

# Minimising the use of 'restraint' in care homes: Challenges, dilemmas and positive approaches



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First published in Great Britain in October 2009  
by the Social Care Institute for Excellence

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## Acknowledgements

The *My Home Life* team would like to thank the Social Care Institute for Excellence (SCIE) for giving us the opportunity to undertake this work. We also thank the research participants (care home staff, residents and relatives; home managers and heads of care; representatives of user and provider organisations; and the education and training facilitators) for their involvement and, most of all, their frank, open and honest views on what is a highly complex issue. We also wish to thank Louise Geoghegan for her administrative assistance to the research team.



# 1 Introduction

The term 'restraint' conjures up disturbing images of patients tied up, restricted in movement and abused. These images should be associated with some institutional practices from the past and yet the continual use of this term in the media in relation to care homes would wrongly suggest that such practices are commonplace today. There is little evidence that this is the case; without doubt, practice in care homes has improved considerably over the past 40 or so years.

That said, avoiding the occasional use of some form of restraint remains a challenge for many care homes, particularly those working with our frailest citizens, who may need to be protected from harming themselves or indeed others under particular circumstances. Where researchers or the press have reported incidences of restraint in care homes, they are quick to lay the blame firmly at the feet of practitioners rather than presenting a more balanced picture of the complexity of caring for some of our most frail citizens within limited resources. Nor do they acknowledge the efforts that practitioners often make to avoid the use of any form of 'restraining' practice, where at all possible. Of course, it is critical that we continue to campaign for poor practice to be eradicated (wherever the setting), but such emotionally charged discourse (specifically in relation to care homes) can serve to support a culture of denial around the topic rather than encouraging a rational, open discussion about the complexity of balancing rights and risks when planning care for individuals.

The aim of this report is to facilitate a dialogue about this very sensitive topic. The report describes findings from a small-scale study commissioned by the Social Care Institute for Excellence (SCIE) and undertaken as part of the *My Home Life* programme ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)), a national programme aimed at supporting quality of life for those living, dying, visiting and working in care homes. The study seeks to shed light on the complexity of the issues facing care homes and to explore how managers and staff have developed strategies for avoiding or minimising the use of restraint. Our purpose was to work with the sector to produce a document that would be helpful to them.

The report seeks to describe some of the challenges facing care home staff in supporting older people with complex needs and provides some examples of where staff have sensitively and appropriately used restraint because there appeared to be no other options available to them. We offer these illustrations of practice in order to communicate the dilemmas that staff face, rather than to excuse thoughtless and inappropriate use of restraint (whatever the health or social care setting). Such practices are a form of abuse and cannot be condoned.

The study was undertaken in the first half of 2009 and was carried out in England only.

Given the small-scale nature of this study, the report only serves to begin the discussion rather than offering conclusive findings and comprehensive guidelines. Some of the names and detailed case studies used have been changed to protect the participants involved.



The research was informed by a review of literature on the same topic, undertaken by Hazel Qureshi for SCIE (Quershi, 2009).

This report regularly makes reference to 'risk management' as it was discussed within the interviews but does not attempt to provide a comprehensive review of research on this theme.

While the report *does not* directly focus on requirements and guidance relating to the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards (MCA DOLS), it seeks to be mindful of the legislative framework within which decisions about the use of restraint are made in care homes.

Any action taken must be in line with the five key principles of the Mental Capacity Act (2005) (which applies to all people), namely:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. (DH, 2009, p 11)

The MCA Code of Practice outlines the circumstances under which restraint is acceptable, explaining that:

- the person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm.'

Sections 6.44–6.48 provide more detail about making such decisions, and give greater clarity to the terms in italics above.

The new MCA Deprivation of Liberty Safeguards provide a framework for lawful deprivation of liberty of those people who lack capacity to consent to arrangements made for their care or treatment either in hospital or in a care home, and who need to be deprived of liberty in their own best interest. It is important to note that the use of restraint under the circumstances outlined above will not necessarily be considered a deprivation of liberty. The MCA DOLS apply to people in hospitals and care homes who meet all of the following criteria. A person must:

- be aged 18 or over
- have a mental disorder such as dementia or a learning disability
- lack the capacity to consent to where their treatment and/or care is given

- need to have their liberty taken away in their own best interests to protect them from harm. (DH, 2009, p 10)

The European Court of Human Rights (ECtHR) has said deprivation of liberty depends on the specific circumstances of each individual case. As a result, there is no single definition or a standard checklist that can be used to identify where people are being deprived of their liberty. However, a number of cases concerning deprivation of liberty have come before the ECtHR and the UK courts. The following list is based on the judgments in several of these cases and indicates what circumstances have led to the courts deciding that patients may have been deprived of their liberty:

- restraint was used to admit a person to a hospital or care home when the person is resisting admission
- medication was given forcibly, against a patient's will
- staff exercised complete control over the care and movements of a person for a long period of time
- staff took all decisions on a person's behalf, including choices relating to assessments, treatments, visitors and where they can live
- hospital or care home staff took responsibility for deciding if a person can be released into the care of others or allowed to live elsewhere
- when carers requested that a person be discharged to their care, hospital or care home staff refused
- the person was prevented from seeing friends or family because the hospital or care home has restricted access to them
- the person was unable to make choices about what they wanted to do and how they wanted to live, because hospital or care home staff exercised continuous supervision and control over them. (DH, 2009, pp 8/9)

People are thus entitled to be cared for in the least restrictive way possible and care planning should always consider if there are other, less restrictive options available to avoid unnecessary deprivation of liberty. However, if all alternatives have been explored and the hospital or care home believes that it is necessary to deprive a person of their liberty to deliver the care or treatment they need, then there is a standard process they must follow to ensure that the deprivation of liberty is lawful (authorised) and that they are protected. The procedure to be followed is carefully described in *Deprivation of Liberty Safeguards: A guide for hospitals and care homes* (DH, 2009). Importantly, this booklet clearly states:

It is important to remember that depriving someone of their liberty in a hospital or care home should be a relatively rare occurrence. Therefore, only a small number of people should need MCA DOLS authorisation. Before applying for an authorisation, the managing authority should ALWAYS think about providing care or treatment in ways which avoid depriving someone of their liberty. (DH, 2009, p 11)

A useful 'Making decisions booklet' (Crown Copyright, 2009) aimed at hospital and care home managers to help them fulfil their statutory roles and responsibilities under the 2005 MCA DOLS legislation can be downloaded (along with other 'Making decisions booklets') at: [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk).

It should be noted in reading this report that the MCA came into force in October 2007, whereas DOLS came into force in April 2009. While many of the staff we spoke to in this study had received formal training in relation to the MCA, local policies regarding the process and protocols for DOLS were still in the early stages of implementation.

## 2 Aims and methodology

The aims of the study were as follows:

- to identify features of the policy and practice environment that might support a reduction in the use of restraint
- to identify innovative examples of organisational arrangements and approaches to support a reduction in the use of restraint
- to explore the use of policy, training and education in care home settings to reduce the use of restraint
- to explore the perspectives of older people and frontline workers on the use and reduction of restraint.

Given the sensitivity of the issues being tackled in this study, the research team wished to develop a methodology that would allow care home practitioners to speak freely and honestly about the subject. With this in mind, and in keeping with the general ethos and values of the *My Home Life* programme, emphasis was placed on the following:

- *A collaborative approach*: rather than 'researching the care home sector', the study was undertaken in collaboration with the care home sector. This was seen as essential both in valuing care home practitioners' expertise and the complex work that they do and in helping them to create a product that was going to be useful to them.
- *Appreciative inquiry*: in gathering the data, an appreciative inquiry approach was adopted (Cooperrider et al, 2003) to focus on positive messages, rather than poor practice. The focus of the study was to identify examples of good practice, where they exist, while acknowledging rather than ignoring the challenges and struggles that staff, residents and relatives face in tackling restraint.
- *Staff, resident and relative perspectives*: the researchers recognised the importance of seeing the care home as a community where the perspectives of and relationships between staff, family, friends and residents are all crucial to improvements in practice (in keeping with the principle of relationship-centred care; see Nolan et al, 2006).
- *Whole systems thinking*: in aiming to move away from a blame culture, it was important to explore how the policies, behaviours and priorities of regulators, commissioners and primary care trusts impact on the ability of care homes to deliver good practice. Given the limited scope of this project, this has been difficult to achieve; however, work is planned for the future to develop this theme.

### 2.1 Detailed methodology

On advice from SCIE, the research team obtained ethical approval for the study from the City University London Ethics Committee. There were three stages to the study: a workshop of care home sector representatives, frontline discussions with residents, relatives and care home staff and a validation exercise with national care home representative organisations.

### **Stage 1: A workshop of care home sector representatives**

The *My Home Life* team convened a workshop bringing together education and training facilitators, care home representative bodies, care home managers and heads of care from large and small care home providers in the independent and voluntary sector. The purpose of this group was to begin an exploration of the topic and to offer advice on the best techniques for gathering examples of best practice from the sector. These individuals were identified through the informal networks that the *My Home Life* Programme had developed.

### **Stage 2: Frontline discussions with relatives, residents and care home staff**

Following on from the workshop, the team undertook in-depth discussions with relatives, residents and care home staff in six care homes (see Appendix 1 for a discussion guide). Discussions took place as individual interviews and mini-focus groups depending on how individuals preferred to engage with the project. Participants from the initial workshop helped identify care home managers who they thought might be interested in taking part in the study. The research team followed up these leads by contacting the care home managers and providing them with information sheets about the research, making it very clear that they were under no pressure or obligation to take part in the study. Three care home managers did not wish to take part in the project. Those care home managers keen to participate were asked to pass information sheets to staff, residents and relatives so that they had the opportunity to contribute in interviews or discussion groups as they so wished.

On the day of arrival at the care home, the research team ensured that all participants had read the information sheet and were aware that they were under no obligation to take part in the study and that they could terminate the interview or remove themselves from the discussion group at any point in time. The research team sought reassurance from the manager that the residents interviewed were able to give continuing consent to take part in the study.

### **Stage 3: Validation exercise with national care home representative organisations**

In the spirit of collaboration with the care home sector, a final workshop was convened bringing together representatives from the care home sector to have early sight of the findings and to allow a fuller discussion to develop around some of the themes. This allowed them to confirm the resonance and relevance of the findings and to identify any perceived gaps.

## 2.2 The participants

Overall, 51 people took part in the project, as follows:

**Table 1: Participants**

	Directors of care	Training managers	Managers/deputies	Care staff	Relatives	Residents	Total
Workshops 1 and 2	4	5	4				13
Care home 1			1	3	3		7
Care home 2			2	2		2	6
Care home 3			2	2			4
Care home 4			1	5	7		13
Care home 5				3		5	8
Care home 6			1		2	2	5
<b>Total</b>	<b>4</b>	<b>5</b>	<b>11</b>	<b>15</b>	<b>12</b>	<b>9</b>	<b>56</b>

Care homes were situated in the South East and Midlands areas and varied in size, provider type and registration:

- 1 residential (private, family-run, under 30 residents)
- 2 residential with dementia registration (not-for-profit, large provider, <40 residents/<50 residents)
- 1 nursing physical disabilities/dementia (private, family-run, <100 residents)
- 1 nursing physical disabilities (private, corporate, <50 residents)
- 1 nursing physical disabilities (not-for-profit, large provider, <40 residents)

### 2.2.1 The residents

The resident population appeared to differ considerably both within each care home and across all of the six care homes. One care home with nursing registration was clearly supporting residents with extremely high levels of mental frailty. Some of the richest data came from relatives and staff within this home; however, it was not possible to directly capture the resident voice due to the residents' inability to give informed consent. The voice of those with high levels of mental frailty is often left out of research, which is a great pity given that it is their experience that is often being sought with a view to service improvement. Typically across the care homes, the manager had identified those residents who they felt were able to talk confidently to us. Some of them were very physically disabled, but often these were residents with real insight into life at the care home. There were two occasions where the interview was terminated early and not included in the sample because

it became very clear that the resident was unable to understand the purpose of the interview or unable to take part in the discussion in any meaningful way. All residents appeared to prefer being interviewed individually rather than with other residents.

