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Safe Physical Intervention

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Introduction

The Winterbourne View [1] scandal rightly turned the spotlight on the use of restraint within care settings. Positive Behavioural Support, restraint reduction and even zero restraint are the new philosophies striving to protect vulnerable people and promote greater autonomy and dignity.

In 2014, the Department of Health published a document entitled: Positive and Proactive Care and A Positive and Proactive workforce provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery [1].

This has resulted in organisations proudly promoting minimal or no restraint practices and developing new strategies or non-physical interventions that make the use of physical restriction redundant.

How did we ever get by using such brutal methods? Is a growing claim. This is the genuine positive outcome for all in many areas of health and social care and must be applauded.

However when patients/service users ARE being restrained and the method is not even acknowledged let alone recorded, then we are embarking upon a great error of denial!.

Some areas - both NHS and Social Care are not recording restraint when clearly it is!.

Some areas are so scared of being labelled abusive; they allow their staff to be become punch bags, just so they claim to have a no restraint policy.

The use of restraint, like any other kind of intervention is dictated by the needs and behaviour of the patient/service user. If a care establishment has a blanket no restraint policy- irrespective of the nature of the patient/service user's behaviour, then any such behaviour that fails to respond to non-physical interventions and presents as a serious risk of harm to the person or to others that requires a physical intervention is either breaching its own philosophy by using restraint or it is neglecting to intervene to act in the best interest of the person, both are wrong!.

This paper will challenge the 'baby and the bathwater' view, but it will also strive to show that the provision of physical interventions and its training is not an abuser's charter. In 2009 a paper on safe holding was presented by me and physiotherapist, Petrus du Plessis. The purpose was to evaluate the risks to bones, joints, tissue viability and dignity, but most importantly develop techniques that are age appropriate, person centred and measureable.

Mental Health Crisis Care

Physical restraint in crisis in June 2013 by Mind [2]. The report found evidence of significant variations in the use of restraint across the country. They raised concerns about the use of face down or 'prone' restraint and the numbers of restraint related injuries that were sustained.

Furthermore out of 84% of nursing staff who had been involved with the use of hands on restraint with older people expressing violence, of only 74% had received training.

Anecdotal evidence obtained through discussion with clinical and social care staff during training courses found that around three quarters of 250 delegates admitted that the training they received was inadequate and often inappropriate.

A spate of civil action cases involving injured carers/patients, including one 72 year old man who punched two female nursing staff, fracturing one nurse's nose, knocking the other's tooth out and throttling a frail 73 year old female patient until she was virtually unconscious resulted in an out of court settlement of £32,000. Litigation involving cases of injury to patients through poor physical restrictive intervention technique are set to increase as the workplace becomes a litigious hotbed.

Care professionals find the subject of restrictive physical interventions (restraint) enormously contentious at the best of times. When the process is linked to vulnerable people, it is guaranteed to provoke emotional and indignant reaction. And so it should do.

However many carers are confirming and re-enforcing the evidence, namely, that the vast majority of carers harbour feelings of anguish and frustration at their severely limited ability to intervene safely and protect a vulnerable person from harm or prevent a patient from causing harm or injury to another patient or carer.

Restrictive physical interventions (RSIs) and their use with frail or older people are often viewed as questionable at best and at worst physical and emotional abuse. A survey by Pulsford et al., [3] further highlighted that staff working in care homes with older people who may become aggressive were largely opposed to physical restraint. Nonetheless it cannot be denied is that there are occasions when RSIs are needed and can work as a safe intervention for severely agitated or dangerously hostile behaviour.

One problem is ensuring that RSIs are taught and used within a sound value base, that the techniques used are refined to take into consideration the frailty, strength and mobility of the patient.

A further problem is the concern that the teaching of clinical staff in the use of physical interventions is often delivered by trainers who have

little knowledge or experience of the link between violence and clinical conditions such as Alzheimer's disease [4].

According to Paterson [5], Physical interventions are never considered 'treatments' but to be ethically defensible they must take place within a therapeutic environment and a therapeutic relationship. In other words when it is used, physical restraint should be seen as being a part of the treatment.

The RCN in its [6] document, let's talk about restraint' adopts a cautious position: it highlights the serious risk of abuse when it is not regulated and there is an absence of policy or guidance on the use of restraint by nurses.

If the uses of RSIs are to be a genuine last resort, practitioners need to ensure that they are used in such a way and not be part of a huge disparity between rhetoric and practice. Being a last resort is more likely to be the case when staff has been taught good risk assessment, distraction and non-physical interventions. This should be linked to the relevant legal, health and safety and ethical principles and maintaining dignity to form the core training philosophy.

