Policy Group: Clinical
Version no.: 1.3
Date of issue: June 2023
Approved by: Policy Oversight Group

Mechanical Restraint Policy

Contents

1. **Policy Summary / Statement** 2
1.1. **When could MR be used?** 2
1.2. **What is not allowed**: 3
1.3. **Patient Subject to a Ministry of Justice Order** 3
2. **Links to Procedures** 3
3. **Scope** 3
4. **Background** 3
5. **Definitions** 4
6. **Key Requirements** 4
6.1. **Stage One – Authorising Use of Mechanical Restraint** 4
6.2. **Stage Two** 5
6.3. **MR device storage, maintenance and replacement** 7
7. **Roles and Responsibilities** 7
8. **Monitoring and Oversight** 8
9. **Diversity and Inclusion** 8
10. **Training** 8
11. **References to Legislation and Best Practice** 9
12. **Exception Process** 9
13. **Key changes** 9
Appendix A - SRE used within the Charity 10
Appendix B - Notification of intention to use Handcuff 11
Appendix C - Mechanical Restraint Recording Form 12
Appendix D – Observation Continuation Sheet 14
Appendix E –Flowchart for MR Procedure 15

TARGET AUDIENCE (including temporary staff)	
People who need to know this document in detail	All frontline clinical staff
People who need to have a broad understanding of this document	Triumvirates and Exec
People who need to know that this document exists	Patients, carers, commissioners

1. Policy Summary / Statement

St Andrew's intention is to minimise any Use of Force and use Mechanical Restraint, only when absolutely necessary, proportionate and for the least time necessary. The wider principles of the Use of Force and Least Restrictive Practice Policy apply.

We also aim to follow best practice in the use of Mechanical Restraint, set out in the Mental Health Act Code of Practice 2015, NICE guidance 10 on the management of violence and aggression (with one exception), and the CQC Brief Guide to Restraint.

Our policy and procedure will:

- Ensure that there is a clear framework for the consideration, authorisation, use and monitoring of mechanical restraint
- That the practice of 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.

1.1. 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'.

1.2. **What is not allowed**:

- MR which involves tying an individual (using tape or their garments) to a part of a building or its fixtures is never appropriate and should not be done in any clinical situation.

1.3. **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

Mechanical Restraint Procedure

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

3. Scope

This applies to the application of mechanical restraint across all clinical services in St Andrew's Healthcare. Handcuffs applied by the police are covered by their own procedures, even if applied on St Andrew's premises.

4. Background

4.1. The use of Mechanical restraint will only be implemented as a planned intervention and only in circumstances that have been agreed as part of a specific care plan approved by the MDT.

4.2. All use of Mechanical Restraint requires Board oversight and approval as per regulatory expectations set out in the Brief Guide. All use of MR needs to be reported to the Board. This will be achieved in 2 parts: via the Clinical Director, the EMD and/or Chief Nurse will be made aware of any planned use of MR and its rationale for individual cases. Report on use of MR will go to Quality and Safety Group and then to the Board Quality and Safety Sub-Committee.

4.3. The care plan for Mechanical Restraint should target specific behaviours in specified circumstances. The care plan must be devised as part of a multi-disciplinary meeting and must include specifically the Responsible Clinician, consultation with the Division Senior leadership team and Essential Skills training team as well as an

IMHA (Independent Mental Health Advocate) (if appropriate). Document that you have involved the patient, family, carers, and case manager/ commissioner in the decision making.

4.4. Patient will have their own specific Soft Restraint Equipment (SRE) solely for their use and not to be shared with other patients. See Appendix A for approved devices.

4.5. SRE must be purchased from an approved supplier. Please contact the Essential Skills Team for the supplier list.

5. Definitions

'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).

