

Restraint Use and Delirium in Critical Care in England and Wales: A Current Law Review

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Abstract

Introduction: This is a law review of restraint use in critical care settings within the United Kingdom with a specific context to England and Wales following the introduction of new statutes and case law developments. The principles discussed could be similarly applied internationally, as the aim of health care is the preservation of life. Care delivery often proves difficult without the use of restraint considering the adversities delirium may present with as a common occurrence. Staff have to be aware of their role, duty, and limitations in legal terms and respond to challenging behavior appropriately and proportionately within the law.

Methods: As a law review, it follows arguments and principles around a topic by analyzing case law and statutory instruments specifically applicable to restraint use within critical care.

Conclusion: Restraint use in critical care settings in England and Wales is justifiable prior to formal authorization regardless the patient has or lacks capacity at the time as long as the restraint use is to maintain life-sustaining treatment or where an action could result in potential deterioration in the condition of the patient. However, there is a need to distinguish between on-going and life-sustaining care provisions. Restraint use in any case has to be in order to protect the patient from harm, enacted in the best interest of the patient, and has to be proportionate with the perceived likelihood of severity of likely harm occurring. Unless the delirium lasts or likely to last for over 28 days, no formal application is required should the need arise. Staff are empowered by statutory and case law measures to act with the use of appropriate restraint to protect their patients and those in close vicinity from harm. Regardless of national jurisdictions, the aim of critical care is to preserve life; hence, the findings within could be applicable internationally.

Keywords

restraint, critical care, capacity, delirium

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The Liberty Protection Safeguards (LPS) have recently replaced the Deprivation of Liberty Safeguards (DOLS), yet much confusion lingers about the subject of restraint use in critical care settings, such as Intensive Care and High Dependency Units (ICU). Most admissions to these units are the results of unforeseen events and any patient can be subjected to delirium due to the very nature of these care settings (Borthwick et al., 2006; Herling et al., 2018). Delirium may manifest in confusion, agitation, and erratic behavior from the patient (Herling et al., 2018) that could result in life threatening conditions, either from the behavior displayed resulting

in accidental or willful indwelling device removal, blood loss, sudden discontinuation of drug therapy, falls, slips or trips, without this being an exhaustive list (Benbenbishty et al., 2010; Borthwick et al., 2006; Gu et al., 2019; Perez et al., 2019).

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Staff providing direct care have to ensure patient safety with immediate actions to protect the patient from harm (General Medical Council, 2012; Health and Care Professionals Council, 2018; Nursing and Midwifery Council, 2015). Delirium may happen any time, given the range of various interventions, medications used, and the challenging and unfamiliar environments patients are exposed to during their critical care stay (Borthwick et al., 2006; Gu et al., 2019; Perez et al., 2019). While delirium may present with sudden onset, patient's capacity may also fluctuate (Borthwick et al., 2006). While this is largely predictable and in cases may also be preventable, there is no simple way of avoiding delirium (Borthwick et al., 2006; Herling et al., 2018). In many cases, physical contact beyond simple verbal interventions may often be required to safeguard the patient or others in their proximity. While it is generally accepted that hospitalization and patient care involves direct physical contact, the use of various forms of restraint in physical or chemical forms in legal terms require the application of the LPS principles under the Mental Capacity Act (MCA, 2019), or if applicable under the various sections of the Mental Health Act (MHA, 1983). Recurrent delirium and unreasonable actions would require the use of the LPS.

In practical terms, the use of gentle verbal persuasion may be less than adequate in many cases, requiring physical intervention in one way or another. Significant time and effort was previously required to complete a DOLS application, but most importantly, the time prior to the application being made is of crucial significance for the health-care team. Unfortunately, with LPS, there will be a similar need to do so, even if that is more simplified under the new legislation (MCA, 2019). The period leading up to the application of LPS/DOLS principles is of a "grey area" for most health-care professionals (Baharloo et al., 2018; Crews et al., 2014), during which important decisions have to be made quickly, in particular by nursing staff to safeguard their patients from harm.

The use of restraint in critical care settings worldwide is widespread and varies in accordance with cultural norms and legal systems (Benbenbishty et al., 2010; Cunha et al., 2016; Gu et al., 2019; Mitchell et al., 2018; Perez et al., 2019). Many have pointed out that the knowledge of nursing and medical staff regarding the application of physical restraint is very poor (Benbenbishty et al., 2010; Cunha et al., 2016; Li & Fawcett, 2014; Perez et al., 2019) and hence is the need for a review of this issue and the dissemination of findings to all concerned to better inform practice.

