

Reference Number: UHB 044 Version Number: 4	Date of Next Review: 22/07/2027 Reference Number: N/A
RESTRAINT IN THE CARE MANAGEMENT OF PATIENTS AGED 16 YEARS AND OVER WITH IMPAIRED MENTAL CAPACITY- POLICY AND PROCEDURE	
Policy Statement <p>To ensure that Cardiff and Vale UHB (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The UHB is committed to ensuring that adult patients with impaired mental capacity are only restrained lawfully and appropriately.</p>	
Policy Commitment <p>We are committed to ensuring that the law regarding decision making – the Mental Capacity Act 2005 and common law – is followed by our staff when they are considering using restraint and the patient lacks mental capacity to consent to it.</p>	
Supporting Procedures and Written Control Documents <p>This Policy and the supporting procedure describe the following with regard to the use of restraint when patients lack the mental capacity to consent to it.</p> <ul style="list-style-type: none"> • The process to follow when restraint is being considered, including documentation • The use of hand mittens to prevent patients from pulling out lines, tubes, etc. <p>Other supporting documents are:</p> <ul style="list-style-type: none"> • Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, TSO London • Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice HMSO (2005) • Mental Capacity Act 2005, HMSO London • Cardiff and Vale UHB, Consent to Examination or Treatment Policy, UHB 100 	
Scope <p>This policy applies to all of our staff in all locations including those with honorary contracts.</p> <p>This policy does not address the needs of children (i.e. under 16 year olds).</p>	
Equality and Health Impact Assessment	<p>An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.</p>

Policy Approved by	Mental Health and Capacity Legislation Committee
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Group with authority to approve procedures written to explain how this policy will be implemented	Health System Management Board
Accountable Executive or Clinical Board Director	Medical Director

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	10 May 2011	Not recorded	<i>New policy</i>
1.1	November 2012	Not recorded	Appendix 4 added (now Appendix 3)
1.2	31 March 2015	Not recorded	Front page amended to confirm that policy is still current whilst review underway
2	2 February 2016	02/03/16	Revised document – no major amendments Duplicated wording removed Re-ordering of some sections Some wording altered to clarify meaning
3	21 February 2020	04/03/2020	Revised document – no major amendments Some wording altered to clarify meaning Flow chart slightly simplified
4	22 nd July 2024	6 th August 2024	Revised document some wording changed in relation to MCA and DOLS Team.

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Appendix 1 Suggested restraint care plan template

Appendix 2 Restraint flowchart

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Appendix 3 The use of hand mittens

1. Introduction

This policy sets out how restraint may be appropriately and lawfully used with patients who lack capacity to consent to it.

Restraining a person who has capacity to agree to it can be done either –

- with the person’s consent, or
- to prevent harm to others (in conjunction with other Cardiff and Vale UHB policies and procedures pertaining to the management of violence and aggression) under common law (“judge made” case law)

Restraining people who lack capacity to it, within care management, is governed by the Mental Capacity Act 2005 (MCA). Staff using restraint are required by law to have regard to the MCA 2005 Code of Practice.

(Note that patients with impaired mental capacity may also be restrained under common law to prevent harm to others.)

2. Aim

The aim of this policy is to provide guidance to staff regarding use of restraint as part of care management with patients aged 16 years and over who lack capacity to consent to treatment and care, so that UHB staff deal with restraint issues lawfully.

3. Objectives

- Assist staff to understand the law regarding the use of restraint
- Assist staff to determine when an application to court may need to be made
- Assist staff to determine when they might need to apply for a Deprivation of Liberty Safeguards (DoLS) authorisation
- Protect the UHB and staff from civil or criminal proceedings

4. Responsibilities

Clinical Boards are responsible for

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- Ensuring that their staff are aware of, and have access to, this policy and procedure
- Ensuring that training on this policy and procedure is available to all staff
- Ensuring that existing training that touches on restraint is reviewed in light of this policy
- Monitoring the use of restraint through formal audit
- Ensuring that audit results are discussed at the appropriate quality and safety or audit meeting

5. The Policy

When making decisions regarding the use of restraint, it is vital to consider the patient's mental capacity to consent to it. Where there is reason to doubt the person's mental capacity, the Mental Capacity Act 2005 must be followed. This will include providing the patient with practical support to help them to make the decision for themselves and, if the support does not help, assessing the patient's mental capacity, using the 'Mental Capacity Assessment Form' to record outcomes. The form and any other information relevant to the capacity assessment must be stored in the patient's notes.