6. Key Requirements

Procedure Detail

There are 2 stages:

1. Authorisation and care planning for use of MR – this has 2 steps
2. Monitoring during use, RiO recording requirements and post-restraint debriefs for staff and patient

6.1. Stage One – Authorising Use of Mechanical Restraint

Step One

- Authorisation of the use of MR must be made by a multidisciplinary team (MDT), which must include a Responsible Clinician, a qualified nurse and at least one other MDT member. If the patients has an IMHA (Independent Mental Health Advocate) or IMCA (Independent Mental Capacity Advocate) they should also be involved. The patient and their carers should be involved in the discussion as far as that is possible and the plan must be fully explained to the patient and their carers (with patient permission). Involvement of a member of the Essential Skills (Safety Interventions) team would also be advisable. The local case manager and commissioner should also be consulted at this stage.
- The RiO Mechanical Restraint Care Plan should be completed
- The MDT authorisation will be expected to enable the Nurse in Charge to make the decision to use MR.

- Use of MR should be referenced as a tertiary strategy on the patient's Positive Behaviour Support Plan (CoP 26.77). It must be evident that primary and secondary strategies to manage the behaviour will be employed before use of MR (unless use of MR is stipulated by a legal directive). The full details of the plan can be recorded in the care plan.

- **Care Planning –** this will vary slightly between care planning for use of handcuffs (for external escorting) and care planning for use of Soft Restraint equipment (to use within ward environments)- both are captured within the MR care plan in RiO (see Appendix B)

- Care Plans for Ward use of SRE should provide clear instruction for:

    - To what part of the body it is to be applied
    - where within the ward the patient will be when the Soft Restraint Equipment (SRE) is applied
    - what observations and care are necessary
    - review requirements
    - maximum duration of application
    - which piece/pieces of Soft Restraint Equipment would be used
    - who is authorised to use it

- Staff are not trained in and **should not apply handcuffs to a resistive patient** and clear contingency plans to address such a situation must be in the care plan.
- Issuing of handcuffs – metal handcuffs are currently kept by security and issued based on completion of a short form by clinical staff, confirming there is a care plan and appropriate authorisation in place. The NIC can complete this form and **it does not require involvement** of the duty doctor routinely (assuming there is a MR care plan in place that has been updated within the last month).

Step 2

- Once a care plan is in place, the Clinical Director of the Division (or the Service Director or the Associate Director of Nursing) will seek approval via the Executive Medical Director and/or Chief Nurse (a Board member) for each case. This is to ensure appropriate Board approval but being responsive to individual clinical need. This approval should be in place, before the use of mechanical restraint, unless the circumstances are exceptional. Even in exceptional, unanticipated cases, there must be an approved MR care plan which can be approved by the RC on call. This should only apply to handcuff use as SRE use has to be bespokely developed.

6.2. **Stage Two**

- Once the MR has been applied, the patient must remain under continuous observation, usually at arms length.
- Every 15 minutes, the patient needs a review by a qualified nurse throughout the period of MR - **this must be recorded in the MR observation form (attached to this procedure)**

- The use of the MR observation form and monitoring requirements is applicable to all types of MR, whether use of metal handcuffs or use of SRE.
- The patient must be reviewed by a Registered Medical Practitioner within one hour and then every 4 hours after the MR has been applied.This review can be undertaken by any grade of medical staff employed by St Andrew's Healthcare. The review must evaluate the physical and mental health state of the patient. The Code of Practice does not specify whether the reviews have to be face to face or verbal, so either method is suitable. If the patient is off-site, then verbal reviews may be more pragmatic.
- In most scenarios, the doctor should be informed as soon as possible that MR is being applied, and if there are significant physical health concerns, then a face to face review should occur.
- If there is a concern, the nurses can request a medical review earlier than the next planned review.
- Verbal or face to face reviews should be recorded as having occurred in the MR Observation Form.

