NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

Positive and Safe, Recognition, Prevention and Management of Violence and Aggression (PMVA) Practice Guidance Note **Safe Use of Mechanical Restraint Equipment – V04**		
Issued **Issue 1 – Jun 18**	**Planned review** **Jun 21**	**PMVA-PGN-01** Part of NTW(C)16 PMVA Policy
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A. Use of Mechanical Restraint Equipment

1 Introduction

1.1 There are no restraint positions which can be considered safe and there is no safe time limit for duration of restraint (Aiken F, 2011) yet, the use of mechanical restraint equipment in Healthcare settings remains a contentious, sensitive and emotive aspect of clinical practice. Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) recognises that in some circumstances the use of mechanical restraint devices may provide the safest and least restrictive means of managing challenging behaviour that presents a high risk of harm to the individual patient and/or others; it may also be a favoured option in a statement of advanced wishes. This guidance should be read in conjunction with the documents and flowcharts in appendices 1-12. The following points, 1.2 – 1.11, must be considered as part of the decision making process prior to the use of emergency restraint equipment.

1.2 The Mental Health Act Code of Practice 1983 (updated 2015) states, “Restraint which involves tying (whether by means of tape or by using a part of a client's garments) to some part of a building or to its fixtures or fittings must never be used".

1.3 NTW acknowledges that the use of mechanical restraint may have harmful outcomes for some services users. As such the use of mechanical restraint should be an exceptional clinical event. Restraint equipment must never be used as a punishment, in a punitive manner or as a substitute for inadequate staffing levels. Staff must always act within the NTW values framework.

1.4 Mechanical restraint devices must only be used where they are a reasonable, proportionate and justifiable response to the risk posed by the patient.

1.5 Mechanical restraint devices must only be used where the patient is unresponsive to de-escalation techniques and other interventions, following risk assessment.

1.6 Mechanical restraint devices must only be used where:

- the benefits of the intervention outweigh the perceived risks involved for example, failure to intervene will result in harm, risk to life; or
- the use of equipment as an intervention has been identified in advance decisions by the patient; or
- other interventions present a greater risk due to specific individual patient presentation; or
- this presents the safest, least restrictive intervention, for example, prevents prolonged use of prone restraint .

1.7 Mechanical restraint devices must only be used where the patient has a known history of absconding, combative and resistive behaviour and is presenting a threat of harm to self or others or if there is an immediate risk of significant harm if the equipment is not deployed

1.8 Mechanical restraint devices must only be used where continued application of physical intervention (PMVA) techniques would place the patient and/or staff at increased risk of physical distress and/or injury due to evidence based documented risks associated with prolonged physical restraint.

1.9 The National Institute for Health and Clinical Excellence (NICE) guidance NG10 stipulates mechanical restraint should only be used in high secure services or in the transfer of patients from medium secure to high secure services. The mental health Act 1983 code of practice however does not make any such stipulation but reinforces necessity and least restrictive intervention based on a robust risk assessment. Additionally NICE Guidance NG10 acknowledges:

- **"The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient"** (National Institute for Health and Clinical Excellence, 2015).

1.9.1 This guidance note reflects the principles outlined in the above statement.

1.10 The Trust recognises the requirement for an individual assessment of risk to be carried out prior to the use of mechanical restraint equipment. This must be conducted by the patient's clinical team and be recorded in a care plan agreed via the Care Programme Approach / Multi-Disciplinary Team (CPA/MDT).

1.11 The principle of least restrictive intervention, as outlined in the Mental Health Act 1983 Code of Practice, must be addressed in the risk assessment process. The decision making process to demonstrate considerations in relation to alternative interventions must be recorded.

1.12 This practice guidance is in place to support practice in relation to the management of high risk situations in services for children under 16 years of age, young people age 16 -17 and adults 18 and over (age definitions from MHA1983 Code of Practice – updated 2015).

1.12.1 NICE guideline NG10 states that mechanical restraint should not be used on children and only used on young people in high secure services, however their definition of child is someone twelve years of age or younger.

1.12.2 The MHA 1983 code of practice makes no reference to the use of mechanical restraint on older children or young people. NTW advocates incorporating assessment of the older child's size, strength, emotional and physical maturity when planning the use of restrictive interventions including mechanical restraint on this group as per NG10 guidance.

1.13 Any decision to deploy mechanical restraint equipment must be made with reference to the legal and ethical principles described in the use of restraint equipment training sessions. Restraint equipment must only be deployed by staff members that have successfully completed training in its use, and remain competent to do so.

2 Context

2.1 Scenarios where restraint equipment **may** be used include:

- The escort of high risk patients for court hearings
- The transfer of patients to prison
- The transfer of high risk patients to a general hospital for a routine appointment or to facilitate emergency treatment
- The emergency internal transfer of a high risk patient, for example to Psychiatric Intensive Care Unit (PICU) and/or seclusion
- The prevention of serious harm to the patient
- The prevention of serious harm to staff or others
- To avoid a prolonged manual physical restraint and the associated risks to health

3 Purpose

3.1 **The scope of this practice guideline includes:-**

- Expert advisory and legislative framework
- Duties, accountability and responsibilities
- Specification, cleaning, storage, and application of restraint equipment
- Staff training requirements
- Clinical considerations regarding the use of restraint equipment
- Risk assessment
- Safeguarding
- Record keeping and reporting
- Related policy documents

4 Expert advisory/legislative framework

4.1 This practice guidance has been developed with reference to the following documents and other relevant statutory legislation, for example, Health and Safety at Work Act:

- The Code of Practice for the Mental Health Act of 1983 (updated 2015) and in particular Chapter 26
- National Institute for Health and Care Excellence NG10 – Violence and Aggression – Short Term Management in mental health, health and community settings (2015)
- The Human Rights Act 1998 – In particular article 2 (Positive Obligation to Preserve Life); article 3 (Prohibition of torture and degrading treatment); article 5 (Right to liberty and security) and article 8 (Right to respect for private and family life)
- The Mental Capacity Act 2005
- Safeguarding practices and the promotion of patient's welfare – Trust policies NTW(C)04 Safeguarding Children and NTW(C)24 Safeguarding Vulnerable Adults at Risk
- Care Coordination including Care Programme Approach Policy - NTW(C)20
- Trust policy NTW(C)16 – Positive and Safe, Recognition, Prevention and Management of Violence and Aggression
- NTW Positive and Safe Strategy
- NTW Clinical Risk Strategy

5 Duties, Accountability and Responsibilities

5.1 The Chief Executive has overall responsibility for ensuring that the Trust complies with statutory and legislative requirements and positive practice guidance. This responsibility will be delegated to appropriately qualified Trust officers.

5.2 Operational and Clinical managers must ensure clinical risk assessment is formulated and records are up to date. Manager must also ensure that the staff team is adequately trained to carry out informed risk assessment and complete the required documentation.

5.3 Clinical teams must work collaboratively to agree the individual care plans based on a robust assessment of clinical risk. Reviews must be carried out in line with NTW Clinical Risk Strategy and the Trust's NTW(C)20 - Care Programme Approach Policy.

