COVID-19

Clinical Guidance For NHS Scotland: Using Physical Restraint For Mental Health And Learning Disability Patients With Confirmed Or Suspected COVID-19

Scottish Government
Riaghaltas na h-Alba
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Version History

Version	Date	Summary of changes
V1.0	20/04/2020	Draft guideline endorsed by PAG 17th April and transferred onto the standardised template.
V2.0	5/08/2020	Guidance amended in response to comments from stakeholders, to strengthen links with the relevant MWC guidance and to further clarify that it is relation to Covid 19 requirements.
V3.0		
V4.0		

Further Information

For more information on COVID see the COVID guidance section of our website, www.gov.scot/coronavirus.

Glossary

PPE	Personal Protective Equipment

Contents

Introduction 4
Purpose 4
Infection Prevention And Control During Physical Restraint 5
Step Wise Management Plan 5
Table One: Recommended Personal Protective Equipement For Healthcare Workers By Secondary Care Clinical Context 6
Physical Health Care Implications Of Restraining Patients With COVID-19 7
Post Incident Debrief 8
Wellbeing 8
References 8

1. Introduction

1.1 COVID-19 presents significant challenges for the care and therapeutic engagement of mental health and learning disabilities patients, recognising the increased potential for stress and distress particularly where options to de-escalate have not been successful. It is recognised that clinical staff are undertaking demanding roles within very unique circumstances. This paper aims to assist services by providing guidance for safe practice for those presenting with (acute) behavioural disturbance thereby ensuring effective infection prevention and control management is in place. This will enable the delivery of safe care for both patients and staff as well as protecting their right to life and health. It does not provide guidance on the underlying principles or techniques associated with control and restraint and therefore should be utilised in conjunction with both national and local guidance to reflect the needs of each clinical area.

1.2 People using restraint in care settings need to make sure that what they are doing respects human rights, and complies with the law and relevant care regulations. More detail on the legal background in Scotland relating to the use of restraint can be found in Appendix 1 of the Mental Welfare Commission for Scotland's Good Practice Guide: Rights, risks and limits to freedom (2013).

It is important to note that the application of this guidance is within the context of the Mental Health (Care And Treatment) (Scotland) Act 2003 or Adult with Incapacity (Scotland) Act 2000 and appropriate procedures for the relevant legislation followed. The principles of these Acts provide a good ethical decision-making framework against which to consider any potential restriction or decision. This is no different in respect to Covid 2019.

The Mental Welfare Commission for Scotland has also produced a Covid-19 Advice Note for Practitioners (https://www.mwcscot.org.uk/node/1432) which is updated regularly and addresses a range of issues which may arise as a result of the current pandemic. In particular, it notes that it is critical that physical restraint is kept to the minimum necessary and is a last resort, where there is no viable alternative. There must be a genuine belief that it is necessary to prevent serious harm including the risk of injury to the person or others. Managing acute disturbance in the context of COVID-19 infection risk is underpinned by ensuring it is the least restrictive, that it is trauma informed, and does not create difficulties and or flashpoints that could otherwise have been avoided (NAPICU, 2020, UK Restraint Reduction Network, 2020).

1.3 Three specific groups are covered by this guidance:

- Those symptomatic and/or suspected of having COVID-19
- Those confirmed as having COVID -19
- Those who during restraint procedures staff may deem high risk due to anticipated body fluid exposure e.g. spit or saliva.

2. Purpose

2.1 The purpose of the guidance is to ensure clarity regarding our ability to support patients at times of stress or distress who are Covid positive or symptomatic which includes:

- Application of Personal Protective Equipment (PPE) within this clinical context
- Provide guiding principles to work alongside locally agreed protocols and guidance.

3. Infection Prevention And Control During Physical Restraint.

3.1 The nature of physical restraint means that it is intrusive in nature reducing the ability of those involved to practise social distancing for the duration of the interaction, increasing the risk of transmission of COVID-19. It is therefore essential that good infection prevention and control (IPC) measures are implemented at all times whether infection is suspected or not (see the National Infection Prevention and Control Manual here). It is vital that essential IPC precautions are reinforced including hand hygiene, social distancing where possible and wearing of appropriate personal protective equipment (PPE). This will ensure the safe delivery of care and protection of both patients and staff whilst preventing the transmission of COVID-19. The Step Wise Management Plan for COVID-19 positive/symptomatic patients based on principles of least restrictive care should be implemented. (Adapted from NHS South London and Maudsley NHS Foundation Trust, COVID-19 Isolation: Use of Force/Restrictive Practice Decision Making Guidance)

3.2 It is recognised that situations can escalate with little or no warning. In addition it may be unknown if the patient has COVID-19. Given the nature of the intervention compliance with agreed standards Personal Protective Equipment as detailed in Health Protection Scotland Guidance: COVID-19 Personal Protective Equipment (PPE), 6th April 2020 is essential.

Step Wise Management Plan.

