Benchmark No. 4
Physical Restraint

British Association of Neuroscience Nurses

Benchmark No.4

Physical Restraint

First PDF edition printed 2017 in the United Kingdom (available online)

A catalogue record for this book is available from the British Library.

ISBN 978-1-911059-04-2

Published by the British Association of Neuroscience Nurses

For more copies of this book, please email: info@bann.org.uk

Designed and Set by the British Association of Neuroscience Nurses

www.bann.org.uk

Printed in the United Kingdom

History

The Neuroscience Nursing Benchmarking Group (NNBG) was established in the 1990`s as a result of increasing concerns over inconsistencies in practices as part of a subsidiary of BANN. The group aims to improve on the quality of care by comparing and sharing practice with each other, and set explicit standards for comparison of current practice against the ideal standard. The group is committed to searching for the best evidence related to specific areas of neuroscience practice. Membership of the group consists of representatives from neuroscience units within the UK and Ireland, together with educational colleagues from both the NHS/HSC and Higher Educational Institutes. The group is further subdivided into regions and this benchmark was developed by the North West group of the NNBG in 2007.

In 2016, the NNBG consolidated back into BANN and further information about NNBG can be found on the BANN website www.BANN.org.uk .

BANN would like to acknowledge the leadership and significant contribution made by the NNBG, and all its contributors, to neuroscience nursing over the years.

Benchmark No.4 Physical Restraint

KEY POINTS

- All registered nurses involved in physical restraint are provided with structured competency based training and education programme for the management of patient with challenging behaviour and cognitive impairment
- A full risk assessment of the patient must be carried out and recorded prior to the use of any physical restraint
- The clinical need for physical restraint is accurately documented
- Following the assessment an individualised care plan will be implemented and evaluated specific to all aspects of care relating to the patient's individual physical restraint needs
- Accurate documentation includes the type of physical restraint employed, date and time that it was implemented, reviewed and discontinued
- The patient is reassessment at regular intervals or when their health needs change
- The appropriate type of physical device is employed to meet the patient's individual needs
- Patients and relatives are included in the decision-making process and on-going management where ever possible
- The least restraining therapy should be chosen for the shortest period of time.

FACTOR 1 – Documentation – assessment and implementation of care

Statement of best practice	Poor ← Level of achievement → Excellent
1.1 A full risk assessment of the patient must be carried out and recorded prior to the use of any physical restraint. (RCN, 2004; NICE, 2005; HSE, 2006) This must include a comprehensive assessment addressing: • the cause of the altered behaviour i.e. physiological/psychiatric/neurological (Braine, 2005). • the use of alternative approaches i.e. environmental modifications, exercise programmes, behavioural and pharmacological management plans • the clinical need for the physical restraint is assessed and accurately documented (DH, 2000; Gallinagh *et al*, 2002). • the least restraining therapy should be chosen for the shortest period of time (DH, 2000; RCN, 2004; NICE, 2005). 1.2 Following the assessment an individualised care plan will be implemented and evaluated specific to all aspects of care relating to the patients` individual physical restraint needs (Gastmans and Milisen, 2006). 1.3 The patient is reassessed at regular intervals or when their health needs change in accordance with local policy (Sullivan-Marx *et al*, 1999; RCN, 2004).	

FACTOR 1 – Documentation – assessment and implementation of care

Statement of best practice	Poor ← Level of achievement → Excellent
1.4 An education resource file is available that supports the risk assessment, the physical restraint method or device used and pharmacological intervention 1.5 Accurate documentation as per policy /protocol which includes: • The type of physical restraint employed • The date and time that it was implemented and discontinued • The date it was reviewed • Pharmacological intervention used is documented and reviewed at regular intervals depending upon the individual patient. The use of haloperidol and chlorpromazine is contra-indicated (Wilkinson *et al,* 1999) • Discussion and information on individual patient's need for restraint is undertaken with family/carers. (Guidance for restrictive physical interventions DH, 2002; Gallinagh *et al,* 2002; Evans *et al,* 2002)	

FACTOR 2 – Protocol

Statement of best practice	Poor ← Level of achievement → Excellent
2.1 The care plan is evidence based, dated and reviewed within the last two years and updated accordingly (DH, 2001)	
2.2 All documentation meets the needs of the individual patient and is based upon the best available evidence	
2.3 There is evidence of daily multi-disciplinary evaluations of care delivered and this is appropriately recorded.	
2.4 There are evidence/research based guidelines/protocols available and used for the management of a patients` challenging behaviour These include the following: • Consideration as to the appropriate products/ device for restraining (Evans *et al,* 2003; MHRA, 2006) which meets the patient's individual needs. • Removing devices such as hand mitts to check for skin integrity and to maintain patient hygiene needs as required with accurate documentation • Repositioning of the patient which is documented	