5.4 Staff deploying restraint equipment must be trained and updated by NTW tutors and act in accordance with legislation, Trust policy NTW(C)16 – Positive and Safe, Recognition, Prevention and Management of Violence and Aggression, plus associated practice guidance as outlined in training.

5.5 The application of the mechanical restraint equipment approved for use in the Trust (that is handcuffs, soft-cuffs, Soft Restraint Belts - SRB, Emergency Response Belt - ERB®, and will be outlined in individual plans in response to robust MDT risk assessment

5.6 NTW Trust Board will receive an electronic report detailing the number of times the mechanical restraint equipment has been deployed in services.

6 Definition of Terms

- **Hinged handcuffs** - Handcuffs joined by a metal hinge which restricts the range of movement of the wearer. To be used to handcuff the patient's hands together

- **Softcuffs** – durable and strong cloth material with Velcro which is designed to create two loops through which the hands are place. They may be used to secure the patient's hands together or to the Emergency Response Belt/Emergency Soft Belt. The principles for use of the soft-cuffs are exactly the same as the use of hinged handcuffs

- **The Emergency Response Belt (ERB) and the Soft Restraint Belt) -** are made out of a tough cloth material. The purpose is to provide a protective restraining device that allows staff to safely manage, relocate and de-escalate patients who present a risk to themselves or others and may be physically violent.

- **Care planned use** – a situation when advance notice of a planned event is available or presenting risk is known

- **Unplanned use** – the Mental Health Act Code of Practice indicates that emergency use of mechanical restraint equipment should not occur. It is however recognised that an unforeseen situation, where failure to intervene could result in significant harm or risk to life (such as a crisis situation to maintain the safety and security of the patient or others, transport for urgent medical treatment), may require an immediate unplanned intervention to ensure compliance to legal and ethical aspects of duty of care.

- **Secure area** – a designated place such as an identified ward or seclusion area where the restraint equipment may be removed

7 Principles of safe and therapeutic practice

- Clinical risk assessment of disturbed behaviour will determine the need to consider the least restrictive intervention to maintain safety and security
- Restraint equipment provides secure control of the person's limbs which minimises the ability to cause harm to self and others
- Restraint equipment offers a secure alternative to patients who do not like to be physically held by staff, isolated in seclusion or sedated
- Restraint equipment can provide a sense of security and containment to patients unable to control their impulses
- Restraint equipment enables staff to relocate a patient safely and effectively
- Restraint equipment, to a degree, limits the patient's ability to run thereby reducing the risk of absconding
- Adequate (minimum of two) staff must be available to safely manage the patient in restraint equipment
- Associated risks must be considered in relation to moving and handling, slips, trips and falls
- The physical and psychological impact of restraint must be addressed in accordance with the individual's history and presentation. This must include reference to advanced wishes outlining the patient's choice whenever possible
- The dignity of the patient must be maintained
- Poor application or positioning of the restraint equipment can cause discomfort and/or soft tissue damage
- Restraint equipment must not be used as a replacement for adequate staffing
- Clinical teams must make explicit in recording how consent is sought and how any inability, or refusal to give, consent is managed in the clinical decision making processes.

7.1 Risk assessment

- The application of any restraint equipment must be based on robust clinical risk assessment. The risk assessment and subsequent intervention must be recorded. The narrative risk assessment may be used for this purpose.
- The multidisciplinary clinical team will assess the risk and determine

the need for the use of secure transportation and assess if restraint equipment will need to be deployed. The risk assessment may be carried out in consultation with a third party where relevant, for example, planned escort by secure transport providers (or police) - See section 7.1.1.

- Based on clinical risk assessment, there may be situations identified where the mechanical restraint equipment is required for an extended period of time. An example of this may be an increased risk of harm to the patient or others if the equipment is removed or if removal is likely to lead to a prolonged manual physical restraint. In such circumstances the mechanical restraint equipment may remain in situ until the patient violent behaviour has de-escalated to a level that staff believe it is safe to remove it. The legal, ethical and safety considerations identified in other sections of this document must be adhered to when considering this course of action and its duration. The rational for any extended use must be recorded and reviewed as part of the post incident process.

7.1.1 Planned use of restraint equipment by third party with clinical escort

- If the application of the restraint equipment is by the third party the responsibility for safe application of the equipment will sit with the third party. The clinical escort will monitor the service user and assess any ongoing risk in consultation with the third party. The third party providing transportation will be responsible for the safe conveyance of all passengers.

7.1.2 Planned use of restraint equipment by third party without clinical escort

- In rare circumstances restraint equipment may be deployed by a statutory body, e.g. police or prison service personnel, to facilitate arrest or transportation, without clinical staff escort. In this circumstance the duty of care for the individual service user will be transferred to the responsible statutory body.

7.1.3 Unplanned use of restraint equipment by third party in an emergency

- The use of restraint equipment in an emergency situation will, when possible, be informed by a risk assessment that involves clinical staff and the third party, e.g. police. However, situations may occur when it is necessary for the intervention to be determined by the responding police officers. In such circumstances the duty of care will be handed over and risk managed in accordance with police procedures.

8 Procedure

8.1 Care planned use of mechanical restraint equipment - (see flowchart Appendix 1)

8.1.1 The planned use of restraint equipment will be for the purpose of relocating/escorting a patient to an area/location out with their current location or safely managing behavior that presents a risk to the patient or others.

8.1.2 Safeguarding principles must be adhered to and all use of restraint equipment must be subject to a robust Multi-Disciplinary Team (MDT) post incident review process.

8.1.3 A comprehensive assessment of risk with specific reference to absconding and/or violence towards self or others must be carried out and recorded by the MDT for each planned use of restraint equipment.

8.1.4 The subsequent risk management plan must include preventative (primary) and reactive (secondary) measures specific to the individual which are designed to prevent the individual's behaviour escalating to the point when restraint equipment or other tertiary interventions become necessary.

8.1.5 Evidence of a decision making process must be available which highlights risks versus benefits of using restraint equipment.

8.1.6 The decision making process must include; why restraint equipment is considered appropriate, what alternatives were considered, why other alternatives were not appropriate and the factors considered to inform the decision. This should be recorded in the patient RIO notes and the FACE risk updated accordingly. An updated risk management plan must be entered in the narrative risk section by a responsible senior clinician.

8.1.7 The MDT must liaise with the relevant Director for authorisation to care plan use of restraint equipment. Authorisation must be recorded in the care plan; the name of the authorising officer, date and time must be specified. The clinical decision to deploy mechanical restraint equipment rests with the multidisciplinary team. Clinical advice can be sourced by the team from appropriately qualified clinicians. Authorisation for use by the responsible Director is in line with governance and monitoring arrangements. The clinical authority and responsibility is held by the requesting clinicians.

8.1.8 All members of the MDT involved in the decision making process and authorising Directors must attend a familiarisation event which covers the legal and ethical aspects of using restraint equipment.

8.1.9 All staff applying restraint equipment must be in date with NTW PMVA training, immediate life support training and restraint equipment training.

8.1.10 Restraint equipment training consists of a 1 day training course which is competency assessed and delivered by appropriately trained PMVA tutors. Attendance on a refresher course as outlined in the Trust's policy NTW(C)16 –

Positive and Safe, Recognition, Prevention and Management of Violence and Aggression is required.