If the patient is assessed as having mental capacity to consent and refuses restraint then its use would be unlawful and could constitute an assault, unless it is used under common law to protect others from harm. It may be subject to an investigation under the law, policies and procedures regarding Adult Safeguarding.

If the patient is detained in hospital under the Mental Health Act 1983, it may be possible to restrain the patient, regardless of whether the patient has capacity to consent to this or whether the patient does consent. The Mental Health Act Office should be contacted for advice where necessary.

5.1 Principles that staff must comply with when working with a person who may or does lack capacity to consent to care and treatment

Whenever staff are working with a patient who either does, or may, lack capacity to consent to care and treatment, staff must have regard to the following principles which are set out in Section 1 of MCA 2005 –

- A person must be assumed to have capacity unless it is established that he lacks capacity

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- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done or the decision is made regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

5.2 What is restraint?

Section 6(4) of the MCA 2005 states that restraint is where a person –

- Uses, or threatens to use, force to secure the doing of an act which the person in question resists, or
- Where the person's liberty of movement is restricted, whether or not he/she resists

Restraint can take a number of forms –

- Mechanical – the patient is restrained with a device, such as a lap belt, bedrails or bucket chair
- Environmental – the patient is restrained by the environment, such as locked ward doors
- Chemical – the patient is restrained by medication
- Personal – the patient is physically restrained by a staff member/ members
- Psychological – directing a patient to stay in bed, on the ward, etc

5.3 Who can decide about the use of restraint?

There may be decisions or people already in place that will set out whether a particular form of restraint can be used and/or who makes the decision –

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Advance decisions – if the patient (aged 18 years and over) has made a valid and applicable advance decision refusing the proposed restraint (i.e. a particular kind of medication) or the treatment for which the restraint is needed, then that intervention cannot be used.

Lasting Power of Attorney – if decisions concerning the proposed restraint have been handed over to another person (attorney/donee) under a Lasting Power of Attorney (patient must be 18 years and over to make a LPA), it is the attorney who must either consent to or decline the restraint.

Court Appointed Deputy – if the patient has a Court Appointed Deputy who has been given authority to take decisions about the proposed restraint, then it is the Deputy who must consent to or decline the restraint.

If none of these are in place then the decisions will need to be made by a clinician in the person’s best interests – see section 5.7.

5.4 The circumstances in which restraint may be used

Restraint can only be used where a patient lacks mental capacity to consent to it if –

- The staff member using it reasonably believes that it is necessary to prevent harm to the patient **and**
- Its use is proportionate both to the likelihood and seriousness of harm **and**
- The restraint must be in the patient’s best interests (see Principles above, para 4.1) **and**
- The restraint is the least restrictive appropriate and available means by which to keep the patient safe from harm (see Principles above, para 4.1)

The decision to use restraint and the reasons why the four criteria are met, in accordance with MCA 2005, must be thoroughly recorded in the patient’s notes.

5.5 The meaning of “proportionate”

This means that the restraint should be the minimal necessary to achieve effective risk reduction and used for the minimal possible time.

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5.6 The meaning of “less restrictive”

The proposed restraint must be the least restrictive of the patient’s rights and freedom following consideration of the appropriate available alternatives.

Staff must consider whether there is a need to use restraint at all or if the patient’s safety could be assured by other means.

If restraint is used which cannot be justified then staff will not be protected by the MCA from being sued or prosecuted.

5.7 The meaning of “best interests”

The checklist of issues (see below) set out in s.4 of MCA 2005 must be considered, including (if it can be ascertained) what the person themselves would have consented to if they had the capacity to do so.

“When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity”. (MCA Code of Practice, page 68, para 5.7)

The decision to use restraint in the patient’s best interests must consider the following (“the checklist”) -

- all the relevant circumstances, and
- the patient’s present feelings and wishes, and
- his/her past wishes and feelings, as far as they are reasonably ascertainable, and
- the beliefs and values that would be likely to influence their decision if they had capacity, and
- the other factors that he/she would be likely to consider if he/she were able to

When considering “all the relevant circumstances” it is important to recognise that the use of restraint can itself cause significant harm. For instance, patients forced to sit for long periods are subject to increased risk of pressure ulcer development, loss of dignity resulting from iatrogenic

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incontinence, loss of mobility resulting from muscle wasting, etc. The use of bedrails may actually increase the risk of serious injury if the person attempts to climb over them, and the use of harnesses introduces the risk of limb dislocation, fracture or asphyxiation. Restraint may also cause the patient distress and if this is likely, this must be taken seriously and considered carefully.

