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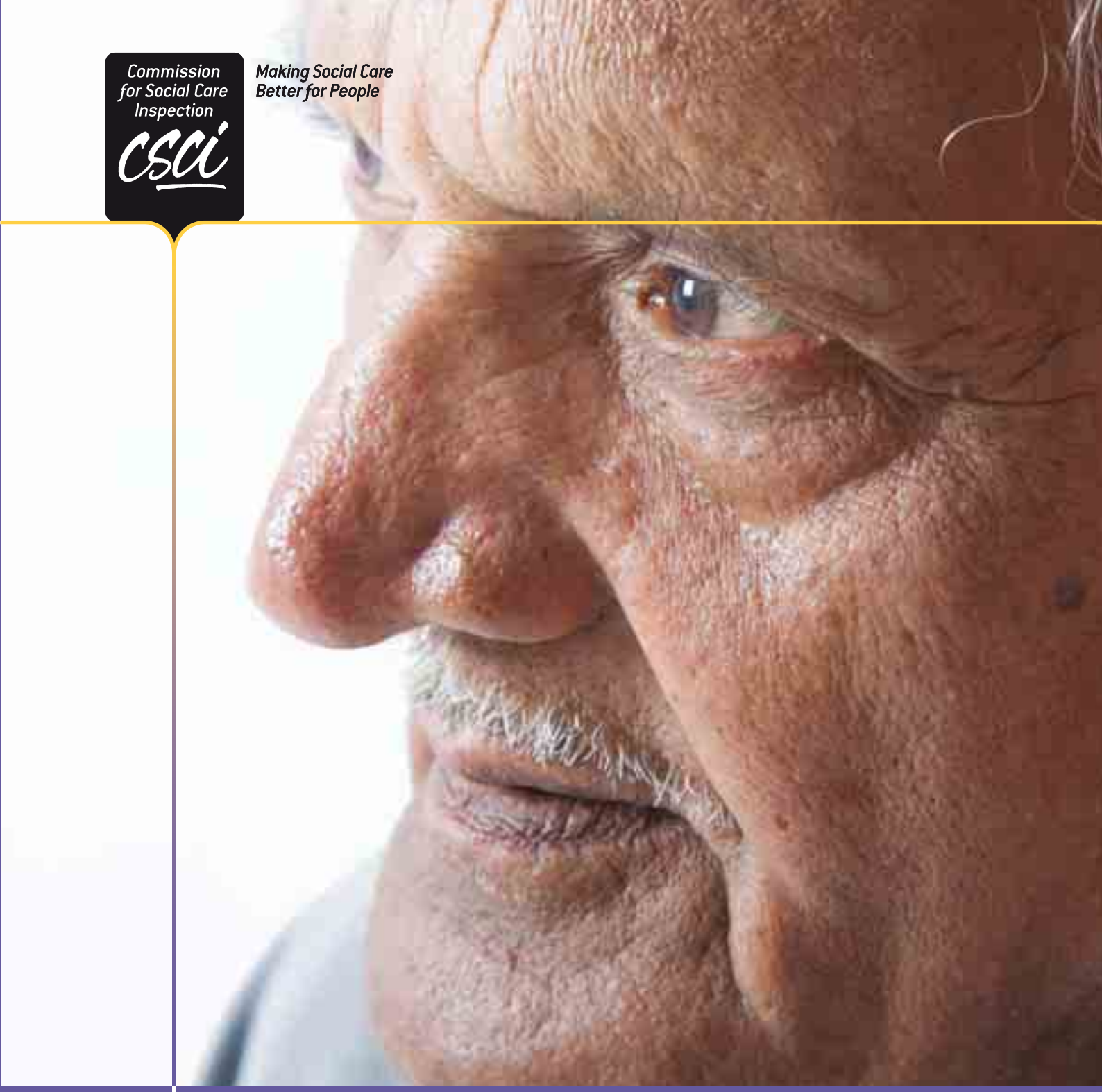

Rights, risks and restraints

An exploration into the use of restraint in the care of older people

November 2007

Vision and values

The Commission for Social Care Inspection aims to:

- put the people who use social care first
- improve services and stamp out bad practice
- be an expert voice on social care
- practise what we preach in our own organisation.

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Contents

Foreword

Respecting people's basic human 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, whether in their own home or in a care home, to make choices about their lives and to take risks.

Social care services have responsibilities to keep people safe from harm and to ensure their safety. It is this need to balance people's rights to freedom and to make choices with ensuring people are safe that is at the heart of this exploration into the use of restraint in the care of older people.

Some of the examples of the use of restraint in this study are extremely distressing to read and will upset and anger people as an affront to human dignity and rights. The evidence cited as coming from concerns and complaints about care services to the Commission for Social Care Inspection (CSCI) was borne out and CSCI took action. The care homes in question were inspected and where care practices were seen to fall short, the homes were kept under scrutiny and inspections conducted more frequently.

This study of people's views and experiences of restraint show there are no simple solutions. There are times when people have found security in some types of restraint. Restraint can take many different forms, including routine care practices that prevent people from moving freely, and there is a debate to be had about these. Some people argue that inadequate resources that prevent people from having a good quality of life are a form of restraint.

This is not a study of the prevalence of restraint. It is important to acknowledge that we cannot provide evidence as to the extent of the kinds of examples provided in this study. This is an examination of people's experiences, why restraint has been felt necessary and whether other methods could have been employed. It explores an area that society has tended to ignore and arguably has even been complicit in.

This study shows the balance of keeping people safe and always respecting people's rights is not just a matter for staff alone to resolve in their daily contact with people needing care and support. This is a human rights issue where government, regulators, commissioners and care providers have responsibilities to support staff and improve services to older people. The public, too, must be involved in the debate and have responsibilities to challenge practice where necessary.

We conclude there needs to be clarity of policy and guidelines about what constitutes restraint that puts the rights of people at the forefront and is based on sound evidence. There need to be adequate training and everyday support to care staff to help ensure best practice. And most importantly, there need to be the resources and working conditions that enable staff to provide the highest quality of care.

1

Introduction

This introductory chapter sets out why the Commission for Social Care Inspection (CSCI) has undertaken this work and introduces the definition for restraint and the different forms it can take. A broad overview of the study methods and structure of the report are also provided.

The **key points** in this chapter are:

- Whether living in their own home, a residential care home or a nursing home, people are free within the law to do what they want and to go where they want unless limited by legislative action.
- Care staff have been placed in difficult situations, expected to keep older people safe from harm and yet to leave them free to live as they wish and to take risks.
- There are no simple solutions to resolving the tensions between people's rights to make choices and take risks and ensuring their safety and well-being.
- To date there is little evidence that restraint makes people's lives safer.
- There are many different forms of restraint, and this report adopts a broad perspective.

1.1 Rights and risks, freedom and safety

> *'Your report must come from the starting position that each individual's human rights and personal wishes are sacrosanct. No one's wishes should be over-turned unless that person lacks capacity, and even then, their wishes and human rights still need to be considered.'*
> (Older person)

> *'We need to be much clearer, more analytical, in the way we use the word 'restraint'. People bandy the words around at the moment and aren't really clear what they mean.'*
> (Older person)

Citizens have the right to do what they want, and to go where they want unless limited by law. But too often in later life people are treated as if they have to be managed, albeit, as is assumed, for their own well-being. However, it is illegal, for example, to prevent an adult leaving their own home or care home.

People are free to manage their own care – whether they are using care services at home, in day care or living in a care home. However, some people need help and support to make decisions about their care. CSCI has highlighted in an earlier discussion paper, *Making choices: taking risks*, that risk-taking is part of everyday life and how social care can support people's aspirations and choices.[1]

The Commission is prioritising work to promote the safeguarding of adults and has recently agreed a joint protocol for working with other agencies.[2] CSCI has noted with growing concern the restraint of people using social care services. Special investigations into learning disability services, for example, have highlighted some very poor practices in the use of different types of

1 Commission for Social Care Inspection (2006). *Making choices: taking risks. A discussion paper*. London: Commission for Social Care Inspection.

2 Commission for Social Care Inspection (2007). *Safeguarding adults protocol and guidance*. London: Commission for Social Care Inspection.

restraint.[3,4,*] The House of Commons Health Committee[5] report into elder abuse called for much more to be known about the restraint of older people using social care services.

This report focuses on the restraint of older people and explores the issues by considering the perspectives of older people and their carers, relatives and care staff.

The Mental Capacity Act 2005 provides a precise legal definition of restraint:

> ***'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.'***[6]

People's understanding of restraint differ, as the following illustrations show. The quotations highlight many of the complexities that lie at the heart of this report.

Restraint was right:

> ***'I was becoming violent towards another person and went to physically attack them. The restraint made me feel more calm as if someone else had taken control.'***
> (Older person)

3 Healthcare Commission and Commission for Social Care Inspection (2006). *Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust*. London: Healthcare Commission.

4 Healthcare Commission (2007). *Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust*. London: Healthcare Commission.

* For example, a joint Healthcare Commission and CSCI report into learning disability services found evidence of:
- people prevented from leaving an area, and contained in locked environments against their wishes
- people exposed to prolonged physical restraint, thereby restricting their freedom of movement and liberty
- physical injuries occurring during periods of reduced observation
- covert administration of medication
- health and safety concerns related to people being locked in bedrooms at night
- the use of closed circuit television to monitor people.[3]

5 House of Commons Health Committee (2004). *Elder abuse. Second report of session 2003-04. Volume 1. Report, together with formal minutes*. London: Stationery Office.

6 Department for Constitutional Affairs (2007). *Mental Capacity Act 2005. Code of practice*. London: Stationery Office, p.290.