- When MR is used, the following must be recorded in the patient's electronic progress notes:
  - the rationale for the decision to mechanically restrain the patient (there would have already been a care plan explaining the circumstances MR could be used)
  - other options attempted to de-escalate the patient which explain that MR was used as a 'last resort'.
  - time medical and psychiatric assessment undertaken and by whom
  - the patient's condition at the beginning of mechanical restraint
  - the response to mechanical restraint and
  - the outcomes of the medical reviews
  - Staff checks on patients SRE and recordings of these checks.
- A Datix event form must always be completed when MR has been used.
- After use of MR, as per the Least Restrictive Practice policy, there should be a post restraint debrief for patients and staff, co-ordinated by the nurse in charge or with the support of the trauma team if a comprehensive/ trauma support debrief is required.
- The Nurse in Charge of the ward is responsible for ensuring that all associated documentation is in order and has been correctly completed and verified

Exceptions to the above:

- If the use of MR is such that a patient is unable to leave the area (e.g. being unable to reach or operate door handles) then this will amount to seclusion (if staff not present) or long term segregation (if staff present but not peers). In these circumstances, the seclusion or LTS policies should be followed
- MR should never be used as an alternative because a safe seclusion environment is not available (CoP 26.86).
- If the use of MR is long term for the management of recurrent DSH and self injurious behaviour, then a different monitoring frequency can be agreed between the MDT and the patient, carer and/ or advocate, but which still ensures appropriate maintenance of the safety and wellbeing of the patient. Every attempt should be made in these patients PBS plans to have periods without use of MR. This situation may apply to those with severe cognitive

impairments. Use of devices such as arm splints are referenced in the Code of Practice as devices that may be considered. *However, the device must meet the criteria for MR i.e. it must restrict or subdue movement –if the device merely protects and reduces harm e.g. a padded cap or helmet, hip protector, but does not restrict or subdue movement, then this does not constitute MR*. These situations, which are extreme, should have the proposed device 'approved' on a case by case basis with the MDT team, Safety Interventions (Essential Skills) team and patients/ carers/advocacy and may not be on a standard approved list as the device may be bespoke to that individual. Use will also need to be approved via Step 2 outlined above.

6.3. **MR device storage, maintenance and replacement**

- SRE are for individual patients only. They should be kept securely on the ward. Once not needed, they should be returned to the Essential Skills team.
- The Essential Skills Team can advise the SRE required on a case by case basis, if it is fit for purpose and where the SRE can be purchased from.

Handcuffs: at present these are held and maintained by security.

Key Documents			
Name of form	**Where to find the form**	**Who to complete**	**Frequency of completion**
MR care plan	RiO care plan section	MDT	Monthly review
MR observation form	Upload to document store	Nursing	Per episode
MR authorisation form	Word document	NIC	Per episode

7. **Roles and Responsibilities**

Role	Responsibility
EMD/ Chief Nurse	To discuss and approve cases brought by the divisional leadership To ensure a report is provided to the Board/ Board Sub-Committee
Divisional Triumvirate	To ensure EMD/ Chief Nurse informed of planned use of MR and that it has been appropriately care planned
MDT	To appropriately care plan and ensure MR is only being used when other primary and secondary prevention measures have not been effective
Essential Skills Team	Bespoke training and advice on equipment
Learning and Development Team	Maintain the content and quality of training materials and ensure there is access to relevant staff
Central Audit Team	To audit aspects of MR practice as part of a central audit programmes as required

8. Monitoring and Oversight

There is a line of oversight and monitoring from the Board, to the Charity Quality and Safety Committee, to the Quality and Safety Group, and the Restrictive Practices Monitoring Group, with a line of sight from each 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 every 2 months to the Quality and Safety Group and then into the Quality and Safety Committee (Board level sub-committee).
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).

Use of Force data for protected characteristics will be monitored, minimum 6monthly, and part of ward to board governance

9. Diversity and Inclusion

St Andrew's 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.

10. 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.

Mechanical restraint is referenced and an awareness given on both the refresher and initial course.
There is an e-learning package that covers the theory of mechanical restraint and legal aspects.

Then two differing face-to-face sessions,

- Handcuff Training , covers conventional metal handcuffs and soft cuffs.
- Soft Restraint Equipment Training, covers use of the soft restraint kit containing belts and other apparatus if required.