The Mental Capacity Act 2005 [7] and in particular the Deprivation of Liberty Safeguards and of no less value the role of Article 3 of the Human Rights Act 1998 [8] have an overarching influence on the use of restrictive physical interventions. Article 3 is the only absolute European Convention right meaning it is not bound by restriction or exception. It states that:

'No one shall be subjected to torture or inhuman or degrading treatment or punishment'. The real danger is that badly taught and unsafely used, restraint is degrading and may be viewed as inhuman or even torture.

Defining Restraint

Section 6 of the Mental Capacity Act 2005 (op cit) defines restraint as: The use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists.

Furthermore the Act states: Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm.

Developing a safe holding technique for use with older people who exhibit challenging behaviour in the form of aggressive behaviour

Allowing for the fact that the ideological debate persists on whether restraint has a role in dealing with challenging behaviours with vulnerable people. What cannot be denied is that care staff does get being injured by violent patients. Also other patients may well be in serious danger of violence from fellow patients and patients may be injured by staff who as a result of this guidance hiatus use inappropriate restraint techniques to prevent a violent incident from occurring. Based upon the above theoretical and value base the aim was to develop a technique that is built upon a culture of care and dignity.

- Aims to be of a least restrictive and physiotherapeutically sound intervention. Identifies risk factors for each aspect of the techniques in terms of injury to the patient or the staff.

The authors examined a number of physical restraint techniques available and decided to refine a safe holding technique that could be easily taught to and used by nurses and carers working with vulnerable patients who may express violence.

Underpinning of the course design with the importance of promoting the following guidelines

- Ensure each person is risk assessed in terms of muscular skeletal efficiency.
- Ensure the intervention is part of an overall graduated response.
- The intervention must be part of the person's care plan.

Consider the fact the intervention may be seen as restriction or deprivation of the person's liberty and carried out in their best interest.

The Safe Holding Technique

In conjunction with the Best Interest Criteria as laid down by the British Institute of Learning Disabilities [9] (BILD 2006), this technique aims to, avoid and minimise, "potentially dangerous postures and positioning with reference to ergonomic, physiological and biomechanical factors." Also it has been designed to avoid hyperextension and hyperflexion.

The technique is designed to be used by staff to gradually take control of a patient who may be increasing in agitation and needs to be guided away from a situation which is possibly exacerbating their emotional arousal.

Stage 1

As part of a graduated response, the carer approaches the person from the front. Then, whilst continuing to reassure verbally, gently place a hand on each shoulder.

- **Joints involved**

The carer uses shoulders, elbows and wrist/hands.

- **Muscle groups involved**

The carer is stabilising the patient by applying gentle pressure to the outside shoulders of the patient using their shoulder, chest (pectoral) and elbow flexors (biceps) (Figure 1).

- **Risk of injuries**

There is a low risk of injury to the carer or patient's joints and muscles. The stage 1 technique is used in cases where the patient is cooperative, which minimises risk of injury.

- **Ease of use**

This is very easy to perform. Guidance is given to the patient through the central key points of the upper body.

- **Effectiveness**

As long as the patient is cooperative this is very effective.

- **Overall score**

This is a green light hold.

Figure 1: Stage 1.

Stage 2

- **Joints involved**

The carer uses shoulders, elbows and wrist/hands.

- **Muscle groups involved**

The carer is stabilising the patient by applying firm pressure to the nearest shoulder and opposite elbow of the patient using their shoulder, chest (pectoral) and elbow flexors (biceps) (Figure 2).

- **Risk of injuries**

The risk of injury to the patient or carer's joints and muscles is low. The stage 2 technique is used in cases where the patient is becoming less cooperative and more resistant. For this technique it is important to have a second member of staff on standby if necessary to apply the third stage.

- **Ease of use**

This is very easy to perform. Guidance is given by blocking the patient's elbow on the outside and fixing the shoulder on the inside.

- **Effectiveness**

As long as the patient is cooperative this is very effective. This is to keep the patient's upper limbs in control and to stop any lashing out. This entitles the staff to perform the third and fourth stage if necessary.

- **Overall score**

This is a green light hold.

Figure 2: Stage 2.

Stage 3

- **Joints involved**

Both carers uses shoulders, elbows, wrists and fingers (Stage 3).

- **Muscle groups involved**

The carers are stabilising the patient's arms by holding on to the wrists on the outside and hooking their inside arm in from underneath the patient's arms and holding onto their own clothing using their shoulder muscles, chest (pectoral) muscles and elbow flexors (biceps) (Figure 3). Grip strength is essential to control the patient's upper limbs.