Restraint was wrong:

> *'I have twice come across patients in care homes who have been sedated to keep them immobile or quiet. GPs [general practitioners or doctors] should not collude in over-sedation. In the last 12 months I have also been asked to assess for cot sides where preventing wandering rather than falls prevention was the real reason for the request.'*
> (Health professional)

Uncertain what is best:

> *'My mother has vascular dementia and cannot walk. She has raised bed rails at night in her nursing home so she doesn't fall out of bed. On her first night she somehow managed to jump out of bed. She is very frail and cannot turn over or sit up on her own now. She doesn't like the bed rails and feels trapped but on the other hand I wouldn't like her to fall and break her hip again.'*
> (Relative)

Restraint at home:

> *'My aunt ties my uncle into his chair because he has stroke-related dementia and forgets that he is paralysed and tries to get up. If she has to go out and leave him alone she says she has to use a lap belt to tie him in.'*
> (Relative)

As staff we should have done better:

> *'A resident was attempting to leave the home; it was felt this was unsafe and he was brought back. Doors were then locked, causing increased frustration, leading to aggressive behaviour, full restraint and use of medication. Felt personally it would have been beneficial to give explanation and allow staff to escort. I felt helpless and upset.'*
> (Nurse)

Tension in interpreting policies:

> *'My wife has advanced dementia at a young age and thus may easily fall and hurt herself. When she is in her chair, a waist belt is always in place. Once a nurse from the local hospital saw this and reported this as 'restraint' to CSCI without bothering to find out the reasons. This wasted a lot of people's time and put my wife at risk until we could close the information loop.'*
> (Relative)

Disagreements between relatives and staff:

> *'Currently a daughter is insisting that her mother is restrained by the use of a small table to prevent her from falling from a chair. Her mother has dementia and does not speak English. She often kicks the table away, causing bruising to her legs, which the daughter claims is caused by poor care. The daughter does not appear to be aware that the table is a form of restraint.'*
> (Social services care manager)

Restraint in daily life:

> *'I have seen a lady being forced to her room and told to stay in it and not come out because the staff were busy and couldn't keep running after her when she managed to get outside time and time again. This was last year and I felt terrible at the time.'*
> (Home care worker)

These examples provoke a number of questions:

- What is it like in later life to be stopped from doing what you want to?
- Is such restraint necessary?
- Could – indeed, should – any of the situations that are described in this report have been handled differently?

There are two themes central to the discussion:

First, there are no simple solutions. Older people's desire to live as they wish can be limited by numerous factors. Care staff are involved in the intricacies and intimacies of people's daily lives. Sometimes this involvement will be helpful and acceptable; at other times it is unacceptable.

Second, people who provide care have been left in a very difficult situation. It could be argued that society has backed away from the dilemmas and ignored the ways in which older people have been restrained. Staff have been left both to keep people safe and to act within the law in respecting people's rights.

It is the tensions between people's rights and freedom to make choices and take risks alongside the need for staff to ensure people are kept safe that are at the heart of this report.

1.2 A broad understanding of restraint

As the examples above show, restraint can take many forms and people's understandings differ. For the purposes of this study and to understand restraint from the perspective of older people we have taken a broad interpretation of restraint that includes:

- **Physical restraint:** a physical restriction to moving around as one wishes. This might be by using belts or cords, sheets or blankets to tie or secure someone to a place such as a chair or a bed; chairs or beds from which someone is unable to move; bed or side rails; or chair or lap tables.
- **Physical intervention:** direct physical intervention by another person which can involve the use of techniques to physically 'manhandle' individuals. Someone may hold a person in a chair or bed, or physically stop them from going where they want. A further possibility is someone being physically carried or moved from one place to another.
- **Chemical restraint:** the use of drugs and prescriptions to change people's behaviour. Some medication is prescribed to be taken "as and when required" (also known as PRN, or *pro re nata*) which places a lot of responsibility on staff.
- **Environmental restraint:** designing the environment to limit people's ability to move as they might wish, such as locking doors or sections of a building, using electronic key pads with numbers to open doors, 'baffle' locks or complicated door handles.

- **Electronic surveillance:** this includes electronic tags on people, exit alarms on doors and television cameras (closed circuit television (CCTV)) to monitor people's movement.
- **Medical restraint:** various medical procedures impinge on people's lives – such as catheters or feeding tubes. Individuals may attempt to remove these (for whatever reasons) and people may take steps to prevent this.

These different forms of restraint indicate that the term 'restraint' may not relate solely to actions that are improper. Confusion arises where the term is seen by many people as always having a negative connotation and never a 'neutral' meaning.

1.3 The extent and evidence about the use of restraint

This study has not sought to research the prevalence of the use of restraint in people's own homes and care homes. Data collection is problematic given the lack of clarity about what constitutes restraint. Relying on reporting by staff or records tends to underestimate the use of restraint.[7]

Studies largely focus on physical restraint in care homes and less is known about the restraint of older people living in their own homes,[8,9,10,11] or receiving care services in the community, such as day care. The UK elder abuse study[12] examined physical restraint, for example, being tied up, locked in a room or overmedicated, as part of its definition of physical abuse. Of over 2,100 participants aged over 65 years, four people in 1000 had experienced physical abuse from family, close friends and care workers in the community (excluding care homes). It is important to note that in this example, 'physical abuse' refers to more than the use of restraint.

7 Laurin D., Voyer P., Verreault R., Durand, P. (2004). Physical restraint use among nursing home residents: a comparison of two data collection methods. *BMC Nursing*: 3.

8 Strumpf N.E., Robinson J., Wagner J. and Evans L. (1998). *Restraint free care: individualized approaches for frail elders*. New York: Springer Publishing.

9 Evans D., Wood J., Lambert L. and FitzGerald M. (2002). *Physical restraint in acute and residential care: a systematic review*. Adelaide: The Joanna Briggs Institute.

10 Hamers J.P.H., Stirk W. and Gulpers M. (2004). Use of physical restraints with cognitively impaired nursing home residents. *Journal of Advanced Nursing*, 45: 246-51.

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

12 O'Keeffe M., Hills A., Doyle M., McCreadie C., Scholes S., Constantine R., Tinker A., Manthorpe J., Biggs S. and Erens B. (2007). *UK study of abuse and neglect of older people*. London: National Centre for Social Research and Kings College London.

In the United States, between 12 and 49% of residents in nursing homes were reported to have been physically restrained in the 1990s (if side rails on beds are excluded as a form of physical restraint).[13] In a 1997 Australian survey, between 15 and 26% of nursing home residents were restrained.[14] A Dutch nursing home study found that nearly half of the residents were physically restrained by chairs with a table, belts or bed rails.[15]

The overriding reason given for the restraint of older people is for their greater safety, to prevent people coming to harm, in particular from falls and walking around.[16] Yet, perhaps surprisingly, there is little evidence that restraint makes people's lives safer.[17] Reducing restraints has not been shown to make significant differences in the number of falls. Restraints may slightly reduce the number of minor accidents but increase the likelihood of serious consequences from falls. Fall prevention programmes that, for example, ensure people make frequent visits to the toilet and minimise the use of medications associated with falling are more successful in reducing accidents from falls than do restraints.[18] The impact of restraints used for behaviour such as to stop people from what is seen as persistent walking (commonly referred to as 'wandering') is less easy to evaluate.

13 Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute.

14 Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute.

15 Hamers J.P.H., Stirk W. and Gulpers M. (2004). Use of physical restraints with cognitively impaired nursing home residents. *Journal of Advanced Nursing*, 45: 246-251.

16 Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute; Karlsson S, Bucht G, Eriksson S and Sandman P. (1996). Physical restraints in geriatric care in Sweden: prevalence and patient characteristics. *Journal of the American Geriatric Society*, 44 (11): 1348-54.

17 Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute.

18 Krauss M.J., Evanoff B., Hitcho E., Ngugi K.E., Dunagan W.C., Fischer I., Birge S., Johnson S., Costantinou E and Fraser V.J. (2005). *Journal of General Internal Medicine*, 20: 116-122.

Chemical restraint (also known as the 'chemical cosh') of people is also a cause of concern. In a 1995 study, UK nursing home residents received up to four times as many prescriptions as older people in their own homes. It is noted that 50 to 80% of antipsychotic medicines prescribed to nursing home residents were inappropriate and that antidepressants were under-prescribed.[19] CSCI has been concerned about the management of medication in care homes and the report *Handled with care?* identified a number of failings against the national minimum standards for care homes.[20]

Restraints do have harmful effects on people's physical and mental health, primarily because of people's reduction in mobility. Their use may lead a decline in people's levels of fitness, their ability to walk and sleep patterns. Restraints have also been associated with incontinence, pressure sores, depression and cognitive decline.[21]

Staff may feel stressed and unsupported with regards to the use of restraint,[22] but research has shown that education and training programmes can enable staff to deal with difficult situations in ways that do not require restraint.[23,24]

1.4 Alternatives to restraint

Guidance emphasises the need to examine the causes and reasons for why restraint may be necessary before using it.[25,26,27] For example:

- physical discomfort may explain restlessness
- disorientation or falling may be caused by medication

19 Furniss L. (2002). Use of medicines in nursing homes for older people. *Advances in Psychiatric Treatment*, 8: 198-204.

20 Commission for Social Care Inspection (2006). *Handled with care? Managing medication for residents of care homes and children's homes – a follow-up study*. London: Commission for Social Care Inspection.

21 Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute.

22 Poole J. and Mott S. (2003). Agitated older patients: nurses' perceptions and reality. *International Journal of Nursing Practice*, 9: 306-312.

23 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: 616-625.

24 Testad I., Aaland A.M. and Aarsland D. (2005). The effect of staff training on the use of restraint in dementia: a single-blind randomised controlled trial. *International Journal of Geriatric Psychology*, 20: 587-590.

25 Clarke A. with Bright L. (2002). *Showing restraint. Challenging the use of restraint in care homes*. London: Counsel and Care.

26 Counsel and Care (2001). *Residents taking risks. Minimising the use of restraint – a guide for care homes*. London: Counsel and Care.

27 Royal College of Nursing (2004). *Restraint revisited – rights, risk and responsibility. Guidance for nursing staff*. London: Royal College of Nursing.

- anxiety or aggression may reflect that people do not feel their needs are being met.

Good quality care planning and delivery help to minimise the situations where restraints are necessary. Good quality care also uses de-escalation techniques (verbal communication to calm a person down) and therapeutic approaches (such as relaxation and massage) to help older people when, for example, they are exhibiting challenging behaviour.

1.5 This study

This study explores the use of restraint in the care of older people. The exploration is based on wide consultation and findings from:

- a survey gathering the views and experiences of 253 older people and their carers, care workers and professionals (including managers of care services and social workers) and policy makers; and follow-up questions with a sub-sample of respondents on special topics
- eight group discussions with 76 older people and their carers
- letters and phone calls from older people and their carers sharing views and experiences of restraint
- analysis of CSCI datasets, including inspection reports and data on complaints and allegations
- stakeholder workshops with older people, their carers and representatives from care home bodies, government, academics and the voluntary sector to share and verify findings.

Appendix 1 provides more information about the study methods.