Our approach in undertaking interviews with residents was to make use of the interview schedule that was developed but to acknowledge that residents had different capacities for following a structured or semi-structured interview. If residents strayed into other areas of discussion that remained relevant to the topic, we would follow the direction that the resident wished to pursue and bring them back to the key topic areas as required. This helped to ensure that residents felt safe and relaxed in the interview and felt able to talk freely, rather than feeling that they were being 'tested' on their knowledge!

Of the nine residents interviewed, three were men.

### 2.2.2 The relatives

The care home managers typically sent out information sheets to relatives to invite them to be part of the study, or informally passed the information on when relatives were visiting the home. Relatives were generally interviewed alone, although one group of three relatives opted to talk in a group. In practice, the research team worked to the convenience of the participants in terms of how, when and where they wished to be interviewed.

### 2.2.3 The staff

Proper attention was given to ensuring that all participants felt able to talk in confidence about the sensitive topics relating to restraint. This appeared to be most important for the staff, who may have worried about saying anything that contradicted the care home policy or ethos. The research team included individuals who had worked for many years in care homes and this appeared to help staff feel at ease. Staff were interviewed in groups and offered the chance to speak to us individually afterwards if they wanted to talk in confidence. One staff member took up this opportunity. Care home managers were interviewed individually. There were no obvious differences between the views of care home managers and the other staff interviewed that could be picked up in this small-scale study.

## 2.3 Defining 'restraint'

For the sake of the study, the researchers adopted the broad everyday definition of restraint identified as most useful by the literature review undertaken by Hazel Qureshi for SCIE (Qureshi, 2009). Restraint was defined as:

Stopping people from doing things they appear to want to do, or restricting their movement.

The literature review identified eight areas of restraint:

1. Manual restraint by staff (holding people down, stopping people from doing something)
2. Arrangement of furniture (to keep people in bed, to stop people getting up or creating an obstacle to part of the room)
3. Lap belts, wrist and vest restraints (inappropriate use of ...)
4. Bedrails (inappropriate use of ...)
5. Removal of walking aids or means to summon assistance (call bells)
6. Locked doors, intended to safeguard a particular person at risk, may thereby unacceptably restrict the movement of all residents
7. Over-medication: psychotropic drugs, sleeping tablets etc
8. Staff instructions or institutional rules or practices may be seen as restraint, for example rules about entering the kitchen, residents not being encouraged to express freedom, choice and control.



## 3 Findings

### 3.1 Perceived overlap between 'restraint' and 'abuse'

Within the first workshop of care home representatives, time was given for participants to discuss the definition that had been adopted for the study. Many participants were expecting a more narrow definition than the one we had adopted. Some felt that the definition should focus solely on direct forms of 'physical/manual restraint' but there was no consensus on this.

Participants felt that the term 'restraint' was not very useful in helping to facilitate a discussion about care home practice: it was seen as interchangeable with the term 'abuse', and staff may not have found it easy to admit that it might be taking place in the care home. Participants were also concerned about the broadness of the definition that was used: 'restraint' seemed to cover both those practices that could be legally defined as examples of 'abuse' as well as those practices that were deemed to be undesirable but not of such severity to warrant formal investigation. While participants wished us to distinguish between abuse and poor practice, it became clear that this was not as easy as it sounds because a specific practice may be considered abuse in one context but not in another, as Hazel Qureshi notes in her briefing paper on restraint for SCIE (Qureshi, 2009):

Actions that meet the definition of restraint are not always wrong. For example, if a person consents to an action by staff, or can easily remove any device that restricts their movement, then this either would not be regarded as restraint, or, at least, would be likely to be acceptable in law.

It was argued that used out of context, the term 'restraint' does not have a fixed social value: in most cases it could be considered as either inappropriate or undesirable but, in a minority of situations, it could be viewed as the only or best option available. For example the MCA Code of Practice, section 6.44 (DH, 2009) states that 'provided you are able to show (ie a documented risk assessment) that the person being cared for is likely to suffer harm unless proportionate restraint is used', then restraint is not necessarily bad; it could be best practice.

### 3.2 Previous poor practice in the use of restraint

A typical comment that arose frequently in the study was the fact that care home practice had improved significantly over the past 40 or so years and that this was often not acknowledged or recognised by the public. Many participants described examples of practice that were in common use decades earlier but that would certainly not be considered as 'acceptable' or 'common' today. As one practitioner put it:

"I think restraint actually happens less now because there has been so much publicity in the past. From the 1960s when I worked in a home we used to have the chairs where we used to sit residents in, we used to have the tables that we pushed in. We didn't actually think that we were doing anything wrong then, as opposed to now these things are seen as abuse, that their rights were being evaded." (care home practitioner)

Other examples of poor practice from the past are shown below, in Table 2.

**Table 2: Examples of poor practice, restraint and abuse from earlier decades**

Restraint
1. Residents were undressed before tea and in bed by 6pm.
2. Catheter bags were strapped to the leg or bed and impeded movement. Residents were fed breakfast while sitting on the commode.
3. Door handles were placed out of reach.
4. A pillow was tightly rolled in a draw sheet and firmly wedged at the bottom of the bed – this was designed to stop people sliding down the bed, but also prevented movement in the bed.
5. Each resident's room was marked with a green or red sticker and the culture of the home at night was to ignore calls bells from the rooms marked with red stickers – staff would be run off their feet otherwise.

In the following section we begin to explore the dilemmas facing care homes in trying to reduce the use of restraint. We explore each category of 'restraint' as a separate section but recognise that in practice there is some overlap across these categories.

### 3.3 Manual restraint

This type of restraint refers to any practice involving holding people down or physically preventing someone from doing something.

There appeared to be a general consensus among those practitioners involved in the study that 'holding people down' or 'physically stopping people from doing something' would be deemed as completely unacceptable in the vast majority of cases. Where there had been no formal assessment of risk, no thorough examination of alternative strategies involving the resident, relatives and external support, such forms of manual restraint could be considered to constitute abuse.

That said, a range of challenges were identified that sometimes make it very difficult in the everyday context of care home practice to avoid some level of physical restraint, as described below in Case study 1.

#### Case study 1

Miss Green, a resident experiencing late stage dementia, frequently lashes out at staff (and even relatives) who are supporting her to get washed/eat/drink. There is a risk both to the staff and to the resident herself. Every attempt has been made to find creative ways to stop this behaviour: staff have tried different approaches, tones of voice and routines, but the behaviour continues. External support and advice has also been sought. The behaviour appears not to be an expression of anger directed at any specific aspect of the environment or task being undertaken. Ultimately, in discussion with relatives and outside agencies, it has been agreed that the resident lacked capacity to make decisions, and that, subject to ongoing

assessment and exploration of alternative strategies for supporting the resident, a gentle holding down of the arm while the resident is assisted with daily activities was acceptable.

### Case study 2

Mrs Charlesworth, a resident with dementia, shouts expletives at other residents on a daily basis. She expresses herself through screaming, and what appear to be aggressive outbursts. The care home is trying to access help from outside agencies to explore the reasons behind this behaviour and is looking at how the environment might be altered to reduce this distressing behaviour. In the meantime, other residents, particularly those with dementia, are becoming distressed and, in some cases, threatening to be violent towards her. There is an identified risk of harm to the resident and to others. With agreement of the relatives and external agencies (including the safeguarding adults team and DOLS assessor), the resident is encouraged to reside in one area of the care home where other residents cannot hear her; this might require some level of gentle physical encouragement. This is an interim measure while an alternative action is identified with outside support.

### Case study 3

Mr Townsend had to be physically restrained because he attacked a member of staff and one of the residents. He had to be physically removed from the scene and taken to his room because of the high risk of continued violence. The MCA Code of Practice, section 6.43 would support staff with these actions. Under common law staff are able to take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to that person and to anyone else. Immediate outside help was requested but the incident was a one-off and did not occur again.

These examples illustrate the complexity of care that many care homes are engaged with, sometimes with limited resources and a lack of regular support from external agencies. The need to work with the safeguarding adults team and the local DOLS assessors, as well as family members and the residents themselves, is paramount in identifying the least restrictive option available to them.

#### 3.3.1 Good practice

In response to the dilemmas offered above, the study found evidence of staff demonstrating high levels of competence in their ability to reduce aggression, anxiety and distress among residents which, in themselves, had the effect of minimising the need for restraint. Their negotiating, listening and general communication skills were notable. Managers demonstrated how they actively identified members of staff who had personal qualities that the resident responded to positively. One relative spoke of a staff member with a very strong personality,

who had a way of reducing the frustration and aggression of their mother who had lashed out at everyone even before coming into the home.

It was apparent that in rare cases where forms of restraint seemed the only alternative for the safety of all, thorough risk assessments were undertaken, care plans agreed with the resident/relatives and advice was sought from external agencies about any other interventions that might be developed. Typically, such incidences were rare because the staff had developed positive relationships with the resident and relatives and, through this process, had developed individualised strategies for supporting the resident to reduce the need for restraint.

### 3.4 Other forms of manual restraint

#### 3.4.1 Stopping people from getting out of a chair or moving about the home

Many participants we spoke to were unclear whether manual restraint would include those practices where staff felt the need to intervene where a resident was, unknowingly, putting themselves at risk of harm. A typical scenario mentioned related to how residents (particularly those with dementia) might try to get up from a chair without an awareness of the risks that they were taking. While the care plan may make note of the need to support the resident to walk, this was fine when there were plenty of staff available, as risks could be minimised, but during the mornings or at handover, there were limited staff available in the lounge and so they were unable to give proper time to escort a resident. One staff made note of the difficulty in giving full attention to one resident if being asked to be responsible for the entire resident group at these busy times:

“Sometimes people want to move about but they are at risk of falling and there are too few staff on, what do you do?” (care home practitioner)

In these cases, practitioners would try to reassure a resident, negotiate with them a time when staff would become available to help but sometimes physical intervention seemed necessary (in the form of gentle physical contact in combination with verbal reassurance, such as a hand to the shoulder or support to help the resident return comfortably to a seated position).

#### 3.4.2 Good practice

Staff spoke about the importance of supporting residents to take informed positive risks where they wished. For those residents lacking capacity to make decisions, good practice was about working closely with relatives to open up a dialogue about the appropriate balance of rights and risks.

Good practice was also about offering residents exercise and balance training to reduce risks associated with walking.

