and relatives
- Patient feels isolated, trapped or imprisoned, which in turn leads to reduced self esteem and dignity, and hinders rehabilitation
- Prevention of injury resulting from a fall out of bed e.g. head injury, fracture neck of femur, bruises/lacerations

Not Using Bed Rails

Potential Risks Potential Benefits
- Physical pain/injury resulting from a fall out of bed
- Psychological distress caused by falling out of bed
- Patient falls out of bed
- Able to get up out of bed “freely”.
- Preparation for discharge from hospital to an environment where bed rails will not be provided
- Consideration must also be given to the fact that bed rails add approximately 50cm to the height of the bed, so a patient who falls when climbing over a bed rail will fall from a greater height and therefore be at an even greater risk of sustaining injury.
Appendix 6

**Flow Chart - Deciding when to Use Bed Rails**

1. Is patient at risk of falling out of bed?
   - Yes / possibly
     - Consider alternative ways to prevent falls from bed and use as appropriate
   - No
     - Do not use bed rails

2. Is further action required to prevent patient falling out of bed?
   - Yes
     - Consider using netting / mesh bed sides (cannot be used with profiling beds)
     - No
       - Do not use bed rails
   - No
     - Do not use bed rails

3. Are netting / mesh bed sides available?
   - Yes
     - Consider using netting / mesh bed sides (cannot be used with profiling beds)
   - No
     - Do not use bed rails

4. Do any of the criteria supporting the use of bed rails apply?
   - Yes
     - Consider using bed rails only as a last resort
   - No
     - Do not use bed rails

5. Do any of the criteria against the use of bed rails apply?
   - Yes
     - Consider using bed rails only as a last resort
   - No
     - Do not use bed rails

Balance the risks arising from questions 4 & 5 above and make a decision accordingly

Consideration must be given to the patient’s position in the ward to allow for observation whilst bed rails are in use.
Appendix 7

Criteria supporting the use of bed rails:
1. Patient is on a pressure-redistributing mattress with which the use of bed rails is recommended.

2. Patient (in hospital) uses bed rails at home.

3. Patient has osteoporosis and is more likely to suffer a fracture if he / she falls out of bed. (Use netting/ mesh bed sides instead of bed rails)

4. Patient has expressed a wish to have bed rails. (Encourage netting / mesh bed sides instead of bedrails)

5. Patient known to have previously fallen out of bed, resulting in injury and / or distress. (Use netting /mesh bed sides instead of bed rails)

Criteria against use of bed rails:
1. Patient has fragile skin and is therefore more likely to suffer a bruise or laceration when coming into contact with bed rails.

2. Patient is known to ‘climb over’ bed rails. Bed Alarms may be appropriate for patients who require assistance, but attempt to get out of bed unaided.e.g. variable height bed at its lower level e.g. SensorCare Bed Alarms1
Appendix 8

Patient Information leaflet on the use of bed rails.

What are bed rails?
Bed rails (sometimes called cot sides or safety rails) are fitted to the sides of the bed and are intended to prevent patients from falling out.

Would bed rails be helpful?
Hospitals have used bed rails for many years. In the past, if patients were anxious about falling out of bed, they often felt that bed rails helped them to feel safer and more comfortable.

Why might I be safer without bed rails?
More recent research has suggested that although bedrails might make you safe, they could actually create problems for you.

This is because:
- The bed rail is about 18 inches high. This means that if you fall from your bed, over the rail, you fall from a much greater height.
- There is a risk that you could trap your arm or leg in the bed rail. This can be painful and cause serious bruising.
- Bed rails may make it more difficult for you to move about when you are in bed. This can restrict your independence.
- When bed rails are on your bed, you may find it difficult to get in and out of bed, even when they are in the down position.

What are the alternatives?
We understand that people do sometimes feel concerned about the possibility of falling out of bed. However, there are lots of alternatives to using bed rails and staff are always happy to talk these through with you.

These alternatives might include:
- Identifying what your concerns and fears are so we can look at how to address them
- Carrying out a thorough assessment of your particular risks of falling – this means we can pay attention to your individual needs
- Keeping your bed at its lowest height so you feel more secure
- Ensuring your call system is always readily available so you can get help at once if you need it
- Keeping your bedside table within easy reach, so you don’t have to stretch to reach drinks etc
- Using nightlights so that you can see better.

What if I still feel I need bed rails?
Staff are happy to talk through all the issues with you. If, after a full discussion you still feel that you need bed rails, we can
arrange this and we will record your decision in your patient notes.

**What if I want to know more about this?**
Please ask a member of the nursing staff if you want to find out more about this issue or talk to:

This leaflet is available in alternative formats on request.
1. Rapid Impact Checklist

An Equality and Diversity Impact Assessment Tool:

Which groups of the population do you think will be affected by this proposal?

Other groups:
- Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers)
- Women and men
- People with mental health problems
- People in religious/faith groups
- Older people, children and young people
- People of low income
- Homeless people
- Disabled people
- People involved in criminal justice system
- Staff
- Lesbian, gay, bisexual and transgender people

All except Children are not considered within the policy document.

N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed

What positive and negative impacts do you think there may be?

Which groups will be affected by these impacts?

What impact will the proposal have on lifestyles?
For example, will the changes affect:

- Diet and nutrition
- Exercise and physical activity
- Substance use: tobacco, alcohol and drugs?
- Risk taking behaviour?
- Education and learning or skills?

The proposal will have a positive impact on diet and nutrition, exercise and physical activity, risk taking behaviour and education and learning by understanding the when to consider the use of restraint and bedrails and understanding the positive and negatives aspects of the use of restraint and bed rails.
## Will the proposal have any impact on the social environment?

Things that might be affected include:

- Social status
- Employment (paid or unpaid)
- Social/Family support
- Stress
- Income

The proposal may reduce stress by development of a clearer understanding of restraint in the organisation.

The proposal will support social and family involvement in the decision making process.

## Will the proposal have any impact on the following?

- Discrimination?
- Equality of opportunity?
- Relations between groups?

Yes, the proposal will support equality and diversity within the organisation.

## Will the proposal have an impact on the physical environment?

For example, will there be impacts on:

- Living conditions?
- Working conditions?
- Pollution or climate change?
- Accidental injuries or public safety?
- Transmission of infectious disease?

Yes

Accidental injures public safety by understanding the use of restraint and guidance being provided by the organisation.

## Will the proposal affect access to and experience of services?

For example,

- Health care
- Transport
- Social services
- Housing services
- Education

The proposal will support healthcare services.
### Rapid Impact Checklist: Summary Sheet

<table>
<thead>
<tr>
<th>Positive Impacts (Note the groups affected)</th>
<th>Negative Impacts (Note the groups affected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients within the healthcare service</td>
<td>None</td>
</tr>
</tbody>
</table>

**Additional Information and Evidence Required**

None

**Recommendations**

- Training and development of staff within the organisation surrounding the use of restraint including bed rails

**From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?**

