Appropriate Use of Restraint

1. Background

In many cases restraint is used because of the mistaken belief that it is necessary to ensure resident safety, prevent agitation, provide physical support, or prevent falls. Such assumptions, however, are most often incorrect. Physical restraints are generally harmful to residents and may have negative effects. For example, restraints can impede an individual's capacity to walk, get food or fluids, change position, use the toilet, and socialise.

Physical consequences may include injuries, falls, incontinence, malnutrition, dehydration, bone demineralisation, muscle atrophy, skin tears, pressure sores, contractures, cardiac arrhythmias, infection, poor circulation and ultimately may lead to death.

Emotional consequences of restraint include distress and worsening agitation. Individuals with dementia may exhibit marked behavioural disturbances in response to being restrained. People with and without dementia experience emotions ranging from frustration and anxiety to anger and terror when restrained, and often this leads to depression and a further restraint on their life

Abbeyfield The Dales Ltd (ATD) respects residents' fundamental rights to dignity, freedom and respect and aims to provide restraint free care wherever possible. ATD provides a person-centred environment where residents are safe from harm without their liberty being restricted.

This policy and procedure has been developed to support the provision of restraint free care, to provide clear guidance about when the use of restraint is appropriate, and to explain the procedures that must be followed in the event that restraint is absolutely necessary.

2. Objectives

This policy has been developed to ensure:

- The needs and wishes of the resident will be at the centre of all decision making and we will involve and consult with the resident's family and close friends unless the resident instructs otherwise.
- We provide human rights based person-centred care and support that is based on compassion, dignity and kindness.
- We support residents to balance safety from harm with freedom of choice.
- Staff work in a positive and proactive way to minimise the use of all forms of restrictive practice.
- Restraint is only ever used as a last resort.
- Any restrictive intervention is legally and ethically justified and compliant with current legislation, policy and accepted good practice
- ATD complies with all relevant legislation and regulations.

3. Scope

All established staff, agency staff and volunteers providing care and support to residents and people in the community.

4. Policy

- ATD has a duty of care to protect residents from harm and unnecessary risk, whilst respecting their right to dignity, freedom, and respect.
- Residents are free to do what they want and go where they want unless limited by law.
- Making choices and decisions and taking risks are a normal and important part of everyday life.
- When residents voluntarily choose to live with a level of risk, and have the mental capacity to make these decisions, there can be no breach of duty of care.

Some residents may be exposed to greater risks due to their frailty or their capacity to make informed choices and decisions. Care home staff should support residents to understand any risks they are taking and to make informed decisions so they can live the lives they choose whilst respecting the rights of others.

4.1. Definitions of Restraint and the Law

There are many different definitions of restraint, and it can be a difficult issue to understand and one which poses ethical dilemmas. The term restraint will mean different things to individuals, and it is important to note that actions which restrain an individual are not necessarily intentional.

In everyday language restrictive practices mean making someone do something they don't want to do or stopping someone doing something they want to do. Restrictive practices are a wide range of activities, some deliberate and some less so, which restrict people. Restrictive interventions lie within this and are a range of specific interventions.

Restraint may or may not also amount to a deprivation of liberty. Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of their liberty unless in accordance with a procedure prescribed in law'. The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive an individual of their liberty who lacks capacity to consent to their care and treatment to keep them safe from harm.

A Supreme Court judgement in March 2014 referred to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:

- Is the person subject to continuous supervision and control?
- Is the person free to leave? the focus isn't whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

DoLS can only be used if a person is in hospital or a care home. If a person is living in another setting, including in supported living or their own home, it is still possible to deprive the person of their liberty in their best interests, via an application to the Court of Protection.

This policy will consider restraint and restrictive interventions, and deprivations of liberty as well as broader forms of restrictive practices that might be used as a routine feature of someone's care and support rather than solely in response to some form of crisis. Throughout this policy the term restraint is intended to include any restrictive intervention.

