

Guidance for inspectors

How to move towards restraint free care

This guidance will help you to understand why it is so important to limit the use of restraint in care services. And also give you some understanding of different types of restraint. It will let you know how the service you are regulating should manage restraint, and what you need to look for when inspecting.

Main points:

1. Respecting people's rights to dignity, freedom and respect underpin good quality social care. People may need support in managing their care and making decisions but they have the right to make choices about their lives and to take risks.
2. People using care services are free to do what they want, and go where they want unless limited by law.
3. Restraint is illegal unless it can be demonstrated that for an individual in particular circumstances not being restrained would conflict with the duty of care of the service. And that the outcome for the individual would be harm to themselves or for others.
4. Enabling people in care services to take risks, make choices and keeping them safe is a difficult balance.
5. Restraint can take many different forms. It is not limited to a physical intervention by another person stopping someone doing something. It can include amongst other things the use of drugs, the environment or surveillance to restrict people's actions.
6. Where people in care services have capacity restraint 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.
7. In all cases restraint should very much be seen as the 'last resort', with other techniques and strategies always being employed before restraint is considered as an option.

8. Any restraint should be in the best interests of the person. Based upon the level of risk present, taking account of the person's size, gender, age and medical conditions. It should be used for the minimum amount of time and with the least amount of intervention.
9. Any restraint should always follow agreed policies and procedures that focus on best practice and improved outcomes for the individual.
10. The misuse of physical restraint has resulted in many injuries, and in the most serious case, deaths. If restraint is seen to be necessary to maintain an individual's safety, or the safety of others, the agreed methods of how and when it should be used must be clearly detailed, and those involved in the intervention must have received the appropriate training.
11. As an inspector you must be able to:
 - Know when restraint is taking place.
 - Whether the restraint is legal.
 - Whether the restraint is appropriate.
 - Assess the quality of the practice being used.
 - Know what action to take.
12. This guidance **will** help you to:
 - Recognise when restraint is taking place in a service.
 - Understand the balance, and potential conflict, between promoting the rights and safety of the individual.
 - Understand the relevant legislation that affects restraint.
 - Know what codes and principles should be followed when restraint is taking place.
 - Understand how services should be managing restraint within their service.
 - Know where to go to find out more information about restraint.
13. This guidance in itself **will not**:
 - Give you in depth detail of physical intervention techniques or other restraint practices.
 - Be the only resource you will need.
 - Give you the answers to all the dilemmas that you might come across.
 - Cover the deprivation of liberty safeguards that are being developed by the Department of Health for introduction in 2008 (these are known as the Bournemouth safeguards).

Guidance:

How do we define restraint?	<ul style="list-style-type: none">• The Mental Capacity Act 2005 describes restraint as: the use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.• This guidance takes a wide view of the definition of restraint and incorporates other widely used terminology such as 'physical intervention' or 'restriction of liberty' in its scope.
What are the different types of restraint that we consider in services we regulate?	<ul style="list-style-type: none">• What is generally termed 'physical restraint' can be subjective and wide ranging, however we can be more precise in our definitions:<ul style="list-style-type: none">○ Physical restraint can be defined as stopping an individual's movement by the use of equipment that is not specifically designed for that purpose. This could be through the use of bed rails, belts, tables or chairs etc.○ 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. This should not be confused with interventions such as guiding and prompting that are intended to support the person.○ Mechanical restraint is the use of belts, arm cuffs, splints or helmets to limit movement to prevent self-injurious behaviour (SIB) or harm to others.• 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 or stairs, poor lighting or heating etc.• Chemical restraint is the use of drugs and prescriptions to change or moderate people's behaviour. This is also known as covert medication.• Forced care is the act of 'forcing' someone to receive care. This could be food, medication, clothing etc.• Threatening or verbal intimidation this could be used to make a person subservient or scared of doing what they want to do. It may also be acts calculated to lead people to believe they have no option but to remain in a particular care setting, or make them fear repercussions should they choose to resist or leave.• Electronic surveillance - examples include the use of electronic tags, exit alarms, CCTV and pressure pads to monitor or restrict movement.• Cultural restraint can be the result of constantly telling people not to do something, or that doing what they want to do is not allowed, is illegal, or is too dangerous. It could also include being got up or put to bed at unwanted times, or having meals at a time to suit the staff. It could also be seclusion in bedrooms because of their behaviour resulting in deprivation of activities and other stimulation.• Medical restraint is the fixing of medical interventions such as catheters to deliberately restrict movement or being positioned to prevent their removal.

