There are several types of restraints, including physical and mechanical restraints.

- **Physical (manual) restraint:** holding or immobilising the patient using physical force.
- **Mechanical restraint:** use of any means, methods, materials or clothing preventing or limiting the ability to voluntarily move all or part of the body for purposes of safety for a patient whose behaviour presents a serious risk for their integrity or that of others.

Mechanical restraint is an exceptional measure, limited in time, which is implemented at the decision of a psychiatrist, in accordance with the law on the modernisation of the French healthcare system of 26 January 2016, as part of a therapeutic approach, after a multidisciplinary consultation, which imposed the prescription for intensive monitoring and support.

The use of a mechanical restraint measure is a complex process, of last resort, justified by a clinical situation. The process itself includes numerous elements, decision, patient support, provision of care, monitoring, etc., which are implemented by various healthcare professionals from a care team in accordance with their fields of competence and responsibility.

*Only mechanical restraint is dealt with in this good practice guideline.*

### KEY POINTS

- Restraint is indicated exceptionally as a last resort, for a limited period and when strictly necessary, after patient evaluation and only in the context of seclusion.
- Mechanical restraint can only be practised in the context of seclusion. Only patients who are subject to involuntary psychiatric care may be placed in seclusion.
- Mechanical restraint is implemented by the decision of a psychiatrist, from the outset or secondarily.
- An interview and medical examination are performed when the mechanical restraint is implemented.
- A special prescription followup sheet must be present in the patient’s record.
- At the initiation of the measure, the indication is limited to 6 hours. If the state of health makes it necessary, the decision and prescription form must be renewed within these 6 hours. In the event of extension, the decision and prescription form must be renewed every 24 hours. Mechanical restraint beyond 24 hours should only occur in exceptional cases.
KEY POINTS (CONTINUED)

- The patient receives a minimum of two medical visits every 24 hours.
- It is essential that, when the mechanical restraint is implemented, the patient is given a clear explanation of the reasons for using restraint and the criteria for having it removed.
- A mechanical restraint measure must be implemented in conditions of adequate safety for the patient and the healthcare team.
- Mechanical restraint should be done in a seclusion space provided for and dedicated to this purpose in order to obtain a caring and secure environment, particularly in architectural terms. The patient’s privacy must be respected and rest and quiet must be allowed.
- The mechanical restraint should be removed, by medical decision, as soon as its continuation is no longer clinically justified.
- After the restraint is removed, the patient is offered the opportunity to review the episode with the team members. This results in a clinical analysis outlined in the patient record.
- After mechanical restraint, the multidisciplinary team must take time to review it.
- Each mechanical restraint measure must be recorded in a logbook, with the patient’s anonymity maintained. This logbook provides the name of the psychiatrist who decided on the measure, the date and time thereof, its duration and the names of the healthcare professionals monitoring the patient.

INDICATIONS

- Prevention of imminent violence by the patient or as a response to immediate, uncontrollable violence, with underlying mental disorders, with a serious risk to the safety of the patient or others.
- Only when less restrictive alternative measures have been ineffective or inappropriate, and where behavioural disorders lead to a substantial and imminent danger to the patient or others.
- Restraint is indicated exceptionally as a last resort, for a limited time and strictly necessary, after patient evaluation and only in the context of seclusion.
- The measure is completely justified clinically.

