Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we are committed, by the issue of this Policy, to ensuring that adult patients with impaired mental capacity are only restrained lawfully and appropriately.

Policy Commitment

We are committed to ensuring that the law regarding decision making – the Mental Capacity Act 2005 – is followed by our staff when they are considering using restraint and the adult patient lacks mental capacity to consent to it.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedure describe the following with regard to the use of restraint when patients lack the mental capacity to consent to it.

- The process to follow when restraint is being considered, including documentation
- The use of hand mittens to prevent patients from pulling out lines, tubes, etc.

Other supporting documents are:

- Mental Capacity Act 2005, HMSO London
- Cardiff and Vale UHB, Consent to Examination or Treatment Policy, UHB 100, February 2012 (currently subject to review)

Scope

This policy applies to all of our staff in all locations including those with honorary contracts.

Adults, for the purposes of this policy, are people aged 16 years and over. This policy does not address the needs of children.

Equality Impact

An Equality Impact Assessment (EqIA) has been completed
Assessment
and this found there to be no impact that would necessitate action.

Health Impact Assessment
A Health Impact Assessment is not required for this policy.

Policy Approved by
Mental Health and Capacity Legislation Committee

Group with authority to approve procedures written to explain how this policy will be implemented
Health System Management Board

Accountable Executive or Clinical Board Director
Medical Director

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

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Review Approved</th>
<th>Date Published</th>
<th>Summary of Amendments</th>
</tr>
</thead>
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<tr>
<td>1</td>
<td>10 May 2011</td>
<td>Not recorded</td>
<td>New policy</td>
</tr>
<tr>
<td>1.1</td>
<td>November 2012</td>
<td>Not recorded</td>
<td>Appendix 4 added (now Appendix 3)</td>
</tr>
<tr>
<td>1.2</td>
<td>31 March 2015</td>
<td>Not recorded</td>
<td>Front page amended to confirm that policy is still current whilst review underway</td>
</tr>
<tr>
<td>2</td>
<td>2 February 2016</td>
<td>02/03/16</td>
<td>Revised document – no major amendments Duplicated wording removed Re-ordering of some sections Some wording altered to clarify meaning</td>
</tr>
</tbody>
</table>
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**Appendix 1** Suggested restraint care plan template

**Appendix 2** Restraint flowchart

**Appendix 3** The use of hand mittens
1. Introduction

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

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

- With the person’s consent, or
- To prevent harm to others (in conjunction with other Cardiff and Vale University Health Board policies and procedures pertaining to the management of violence and aggression).

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

2. Aim

The aim of this policy is to provide guidance to staff regarding use of restraint with adult patients (i.e. those aged 16 years and over) who lack capacity to consent to treatment and care, so that University Health Board (UHB) staff deal with restraint issues lawfully.

3. Objectives

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

4. Responsibilities

Clinical Boards are responsible for

- Ensuring that their staff are aware of, and have access to this policy and procedure
- Ensuring that training on this policy and procedure is available to all staff
- Ensuring that existing training that touches on restraint is reviewed in light of this policy
- Monitoring the use of restraint through formal audit
5. The Policy

When making decisions regarding the use of restraint, it is vital to consider the patient’s mental capacity to consent to it. Where there is reason to doubt the person’s mental capacity, an assessment of mental capacity will be required, using the ‘Mental Capacity Assessment Form’ to record outcomes. The form and any other information relevant to the capacity assessment must be stored in the patient’s notes.

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

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

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

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

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

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

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

Restraint can take a number of forms –

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

5.3 Who can decide about the use of restraint?

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

**Advance decisions** – if the patient has made a valid and applicable advance decision refusing the proposed restraint (i.e. a particular kind of medication), then that intervention cannot be used.

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

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

If there are none of these in place then the decisions will need to be made by a clinician in the person’s best interests – see section 5.7.
5.4 The circumstances in which restraint may be used

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

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

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

5.5 The meaning of “proportionate”

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

5.6 The meaning of “less restrictive”

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

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

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

5.7 The meaning of “best interests”

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

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

The decision to use restraint in the patient's best interests must be based on the following (“the checklist”) -

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

When considering “all the relevant circumstances” it is important to recognise that the use of restraint can itself cause significant harm. For instance, patients forced to sit for long periods are subject to increased risk of pressure ulcer development, loss of dignity resulting from iatrogenic incontinence, loss of mobility resulting from muscle wasting, etc. The use of bedrails may actually increase the risk of serious injury if the person attempts to climb over them, and the use of harnesses introduces the risk of limb dislocation, fracture or asphyxiation. Restraint may also cause the patient distress and if this is likely, this must be taken seriously and considered carefully.