<p>What is the legislative and regulatory framework that underpins restraint, and what other guidance and codes of practice apply?</p>	<ul style="list-style-type: none"> • There is no one piece of legislation that specifically looks at the use of restraint, but there are a number of laws that have a direct relevance and include reference to restraint within them. • The most relevant legislation for us as regulators is the Care Standards Act 2000 and it's associated regulations (e.g. Care Homes Regulations 2001, Domiciliary Care Agencies Regulations 2002). These provide us with the legal framework to act if we see inappropriate physical restraint or physical intervention taking place. • In particular Regulation 13 (7) (a) of the Care homes Regulations 2001 (as updated in October 2007) says '<i>the registered person shall ensure that no service user is subject to physical restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances</i>'. • And Regulation 13 (7)(b) '<i>in the case of a person that lacks capacity in relation to the matter in question, the act meets the conditions of section 6 of the 2005[Mental Capacity] Act</i>'. • Regulation 13(8) of the Care Homes Regulations says '<i>on any occasion on which a service user is subject to physical restraint, the registered person shall record the circumstances, including the nature of the restraint</i>' • Also less specific, and do not directly mention restraint, but could be used by us to make requirements on non-physical restraint are Care Homes Regulations 2001: <ul style="list-style-type: none"> ○ 12(1)(a) <i>The registered person shall ensure that the care home is conducted so as to promote and make proper provision for the health and welfare of service users.</i> ○ 12(3) <i>The registered person shall, for the purpose of providing care to service users, and making proper provision for their health and welfare, so as far as practicable ascertain and take into account their wishes and feelings.</i> ○ 13(6) <i>The registered person shall make arrangements, by training staff or by other measures, to prevent service users being harmed or suffering abuse or being placed at risk of harm or abuse.</i> • This list is not exhaustive. There could be more relevant regulations that you could use depending on the nature of the restraint. • Other legislation includes: <ul style="list-style-type: none"> ○ The Human Rights Act 1998. <ul style="list-style-type: none"> • It includes a number of provisions which could be relevant to the use of restraint. Article 3 <i>prohibits 'torture and inhuman or degrading treatment'</i>; Article 5 acknowledges that '<i>everyone has the right to liberty and that it should only be restricted if there is specific legal justification</i>' and Article 14 outlaws '<i>discrimination of all types</i>'. • It makes it an offence for any public body to act in a way that contravenes a person's human rights; however a recent case has determined that it does not apply to private providers of care services. • We are a public body and we must ensure that in our
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Legal framework continued...

regulation of care services we do not act in a way that breaches a person's human rights. We must therefore take action when we see restraint taking place that is not legitimate.

- **Mental Capacity Act (MCA) 2005.** The MCA came fully into force on 1 October 2007. It is designed to protect people who lack the ability to take decisions for themselves. It establishes:
 - 5 key principles:
 1. A person is assumed to have capacity.
 2. People must be helped to make decisions.
 3. Unwise decisions do not necessarily mean lack of capacity.
 4. Decisions must be taken in the person's best interests.
 5. Decisions must entail the least possible restriction of freedom.

It goes on to detail:

- How and when a person's ability to take some or all decisions – their 'capacity' to do so – should be assessed.
 - The MCA code of practice defines a 2 stage of test of capacity, and defines incapacity.
 - The responsibilities and duties of people who take decisions on other people's behalf.
 - The Act defines restraint and gives criteria that need to be met for restraint to legally occur, they are:
 - The person lacks capacity and it will be in the person's best interests *and*
 - It is reasonable to believe that it is necessary to restrain the person to prevent harm to them *and*
 - Any restraint is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm
- In addition to these legislative provisions, other guidance and codes of practice are relevant. In particular:
 - **Department of Health (DH)** release circulars under section 7 of the Local authority social Services Letter (LASSL) Act 1970. They released guidance (with DfES) in July 2002 called '**Guidance for restrictive physical interventions. How to provide safe services for people with learning disability and autistic spectrum disorder**'. This guidance was for providers, commissioners and regulators. Its purpose was to ensure that physical interventions are used as infrequently as possible, that they are used in the best interests of using services, and that when they are used, everything possible is done to prevent injury and maintain the person's dignity.
 - Staff working in social care have a **duty of care** towards the people they are supporting. '**Independence, choice and risk a guide to best practice in supported decision making**' (DH 2007) defines duty of care as 'obligation placed on an individual