Training is delivered at the request of clinical areas: **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**

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.

11. References to Legislation and Best Practice

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

12. Exception Process

Please refer to the exception process Policy and Procedure Exception Application Link

13. 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
1.2	7.03.2023	Roles and Responsibilities added and clarified; Training section expanded; updated to include reference to MR care plan on RiO
1.3	21.06.23	Removed Appendix B – renamed appendices

Appendix A - SRE used within the Charity

Examples of Soft Restraint Equipment devices available for teams within the charity

1. Soft Restraint Belt Kit

Three belts that can be used to restrict movement of parts of the body. Can also be used to relocate patients to safer areas by putting handles onto the body. Enables staff to lift, support and move patients to safer areas.

Kit contains 3 belts and 3 sets of soft cuffs.

2. Soft Cuffs

Provides an alternative to more traditional metal handcuffs used for transfers or transport of patients. Can be used in conjunction with Soft Restraint Belts to manage risk from patients

3. The Safer Holding System

A piece equipment that combines a soft restraint belt with soft cuffs. To be used to manage patient engaging in self-injuring behaviour and minimise the use of manual physical restraint from staff.

Appendix B - Notification of intention to use Handcuff

Patient Initials	
Ward	
RiO ID	
MHA Status	

Name of current RC	

Date Handcuffs Required	

Confirmation there is an RC authorised MR care plan and date of completion/ review to be within last month:	

Request made by:	

Please upload to RiO document store and can be printed to show security if needs be

Appendix C - Mechanical Restraint Recording Form

Ward…… **Datix. No:**

PATIENT'S NAME:		RiO number	
DETAIL IN THE AREA BELOW SPECIFIC DETAILS FROM THE MEETING HELD AUTHORISING THE USE OF MECHANICAL RESTRAINT			
IS THERE A MECHANICAL RESTRAINT CARE PLAN AUTHORISING USE OF MR?		DATE OF CARE PLAN DATE of LAST UPDATE (last update should be no longer than 1 month)	
MECHANICAL RESTRAINT DETAILS			
WHAT BEHAVIOUR WAS EXHIBITED PRIOR TO THE INTERVENTION?			
IS THIS STATED IN THE PLAN? YES		NO	
STATE WHAT DEVICE WAS USED			
TIME MECHANICAL RESTRAINT DEVICE WAS APPLIED			
SIGNED (NIC)			
TIME RC / DUTY DOCTOR INFORMED			
TERMINATION OF MECHANICAL RESTRAINT			
DATE TERMINATED		TIME TERMINATED	
DURATION OF MECHANICAL RESTRAINT IN MINUTES			
ANY DAMAGE TO THE DEVICE THAT NEEDS REPAIR BEFORE NEXT USE? Yes/No			

DECISION MADE BY	NURSE IN CHARGE	NAME	DUTY DOCTOR / RC	

POST MECHANICAL RESTRAINT REVIEW

POST MECHANICAL RESTRAINT REVIEW WITH PATIENT PATIENTS PERSPECTIVE	YES/NO (IF NOT, WHY) SUMMARISE
LESSONS LEARNED AND ANY ACTIONS TAKEN?	
WHO FACILITATED THE POST MECHANICAL RESTRAINT REVIEW?	
WERE ANY INJURIES SUSTAINED BY THE PATIENT AS A RESULT OF USING THE DEVICE? PLEASE STATE	
NAMES OF OTHER STAFF INVOLVED IN THE REVIEW (IF ANY)	

Appendix D – Observation Continuation Sheet

RECORD OF MECHANICAL RESTRAINT OBSERVATIONS DATE:

TIME	OBSERVATIONS – OF PHYSICAL and PSYCHOLOGICAL Health TO BE DOCUMENTED EVERY 15 MINUTES ; time of medical reviews can be noted here as well; if applicable, note food and fluids offered and taken	SIGNATURE / PRINT NAME Must be Qualified Nurse

Appendix E –Flowchart for MR Procedure