Level	Primary Interventions	Secondary Interventions	Tertiary Interventions. May include planned physical restraint to administer treatment.
Risk	Lower risk: Co-operative	Escalating risk: Uncooperative but not actively	High risk: Behaviourally disturbed, reckless or

		resistive or aggressive.	purposeful spread of infection such as spitting
Intervention	• Access to accessible information of COVID-19 for people with Learning Disability, Anxiety mitigation strategies • Understand and meet basic needs • Trauma Informed approach to care • Information giving • Maximise positive interactions	• Verbal de-escalation and redirection • Solution focussed	• Distraction • Access to technology • Restraint • Seclusion • Time limited, regularly reviewed

Table 1 of the guidance detailed below: “Recommended Personal Protective Equipment for healthcare workers by secondary care clinical context” is relevant for the mental health and learning disability in-patient settings.

Table 1: Recommended Personal Protective Equipment for healthcare workers by secondary care clinical context.

Context	Disposable Gloves	Disposable Plastic Apron	Disposable Fluid Resistant Gown	Surgical Mask	Fluid Resistant (Type FII) Surgical Mask	Filtering Face Piece Respirator	Eye/Face Protection
Working in an Emergency Department/ Acute Assessment	√ Single Use	√ Single Use	X	X	√ Sessional	X	√ Sessional

area with possible or confirmed cases. Direct Patient Care (within 2 metres)							

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

3.3 Sessional use is described as a period of time where a health or social care worker is undertaking duties in a specific clinical setting or exposure environment. Once Personal Protective Equipment is removed and discarded, hand hygiene must be performed. Evidence from across the world has shown that transmission of COVID-19 to healthcare workers may be associated with touching of the face and eyes when adjusting the facemask therefore it is important to ensure that time is taken to correctly fit the facemask. The wearing of facial Personal Protective Equipment (fluid resistant surgical mask and eye protection) will reduce the risk of splash from blood or body fluids into the mucous membranes of the nose, mouth and eyes.

4. Physical Health Care Implications Of Restraining Patients With COVID-19.

4.1 It is recognised that COVID-19 can result in severe respiratory symptomatology. Therefore, before a decision to implement physical restraint is made, a full risk assessment should have been carried out on the patient, ideally at point of admission to the service and updated as necessary. Factors such as: Covid-19 status, existing physical injuries, cardiac / respiratory problems, obesity, pregnancy, alcohol / drug use, epilepsy and psychological trauma, age and disability should be considered; however this list in not exhaustive.'

4.2 Restraint can increase the risk to both patients and staff. It could result in either party being injured, protective clothing being damaged, face masks being ripped off, exposing both staff and the patient to the risk of contamination. First responders should be relieved as soon as possible if not wearing the appropriate Personal Protective Equipment. Infection prevention and control procedures following any physical contact with patients with or suspected of having Covid-19 should be undertaken.

4.3 Medication if utilised should be authorised under the Mental Health (Care And Treatment) (Scotland) Act 2003 or Adult with Incapacity (Scotland) Act 2000 and appropriate procedures for the relevant legislation followed. It should continue to be directed by local protocols but require some additional consideration to the specific contra-indications and side effects associated with COVID-19. Where possible, short acting oral medication should be offered as the first choice.

4.4 Physical health monitoring utilising NEWS, especially respiratory rate and level of consciousness, should be carried out when either oral or parenteral rapid tranquillisation is administered.

5. Post Incident Debrief: Covid 19

5.1 It is essential that both the individual and staff members have an opportunity to reflect on the incident with a view to make improvements on how a similar situation may be avoided enabling social distancing to be maintained where possible alongside the effectiveness of infection prevention and control measures utilised. The Advocacy Services should be offered to the individual to support them in this discussion should they wish. Application of infection, prevention and control measures should be documented in the individual's records.

6. Wellbeing

6.1 Both staff and patients should be signposted to locally and nationally available wellbeing resources.

7. References

7.1 Lee AM, Wong JG, McAlonan GM, Cheung V, Cheung C, Sham PC, et al. Stress and psychological distress among SARS survivors 1 year after the outbreak. Can J Psychiatry 2007, 52: 233–240.

7.2 Lewys Beames, Lead Nurse - Reducing Restrictive Practice, David O'Flynn - Consultant Psychiatrist Trust MHA Clinical Lead and Kay Burton – Head of Mental Health Legislation all at South London and Maudseley NHS Foundation Trust

7.3 Mental Welfare Commission; Good Practise Guide: Rights, Risks And Limits To Freedom. March 2013.

7.4 NAPICU; Managing Acute Disturbance In The Context Of COVID-19. 26.03.2020.

https://napicu.org.uk/wp-content/uploads/2020/03/NAPICU-Guidance_rev1-1.pdf

7.5 Restraint Reduction Network; Comment On Potential Impact Of COVID-19. https://restraintreductionnetwork.org/uncategorized/comment-on-the-potential-impact-of-covid-19/

7.6 Scottish Government; Mental Health (Care and Treatment) Scotland Act 2003

7.7 Zhu, Y., Chen, L., Ji, H., Xi, M., Fang, Y. and Li, Yi (2020) The risk and prevention of novel coronavirus pneumonia infections among inpatients in psychiatric hospitals. Neuroscience Bulletin, 36: 299–302. https://doi.org/10.1007/s12264-020-00476-9

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