- Anything which interferes with, or stops, a person doing what they appear to want to do is restraint. The Mental Capacity Act 2005 states that someone is using restraint if:
    - They use force – or threaten to use force - to make someone do something they are resisting; or
    - Restrict a person's freedom of movement, whether they are resisting or not.
- Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

- Restraint is illegal unless it can be demonstrated that not restraining an individual resident would conflict with the duty of care of the care home and that the outcome would be harm to the resident or others.
- Restraint of residents who have capacity may only take place with their consent or in an emergency to prevent harm to themselves or others or to prevent a crime being committed.

In its broadest sense, any method or device which restricts the freedom of an individual is a form of restraint. It is the effect of the method or device on a person that results in it being considered a restraint. There are many different types of restraint and care home staff should be able to recognise restraint in all its forms.

4.2. Restraint Principles

We will use a positive and proactive approach to the care of residents to minimise the use of all forms of restrictive practice.

We will adopt the following six key principles which underpin positive and proactive care:

1. Comply with the relevant rights in the European Convention on Human Rights always
2. Understanding people's behaviour allows their unique needs, aspirations, experiences, and strengths to be recognised and their quality of life to be enhanced
3. Ensure involvement and participation of families, carers and advocates for people with care and support needs wherever practicable and subject to the person's wishes and confidentiality obligations
4. People must be treated with compassion, dignity, and kindness
5. Health and social care services must support people to balance safety from harm and freedom of choice
6. Positive relationships between the people who deliver services and the people they support must be protected and preserved.

In accordance with current legislation, policy and accepted good practice, restraint should only be carried out where it is legally and ethically justified. This means it must be essential to prevent serious harm to somebody and it must be the least restrictive option. See Appendix 1, Flow chart guide to decision making before using restraint.

Where a resident has capacity, restraint will only take place with their consent or in an emergency to prevent harm to themselves or others or to prevent a crime being committed. For residents who lack capacity to consent to restraint, staff must balance the resident's right to autonomy with the right to be protected from harm. Any decision to use restraint for a resident who lacks capacity, must be made in their best interests within the framework of the Mental Capacity Act.

The five statutory principles of the Mental Capacity Act which must be followed are:

1. Assume the resident has capacity unless there is evidence otherwise. Capacity is specific to each decision and consent must be obtained for each element of the care plan.
2. Do not treat the resident as unable to make a decision unless everything practically possible has been done to help them reach a decision – for example conveying advice in a way that the resident will be able to understand
3. Unwise or eccentric decisions don't of themselves prove lack of capacity – everyone has a right to pursue choices that others might view as unwise or risky.
4. If making a decision on someone's behalf, or acting on behalf of a person who lacks capacity, you must do so in their best interests – the 'best interests' principle only applies to those unable to make decisions after being given all of the support necessary

5. Look for the least restrictive option that will meet their need – when making a best interest decision about a resident's care and support plan care staff must consider all the options and then choose the one that meets the need and is the least restrictive.

All relevant staff will receive training so that they understand the legal and ethical implications of restrictive practices, and the techniques they can use to minimise the use of restraint.

4.2.1. Physical Restraint

Physical restraint can be defined as stopping an individual's movement using equipment that is not specifically designed for that purpose. This could be using bed rails, tables, or chairs etc.

4.2.2. Physical Intervention

Physical intervention is direct action by one or more members of staff holding or moving the person or blocking their movement to stop them going where they wish.

4.2.3. Mechanical Restraint

Mechanical restraint is the use of belts, arm cuffs, splints, or helmets to limit movement to prevent self-injurious behaviour or harm to others.

4.2.4. Environmental Restraint

Environmental restraint is designing the environment to limit people's ability to move as they might wish. This could be through locking doors, using coded electronic keypads, complicated door handles, narrow doorways, not providing corridor rails, steps of stairs, poor lighting, or heating etc.

4.2.5. Chemical Restraint

Chemical restraint is the use of drugs and prescriptions to change or moderate a person's behaviour.

