Reducing need to restrain vulnerable patients

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Positive behavioural support
The guidance recommends an individualised, recovery-based approach for patients and clients that incorporates positive behavioural support. It states that evidence has shown that such support can enhance quality of life and reduce behaviours that challenge, which in turn can lead to a reduction in restrictive interventions. Patients may engage in challenging behaviours because:
- They have challenging or complex needs that are not being met. These could be associated with personal preferences, sensory impairments or mental or physical conditions;
- They are exposed to challenging environments that lack stimulation, have institutional blanket rules, restricted or unpredictable access to preferred activities and insufficient positive social interaction or choice;
- They have a generally impoverished quality of life.

Positive behavioural support addresses these underlying difficulties, using a person-centred, values-based approach to ensure patients are living the best life they can. This may involve assisting them to develop personal relationships and improve their health. It also includes skilled functional assessment to understand probable reasons for episodes of challenging behaviour, and what predicts and sustains this. Based on this assessment, behaviour support plans outline primary, secondary and tertiary preventive strategies.

Primary strategies involve addressing challenging aspects of the patient's environment, enhancing quality of life and supporting patients to meet their own needs. Secondary strategies include...
de-escalation techniques, distraction, diversion and sometimes disengagement to be used by carers and staff when a patient becomes anxious, aroused or distressed. Tertiary strategies are used in crisis situations where patients put themselves or others at significant risk of harm, and may involve restrictive interventions.

The guidance recommends that anyone likely to be exposed to restrictive interventions should have a behaviour support plan, and that such plans should be incorporated into care-programme approach care plans or personal recovery plans (Box 1).

Managing unforeseen behaviour
The DH (2014) guidance recommends that restrictive interventions should never be used to punish, or for the sole intention of inflicting pain, suffering or humiliation. They should only be used when there is a real possibility of harm to the patient, staff or the public if no action is taken. In addition, the guidance states that:
- Techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm;
- Action taken must be the least restrictive option that will meet the need; and
- Any restriction should be imposed as a last resort, and for no longer than absolutely necessary.

What is done to patients, why and with what consequences must be subject to audit and monitoring and must be open and transparent. Service users and carers must be involved in reviewing plans for restrictive interventions.

Intervention techniques
The guidance offers recommendations on physical restraint, mechanical restraint, chemical restraint, seclusion and long-term segregation.

Physical restraint
Where physical restraint is concerned, staff must not cause deliberate pain to force compliance with their instructions. Where there is an immediate risk to life, recognised techniques that cause pain as a stimulus may be used, but they must be used proportionately and only in exceptional circumstances. The guidance recommends that staff should not:
- Deliberately restrain someone in a way that impacts on their airway, breathing or circulation;
- Cover the person's mouth or nose or put pressure on the neck region, rib cage or abdomen;
- Intentionally restrain someone in a prone (face down) position on any surface.

If they do unintentionally restrain someone face down, staff should release their holds or reposition the person into a safer alternative position as soon as possible. They must not deliberately allow someone to fall, unless there is a need to escape from a life-threatening situation, and must not use painful restraint or breakaway techniques other than for an immediate rescue in a life-threatening situation.

While restraint is being used, a member of staff should take responsibility for communicating with the patient to try and de-escalate the situation, and support staff should monitor the patients airway and physical condition throughout. If the patient's physical condition and expressions of distress give rise to concern, the restraint must stop immediately. There should be recording and debrief after incidents of restraint, and staff should monitor the patient for signs of emotional or physical distress for a significant period of time.

Mechanical restraint
The guidance states mechanical restraints should never be a first-line means of managing disturbed behaviour and should be used only in exceptional circumstances. It recognises that after assessment, there may be circumstances in which mechanical restraints need to be used to limit very intense, frequent self-injurious behaviour, for example among some people with severe cognitive impairments. There may also be occasions when restraint is needed for security, such as when transferring prisoners into a healthcare setting.

Chemical restraint
Medication for controlling or subduing disturbed or violent behaviour should only be prescribed and administered for a person who is:
- Highly agitated or aggressive;
- Making serious threats to others and being destructive to their surroundings;
- Unresponsive to other therapeutic interventions.

The guidance stresses this must be a very short-term strategy designed solely to reduce immediate risk, and that this is distinct from treating any underlying mental illness. It states oral medication should be considered first for rapid tranquillisation and, if an intramuscular injection is required, the prescriber should take account of the need to avoid face-down restraint when choosing the injection site.

Seclusion
The guidance states only people detained under the Mental Health Act should be considered for seclusion. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, it should be used for the shortest possible period to manage the emergency situation. An assessment for detention under the Mental Health Act should then be undertaken immediately.

Long-term segregation
Long-term segregation should only ever be used for hospital patients who present an almost continuous risk of serious harm to others. It should never take place out of hospital and should never be used with people not detained under the Mental Health Act.

When restrictive interventions are not enough
The guidance refers to NHS Protect (2013) guidance, which indicates trigger points for seeking further assistance from the police. Staff have a responsibility to alert police to any specific risks or health problems the person may have.

Conclusion
The DH (2014) guidance offers clear advice on managing people with challenging behaviour and avoiding physical restraint, which should only be used as a last resort.

References

Department of Health (2014) Positive and Proactive Care: Reducing the Need for Restrictive Interventions. tinyurl.com/DH-restraint


BOX 1. THE SAFEWARDS MODEL

The Safewards model has demonstrated significant efficacy at reducing conflict and the use of physical restraint, seclusion and rapid tranquillisation in acute UK mental health settings (Bowers, 2014). It involves practical steps to avoid flashpoints, achieve de-escalation and embed alternatives to restrictive interventions. The Department of Health says all providers should consider how the Safewards model could apply to their context.