This is a significant issue affecting the daily practice of critical care staff, whose actions or omissions could potentially significantly affect patient conditions against their anticipated path toward recovery at times they are most vulnerable. How is restraint use justifiable up to the

point where a formal authorization is in place? The time leading up to the application of such decisions is of critical matter for all critical care staff, not only nurses.

Key Terms/Definitions

Delirium. An acute deviation in state of mind resulting in a loss of capacity.

Capacity. The capability of a person to make a decision for themselves through communication, comprehension, information processing, information retention, and sound reasoning (MCA, 2005).

Restraint. The use, or threat of use of force to secure an action against the wishes of an individual; or the restriction of an individual's liberty of movement, whether or not the individual resists (MCA, 2005)

Deprivation of Liberty. Any act or omission that limits the freedom of movement of an individual. This is enacted with the use of various forms of restraint or environmental factors. Lady Hale in Cheshire West has defined a condition simplifying if a person is "under continuous supervision and control and not free to leave" (§7), then they are deprived of their liberty. Applying this principle, all critical care patients are deprived of their liberty; however, as the Ferreira case sets out, critical care does not constitute a "state detention" (§12).

Critical Care. A hospital unit where life-sustaining treatment is provided through continuous care delivery for patients whose condition is likely to deteriorate rapidly without specialist intervention.

Life-Sustaining Treatment. A set of clinical procedures to sustain life where the likelihood of fatality is imminent otherwise

On-Going Care. A set of clinical procedures with the aim to rehabilitate an individual to their previous state of health or to improve their health through various means, where the individual's life is not at imminent risk.

Vital Act. An action which is believed to be necessary to prevent a serious deterioration in the condition of the patient (MCA, 2019). The difference in between a vital act and that of life-sustaining treatment can be elaborated as such that a vital act can be the use of restraint to provide the life-sustaining treatment, as well as broadly covering the terminology of life-sustaining treatment, although life-sustaining treatment may consist of a set of procedures involving multiple consecutive and simultaneous actions.

Brief Review/Discussion of Topic

Statutory Framework

In the United Kingdom, restraint use is based around the principles of capacity and mental health (MH), as outlined in the MHA (1983, 2007) and MCA (2005, 2019). These statutes all apply to the jurisdiction of England and Wales in general. In accordance with MH conditions, a person may be detained under sections of the MHA (1983, 2007) with the principal aim of treating the psychiatric condition and thus protecting the public, whereby accompanying physical health conditions may also be treated simultaneously.

With the application of the LPS/DOLS principles under the umbrella of the MCA (2005), particular activities may be limited at the moment following the application of appropriate notifications, which usually also involve a capacity assessment; while at the same time may or may not involve a best interest decision. LPS/DOLS are enacted as a result of a temporary deficiency in the person's capability during their ongoing care delivery; hence, the onus is on the enablement of care that restores the person's physical health to their previous state, unaffected by the illness for which they receive treatment at the time.

The extent of the MHA (1983, 2007) and MCA (2005) was limited to health-care settings, such as hospitals and care homes (Crews et al., 2014); however, with the MCA (2019) in effect, this restriction has been eliminated, and the principles outlined within can be enacted to any particular setting where care delivery can take place.

Neither LPS/DOLS under the MCA (2005, 2019), nor decisions under the MHA (1983, 2007) can be retrospectively applied; hence, the time leading up to their application results in ambiguity regarding the use of restraint in the absence of a formal authorization.

The use of DOLS is commonly restricted to, but not limited in its application solely for restraint use (Crews et al., 2014) and the new principles under the LPS apply similarly. The matter of restraint use is important to discuss both from medical, nursing and allied health professional perspectives, as delirium is a fairly common occurrence among critical care patients (Gu et al., 2019; Herling et al., 2018), whose actions may at any time prove fatal or bear significant consequences.

Critical care staff have to be aware of the extent and limitations of their professional liability and need to have a sound understanding of reasonable steps that may be used to safeguard their patients, should the circumstances require.

There is no clear definition on what a Deprivation of Liberty (DOL) is. According to MCA Code of Practice (MCA COP) §2(3) (2009), "the difference between deprivation of liberty and restriction upon liberty is one of

degree or intensity. It may therefore be helpful to envisage a scale, which moves from 'restraint' or 'restriction' to 'deprivation of liberty.'" For the avoidance of any doubt, this document presented to the reader defines a DOL as any act or omission that limits the freedom of movement of an individual via various modes of restraint use.