As noted above, supporting a resident to get up from a chair and mobilise was not always practicable, particularly where staff numbers were limited. In these cases,

staff would try to inform residents of the risks they were taking, promising to support them as soon as they were free or had more support available:

"If say we say 'yes we will help you' at the opportune time it's more important to fulfil that promise so that they do not feel deceived, because that can have a negative impact." (care home practitioner)

A general view was that if a resident was able to make an informed decision, then staff should respect this as a choice that the resident wished to make and offer support where they could provide it:

"If a resident wanted to move and could make a decision, I would allow them the choice and if anything happens you document it. As long as you mention fully what happened." (care home practitioner)

One practitioner described how without often knowing it, staff would 'monitor risk from a distance'. They would be aware of the risks that residents were taking in getting out of their chairs but only intervene where a resident seemed to be losing balance. This was only possible for residents who would choose to stay in the lounge. Staff would be keenly aware of the physical and mental well-being of residents on a particular day, and would monitor them. This was seen as being less intrusive and was often welcomed by residents if they found themselves beginning to lose balance.

"There's one person who is a bit unsteady when she walks we have to keep an eye on her. We actually did a care plan for that." (care home practitioner)

This monitoring role could be quite stressful if demands were being made by many residents all at the same time, and practitioners need to be aware of how such stress placed on them can sometimes be expressed within interactions with residents. If residents pick up agitation from staff, this might make them more likely to try to get up unaided in order to remove themselves from the situation.

"... we have ... residents who ... they have tried to get up, sometimes we let them try and stand up and let them see how far they can go if you're there in the room where they are you keep an eye, but you let them see for themselves what they are going to do. The more you try to sit them down the more aggressive they get so it's best to leave them to do as much as they can and you're still around, then when you see a danger coming then that's when you do something." (care home practitioner)

Staff noted the need to step back and reflect on how they communicated with residents. Physical or manual restraint may not be necessary if interactions were positive and reassuring and if purposeful activity was introduced to reduce a resident's desire to move from their chair.

Ultimately, staff felt that manual restraint was avoidable if sufficient staff were available to attend to residents' needs. One care home involved in the study had altered the rota system in order to ensure appropriate levels of staff 'on the floor' at all times:

"It's not a one-to-one care home: we can't allocate one member of staff to one resident. We had residents who tried to get up and would fall, and so we developed a system based on that experience. Now we allocate staff to sit and supervise the residents. So we've got two staff in the morning and two in the afternoon, so if somebody needs to do something or go over there we've got somebody there to supervise. The system developed over time, it wasn't just a great idea that came out of nowhere." (care home practitioner)

The limited availability of staff to assist residents should not be seen as an excuse for staff to adopt restraining practices.

### 3.4.3 Manual restraint: stopping people moving around the care home

Again, practices that bluntly stop residents moving about the home were considered to be evidence of poor practice, potentially even abuse, unless assessed as being in the best interests of the resident in accordance with the MCA or health and safety regulations.

That said, manual restraint, again in the form of 'gentle physical persuasion', was sometimes perceived as necessary to protect the rights of other residents or the safety of an individual resident. Some care home practitioners admitted that at times, when staffing was short, it was very difficult to expect them to be able to monitor the safety of those residents sitting in the communal lounge and also those who wished to stay in their bedrooms. Typically, staff would try to encourage residents to remain in the lounge rather than going to other areas of the home to make it easier for them to monitor their well-being.

### Case study 4

A resident has dementia and is used to walking around the care home. Despite the best efforts of the home to create purposeful walking where residents gain stimulation from being in certain areas of the home, this resident has the habit of walking into other residents' rooms and urinating on the beds. This is particularly distressing for those residents who are bed bound. Clearly advice needs to be sought to reduce the effects of such behaviour on other residents. Again, the case study raises the key challenge of providing care in a communal setting where staff are required to balance the freedom of one resident while protecting the rights of another.

### 3.4.4 Good practice

In response to the above case study, there was clearly a need to explore why the resident was walking around the home, and whether he was searching for the toilet. There are resources available to help care homes to support purposeful walking. The use of Dementia Care Mapping could be adopted in these cases to really understand why the resident is walking into other people's rooms.

The issue of balancing up one resident's rights against another continues to be a challenge. Is it always possible to get this right?

### Case study 5

A tall male resident with dementia had walked across the lounge and was standing over a slight female resident sitting in a chair. The male resident was scaring the female resident, who, because of arthritis, had no means of escaping him.

Ultimately, good care practice is about the interpersonal skills of the care staff. Manual restraint in the form of physical 'encouragement' to move away from another resident might not be necessary if staff are able to verbally encourage the resident to move away, or to engage with something that might be more interesting to them.

"I think if you take the time to sit and explain it to the resident. Sometimes it works and sometimes it doesn't." (care home practitioner)

Staff also raised a concern about residents deciding to spend time alone in their own rooms. There was a temptation to encourage all residents to remain in the lounge to make monitoring/supporting them much easier. The general rule of thumb expressed by one care home practitioner was to work in partnership with the residents (and relatives) to minimise any potential hazards in the bedroom and to come to an agreement on the risks that the individual wished to take and record them in a care plan.

In some cases, strategies had been adopted (5-minute checks in bedroom, ongoing review of risks of falling and risks of social isolation).

"It would be noted in their care plan. Whoever's on that floor, we all have to check every 5-10 minutes in their rooms to check that they're ok." (care home practitioner)

To conclude, there would seem to be little need for manual restraint except in extreme situations where violence or aggression or inappropriate behaviour of residents may impact on others. Specialist advice and support from the local safeguarding adults team and Deprivation of Liberty assessors are essential in these instances. Where residents are putting themselves or others at risk through getting up, or walking into other people's bedrooms, this may signify the need for greater one-to-one support for the resident where funding for this can be accessed. In all cases where restraint is used residents, relatives and staff need to be involved in discussions about the need to balance rights and risks and decisions taken.

### 3.5 Arrangement of furniture (to keep people in bed, to stop people getting up or creating an obstacle to part of the room)

Participants of the study were typically unaware of any examples of this form of restraint. They were aware of times in the past where the use of tables to stop residents getting out of chairs, the use of chairs to barricade residents in their beds, and positioning furniture to make certain areas of the care homes inaccessible were commonplace, but noted that these were certainly not current acceptable practices and could potentially be very dangerous.

#### Case study 6

One resident noted how heavy 'fire doors' had the same effect. In line with health and safety requirements, fire doors are required to be closed in care homes. Care homes can purchase fire doors that close automatically when the fire alarm is sounded. For others, such doors remain constantly closed, which does have the effect of inhibiting the movement of residents.

There was a brief mention in the study of how 'Buxton' chairs were often associated with the issue of restraint. These specialist chairs that are used to provide support and pressure area care to residents who are unable to sit in normal chairs could potentially be used to stop residents from moving. Such chairs are less common these days and should only be used with advice from an occupational therapist. However, one participant pointed out that there are new chairs on the market (rollabout chairs) which, if used properly, are particularly useful for bed-bound residents with no muscle tone. These chairs enable residents to be sat up for short periods of time and to join other residents in communal settings. However, inspectors do not always appreciate the appropriate use of these chairs.

#### Case study 7

A Care Quality Commission inspector arrived to do a key (unannounced) inspection in a care home. On showing her round she immediately stated that the care chairs (rollabout chairs) were inherently considered a form of restraint. She hadn't seen a single patient yet so had no idea about dependency or capability. When the member of staff showing her round stated that the people who used them would otherwise be bed bound, she simply reiterated her view that they were inherently considered a form of restraint if you had any ability to weight bear. The care home staff were concerned that her mind was made up before any consideration of the circumstances.

### 3.6 Lap belts, wrist and vest restraints

Wrist and vest restraints were not in evidence in the care homes that were part of this study, and none of the participants were aware of such restraints in any other



care home. As noted in the literature, this form of restraint, where residents are physically attached to chairs/beds using wrist or vest straps, are probably historical and were previously more common in the US.

Lap belts were in common use as a legitimate means to keep residents safe while mobilising in a wheelchair. There is a potential risk that by keeping a resident in a wheelchair with the lap belt on, it restricts their freedom to move around freely. Lap belts can also be dangerous if the resident attempts to get out of the wheelchair but is still 'strapped in'.

### 3.6.1 Good practice

The general rule adopted by many care home practitioners we interviewed was that when the wheelchair is in motion, the lap belt would be used to prevent the resident from slipping out. However, once the resident had reached their destination, they would be encouraged to transfer to another chair.

For those residents who have involuntary sudden body movements, advice would need to be sought as to the best use of the lap belt. Advice should also be sought with those larger or very thin residents for whom the lap belt may be a discomfort or even a danger.

### 3.6.2 Dilemmas

In some cases residents refused to wear lap belts or refused to get out of their wheelchair. Again, in these cases, working with residents and relatives to assess the risk and to agree a care plan was seen as good practice.

## 3.7 Bedrails

Bedrails (historically called 'cot-sides') are common in many care homes as a way of preventing residents from falling out of the bed. That said, used inappropriately (especially with pressure-relieving mattresses), bedrails can have the opposite effect. Residents (particularly those who are confused or who experience involuntary body movements or spasms) may climb over the rails or become jammed between the bed and the rails. Even if the purpose is to protect the resident, the use of bedrails could be considered to be a form of abusive practice if they serve to contain residents against their will.

### 3.7.1 Good practice

There are various codes of practice for the instalment, upkeep and use of bedrails that should be available to care home managers from the manufacturer. In addition, the Health and Safety Executive (HSE) (2007) have produced a very useful booklet on *Bedrail risk management*, which includes a checklist of questions to consider for the safe use of bedrails and also routine inspection of bedrails.

One staff member felt that as a rule of thumb, if a resident was mobile, bedrails should not be used unless the resident clearly stated a wish for them. One resident,

who had been used to sleeping in a double bed, was prone to falling out of the single bed within the care home (there was no room for a double), and so requested that the bedrails remained up.

As with all forms of restraint, the need to assess and continually review the use of bedrails with residents (and relatives where necessary) and to develop care plans in response to this assessment was seen as good practice.

### 3.7.2 Dilemmas

Staff and relatives described the challenges of supporting those residents who, because of their confusion or involuntary body movements, were prone to falling out of bed but were even more at risk with bedrails. Two examples were given of residents who, because of their complex health condition, were unable to control body movements: sometimes their legs would drop across the top of the rails.

In these instances, a range of approaches was adopted. In some instances, with agreement from residents and relatives, bedrails would be removed and a mattress would be placed next to the bed to soften any fall. In another situation, the bed would be removed altogether and a mattress placed on the floor for the resident to sleep on. Where possible, beds would be lowered to reduce any impact of falling. Getting expert help and notifying the regulatory body of such action was seen as good practice.

One practitioner described how a resident was endangering himself, not just by falling out of bed over the bedrails, but also strangling himself on bedding and bedclothes because of his involuntary physical movements. With relatives' agreement, a decision was made to remove the bedclothes and increase the temperature of the room to allow him more freedom to move around in the bed without risk of harm.

In these complex cases, there was evidence that some care homes had managed to secure additional funding to provide one-to-one support to the resident so that risk was minimised. The need for professional advice from an occupational therapist, geriatrician or psychologist is essential when providing such complex levels of care.

## 3.8 Deprivation of walking aids or means to summon assistance

### 3.8.1 Deprivation of walking aids

The idea of removing a walking aid, such as a Zimmer frame or walking stick, to prevent someone from mobilising, was unheard of in the homes we spoke to. Staff recognised that this would cause more danger to residents who would attempt to walk unaided.