4.2.6. Forced Care

Forced care is the act of forcing someone to receive care. This could be food, medication, clothing etc.

4.2.7. Threatening or Verbal Intimidation

Threatening or verbal intimidation which is used to make a person subservient or scared of doing what they want to do. It may be making someone believe they have no choice but to stay in the care home or make them fear repercussions should they choose to resist or leave.

4.2.8. Electronic surveillance

For example, the use of electronic tags, exit alarms, CCTV, and pressure pads to monitor or restrict movement.

4.2.9. Cultural restraint

Cultural restraint can be the result of constantly telling someone not to do something, or that doing what they want to do is not allowed, is illegal or is too dangerous. It could include being got up or put to bed at unwanted times or having meals at a time to suit the care home staff. It could also be seclusion in a bedroom because of the person's behaviour resulting in deprivation of activities, social contact, or other stimulation.

4.2.10. Medical restraint

Medical restraint is the fixing of medical interventions such as catheters to deliberately restrict movement or being positioned to prevent their removal.

4.3. When is Restraint Legally & Ethically Justified

Staff should always strive to support and care for people in ways that are enabling and empowering. When people are distressed, ill, angry, confused or lack understanding of their situation they may need some degree of restriction to keep them or other people safe. All restrictive interventions should be expressly acknowledged and must be legally and ethically justifiable.

Decisions to use restraint must be transparent and establish clear lines of accountability. Many of these decisions will involve assessing whether the person involved has the mental capacity to make a specific decision, for example to understand that a product or foodstuff may be unsafe, or to refuse or accept treatment. Anyone carrying out or observing restraint must be sure that it is absolutely necessary to prevent harm, that it is the least restrictive option available, that it is not done routinely for convenience, and that it is done for the shortest possible time.

It is preferable that restraint should be considered and planned, and involve the resident, and their family where appropriate, and relevant multi-disciplinary professionals. Staff must ensure that planning, monitoring, and reviewing takes place to find a more positive alternative on a longer-term basis.

Staff must not cause deliberate pain to a resident to force compliance with their instructions.

The Mental Capacity Act Code of Practice says that any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity.
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

Restraint may be legal under common law if it can be demonstrated that not restraining an individual resident would conflict with the duty of care and that the outcome would be harm to the resident or others.

4.4. Positive and Proactive Care

This involves adopting a person-centred approach to all aspects of care in a way that recognises the person and takes a positive, solution-focused attitude. This includes the following:

- Knowing that the rights of the individual are paramount and respecting them.
- Valuing the individual’s history, skills, aspirations, and knowledge.
- Involving and nurturing the individual and their support network, e.g. friends, family, community, professionals.
- Understanding that people’s behaviour serves an important function for them and is a form of communication.
- Recognising that behaviour may be influenced by a chronic, intermittent, or acute physical condition such as very high temperature / effects of anaesthesia, epilepsy, pain or the influence of drugs or alcohol.
- Recognising that behaviour may be influenced by their environment and the behaviour of others.
- Promoting choice and control for individuals in all the decisions made about their lives and involving their friends and families where this is relevant.

- Providing a space for the individual's voice and preferences to be heard; giving access to independent accessible information, advice, and advocacy to ensure that choices are well informed and current.
- Always consider people's culture and belief systems.
- Valuing workers and recognising their individual and team strengths
- Developing holistic, strengths-based plans of care that encourage positive risk-taking and enable people to live less restricted lives, while maintaining a 'duty of care'.
- Where it is not possible for the individual to make a decision at the time it needs to be made or by indicating their decision in advance, then a best interest's decision should be made – again involving all relevant people.
- Understanding that restrictive interventions are only to be used once all other planned proactive and reactive interventions have been tried or are not practical.
- Wherever possible, working with the individual and supporting them (and their family should they choose to involve them) to understand the restrictive practices that are affecting them, preferably prior to use.

