

Policy Group: Clinical
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Approved by: Charity Executive Committee

Mechanical Restraint Policy

1. Policy Summary / Statement

St Andrew's intention is to follow the Mental Health Act Code of Practice and NICE guidance 10 on the management of violence and aggression (with one exception), in any application of the use of mechanical restraint. The general principles of the Least Restrictive Practice policy also apply.

'Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (CoP 26.75).

Mechanical restraint (MR) should only be used exceptionally, when other forms of restriction cannot be safely employed. It should adhere to the principles of least restrictive practice: be necessary and proportionate to the risk posed by the individual and the level of harm threatened; and used for the shortest time possible to ensure patient and staff safety.

MR should, ideally, be a planned intervention and should not be used to compensate for inadequate staffing (CoP 27.76).

Our policy and procedure will:

- Ensure that there is a clear framework for the consideration, authorisation, use and monitoring of mechanical restraint
- That MR is Board approved as per Regulatory requirements
- That it is used in a way that respects human rights and places as paramount the physical and emotional safety and wellbeing of the patient
- Ensure that the patient receives the care and support rendered necessary by use of mechanical restraint both during and after it has taken place
- As MR implies the use of a 'device', the policy and procedure will make clear the 'devices' approved for use in St Andrew's Healthcare.
- Ensure that only staff trained to safely apply an approved device are involved in device application.
- Recognise that NICE guidance states that MR should only be used in high secure services, but the Code of Practice does not make this distinction, and that the policy and procedure sets out the safeguards and process to allow use in our services.

When could MR be used?

In principle, MR should only be used when:

The benefits of the intervention outweigh the perceived risks, for example when a failure to intervene will result in significant harm or threat to life OR it presents the safest, least restrictive intervention, for example preventing the use of prolonged restraint or when other interventions carry a greater risk of harm to the patient or others

MR should never be used as an unplanned response to an emergency situation (CoP 27.76) and so the **circumstances in which one may predict consideration for the carrying of or use of MR** are:

- Escort of high risk patients to and from prison/ Court, or between healthcare settings, including to receive emergency treatment. There may be specific conditions from the Ministry of Justice, stipulating the carrying of handcuffs or the use of handcuffs in certain situations when a patient has to leave the secure perimeter. Metal handcuffs would only be used to transfer between St Andrew's and these settings and would not be used within in-patient environments.
- Prevention of serious high intensity and frequency deliberate self-harming behaviours that may result in prolonged physical restraint or requirement for rapid tranquillisation. Devices could include safer holding systems, soft cuffs and straps. See list of 'approved devices'.

What is not allowed:

- MR which involves tying an individual (using tape or their garments) to a part of a building or its fixtures should never be done.

Patient Subject to a Ministry of Justice Order

There may be occasions when the use of mechanical restraint (namely handcuffs) is required for security purposes when transferring prisoners into a healthcare setting, or for security purposes for the transfer of restricted patients in secure settings to non-secure settings. The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the patient, as well as their presenting physical and mental condition and the need to maximise their dignity. Escorting staff should alert medical staff to any identified risks if restraints were to be removed; however, if requested by medical staff, they should be removed whilst medical treatment is carried out.

On occasion, in high-risk cases, the Secretary of State for Justice will make permission for a restricted patient to leave hospital conditional on the use of restraint. Staff should discuss any concerns about this with Mental Health Casework Section.

2. Links to Procedures – MR Procedure

Policies and Procedures are available via the Policy A-Z SharePoint Page:
[Policies - Policies - A-Z \(sharepoint.com\)](#)

3. Monitoring and Oversight

There is a line of oversight and monitoring from the Board, to the Charity Quality, Safety and Assurance Committee, to the Safety Group, and the Restrictive Practices Monitoring Group, with a line of sight from each Integrated Practice Unit (IPU)/ Division Clinical Governance Meeting.

All aspects of the MR policy and procedure will be assured at multiple levels:

First Line Assurance- provided by front line staff who have received required induction, training and have access to the policy and procedure

Second Line Assurance- every use of MR is recorded on DATIX and should come to the attention of the Head of Operations and any daily triage function, who can review and ensure the policy and procedure was followed and use was justified.

Third Line Assurance- Quality business partners will undertake random and targeted audits to assure the accuracy of the previous levels of assurance. MR practice may also be audited as part of the central Charity Audit and Assurance Programme. The Restrictive Practice Monitoring Group will scrutinise any use of MR. A report on use of MR is submitted monthly to the Charity Executive.

Fourth Line Assurance- we will ensure we share, learn lessons and address any gaps in MR practice highlighted by external inspections of the service.

Data on rates of MR will form part of the Safety Framework dataset (as and when this is possible).

4. Diversity and Inclusion

St Andrews Healthcare is committed to *Inclusive Healthcare*. This means providing patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity, and not tolerating discrimination for any reason

Our goal is to ensure that *Inclusive Healthcare* is reinforced by our values, and is embedded in our day-to-day working practices. All of our policies and procedures are analysed in line with these principles to ensure fairness and consistency for all those who use them. If you have any questions on inclusion and diversity please email the inclusion team at DiversityAndInclusion@standrew.co.uk.

5. Training.

Staff should only use methods of restrictive interventions for which they have received training. All St Andrew's staff with clinical contact will receive de-escalation and physical intervention training and are required to attend 12-month refresher training.

All Doctors and Registered Nurses must complete annual training in Immediate Life Support.

Training records should record precisely the techniques for which a member of staff has received training

An e-learning module on Restrictive Practices and Seclusion is required to be completed by all clinical staff.

Training in application of MR will be done on a case by case basis by the Essential Skills Team when required, as the device and its application will be bespoke to that individual and this need cannot be met with generic training.

6. References to Legislation and Best Practice

- DH (2015) Mental Health Act Code of Practice
- DH (2014) Positive and Proactive Care: reducing the need for restrictive interventions. www.gov.uk
- NICE (2015) *Violence and Aggression: Short-term management in mental health, health and community settings. Updated edition* (NICE Guideline 10). London: NICE
- R (on application of Munjaz) v Mersey Care NHS Trust
- Care Quality Commission (2012) *The State of Health Care and Adult Social Care in England 2011/12*. London: The Stationery Office
- Care Quality Commission (2018) *Brief Guide to restraint (physical and mechanical)*. London: The Stationery Office

7. How to change or get an exception to this policy

Please refer to either the [Policy and Procedure Update Application Link](#)

Or the exception process [Policy and Procedure Exception Application Link](#)

8. Key changes

Version Number	Date	Revisions from previous issue
1.0	4.3.20	Rewritten into new Policy and Procedure Template
1.1	19.10.20	Minor adjustments by Deputy Medical Director