8.1.11 A minimum of 2 staff must be available to deploy Handcuffs/soft-cuffs at least one of whom is trained in the application of handcuffs.

8.1.12 A minimum of 2 ERB®/SRB trained staff must be available to deploy this equipment with an additional 2 members of staff available in case the patient needs to be relocated.

8.1.13 The number of ERB/SRBs being used will be dependent on the risk assessment. A minimum of 3 belts will be required if the patient is to be carried.

8.1.14 A minimum of 4 staff are needed when carrying a patient in ERB/SRBs

8.1.15 There must be recorded evidence of the patient's and, where appropriate, nearest relative's views regarding the use of restraint equipment

8.1.16 An appropriately trained PMVA tutor should be invited to attend a case review to constructively "challenge" the planned use of restraint equipment and offer advice or suggestions for less restrictive interventions.

8.1.17 A care plan must be in place explaining the need for restraint equipment, the circumstances surrounding its use, physical health, psychological and emotional issues, safety issues and care of the patient during and after use of restraint equipment.

8.1.18 During planned escorts the care plan must state if the equipment should be used for the entire duration of the escort or as a contingency measure in the event of escalating risk.

8.1.19 Any deployment of restraint equipment must be within the context of the care plan. The nurse in charge is responsible for ensuring this occurs and that the staff involved in the restraint process are fully briefed.

8.1.20 Safeguarding aspects must be taken into consideration with respect to vulnerable adults/children; appropriate documentation must be completed.

8.1.21 Authorisation for planned use of restraint equipment will be a joint decision between the MDT from a clinical perspective and the Director responsible for the service from an organisational governance perspective. Any disputes must be taken to the Security Management Director/Executive Director of Nursing and Operations.

8.1.22 The Mechanical Devices Authorisation check list (Appendix 13) must be completed and circulated securely to clinical nurse manager and associate director, for planned authorisation/re-authorisation and mechanical restraint equipment care plan requests.

8.1.23 Prior to deploying mechanical restraint equipment for planned use the nurse in charge must refer to Appendix 1 of this document.

8.1.24 Ongoing need must be reviewed at MDT monthly and re-authorisation confirmed as necessary with the authorising Director.

8.1.25 A care plan for use of restraint equipment must be submitted to the authorising Director along with the request for authorisation.

8.1.26 The care plan must include the following:

- Clinical Issues and rationale for ERB/SRB
- Process issues with regard to adherence to trust policies in relation to primary, secondary and alternative tertiary interventions in place
- Why other tertiary options are not appropriate
- Mechanics of ERB/SRB, for example, number of belts used
- Complications and mitigations e.g. physical health issues
- Safeguards e.g. MDT members involved in decision, parental consent, advance decision in place
- Body map noting any known injuries prior to use
- Post incident body map must be utilised following mechanical restraint use (or reasons why this has not occurred must be clearly documented)

8.2 Un-planned use of restraint equipment (see flowchart Appendix 2)

8.2.1 It is recognised that there may be certain circumstances when the level of risk of harm indicates the use of mechanical restraint equipment.

8.2.2 This refers to an unforeseen situation where failure to intervene could result in significant harm or risk to life such as a crisis situation to maintain the safety and security of the patient or others, transport for urgent medical treatment.

8.2.3 In such circumstances the senior clinician in charge must decide if an unplanned application is necessary, proportionate to the risk presenting, and ethically justifiable.

8.2.4 For unplanned use the nurse in charge must refer to the decision making flowchart to determine if the use of restraint equipment is appropriate (Appendix 3).

8.2.5 The incident form and patient RIO notes must include a detailed description of the risks presenting, alternatives considered and the rational for the use of the restraint equipment.

8.2.6 All staff applying restraint equipment must be in date with training (including Immediate Life Support - ILS) as outlined in section 7.1.

8.2.7 Unplanned use of handcuffs must only occur if there is a minimum of 1 handcuff trained staff member available and an additional member of ERB /SRB staff to provide support.

8.2.8 Unplanned use of ERB/SRB must only occur if there is a minimum of 2 ERB/SRB trained staff available and an additional 2 members of staff to provide support.

8.2.9 Following the unplanned use of MRE, the relevant Group Director to be informed of its use, (via email) as soon as possible after the event.

8.3 Application of Mechanical restraint equipment

8.3.1 Consideration must be given to patient dignity when applying or removing restraint equipment. Whenever possible application and removal of restraint equipment must be carried out in a private area; this may necessitate the need to remove other patients and visitors from the vicinity.

8.3.2 Once applied, the restraint equipment will remain in situ until the patient has reached the designated secure area or risk assessment has determined that the patient has de-escalated and it is safe to remove the equipment. The exception to this may be clinical need such as essential medical treatment e.g. X-Ray.

8.3.3 When not in use the restraint equipment will be stored in the pouch provided. The handcuffs and key will remain in the possession of the lead escort. A spare key will be carried by a second member of staff.

9 Escorts

9.1 The nurse in charge will be a first level registered nurse (RMN/RMNH) at band 5 or above.

9.2 All escorts will be in date with PMVA, restraint equipment and Immediate Life Support (ILS) training.

9.3 All escorts will have received a briefing and be familiar with the risk assessment and plan of care agreed.

9.4 The lead escort will provide a handover to receiving staff on return to or arrival at the designated area.

10 Engagement and observation

10.1 While restrained in restraint equipment the patient must be in the care of at least 2 members of staff at all times, one of whom must be the same gender as the patient.

10.2 Staff observing the patient must continually attempt to engage the patient in order to re-establish the therapeutic relationship, problem solve and de-escalate the situation in order to facilitate safe removal of the restraint equipment.

11 Post incident

11.1 Reporting and recording

- The electronic incident reporting system and patient's RIO notes must be completed for each incident requiring the use of mechanical restraint equipment. This is necessary for care planned use and unplanned use. The patient RIO notes and FACE risk must be updated accordingly.
    - In accordance with NTW(C)16 PMVA Policy, there must be continuous physical health monitoring of anyone subject to restraint and at least 2 hourly post restraint monitoring for up to 24 hours as required
    - In addition to physical observations the patient will be offered a 'body check' (external, visual and always witnessed) by nursing or medical staff as appropriate. This should be recorded in the patient's RIO notes
    - If the patient declines a body check the reason for this must be recorded and a check carried out as soon as the patient consents. Any injuries sustained or marks must be recorded and appropriate treatment arranged as necessary
- Details on the electronic incident reporting system must be completed in full and the narrative should include the following;
    - Who initiated deployment of the restraint equipment
    - Why restraint equipment was requested
    - What alternatives were tried before considering deploying restraint equipment
    - Names and designations of staff who applied the restraint equipment
    - Duration of application
    - What mechanical restraint equipment was used and application sites
    - Equipment application sites must be recorded
    - Patient response to being in restraint equipment e.g. stopped resisting, became irate, panicked
    - Final outcome e.g. successful de-escalation, seclusion

- The carers of any patients under 18 years of age must be informed of each use of mechanical restraint equipment, unless MDT agreement and the wishes of the patient with capacity indicate otherwise

- The clinical team must inform the case coordinator for any child under local authority care of each use of mechanical restraint equipment.