1.6 Report structure

Following this introduction, the remainder of the report covers:

- a summary of relevant national policies – chapter 2
- a description of people's understandings and experiences of restraint – chapter 3
- an examination of who gets restrained and why, and staff dilemmas – chapter 4
- concluding discussion – chapter 5.

2

The national policy context

The Human Rights Act 1998 and its principles are an essential part of the context to this report. Current policies and initiatives that support older people's choices, including taking risks, are also considered in this chapter. The Mental Capacity Act 2005 and deprivation of liberty safeguards are discussed within the context of restraint.

The **key points** in this chapter are:

- The Human Rights Act offers a framework to encourage high standards of care and the force of law to make sure that respect for human rights becomes the norm.
- National policy makes it clear that people should decide and control their own care and be treated with respect and dignity when using social care and health services.
- The use of restraint should only be undertaken in an emergency where staff judge that they must intervene to protect an older person, someone else, or themselves. Full risk assessments need to be undertaken and the least restrictive action should be justified.
- The older person should be fully involved in all decisions about their care, and if the person lacks capacity, someone should act on their behalf.
- The inappropriate use of restraint is against the law. Restraint can constitute assault, battery or false imprisonment and can lead to criminal prosecution.

2.1 Human rights

Human rights principles of fairness, respect, equality and dignity apply to everybody. The Human Rights Act 1998,[28] which came into force in October 2000, sets out the right to liberty and security of a person: there is to be no deprivation of liberty except in accordance with a procedure prescribed by law. The Act has a number of implications for this study into the use of restraints, including the rights of people to have their privacy respected and that physical and chemical restraints are unlawful unless there is sufficient reason.

The Human Rights Act requires public bodies to act preventatively to ensure that the right systems are in place rather than, as is the case under common law, seeking to take action after things have gone wrong. The Act therefore provides a framework to encourage high standards of care and because it has the force of law helps to make sure that a positive approach to respecting human rights becomes the norm.

The Act refers to public authorities, which was confirmed by a House of Lords ruling in April 2007.[29] This means that the Act does not apply to older people living in homes that are run privately or by charities.

The Joint Committee on Human Rights, in reporting on the human rights of older people in healthcare, has drawn a distinction between a "duty to provide" under care standards legislation and a "right to receive" under human rights legislation. The Joint Committee recommend that human rights principles should be championed to transform health and social care services.[30]

2.2 Making choices: taking risks

When people use care services, their rights, as citizens, are unaffected. Whilst people may encounter some constraints on their lifestyles, their responsibility for their own lives remains the same. This point is important because some people think that receipt of a service, particularly a move to a care home, changes the extent to which someone remains responsible for their own life. This view is mistaken.

28 Human Rights Act 1998 – Chapter 42. London: Stationery Office.

29 House of Lords (2007). *Opinions of the Lords of Appeal for Judgement in the Cause YL by her Litigation Friend the Official Solicitor v. Birmingham City Council and others. Hearing on Wednesday 20 June 2007*. London: House of Lords.

30 Joint Committee on Human Rights (2007). *The human rights of older people in healthcare. Eighteenth report of session 2006-07. Volume 1. Report and formal minutes*. London: Stationery Office.

The choices that people who use care services make may be different, or even competing, with those around them – including carers, relatives and care workers. This can be difficult and sometimes confusing for the people concerned but the fundamental principle is clear: people have the right to live their lives as they wish, as long as this does not stop others from doing the same.[31] Removing risks is impossible, and any process or policy that attempts to do so may diminish the quality of people's lives.

National policy is clear. Older people are to be treated as individuals and enabled to make choices about their own care. In particular, older people should not be treated differently than others with regards to assumptions about their capacity to contribute to decisions about their care and to wider society. The Government is committed to tackling the inequalities older people face,[32] and *Opportunity age*[33] underlines its strategy to end the perception that older people are 'dependent'.

The Government's Green Paper on adult social care – *Independence, well-being and choice*[34] – and its White Paper – *Our health, our care, our say*[35] – emphasised people's choice as social care and health service users. *The National service framework for older people,*[36] and its subsequent review,[37] strongly promotes person-centred care by listening to, and acting upon, people's views about their own care.

At the heart of government's objectives to achieve better services for older people is its emphasis on personalised care, the promotion of choice and control, and personal dignity and respect when older people use social care and health services.

31 Department of Health (2007). *Independence, choice and risk: a guide to best practice in supported decision making*. London: Department of Health.

32 Office of the Deputy Prime Minister (2006). *A sure start to later life. Ending inequalities for older people. A Social Exclusion Unit final report*. London: Office of the Deputy Prime Minister.

33 HM Government (2005). *Opportunity age. Meeting the challenges of ageing in the 21st century*. London: Stationery Office.

34 HM Government (2007). *Independence, well-being and choice. Our vision for the future of social care for adults in England* (Cm 6499). London: Stationery Office.

35 HM Government (2006). *Our health, our care, our say: a new direction for community services* (Cm 6737). London: Stationery Office.

36 Department of Health (2001). *National service framework for older people*. London: Department of Health.

37 Department of Health (2006). *A new ambition for old age. Next steps in implementing the national service framework for older people*. London: Department of Health.

2.3 Care Standards Act

Older people living in care homes – whether public, private or charitable organisation – are covered by the Care Standards Act 2000.[38] The regulations and national minimum standards make a number of references to care that have a bearing on restraint.[39,40] These include reference to physical restraint:

> ***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.***[41]

Relevant regulations relating to care homes and home care settings are summarised in Appendix 2.

2.4 The Mental Capacity Act 2005

The Mental Capacity Act 2005[42] provides an important framework for people who are unable to make decisions for themselves. The Act sets out procedures for the people acting on behalf of the person who is unable to make decisions. The key principles are:

- people must be assumed to have capacity unless it is established that they do not
- people must not be treated as incapable of making a decision until other options have been tried
- people must not be treated as incapable of making a decision because their decision may seem unwise
- actions on behalf of people without capacity must be taken in their best interests

38 Care Standards Act 2000 – Chapter 14. London: Stationery Office.

39 Department of Health (2003). *Care homes for older people. National minimum standards. Care Homes Regulations (third edition)*. London: Stationery Office.

40 Department of Health (2002). *Domiciliary care. National minimum standards. Regulations*. London: Department of Health.

41 Department of Health (2003). *Care homes for older people. National minimum standards. Care Homes Regulations (third edition)*. London: Stationery Office Regulation 13(7 & 8), p.67.

42 Mental Capacity Act 2005 – Chapter 9. London: Stationery Office.

- the least restrictive action must be taken (the minimum force for the shortest time)
- others must be consulted where practicable.

Restraint is recognised as verbal or physical and may involve threatening a person with an action, holding them down or locking them in a room. It also includes chemical restraint such as sedation.[43] Certain criteria need to be met for restraint to legally occur:

- 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*
- the restraint is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.

Where these criteria are met the restraint must be the minimum amount of force for the shortest time possible. However, where there is inappropriate use of restraint there is no protection from liability through the Mental Capacity Act.

The Independent Mental Capacity Advocates (IMCAs) service was created under the Act. The IMCAs provide a different service to ordinary advocates, by providing support and representation for people who lack capacity to make important decisions about medical treatments and changes to accommodation. In these circumstances IMCAs are only used when there is no-one else available to provide independent support. Local councils also have powers to instruct an IMCA to support and represent a person in adult protection cases (also known as safeguarding adults procedures) – in these cases it is not restricted to situations where the person has no-one else available.

43. Richards S. and Mughal A. (2006). *Working with the Mental Capacity Act 2005*. North Waltham: Matrix Training Associates.

2.5 Duty of care

Staff working in health and social care have a duty of care towards those with whom they are working. This term is sometimes used loosely by people to assert that they have to keep people safe. It is the role of staff to keep people safe but should not be interpreted as protecting people from all risks or any incident whatsoever.

Independence, choice and risk[44] defines duty of care as an "obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could foreseeably harm others". The definition makes an important distinction between putting people at risk and enabling people to make their own choices and to take reasonable risks. When people 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.

2.6 Restriction and deprivation of liberty: the Bournewood safeguards

The Bournewood judgement, a case considered by the European Court of Human Rights, related to a man with learning disabilities who was admitted to Bournewood Hospital.[45] The man was autistic, unable to speak and his level of understanding was limited. While at day care, he had become agitated. He had been sedated by a doctor and was admitted to the hospital because staff remained concerned about him. However, he was not detained formally under the Mental Health Act 1983 because, whilst he lacked capacity to consent, he was compliant with the actions being taken by the professionals involved.

The European Court of Human Rights unanimously held that there had been a violation of the man's right to liberty and security, and the right to have the legality of his detention reviewed by a court. The court's decision recognises a distinction between restriction and deprivation of liberty, said to be one of degree or intensity.[46] There are situations in the provision of care services where restrictions are placed on people's freedom of movement and further

44 Department of Health (2007). *Independence, choice and risk: a guide to best practice in supported decision-making*. London: Department of Health.

45 European Court of Human Rights (2004). *Chamber Judgement. H.L. v. The United Kingdom*. Strasbourg: European Court of Human Rights.

46 Department of Health (2006). *The Bournewood safeguards: draft illustrative guidance*. London: Department of Health.

clarification of the distinctions between restriction of liberty and deprivation of liberty are needed. The European Court of Human Rights judgement has identified factors that contribute to deprivation of liberty. Within the context of restraint, these factors include:

- restraint was used, including sedation, to admit a person who is resisting
- professionals exercised complete and effective control over care and movement for a significant period
- professionals exercised control over assessments, treatment, contacts and residence
- the person would be prevented from leaving if they made a meaningful attempt to do so
- a request by carers for the person to be discharged to their care was refused
- the person was unable to maintain social contacts because of restrictions placed on access to other people
- the person lost autonomy because they were under continuous supervision and control.[47]

The Mental Health Act 2007 has amended the Mental Capacity Act to introduce the deprivation of liberty safeguards. The safeguards will apply to hospitals and to care homes to ensure that people who lack capacity are not deprived of their liberty without lawful authorisation. An addendum to the Mental Capacity Act Code of Practice will provide more detail about how the new safeguards will operate in the future.

2.7 Restraint and criminal justice

The inappropriate use of restraint is illegal and different forms of restraint can be against criminal and civil law. The criminal justice perspective adds further complexity and makes the job of judging best interest by staff even more difficult.