Restraint should always be used as a last resort under any circumstance in accordance with biomedical ethical guidelines (Beauchamp & Childress, 2001) and in accordance with MCA COP §6 (2007). Restraint use is warranted in law with the application of various statutory instruments, based on varied sections of the MHA (1983, 2007), and in accordance with the MCA (2005, 2019). Under MHA §§2-5 (1983), approved mental health professionals (AMHP) can apply their powers to "section" a patient following which restraint use is warranted on MH background; however, this is not the case with patients experiencing delirium, where the temporary state of confusion is not the result of an MH condition as defined by the MHA (1983, 2007).

During delirium principles introduced under the MHA (2007) amending the MCA (2005) applies, referred to as DOLS from hereon. Under MHA §50(4 [B]) (2007), restraint use is warranted on patients for life-sustaining treatment under particular circumstances given they are cared for in a critical care setting; with the purpose of providing "life-sustaining treatment, or a vital act," constituting "an action necessary to prevent a serious deterioration." Arguably most interventions on a critical care unit are necessary to avoid deterioration in patient condition, although where the boundary between life-sustaining and on-going care provisions lie is yet undefined. Nevertheless, restraint use as such is condition to the appropriate authorization made for the person in care at the time. The authorization of an application can be carried out by suitably qualified personnel in accordance with MCA COP §6 (2007) and the MHA (1983, 2007) by AMHPs, and under the new LPS (MCA, 2019) principles by approved mental capacity professionals. Critical care staff at times may be required to provide appropriate and immediate restraint to prevent "serious deterioration" (MCA §2, 2019) in patient condition. Under the MHA (2007), restraint use is permitted if the patient in question lacks capacity to consent to an act; whereby this action is in his best interest; where restraint use is necessary to protect the patient from harm; and that restraint is a proportionate response to the likelihood of the seriousness of the potential harm caused. Following suit, MCA §2 (2019) defines the conditions upon which a vital act may be enforced on a person similarly: (a) if the intention is partly or wholly to give life-sustaining treatment or doing any vital act where the vital act is believed necessary to prevent a deterioration in the care of the patient; (b) that the

steps are necessary to give the life-sustaining treatment; (c) where it is reasonable to suspect that the person lacks capacity; and (d) where there is an authorization under the LPS/DOLS principle in place for the patient in question or in case of an emergency.

The MCA (2005) replaces common law doctrines and provides a statutory framework for making decisions on behalf of people who may lack capacity to make decisions for themselves. Under the MCA (2005), a person is unable to make a decision when they cannot either understand the information given to them that is relevant to the decision; retain that information long enough to be able to make the decision; use or weigh up the information as part of the decision-making process; or communicate that decision. All care delivered to people without capacity must comply with the principles set out in the MCA (2005), which provides protection to both the person being treated for and to those delivering that care from potential liability provided there is a “reasonable belief” on their behalf that the person at the time was lacking capacity to consent for a particular decision and if the care delivered is in the best interest of the person. To act in line with the MCA (2005), appropriate steps must be taken prior to taking action (MCA COP, 2007).

The MCA COP (2007) specifically addresses emergency situations, whereby a person lacking capacity to consent requiring emergency medical treatment to save their life or prevent them from harm, the steps that are reasonable to perform will differ from those in nonurgent cases, specifically, that in emergency scenarios, it will almost always likely be in the person’s best interests to give urgent treatment without delay under MCA COP §6 (35) (2007). MCA §5 (2005) provides protection from legal liability in relation to the delivery of care of people without capacity; however, the lawful extents are not clear. On the other hand, MCA §5 (2005) emphasizes on no such cover against civil liabilities; furthermore, MCA §44 (2005) clearly establishes liabilities under negligence. This highlights that where there is a reasonable belief that immediate harm may result from an inaction; restraint use is always required. MCA §5 (2005) discusses restraint use and allows its use in certain situations. The key in applying reasonable use of force would be ultimately determined with the “Bolam test” at courts. Health-care professionals are legally required to “have regard to” (MCA COP, 2009, p. 8) the MCA COP (2007, 2009), and should be able to explain how they have had regard to it when acting or making decisions in connection with the care and treatment of a person who lacks capacity to make a decision for themselves.