CONTRAINDICATIONS

- Never in order to punish, inflict suffering or humiliation or establish dominance.
- On no account to resolve an administrative, institutional or organisational problem or in response to a shortage of intereners or healthcare professionals.
- The clinical condition does not require restraint.
- A risk-benefit assessment should be performed when there are risks associated with the patient’s physical condition, an organic condition for which the diagnosis or prognosis may be serious.
METHODS OF IMPLEMENTATION

- Mechanical restraint can only be practised in the context of seclusion. Only patients who are subject to involuntary psychiatric care may be placed in seclusion.
- Mechanical restraint is implemented by the decision of a psychiatrist, from the outset or secondarily. In the latter case, the decision, which may be taken by the care team, must be confirmed within the hour following the start of the measure, after a medical examination to determine whether the mechanical restraint is justified and whether it should be continued or removed.
- An interview and medical examination are performed at the time the mechanical restraint is initiated, in order to:
  - assess the patient’s mental, emotional and physical status, with particular attention being paid to the cardiac and respiratory status;
  - explain to the patient the reasons for the restraint and the criteria that will enable it to be removed;
  - explain the monitoring that will be performed;
  - discuss, with the care team involved in implementing the measure, the factors that triggered the episode, the less restrictive measures used, the clinical reasons for the mechanical restraint and the clinical course of the patient in mechanical restraint;
  - identify and implement the care that will hasten the mechanical restraint being removed.
- The doctor should preferably be the psychiatrist treating the patient in the care unit. If the decision is taken by a resident or by a doctor who is not a psychiatrist, and during on-call periods, this decision must be confirmed by a psychiatrist within the following hour. This confirmation may be made by telephone on the basis of the information exchanged. This information must be documented in the patient record.
- A specific prescription form for the follow-up of the decision must be present in the patient record and should include:
  - the patient ID;
  - the start and end date and time of the mechanical restraint;
  - the name of the unit, the conditions of hospitalisation;
  - the reason for mechanical restraint, the risks of imminent or immediate uncontrollable violence towards others or towards themselves, clearly outlined;
  - details of what was unsuccessfully implemented beforehand, in order to document that the measure is being taken as a last resort;
  - investigation of contraindications to mechanical restraint;
  - the methods by which pharmacological treatment is administered, favouring oral route whenever possible, in an emergency, by completing the treatment form;
  - the methods used for monitoring, adjusted to the assessment of physical and psychological risks.
  - the instructions allowing the patient to eat, drink, go to the toilet or wash, clearly outlined.
- The patient should be ensured access to food, hydration and hygiene.
- At the initiation of the measure, the indication must be limited to 6 hours at most. If the state of health makes it necessary, the decision and prescription form must be renewed within these 6 hours. In the event of extension, the decision and prescription form must be renewed every 24 hours in consultation with the care team. The care team shall reassess the clinical status and may ask the psychiatrist to remove the measure at any time. The measure should not continued for longer than necessary. Mechanical restraint beyond 24 hours should only occur in exceptional cases.
- The patient receives a minimum of two medical visits every 24 hours.
- In no case should mechanical restraint become a routine procedure for a patient with at-risk behaviour. Every time a patient displays such behaviour, the authorised professionals must examine the underlying causes of this behaviour.
- Planned mechanical restraint is to be forbidden. The measure “as needed” may never apply.

LOCATION FOR IMPLEMENTATION

Mechanical restraint is associated with placement in seclusion. It may only happen in a dedicated space with specific equipment. Mechanical restraint can only be done when lying down.
EXCEPTIONS

In the context of severe psychiatric disorders with self-aggressive behaviour or repeated mutilations, and for the purpose of preserving the physical integrity of the patient, it may be possible to use an ambulatory mechanical restraint means such as restraining garments.

This restraint is not necessarily associated with seclusion and is applied in a specific care plan established by the psychiatrist treating the patient, outside an emergency context.

The use of this practice must be the subject of regular clinical evaluation.

These measures must be evaluated at the department level in order to strengthen analysis on the organisation of care.

MONITORING

- Each examination or monitoring must be recorded in the patient record, where a sheet may be identified listing the name of the carer, the date and time as well as the examinations or monitoring performed. In particular, this concerns:
  - observations and care performed during monitoring;
  - medical examinations performed;
  - food and drink consumed;
  - personal care (hygiene, elimination);
  - treatments administered;
  - visits by the care team and a statement of clinical status.