- Any marks or bruising on a patient who has been subject to mechanical restraint must be reported through line management and the Trust Safeguarding Team at the earliest opportunity. Parents /families/carers must be contacted as per MDT agreement. Any marks or injuries must identified on a "body map" (Appendix 4 and 5) and the completed body map must be scanned into RiO.

11.2 **Post incident review**

- Post incident review/debrief must be carried out as per Trust policy NTW(C)16 – Positive and Safe, Recognition, Prevention and Management of Violence and Aggression; NTW(O)05 - Incident policy (including the management of Serious Untoward Incidents) regarding After Action Review

- Constructive challenge in relation to use must be carried out during post incident review by the Clinical Nurse Manager of the service area concerned.

- The patient's risk assessment should be reviewed to identify any new risk indicators.

- The patient's care plan should be reviewed to identify if there is a need to modify it.

- Where possible the patient must be included to collaborate in their future management plans in order to inform advance wishes.

- Patient must be offered access to independent support e.g. Advocacy.

- Staff involved must be offered post incident support via the clinical management team.

- Any unplanned use of restraint equipment must be discussed within the MDT to fully explore the reasons for the incident, learning from the incident and potential need for an ongoing restraint equipment care plan.

12 Safeguarding

12.1 Safeguarding lead must be informed of intention to include restraint equipment as a management strategy for violent behaviour on patients under the age of 18 and should be included in the decision making process

12.2 Report to be sent to safeguarding lead on the amount of restraint equipment use via the electronic incident reporting system specifically identifying those under the age of 18 years.

12.3 The safeguarding team may be contacted for advice for patients over the age of 18 years should there be any concerns

13 Training

13.1 Training consists of a 1 day competency assessed course which includes a theoretical and practical component

13.2 The theoretical component will include;

- Moral and ethical issues
- Legal issues
- Patient safety
- Patient care
- Risk assessment
- Reporting and recording
- Post incident procedures

13.3 The practical component will include:

- Safe application and removal of restraint equipment
- Relocating patients using restraint equipment
- The use of handcuffs/Soft-cuffs® with the ERB®,SRB
- Priority for training will be given to areas identified as high risk for violence as indicated by the electronic incident reporting system or areas where there is an identified individual presenting a significant risk to self and / or others

- Training will only be delivered by PMVA tutors who have had additional instruction in teaching use of restraint equipment. Cascade training is not permitted.

- Only staff who have successfully completed the 1 day restraint equipment course may be involved in the application/removal of restraint equipment

- Prior to attending restraint equipment training staff must be up to date with PMVA and ILS training

- To remain up to date staff must attend a 1 day annual refresher

13.4 Implementation

13.4.1 This is a specialised training package delivered only to staff members who work in areas with an identified need based on clinical risk assessment. Restraint equipment use is not considered routine practice.

13.5 Embedding

13.5.1 This will occur via the specialist PMVA related course described in this document. This training will only be delivered to staff working within the areas identified as requiring mechanical restraint equipment following risk assessment and training needs review.

13.5.2 The training department will maintain an up-to-date list of restraint equipment tutors and restraint equipment trained staff.

13.5.3 Ward areas will maintain an up-to-date list of restraint equipment trained staff.

14 Monitoring

14.1 All use of restraint equipment to be recorded in line with incident reporting procedures.

14.2 Audit

14.2.1 The Positive and Safe steering group will receive monthly reports and facilitate audit and service evaluation in response to any emerging themes. Themes will include:

- Areas of high use
- Incidences requiring restraint equipment use
- Reasons for use
- Duration of use
- Impact of use
- Injuries sustained

14.3 Locality governance groups outlined in the NTW Positive and Safe Strategy will monitor use in services and have in place restraint reduction implementation plans in place.

15 Procurement of equipment

15.1 Equipment may only be obtained from a recognised provider. Requests for equipment should follow the process outlined in Appendix 5.

16 Care and Storage of the restraint equipment

16.1 Restraint equipment must be kept in a locked cupboard with the key maintained under the supervision of the nurse in charge.

16.2 Restraint equipment must be checked on a monthly basis using the checking form (Appendix 9 and 10.)

16.3 Maintaining equipment

16.3.1 The handcuffs must be given a visual inspection after each use to check for signs of damage. Any damage, faults with operation or missing keys must be reported to the Senior Nurse on Duty immediately.

16.3.2 The belts must be given a visual inspection after each use to check for signs of damage/decay.

16.3.3 If the ERB®/SRB/Softcuff is soiled, machine-wash and hang to dry. A mild anti-bacterial soap may be used as needed. Do not place the ERB®/SRB/Softcuff in a clothes dryer, as the heat may damage the threads and weaken the ERB®/SRB/Softcuff.

16.4 Faulty equipment must be withdrawn from use and clearly identified as out of use but remain stored in the locked cupboard until removal for repair or disposal. The Ward Manager must request authorisation from the Associate director to replace any damaged equipment. The Safer Care Group medical devices coordinator must be notified if any equipment is taken out of operational use for audit purposes.

16.5 Advice can be obtained from the infection prevention team in the event of soiling from blood or bodily fluid.

17 Associated documentation

- NTW Positive and Safe Strategy
- NTW Clinical Risk Strategy and associated practice guidance note

Clinical Policy Documentation

- NTW(C)01 - Resuscitation Policy
- NTW(C)02 - Rapid Tranquilisation Policy
- NTW(C)10 - Seclusion Policy
- NTW(C)16 – Positive and Safe Management of Violence and Aggression Policy