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

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

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

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

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

5.8 Court of Protection

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

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

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

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

5.9 Common law

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

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

5.10 Civil Law and Criminal Offences

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

Conviction under this section is punishable by imprisonment (for up to 5 years) and/or a fine.
Furthermore, if a staff member restrains a patient without a sound professional and legal basis, the client (or someone on their behalf) may bring a civil claim against the staff member in negligence and make a claim for compensation for any harm suffered as a result of the restraint. Both the length of time the restraint lasted and the amount of force used would be factors for the courts to assess to determine whether the restraint was reasonable and professionally accepted and thereby justifiable.

5.11 Deprivation of Liberty

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

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

All three criteria must be met. The UHB pro forma for assessing possible deprivations of liberty should be used –
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/MEDICALDIRECTORCLINICALPORTAL/MCA_DEPRIVATION%20OF%20LIBERTY/TAB49715/DOLS%20PRO%20FORMA%2010111141.PDF

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

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

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

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

Please see DoLS Code of Practice for further information and guidance.
6. Contact details in the event of queries

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

For queries that cannot be resolved please contact –

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

7. The Procedure

7.1 The process to follow

Consider and work through the following –

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

7.2 Recording requirements

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

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

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

7.3 Disagreement about the use of restraint

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

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

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

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

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

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

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

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

7.5 Mechanical restraints

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

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

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

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

Please see Appendix 3 regarding the use of hand mittens.
7.6 Adverse events involving restraint

Any adverse clinical events resulting from the use of restraint must be communicated to the patient’s Consultant at the earliest possible opportunity and reported in accordance with the UHB’s Incident, Hazard and Near Miss Reporting procedure.

7.7 Deprivation of Liberty Safeguards (DoLS)/Court authorisation

If an assessment using DoLS pro-forma – http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/MEDICALDIRECTORCLINICALPORTAL/MCA_DEPRIVATION%20OF%20LIBERTY/TAB49715/DOLS%20PRO%20FORMA%202011141.PDF - indicates that the patient may be being deprived of their liberty, then an application must be made for DoLS/court authorisation.

If it is necessary to provide treatment and care to a person aged 16 – 18 years in a way that involves depriving the patient of his/her liberty, urgent legal advice via the appropriate Clinical Board lead must be sought.

Further guidance is provided at Chapter 2 of the Deprivation of Liberty Safeguards (DoLS) Code of Practice which is available in clinical areas. The DoLS Co-ordinator can be contacted for advice.
Cardiff and Vale University Health Board

**Suggested Restraint Care Plan template**
Appendix 1 to procedure on the use of Restraint in the Care Management of Adults with impaired mental capacity

<table>
<thead>
<tr>
<th>Problem</th>
<th>Care Plan</th>
</tr>
</thead>
</table>
| Use of planned restraint to reduce harm | Restraint may be used in the card and treatment of ................. to prevent anticipated harm of .................  
Explain to the patient the harm that the restraint is designed to avoid  
Provide details of assessment and plan below:  
What type of restraint is it?  
Provide full details below: |
| When is the restraint to be applied? | Specify maximum length of continuous time the restraint can be applied:  
Specify the time periods the restraint should be removed:  
Explain how ................. will be cared for during the periods of non-restraint:  
Document any contra-indications and evaluate the patient response to and effectiveness of the use of the restraint |
| Set out the timescale for review | |
| Note date and time restraint prescribed: | Date and sign care plan. |
RESTRAINT FLOW CHART FOR PATIENTS AGED 16 YEARS AND OVER
(Policy on the use of Restraint in the Care Management of Adults who lack Mental Capacity to Consent to Treatment and Care)

Does the patient lack capacity to consent to the proposed restraint?

Yes

Has the patient made a valid and applicable advance decision refusing the type of restraint (i.e. specific medication) being proposed?

Yes

That particular restraint cannot be used.

No

Is restraint necessary to prevent harm to the patient?

Yes


No

If the Attorney/Deputy has the authority does he/she consent to the use of the restraint?

Yes

That restraint cannot be used.

No

Does the patient have an Attorney under a LPA or a Court Appointed Deputy who has authority to decide?

Yes

Restraint cannot be used unless it is to protect others.

No

Is restraint necessary to prevent harm to the patient?

Yes

Is the restraint proportionate to the likelihood and seriousness of harm?

Yes


Yes

Is the restraint the least restrictive means of the appropriate choices by which the patient can be kept safe from harm?

Yes

Use prescribed restraint & review.

No

Restraint cannot be used.

No

Restraint cannot be used unless it is to protect others from harm.

NOTES
1) References to MCA 2005 are to the Mental Capacity Act 2005 and its accompanying Code of Practice.
2) Where restraint forms an aspect of treatment, consideration must be given to the completion of Consent Form 4.
3) Please ensure that all documentation supports defensible decision making.
THE USE OF HAND MITTENS

The use of hand retaining mittens to prevent harm by retaining invasive devices, lines or tubes in the care of patients who lack mental capacity to consent to their use, is restraint.