4.5. Safeguarding Vulnerable Adults

Inappropriate restraint of a resident will constitute abuse under the Safeguarding Vulnerable People and Dealing With Abuse policy and will result in disciplinary action.

5. Finance, Value for Money & Social Value

N/A

6. Supported Appendices

APPENDIX 1: Flow Chart - Restraint Five Step Decision Making Process
APPENDIX 2: Record of Restraint and Intervention

7. Linked Policies

Medication Administration - Domiciliary/Extra Care (C035P)
Bed Rails (C006P)
Behaviour that Presents Risks (C007P)
Safeguarding Vulnerable Adults (LG031P)
Statutory Notification of Events (C028P)
Mental Capacity Act (C015P)
Deprivation of Liberty Safeguards (MCA DOLS) (C010P)
Care Planning & Key Working (C0008P)

8. Legislation/Regulation

Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended)
Mental Capacity Act 2005
Equalities Act 2010
European Convention of Human Rights and The Human Rights Act 1998, in particular:

- Article 2 Right to life
- Article 3 Prohibition of torture, inhuman or degrading treatment
- Article 5 Right to liberty and security of person
- Article 8 Right to respect for private and family life
- Article 10 Freedom of expression
- Article 14 Prohibition of discrimination

DoH Guidance - Positive and proactive care: reducing the need for restrictive interventions

9. Review

Every 3 years, subject to any regulatory or legislative updates.

10. Procedure/Guidance

ATD aims to provide a restraint-free environment for residents, and we will do this by:

- Creating an environment where responsible risk taking is regarded as normal.
- Providing person-centred care through the assessment of each resident's life history, habits and preferences and individualised care planning so that individual needs can be met without the need for restraint.
- Understanding that behaviour and language that is challenging and presents risks indicate unmet needs and that the first response should be to try to understand what is being communicated and to identify the unmet needs.
- Ensuring that residents, their families, and staff within the care home are aware of risks that may be associated with any activity residents may undertake and also understand the care home's duty of care to protect and safeguard residents at all times.
- Minimising the risk of harm to residents by using a planned approach to risk management; and
- Ensuring staff are properly trained so that they understand the legal and ethical implications of restraint, and the techniques they can use to prevent the use of restraint.

10.1. Restraint will only ever be used:

- When it is necessary and after all other approaches have been considered.
- When it is in the best interests of the individual.
- As a proportionate response to the level of risk of harm to the individual or others.
- For the minimum amount of time possible.
- By employing the least restrictive option which focuses on the outcomes for the individual.
- In accordance with this policy and procedure and current legislation.

10.2. Planning Restraint Free Care

The Registered Manager should take a proactive approach to reduce and prevent the use of restraint. This should be done by:

- Using individualised person-centred care planning, and a person-centred approach when providing care for residents.
- Recognising the needs of residents regarding their race, gender, sexual identity, sexual orientation, disability, age, religion, or beliefs.
- Demonstrating the continuing involvement of the multi-disciplinary health and social care team.
- Using risk assessments to manage risks and determine appropriate actions, paying particular attention to actions that might be seen as restraint.
- Using therapeutic alternatives to restraint.
- Awareness that buildings and the environment may constitute a form of restraint.
- Enabling residents to communicate their needs and make choices in a proactive way.
- Providing a range of person-centred activities for residents to increase stimulation.
- Providing chairs and beds that do not limit movement.
- Ensuring there are continence programmes in place for residents who need them.
- Providing appropriate training for all staff to raise awareness of restraint and ensure care staff understand the strategies, techniques, and interventions they can use to prevent the use of restraint. Care staff need opportunities to develop their skills and knowledge, and to share learning about how to respond to the challenges they face.
- Monitoring and managing staff attitudes and behaviours.