- **Risk of injuries**

The carer: There is little risk of injury to the carers. All muscle and joints are in normal range. The stage 3 technique is used in cases where the patient is resisting. There will always be a risk of head butting the carer during this technique, however, if this should happen the carers can easily free themselves from the patient and retreat.

- **The patient**

The patient's upper limbs are in the anatomical position (palms facing forward) so that there is no stress on the shoulders, wrist/hand or nerves. This is important because if the patient resists or start to become more violent the joints and peripheral nerves are protected. Caution should be taken when applying pressure to the extended elbow of the patient (Figure 3). The pathomechanics of hyperextension combined with supination induces ligament legions (Tyrdal and Olsen, 1998) [10]. In this case there is minimal supination.

- **Ease of use**

This is easy to perform. Teamwork is fundamental to ensure successful escorting using stage 3. Guidance is given to the patient through the peripheral key points (hands) of the upper body.

- **Effectiveness**

Teamwork plays a big role during stage 3. Working in two's and ensuring there is little risk to the patient makes this technique effective. By fixing the patient's wrists peripherally will ensure that little damage can be done by the patient and good control by the two carers can be applied.

- **Overall score**

Because of the effectiveness, ease and minimum risks to both carer and patient this is a green light hold.

Stage 4

- **Joints involved**

The patient: The patient's wrists, elbows and shoulders are all in normal range (Figure 4).

The carer: The carer uses fingers to grip, elbows and shoulder joints.

- **Muscle groups involved**

The carers must use sufficient grip strength to control the patient's upper limb via the wrists (Figures 4 and 5). The carers use their elbow flexors (biceps) and shoulder adductors to flex the patient's elbows so that it could be tucked in under the carer's shoulder (Figures 4 and 5).

Figure 3: Stage 3.

The carer's inside hand let go of own clothes and then grip onto their own wrist instead to tighten the overall grip. It is then essential for the carers to adduct their shoulders, flex their elbows and maintain full grip strength to keep the patient in a static position (Figure 5). This will ensure the patient is fully secured and will be unable to lash out or become violent.

- **Risk of injuries**

The patient: As mentioned above the upper limbs of the patient is in the anatomical position. Then the patient's upper limbs will be placed in a flexed elbow position. This will not cause any injuries to the patient's shoulders, elbows and wrists. All joints and muscles are in normal range. The patient's arm will be in such a fixed position that it will be possible for the patient to lift their legs without putting much strain on the carers.

The carers: The carers hold the patient in the anatomical position (palms facing forward) with the carer's thumb upwards during the starting position (Figure 3). This is important for the carers because this ensures that they do not have to let go of the patient's wrist and adjust their grip. It is possible to put the patient straight into the escort hold (stage 4) (Figure 5). This minimises risk, because if the patient has his hand free there is chance for a potential assault. The carers can protect their back by both carers slightly leaning into the carer for a more secure hold.

There is little risk to both the carer and the patient during stage 4.

- **Ease of use**

This stage is very dependent on teamwork between the two carers involved. The technique needs a lot of practice and speed, surprise and body weight plays a major role. There is an element of strength involved and carers' needs to be carefully chosen to certain patients. The carer must be able to manipulate the upper limb of the patient into the flexed elbow position.

This technique is well structured and as mentioned before it is safe.

- **Effectiveness**

Stage 4 is very effective in controlling the patient. It fixes the patient in a comfortable position, which is very difficult for the patient to assault the carers. The carers can stand or sit with the patient using this hold. As mentioned before the patient will be fixed between the two carers. By having the carers move closer together, this will protect their spines as well as injury to any part of their body if the patient had to struggle or suddenly lift their feet off the floor.

- **Overall Score**

Because of the effectiveness, ease and minimum risks to both carer and patient this is a green light hold.

Figure 4: Stage 4.

Figure 5: Close up.

Conclusion

This simple analysis of one type of physical intervention is hardly a complete review of all techniques relevant to the safe management of challenging behaviour amongst vulnerable people. This is the first paper exploring the physiological and biomechanical aspects of physical interventions.

More research is clearly indicated, but the aim must be to make safer RPIs available and provide guidance, hope and support to the

thousands of carers who are genuinely frightened to intervene safely using a last resort physical intervention due to the erroneous view that to do so is always abuse or assault.

But one great paradox about delivering good training in the use of physical interventions is the fact that by training staff how to use such interventions, the aim and expectation is that staff will not have to use them!

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