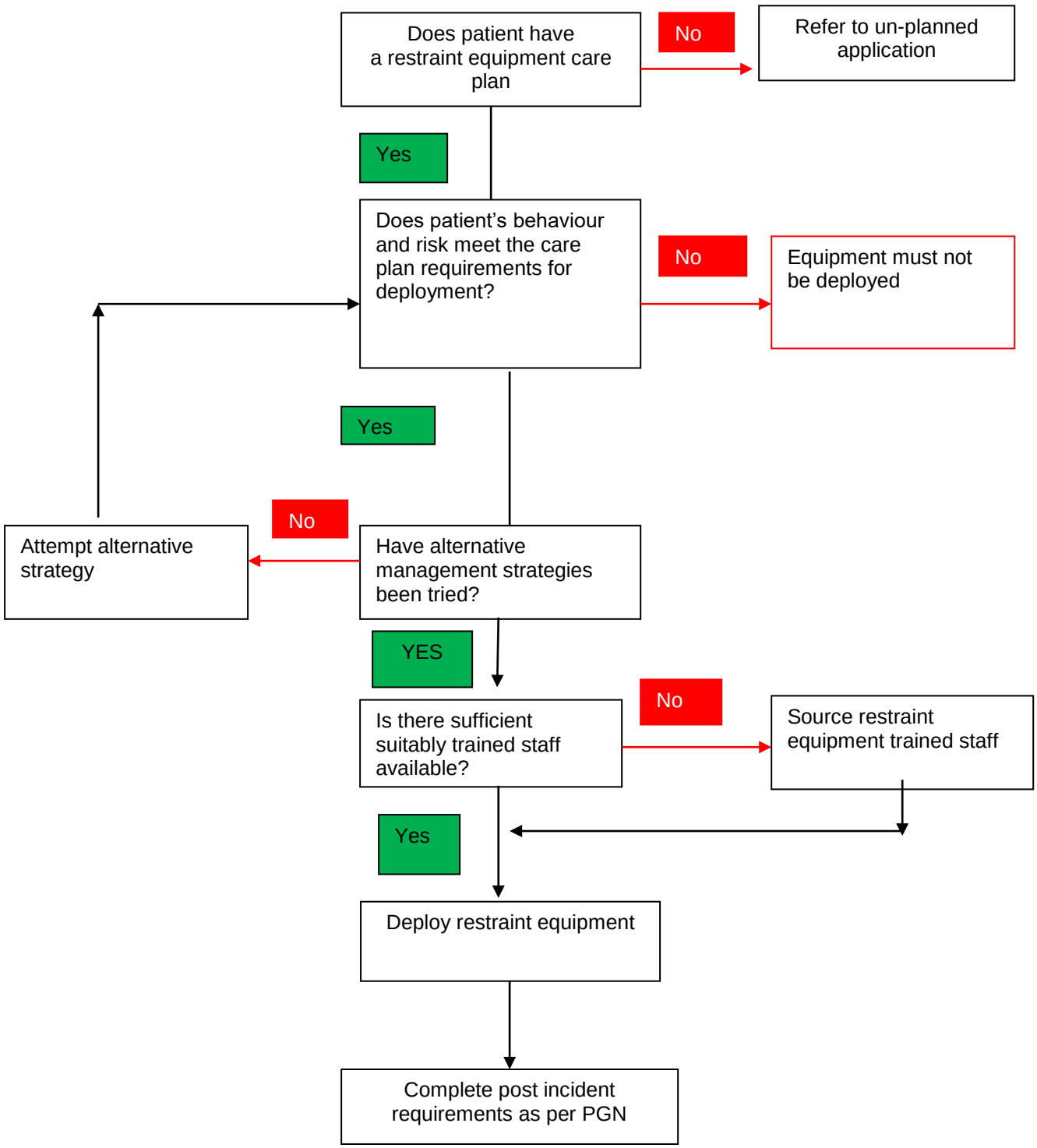
- NTW(C)19 – Observation Policy
- NTW(C)20 - Care Coordination and Care Programme Approach Policy
- NTW(C)34 – Mental Capacity Act Policy
    - MCA-PGN-02 – Advance Decision to Refuse Treatment and Advance Statement PGN
- NTW(C)36 – Deprivation of Liberty Policy
- NTW(C)55 - Mental Health Act Policy

- NTW(O)01 - Development and Management of Procedural Documents Policy
- NTW(O)05 – Incident Policy and practice guidance notes
- NTW(O)08 – Emergency Preparedness, Resilience and Response (EPRR) Policy
- NTW(O)21 – Security Management Policy and Practice Guidance Notes
    - SM-PGN-01 - Closed Circuit Television (CCTV) PGN
    - SM-PGN-02 – Lone Working PGN
    - SM-PGN-06 - Police Liaison PGN
    - SM-PGN-11 - Managing Offences PGN
    - SM-PGN-15 - Guidance on the aftercare with the use of Taser and CS Incapacitant Spray (CS) PGN
- NTW(O)42 – Equality, Diversity and Human Rights Policy
- NTW(O)37– Transport Policy and practice guidance note
    - TP-PGN-08 – Secure transport