- Monitoring the effects of medication and arranging regular medication reviews.
- Monitoring and clearly recording the use of PRN (as required) medication.
- Recognising that when residents are happy and contented, they are less likely to demonstrate behaviours that could necessitate restraint.
- Assessing and predicting triggers for behaviours that could necessitate restraint.
- Monitoring residents' behaviours and regularly reviewing care plans.
- Ensuring residents can keep as mobile as possible.
- Ensuring residents have regular contact with their family, legally appointed representative, or mental capacity advocate, and that these people are routinely consulted when restraint is an issue; and
- Talking openly about restraint with residents, relatives, and staff to help promote good practice.

10.3. Risk Management

- Residents who have mental capacity are responsible for the risks they take but the care home also has a responsibility to manage risks. The primary aim of the risk management process is to balance independence and safety in an informed way. Effective risk management will minimise the perceived need for restraint.
- Individualised risk assessments should identify strategies that enable residents to enjoy freedom of choice and movement, whilst keeping them as safe as possible. This might include the provision of additional safety equipment, aids/adaptations, or monitoring equipment to assist the resident to manage more independently. Risk assessments should form part of a full assessment and outcomes should be recorded in the resident's care plan.
- Individual residents may be provided with additional safety equipment as agreed with them and detailed in their care plan. This may include aid/adaptations or monitoring equipment to assist the resident to manage more independently.
- Minimising risks in a care home is achieved by good management and care practice. Rigorous compliance with Health and Safety policies and associated procedures will ensure a safe environment, and delivering care in accordance with policies, procedures and agreed care plans will minimise unnecessary and foreseeable risks.
- All staff should be aware of the needs of the residents and should be continually alert to the risks which can arise from normal daily activities. By establishing good relationships and effective communication with residents, staff will be well placed to reduce the incidence of unforeseen risks.
- The physical environment should be suitably arranged, furnished, and equipped to provide an appropriate level of safety and security. Furniture and fittings should be suitable for the residents who live in the care home and should protect residents from risks. Using the physical environment to promote a sense of wellbeing can help avoid some of the situations that result in the use of restraint. Windows with a view to an accessible outside space, good lighting, distinctive colours for different units, open shelves and cupboards inviting individuals to explore the contents, and clear signage are just some of the ways in which the environment can be used positively. Many possible changes can be identified with the help of staff, resident, and relatives, and often made with little expense; and
- Doors may need to be alarmed or locked when not being monitored (this may include the front door, which if locked also safeguards people in the home from intrusion). However, careful consideration should be given to door security systems to ensure that all residents are not restrained because of safeguards for a resident most at risk.

10.4. Strategies, Techniques & Interventions

The key to providing restraint free care is individualised person-centred care, which depends on staff knowing the resident as a person. Effective care planning involves knowing a resident's needs and preferences and understanding how to make use of the resident's abilities to avoid conditions that lead to behaviours that present risks and inappropriate use of restraint.

Staff should help residents to avoid difficult situations that might escalate. The following is a list of interventions and techniques that staff can use to de-escalate a potentially difficult or violent situation:

10.4.1. Non-verbal calming interventions:

- Planned ignoring – down play situation by intentionally disregarding behaviour but not the person.
- Planned attention – pay extra attention or involve a resident more.
- Eye contact – show attention by eye contact.
- Time out/away – remove outside stimulus and distractions.
- Body language – do not intimidate; appear comfortable, relaxed and in control.
- Close proximity – getting physically closer if safe to do so which may deter behaviour.

10.4.2. Verbal de-escalation interventions:

- Listening – enabling resident to vent feelings or frustration.
- Validating – acknowledging anger or other feelings.
- Distracting – using short questions requiring short answers.
- Reassuring – showing willingness to help with a problem.
- Modelling – using voice control IE model the voice to a level the resident can use.
- Reminding – explaining (or reminding) of natural consequences.
- Redirecting – changing activity to divert energy and attention to a substitute activity.
- Mediating – offering one to one discussion; and
- Calming – suggesting the resident breathes deeply; washes their face; writes, knits, reads, sings, walks etc.

