

# COVID-19

## Clinical Guidance for NHS Scotland: Using Physical Restraint For Patients With Confirmed Or Suspected COVID-19



Scottish Government  
Riaghaltas na h-Alba  
gov.scot

## Version History

Version	Date	Summary of changes
V1.0	20/04/2020	Draft guideline endorsed by PAG 17 <sup>th</sup> April and transferred onto the standardised template.
V2.0		
V3.0		

## Further Information

For more information on COVID see the COVID guidance section of our website, [www.gov.scot/coronavirus](http://www.gov.scot/coronavirus).

## Glossary

PPE

Personal Protective Equipment

## Contents

Introduction.....	4
Purpose .....	4
Physical Restraint During COVID-19.....	4
Medication Use For Acute Behavioural Disturbance.....	6
Infection Prevention And Control During Physical Restraint.....	6
Step Wise Management Plan .....	7
Table One: Recommended Personal Protective Equipement For Healthcare Workers By Secondary Care Clinical Context .....	8
Physical Health Care Implications Of Restrining Patients With COVID-19.....	8
Post Incident Debrief .....	9
Wellbeing .....	9
References .....	9

## 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. It should be utilised in conjunction with local guidance to reflect the needs of each clinical area.

1.2 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:

- Effective management of people displaying significant challenges with acute behavioural disturbance in the context of COVID-19
- Application of Personal Protective Equipment (PPE) within this clinical context
- Provide guiding principles to work alongside locally agreed protocols and guidance.

## 3. Physical Restraint During COVID-19

3.1 Clinical practice will continue to be underpinned by:

- The principles of human rights,
- Respect,
- In accordance with known wishes,
- Minimise psychological harm wherever possible
- Provide least restrictive care necessary within the circumstances
- Provide maximum benefit

- Trauma informed care

3.2 It is critical that physical restraint is kept to the minimum necessary. 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).

Preventative approaches such as:

- The use of tools to support the early prevention and recognition and deterioration of mental ill health/challenging behaviour.
- Robust communication with clinical teams through safety briefs
- Physical health monitoring utilising NEWS (with particular attention to respiratory care),
- Prevent boredom and the build-up of frustration as a result of shielding or social distancing measures in place to prevent the transmission of COVID-19.
- Avoidance of flashpoints,
- Access to meaningful activity
- Maintaining communication with the outside world through the use of digital technology or agreed plan of contact with a named person in line with NHS COVID- 19 visiting policy.

3.3 Zhu, Y (2020), suggests from Wuhan, many patients within in-patient mental health services are and were *'relatively and or completely detached from what is happening in the wider community.'* This may require staff, to convey the seriousness of the situation requiring action, while at the same time not raising fear or frustration to the extent that creates further escalation/flashpoints and or trauma. The aim being to enable social distancing, shielding and isolation in line with Health Protection Scotland Guidance to be implemented to meet the needs of each individual.

3.4 For individuals positive or suspected to have COVID-19 and require to isolate the following action should be implemented (NAPICU):

- Ensure adequate and ongoing mental health assessment, planning, care and review providing one to one therapeutic interventions to meet the needs of individuals.
- Provide contemporary information regarding Covid-19 in an accessible format
- Ensure items available to the person which could improve experience of isolation, reducing the potential for disturbance/flashpoints.
- Items helpful in meaningfully occupying time should be allocated for the

person's individual use, and not re-introduced to the general unit/ward area use until cleaning or disposal consistent with infection prevention and control recommendations.

- Items that can be disposed of following use should be disposed of in line with infection prevention and control guidance.

## 4. Medication Use For Acute Behavioural Disturbance.

4.1 The choice of medication should be directed by local protocols but require some additional consideration to the specific contra-indications and side effects associated with COVID-19. Where possible, oral medication should be offered as the first choice.

4.2 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

4.3 If a patient with suspected (awaiting testing/results) or diagnosed COVID-19 is acutely disturbed, and there are no signs of respiratory compromise (decreased or increased respiratory rate), cardiovascular disease or decreased level of consciousness; then medication can be used with caution as the full effects of COVID-19 are still unknown. Consider short acting medication as a patient's physical health condition may rapidly deteriorate.

4.4 Ensure the medication for acute disturbance is an effective dose as an ineffective dose may lead to the increased need for additional injections.

## 5. Infection Prevention And Control During Physical Restraint.

5.1 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)

5.2 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), 6<sup>th</sup> 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 resistive or aggressive.	High risk: Behaviourally disturbed, reckless or purposeful spread of infection such as spitting
Intervention	<ul style="list-style-type: none"> <li>• Access to accessible information of COVID-19 for people with Learning Disability, Anxiety mitigation strategies</li> <li>• Understand and meet basic needs</li> <li>• Trauma Informed approach to care</li> <li>• Information giving</li> <li>• Maximise positive interactions</li> </ul>	<ul style="list-style-type: none"> <li>• Verbal de-escalation and redirection</li> <li>• Solution focussed</li> </ul>	<ul style="list-style-type: none"> <li>• Distraction</li> <li>• Access to technology</li> <li>• Restraint</li> <li>• Seclusion</li> <li>• Time limited, regularly reviewed</li> </ul>

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 area with possible or confirmed cases.  Direct Patient Care (within 2 metres)	✓ Single Use	✓ Single Use	✗	✗	✓ Sessional	✗	✓ Sessional

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

5.3 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.

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

6.1 It is recognised that COVID-19 can result in severe respiratory symptomatology. It is essential that this and any underlying co-morbidity are considered throughout the physical restraint procedure. Long and protracted restraint should be avoided. Use of restraint positions that may interfere with a person's diaphragmatic movement, lung function that is likely to affect their ability to breathe should be avoided where possible.

6.2 Prolonged restraint can increase the risk to staff. It could result in staff being injured, protective clothing being damaged, face masks being ripped off, exposing staff 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.

## 7. Post Incident Debrief

7.1 It is essential that staff and patients have an opportunity to reflect and consider:

- The lead up to the need to apply physical restraint
- Physical restraint procedure followed
- Infection Prevention and Control Practise
- Revised risk assessment and care planning opportunities

7.2 Identifying what went well and what improvements should be made is essential in ensuring practise is person centred, safe and effective.

## 8. Wellbeing

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

## 9. References

9.1 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.

9.2 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

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

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

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

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

9.7 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>

© Crown copyright 2020

You may re-use this information (excluding logos and images) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit <http://www.nationalarchives.gov.uk/doc/opengovernment-licence/> or e-mail: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Scottish Government, St Andrew's House, Edinburgh, EH1 3DG