<p>Legal framework continued...</p>	<p>requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could foreseeably harm others'. This means that when people using services voluntarily choose to live with a level of risk (and have mental capacity to make these decisions) there can be no breach of duty of care. Historically duty of care has been seen as a way of limiting risk, reducing choice and imposing restrictions on how people live their lives. The principle of duty of care should inform the risk assessment process, but not be used as an excuse to artificially create limits on peoples' rights and choices to live the lives they choose</p>
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<p>Why is a person's 'capacity' so important?</p>	<ul style="list-style-type: none"> • If a person has capacity, does not consent and there is no risk of harm to other people then restraint is not justified. • Everyone should be assumed to have capacity until it is shown otherwise. • People should be given as much help as possible to support their ability to make decisions. • To have capacity the person needs to be able to understand the information they are being given, to retain the information, come to a decision and communicate that decision. • A person might have a temporary or intermittent loss of capacity Example: <i>the effects of alcohol or drugs might make it so a person does not have capacity for a period of time.</i> • Someone can only give consent if they have capacity and while a person is unlikely to give consent to restraint if they have capacity, this might happen in certain situations when the person recognises that their actions might endanger others or themselves. • A person's capacity might vary from situation to situation – meaning that the individual circumstances are important, in effect a person
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	<p>might:</p> <ul style="list-style-type: none"> ○ Have the capacity to make a decision in one particular area but not in another. ○ Have capacity about an issue at one particular time, but not at another. <ul style="list-style-type: none"> ● The decisions of a person with capacity must be respected even if they appear unwise or eccentric. ● If the person does not have capacity others must be consulted where practicable. ● All actions on behalf of people without capacity must be taken in their best interests.
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<p>Who decides if a person has capacity?</p>	<ul style="list-style-type: none"> ● Anyone can decide if someone has capacity or not. Example: <i>A care assistant can legitimately decide what clothes a person should wear if they do not have the capacity to make the decision themselves.</i> ● The more complicated or serious the implications regarding the capacity issue the more safeguards there should be put in place to prevent abuse of the decision making process. ● We have separate guidance that goes into more detail of the principles of capacity, and the process that services should be follow. It is important to be familiar wit these principles before making any assessment. The links to this guidance can be found at the end of this document.
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<p>What happens if a person does not have capacity?</p>	<ul style="list-style-type: none"> ● The fact that someone does not have capacity does not mean that restraint or other practices to limit a person's freedom can be freely used. ● If someone does not have capacity then the MCA (and its code of practice) defines a clear process that care services should follow to assess and record decisions that are being made on a person's behalf. ● If it has been agreed that someone lacks capacity then the decisions made on their behalf must be clearly defined. This is because it is important that services do not assume someone lacks capacity in all situations this could result in people being unnecessarily restrained.
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<p>Are there any differences in the types of service we regulate?</p>	<ul style="list-style-type: none"> ● The same principles apply to all services that we regulate ● Some types of restraint might be more prevalent in certain settings – Examples: <i>environmental, physical, cultural or medical restraint in care homes for older people, or physical intervention and mechanical restraint in homes for younger adults.</i> ● There might be a higher awareness level of the principles and what constitutes restraint in certain service types than others. Examples: <i>In homes for younger adults whose behaviour can challenge the service there should be a wider understanding of the issues surrounding restraint than there is in domiciliary care agencies.</i> ● Traditionally there has been more information available for services for people with learning disabilities and/or people with autistic spectrum disorder. ● An understanding of restraint does not necessarily mean that practice will be any better.
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<p>Should I be more concerned about certain types of restraint than others?</p>	<ul style="list-style-type: none"> • You should focus on outcomes for the individual. Example: <i>A person with dementia may be restricted into a particular area of a home, with doors that have key pad access, because there is a high risk of them wandering out of the building onto the main road. However, another method of keeping them safe could be using medication (chemical restraint) to make them drowsy and affect their mobility so they cannot wander around. There are very different outcomes for the individual in these two methods.</i> • The type of restraint used must be proportionate to the level of risk of harm to the individual or others. The guiding principle must be to use the least restrictive option. • However any type of physical intervention that means that a person is held in a prone (on their front) position is potentially extremely dangerous, and very careful management of these types of restraint need to be demonstrated. • Restraint should only ever be used as a 'last resort', and if it is used the service should be very aware of the particular issues in the client group being supported. Example: <i>Any physical intervention with older people should have due regard for their frailty.</i>