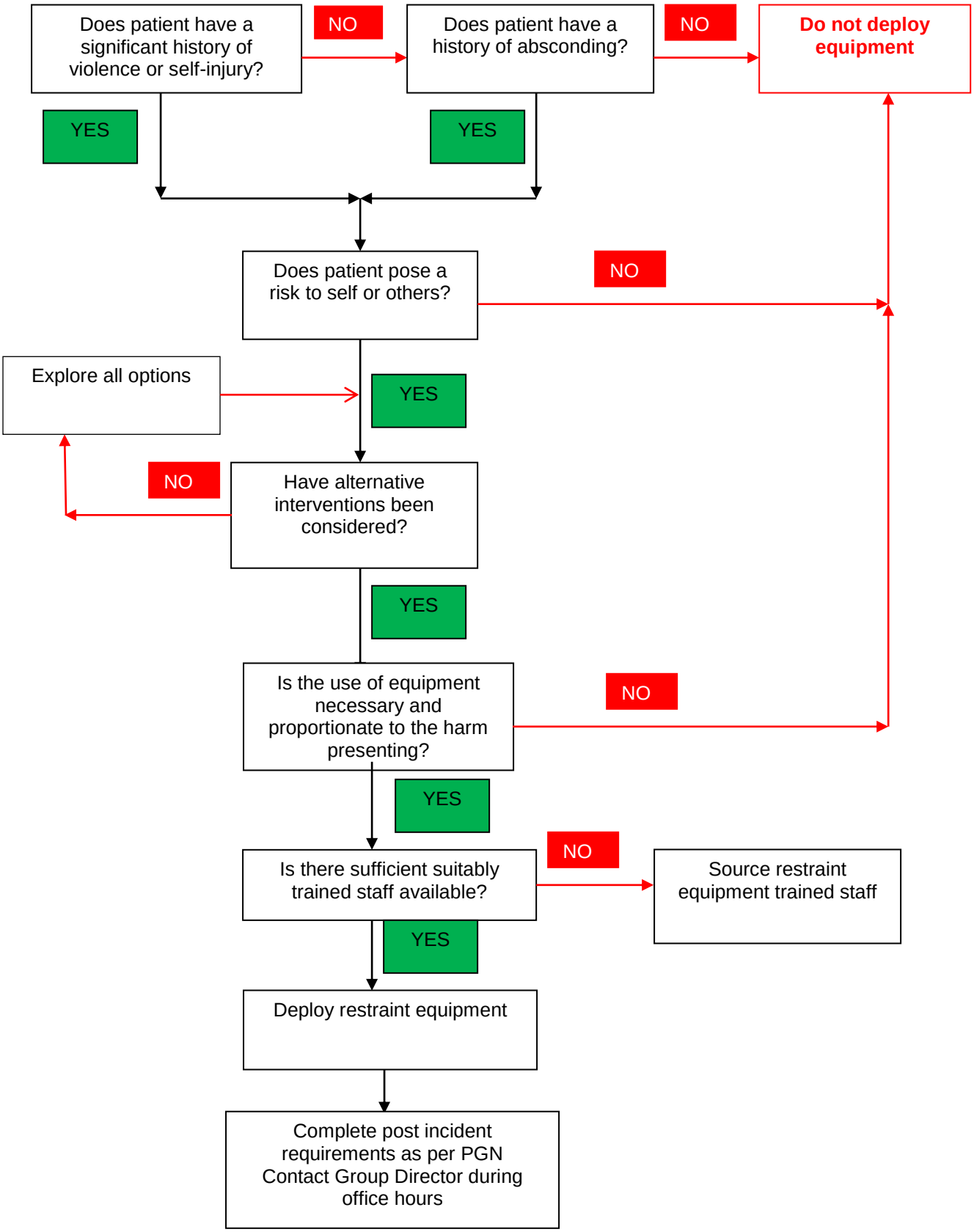
Appendix 1

Decision making flowchart

Care planned use of Mechanical restraint equipment



Decision making flowchart
Un-planned use of restraint equipment Appendix 2

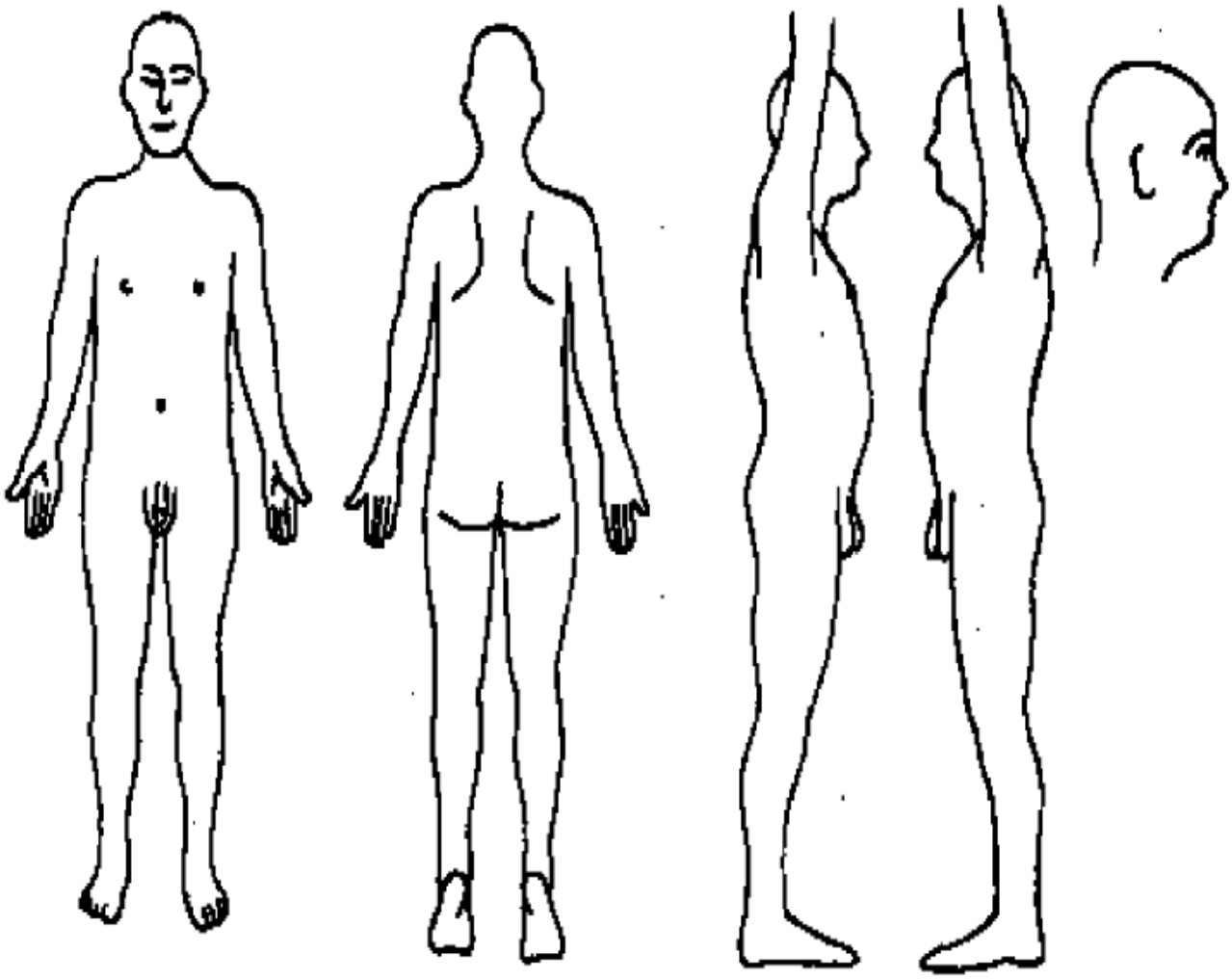


Appendix 3


Gather information and intelligence
Assess threat and risk and develop a working strategy
Consider powers and policy
Identify options and contingencies
Take action and review what happened
Code of Ethics

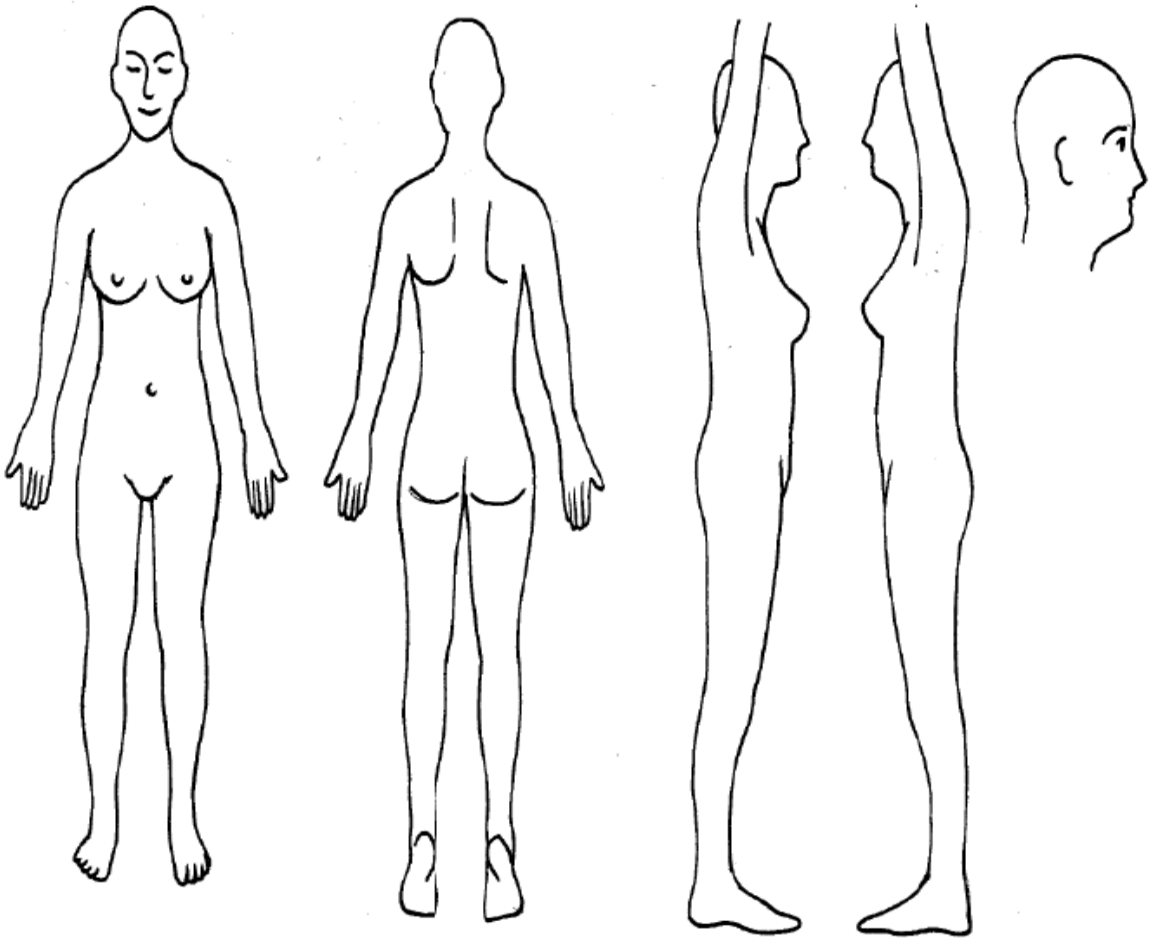
Appendix 4

Body map (male)