FACTOR 2 – Protocol

Statement of best practice	Poor ← Level of achievement → Excellent
2.4 cont. • The types of physical restraint e.g., bed rails, hand mitts, wrist/arm restraint, wheelchair belts, over chair tables, seclusion, one-to-one specialing and wander guards • The use of pharmacological intervention • Family are involved were deemed appropriate	
2.5 Staff are aware of the policy /protocol and there is evidence of application to practice	
2.6 Policy protocol is up-to-date and reviewed at least every 2 years	
2.7 Policy protocol is research/evidence based with rationale for practice referenced	

Factor 3 – Education

Statement of best practice	Poor ← Level of achievement → Excellent
3.1 All registered nurses involved in physical restraint are provided with structured competency based training and an education programme for the management of patients with challenging behaviour and cognitive impairment (DH, 1999; RCN, 2004; NICE, 2005) This will include a formal assessment of competence and knowledge, and be recorded in a competency record or staff assessment procedure (NMC, 2004; DH, 2004) this will include: 1. Defining physical restraint and describe the common devices/methods used 2. Awareness of the rationale for the physical device/method 3. The relevant device dependent upon the patient's clinical needs and condition 4. Nursing care relevant to the physical device e.g., repositioning and pressure area care 5. Identification of the potential risks and complications and the measures to reduce them when managing patients with a physical device 6. Correct application and removal of device 7. Awareness of their responsibilities and professional accountability when employing physical restraint	

FACTOR 3 – Education

Statement of best practice	Poor ← Level of achievement → Excellent
3.1 cont. 8. Staff can demonstrate awareness of the legal and ethical ramifications of employing physical restraint devices: i. Mental Health Act (1987, 2007) Great Britain, Mental Treatment Act (1945) Ireland ii. Mental Incapacity Act Scotland (2000) England, Wales Northern Ireland (DH, 2005) iii. Human Rights Act (1998)	
3.2 Staff receive training on how to complete a comprehensive risk assessment form (HSE, 2006)	
3.3 Staff are aware of the policy/guidelines for the management of patients with challenging behaviour (Audit Commission, 1998; DH, 2000)	
3.4 There is evidence of continual practice development (NMC, 2004)	
3.5 Protocols and guidance and all relevant documentation is easily accessible and visible in the appropriate clinical area	

FACTOR 4 – Patient Information

Statement of best practice	Poor ← Level of achievement → Excellent
4.1Patients/carers have access to verbal and written information with the opportunity to discuss this and its relevance to the family member's individual needs (Vassallo, 2005)	
4.2Written information is available for patients & carers (Hickey, 2003) and alternative methods of communication are available	
4.3Patients and relatives are included in the decision-making process and on-going management wherever possible.	
4.4Patient/ family/carer must be given the following information: ▪ Rationale for the physical restraint device ▪ Type of restraining device used ▪ How often the patient will be reviewed ▪ Possible complications ▪ Risks and benefits ▪ Likely duration of the restraint device (NICE, 2005)	
4.5Any information verbal /written that is given to the patient/carers is documented in the patient's notes	
4.6The information that is given is current and evidence based (DH,2002; DH, 2003)	

FACTOR 4 – Patient Information

Statement of best practice	Poor ← Level of achievement → Excellent
4.7 Patient information is developed and reviewed in accordance with local policy seeking user and carer views were possible	

References

Braine, M.E. (2005). The management of challenging behaviour and cognitive impairment. *British Journal of Neuroscience Nursing* 1(2): 67–74

Bray, K., Hill K, Robson, W., Leaver, G., Walker, N., Leary, M. Delaney, T. Walsh, D., Gager, M,. & Waterhouse, C. (2004) British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units. *Nursing in Critical Care* 9 (5): 199–212

Department of Health, Welsh Office (1999) *Mental Health Act 1983: Code of Practice*. London, The Stationery Office.

Department of Health and Home Office (2000) *Reforming the Mental Health Act* Cm5016-I London, Stationary Office.

Department of Health (2001) *Reference Guide for Consent for Examination or Treatment* London, Department of Health.