Consideration of best interests must therefore include a detailed risk assessment of whether the risk of using restraint is considered less than the risk it aims to reduce.

The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of the following –

- Anyone named by the person as someone to be consulted with
 - Anyone engaged in caring for the person or interested in his welfare
- Any donee/attorney of a Lasting Power of Attorney who does not have authority to make the decision
- Any Deputy appointed for the person by the Court who does not have authority to make the decision

In determining best interests, staff must take into account the detailed guidance contained within the MCA Code of Practice. An incapacitated person’s best interests, including the consultations that occurred with others in order to arrive at what is in their best interests, must be recorded in the patient’s notes.

Staff must never use restraint for other purposes – e.g. to compensate for inadequate staffing levels or just so they can do something more easily. Unlawful restraint may constitute a criminal or civil offence (see para 5.10).

5.8 Court of Protection

Where incapacitated patients need treatment that may be “serious medical treatment” (see below) and are refusing or objecting to it, legal advice must be sought with a view to seeking Court authorisation for the treatment.

“Serious medical treatment” is defined as treatment which involves providing, withdrawing or withholding treatments where:

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- if a single treatment is proposed there is a fine balance between the likely benefits and burdens to the patient and the risks involved
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient
(either from the effects of treatment or its wider implications)

Whether treatment is considered 'serious medical treatment' in any given case will depend on the circumstances and consequences for the patient.

5.9 Common law

In addition to MCA 2005, the common law imposes a duty of care on health care staff. The MCA Code of Practice confirms that if a person with impaired mental capacity is acting in a way which may cause harm to others, staff may, under the common law, restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

However, the MCA 2005 could also be used to justify restraint if it was considered that the incapacitated patient's actions would provoke a reaction that would cause harm to the patient.

5.10 Civil Law and Criminal Offences

Section 44 of MCA 2005 states that staff will be guilty of an offence if they ill-treat or wilfully neglect patients who lack capacity.

Conviction under this section is punishable by imprisonment (for up to 5 years) and/or a fine.

5.11 Deprivation of Liberty

A deprivation of liberty occurs when a person who lacks capacity to consent to being in hospital to receive treatment and care is

- Under continuous supervision, and
- Under continuous control, and
- Is not free to leave

All three criteria must be met.

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Where it is identified that a deprivation of liberty might be occurring in hospital or in a care home, providing the person is aged 18 years and over, an application should be made for a Deprivation of Liberty Safeguards (DoLS) authorisation.

Where the deprivation is occurring in other settings, such as supported living or the person's own home, providing the care is being arranged/paid for/provided by the state (i.e. NHS or Local Authority), legal advice must be sought about whether authorisation from the Court of Protection is required.

If it is necessary to provide treatment and care to a person aged 16 or 17 years in a way that involves depriving the patient of his/her liberty, and they do not meet the criteria for detention under the Mental Health Act 1983, urgent legal advice must be sought via the appropriate Clinical Board lead.

When using restraint, UHB staff must keep under continuing review whether it is appropriate to seek a DoLS/Court authorisation.

Please see DoLS Code of Practice for further information and guidance.

6. Contact details in the event of queries

In the event of any queries about this policy, in the first instance advice should be sought from a senior clinician.

For queries that cannot be resolved please contact –

- Mental Capacity Act Team
- Consultant Nurse for Older Vulnerable Adults

7. The Procedure

7.1 The process to follow

Consider and work through the following –

- Identify that restraint may be required because the patient is at risk of harm

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- If there is reason to doubt the patient’s mental capacity to consent to restraint, provide support to help the patient decide for themselves
 - If the support doesn’t help the patient to make the decision, assess patient’s capacity to consent to restraint, if there is reason to doubt their capacity. Record the assessment using the UHB’s [Mental Capacity Assessment Form](#) (which can be found on the [Mental Capacity Act Team’s SharePoint page](#)) and keep a copy in the patient’s notes
 - If patient lacks capacity to consent to restraint, continue
 - Has the patient made a valid and applicable Advance Decision refusing the proposed restraint (i.e. a particular kind of medication), or the treatment that the restraint is required for? If so, that intervention cannot be used
 - Does the patient have an Attorney or Deputy with the relevant authority? If they do, then their consent to the restraint must be sought and recorded in the patient’s notes
- Where the patient does not have an Advance Decision, Attorney or Deputy, their best interests must be determined including the risks and benefits of the different appropriate types of restraint, along with the consideration of the less restrictive principle
- Consultation must be undertaken about the restraint with anyone named by the patient as someone to be consulted
 - The patient’s family, friends and carers
 - Anyone else with an interest in the patient’s welfare, including the attorney of a Lasting Power of Attorney or any Court Appointed Deputy who does not have authority to make the decision on the person’s behalf
 - An Independent Mental Capacity Advocate (IMCA) may need to be instructed if there are no carers/ family/ friends or Lasting Power of Attorney/Court Appointed Deputy to consult with regarding the use of restraint, as the use of restraint to facilitate treatment and care may constitute ‘serious medical treatment’ requiring specific referral to an IMCA