There was one example where staff had inadvertently restrained the movement of a resident by failing to ensure that the resident had the walking aids that they needed.

“Sometimes I find with some carers they’ll come in, move the table and my Zimmer all the way to the side so that they can sit there, and then when they get up to go away they forget to replace my Zimmer to its original position.” (resident)

Another resident told us that she had requested a Zimmer frame so that she could try to walk but the home had not given her one. Staff were using a wheelchair to help the resident move around the home and had assessed the resident as unable to use a Zimmer. However, it is clearly important that residents are able to demonstrate to themselves that they may not be able to walk unsupported rather than being told that such activity is too risky. That said, any risk to the staff assisting the person to use a frame would need to be assessed.

### 3.8.2 Call bells

Many of us who have worked in a care home would be familiar with the example of a resident who spends a large proportion of the night pressing their alarm cord from their bed to summon assistance. Staff were aware of the fact that, historically, staff might remove the alarm cord from the resident to ‘get some peace’ but again this appeared to be something that did not take place in the care homes we visited and was considered to be both dangerous and a form of restraint in terms of stopping the resident from getting the support that they may require.

### 3.8.3 Good practice

“There was one resident that would press the bell a lot. She presses the bell and we go to her and ask her what she wants, then after a few minutes when you just go out of the door, she presses the bell again. So then you go back. It’s part of the job, it’s our responsibility, you have to take a breath to keep calm, because it’s pointless letting it bother you.” (care home practitioner)

Staff and residents spoke about how difficult it was to give attention to every resident all the time:

“If they all want to go to the loo at the same time, what do you do?” (care home practitioner)

They talked about the need to respond immediately to the call and explain why they might not be able to offer assistance immediately. Staff also acknowledged the importance of putting themselves into the position of the resident to really try to understand what it must be like to be dependent on others for support. Staff acknowledged the anxiety or distress that residents might feel if they felt that they were unable to get attention when they needed it. Some staff recognised that sometimes the need was more psychological than material. Being able to reflect on what might be causing residents to constantly call for help was therefore seen as very important.

Again, good interpersonal skills are crucial here in helping to reassure residents that staff are present and are trying to respond to calls as quickly as they can. Staff did note how frustrating it could be when you had to constantly respond to the call bell,

but recognised in themselves when they were close to losing their patience and, on these occasions, would take a minute or so to re-settle themselves or get help from another member of staff.

### 3.9 Locked doors

Of all the issues covered in the study, the pros and cons of locked doors was something on which everyone had a view. Most of the care homes we visited had a locked door with a coded keypad to release the door lock. Care home practitioners felt that the main reason the door was locked was to prevent strangers coming into the home rather than to stop residents from leaving.

Our starting point for this discussion was that, unless legally required to remain in the home, all residents were entitled to leave the care home whenever they pleased, day or night. However, the issue of locked doors does not necessarily in itself mean that a person is being deprived of their liberty. The DOLS Code of Practice, section 1.13 states that someone can only be deprived of their liberty '*in their own best interest, to protect from harm if it is a proportionate response to the likelihood and seriousness of harm, and if there is no less restrictive alternative*'. Therefore, a locked front door, particularly at night, might be considered an appropriate action. Clearly many of the staff were aware of the implications of the MCA DOLS, which require a formal assessment process to be undertaken where residents might be considered to be deprived of their liberty.

Some staff were quite comfortable with the notion of residents being able to leave the care home when they wanted to. For others, it called into question their 'duty to care'. "Aren't we responsible for their safety? What would happen if they had an accident or got lost?" A common issue that arose out of many interviews related to the fear that managers and staff feel in allowing residents to take risks, particularly in going out without support. Wouldn't they be blamed if a resident 'under their care' had an accident? Wouldn't the local press latch on to the story as an example of abuse? Clearly more thinking is needed in exploring the balance of practitioners' 'duty to care' with a resident's rights and liberty.

#### Case study 8

One manager gave an illustrative dilemma of a large female resident who used a wheelchair to get around the home and who was adamant that she wished to leave the home unescorted. Outside the home was a large hill, and the manager feared that the resident would lose control of the wheelchair and cause a serious accident to herself or others. The resident was aware of the risk that she was taking, but the manager struggled with the idea of simply allowing the resident to leave on her own, even though she recognised that ultimately the resident was able to make an informed choice. Ultimately the manager felt that she would have to release a member of staff to escort the resident even if that meant leaving the floor short of staff. For her, restraining people if it is in their own interests of safety was something she felt might have been necessary. In this case, a properly negotiated care plan that spelt out the risks and recorded the outcomes of

discussions with the resident may be useful both in reducing the perceived need for restraint and in identifying any underlying reasons why the resident wished to take such high risks.

### 3.9.1 Good practice

We heard plenty of examples of good practice where the culture of the care home was to encourage all those with capacity to move freely in and out of the home as they wished. Some staff we spoke to literally laughed at the notion that residents might not be allowed to leave the home: their culture was one of supporting positive risk taking, where residents were free to do as they please.

“Residents are allowed to move freely, they know the codes and come down and they go to the parks and the pubs.” (care home practitioner)

But this was not always the situation: there was a sense that staff, relatives and even other residents sometimes felt anxious about a resident leaving the home unescorted. In these cases, risk assessments with the resident and relative(s) was seen as crucial and where possible, care homes would try to ensure that staff were available to escort residents or offer organised trips or outings to reduce the risks involved.

Again, discussions returned to the fact that there are many occasions when it is simply not possible to provide one-to-one assistance to a resident who wishes to go out. In these situations, the care home practitioners had developed a range of highly individualised strategies for monitoring the well-being of the resident where a risk of harm had been identified.

One staff group described how they would become familiar with where residents chose to walk, and without being intrusive, keep an occasional eye on where the resident had got to, or if the resident was seeking to get to a particular destination, would ring to check they had arrived (with the agreement of the resident).

One care home (interviewed for a different study, *My Home Life*, 2008) had worked closely with a resident to continue to use a mobility scooter unaided outside the home, despite the fact that on one occasion, the scooter had fallen off the kerb into the road and caused a minor traffic incident. The care home was determined to support the resident to continue to retain his independence. Staff helped the resident regain his skills and confidence in using the scooter and had equipped him with a mobile phone in case of emergencies.

### 3.9.2 Residents formally assessed as being at significant risk of harm if leaving the home unescorted

For those residents who, under the DOLS guidance, had been assessed as being at risk of significant harm if leaving the care home unescorted, the challenge of avoiding restraint remained. Many practitioners were aware of situations where a resident had attempted to leave the care home and staff had clustered to stop them from

leaving. Such a situation can result in great anger, distress and increased agitation for the resident. Avoiding such situations required individualised responses. Staff talked about how their primary concern was a need to reduce the resident's desire to leave the home unescorted by ensuring that there was stimulation and purposeful activity in the home. Second, there was a range of ways in which staff could reduce the distress or feeling of being restrained if a resident wished to leave the home.

In one care home it was reported that an agitated resident was adamant that she needed to leave the home to collect her children from school. The care home had agreed a strategy where a member of staff would escort her up the road to a local school, at which point the resident became aware that the children were still in their classrooms and was happy to return to the care home.

"We actually do have a resident, who says she wants to go out, not she wants to, she is going out. She is quite vulnerable, but rather than crowd her and say no you can't go out, we say ok off you go but as long as there's a member of staff about five paces back behind her. Just to see where she's going, because she don't actually go far." (care home practitioner)

Staff talked about diversion techniques that they had developed:

"Sometimes you can distract, say if a member of staff came out with a resident, that member of staff can cross the road, go on ahead, then come back down to meet the resident and ask 'hello, where are you off to? I'm just going back to work do you want to come back with me?'" (care home practitioner)

Staff talked about how they had developed relationships with residents and relatives to really understand the underlying reasons why a resident might be agitated and wanting to leave the care home. Staff acknowledged the need to be working to support residents to go out as often as possible. Care homes have demonstrated that they often identify highly creative ways to enable residents to feel free to leave the care home without the need for unnecessary risk taking. The use of family and volunteers to act as additional resources to the home and to the residents can be helpful here.

In this small study, relatives tended to be particularly keen on the need to keep doors locked for the residents' own protection. Relatives told us that one of the reasons for coming into the home was the fact that the resident that they visited had been at major risk of 'wandering' when they were in their own home. Creating a positive dialogue with relatives and residents to help understand these fears and worries and how they might infringe on the rights and freedoms of the resident were seen as critical in resolving this issue.

### 3.10 Over-medication

There has been plenty of press coverage about residents who have been 'chemically restrained' through inappropriate or over-medication. Some of the care home managers we spoke to noted that some of their residents had come into care homes with medication that may have been necessary in a hospital or community setting

to reduce agitation or 'challenging' behaviour, but was seen as less essential for some residents in a care home where staff are more available to adopt social therapeutic interventions as a positive and effective alternative.

The responsibility for reviewing medication for residents lies with the health service and in particular the GP or pharmacist. That said, as advocates for residents, care homes should consider themselves as responsible for ensuring that the residents get access to regular medication reviews, specialist medical advice and support as appropriate.

### 3.10.1 Good practice

"If the doctor prescribes a type of tranquiliser drug and we feel the resident doesn't need that drug, or if we find that she becomes too sleepy or too tired, then we will contact the GP again and mention that we think the drugs being used are too high or not quite right for the resident." (care home manager)

All the care homes interviewed made note of their proactive efforts to foster positive relationships between themselves and the local GPs and primary care trusts. Some GPs were considered to be better than others at tackling the huge challenges in responding to the needs of older people with dementia without the use of drugs. A few of the care homes we spoke to felt, through their efforts, they were now trusted by the GPs as equal partners in working to reduce the need for sedatives, seeking their advice and working together to explore alternative non-pharmaceutical interventions. In these care homes, managers concluded that their efforts had led to residents being less chemically restrained, more alert, and, as one practitioner put it, "more alive".

"I have been able to get the GP to cut back on the majority of the medication which deal with psychotic behaviour. The effects of one medication were making [the resident] feel very very sleepy. Now she's more talkative, which is good. About three weeks ago her daughter visited and she was able to complete a crossword puzzle. Now she is able to walk around much better." (care home manager)

Outside this study, good practice was identified with a care home that used a range of social therapies as alternatives to medication: massage, talking therapies and 'doll therapy' (a technique whereby dolls are placed around the home for residents, particularly those with dementia, to pick up and form relationships with, should they wish) were just some of the interventions used. In developing these strategies, staff need to be well trained and well supported before engaging in such therapies (*My Home Life*, 2009).

Greater work is needed to develop a fuller understanding of how we can better support staff to feel able to manage 'challenging behaviour' without the use of antipsychotic medication and to explore the covert use of medication where drugs are given to residents in a disguised format.

### 3.11 Staff instructions, or institutional rules or practices

While most of the forms of restraint covered in this report relate to very practical aspects of care, it remains the case that the culture of a care home can determine how free or how restrained residents feel to live their life as they choose.

#### 3.11.1 Dilemmas

Residents, relatives and staff interviewed found this a particularly fascinating and quite challenging area of discussion. How do the attitudes and assumptions of staff, residents and relatives impact on the culture of a home? Do residents really feel able to leave the care home as they please? Do residents feel comfortable in asking for help without any feeling of restriction? Are they free to stay in bed all day should they wish or to take risks that others might not feel happy to do?