Appendix 5

Body map (female)



Appendix 6

Suggested care plan / reporting considerations

Care Plan

Context/need

In this section describe the circumstances which determine the need to use mechanical restraint equipment;

e.g. is this a once only requirement for escorting a patient outside a secure area; will this be an ongoing care plan to manage high risk behaviour such as self-harm or violence? Has there been a significant risk incident that necessitated unplanned use?

Decision making process

Explain why it was considered appropriate to agree to using mechanical restraint equipment;

What discussions were held and with whom;
What alternative strategies were considered and why they were rejected;
Include risk factors in this section;

- What kind of behaviour is anticipated
- Describe previous risk behaviour
- Current state of mind
- Current behaviour
- Who is at risk
- What are the anticipated benefits of using Mechanical restraint equipment
- What type of equipment will be used

For escorting requirements the patient should be considered a risk of at least one of the following:

- Risk of absconding
- Risk of harm to self
- Risk of harm to staff
- Risk of harm to the public

Has the plan to use mechanical restraint equipment been discussed with the patient/next of kin?

- If yes what was the response
- If not, why not

Plan

For an escort include details such as:

- Destination
- Reason for journey
- How many staff will be escorting the patient (include gender)
- What type of Mechanical restraint equipment will be taken
- Expected duration if known
- Who is identified as lead escort
- Is Mechanical restraint equipment to be used for the entire duration of the journey or is it part of a contingency plan
- Under what circumstances will the Mechanical restraint equipment be applied/removed

If the escort is for a social reason such as a home visit describe:

- Who will be at the destination (names and relationship to the patient)
- What course of action to be taken if unexpected people are there

For longer term care plans

- Describe the relapse indicators

- Describe preventative measures to be employed to prevent the use of restraint/Mechanical restraint equipment use e.g. de-escalation strategies

- Describe the intended use of Mechanical restraint equipment e.g. to transport the patient to a safe area; to maintain safety during the de-escalation process

- Location for de-escalation

- How the patient's dignity will be maintained e.g. privacy

- How the patient will be reintroduced to the ward milieu

- Describe the behaviour required from the patient to remove the Mechanical restraint equipment

For all circumstances describe how

- Will patient dignity be maintained
- To safeguard the patient's physical health
    - Breathing
    - Blood flow to extremities
    - Comfort
    - Psychological wellbeing
    - Post incident debrief arrangements

Practice Guidance for the use of Restraint Equipment

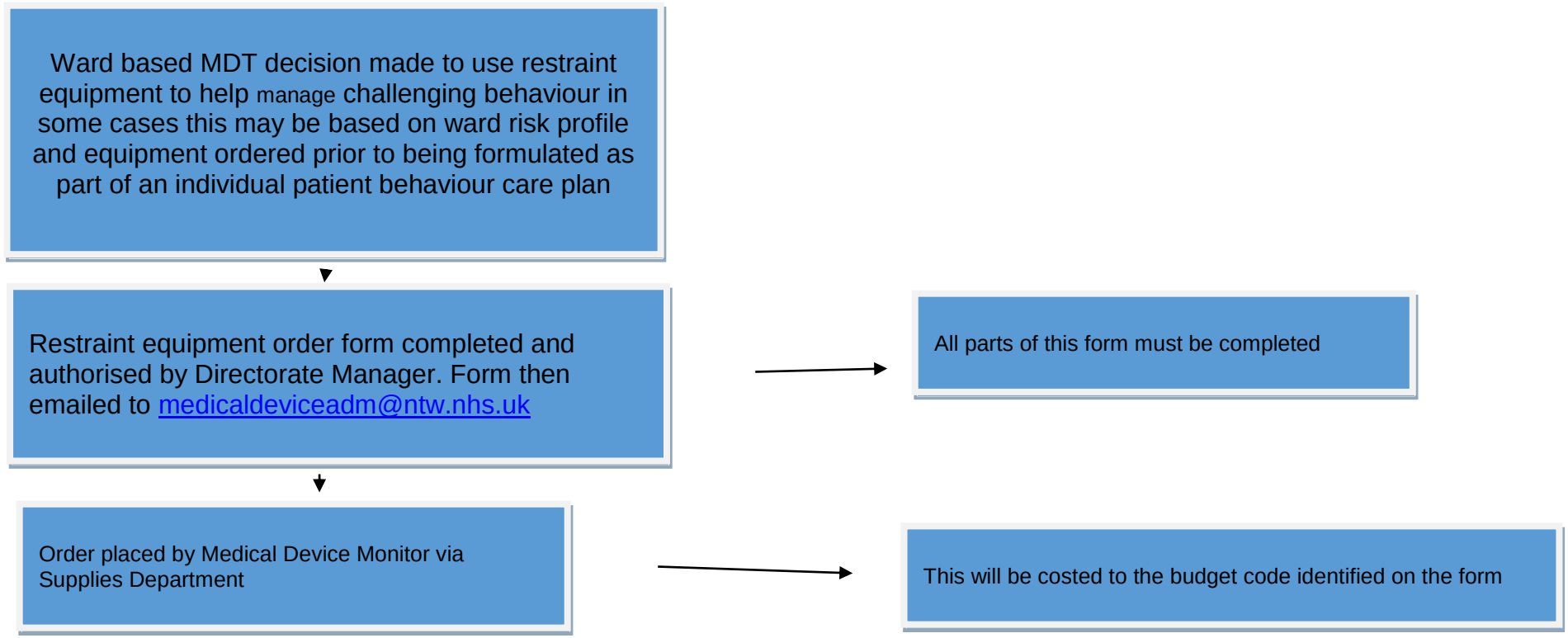
Restraint Equipment Order Form

Please ensure this form is completed fully before sending to medicaldeviceadm@ntw.nhs.uk

Ward		**Date:**	
Equipment required ***Specify handcuffs / emergency response belt**			
Number required			
Identify where equipment is to be stored			

Provide rationale for ordering this equipment			
Summarise the training arrangements to ensure staff can safely deploy equipment and record use in line with PGN			
Summarise the arrangements in place to support the formulation of MDT care plans to cover the use of and review of this equipment in line with PGN.			
Associate Director Approval		**Date:**	
Cost Centre Code			
Subjective Code			

Restraint Equipment Ordering Flowchart



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Appendix 9

Monthly Handcuff Equipment Check

Set No: being checked		**Date**		**Time**	
Check carried out by:		**Signature**			

Equipment	**Present?** (YES OR NO)	**Are Corresponding Keys Present? (** YES OR NO**)**
Hinged cuffs		

(If any items are found to be missing this must be reported to the Ward Manager immediately and details recorded below).