- The patient receives at least two medical visits per 24 hours in order to:
  - assess the patient’s physical condition, notably the risk of thromboembolic complication, as well as their mental condition and behaviour;
  - assess the need to continue the measure;
  - assess the effects of the pharmacological treatments;
  - reassess the frequency and nature of the monitoring to be performed.

- The care team may request the medical assessments to be performed more frequently if a change has been observed that would permit the mechanical restraint to be removed or if there is a deterioration in the patient’s physical or mental condition.

- The frequency with which the physical and mental condition will be monitored by the care team shall be defined by the doctor and shall be based on the therapeutic requirements and risk(s) presented by the patient/doctor. It therefore falls under the clinical judgment of the doctor.

- Monitoring of the mental condition by the care team shall be performed at least every hour and may even be continuous.

- The monitoring of physiological parameters (blood pressure, heart rate, oxygen saturation, etc.) shall be performed by the care team according to the medical prescription.

- Withdrawal syndromes are taken into account by offering substitution treatments, particularly for tobacco.

- Checking on the fastening points, skin condition and physiological needs of the patient is the role of the nurse.

- This regular monitoring of the patient should enable contact to be re-established, the alliance to be worked on, and risks of physical complications to be prevented. It is performed by at least two members of the care team:
  - with particular attention being paid to the patient’s mental condition and to any potential signs of exacerbation of the physical condition;
  - with particular attention being paid to signs of cardiac or respiratory failure;
  - taking into account hydration, nutritional status, hygiene and toilet needs.

- Any incident must be documented in the patient record.

- The prevention of thromboembolic diseases should be considered for each patient depending on the risk/benefit ratio, especially by prescription of an anticoagulant treatment.
Particular attention is given to patients with the highest physical or mental risks, particularly:
- extremely agitated patients;
- patients intoxicated with alcohol or psychostimulants;
- patients with a history of cardiac or respiratory disorders, morbid obesity, neurological and/or metabolic disorders;
- elderly patients;
- women during pregnancy and in the postnatal period;
- patients who have been abused in the past.

It is essential that, when the mechanical restraint is implemented, the patient is given a clear explanation of the reasons for using restraint and the criteria for having it removed.

The explanation must be presented in terms that the patient can understand and must be repeated, if necessary, to facilitate understanding.

It is necessary to explain to the patient what will happen during the period of mechanical restraint (monitoring, medical examinations, treatment, washing, meals, drinks).

In the pursuit of a therapeutic alliance with the patient, except in accordance with legislative provisions (adults under guardianship, minors) and in compliance with the code of ethics, the patient is asked whether they wish to notify their nominated representative or relative. In this case, the most appropriate means for delivering this information must be sought.

A mechanical restraint measure must be implemented in conditions of adequate safety for the patient and the healthcare team.

Departments should possess care teams tailored to daily needs with respect to psychiatric care and safety.

A sufficient number of carers must be present to ensure that the crisis situation is managed in a safe and effective manner.

In highly tense situations, the team must be able to identify the moment when the patient is still accessible and available for dialogue and the moment when this is no longer the case. This is the time when the team must act while maintaining verbal communication.

Part of the team is dedicated to the crisis situation, another part of the team cares for and reassures the other patients. A healthcare professional must provide leadership and coordinate the management of interventions.

It is necessary to delineate, as quickly as possible, a care room that is separated from other patients and to position the carers within the room near an exit.

If the unit doctor or on-call doctor is not present, he/she must be informed of the situation and asked to intervene as quickly as possible. If it is a doctor who knows the patient, he/she must be informed of the factors identified as explaining the crisis situation (frustration, intoxication, hallucinatory exacerbation, etc.). If an on-call doctor is involved, briefly explain the patient, the existence of contact persons, potential alliance factors, etc.