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<p>What should a service be doing to prevent the need for the use of restraint?</p>	<p>A service that is proactive in reducing the levels of restraint should:</p> <ul style="list-style-type: none"> • Use person centred planning, and a person centred approach when providing care to a person. • Recognise the particular needs of people regarding their race, gender including gender identity, sexual orientation, disability, age, religion or belief. • Demonstrate the continuing involvement of the care manager (if applicable) and extended multi- professional team e.g. Speech and language therapist, psychologist, occupational therapist. • Use risk assessments to provide governance to actions that might be seen as restraint. • Be using therapeutic alternatives restraint and understanding that restraint must only be used as a 'last resort'. • Be aware that the buildings and the environment may constitute a form of restraint, and be proactive in how they enable people to make choices. • Provide a range of person centred activities and programmes for people using the service to increase stimulation. • Ensure that people who use services are enabled to communicate their needs. • Provide chairs and beds that do not limit movement. • Ensure that there are continence programmes in place for people that need them. • Ensure that there is clarity provided to staff about what is acceptable practice. • Constantly monitoring and managing staff attitudes and behaviours. • Monitor the effect of medication and arrange regular medication reviews. • Monitor and clearly record of the use of 'as required' (PRN) medication. • Be aware that when a person is happy, contented and 'free from fear'
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<p>What should a service be doing to prevent the need for the use of restraint? Cont...</p>	<p>they are less likely to demonstrate behaviours that could necessitate restraint.</p> <ul style="list-style-type: none"> • Be proactive in their assessing and predicting triggers for behaviour that could result in restraint. • Monitor behaviour and regularly review care plans. • Train staff appropriately and raise awareness of restraint. • Have good policies and procedures – which have input from people using services. • Ensure that people using services are kept as mobile as possible, and use innovative methods to achieve this. • Ensure that people who use services have regular contact with their legally appointed representative or mental capacity advocates, and that these people are routinely consulted when restraint is an issue.
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<p>Why should I be concerned if restraint is happening regularly in a service?</p>	<ul style="list-style-type: none"> • It could mean that the service is breaking the law and using practices that are illegal. • It could show a lack of focus on the individual and working in a person centred way. • It could indicate that care planning is poor, with a lack of information about the person's life and methods of support. • If the same type of restraint is used, it could indicate that restraint is becoming habitual. (However you should be aware that it could also mean that the service is planning well and is using a method that is successful. You will only know by further investigation of care plans, recordings and discussion with relevant people) • It could indicate that restraint is not being accurately and consistently recorded. • It could be an indication of poor recruitment or training of staff. • If it is happening to the same person, or group of people it could indicate lack of skill or experience in working with a particular client group or behaviour. • It demonstrates lack of alternatives being explored. • It could be institutional abuse. • It could indicate a lack of multi disciplinary approach. • It could ask questions about the placement: Is the person in the right setting? • It could indicate some systematic problems with the environment. • It could be an indicator of collusive practice taking place, everyone thinking the practice is acceptable, with a lack of opposition. • It could indicate that there is a lack of staff to manage issues without resorting to the use of restraint. • It could be they have not properly assessed the person's capacity in a range of specific situations • The service could be adopting a 'blanket approach' to restraint e.g. locked doors for all people using the service. • Could be that one particular group is being targeted e.g. dementia.
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<p>If restraint is taking place what should we expect to see within a service?</p>	<ul style="list-style-type: none"> • Appropriate training for staff • That it is only being used as a final option when there is no less restrictive alternative. It should be used for the shortest possible time and as safely as possible. • A focus on prevention to limit the use of restraint. Prevention can be either primary or secondary: <ul style="list-style-type: none"> ○ Primary prevention is based on: <ul style="list-style-type: none"> ▪ Putting systems and process in place to limit the possibility of the need for restraint ▪ Having an awareness of the person's needs and methods of communication. ▪ Working in a person centred way. ▪ Having sufficient staff numbers available. ▪ Having a staff team that is skilled, experienced and used to supporting the person. ▪ Helping people using services to avoid difficult situations that might escalate. ▪ Understanding potential triggers of behaviour that might result in the need for restraint. ▪ Using person centred plans. ○ Secondary prevention is more immediate action that needs to be taken if the primary prevention has not been successful, and is based on: <ul style="list-style-type: none"> ▪ Diffusion and de-escalation of behaviour. ▪ Recognising and acting upon the early stages of when behaviour could escalate into violence or aggression. • Clear policies and procedures about restraint that: <ul style="list-style-type: none"> ○ Reflect current legislation and best practice. ○ Have been developed with the input of people that use services and professionals. ○ Clearly explain what is meant by restraint and its scope. ○ When restraint can be used and the procedures to follow ○ Are widely known by staff and explained to people that use services. ○ Are regularly reviewed.