Case Law

Capacity always has to be assessed before any action is taken, no matter how brief the situation may last

(Humphreys et al., 2014). Should a capacity assessment be required and should that demonstrate that a person in critical care lacks capacity, an LPS/DOLS application may be made either as a request for an urgent or standard authorization. DOLS were introduced into the MCA (2005) as a result of *HL v. United Kingdom* (2004), after a mentally incapacitated patient’s admission and treatment in a hospital was deemed as a DOL, which was concerned with the person lacking the capacity at the time to make decisions for himself and thus was unable to make a decision regarding his own care; and whether the patient’s best interest required detention or the use of restraints. The LPS replace DOLS following the Cheshire West ruling, although most of the principles applicable to the delivery of emergency care remain the same. Since the Ferreira case MCA §14 (2008) outlining the DOLS principles were not commonly applicable in critical care settings as any kind of DOL would likely have applied for less than 7 days in an ICU setting, besides the ruling goes in depth explaining “that obtaining authorisation for a DOL would divert medical staff in an ICU from caring for the patients.” Critical care induced delirium is usually short-lived, and usual patient stay is likely to be less than 7 days. However, the DOLS system was reviewed following the appeals of *P (by his litigation friend the Official Solicitor) v. Cheshire West and Chester Council and another and P and Q (by their litigation friend, the Official Solicitor)* (2011; referred to as the “Cheshire West” case), the U.K. Supreme Court has clarified the test for identifying a DOL where the living arrangements and care of a person who lacks capacity are concerned, in particular applying that a DOL takes place where a person is “under continuous supervision and control and is not free to leave” (§7). This in effect has lowered the threshold for application criteria, and has also broadened the scope of application to any setting, rendering the DOLS legislation ineffective. In practical terms this meant that in critical care settings people who lack capacity all fall under the criteria and thus should have been subject to DOLS. As a result, changes were made to the system resulting in the MCA (2019) introducing the LPS.

In *NHS Trust & Ors v. FG (2014)*, it was found that the application of DOLS was required based on the need for an invasive and intensive intervention to a person with “unsound mind,” as the treatment was materially different from that would have been for a person with “sound mind.”

In *R (Ferreira) v. HM Senior Coroner for Inner South London and others* (2017; referenced as the “Ferreira” case), it was found that “medical treatment in an ICU does not generally constitute a Deprivation of Liberty” (§12, §41, §49–50) as ICU treatment is “not state detention” (§12) as long as the person being cared for

is of “unsound mind” (§4-5, §19, §49), and that the treatment “would have been administered to a person who did not have her mental impairment” (§10), with “the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital” (§10) and as a result the person is “for perfectly understandable reasons, not free to go anywhere without permission and close supervision” (§39). This has been a most significant case, as Ferreira set out with a precedent that application of DOLS was not strictly required in a critical care setting. MCA §5 (2005) enables a hospital to give treatment to a person who lacks capacity to consent to it where the treatment is in the patient’s best interests. In fact, Ferreira goes in depth explaining

that obtaining authorisation for a DOL would divert medical staff in an ICU from caring for the patients. In any event, the vast majority of patients will be physically unable to leave because of their condition and because of the difficulty of withdrawing their treatment to enable them to leave safely” (§8).

This ruling has addressed concerns under Cheshire West in terms of critical care settings regarding the “continuous supervision and control” element of the setting and the element of patients not being free to leave these departments not resulting in “state detention.” However, there are a number of other considerations which have not been addressed by this ruling, but further raised concerns, regarding that capacity, for example, may fluctuate in critical care patients, in cases of defining what constituting emergency and ongoing care; the specific staff to whom this ruling applies to; what may apply when the root cause of a condition is the hospital; regarding the setting; also when considering that many critical care patients may also be detained by the police.

In contrast with Ferreira, in *London Borough of Hillingdon v. Neary* (2011), it was upheld that a DOLS authorization is required for ongoing care patients, accompanied by a best interest decision. It is important to recognize here the distinction made between treatment regimes.

In *Austin and others v. The United Kingdom* (2012), it was found that interference and restrictions on people by limiting their movement are justifiable based on a potential “loss of control” (§18). In *Commissioner of Police for the Metropolis v. ZH* (2013), the courts have found that it is lawful to deprive people of their liberty for short periods of time, although the extent of time has not been defined. In *Re P* (2014), it was upheld that in an emergency life-sustaining treatment is lawful, even if it amounts to a DOL without a formal application.

From another perspective, it is also important to examine the common law duty of care existing in between critical care staff and their patient, which also

considers the possibilities for negligence in case of omissions, in case an action could have prevented harm. Under *Donoghue v. Stevenson* (1932) with the application of the “neighbourhood test,” there is a duty of care between critical care staff and patient. Under the tort of negligence, critical care staff directly providing care are likely personally liable for omissions leading to harm. Critical care staff are also in a position of control over their patient, and it is reasonably foreseeable that harm would result from their inaction, regardless of the capacity of their patient at the time, as was established in *Home Office v. Dorset Yacht Co Ltd* (1970). Using the “Caparo test” as established in *Caparo Industries Plc v. Dickman* (1990), harm is reasonably foreseeable in case of a critical care patient allowed acting unreasonably resulting in injury to himself; where there is a relationship of proximity; and where it is fair, just, and reasonable to impose a duty of care toward the prevention of the foreseeable injury, which indicates that there is not only a personal civil liability, but also an institutional duty from the care provider.