At the same time, reinforcements are requested for a support intervention. A healthcare professional from the unit concerned meets and informs the reinforcement team. The intervention by reinforcements must be subject to a written procedure, which specifies the role of reinforcements in a team strategy and can provide for scaled responses.
PATIENT AND CARER SAFETY – CONDITIONS FOR MECHANICAL RESTRAINT (CONTINUED)

- The teams must be educated and trained in the prevention and management of violence and in defusing techniques.
- Since somatic risks are increased in mechanical restraint, resuscitation equipment, including a defibrillator, oxygen, equipment for infusion and aspiration and resuscitation drugs, must be nearby and quickly available.
- The care team must be trained in first aid, and the doctors must be trained in the use of resuscitation equipment.
- The mechanical restraint measure must respect the rights of patients to dignity and respect of their physical integrity.
- The start and finish of every mechanical restraint measure is brought to the attention of the on-call hospital practitioner, the resident and the on-call supervisor.

PRACTICAL REALISATION OF MECHANICAL RESTRAINT

- Mechanical restraint should be done in a seclusion space provided for and dedicated to this purpose in order to obtain a caring and secure environment, especially architecturally. The patient’s privacy must be respected and rest and quiet must be allowed.
- The doctor present participates in the implementation of the mechanical restraint.
- The patient is immobilised by 4 carers (one per limb, each holding the upper arm and forearm or the calf and the thigh) and a fifth carer holding the head. During the implementation of the mechanical restraint, the patient's head must be protected while ensuring that they are always in a position that allows them to breath.
- Insofar as possible, a member of the team should supervise the implementation of the mechanical restraint to ensure:
  - the protection of the patient’s head and neck;
  - the ability of the patient to breathe;
  - the vital signs.
- In each licensed psychiatric facility designated by the regional health authority's director general to provide psychiatric care without consent, a specially trained security team can support carers for implementing mechanical restraint.
- The carer team:
  - ensures that the manual restraint before the implementation of mechanical restrain does not hinder the patient’s ability to breathe by applying pressure on the rib cage, neck or abdomen or by obstructing the mouth or nose;
  - applies justified, appropriate and reasonable force during manual restraint, proportional to the situation and for the shortest time possible;
  - ensures that the patient under restraint can turn their head to the side.
- The patient is lying supine, on an appropriate bed, each limb is held by a locked fastener. Depending on the level of restraint required by the clinical situation, a waist belt may be positioned. The material of the restraint and the fasteners must be appropriate to the weight and build of the patient.
- Never place a towel, bag or pillow on the patient's face, during or after implementation of restraint.
- If possible, the head of the bed should be raised to limit the risk of inhalation.
- Dangerous objects must be kept away from the patient (lighter, belt, sharp objects, etc.).
- A functional call device connected to carers must be accessible by the patient.
- If necessary, a sedative treatment is administrated from the outset, orally if possible.
- The room of the patient under restraint and in seclusion is kept available at any time as soon as their clinical condition improves.
- Patient management requires physical monitoring and interaction which cannot be replaced by a video surveillance system.
TERMINATION OF THE MECHANICAL RESTRAINT MEASURE

- The mechanical restraint should be removed, by medical decision, as soon as its continuation is no longer clinically justified.
- The care team can ask the doctor to terminate the measure at any time.
- Mechanical restraint cannot be maintained for organisational or institutional reasons, or as a response to the shortage of health professionals.
- The reason, time and date the mechanical restraint is removed must be documented in the patient record.
- Depending on the clinic, removing the mechanical restraint is not automatically associated with lifting the seclusion measure.