47 Department for Constitutional Affairs (2007). *Mental Capacity Act 2005. Code of practice*. London: Stationery Office.

The legal issues that have been exposed for people with learning disabilities are exactly the same as for older people.[48]

- Common assault "must be accompanied by a hostile intent calculated to cause apprehension in the mind of the victim". The principle is important for people who lack capacity – "they may have fears about particular courses of action which others... [with capacity] might not have".[49]
- Battery is any unlawful physical contact, such as touching, or grabbing clothes.
- Assault occasioning actual bodily harm refers to any injury intentionally inflicted to affect someone's physical health or well-being and must have caused pain or discomfort.
- False imprisonment is the limit on someone's freedom of movement, such as leaving a room.

It is, however, lawful for individuals to defend themselves, or others, from attack.

The Mental Capacity Act also introduced a new criminal offence of the wilful neglect or ill treatment of a person that lacks capacity.

2.8 Decision making within current policy and guidance

The thrust of legislation and guidance is clear. Older people should be treated with respect for their dignity and human rights. Older people using home care services or living in care homes "must be assumed to have capacity unless it is established that they do not". They make their own decisions about their lives. Their wishes take priority over those of relatives. Therefore, unless older people do not have capacity, restraint may only take place with their consent or in emergency to prevent harm. Used inappropriately, restraint can constitute abuse – which is subject to referral under the local multi-agency procedures for safeguarding adults – as well as being a criminal offence.

48 Lyon C.M. and Pimor A. (2004). *Physical interventions and the law: legal issues arising from the use of physical interventions in supporting children, young people and adults with learning disabilities and severe challenging behaviour*. Kidderminster: British Institute of Learning Disabilities.

49 Lyon C.M. and Pimor A. (2004). *Physical interventions and the law: legal issues arising from the use of physical interventions in supporting children, young people and adults with learning disabilities and severe challenging behaviour*. Kidderminster: British Institute of Learning Disabilities, p. 146.

3

People's understandings and experiences of restraint

This chapter presents people's views on restraint and their experiences of different forms of restraint.

The **key points** in this chapter are:

- Restraint is generally understood to be either stopping people from doing what they want or doing things against their will.
- Three quarters of those who responded to the survey said that they or someone that they knew had been restrained.
- Restraint takes a wide variety of forms, and there are examples where people have been subjected to gross indignities.
- Some people would include in the understanding of restraint the way services are delivered that deny them a quality of life.
- People gave examples of forms of restraint that give them a sense of security, such as electronic tagging that may offer the least restrictive option in their lives.

3.1 People's views and definitions of restraint

We found that most people understood the term 'restraint' to involve placing limits on individuals' will or ability to do what they want:

> *"My father has dementia and cannot communicate; he gets frustrated, wants to do things the carers don't want him to. They make him sit down all the time, often pushing him back in the chair and force him to dress and undress. Sometimes they have to hold him to stop him hitting out. I call this restraint."*
> (Relative)

> *"If I wanted to do something on my own and they would stop me."*
> (Older person)

The words used most frequently by survey respondents† to describe restraint were about:

- "Prevented from doing things": 15 people from the older people and relatives group and 77 from the total.
- "Restrictions to freedom or ability to move freely": nine people from the older people and relatives group and 55 from the total.
- "Stopping": nine people from the older people and relatives group and 44 from the total.
- "Controlling": 11 people from the older people and relatives group and 21 from the total.

The survey also captured wider definitions of what restraint meant. Other popular definitions included:

- Psychological restraint: "denied freedom to speak and freedom of choice" (Health care worker).
- "Not listening to needs and wishes" (Relative).
- "Restraint on citizenship" (Relative).

† We refer to two groups of survey respondents: (i) older people, relatives, advocates and those completing the survey on their behalf – 59 people; (ii) all survey respondents – 246 people.

People told us about procedures "that take away choice" (Older person) and being "forced into submission" (Older person). One person's definition captured both the different types of restraint and the range of situations in which they might be applied:

> *"Any behaviour by one person that prevents another person exercising their autonomy: physical, chemical, environmental, excessive surveillance, forced meal times, restricted access to social activities, friends, family..."*
> (Care home worker)

The appropriate, and sometimes necessary, use of restraint was also emphasised:

> *"An external means of keeping a person from deliberately or accidentally injuring themselves, or somebody else when reasoning with them would not be successful."*
> (Relative)

> *"Medication ... can in a limited and very controlled form be of benefit."*
> (Care home worker)

Some people registered their dislike for the word 'restraint', preferring terms such as 'physical intervention' or 'holding techniques'. As one person commented:

> *"[Restraint] is a badly used term about control of people."*
> (Health care worker)

Some specific views were discussed in our consultations with people from black and minority ethnic groups. They focused discussion on the difficulties they had in accessing culturally sensitive services, and the communication difficulties they routinely encountered:

> *"The lack of language – means that some people are more susceptible, because they are weak, more abuse, more restrained by others. ... Language difficulties make relationships [with care workers] difficult, and we feel a barrier."*
> (Older person)

People from black and minority ethnic groups also commented that language difficulties made it difficult to understand what the correct procedure was and made it difficult to know what was wrong because they were unfamiliar with the way care is provided.

> *"Explain the law, rights and the Government strategy."*
> (Older person)

3.2 Experiences of restraint

In the two care homes where we held meetings with residents, no one reported being physically restrained by bed rails or belts. Most residents said that they liked the front door being locked as it gave them a sense of security, though a few added that they had to get used to asking staff when they wanted to go out:

> *"You feel you want a bit of freedom to go out when you want."*
> (Older person)

> *"It's difficult when there are people with different capabilities."*
> (Older person)

On further discussion, one man said that he had felt "like a caged lion". He had the number of the keypad and mostly could manage that. He thought that it was "a man thing" not to like having to ring the bell to return. Several referred to having to adjust, and all then stated that they were happy with the life to which they had become accustomed. There remains a question as to whether all the adjustments were necessary.

In one home all those at the meeting except for a person using a wheelchair said that they could get up when they wanted to. The person using the wheelchair needed assistance and asked staff when they wanted her to get up; "I leave myself in their hands".

During the group discussion it emerged that there were two residents who had to be stopped from leaving and the staff member spoke of people trying to "escape". Staff reported standing in the way and waiting until people calmed down. This was not acknowledged as a form of restraint.

Of all 253 participants to the survey, 74% said that they or someone they knew had been restrained. In most cases people were reporting restraint of others.

This is a high figure which probably reflects that people responding to an open invitation to a survey are likely to be those with a special interest in the topic.

One daughter wrote to us about her mother's experiences living in a nursing home. Her mother had dementia. She had been incontinent in bed, described by her daughter as very unusual and possibly due to a change in medication. Care staff were unable to persuade her to leave the bed to be washed and changed. She began to hit out and the home manager restrained her by the wrists:

> *"I felt very upset that my mother was described as 'wild' by the manager when I would have described her as 'frightened and embarrassed'."*
> (Relative)

The daughter recognised the challenges facing staff and argued for the need for transparency and clear protocols for restraint. The family sought medical intervention for their mother's depression but would not agree to 'as and when required' medication to make her comply with staff instructions during washing and bathing. So, weekly, the daughter took her mother to her house and helped her shower and change clothes.

The following section of this chapter provide graphic pictures of restraint. Some of the examples illustrate gross indignities to which older people have been subjected.

3.3 Physical restraint

In care homes, we found examples of people being confined to their beds through various methods:

- Cocoon (a cocoon is a bed valance placed under the mattress and connected with the top cover by a zip or may also be constructed with bed sheets).
- "A large wedge cushion placed under the side of her mattress causing her to roll into the wall ... wrapped tightly in a blanket, she was extremely hot and thirsty and very distressed" (Relative).
- "A large chair and other furniture up against her bed to prevent her getting up, 'in case she fell', although she had no history of falls" (Relative).

We reviewed recent inspection reports, and in one care home found that 19 people had bedrails fitted as a safety measure. There may be exceptional cases when bed rails are provided for safety reasons. However, these measures must be subject to risk assessment and a recording of the decisions. The least restrictive method must be justified.

The survey, review of CSCI inspection reports, and review of concerns and complaints about care submitted to CSCI[‡] found that chairs might be used to restrain people.

- "Disruptive residents fastened into wheelchairs and then locked in bedrooms" (Care home manager).
- "An older person restrained by a strap, which had slipped and was around her upper arms and neck" (Complaints data).
- "She found her mother strapped in a wheelchair by a black belt with loops for her arms, fastened at the back. She was wet and soiled" (Complaints data).
- "A resident who frequently fell when trying to move from her wheelchair in distress because she could not remove the straps that were fixed" (Health care worker).

Other means were used to ensure people could not move around.

- "A walking frame put out of reach" (Nurse).
- "Someone placed on a bean bag – undignified and bad for posture" (Complaints data).
- "A table placed in front of a chair" (Care home worker).
- "Trays used to serve meals left on the chairs – people unable to get out of their chairs" (Complaints data).
- "A stool placed under the foot of a chair to stop movement" (Complaints data).
- "A chair too low for someone to get up" (Complaints data).

‡ It is important to note that if a concern or complaint is referred to the CSCI, the commission uses it powers of inspection to look into these. All the examples in this report proved to be factually correct. In these situations where regulations are breached, the CSCI uses its powers of enforcement and either recommends or requires action is taken by the care provider to put matters right. If the provider fails to meet a requirement, the CSCI can consider closing a service.

Restraint was also reported to be used to prevent older people from disrupting the care being provided:

> *"Two staff routinely wrapped immobile and incontinent residents tightly in bed sheets, to prevent them from 'rooting' or pulling out incontinent pads, thus making it easier to get them up."*
> (Care home manager)

There were also examples of people being unintentionally restrained because of inappropriate equipment provision. One example came from a relative about the problems with bed rails supplied by the health authority for a man living at home:

> *"...he got his leg stuck in them several times; staff refused to supply bumpers to protect him from the rails as they said these were a risk of strangulation."*
> (Relative)

3.4 Physical intervention by staff

Sometimes staff use force on older people. The examples that follow are all concerns or complaints submitted to CSCI about the improper use of force:

- "A staff member dragged a resident by the hair and tied her to a chair" (Complaints data).
- "A resident removed from the lounge following an aggressive outburst" (Complaints data).
- "A resident sustained bruising to his arms following restraint" (Complaints data).