10.5. Appropriate Use of Restraint

Restraint should always be seen as a 'last resort' and should only be considered when all other techniques, strategies and interventions have been tried without success. However, in some cases using restraint is the most appropriate course of action and not to do so on these occasions could be considered neglect.

Restraint can be used:

- If the resident consents to it, perhaps because it makes them feel safer. For example, the use of bedrails to prevent a resident from falling out of bed.
- If it is part of the resident's care plan and they have agreed to it. For example, the use of a pressure mat at the side of a resident's bed where the resident might not be able to use the call bell to summon assistance.
- If the resident lacks the capacity to consent but is behaving in a way that may cause harm to themselves or others.

The Mental Capacity Act 2005 helps us to understand that restraint can be used if it is believed to be in the resident's best interests.

The amount or type of any restraint used must be considered necessary to prevent harm to the resident or others. It must be a proportionate response to the likelihood and seriousness of harm to the resident or others, used for the shortest possible time, with the least amount of restriction, and as safely as possible.

Wherever possible, care home staff should seek the views of other people involved in the care of the resident in order to decide on what actions might be best to protect them from harm.

10.6. The Five Step Framework

Although some difficult situations demand an immediate decision about whether to use restraint, most develop over a longer period. A five-step framework has been developed by the Social Care Institute for Excellence (SCIE) to help staff to make informed decisions.

10.6.1. Step 1 - Observe:

Think about the situation that might prompt the need for restraint and consider the following:

- What is the resident saying and how do they look?
- What are they doing?
- What are the staff saying?
- When is it happening?
- Who is it a problem for?
- Is anyone else involved or present?

10.6.2. Step 2 - Do some detective work:

Try to find out:

- What the behaviour might mean?
- What risks are associated with the behaviour?
- Who is it risky for?
- Who else should be consulted?
- What the legal position is?

10.6.3. Step 3 - Consider options and make a decision:

Think about:

- What are some options for how you could respond?
- What works to help this person?
- When are they happiest?
- Which is the least restrictive option if restraint is needed?

10.6.4. Step 4 – Implement the plan:

Agree:

- How long the approach should be tried before it is reviewed?
- What records should be kept?

10.6.5. Step 5 – Monitor and review the plan:

Consider:

- Has the intervention helped?
- Who has it helped?
- What does everyone think?
- Are any changes needed or do staff need to try something different?

10.7. Use of restraint in an emergency

Sometimes staff may have to deal with a situation that no-one had expected or prepared for. In an emergency, where staff perceive a resident or others to be in immediate danger,

the priority must be to protect the resident and others from harm as far as possible and the focus should be on the outcome for the resident concerned. Staff must always be mindful that the negative effects of restraint on an individual resident may make a difficult situation worse.

The senior member of staff on duty should carry out a risk assessment to ensure the appropriate techniques are used. The risk assessment must be completed and recorded before restraint is agreed and used, but in an emergency, it may not be possible to complete the record of the risk assessment until after the event. However, in all cases, the assessment should include:

- The behaviour that presents the risk and the likely or possible reasons for it.
- The level of risk involved and likelihood of harm.
- Who is at risk of harm IE the resident, other residents, staff.
- Details of interventions already tried.
- The least restrictive intervention to be used and the minimum duration of the restraint.

The senior member of staff on duty must ensure that an accurate and detailed account of the circumstances and restraint used is recorded in the resident's daily records and that the care plan is reviewed and updated accordingly.

Whenever unplanned restraint has been used, the matter should be reported as soon as possible to the Registered Manager.

All incidents involving restraint should be followed by an assessment of the person restrained and others involved in restraint for signs of injury and any emotional or psychological impact. The impact of an incident may not be immediately apparent and so the wellbeing of people affected may need to be monitored over a period. Where necessary, appropriate healthcare professionals should be involved.