ANALYSIS WITH THE PATIENT AT THE TIME THE MECHANICAL RESTRAINT MEASURE IS TERMINATED

- After the restraint is removed, the patient is offered the opportunity to review the episode with the team members. This results in a clinical analysis outlined in the patient record.
- This analysis should enable:
  - mobilising the ability for self-control and identifying, together with the patient, possible alternative interventions in subsequent episodes and the factors that can be quickly identified to reduce the risk of a new incident;
  - listening to and recording the patient’s perceptions on the mechanical restraint episode and their relationship with the care team;
  - ensuring that the patient’s rights and physical and mental integrity were taken into account throughout the restraint.
- As soon as possible when the restraint is removed, and if the patient is accessible, it is important to help them understand the recent events that they experienced during one or more interviews that have several objectives:
  - to support and manage the patient after the episode;
  - to provide the patient with emotional support and to validate their feelings about the event: helping them talk about their distress and experience before, during and after the crisis;
  - To reinforce the relationship with the patient;
  - to inform the patient about the event;
  - together with the patient, to better understand the event so as to prevent its recurrence;
  - to help the patient understand, if possible, the internal factors that led to this crisis, as well as their symptoms;
  - to identify the contextual factors that could have contributed to the crisis;
  - to initiate or continue therapeutic education concerning the recognition of early warning signs and the identification of calming factors and resource persons.

REVIEW PERIOD BY THE MULTIDISCIPLINARY TEAM

- After mechanical restraint, a review period by the multidiscipline team must take place, consisting of:
  - performing a preliminary analysis with various points of view;
  - defining the clinical dimension;
  - recontextualising the patient’s behaviour;
  - performing an analysis of all the factors. Making a distinction between what pertains to the team, to the institution and to the patient;
  - identifying what could have been prevented and/or what enabled a resolution without violence;
● letting carers express their difficulties in the face of this practice, which is sometimes experienced with guilt; also allowing expression of fear or of the difficulty of taking care of a patient, who is or was behaving violently;
● reviewing what led to the restraint; the information on the restraint as well as its removal must be given to the entire team with full transparency, particularly to the members present on the day of the event;
● allowing the expression of difficulties encountered in the face of contradictory requirements and ethical dissonance;
● reflecting on the alternatives to restraint: reworking on prevention as a team, improving the relational capacity through the availability, reinforcement and qualification of the care team.

DATA COLLECTION AND ORGANISATION POLICY

An administrative logbook should be kept at each licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent, pursuant to Article 72 of Law 2016-41 of 26 January 2016.

● For each mechanical restraint measure, this logbook, while maintaining the anonymity of the patient, provides the name of the psychiatrist who decided on the measure, the date and time thereof, its duration and the names of the healthcare professionals who monitored the patient.
● The logbook, which may be in digital form, must be presented on request to the departmental committee for psychiatric care (CDSP), to the Controller-General of Prisons or their delegates, and to Members of Parliament.
● From the data collection, the care units, departments, sectors and the HCO medical committee (CME, commission médicale d’établissement) review the evolution of the number of mechanical restraint measures. The committee for hospital care, rehabilitation and medico-technical care (CSIRMT, commission des soins infirmiers, rééducation et médicotechnique) is involved in this work. The licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent should use this review as a basis to define a policy aimed at reducing the use of mechanical restraint. This policy should be supported by the presence of multidisciplinary care in healthcare units, which is adapted to the needs of relationship-based care. This shall be based, particularly in the case of new graduates, on a training programme in clinical matters and psychopathology as well as on training in the prevention of violence and de-escalation. The criteria for evaluating this policy should be defined (including in particular: number of carers trained in de-escalation, number of professional practice evaluations [PPE], specific protocols, etc.).
● Every year, the licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent establishes a report on mechanical restraint practices, the policy defined to limit their use and the evaluation of its implementation. The HCO medical committee makes it a focus of its policy on the quality and safety of healthcare and a part of its medical plan. This report must be presented for an opinion to the supervisory board and to the user committee (CDU, commission des usagers).
● Any adverse event subsequent to the mechanical restraint must be reported and be subject to team review, and possibly of feedback in serious cases (see Decree 2016-1606 of 25 November 2016 concerning the notification of serious adverse events associated with healthcare and regional facilities to support quality of care and patient safety).