The culture of the care home is determined for the most part by the manager or owner of the home, the individual who is seen as the leader. Helping staff, residents and relatives to reflect on whether residents are truly encouraged to make informed choices about every aspect of their lives is so important. Some of the residents we spoke to in the study noted that they didn't always ask for assistance because they didn't want to complain or make a fuss, or felt that they had to abide by the rules of the home (one resident noted that patients in hospitals in earlier eras were expected to do as they were told!).

#### 3.11.2 Good practice

Positive risk assessment and reflective practice is a crucial aspect of this. The culture of a care home must begin from the perspective of assuming that a resident can do any activity they wish, and where there are risks involved, strategies need to be adopted to find ways to enable residents to continue to undertake this activity. Some of the care homes we spoke to had adopted this approach:

"Yes, you get plenty of freedom; you can do what you like. Probably if I stood on my head I don't think they'd stop me." (resident)

"Sometimes there is a resident who says 'I just want to stay in my room today' and that's fine, they're all entitled to do so." (care home manager)

In one home, training and leadership had helped open up the culture, and staff had seen a real change in practice. Others recognised that it was a constant battle against a task-orientated, risk-averse protectionist culture. They felt that without constant communication, practice quite naturally slipped back to this.

The study gave plenty of examples of how residents were free to choose the time they wished to get up, to make themselves drinks and prepare meals, having been assessed for risk and supported appropriately.

"If somebody wants to make a cup of tea then I will obviously assess the person, you know, whether or not you think they're going to burn themselves and just



watch them and observe them really, just make sure that they're aware that they could burn themselves with the hot water." (care home practitioner)

There were also examples of regular communication with relatives about the risks involved:

"I think the families do speak to us and there is good rapport with them, they would rather the resident went out and took the risk than to sit here in front of a TV. One of my residents goes to the off licence and gets her alcohol. If she's gone for more than 15 minutes, we ring the shop and ask 'Is she there? Has she left?'"(care home practitioner)

Outside this study, clear evidence has been gathered on homes where residents are truly playing a central role in decision making about every aspect of care home life. There are examples of residents who were involved in recruiting staff, who helped to take responsibility for planning activities, designing the garden or taking jobs in the home as handyperson or cleaner (*My Home Life*, 2008). While these activities might seem patronising to others, they appeared to be welcomed by the residents and offered a real sense of freedom and control.

"We encourage residents to do whatever they want. We're trying to encourage them to cook. We've changed the activities, we go out more, we're introducing lots more activities to everyone." (care home practitioner)

Such choice is typically less available to more dependent populations, because of cognitive impairment or a lack of ability to articulate their wishes. Good practice requires considerable effort by the staff to develop positive relationships with residents and relatives, to understand what is important to them, to develop communication techniques and to act as their advocates in helping them regain independence and choice. Regular training, supervision and time for reflection are helpful here, but developing such a culture can be a major challenge, particularly where staff turnover is high and motivation is low.

How the culture of a care home impacts on choice and control cannot be explored in detail in this small study. It is a highly complex issue, which the research team will be exploring in greater depth in the next few years. Some additional thoughts are offered in the discussion at the end of this report.

### 3.12 Other forms of restraint mentioned in the study

Aside from the eight types of restraint identified in the literature review carried out for SCIE, a number of other areas of restraint were raised from the discussions.

#### 3.12.1 Alcohol, cigarettes, sex

"One couple, they've passed away now, but they used to drink together. But sometimes they would get to the extent where they would drink so much, we had to help him or her into bed, but we never ever stripped the bottle away." (care home practitioner)

To what extent do we support residents' choice to drink or smoke or engage in sexual activity? Some care homes may question whether supporting residents to get drunk or smoke 40 a day complies with the MCA in respect of a best interest decision. This is a difficult area that needs greater exploration. If someone lacks capacity to understand the implications of their drinking/smoking/having sex (they may not be aware of the fact that they have just had a cigarette or a drink for instance), there is a need for a care plan that strikes a balance between their choice and their well-being without imposing our own opinions on the acceptability of such practices.

### 3.12.2 Environmental restraints

Within the study there was a perception that health and safety regulations created great restrictions on residents in relation to such matters as keeping windows open or entering the main care home kitchen. For those care homes fortunate to have smaller units with resident kitchen facilities, this is less of a problem. More work is needed to consider how health and safety regulations may directly or indirectly restrict residents' choice and freedom.

## 3.13 Negotiating and managing positive risk taking

This section explores how the care homes in this study have developed processes for managing and supporting risk with their residents. Given the limited scope of this study, a review of literature has not been undertaken on this subject. That said, we recommend that further work is developed to summarise the key principles of good practice that emerge from the literature for use by the care home sector.

There is no doubt that the discussions on avoiding unnecessary restraint were intertwined with discussions around risk management. Many of the care homes had developed formal processes to ensure that positive risk taking was part of the culture of the home, and that where there was a risk to a resident, care homes formally recorded whether the resident or family members were happy to accept that level of risk and to explore whether alternative strategies could be developed that would lead to the same goal but with reduced levels of risk.

### 3.13.1 Balancing up risk and rights

As noted earlier, when assessing risk, care home practitioners need to acknowledge that one resident's right to do something might be a risk or an infringement of rights/freedom of others. Care homes are communities where one resident's behaviour will both be influenced by and affect staff, relatives and other residents. In some cases, a decision has to be made about whether we restrain one resident's freedom to act as they wish if it is affecting another resident's freedom. The case study below illustrates this point.

## Case study 9

A resident with physical disabilities wishes to remain in bed until 12.30pm at which time she will require support from two staff to get her up (which takes about 40 minutes). Despite staff efforts to negotiate with her, she is adamant that she will not be happy to be got up any later or any earlier than this time. However, this is lunchtime in the home, and staff are all needed to support other residents. If these two staff are taken away from the dining room, other staff will feel pressurised and lunch will be less of a pleasant and relaxed occasion for other residents. How do we resolve this? Why is this resident so fixed in her desire to get up at a set time? Is there support that she needs? In the short term do we stop the resident from getting up or do we stop other residents from getting to the table at lunchtime?

One care home manager felt that her staff needed to act as 'detectives', always assessing both how the environment was affecting the behaviour of residents and how their own practice might be affecting behaviour. In the case above, practitioners need to understand the reasons behind why a resident is so adamant that she must get up at a fixed time and how the environment of the care home might be exacerbating the need for this resident to want tight control over her routine. If we are flexible to one resident who is able to articulate powerfully her views, are we more likely to ignore those who are quiet, lacking confidence or the ability to express themselves?

At the same time we should acknowledge how challenging these negotiations and decisions are for care staff, given limited staff/resident ratios and the sheer workload placed on care home practitioners.

### 3.13.2 Managing risk for those lacking capacity to make decisions

The big issue for many care homes is how to work with residents who lack capacity to make decisions and to take risks to be less restrained by the routine of the care home environment. The care homes we interviewed typically engaged relatives in the process of risk assessment. Discussions would be held to explore the balance of rights and risks: what risks could be minimised without restraining a resident? What risks were unacceptable given the potential harm that might occur? What risks were high but acceptable given the importance of such activity for the resident themselves? Where possible, residents would be properly engaged in such discussions. One of the five key principles of the MCA is that 'A person must be assumed to have capacity unless it is established that he lacks capacity'. Assessments of capacity are thus only valid at the point they are made. This is seen as one of the major benefits of the MCA in that it has given care homes a set of rules to work by and hence much more clarity. However, the challenge remains of how staff work to convey to residents with cognitive impairment the risks that they are taking and the decisions that have been made on their behalf. As noted earlier, staff are required to possess excellent communication skills to help residents understand the risks that they are taking or the reasons why they are being encouraged not to engage in a certain activity.

In circumstances where, despite the best efforts of the staff, residents continue to carry out this high-risk behaviour, care home practitioners felt that residents should either be allowed to undertake such behaviour, and all attempts to reduce risk be documented, or some sort of minimal restraint should be employed as a last resort. The need to constantly review the care plan to see whether it is achievable is vital in these cases. Once again staff need to be aware of the legal requirements to comply with the MCA when considering these complex decisions.

### 3.13.3 The fluctuating nature of risk

The findings show how care homes are attempting to engage with the complexity of risk as it may change on a day-to-day or even minute-to-minute basis. The lucidity of a person living with dementia may have a temporal quality: their ability to make informed decisions and take risks may be greater at certain times of the day and under certain (environmental and other) conditions. In minimising restraint, care home practitioners need to consider times and conditions where restraint may be more necessary than others. One care home spoke of how care plans would be reviewed and altered regularly in response to the ever-changing circumstances of their residents:

“Because they come in with a care plan saying they can do A, B and C and they’ve been with us over a number of years and their condition deteriorates, we write a short-term care plan which is reviewed every two weeks and then reviewed again every month. When we change the short-term care plan we usually speak to the family as well.” (care home practitioner)

### 3.13.4 Assessing longer-term risks of behaviour

The study also identified that while there are short- and medium-term consequences of supporting a resident to take risks, the longer-term consequences also need to be explored. Two examples illustrate this:

#### Case study 10

A resident is assessed to be at high risk of falling and lacking capacity to make decisions. The resident is therefore encouraged to get up only with support from a member of staff. This means that the individual may spend more time sitting than they would wish, which in turn will lead to more muscle wastage and the longer-term consequences of greater unsteadiness and risk in walking. With this in mind, where the decision has been taken with residents to discourage unaided walking, the longer-term risks and the much greater risk of falling need to be weighed up.

## Case study 11

The decision to allow someone to walk around unsupported may have longer-term consequences if they suffer a fall. One relative talked about how she didn't want her mother to get up and walk around unaided, not because she could fall, but because the fall might lead to the resident requiring a spell in hospital. This relative knew that her mother feared hospitals. A hospital stay would be highly distressing and disorientating and could ultimately lead to her further mental deterioration.

It is clear that risk needs to be explored in the wider context of the quality of life of a resident in a care home. This raises the question of how we measure the comparative quality of life of a resident who is enabled to take positive risks but dies as a result of a fall or accident with a resident who lives a longer life but is restrained from taking any activity that has risk associated with it. These are large questions that need a wider societal debate. Nevertheless there is now a clear legal framework that underpins decision making for staff provided by the MCA.

### 3.13.5 Balancing different opinions

Risk assessment requires the involvement of residents, relatives and staff working together. But to what extent are the fears, anxieties or ageist values of the relatives and staff reducing our ability to undertake an objective assessment that puts residents' quality of life first?

The study seemed to show that each relative and resident had a different perspective on what was an acceptable risk. Some relatives we spoke to appeared to be more risk-averse than the staff or residents: worried about the safety of their relative (resident), many stated that they would prefer that the staff stopped residents from undertaking risky behaviour. They struggled with the dilemmas posed around balancing risk and rights and were open about how upset they would feel if their relative (resident) came to harm. Two people spoke independently about the trauma and stress that they faced in keeping their relative safe from falling/'wandering' when they were living in the community. For them, admission to the care home was primarily about ensuring their relative's safety and protection. It became clear that this was of greater importance to them than supporting their relative (resident) to make choices about the risks that they wished to take.