10.8. Record of Restraint and Intervention

To help protect the interests of residents with whom restrictive interventions are used, it is good practice to involve the resident and, wherever possible, relatives, advocates, and other relevant representatives (e.g. the attorney or deputy for a person who lacks capacity) in planning, monitoring, and reviewing how and when they are used. This includes ensuring all reasonable adjustments are made and that documentation is in a format the resident understands. If the resident is not involved this should be fully documented and justified.

Following any occasion where restraint is used, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident) using **Appendix 2: Record of Restraint and Intervention form**. The record should indicate:

- the names of the staff and people involved
- the reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)
- the type of intervention employed
- the date and the duration of the intervention
- whether the person or anyone else experienced injury or distress
- what action was taken.

The following people should be informed and involved:

- The resident.
- The resident's representative or advocate.

- Relevant members of staff.
- Health or social care professionals involved in the resident's care.
- The Registered Manager.
- The Registered Manager's line manager.

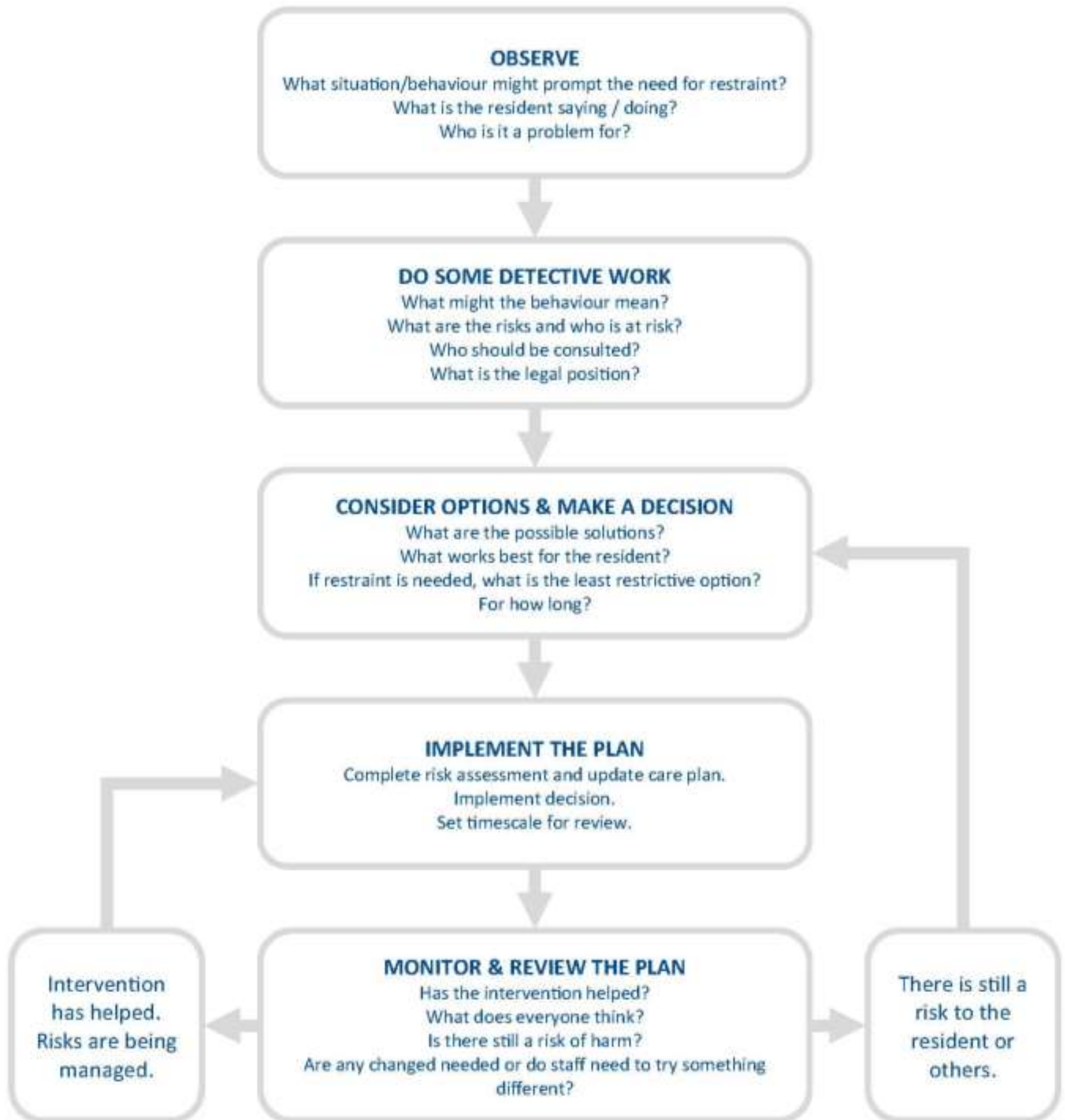
The Registered Manager is responsible for notifying the Care Quality Commission in accordance with regulatory requirements.