Department of Health (2002) Guidance for Restrictive Physical Interventions London, Department of Health.

Department of Health (2002) Delivering the NHS Plan: next steps on investment next steps on reform The Stationary Office, Department of Health.

Department of Health (2003) *Toolkit for producing patient information* Version (2.0) London, Department of Health.

Department of health (2004) The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process (October 2004)
Department of Health, London

Department of Health (2005) *Mental Incapacity Act.* London, The Stationary Office Limited.

Evans, D., Wood, J. and Lambert, L. (2002) A review of physical restraint minimization in the acute and residential care settings. *Journal of Advanced Nursing* **40**:616–25

Evans, D., Wood, J. and Lambert, L. (2003) Patient injury and physical restraint devices: a systematic review *Journal of Advanced Nursing* 41 (3): 274-282

Fleminger, S., Greenwood, R.J. and Oliver, D.L (2002) Pharmacological management for agitation and aggression in people with acquired brain injury. In: *The Cochrane Library*, Issue 2.

Gallinagh, R., Slevin, E. and McCormack, B. (2002) Side rails as physical restraints in the care of older people: a management issue. *Journal of Nursing Management* **10**:299–306

Gallinagh, R., Nevin, R., Mc Ilroy, D., Mitchell, F., Campbell. L., Ludwick, R. and McKenna, H. (2002) The use of physical restraint s a safety measure in the care of older people in four rehabilitation wards: findings from an exploratory study. *International Journal of Nursing Studies* 39, 147-156

Gastmans, C. and Milisen, K. (2006) Use of physical restraint in nursing homes: clinical–ethical considerations. *Journal of Medical Ethics* 32, 148-152

Health and Safety Executive (2006) Health and Safety Executive Five Steps to Risk Assessment. www.hse.gov.uk/risk/fivesteps.htm

Hickey, J. (2003) T*he Clinical Practice of Neurological and Neuromedical Nursing* 5th edition, Lippincott Williams & Wilkins.

House of Commons Select Committee on Health. (2004)
Second report Elder Abuse Health Committee Publications. HC111-1, House of Commons, London, Stationary Office Limited
http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/111/11101.htm

House of Commons House of Lords (2004)
Joint Committee On Human Rights – Third Report Deaths in Custody 3rd Report HC137-1 House of Commons, London, Stationary Office Limited,
http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1512.htm

Human Rights Act (1998) London, HMSO

Independent Inquiry into the Death of David Bennett - Recommendations (2004)

NMC (2004) *Nursing and Midwifery Council.* NMC, London.

Martin, B. (2002) Restraint use in acute and critical care settings: changing practice. *AACN Clinical Issues* 13(2): 294–306

Medicines and Healthcare products Regulatory Agency (MHRA)(2006) Safe Use of Bed Rails DB2006 (06)

Department of Health [Ireland] (1945) *Mental Treatment Act.* Dublin: The Stationery Office.

National Institute for Clinical Excellence (2005) *Violence. The short term management of disturbed/(violent behaviour in in-patient psychiatric settings and accident and emergency settings* Clinical Guideline 25, London, NICE

Scottish Executive Health Department (2001) *Adults with Incapacity (Scotland) Act 2000* ISBN 0 10 590005 2. HMSO.

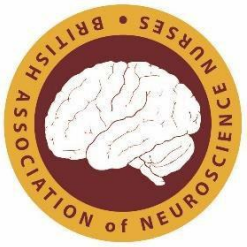
Sullivan-Marx, E.M., Strumpf, N.E., Evans, L.K., Baumgarten, M. and Maislin, G. (1999). Predictors of continued physical restraint use in nursing home residents following restraint reduction efforts. *Journal of the American Geriatrics Society*. 47: 342-348 .

Ritchie, S. (1985) *Report to the Secretary of State for Social Services concerning the Death of Mr. Michael Martin* London. SHSA.

Royal College of Nursing (2004) *Restraint Revisited- rights, risks and responsibilities. Guidance for nursing staff.* London, Royal College of Nursing.

Wilkinson, R., Meythaler, J. M., & Guin-Renfroe, S. (1999). Case study: Neuroleptic malignant syndrome induce by haloperidol following traumatic brain injury*. Brain Injury* 13, 1025-1031

Vassallo, M., Wilkinson, C., Stockdale, R. *et al.* (2005) Attitudes to restraint for the prevention of falls in hospital. *Gerontology* **51** (1) :66–70



Benchmark No.4
Physical Restraint

ISBN 9781911059042