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<p>What documentation should providers be completing?</p>	<ul style="list-style-type: none"> • Risk assessments that: <ul style="list-style-type: none"> ○ Are relevant for the risk assessment of identified behaviour ○ Are individualised. ○ Are relevant for specific situations, and not generic. ○ Use information included within the person's care plan. ○ Balance the activity with potential for the risk of harm. ○ Involve the person using services and / or others people important to the person using services. ○ Recognise the wider scope of restraint including possible environmental, chemical and cultural restraint. ○ Use a multi disciplinary approach.
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	<ul style="list-style-type: none"> ○ Explore alternatives to restraint ○ Focus on prevention ● Providers must Record when restraint has taken place. This recording should be: <ul style="list-style-type: none"> ○ Clear, consistent and individualised. ○ Completed as soon after the event as possible. ○ Used to identify why restraint took place. ○ Used to detail what actually happened, including: <ul style="list-style-type: none"> ▪ When? ▪ Who was involved? ▪ How long the restraint lasted? ▪ What form did the restraint take? ▪ Were there any injuries? ▪ Was there any impact of the restraint on other people using the service? ▪ Have the relevant people been informed that restraint took place? ○ Used to record what has been learnt, including: <ul style="list-style-type: none"> ▪ What did not work well? ▪ What did work well? ▪ What could be done differently, and was the least restrictive form of restraint used? ▪ Are there any training needs identified for staff? ▪ Discussing the event with the person using services and seeking and recording their views. ▪ Does the person's care plan need updating? ▪ Are risk assessments still valid? ▪ What are the implications for debriefing people that use services, staff or other witnesses ● Any planned restraints should be monitored and regularly reviewed to ensure that they are still appropriate to meet the need and are part of a more proactive approach to reducing the impact of the person's behaviour. ● Recording should show evidence of consultation with any legally appointed representatives, or mental capacity advocates.
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<p>What training should staff have received?</p>	<ul style="list-style-type: none"> ● Staff should receive training in the wider implications of restraint (including legal issues) and the different types of restraint. ● Training should be provided in the area of equality and diversity to help recognise particular issues regarding a persons race, gender including gender identity, sexual orientation, disability, age, religion or belief. ● Training should be based on an audit of the specific needs of the people being supported, and tailored to address these identified needs. ● Staff should not receive training in unacceptable restraint methods as this could legitimise restraint that should not be used in any circumstances. E.g. Restraint that relies on the direct infliction of pain. ● Any staff using planned physical intervention must have had appropriate training in its use. ● Physical interventions training delivered to staff who work with people with learning disabilities or an autistic spectrum condition should be from a source accredited by BILD (British Institute of Learning
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	Disabilities).
Does every case of restraint need reporting to us by Regulation 37?	<ul style="list-style-type: none"> • No, it depends on the impact of the restraint. • We need to know if there was: <ul style="list-style-type: none"> ○ Significant distress caused to the person that might have resulted in PRN medication or a change to the persons care plan. ○ Injury to person, staff, other person using the service or member of the public. ○ Hospitalisation. ○ Damage to property. ○ Police involvement.
Where do I include information about restraint in my report?	<ul style="list-style-type: none"> • Care homes for adults 18-65: National Minimum Standards (NMS) 23.5, 2.5, 9.2 and 35.8 are all relevant. • Care homes for older people: NMS 18.5 • Adult placement schemes: 10.4 • Domiciliary Care: NMS 14.5 and 24.1
What do I do if I have serious concerns about the level of restraint in a service?	<ul style="list-style-type: none"> • Explain your concerns to the registered person and the reasoning behind them. • Give an opportunity to the registered person to explain why they are using restraint, and assess their response. • If necessary seek further advice on what is considered best practice. • If you feel the practice is in breach of the regulations you should make a requirement on the service using the most relevant regulation. • Adjust the timescale that you attach to the requirement to match the seriousness of the issue, with more serious issues having an immediate requirement. • If what you see could be seen as being abusive then you should make a safeguarding referral to the local authority or the police using our safeguarding methodology. • If what you see is criminal then you should inform the police using the safeguarding methodology
Where else can I go to get more information about restraint?	<p>There is a lot of information about restraint, and the effects of restraint, that you might find useful to increase your knowledge. The main sources that you could refer to are:</p> <ul style="list-style-type: none"> • Our own guidance on: <ul style="list-style-type: none"> ○ Mental Capacity Act 2005 ○ Equipment and restrictive practice ○ Legal briefing on Mental Capacity Act 2005 • Mental Capacity Act code of practice • Our study on restraint (released December 2007) • British institute for Learning Disabilities (BILD) • Counsel and Care

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| | <ul style="list-style-type: none">• Nursing and Midwifery Council (NMC)• Royal College of Nursing (RCN)• Department of Health (DH) guidance on restrictive practices• National Institute on Mental Health Excellence (NIMHE)• Health and Safety Executive (HSE)• Our learning and resource centre |
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