The circumstances in which hand retaining mittens may be used:

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

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

Who can be a decision-maker? (Section 5 Mental Capacity Act Code of Practice).

Many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the ‘decision-maker’, and it is the decision-maker’s responsibility to work out what would be in the best interests of the person who lacks capacity.

- Where the decision involves the provision of medical treatment, the clinician responsible for carrying out the particular treatment or procedure is the decision-maker
- If a Lasting Power of Attorney has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority

The decision-maker for the use of hand retaining mittens is likely to be the nurse caring for the patient at the time mittens are applied or worn.

After application of the mittens, the patient’s response to the restraint must be monitored and their use reviewed. If it appears that their use is causing more harm, including agitation and distress, than the harm the patient may experience without the mittens, then their use should be discontinued.
### APPENDIX 3 – CARE PLAN FOR THE USE OF HAND MITTENS

Please ensure you update this care plan regularly and provide further details in the patient’s notes if required.

<table>
<thead>
<tr>
<th>Date</th>
<th>Number</th>
<th>Identified Problem</th>
<th>Desired outcome</th>
<th>Prescribed Action</th>
<th>Nurse name (please print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>Maintaining patient safety in relation to invasive devices/lines or tubes. Please specify……………………</td>
<td>To prevent harm and maintain safety.</td>
<td>To consider the use of hand retaining mittens to retain invasive devices/lines or tubes.</td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
<td><strong>Mental Capacity (Age 16 plus)</strong> Is there reason to think that the patient may lack capacity to consent to hand restraints?</td>
<td>If NO hand restraints may be used with patient’s consent.</td>
<td>If YES complete the Mental Capacity assessment and attach form</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td><strong>Advance Decision (Age 18 plus)</strong> Has the patient made a valid and applicable advance decision regarding use of hand restraints?</td>
<td>If NO, go to box 4</td>
<td>If YES hand restraints cannot be used on this patient.</td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td><strong>LPA or CAD</strong> Has the patient made a personal welfare <strong>Lasting Power of Attorney</strong>, or does the person have a <strong>Court Appointed Deputy</strong>?</td>
<td>If NO, go to box 5</td>
<td>If YES consent is required for the use of hand restraints from the Attorney or CAD. Sign when consent obtained - ………………………………… Date …………………….</td>
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<td>5.</td>
<td></td>
<td><strong>Best Interests</strong> Is the restraint to prevent harm to the patient? Is it use proportionate to the likelihood and severity of harm? Is it the least restrictive appropriate way of addressing the harm? Is it in the patient’s best interests?</td>
<td>Ensure that the record of the decision to use mitts covers all 4 points.</td>
<td>Please attach best interests form showing how best interests have been determined or specify where this is recorded.</td>
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Consult friends and family.

<table>
<thead>
<tr>
<th>Date</th>
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<th>Desired outcome</th>
<th>Prescribed Action</th>
<th>Nurse name (please print)</th>
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<td>6.</td>
<td></td>
<td><strong>Decision Maker</strong></td>
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<td></td>
<td>Please record details of decision maker for the initial use of hand retaining mittens.</td>
<td>The clinician responsible for making the decision about the use of mittens is clearly identified and takes responsibility for ensuring that relevant staff are aware of this care plan</td>
<td>Decision-maker to ensure that the use of mittens is monitored and reviewed each shift.</td>
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<td>Name:</td>
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<td>Review Date:</td>
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<td>7.</td>
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<td><strong>Patient Safety</strong></td>
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<td>Potential risk to patient’s safety through the use of hand retaining mittens.</td>
<td>To ensure patient safety is maintained.</td>
<td>Applying the hand retaining mittens following the safety information leaflet provided in each pack.</td>
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<td>8.</td>
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<td><strong>Skin Integrity</strong></td>
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<td></td>
<td></td>
<td>Pressure damage to patient’s hands or wrists</td>
<td>To prevent pressure damage to the patient’s hands or wrists.</td>
<td>Follow skin bundle, ensuring the hands mittens are removed and hands are checked at least every 8 hours and removed when staff or visitors are present at the bedside.</td>
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<td>9.</td>
<td></td>
<td><strong>The Senior Nurse</strong> must be informed and sign this form</td>
<td>Informed by: Designation: Date:</td>
<td>Reviewed by Senior Nurse: Name: Date:</td>
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<td>10.</td>
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<td><strong>Please date when first applied</strong></td>
<td>Date:</td>
<td>Reason discontinued</td>
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<td><strong>Please date when discontinued</strong></td>
<td>Date:</td>
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