"If it was me and my mother, I would hope that they would stop them from going out." (relative)

Residents were talked through the list of different forms of restraint and asked if they felt that such examples existed in the care home. Residents' views varied enormously. Some talked about how they didn't like to see other residents take risks; they wanted staff to ensure that they were always safe. Some residents felt that over time their self-confidence had been reduced because of falls. They had become more conservative about taking risks. Others felt that they were quite capable of judging the risks for themselves and didn't want staff to make decisions for them:

"If you're thinking straight still, you see the danger for yourself." (resident)

Residents made comments about the interactions between staff and other residents that they saw. Many talked positively about the staff and were very aware of how the workload of the staff made it impossible to respond to every request for assistance immediately. The data collected from three or four of the residents was extremely rich but it would be irresponsible to report these findings in this report given the limited sample size. The *My Home Life* team are keen to develop this data to include more interviews in order to tease out in more detail the lived experience of older people living in care homes in relation to the issues of risk, rights and restraint.

A really interesting finding coming out of the interviews with relatives and residents was the fact that many had previously never really thought through the issue of balancing rights and risks but appeared very glad to do so, welcoming the time and space to pause and consider the dilemmas involved.

This study has shown that care home practitioners need to demonstrate great skill in helping staff, residents and particularly relatives to fully engage with difficult decisions around the care and the level of risk associated with residents' behaviour or actions. Good practice is where care home managers can help staff and relatives understand how emotions such as guilt or fear might affect our ability to think rationally about what is an acceptable and unacceptable risk for the resident.

"It is the cross-reference between relatives, the resident and management that I think makes it what it is. It is a shared responsibility." (relative)

More work needs to be undertaken around these issues.

### 3.14 Risk assessment tools and restraint policies

"I get assessed all the time now. Before and after shift changes I can see ... staff talking to each other about residents and informing each other about changes etc." (resident)

The care homes we interviewed all had formal policies in place to assess risks. Some had generic risk assessment tools covering most areas of practice; others had more detailed assessment tools relating to falls, bedrails etc.

"We identify the risk, the pros and cons of taking the risk, the resident if they're able to sign it themselves, and then the relative countersigns it." (care home practitioner)

No standard risk assessment tool was identified as being used across the care home sector, although there was some interest in developing a generic risk assessment tool that had the endorsement of the HSE and the care home regulator.

Some care homes had developed policies specifically in relation to restraint, while others had policies for various practices such as the use of bedrails or lap belts. Some homes had incorporated policies on restraint into wider policies relating to the

implementation of the MCA. Again, some homes valued the idea of having a standard restraint policy that could be shared across the care home sector.

A range of other tools had been developed: one home had created a form that was sent to the police if a resident had left the care home and could not be found. It included a photograph of the resident and a physical description as well as space for care home managers to make comments about the places where the resident may have gone.

Another home had developed new care plans that focused specifically around what the residents could do rather than what they couldn't; it clearly communicated that positive risk taking was seen as an important aspect of life in the home.

"Our care plans specify what residents can do. It's separated into 'what I can do', 'what I need help with', so that will indicate 'I can make a cup of tea for myself', or 'I need help with preparing a cup of tea'. Even if they do make a mess or they do it completely wrong, it doesn't matter. At least they're still trying, they're doing something." (care home practitioner)

### 3.15 Training and practice development

Many of the staff we spoke to had received formal training in relation to the MCA. Some of this training had been led by the care home manager, some by external training providers. Training was generally felt to be helpful but certainly not a substitute for more informal approaches to practice development.

"We've had refresher training sessions on [restraint] and that has driven home the message about various techniques that can be used [as an alternative to] restraint, such as validation therapy." (care home manager)

"We held a forum on issues related to dementia which was well attended by relatives and volunteers and we had a good discussion on how things are, and what we try to do to make life better for the residents. I think it has helped – yes, they've got a much better understanding now definitely." (care home manager)

Some managers had brought in training when a particular issue relating to a resident emerged:

"In my home, a resident with challenging behaviour came in and the staff didn't have the right training. So we organised staff training for everyone to help them deal with her problems. When she was showing challenging behaviour it was because she'd forgotten that her husband had died. We [developed] a memory box and it triggered everything and she remembered, and now she isn't very challenging at all." (care home manager)

In some cases, managers felt that outsiders could help open up sensitive discussions with staff who might feel afraid of raising a difficult issue with the manager for fear of being blamed.

### 3.15.1 Ongoing practice development

While training, policies and process tools are an important part of minimising restraint in care homes, they are worthless unless there are formal and informal processes for communication with staff, residents and relatives.

Establishing a culture in the care home where all staff are fully aware of the risks that residents are willing to take and the strategies that will help reduce risk or distress is crucial, yet it remains a constant challenge for care home managers, particularly where there is high staff turnover.

“Usually we look at the risk and document it in the care plan assessments. These get discussed at handover. The fact that we have a continuity of staff in the care home it’s not as if we are getting strangers [working] here, so everybody knows about the residents and the risks. When we do have a new person who we know is new to the floor then we brief them on what kind of care is given to whom.” (care home practitioner)

Managers in the study spoke of the real challenges facing them in instilling a positive culture and in ensuring good communication across all staff in the home, particularly given the increasing amount of paperwork that they had to deal with. Being available and approachable was vital to help staff respond appropriately to complex issues:

“I think the support we get from the senior staff is very crucial because what we try to do is move away from the task-oriented way of doing things, and allowing the residents to live as they want to. If someone doesn’t want to get out of bed it shouldn’t be a problem at all. Previously it would be, it would be seen as the care staff not wanting to do what is required of them.” (care home practitioner)

“I think this care home is very empowering, we’ve got the support from the manager. If there is a problem we go to her and say this is what we are struggling with. We have a discussion about it.” (care home practitioner)

Care homes that we spoke to had developed different processes for communicating and reflecting on some of the ethical dilemmas they faced. One care home had set aside time for staff to come together to explore some of these issues. Another care home had a Friday reflection group where staff were given time to consider the week’s work, the residents and the challenges that they faced. One care home working with extremely frail individuals (outside this study) ensured that all staff attended formal clinical supervision sessions to help support them to cope with the demanding work and to reflect on their practices.

Aside from formalised sessions, care home managers were committed to ‘getting out on the floor’ as much as possible, modelling good practice, having an ‘ear to the ground’, being able to support and offer advice on a minute-to-minute basis. The common view was that there was never enough time to do this.



The task of creating a culture which supports residents to make choices about the risks that they wish to take is a mammoth challenge for care home managers and one that requires real support from the wider health and social care system.

The study heard of one manager who had made every attempt to support the wishes of a resident to walk unaided in the care home. A risk assessment had been carried out with the resident's and relatives' involvement and a care plan agreed that clearly communicated the resident's wish to walk unaided. Sadly in this case, the woman had a fall and died soon after. The fall was an identified risk for that resident but, for her, taking such risks was crucial to her quality of life.

The manager spoke of her own grief and distress at the death of this resident with whom she had developed a very close relationship. She hoped that outside agencies would acknowledge this distress and support her to continue her good work in the care home. However, rather than receiving support, the manager became the subject of a formal investigation, initiated by a relative and supported by social workers, some of whom had previously been allies and professional friends with the manager. This response exacerbated the manager's distress and prompted her to instil a more risk-averse culture in the home to ensure that such an incident never happened again.

The above story demonstrates the need for an open and honest dialogue between care homes and the wider community about the potential negative consequences of adopting a culture of positive risk taking.

## 4 Discussion

This report summarises a very small-scale project, which cannot provide all the answers to this difficult ethical issue. The intention is to share a better understanding of the complexity of care and to facilitate a more informed dialogue about how care homes can deal and are dealing with this sensitive topic.

This study was undertaken with a small number of care homes that were happy to be interviewed and so cannot be seen as representative of care homes in general. Care homes self-selected to be a part of this study. The decision to take part demonstrates an openness to outsiders and a confidence in their own practice that may not be a characteristic found across all care homes.

Data were gathered from interviews rather than direct observation of interactions between staff, relatives and residents. Consequently, the study reports only what participants have told us about their practice rather than what may (or may not) be happening in the real context of everyday life.

That said, the study would seem to suggest that the use of 'restraint' in care homes appears not as common as portrayed in the media and with careful formal planning and assessment can be avoided in most circumstances, by balancing the rights and risks of individuals.

The study has clearly shown evidence of the challenges and dilemmas involved in providing care to an increasingly frail resident population. Above all, it has shown how some care home staff have developed highly individualised (often informal) strategies for supporting residents without the need for any form of verbal, physical or manual restraint. These staff have demonstrated a range of highly sophisticated communication, negotiation, counselling, reflection and assessment skills in order to implement good practice. It is remarkable that care home practitioners have been able to develop and utilise the many skills required to achieve an acceptable balance of risk given the limited resources available to them.

The study describes how some of the dilemmas facing staff are due, in part, to the lack of staff available at any given time to provide assistance to residents. Low staffing levels should not be viewed as an excuse for restraint. Poor staff/resident ratios in care homes remains an ongoing problem for the sector and needs to be addressed. This brings us to a broader debate about how well care homes are supported by wider society to avoid restraint and promote positive risk taking: some practitioners were very aware that they are working in environments that have a poor public profile. They feared that by supporting residents to take positive informed risks, they were increasing the likelihood of accidents or incidences that could be seen by external people as evidence of neglect, malpractice or abuse.

Getting the right balance between restraining someone for their own protection and supporting people to take a positive risk is not an exact science. There is a huge range of variables that will affect the level of risk at any given time. Care homes cannot legislate or plan for every possibility.

Managers felt stuck between a rock and a hard place. Some felt that the wider health and social care system would quickly criticise any form of restraining practice, without properly appreciating the complex decision making that may have gone on before. They argued that the current government priority of giving greater choice and control to residents actively encouraged risk taking. However, staff did not feel supported and felt they were too easily blamed if positive risk taking led to harm for the resident.

“In this place it is the feeling of we’re damned if we try, we’re damned if we don’t.”  
(care home practitioner)

A provider representative organisation suggested some care homes saw adult safeguarding as a draconian threat, viewing the current system as judge, jury and executioner all rolled into one, with no communication back to providers. They highlighted that the care home industry does not have a national body to set professional standards and this may be worth considering.

If we, as a society, really want to promote choice, control and positive risk taking for our frailest citizens, we need to support care homes to improve staffing levels, invest in appropriate training and support and be more open and accepting of the fact that residents may wish to take risks that could ultimately lead to accident, incident or even their death. As a society we need to debate these issues more openly, so that people feel more comfortable with choices made by others.

Beyond this, we should also acknowledge that we are expecting practitioners, on low pay and with poor status, to take on this difficult ethical and emotional responsibility. In our research, where good practice existed, staff had developed positive relationships with their residents and were better able to manage risk and minimise restraint. However, this is complex work. Can we really expect care home staff to be able to cope emotionally with the responsibility of supporting residents to take risks that might possibly lead to harm? Are we supporting them enough to make these judgements? How do they cope when a resident dies as a result of an accident that could have been avoided if some limited form of restraint had been adopted?

The questions offered here are in part philosophical but in part about the reality of everyday life for residents, relatives and staff in care homes. The study demonstrates that care homes can (if given appropriate resources and support) offer very positive environments for many of our frailest citizens for whom other models of care may be far more restraining. It could be argued, for instance, that domiciliary care may be positive for those able to walk independently, but for those who are bed or chair-bound (restrained by their environment) it may be a very a different experience when only in receipt of services for three half-hour occasions during the day. It is therefore worth considering whether the current government policy of ‘encouraging’ our oldest population (however frail and dependent they are) to remain at home may be in itself one of the biggest causes of inappropriate restraint.