(Please tick Y or N)		**Yes**	**No**
1	Bag / case in good condition? (if answer is no, please complete details below)		
2	Do all cuffs lock / unlock correctly? (if answer is no, please complete details below)		
3	Corrosion present? (if answer is yes, please give details below)		
4	Any apparent weakness? (if answer is yes, please give details below)		
5	Any other potential hazards? (if answer is yes, please give details below)		

Comments/Details	
Date reported to Ward Manager	
Action taken (e.g. cuffs removed/replaced):	

Appendix 10

Monthly Emergency Response Belt (ERB) / Soft Restraint Belt (SRB) / Soft Cuff Checks

Date		**Time**	
Checked by (name)		**Signed**	

Staff should fully open each piece of mechanical restraint equipment (MRE) in turn visually checking for the faults highlighted below and test for any weakness. Where there is any doubt as to the condition of the equipment this should be highlighted on the form below and reported to the ward manager.

ERB Specific Checks

1. Ensure that the loops are secured to the belt with no loose stitching and the Velcro on the compression strap is not damaged

2. Check the loop securing the D-ring for wear.

3. Check handles on both sides to ensure no excess wear and no loose stitching

4. Ensure the main body of the belt is undamaged with no rips or loose stitching

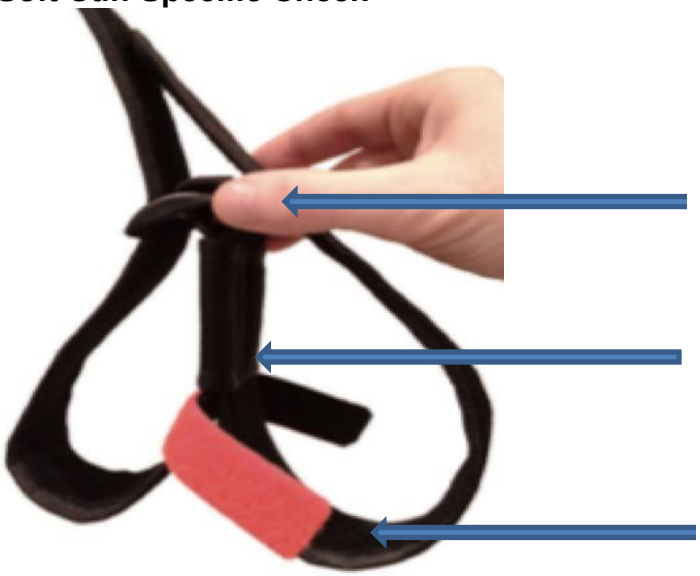
5. Additional General Wear and Tear

Number	Check 1	Check 2	Check 3	Check 4	Check 5	Comments

Action Required

Reported to:

Soft Cuff Specific Check



1. Ensure the plastic buckle is unbroken and in good condition

2. Ensure the body of the cuff is undamaged and with no loose threads

3. Ensure the Velcro is undamaged and the orange retention strap is in place

Number	Check 1	Check 2	Check 3	Comments

Action Required

Reported to:

Appendix 11

Suggested considerations for risk assessment

The ERB®, SRB and handcuffs are not considered weapons but they do fall within the use of force continuum. All force **must** be legally and ethically justifiable in that its use is a reasonable response to an identified risk or threat. To be reasonable it must be demonstrated that the force used was absolutely necessary and proportionate to the presenting risk. Below are suggested headings which may be used in the assessment of risk. These suggestions should not be considered comprehensive.

Information

- Identify sources of information e.g. FACE risk profile, MHRT reports, Social work reports etc

Assessment of risk

- Identify historical risk e.g.
    - previous violence,
    - lengthy restraints,
    - victim type,
    - cause of violence,
    - injury to others during restraint
    - absconding episodes
- Identify current risk
    - Mental state
    - Attitude to treatment
    - Verbalised threats to harm
    - Current attitude to violence
    - Relationship with care team
    - Impulse control
    - Violence indicators in behaviour
- Identify situational risk
    - Availability of victims
    - Security of environment e.g. community
    - Absconding risk
- How probable is an adverse event?
- What degree of harm is likely
- What options are available
    - What options have been considered
    - Why have you chosen the one you did

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Appendix 12

ERB/SRB/Handcuff Tracking Record

Date/time	ERB/SRB	Handcuffs (including keys)	Given to (name/ward)	Authorised by (name/sign)	Director/ Associate director authorised	Returned sign/date	Checked and cleaned on return

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Appendix 13

Inpatient Mechanical Restraint Equipment (MRE) authorisation checklist

- For use with planned authorisation / re-authorisation requests only
- To be completed and sent with the MRE care plan request

Action required	Y/N	Completed by (initials / date)
1. MDT review and document (**in CTM / progress notes**) the need for use of an mechanical Restraint Equipment		
2. MDT agree and document (**in care plan**) the type of device needed :- ▪ Emergency ▪ Restraint Belt (ERB, SRB) ▪ Soft Cuff ▪ Hinged Cuff		
3. MDT state (**in care plan**) :- ▪ the rationale for use ▪ Date MRE Care Plan 1st authorised ▪ Date MRE Care Plans last authorised ▪ Name of Director who last authorised MRE Care Plan ▪ Number of occasions that MRE's have been used in the previous 4 week period ▪ Date that MDT reviewed and agreed that MRE Care Plan required re-authorising		
4. **Ward diary** to note a future date to review the care plan as a prompt to the clinical team before 48hrs of care plan expiry **Note: Routine MRE care plan reviews and requests will be made at CTM at the first meeting of each month**		
5. The copy of this checklist and the MRE Care Plan that requires authorisation to be sent		

to **CNM for review two working days prior to expiry date**		
6. Copy checklist and the MRE care plan to :- ▪ CNM for wards ▪ Associate director ▪ Associate director secretary		
7. CNM will review the authorisation checklist and MRE care plan **within one working day**, then forward to the …….. triumvirate and Specialist Group Directors for review / authorisation **within one working day** **Note: The care plan will be reviewed against the criteria set out above but also against the suggested care plan format outlined in Appendix 6 PMVA-PGN-01(Part of NTW(C)16 PMVA Policy). This gives guidance in relation to care plan completion**		
8. On return of approved MRE care plan from Directors, CNM will return to the ward concerned the same day, copying in the Ward Manager and Responsible Clinician		

Email contacts list:-

1. **Ward to CNM / Associate director**

   - CNM
   - CNM
   - Associate director
   - Secretary to Associate director
   - Ward Manager and Responsible Clinician involved

2. **CNM to triumvirate / Group Directors**

   - Associate director
   - Associate nurse director
   - Clinical Director
   - Group Director
   - Group Medical Director
   - Group Nurse Director
   - Nurse Consultant
   - Group Director PA
   - Group Support Officer