In accordance with the “Bolam test” established in *Bolam v. Friern Hospital Management Committee* (1957)

a medical professional is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view” (p. 587).

Should the need arise for testing a particular case for negligence, the Bolam test is applied in determining what course of action should have been taken by others with specific knowledge under the same circumstances. Currently, there is no established best practice regarding restraint use on critical care units, as the circumstances will differ largely and there is ambiguity over what would surmount to life-sustaining treatment versus ongoing care provisions; however, it is arguable that a patient is admitted to critical care for a course of life-sustaining treatment, without which deterioration would occur, hence is the importance of treatment compliance, as determined by the appropriate personnel, which suggests that an act of restraint for the sake of preventing discontinuation of a treatment regime or deviation in treatment from care plans would be always a desirable course of action. Should best practice established be derived from professional code of conduct as relevant from the regulatory bodies, General Medical Council §26 (2012), Nursing and Midwifery Council §§15-16 (2015), and Health and Care Professionals Council §6 (1) (2018) all advocate toward prioritizing patient safety in their codes of conduct. Regardless of knowing

a person has been affected by an advance decision, MCA COP §5(29) (2007) sets out that emergency treatment “must not be motivated by a desire to bring about the person’s death,” hence the emphasis is on protecting the patient from harm above all, even if that requires the use of restraint at the time, although this yet remains untested.

Recent Developments

Provisions under the MCA (2019) have replaced many aspects of the DOLS legislation with LPS, although most aspects are only slightly different in implementation. The MCA (2019) has broadened the spectrum of application of the key principles outlined in the DOLS with regard to the specific setting considered under MCA §AA1(2[3]) (2019); however, it offers the same protection under MCA §1 (2019) when restraint use is required. The LPS carries new definitions and simplifies the conditions and hence the application processes for the enactment of the same principles outlined in MCA §2 (2005). Under MCA §AA1.2.2(2) (2019), the applicable age restrictions on DOLS have been widened down to apply from the age of 16 years. Under MCA §40(1) (2019), a new professional role is provisioned solely for the pre-authorization and review process in the form of approved mental capacity professionals. Under MCA §28 (2019), the specified timeframe within which an application can be authorized has been prolonged from seven to 28 days under the new legislative framework. This aspect of time lag in essence makes no difference from the previous for the critical care setting in relation to restraint use, and when this is read in conjunction with MCA §2 (2019) implies that no written authorization would be required for the use of restraint in critical care settings where the aim of the intervention is to provide a life-sustaining treatment. This is in line with the Ferreira ruling. The new legislation incorporates case law principles into the new statute, and while it does it does not replace the principles set out in Cheshire West, nor in the Ferreira case, all of these need to be considered with the use of restraint use on a case-by-case basis.

Conclusions/Importance to Nursing Profession

Timely, proportionate and reasonable steps are required to protect patients and others from immediate risk of significant harm in critical care settings in England, whether or not the patient lacks capacity at the time, which warrants the use of restraint, considering the very nature of interventions, even if the use of required restraint as such is carried out without formal authorization in certain situations to maintain life-sustaining treatment, or where deterioration in patient condition

is likely. Considering the opposite, by not acting in order to maintain patient safety, critical care staff may act negligently should harm occur as a result of their omission under MCA §28 (2019).

Implications for Practice

All health-care staff assigned to direct patient care have the same role in ensuring patient safety; however, as nurses are the staff group assigned most closely with direct patient care, they have to safeguard their patients from harm even if that requires the use of proportionate restraint. Proportionate restraint may require the need to involve the use of security personnel or assistance from colleagues and hence is the crucial importance of all to have reasonable understanding of the rationale behind the use of restraint given the circumstances.

This document does not advocate either for or against the use of restraint; however, it aims to ensure nurses’ are aware that it is in their right to use justifiable force should the need arise.

Key Points

There is no need to wait for a LPS/DOLS application for delirious patients on critical care units, unless their delirium is likely to last or have lasted over 28 days under the new legislation. Critical care staff should feel empowered by the discussed to act, as there may be situations whereby not acting is simply not a choice.

Should the need arise in the critical care setting, given the circumstances and in particular cases restraint use may be not only permitted but appears would be required to ensure patient safety. Due to the nature of critical care settings, any action endangering patient care or interference with patient care should be avoided; however, there is a need to distinguish whether the aim of the intervention requiring restraint use serves as “life-sustaining” or as “on-going” care provision.

Disclaimer

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