Managing risk and minimising restraint is complex work that depends on relationships being good between residents, relatives and staff. Practice in care homes needs to be not only evidence-based, but also relationship-centred.

*My Home Life Programme* ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)) offers a vision for best practice that meets both these criteria and is supported by all the national provider organisations representing care homes across the UK (National Care Forum, English Community Care Association, Registered Nursing Home Association, National Care Association, Care Forum Wales, Independent Health and Care Providers [Northern Ireland] and Scottish Care). Led by Age Concern and Help the Aged and in partnership with City University London and the Joseph Rowntree Foundation, *My Home Life* has eight key themes. The first six themes are aimed at staff delivering care. Three of these themes are about the resident's journey in care (managing transition, improving health and healthcare, supporting good end-of-life), whereas the other three themes, aimed at direct care staff, are about how care can be more personalised (maintaining identity, sharing decision making, creating community). The final two themes are aimed at managers and are concerned with how they can support their staff to put the first six themes into practice (keeping workforce fit for purpose, promoting a positive culture). These last two themes require care home managers to take a leadership role in supporting staff to create more positive relationships between residents, relatives and staff (both within care homes and in partnership with outside agencies).

The evidence base for *My Home Life* (NCHR&D Forum, 2007) was derived from a synthesis of the research-based literature on what residents, relatives and staff want from care homes and what works in practice. This evidence-based vision for best practice is underpinned by relationship-centred care (Nolan et al, 2006) that acknowledges the importance of considering not only the needs of residents and relatives, but also the needs of staff. Research has shown that relationships between residents, relatives and staff will be enhanced if each group is helped to feel a sense of security, belonging, continuity, purpose, achievement and significance (see Appendix 2 for evidence-based practical statements about what will help residents, relatives and staff achieve these six senses). Going forward, it would be helpful if all agencies engaged with care homes (inspectors, commissioners, educators etc) could adopt the *My Home Life* vision so that practices could be more consistent. By having a shared vision, the potential to manage risk and minimise restraint is likely to be more successful.

## 5 Recommendations

### For care home providers and managers

#### General

1. Restraint should only be used either:
  - a) as an immediate short-term measure, when absolutely necessary, to prevent significant injury to the resident or another person
  - or,
  - b) with the full agreement of the resident, where a minimum of restraint is perceived by them to be in their best interest and no potential harm to them is anticipated by others
  - or,
  - c) for those residents who have been identified as lacking capacity to make decisions (in accordance with the Mental Capacity Act) and where minimal levels of restraint are considered to be in the best interests of the resident and no alternative options are available.
2. Any form of restraint should be formally assessed with the engagement of the resident and relatives and, where necessary, the DOLS assessor. The care homes should aim to review the care plan regularly and proactively explore positive and creative strategies for supporting the resident that involve less restraint. Staff should refer to the appropriate agencies (GP, community nursing, occupational therapy, social services) to gain advice and support.
3. Ongoing assessment is essential in reviewing the use of restraint as a resident's needs, wishes or physical/mental functioning change.
4. Formal risk assessment policy and procedures must be at the heart of all decision making. Emphasis should be placed on supporting positive informed choices for residents. The process should fully involve residents, relatives and significant others.
5. Restraint can be avoided by ensuring that care planning starts from the perspective of exploring what residents *can do* rather than focusing only on what residents are not able to do.
6. Formal and informal whistle-blowing procedures should be developed to enable residents, relatives and staff to feel able to report unacceptable restraining practices without fear of retribution.
7. Building up a real understanding of the resident's past interests, values and lifestyle is crucial in making an informed judgement on what risks may be acceptable for the resident to undertake. This is particularly important for those who lack capacity to make decisions and have difficulty communicating their needs and wishes.

#### Creating a culture where restraint is identified and reduced

8. Opening a dialogue on managing risk and minimising restraint will depend on relationships being positive between residents, relatives and staff. Such relationships will help the care home to identify creative alternative strategies

- for minimising restraint and encourage staff to prioritise the individual resident's needs and wishes over the routines and regimes of the care home.
9. To ensure good relationships (relationship-centred care) we need to help staff consider what helps residents, relatives and staff gain a sense of security, belonging, continuity, purpose, achievement and significance.
  10. In attempting to realise a culture of positive risk taking in the home, where real resident choice and self-determination are seen as central to the ethos of practice, managers need to consider what leadership training and ongoing support they may require, for themselves and their staff, in order to be successful.
  11. Managers should seek to provide staff with regular opportunities to positively reflect on their practice, their relationships with residents and relatives, and the challenges they face in offering emotional support to their residents. Offering space and time on a regular basis, where staff feel safe to discuss difficult issues, without fear of reprimand, can help staff re-establish connections with their residents, and get closer to understanding how best to provide individualised support without the need for restraint.
  12. Offering staff, relatives and residents an opportunity to come together to explore the dilemmas that they face in relation to the use of restraint can be very helpful in opening a dialogue on this sensitive subject.
  13. Providers need to reflect on how the organisational culture, management styles, policies and processes act to either support or inhibit staff from feeling capable of developing positive relationships with residents and relatives.
  14. Specific resident allocation to a named primary carer may help get to know them better and help with relationship building which will help the home identify individualised strategies for supporting resident choice and avoiding the use of restraint (key worker system).
  15. Staff need to be aware of how their own personal and professional opinions regarding 'what is acceptable resident behaviour' may impact on the care given and the choices available to the resident.
  16. Managers should aim to build positive relationships with those individuals in the local health and social care system who may be able to offer the support needed in helping minimise the use of restraint.
  17. All care homes are urged to subscribe to a philosophy of care. *My Home Life* ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)) provides an evidence-based and relationship-centred vision for quality of life that keeps in mind the perspective of residents, relatives and staff (see Appendix 3 for a summary of *My Home Life*). Such an evidence base will help care homes improve practice and communicate their expertise to the outside world.

#### **For government and statutory bodies**

18. A public debate needs to take place on managing risk and minimising restraint in care homes so that society has a better understanding of the issues.
19. A national professional organisation needs to be established to represent care home staff, promote excellence in care home practice and better shape health and social care policies.
20. Government and local statutory bodies need to acknowledge the fact that care homes are increasingly being required to care for some of our frailest citizens,

many of whom have highly complex needs. Care homes need to be valued as equal partners in the health and social care system and helped to meet their potential in undertaking what is a professional role.

21. Statutory bodies should acknowledge the complexity of balancing rights and risks when working with such frail individuals. They should aim to help care homes to feel confident in asking for advice or support without fear of being viewed as 'problem homes'.
22. Commissioners and inspectors should reflect on how their practices, policies and management styles impact on the culture of a care home. Care home managers may feel unwilling to encourage a culture of positive risk taking in their home if they do not feel that they will be backed up if the agreed risk results in an accident or incident.
23. Primary care services should consider older people living in care homes as a high priority group in terms of access to specialist services such as physiotherapy, occupational therapy and counselling services, given the multiple co-existing conditions that many residents experience. Such therapeutic support will help maximise the independence of residents and therefore reduce the need for restraining practices.
24. Greater priority should be given to reviewing and reducing the use of antipsychotic medication/sedatives in care homes while working with staff to develop alternative therapeutic approaches to supporting the resident.

#### **For research**

25. More in-depth work is needed in exploring the perspectives of residents on balancing rights, risks and the use of restraining practices.
26. More work is needed to shed light on the use of antipsychotic medication in care homes and the covert administration of medication to residents.
27. Examples of best practice in minimising the use of restraint in services for children, people with learning or physical disabilities etc, need to be explored and, where possible, adopted in relation to services for older people.
28. More research is needed to explore the use of different forms of restraint in domiciliary care.
29. Research is needed to explore the issue of financial restraint in care homes. This is not an issue that was covered by this study but remains an area of concern.
30. Pilot and testing of a generic risk assessment tool for care homes, which has the approval of the HSE and Care Quality Commission.

## 6 References

- Cooperrider, D.L., Whitney, D. and Stavros, J.M. (2003) *The appreciative inquiry handbook*, Bedford, OH: Lakeshore Communications.
- DH (Department of Health) (2009) *Deprivation of Liberty Safeguards. A guide for hospitals and care homes*, OPG608, Office of the Public Guardian ([www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)).
- HSE (Health and Safety Executive) (2007) *Bedrail risk management*, SIM 7/2007/06, London: HSE ([www.hse.gov.uk/foi/internalops/sectors/public/070706.htm](http://www.hse.gov.uk/foi/internalops/sectors/public/070706.htm)).
- MCA (Mental Capacity Act) (2005) *Mental Capacity Act*, C 9, London: The Stationery Office ([www.opsi.gov.uk/acts/acts2005/pdf/ukpga\\_20050009\\_en.pdf](http://www.opsi.gov.uk/acts/acts2005/pdf/ukpga_20050009_en.pdf)).
- My Home Life (2008) *The bulletin for care home staff, issue 4: Sharing decision making*, London: Help the Aged.
- My Home Life (2009) *Promoting quality of life in care homes*, A DVD celebrating best practice, London: Help the Aged.
- NCHR&D Forum (2007) *My home life: Quality of life in care homes – A review of the literature*, London: Help the Aged ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)).
- Nolan, M., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006) *The senses framework: Improving care for older people through a relationship-centred approach*, Getting Research into Practice report, Sheffield: University of Sheffield.
- Qureshi, H. (2009) *Narrative literature review on restraint in care homes for older people*, London: Social Care Institute for Excellence.



## Appendix 1: Restraint discussion guide (relatives, residents, care home staff)

Note: The discussion guide was seen as a tool to focus discussion but with some residents and relatives, a more unstructured discussion took place to help ensure that an open and relaxed interview could take place.

Quick introduction to the topic – Hand out definition.

**What is restraint?** A broad everyday definition that emerges from the literature is:

stopping people from doing things they appear to want to do, or restricting their movement.

### Types of restraint identified from the research evidence

1. Manual restraint by staff (holding people down, stopping people from doing something)
2. Arrangement of furniture to keep people in bed, to stop people getting up, or creating an obstacle to part of the room
3. Lap belts; wrist and vest restraints (not generally regarded as acceptable in the UK)
4. Bedrails
5. Deprivation of walking aids or means to summon assistance
6. Locked doors; intended to safeguard a particular person at risk, may thereby unacceptably restrict the movement of all residents
7. Over-medication
8. Staff instructions, or institutional rules or practices may be seen as restraint, e.g. stopping people from going out, rules about entering the kitchen etc, residents not encouraged to have freedom, choice and control

### QUESTIONS (residents, relatives and staff):

The following are general questions that we need covering, but I think we can allow a natural discussion to emerge in order to get real and honest replies.

1. Thinking about care homes in general, do you think that these forms of restraint are common? Go down the list, any thoughts on why they are common? Go with any particular examples and skip question two if own practice examples come up
2. Reflecting on your care home, do you think that any of these types of restraint are used? Go through each area on the list

## PROMPTS for Questions 1 and 2

Pick up on specific examples:

What is the situation? Why is restraint needed? What would happen if restraint was not used? Are there particular times when restraint is more necessary? What other tactics have you developed to reduce the need for restraint (offer example if necessary of 'wandering' – the use of supported purposeful walking, communication with the resident about how they are and what they want)

3. [In relation to the specific example] When do you first consider the need to restrain? Was there a formal decision to restrain someone or does it just happen as part of day-to-day practice?