Others who may need to be informed include the local authority or PCT where they are involved in commissioning the care for resident; the police where a criminal offence has been committed or is suspected; the local authority safeguarding team where abuse of a vulnerable person is involved or suspected; Deprivation of Liberty Safeguards assessor where a person may have been deprived of their liberty.

10.9. Use of restraint in an emergency

www.scie.org.uk

APPENDIX 1: Flow Chart - Restraint Five Step Decision Making Process



APPENDIX 2: Record of Restraint and Intervention

Abbeyfield The Dales Ltd

Record of Restraint & Intervention

THIS FORM MUST BE COMPLETED IMMEDIATELY FOLLOWING ANY UNPLANNED INTERVENTION RESULTING IN RESTRAINT

(To be kept with the care plan)

Any intervention that restricts a resident's freedom should only be used in exceptional circumstances, in accordance with Abbeyfield's Appropriate Use of Restraint Policy and fully recorded.

Incident details :

Resident Name:		Suite/Apt:	
Site:			
Location of incident:			
Date of incident:	/ /	Time:	:
Name(s) of staff involved:			
Name(s) of witnesses:			
Type:	☐ 1 Bed ☐ 2 Bed ☐ Bedsit		

Behaviour that presented risk:

Description of behaviour that presented risk:

Nature of potential harm:

Likelihood of harm:

Interventions already tried:

Did the resident consent to restraint being used? ☐ Yes ☐ No

Did the resident have the mental capacity to refuse or consent? ☐ Yes ☐ No

Record of Restraint and Intervention

Full description of restraint used:

Who was involved in making the decision to use the restraint?

Was anyone injured? ☐ Yes ☐ No

If Yes, complete Accident Reports and give details:

Has the resident suffered any emotional or psychological impact?

What was the duration of the restraint and when was it discontinued?

Who was informed?

Which of the following have been informed and when (state if not applicable):

	Name:	Date:	Time:
Next of Kin:			
Representative/Advocate:			
Registered Manager:			
Social/healthcare professionals:			
CQC:			
LA/PCT:			
Police:			
Safeguarding Team:			

Any additional information:

Signed: Date: / /

Role:

This form should now be passed to the Registered Manager

This section is to be completed by the Registered Manager

Was the restraint necessary to prevent harm?	☐ Yes ☐ No
Was the action taken a proportionate response?	☐ Yes ☐ No
Was the restraint in the best interests of the resident?	☐ Yes ☐ No
Was the action taken the least restrictive option available?	☐ Yes ☐ No
Was the restraint used for the least amount of time possible?	☐ Yes ☐ No
Has the care plan been reviewed and updated as a result of this incident?	☐ Yes ☐ No
If the resident lacked capacity to refuse/consent, has an assessment of mental capacity been completed?	☐ Yes ☐ No

If No to any of the above, or if any further actions are required, give details here:

Lessons learned from this incident:

Signed:

Registered Manager:		Date:	/ /
Line Manager:		Date:	/ /