7.2 Recording requirements

If a decision to apply restraint is made then the recorded assessment must demonstrate that

- The patient will be at risk of harm if they are not restrained
- The patient lacks capacity to consent to the restraint , with evidence of this assessment
- The restraint is the least restrictive of the available, appropriate alternatives

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- The restraint is proportionate to the likelihood and severity of harm
- The risks posed by the restraint are less severe than the harm the patient might experience if not restrained
- Any valid and applicable Advance Decision to Refuse Treatment has been complied with
- Consent has been sought from an Attorney or Deputy, where either is in place and has the necessary authority
- In other cases, the Best Interests Checklist has been followed, appropriate others have been consulted and a decision about restraint has been made
- A Restraint Care Plan has been developed
- The review periods for the use of restraint have been agreed

All assessments and decisions must be recorded in the patient's notes.

7.3 Disagreement about the use of restraint

Any disagreement amongst family or friends about the use of restraint (or any disagreement amongst the clinical team) must be recorded in the medical notes and a second opinion should be sought, where possible, before the restraint is applied.

If serious disagreement persists, then further consideration will need to be given to the patient's best interests. It may be appropriate to seek advice from the Mental Capacity Act Team or a Solicitor (via senior management).

If the dispute has to be referred to the Court of Protection, Section 6 of the MCA permits action to be taken in the meantime where it is necessary to sustain life or to prevent serious deterioration.

7.4 Restraint Care Plan

The decision maker must plan the use of restraint, specifying in the patient notes

- The type of restraint to be used
- The times for its use and non-use
- The frequency of review

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The use of restraint in reducing the identified risk and causing additional risks must be closely monitored by the decision maker, who holds overall responsibility for the restraint and may be called upon to justify its use. The application of restraint should be time limited and must be for the shortest time possible. It is essential that, where possible and appropriate, significant periods of non-restraint are built into the care plan.

Consider carefully how often the restraint should be reviewed, as this must be determined on an individual patient basis. For example, it may be appropriate for the review period to be longer for long term/minor restraint.

A specific Restraint Care Plan (see Appendix 1) must be completed for the patient who is subject to restraint.

7.5 Mechanical restraints

Any new proposed mechanical restraint must be a manufactured product approved by the Vulnerable Adults Risk Management Working Group and purchased through UHB procurement procedures.

The manufacturer of the product must provide detailed advice about the safe and appropriate use of the mechanical restraint, either on a ward or individual basis, according to the type of restraint being used. Any health and safety notices concerning a particular product should be discussed at each Clinical Board's Quality, Safety and Experience meeting to ensure that manufactured restraint products are safe and fit for purpose.

Non-manufactured restraints, e.g. bandages to tie a person to a bed/chair or bind their hands, must never be used.

Any concerns about manufactured restraint products must be referred to the UHB's Health and Safety Department.

Please see Appendix 3 regarding the use of hand mittens.

7.6 Adverse events involving restraint

Any adverse clinical events resulting from the use of restraint must be communicated to the most senior clinician in charge of the patient's care

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at the earliest possible opportunity and reported in accordance with the UHB's Incident, Hazard and Near Miss Reporting procedure.

7.7 Deprivation of Liberty Safeguards (DoLS)/Court authorisation

If it is identified that the patient may be being deprived of their liberty, then an application must be made for DoLS/court authorisation.

If it is necessary to provide treatment and care to a person aged 16/ 17 years in a way that involves depriving the patient of his/her liberty, urgent legal advice via the appropriate Clinical Board lead must be sought.

Further guidance is provided at Chapter 2 of the Deprivation of Liberty Safeguards (DoLS) Code of Practice which is available in clinical areas. The DoLS Team can be contacted for advice, in-hours, on 01446 704849.