3.5 'Restraints' or 'constraints' to daily living and quality of life

We were given examples of people's experiences ranging from very poor practice to what was seen as a denial of the resources needed to ensure a reasonable minimum standard of living. The following examples were interpreted by some people as restraints to daily living and quality of life:

- "She was left on a protection mattress on the floor, crying because she was wet" (Complaints data).
- "Call bells taken away" (Complaints data).

Examples were particularly noted around supporting people to use the toilet:

> *"Mrs H was kept waiting up to three hours before being taken to the toilet. The staff only take them to the toilet after lunch and tea. All residents have pads on. Matron said, 'They go to the toilet when I say so; the pads hold three litres of fluid'. Her attitude is that it doesn't matter if they wet themselves. Mrs H said: 'My mum is compos mentis, and knows when she wants to go to the toilet'. Matron said: 'I can't take your mother to the toilet six times a day.'*
> (Complaints data)

A survey respondent described the contrast between restraint and freedom following her mother's move from sheltered accommodation to a care home:

> *"One week she and I were free to go out to a local restaurant and come back when it suited us. A couple of weeks later I did the same thing at the residential home and had a stand-up row with the owner for having dared to bring my mother back as late as 10 pm."*
> (Complaints data)

We also found some examples of people being 'punished':

> *"...left sitting ... in soiled pads for periods of up to three hours because they have been shouting and upsetting others."*
> (Complaints data)

3.6 Chemical restraint

One fifth of all survey respondents referred to the use of medication to sedate or restrain people. Chemical restraint occurs when medication is used inappropriately to control behaviour. For example:

> *"Someone given too much night sedation, possibly after ringing a bell excessively, was drowsy during the day."*
> (Complaints data)

> *"The manager gave night-time medication at tea time so residents could be put to bed at 6.30 pm."*
> (Complaints data)

A survey respondent wrote about her husband's stay in a respite facility. She had realised he seemed drowsy but had not been told that he had been given medication "to help him sleep as he was disruptive at night":

> *"This happened for up to a week before I realised something was wrong. I told the nurse that I wanted the medication stopped. ... Very upset to see my husband in such a 'hung over' state. He was not his normal self. I felt medication gave him a poorer quality of life."*
> (Relative)

3.7 Environmental restraint

The layout of people's environment, locks, controls or keypads on doors or passages (eg stair gates) are environmental forms of restraint. These factors restrain people from going about their lives as they wish.

> *'In order to 'contain' residents within the premises there is an unusually high number of locks and physical bars to free movement. There are four stair gates, six keypad locks and four baffle locks; staff routinely lock nine bedroom doors when the resident is not in the room. The cumulative effect is that many residents are somewhat corralled into the communal areas on the ground floor whilst others are room-bound and relatively isolated. The door to the conservatory has no door furniture so most residents are unable to travel through easily; several were seen fumbling and then giving up. Such high levels of restraint do not suggest an effective framework for residents retaining adequate control over their lives and daily routines and has overtones of a secure facility.'*
> (Inspection report)

Survey participants identified people being locked in rooms, as did evidence from concerns and complaints to CSCI and the review of inspection reports.

> *'The resident was locked in the bathroom: a chair was put under the handle of the door and the light put out. Staff were told to serve her coffee in the toilet.'*
> (Complaints data)

We also found examples of care homes seeking permission from carers and relatives to exercise these environmental controls on people. For example:

> *'A son found his very mobile father locked in his room. Evidently his father's wife had given permission for him to be locked in his room if staff were busy. She also gave permission for him to be placed in a recliner chair.'*
> (Complaints data)

Two older people in a small discussion group spoke of the restricted lives people lead at home:

> *"[My mother's] home had become her prison; her room had become her cell."*
> (Older person)

Another person spoke about someone whose family did not live very close by so they locked their mother's doors to stop her from leaving the house at night. The woman hated being by herself; locking the doors made her frightened, frustrated and upset.

3.8 Forced care

Staff face difficulties if an older person, whether in their own home or a care home, does not agree to personal care that is thought necessary. One resident refused to take off her dirty clothes; staff responded by restraining her so that they could change her clothes. In another case a man was restrained "in order to complete shaving quickly" (Complaints data). There were other, similar occasions:

> *"She became very distressed and aggressive (shouting, kicking, spitting, scratching and lashing out), for example when undressing for bed or using the toilet, so they sometimes needed to restrain her to prevent injury to herself or to staff."*
> (Complaints data)

> *"The care plan reported that two staff members were required as the service user became violent when visiting the hairdresser."*
> (Complaints data)

We identified two examples from our reviews of concerns and complaints to CSCI where residents were restrained when given medication:

> *"Two residents with dementia were physically restrained whilst drugs were forced into their mouths. They were then forced to take water which resulted in one choking."*
> (Complaints data)

3.9 Threatening or verbal intimidation

The way that staff communicate with residents has an immense impact on their lives:

> *'This is a residential home not a nursing home and if you don't buck your ideas up, you will have to go.'*
> (Complaints data)

A visiting health professional was told by a resident sitting on a chair in the hall that she was hungry: could he bring her something to eat? He asked one of the carers passing by to help. Her response:

> *'Stop moaning and complaining. You're not allowed to have your meal until everyone finishes because you shout and this is your punishment as you were given the same punishment during the afternoon and breakfast time'. Later on, the same carer shouted at another resident, 'Just shut up and sit quietly', after the resident asked if he could leave the room.'*
> (Complaints data)

3.10 Freedom, risk, care and safety: electronic surveillance

To examine people's views on freedom, risk, care and safety, 20 people took part in a follow-up questionnaire and were asked for comments on a fictional scenario: in a care home, staff and residents had been considering whether it would be better for residents to have an easier system for leaving the home coupled with electronic tagging.

Of 20 respondents, 15 were opposed to electronic tagging on the grounds that tagging was for criminals, infringed people's rights and privacy, might lead to depression or would not be needed if staff levels were adequate. However, three people thought that tagging might improve resident's lives if the people were in agreement, if they were unaware of danger or if their independence were increased. Tagging might be the least restrictive option. Two people were unsure.

We also convened a follow-up group discussion with four people with dementia and two carers of people with dementia to discuss electronic tagging as a form of restraint. Participants' views were mixed:

> *"There are situations where people like us might benefit. It's happened to me maybe twice in the last few years – I can be walking along on my own and the shutters come down and I just can't remember where I am. I wouldn't mind wearing something like a watch, something like that, in that kind of situation."*
> (Older person)

Participants recognised the practical weaknesses inherent within the technology, including lack of total coverage and people taking the devices off, especially at times when they may be confused. People emphasised that assistive technology, or surveillance, was "not a cure-all...it must not take the place of carers, of people" (Carer).

The group also discussed CCTV. People told us that it was important to consider the wider context in which CCTV is used – commonplace and routinely used in society. However, important boundaries were made with regards to respecting people's privacy:

> *"I can understand cameras for car parks, communal areas and corridors, but not bedrooms. That has got to be kept as a retreat for privacy. What happens in their own rooms is private."*
> (Older person)

Consent was seen as a critical issue:

> *"You have got to address the individual first in the right way, 'are you prepared to have some form of device fitted that will enable you, your partner, your family, to be better informed about where you are at any given time?'. ... Use of this technology is null and void if this conversation is not undertaken, until things are clearly assessed and agreed."*
> (Older person)

4

Dilemmas for staff

This chapter focuses on who gets restrained, why restraint occurs and in what kinds of situations. The uncertainties staff face are highlighted and policies and procedures on restraint are examined to see how far they assist staff.

The **key points** in this chapter are:

- The overriding reason people think that restraint is used is to protect older people, particularly those who are confused, agitated, threatening or persistently walking.
- 80% of survey respondents thought restraint could be justified in exceptional circumstances; yet 59% thought restraint infringed human rights and 63% thought a restraint-free policy a good approach.
- Understanding people's behaviour and advocacy to protect people's rights are essential, as well as trying to find alternative solutions.
- There is widespread suspicion that actions explained as being for the safety and well-being of residents are actually designed to help staff manage workloads, especially where there are staffing and resource pressures.
- Staff are confused as to what constitutes restraint and how to balance people's rights with their safety. Under half of care home policies examined defined restraint and only a third explicitly referred to the rights of the older person.

4.1 Who gets restrained?

The most frequent answer to our survey question, "who gets restrained?" was "people who are a danger to themselves or others" (16% of older people, their carers and relatives and 24% of all participants). People discussed restraint as a control of someone's behaviour that was perceived to be out of control. In these situations, participants identified people who were "vulnerable" or "needing protection", including people with dementia, who were confused, anxious or agitated, and who persistently walk.

One care home worker said that everybody experiences "some form of restraint at some time when using services". Another care home worker said that "people who are reliant on others to deliver care are those who will be restrained". Differences in power exist that are greater when older people "are incapable of exercising their own will for a variety of reasons" (Relative).

Three groups of people were identified as the most likely to be restrained; those people:

- perceived as difficult or threatening
- who cannot be persuaded in other ways to do what others (eg care workers) wish them to, or not conforming, thereby causing a management problem
- who are less physically or mentally able.

One person noted that people who are seen as difficult may be those whose needs are "more difficult to meet or beyond the skill or resources of the carers" (Learning disability provider). One person, for example, wrote about visiting her husband in a nursing home:

> ***"He was having his evening meal in his bedroom not the communal dining area. I asked why and the nurse in charge said she thought it was because he had shouted at the carers that morning. I found this very distressing. His care plan clearly states his cognitive ability is impaired."***
> (Relative)

Another view was that:

> *"Usually only residents with reasonable mobility get an opportunity to go outside and then often only after a struggle and interrogation as to where they are going and for how long."*
> (Older person)

Someone else stated that heavy residents who were not easily transferred from wheel chair to lounge chair "were often left inappropriately in a wheelchair for long periods thus curtailing their freedom of choice and comfort" (Older person).

There are alternatives to restraint, however. There were examples of positive practice and sensitive care. A staff member whispered to a resident who was agitated; the resident responded by whispering back and became calm. Similarly, an inspector observed two residents raise their voices to each other, with one raising a fist:

> *"The staff member watched what was going on quietly, then led one of the residents away and helped them to sit elsewhere. A few minutes later this resident went and sat back next to the first resident and talked to them about the weather."*
> (Inspection report)

4.2 Explanations for why restraint occurs

The fact that participants in the survey and group discussions were concerned about restraint does not mean that they thought all restraint unjustified. The survey helps to reveals the complexities of the issue:

- 80% of all 253 participants thought that restraint could sometimes be justified, though most added provisos: "in exceptional circumstances", "as a temporary measure", "for safety only"
- 59% of participants considered that restraint to infringe human rights
- 63% thought a restraint-free policy a good approach.