More general questions for staff – where appropriate tailor to residents and relatives

4. Are there discussions among the staff about how you best keep the resident safe?
5. To what extent do you discuss the specific issue of restraint with relatives? How do you do this? What issues arise? Are visitors to the home keen that you restrain their relative (resident) for their own safety?
6. To what extent do you discuss the issue with residents? How do you do this? If not, how do you know it's the best thing to do?
7. Are there policies and procedures in the care home about restraint? What are they? How are they fed down to you?
8. Do you monitor or review the use of restraint? How do you engage the resident or relative in this?
9. Thinking more broadly, how do you get the balance right between keeping someone safe and promoting their independence, choice and freedom?
10. Some care homes focus on having a regime based on minimising all risks; others are more open to positive risk-taking for residents. What is the culture here? How has the culture emerged?
11. Thinking generally about supporting people to have choice and control, are there specific examples where you have really been able to promote a resident's freedom and quality of life? (e.g. helping people to have choice over meals, getting them out, getting them involved in the running of the home?) How did these practices emerge?
12. Thinking more generally about staff practice development, what kinds of training, or educational materials, do you have access to? What works and why? What might be useful in terms of helping you to think through practice in this regard?
13. Finally, there are some who would argue that restraining residents is just about staff convenience because it is easier to manage residents. Would you agree?

Is there any other issue that you wish to raise?

## Appendix 2: Evidence-based practical statements for residents, relatives and staff to feel a sense of security, belonging, continuity, purpose, achievement and significance (relationship-centred care)



# The Senses Framework:

**Improving Care For Older People  
Through a Relationship-Centred Approach**

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**ISBN 1-902411-44-7**

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Design and Print: NORTHEND CREATIVE PRINT SOLUTIONS  
TUOS120

### Factors Creating a Sense of Security

#### For older people

- Staff being aware of your life story so that they really know you
- Effective communication
- Introducing all staff so that you know who is who
- Encouraging visitors/people who know you really well, to be involved in your care
- Encouraging residents to bring in their own possessions – again to create a sense of familiarity
- Rearranging furniture if necessary
- Comprehensive assessment of needs on admission, including risk assessment
- Ongoing assessment and evaluation
- Allocation of key workers

*NB We do not always allow individuals to take appropriate risks due to legalities and possible reprimand*

#### For staff

- Effective teamwork and communication
- Effective leadership
- Accurate record-keeping
- Mutual respect – knowing you will be respected as an individual
- Appropriate staffing levels
- Adequate human and mechanical resources
- Training
- Open and approachable management
- Flattened management system
- Confidentiality
- Up to date records
- Compassion and understanding

#### For family carers

- Approachable teams/management
- Effective communication
- Feeling safe to complain without fear of reprimand
- Keeping appropriate people informed
- Advocacy
- Involving the multi-disciplinary team
- Staff being able to mediate between patients without taking sides
- Keep relatives informed of changes in care plan

#### For students

- Appoint a mentor
- Treat the student as an individual
- Clear aims and objectives
- Informing all staff of student's role within the home
- Comprehensive induction programme
- Allow student time to complete their own work (e.g. portfolio)

## Factors Creating a Sense of Belonging

### For older people

- Opportunities to visit the home prior to moving in
- Own room/belongings/privacy
- Wait until invited into resident's room
- Open visiting
- Own place in dining room
- Clarify expectations on admission
- Respect personal choice wherever possible
- Residents' groups with nominated chairperson

### For staff

- Responsibility based on defined roles
- Opportunity to share
- Feeling valued, trusted and competent
- Thanking staff for their contribution
- Work towards common goals to deliver high standards of care
- Having a sense of camaraderie
- Not working in isolation
- Important for care assistants to have a sense of professionalism

*NB More important with big group companies*

### For family carers

- Make relatives feel welcome
- Encourage to take a more active part
- Ensure that staff are there for relatives and residents, physically, mentally and financially
- Encourage involvement in all aspects of care and decision-making
- Value relatives' ideas
- Use appropriate terminology – avoid jargon
- Create care partnerships
- Educate relatives in promoting independence and optimising opportunities to enhance quality of care
- Make sure that relatives are informed of all changes
- 'Be there' for relatives and encourage them to talk
- Individual service planning to create social activities and opportunities

### For students

- Induction programme and booklet
- Explore student's expectations and objectives (possibly using a questionnaire)
- Value their new ideas
- Encourage students to realise that nursing home staff are progressive
- Involve all grades of staff in student learning
- Mentor relationship

**Factors Creating a Sense of Continuity****For older people**

- Life history sheet – developed with relative if possible/appropriate
- Consistency in key worker/associate nurse/support worker
- Visit hospital prior to discharge and ensure a familiar face on admission
- Comprehensive information on discharge from hospital and admission to hospital
- Involve activity co-ordinator in helping resident to continue with enjoyed past time

**For staff**

- Monthly newsletter
- Regular staff meetings
- Clinical supervision and appraisal
- Audit
- Quality standards
- Follow policies/procedures

**For family carers**

- Residents/relatives meetings
- Being involved in care giving
- Involve relatives in reviews of care plans
- Update relatives with information regularly
- Opportunities to go on outing

**For students**

- Good links with university
- Training for mentors to enable links with programme content
- Student induction pack

## **Factors Creating a Sense of Purpose**

### **For older people**

- Create personal profiles including hobbies and interests
- Assess actual and potential abilities
- Identify targets and goals
- Residents committees
- Consider potential for discharge

### **For staff**

- Team nursing
- Care plans
- Standing orders
- Induction and training available
- Assessments of quality of care

### **For family carers**

- Relatives' committee
- Involvement in care planning and delivery (based on relative/resident choice)
- Communication

### **For students**

- Team allocation
- Named resident(s)
- Involvement in decision-making
- Targets for achievement of agreed goals by end of placement

## Factors Creating a Sense of Achievement

### For older people

- Promoting independence (where possible) in relation to activities of daily living
- Promoting mental well being and motivation
- Setting individual goals and needs
- Recognising own capabilities
- Multi-professional approach

### For staff

- Seeing clients improving and gaining confidence in their ability to achieve goals
- Keeping knowledge updated/sharing knowledge
- Regular appraisals/constructive criticism and practice development
- Written evidence of learning/acknowledgement of achievement
- Audit/quality control
- Support of manager/back up

### For family carers

- Family carer interview on admission – identify expectations
- Open visiting
- Communication from care staff
- Opportunities to assist in providing care
- Support systems for relatives
- Acknowledgement of and help to deal with guilt
- Information about services and benefits
- Addressing conflicts and concerns

### For students

- Clear objectives – asking what they want to achieve
- Overview of service provided and learning opportunities
- Spending time with different members of staff
- Encourage students to use their own initiative
- Regular feedback/planned evaluation sessions
- Set objectives for placement and review
- Provide adequate support and mentorship
- Encourage decision-making
- Give feedback on developing skills



## **Factors Creating a Sense of Significance**

### **For older people**

- Find out how clients wish to be addressed
- Involve fully in care planning
- Individualised care planning in identifying individual needs
- One-to-one/forming relationships
- Show an interest in the individual and their family
- Social care assessment identifying family relationships
- Use of photographs

### **For staff**

- Feedback from clients and relatives (either verbally or evidence of contentment)
- Feedback from the local community – knowing you have a good reputation
- Feedback via letters and carers
- Sense of pride in the quality of care provided
- Having opportunity to feedback to education providers

### **For family carers**

- Opportunity for family to give positive and negative comments about the service provided
- Annual quality control (opportunity to make comments about services anonymously)
- Service user forum
- Choices about involvement in the care of a resident
- Welcoming atmosphere

### **For students**

- Time invested in orientation and induction
- Provide student with a mentor who they will see a lot of
- Ongoing support and encouragement to apply theory to practice
- Telling the student that we can learn from them too.
- Direct feedback from clients
- Encouraging students to give feedback and letting them know that their opinions matter

## Appendix 3: Summary of My Home Life programme



### My Home Life Programme

#### Promoting quality of life in care homes

##### What is My Home Life?

**My Home Life** ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)) is a collaborative initiative aimed at promoting quality of life for those who are living, dying, visiting or working in care homes for older people through relationship-centred, evidence-based practice. **MHL** is supported by City University London, Age Concern and Help the Aged, Joseph Rowntree Foundation and all the national provider representative organisations for care homes across the UK. It is a collaborative scheme bringing together organisations which reflect the interests of care home providers, commissioners, regulators, care home residents and relatives and those interested in education, research and practice development. **MHL** is underpinned by an evidence base developed by over 60 academic researchers from universities across the UK. The evidence identifies eight best practice themes which together offer a vision for quality of life in care homes.

- 1. Managing Transitions:** Supporting people both to manage the loss and upheaval associated with going into a home and to move forward.
- 2. Maintaining Identity:** Working creatively with residents to maintain their sense of personal identity and engage in meaningful activity.
- 3. Creating Community:** Optimising relationships between and across staff, residents, family, friends and the wider local community. Encouraging a sense of security, continuity, belonging, purpose, achievement and significance for all.
- 4. Sharing Decision-making:** Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life.
- 5. Improving Health and Healthcare:** Ensuring adequate access to healthcare services and promoting health to optimise resident quality of life.
- 6. Supporting Good End of Life:** Valuing the 'living' and 'dying' in care homes and helping residents to prepare for a 'good death' with the support of their families.

**7. Keeping Workforce Fit for Purpose:** Identifying and meeting ever-changing training needs within the care home workforce

**8. Promoting a Positive Culture:** Developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option.

##### Current Activities:

**1. Delivering Resources:** **MHL** is developing and delivering a range of creative & accessible resources to care homes to help support their practice in line with the evidence base.

**2. Developing Networks:** Connecting care homes across the UK to share best practice ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)). Supporting regional groups to promote **MHL** and engage in local partnership working, in order to improve practice.

**3. Supporting Change:** Working with influential partners (e.g. care home representatives, inspectors, commissioners, educators, government) to embed the **MHL** vision in mainstream thinking. Linking with, building on and learning from other related initiatives across UK.

**4. Maintaining Momentum:** Sharing positive stories about care home practice with the press. Developing an ever-increasing network of people concerned about improving the quality of life of those living, dying, visiting and working in care homes

**The My Home Life Spirit:** My Home Life is all about working in partnership with the care home sector and celebrating the best practice that is being developed up and down the country. The future progress of the programme depends upon the active support of the care home sector and the availability of on-going resources to sustain the work.

For more information or to join the mailing list for '**My Home Life**' by contacting **MHL** at Help the Aged on 020 7239 1881 or [myhomelife@helptheaged.org.uk](mailto:myhomelife@helptheaged.org.uk)



Quality of life in care homes



Age Concern England (charity number 261754) has merged with Help the Aged (charity number 272786) to form Age UK, a charitable company limited by guarantee and registered in England; registered office address 207 - 221 Pentonville Road, London, N1 9JZ, company number 6929795, registered charity number 1126267. Age Concern and Help the Aged are brands of Age UK. The three national Age Concerns in Scotland, Northern Ireland and Wales have also merged with Help the Aged in these nations to form three registered charities: Age Scotland, Age NI, Age Cymru. 106969 05/09

## Minimising the use of 'restraint' in care homes: Challenges, dilemmas and positive approaches

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