Thus restraint is thought to infringe human rights but may be necessary on rare occasions; although the preferred goal is a restraint-free environment.

Participants stress, first, that it is essential to try to understand what the resident feels like; the way that they interpret their experience. This allows one to think about other ways of managing events. Second, the wishes of the older person must be dominant, even when these involve actions that seem to others to be risky. It is interesting that this was also the perspective of most of the relatives who participated.

4.3 Seeking to understand situations from the perspective of the older person

When commenting on the vignettes (hypothetical fictional scenarios), a persistent theme was that there must be a searching to understand the reasons for behaviour. "People who walk around are doing so for a purpose" (Care home manager). Without this, restraint "has been applied to cure the symptoms but not the root causes" (Home care manger). In response to the fictional scenarios presented in the survey, several people had a number of questions:

> *"Why was she agitated? What was upsetting her? Did anyone sit with her to allay any fears or worries?"*
> (Relative)

Clearly it is most important to see restraint from the perspective of the person being restrained.

4.4 Clarity about the rights of the older person

> *"Sometimes we try to 'protect' others, of all ages, but particularly children and older people, because we feel anxious. This should not stop an individual making decisions that may lead to risk taking, as they often know more about their capabilities than carers do. Finding the right level between common-sense decisions and risk taking is difficult and we need to constantly review decisions made with and for others."*
> (Social services care manager)

It was noticeable that several people recognised that there are many older people who do not sleep through the night. In their own homes individuals may have developed ways of coping – reading, walking around, making a drink, watching television or listening to the radio. In a care home, not sleeping may be seen as a problem that has to be rectified:

> *'A resident in a wheelchair had been moving around the corridor during the night and staff had assisted him back to bed. The staff had removed the wheelchair from the room.'*
> (Inspection report)

The commentator noted how taking away someone's wheelchair not only takes away the resident's choice but also increases the risk of the resident falling should they decide to try and walk unassisted.

Examples were given where people had no say in what happened to them:

> *'A resident had been sitting at the table talking with the inspector. At 7.10 pm the inspector left the dining room. The inspector next saw this resident in bed at 7.20 pm. The resident said that she had not asked and did not want to be in bed. The care plan said that the bedtime was 9 pm. When staff were questioned about this they said that this resident had to be put in bed for their safety. They were at risk if left in the lounge in the chair.'*
> (Inspection report)

Participants in the online survey and group discussions stressed that older people may not get the "information, advice, advocacy and general support that enables them to lead the life they would wish to lead" (Older person). Needless to say, people should be full participants in decisions about their lives and care.

There are times when consent for restraint is sought from a person with power of attorney or a solicitor. The use of outsiders may conflict with the authority of the older person. Indeed, there may be confusion between using people such as general practitioners or physiotherapists as expert advisers and using them to authorise the use of restraint.

4.5 Recognising the impact of restraint and looking for alternatives

Others recognised that not only may restraint be a worrying, perhaps frightening and humiliating experience, but it may also have repercussions for health. If people walk less, are sedated or feel that they have to conform, what are the consequences?

This argument was linked to another– that there had to be a search for alternatives. Whether discussing their own experiences or responding to the vignettes, people were insistent that usually there are better ways of working alongside older people in providing care.

> *"Instead of physical restraint, staff should try to engage the person and find ways to alleviate the anxiety that often lies behind 'wandering' and find appropriate means of distracting them."*
> (Relative)

Another approach people suggested was to try to minimise risk, for example by using hip protectors or knee and shoulder pads for someone who was prone to falls. In addition someone could be accompanied on walks. A 'bean bag' type chair might be better than a recliner; and a mattress on the floor might be better than bed rails, as "the person will still be able to move, or crawl" (Relative), however undignified this might seem. However, there have been examples cited earlier in this report where both of these practices were considered inappropriate, and there is little evidence upon which to justify them. Clearly, there is much complexity surrounding the issue of restraint.

4.6 Staff shortages and the use of restraint

There is widespread suspicion that actions presented to ensure people's safety and well-being are designed to help staff manage workloads.

- "There weren't enough staff to work with residents individually or even supervise movement, so their explanation was it was for her own safety" (Older person).
- "Staff often justify restraint by stating that relatives complain and want their [relative] to be kept safe, or that they [the staff] do not have time to do things in the way they would like to do" (Older person).

The following inspector's account captures the complex interplay between staff shortages, the wish to ensure that residents were supervised and staff who appear not to understand the rights of residents:

> *"All of the residents were up and dressed by 7.30 am. In order to supervise the 13 service users the staff members endeavoured to ensure that they were all seated in the lounge. A female resident who had dementia insisted on going downstairs to the lower ground floor. A member of night staff attempted to persuade her to go upstairs to the lounge. The situation rapidly became a confrontation with the member of staff becoming more frustrated and the resident becoming increasingly angry. Eventually the member of staff 'grabbed' her by the arm to get her upstairs but this only exacerbated the situation. The situation was only resolved when the member of staff left her sitting on the stairs."*
>
> (Inspection report)

Staff have voiced their concerns about the use of restraint, feeling "helpless and upset"; that "there should have been other ways of dealing with the situation"; and how they "found this way of dealing with [a person] completely inappropriate and dismissive of human rights". This was where:

> *"A resident was shouting out and disturbing other residents; she was taken into her room and the door was closed. It was an elderly woman in a wheelchair so she was unable to leave the room."*
>
> (Care home worker)

4.7 Restraint: the last resort?

Restraint was thought justifiable on rare occasions, when there was no alternative to preventing harm to the individual or others. People qualified the need for restraint in a number of ways. For example:

> *'Those using restraint should be able to justify it as the only possible thing to do after all other ways of dealing with the situation have been shown to be impossible, and they should have to give this justification each and every time to an independent and appropriately knowledgeable person/body.'*
> (Advocate for older person)

Most importantly, as the quotations above highlights, the decision to use restraint should be based on an individual's situation. There are dangers when actions relating to one person become imposed on everybody. For example, where a keypad system on the front door of a home introduced to ensure the safety of one person becomes a restraint to everybody, regardless of their personal situation.

People argued also for the use of restraints as short-term responses while other solutions were sought; and where "the person is being irrational and unable to understand the risk they are taking" (Social services care manager).

Two further points deserve attention. First, restraint may be the lesser of two 'evils'. "If locking the door means a woman with dementia can stay at home cared for by her husband, should we stop him doing it?" (Locality manager). Second, was the reminder that managers have a responsibility to employees and other residents. "We can be guilty of acts of omission as well as commission if by our failing to act people get hurt" (Independent living service manager).

4.8 Staff uncertainties: policies and practice

Evidence from inspectors' reports reveal that levels of restraint are much higher than those recorded by staff in care homes. Inspection reports stress that restraint must be subject to risk assessment and the decisions recorded:

> *'On one occasion staff had physically restrained a service user and on another had administered medication in an inappropriate manner. These incidents had not been reported to the manager.'*
> (Inspection report)

Inspection reports identified a tacit reluctance to acknowledge that restraint occurs:

> *'A resident attempted to attack a visitor and other residents and was restrained by staff. At first the manager denied restraint had happened; later she said that there had been restraint but not recorded as such. 'It is done but not recorded. Nurses can't win; one nurse was suspended for restraint'. Terms such as 'moved' or 'escorted' were recorded instead of restraint. Staff members interviewed said they saw the resident being 'held by his arms' with a staff member 'standing at either side'. Another staff member said 'We don't use restraint'.'*
> (Inspection report)

All home care services, care homes and nursing homes are required by CSCI to have certain policies in place, of which restraint is one. Problems have been identified where these policies and procedures are in place but staff are not following them or keeping good records:

> *'The home has a policy and procedure regarding the restraint of service users should this become necessary. The home does not follow this process and detailed written records of such instances are not kept.'*
> (Inspection report)

Care workers and managers consulted about these issues all agreed that:

- staff are confused as to what constitutes restraint
- advice is needed on what should be included in a restraint policy
- policies are helpful in the day-to-day situations that occur in a care home
- staff are often unsure how to balance the rights of residents to decide what to do and their responsibility to look after residents
- there are often differences of opinion between residents and other staff as to whether residents should be restrained.

They thought the most important topics a restraint policy should cover were, in order of importance:

- definition of restraint
- knowing when it is appropriate to use restraint
- circumstances when restraint is never allowed
- legal implications
- management of certain behaviours
- training and safety for staff
- residents' rights
- decision making: whom to involve
- differences between types of restraint
- ethos/philosophy eg 'restraint only as a last resort'
- good and safe practice.

Best practice is for risk assessments to be undertaken and decisions recorded. The decisions should justify that it is the least restrictive method. Restraint records should be subject to regular review by managers.

People added that there was a need for authoritative guidance on restraint, communicated to everyone, that dispenses with current differences between agencies and clearly states what is and is not allowed.

It is instructive to compare this with an analysis that was undertaken of existing policies. We analysed 26 care home policies on restraint and found:

- Under half had a definition of restraint, and most of these referred to physical and chemical restraint. Some mentioned physical intervention and locking external doors; one included a general description: restraint "means restricting someone's liberty or preventing them from doing something they want to do". There was a single reference to threatening and financial restriction.
- All included a statement of principles.
- Six explicitly referred to the rights of the older person.
- Half mentioned how to obtain the consent of the older person, though four stressed this to be a necessity and only three referred to procedures for obtaining consent when the older person was judged to have incapacity.

Two providers stated that the home operated a no-restraint policy, though one allowed for restraint in exceptional circumstances; one noted that any restraint must be justified by law; another added that restraint was to be the minimum necessary. Finally, germane to the debate about rights and risk, there was a statement that was explicit about the timing of any action:

> ***"Intervening before a resident has embarked on what a staff member may consider to be an inappropriate activity and in order to prevent them hurting themselves is not permissible without their consent."***
> (Care home restraint policy)

Some policies were explicit as to the circumstances when restraint was prohibited: residents were never to be threatened, locked in rooms or out of the building, tied by their clothing, have tables placed in front of chairs to restrict movement; medication was not to be used to restrain.

There was a wide range of legislation referred to in the policies (eg Mental Health Act 1983, Police and Criminal Evidence Act 1984; Public Order Act 1986, Human Rights Act 1998,), though there was no consistency across the policies reviewed. Appendix 3 provides details of the good features of the policies analysed.

5

Concluding discussion

This concluding chapter discusses the key findings and the implications for practice, care provision, commissioning, regulation and government policy.

The **key points** in this chapter are:

- The report shows the balance between keeping people safe and always respecting their rights is not just a matter for staff alone to resolve in their daily contact with people needing care and support.
- This is a human rights issue where government, regulator, commissioners and care providers have responsibilities to support staff and improve services to older people.
- There needs to be clarity of policy and guidelines about what constitutes restraint that puts the rights of older people at the forefront and is based on sound evidence.
- There also needs to be adequate training and everyday support to care staff to ensure best practice.
- Most importantly, there need to be the resources and working conditions that enable staff to provide the highest quality of care.

5.1 Human rights

This study has found examples of the use of restraint in ways which are unacceptable and infringe people's human rights to dignity and choice. We have no evidence whether or not these are widespread, but every one of these examples gives cause for concern. Older people who need care and assistance have the right to take decisions about their lives, unless their freedom to do so is constrained by legislation.

Older people who can make their own decision should decide and control their own care, including any decisions to be made about restraint. There are, however, some people who need support in making decisions and a growing number of older people with dementia who have limited mental capacity to make decisions for themselves.[50] The Mental Capacity Act 2005 provides the proper framework for reaching decisions as to what is in people's best interests. After October 2007, when the Mental Capacity Act 2005 comes fully into force, staff using restraint must:

- demonstrate the lack of capacity of the person before they take action
- record their assessment and the action taken
- review their actions.

5.2 Tensions between rights and responsibilities

Whilst people's human rights must be respected at all times, this study has also shown very real difficulties in balancing people's rights to make decisions with the responsibilities of care services to ensure people do not come to harm. In many ways these dilemmas and ambiguities have been left for people doing the day-to-day caring to resolve. Yet these are responsibilities for everyone – care providers, council commissioners, government, regulators and the public. It is essential to understand the complexity of the job of caring, the tensions in practice and the situations that care workers find difficult to manage. Over-simple and unrealistic assertions about the roles and responsibilities of staff must be avoided.

50 King's College London and the London School of Economics (2007). *Dementia UK. A report to the Alzheimer's Society on the prevalence and economic costs of dementia in the UK produced by King's College London and the London School of Economics*. London: Alzheimer's Society.

Care staff have an obligation to carry out their work to a reasonable standard. Part of the tension for them, and a part of the confusion for others, lies in an interpretation of what that work involves. Their tasks may be set out in terms such as supporting and attending to the physical needs of older people, but their role is more complex, falling, perhaps uneasily, between that of a personal assistant to respond to requests, hotel staff looking after guests and a caring relative. There is no one correct style and there has to be negotiation between an older person and staff about what is wanted and what staff can be expected to do. It is unacceptable for staff in care homes to leave residents sitting on the lavatory for long periods or to refuse to answer call bells; yet, staff are supporting numbers of residents and cannot necessarily respond to each precisely when wanted.

At the core of positive practice lies recognition of the authority of the older person to determine how they want to live. Nevertheless, asserting these rights does not resolve each situation for staff. Tensions remain: does the lifestyle within the home, what staff say and do, help people to live as they want or prevent them from doing so? How do staff respond to relatives' concerns, but also assert the authority of older people to determine how they want to live? And in the minutiae of daily life, when does the comfort of a reclining chair turn to restraint, or the convenience of a table beside a chair or the safety of a lap belt turn into a means of immobilising?

Staff need every support in dealing with these tensions.

5.3 Clarifying what is meant by restraint

As a first step, there needs to be clarity about what is meant by restraint. Some actions are readily defined as restraint, such as strapping to a chair or stopping someone from getting out of bed. Other activities are less easy to define. Restraint takes many forms, and it is important to recognise the subtleties and nuances in the ways in which it may be carried out. The lack of standardisation adds complications to understanding restraint: should 'restraint' refer only to illegal restraint or only to physical restraint? A broad definition allows recognition of the numerous ways in which restrictions are placed on people's freedom to live as they want. A narrow definition encourages precision in practice. Most guidance and legislation refers to physical restraint.

In some ways the claim that there is no straightforward definition of the term 'restraint' may seem to overcomplicate. To restrain someone is to stop them from doing something. Key dimensions in looking at restraint are:

- **The nature of the agreement of the individual:** have people properly understood the pros and cons of the restraint, and considered other options?
- **The nature of the control of the individual:** is the person able to end the use of restraint when they wish?

For some, the word 'restraint' implies positive action, intent and motivation:

- **Positive action:** someone does something that will restrain another person, such as putting side rails on a bed; by way of contrast, people's abilities to do what they want may be restrained because of lack of resources.
- **Intent:** distinguishes actions that are intended to restrain from those that restrain unintentionally.
- **Motivation:** people may claim that they restrain someone for the safety of that individual; whether such actions can be justified because they seem to be of benefit is an important question to be asked in these situations.

People taking part in this study highlight the importance of maintaining a broad definition that captures the wide range of people's experience. A definition should include:

- **Physical intervention:** one or more members of staff holding or moving someone, or blocking their movement to stop them from leaving.
- **Physical restraint:** stopping an individual's movements by the use of equipment (eg bed rails, belts and tables).
- **Denial of practical or staff resources to manage daily living:** such as not taking people to the toilet, removing or not answering the call bell.
- **Environmental restraint:** managing the environment to restrict free movement, eg by locks or complicated keypads.
- **Chemical restraint:** the use of medication to restrain; this could be regularly prescribed medication, medication prescribed to be used 'as required', over-the-counter medication, or illegal drugs.

- **Electronic surveillance:** close circuit television, electronic tagging, pressure pads and door alarms may be used to monitor and subsequently control people's behaviour.
- **Medical restraint:** fixing medical interventions, such as drips, so that the individual cannot remove them.
- **Forced care:** restraining a resident so that personal care may be carried out, forced feeding or making people take medications.

Some people argue that routines that require people to get up, go to bed or have meals at unwanted or unreasonable times can impose set lifestyles on people and this constitutes restraint. Others see these as *constraints* on people's lives that fall outside of the definition of 'restraint'.

There is debate also about whether electronic surveillance constitutes restraint. CCTV may be a good care monitoring device and electronic tagging can help to monitor people outside of their usual care environment. However, do these technologies invade people's privacy, constitute restraint, or even constitute a form of house arrest? Clearly, electronic surveillance can enhance the quality of care people receive, but as with any form of restraint, or potential form of restraint, its use does need to be justified on an individual basis.

5.4 Guiding principles if people are at risk of harm

Restraint limits the ability of people to live as they wish and should never be used unless no other options can be found and the practice is within the law. Where there is judged to be an immediate risk of harm to the individual or others, restraint would be legitimate if:

- consideration is given to the best interests of the individual and others
- there is a serious risk of harm to older people or others
- other methods to control the situation, such as de-escalation, have been tried, found to be unsuitable or failed
- the least practicable amount of force is used for the shortest time
- used according to agreed guidelines (that are regularly audited and revised) and where a risk assessment has been conducted and decisions fully recorded

- it is a last resort, as an urgent action only to be used in exceptional circumstances.

Where there is not judged to be an immediate risk, any restraint may be illegal unless the proper processes have been followed. As this report has discussed:

- The starting point should be the human rights of older people. The legal status of an older person does not change when they receive home care services or move into a nursing or care home, although some older people living in any setting may be subject to legal restrictions under the Mental Capacity Act or the Mental Health Act.
- Older people should be able to exercise control and choice.
- Some aspects of daily living will present challenges for older people and those responsible for providing services. Before taking any action, staff should review the circumstances, trying to understand the experience from the perspective of the older person; subsequently they should assess what actions are to be taken.
- The wishes of older people must be dominant, although the views of relatives and advocates, and the expert advice of professionals, should be sought.
- Care plans should specify what is to be done and include time limits and reviews.

Understanding the 'duty of care' of the care provider is fundamental. It distinguishes between putting people at risk and enabling them to choose to take reasonable risks – duty of care does not therefore mean people have to be kept safe from every eventual risk. No environment is entirely risk-free.

5.5 Reducing restraint

The following values are inherent to the evaluation of any possible use of restraint:

- respect for the dignity of older people
- respect for autonomy
- promoting overall well-being
- promoting self-reliance.

Respect for people's well-being demands that thought is given to more than a person's physical safety. The main reason given by care staff for the restraint of older people is to keep people safe. But this is a myth that it does keep them safe. Physical restraint may reduce the number of minor accidents but increases the risk of more serious outcomes for older people. For example, older people may become:

- frustrated by restraint mechanisms, so that those determined to move are likely to have worse accidents
- less mobile, less fit and less able to walk
- more likely to develop pressure sores, become incontinent and depressed.[51]

Several factors contribute to reducing the use of restraints. The first factor is a clear policy about restraint that is communicated and understood by all staff, people using services, their carers and relatives. The policy should adopt the principles outlined in 5.5, and should emphasise de-escalation techniques and therapeutic approaches to avoid the inappropriate use of restraint.

The second factor is to fully understand each older person so solutions can be found, rather than 'problems managed'. This will involve:

- close liaison between care managers undertaking care assessments and care providers
- regular reviews of people using care services
- involving carers and relatives
- engaging advocates who speak up for older people
- having skilled care staff.

The third factor is that support for staff is crucial, both in the way homes or home care services are managed and their culture of care, and in the training, awareness raising and supervision of staff.

51 Evans D., Wood J., Lambert L. and FitzGerald M. (2002) *Physical restraint in acute and residential care*. Adelaide: The Joanna Briggs Institute 2002; Cheung P. and Yam B. (2005) Patient autonomy in physical restraint. *International Journal of Older People Nursing* in association with *Journal of Clinical Nursing*, 14, 3a: 34-40.

Training and educational programmes for staff reduce the use of restraints.[52] These need to be backed up in practice with, for example, requirements that an assessment is undertaken before any restraint (other than in an emergency) is used. It is important to underline that most staff working with older people do not need to be trained in intervention techniques. Instead negotiation and de-escalation of difficult situations need to be at the centre of training and educational programmes for staff working with older people.

Issues concerning restraint should also be included in training about the protection of vulnerable adults. Care staff need a framework to determine when acts of restraint become a matter of abuse.

5.6 Resource pressures

Finally, the problems highlighted in feedback from older people, carers and care staff, where restricted resources have been linked to the use of restraint in all its forms, cannot be used as an excuse for bad practice. However, there are dangers that pressures on the care system are shifted on to staff working directly with older people so that the limits on their time with each person forces them into ways of working that neither they, nor the older person, would want. Council purchasing staff and care providers have responsibilities to negotiate prices and funding that allow for high quality care where there are adequate numbers of trained and skilled staff.

52 Evans L., Strumpf N. and Williams C. (1991) Redefining a standard of care for frail older people: alternatives to routine physical restraint. In *Advances in Long Term Care*, edited by P. Katz, R.L. Kane, and M. Mezey, vol. 1, 81-108. New York: Springer.

5.7 Next steps

CSCI wants to engage everyone in this debate about the use of restraint – people who use services and their carers, care workers, care providers and commissioners as well as the general public – to improve the current situation.

CSCI will take this report forward by:

- Updating our guidance for inspectors on restraint and publishing this on our internet site for professionals.
- Holding discussions with providers to ensure they are working with their staff to address issues about restraint.
- Continuing to report on the use of restraint and recommending this topic is kept under review by the new care and health regulator.

Appendix 1: Study methods

The evidence for this study draws on CSCI's intelligence coupled with additional fieldwork activities. Key themes from the evidence sets were analysed thematically, and these themes used to draw out the main finings for discussion in this report.

1 CSCI intelligence

Meetings with CSCI regulatory staff: a half-day seminar with 21 regulatory inspectors and managers, responsible for the inspection of home care and care home services for older people, was convened to gather information on current practice and policies. Regular meetings with a smaller advisory team of CSCI staff were also held during the course of the study.

Analysis of CSCI datasets: inspection reports for one calendar year (2006 to 2007) were searched for references to restraint. The word 'restrain' was found in reports on 610 homes after those referring to window restraints were excluded. This was followed by a further search for key words indicating different types of restraint.

The complaints and allegations received by CSCI (between April 2004 and February 2007) were reviewed for incidents of restraint. CSCI received 57,283 complaints and allegations in the period studied. Of these, 337 were identified as relating to restraint.

2 Fieldwork activity

Group discussions: eight group discussions were held with 76 older people and their carers and families. Two of these groups were held in care homes, and five groups with people in the community. Three of these community groups were held with members of ethnically diverse communities (people from Iraq, Bengal and Kurdistan living in England).

We also met regularly with older people, carers and family members of the *Living with Dementia Working Group* (convened by the Alzheimer's Society).

Overall, 76 people took part in these discussions; 25% of people were from black and minority ethnic groups.

Survey: between April and June 2007 a survey was carried out – online and with paper copies available. The survey asked about people's views and experiences of restraint and also used a series of hypothetical fictional scenarios (called vignettes), which helped to clarify the perceptions and the principles that lie behind restraint.

We received 253 responses to the survey:

- 195 were women; 55 men
- 211 were aged 18–59; 38 were aged 60 and over (this includes 19 who termed themselves older people, and others who were, for example, staff members)
- 3 completed the survey on behalf of an older person
- 25 were relatives of an older person
- 51 were staff members of care homes
- 48 were health care workers
- 18 were managers of care homes
- 13 were care home group managers
- 11 were social services care managers
- 9 were trainers or NVQ assessors, of whom 1 was a trainer in de-escalation techniques
- 8 were home care staff

- others were managers or staff in voluntary organisations (7), academics (3), solicitors (2), social workers in health services (2), social services staff other than commissioners (2), manager of an independent living service, consultant, nurse or social worker
- 84% defined themselves as White British; there were few respondents from black and minority ethnic groups.

Follow-up questionnaires: to follow up further lines of questioning, a sub-sample of survey and group discussion participants were invited to provide further comment to vignettes and position statements.

Analysis of care home policies on restraint: 180 care homes were randomly selected and invited to submit their policies on restraint to us. We received 26 policies (including eight from large corporate providers). These policies were content analysed.

Stakeholder seminars: two seminar events were convened to share early findings from the study, and to allow people to verify and comment on the key findings. The first meeting was convened with 21 older people, their carers and relatives (six people were from minority ethnic groups). The second meeting was held with 15 representatives from government, care provider organisations, academics, and the voluntary sector.

Appendix 2: Regulations

The Care Homes Regulations 2001 as amended[53] stipulate that the registered person:

- is to "ensure that the care home is conducted so as to promote and make proper provision for the health and welfare of service users" – regulation 12(1)
- "shall so far as practicable enable service users to make decisions with respect to the care they are to receive and their health and welfare" – regulation 12(2)
- shall "so far as practicable ascertain and take into account their [service users'] wishes and feelings" – regulation 12(3)
- conduct the home "in a manner which respects the privacy and dignity of service users" – regulation 12(4a).
- is to ensure that "unnecessary risks to the health or safety of service users are identified and so far as possible eliminated' – regulation 13(4c)
- is to "make suitable arrangements to provide a safe system for moving and handling service users" – 13(5)
- is to make the service user's plan available to the service user and keep the service user's plan under review – regulation 15(2)
- is to "give notice to the Commission without delay of the occurrence of ... any event in the care home which adversely affects the well-being or safety of any service user" – regulation 37(1e).

53 Department of Health (2003). *Care homes for older people. National minimum standards. Care Homes Regulations (third edition)*. London: Stationery Office.

There are specific references to physical restraint:

"The registered person shall ensure that no service user is subject to physical restraint unless

(a) 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; or

(b) in the case of a person who lacks capacity in relation to the matter in question, the act meets the conditions of section 6 of the 2005 Act" – regulation 13(7)(a)(b).

"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" – regulation 13(8).

The latter point is repeated with a requirement that there is "a record of any physical restraint used on the service user" – regulation 17(1a), schedule 3(p).

It should be noted that insofar as there are references to restraint, they are to *physical* restraint.

Except regulation 17(1a) schedule 3(q) – there is a requirement to keep "a record of any limitations agreed with the service user as to the service user's freedom of choice, liberty of movement and power to make decisions".

The Domiciliary Care Regulations 2002 as amended[54] stipulate the registered person must ensure:

"...no service user is subject to physical restraint unless –

(a) 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; or (b) in the case of a person who lacks capacity in relation to the matter in question, the act meets the conditions of section 6 of the 2005 Act" – regulation 14(10)(a)(b).

"On any occasion on which a service user is subject to physical restraint by a person who works as a domiciliary care worker for the purposes of the agency, the registered person shall record the circumstances, including the nature of the restraint" – regulation 14(11).

54 Department of Health (2002). *Domiciliary care. National minimum standards. Regulations*. London: Department of Health.

In addition, the national minimum standard states:

"Physical intervention is only used as a last resort, in accordance with Department of Health guidance and protects the rights and best interests of the service user, including people with special needs, and is the minimum necessary consistent with safety" – Domiciliary Care National Minimum Standard 14.6.

Appendix 3: The constituents of good restraint policies

1 Principles

- Older people receiving home care and living in care homes retain their full rights to determine how they want to live within the constraints of the law and are entitled to take risks in daily life just like anybody else.
- In all decisions the best interests of the older person are paramount.
- Staff have the responsibility to help people to evaluate such risks and, within the confines of the job, to support them with the decisions they have made.
- Living in a care home of necessity places some constraints on those who live there. However, the environment of the care home should be the least restrictive possible.
- If decisions to use restraint are taken, it must be the least restrictive option and undertaken for the shortest viable length of time.
- Restraint limits the ability of people to move around or live as they wish and should never be used unless:
  - it has been requested by older people who understand the impact of restraint and the other options available, or
  - it is proposed following a risk assessment and agreed by those with capacity, or the proper procedures are followed for those without capacity, or

– it is judged immediately necessary by care staff to protect an individual older person, others in the vicinity or staff themselves.

2 Procedures

Some aspects of daily living will present problems for older people and those responsible for providing services. Intervention that might lead to restraint should never be taken without following set procedures, except in emergency:

- **Risk assessment:** before taking any action staff should review the circumstances, searching to understand the experience from the perspective of the older person, and assess what actions are to be taken. The relative risk of doing something versus not doing something should be risk assessed and decisions recorded.
- **Consent:** the wishes of the resident must be dominant, although the views of relatives and advocates, and the expert advice of other professionals, should be sought.
- **Care plans:** the plans that are drawn up should specify what is to be done and include time limits and reviews.
- **Records:** all types of restraint used and limitations on freedom of choice, liberty of movement and power to make decisions must be recorded. Decisions should be reviewed regularly.
- **Staff:** need appropriate training.

3 Policy documents

These should include the following:

- the purpose of the document (for whom available, relationship to other documents)
- a definition of restraint
- a discussion of lifestyle and the ways that routines and staff may impose on residents
- the principles underpinning practice and their relationship to restraint
- who in the care setting can make decisions to use restraint and who can carry the decisions out

- the types of restraint that are prohibited
- the relevant legislation, including the Human Rights Act
- the rights of older people, including a) the necessity of their consent to any restraint unless they have been judged to lack capacity or the situation is judged to be an emergency, and b) the fact that nobody else (including relatives and general practitioners) has authority to make decisions on their behalf unless empowered by the courts
- these rights include the same right to take risks as all other citizens
- procedures that have to be followed when restraint is being considered
- good practice – ways of handling difficult situations, including de-escalation
- the training for staff that is available, or required
- how the use of restraint will be recorded and monitored
- references to further documents, for example on the impact of restraint
- proper maintenance and review of equipment that is only to be used for the purpose for which it was designed in accordance with the manufacturers' instructions and health and safety legislation.

Appendix 4: Acknowledgements

The Commission for Social Care Inspection gratefully acknowledges the older people, their carers and relatives, care staff and other professionals who shared their views and experiences during the course of this study.

Thanks are also due to the organisations that supported and publicised the study, and the individuals that attended the seminars to discuss the key findings from the study.

CSCI is especially grateful to members of the Living with Dementia Working Group (convened by the Alzheimer's Society) for their strong contributions and support for the work throughout.

Alongside CSCI staff, Eskrigge Social Research designed the fieldwork and analysed, interpreted and wrote up the findings.

Responsibility for this report rests with the Commission for Social Care Inspection.

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