This policy/procedure relates to how the Trust addresses issues regarding the Safe and exceptional use of Mechanical Restraint in all forms.

The policy takes into account Violence and aggression: short term management in mental health, health and community settings’ (NICE Clinical Guideline 10) (2015) and Positive and Proactive Care: Reducing the Need for Restrictive Interventions (Department of Health 2014)

This policy reflects changes made to Mental Health Act 1983 Code of Practice 2015 in section ‘Care Support and Treatment in Hospital’ sections 26.75-26.87.
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

THE SAFE & EXCEPTIONAL USE OF MECHANICAL RESTRAINT IN ALL AREAS OF THE TRUST

1.0 Introduction
2.0 Definition of Mechanical Restraint
3.0 Restraint: The Legal Framework
   3.2 Emergency Use of Mechanical Restraint
4.0 Duties
5.0 Identifying the Situations that may require Mechanical Restraint
6.0 Identifying the Appropriate Piece of Equipment
7.0 Development of a Mechanical Restraint Treatment Plan
8.0 Gaining Approval for the use of Mechanical Restraint in an Emergency
9.0 Monitoring the Physical Wellbeing of the Patient Being Restrained Mechanically
10.0 Observations
11.0 Aftercare
   11.1.1 Review of MR Use
12.0 Documentation
13.0 Source Documents
14.0 Implementation/Staff Training and Licensing
15.0 Target Audience
16.0 Equality Impact Assessment
17.0 Review Date
18.0 Consultation
19.0 Process for Monitoring Compliance
20.0 Legislation Compliance
21.0 Champion and Expert Writers
22.0 References/Source Documents

Appendix 1  Equality Impact Assessment Screening Tool
Appendix 2  Record of Changes
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

THE SAFE & EXCEPTIONAL USE OF MECHANICAL RESTRAINT IN ALL AREAS OF THE TRUST

Please Note: Each directorate will have a local procedure to support this policy.

1.0 INTRODUCTION

1.1 Mechanical Restraint is a highly restrictive area of practice and consideration of all other forms of management must be tried and exhausted before it is considered. Devices that are now available represent an evidence based approach to the use of Mechanical Restraint but must be used as a last resort and for the shortest time possible in line with a robust risk assessment and risk management plan.

1.2 Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing (26.76 Code of Practice 2015)

The use of mechanical restraint is always a last resort for managing situations in the care setting. Consideration must always be given to the use of all other forms of management relevant to the individual patients risk assessment and care needs.

1.3 The use of Mechanical Restraint always remains the most restrictive possible level of response to actual violence or life threatening self-injury and must never be considered usual practice. Well trained, experienced and responsible staff can make the use of Mechanical Restraint a safe and timely intervention when guided correctly by a robust policy.

Violence to others: “The use of mechanical restraint to manage extreme violence directed towards others should be exceptional, and seldom used in this or other contexts outside of high secure settings.” Positive and Proactive Care: Reducing the Need for Restrictive Interventions (79, Department of Health 2014)

Violence to self: “It is recognised that following rigorous assessment there may be exceptional circumstances where mechanical restraints need to be used to limit self-injurious behaviour of extremely high frequency and intensity.” Positive and Proactive Care: Reducing the Need for Restrictive Interventions (80, Department of Health 2014)

1.4 This policy outlines a process that can achieve the above.

1.5 Nottinghamshire Healthcare NHS Foundation Trust is committed to the safe and professional management of aggressive and violent incidents consistent with the framework of current legislation.

- Mental Health Act –Code of Practice (2015),
- Health and Safety at Work Act (1974)
- Criminal Law Act 1967 3 (1).
- Common Law: “Cases of Necessity”
- Mental Capacity Act 2005,
- BILD Use of Mechanical Devices
- Safeguarding; No Secrets (2000)
- Positive and Proactive Care: Reducing the Need for Restrictive Interventions (2014)
2.0 **DEFINITION OF MECHANICAL RESTRAINT**

2.1 “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.” 26.75 Code of Practice 2015).

2.2 Mechanical restraint is the application and use of specialised materials or therapeutic aides designed to significantly restrict the free movement of an individual, with the intention of preventing injury; as a result of behaviour that poses significant and proportionate risk to the individual or others of serious long term harm or immediate injury.

2.3 Mechanical Restraint involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person getting out of bed. Controls on freedom of movement, such as keys, baffle locks and keypads, can also be a form of mechanical restraint.

“Let’s talk about restraint” Royal College of Nursing

2.4 “As a last resort, the application and use of materials or therapeutic aids such as:

- High/Low Profile Beds
- Bed rails used in one area
- Wheel chair lap straps
- Wheel chair foot sandals
- Sensory devices that alert you when a patient is out of bed
- Certain seating that may restrict a patient’s movement- unless this is a specific postural central measure as recommended by the Physio/OT e.g.
- Handcuffs
- Emergency Restraint Cuffs
- Cuffs with belt
- Pinel Belts
- Emergency Response Belt (ERB)
- Emergency Enveloping Lifting Sling (EELS)
- Velcro Leg Strapping/Belts
- Shoulder Restraint
- Wheelchair/car and bus seats/ shower chairs
- Wheelchair and chair lap straps
- Sandal foot plates on wheelchairs with straps
- Vehicle Harnesses
- Mittens

This list is not exhaustive, though if the device you are using doesn’t appear in this list it must be checked as being acceptable by senior managers.

Mechanical devices may be:

- *Partial in that it significantly impairs the free movement of a limb or*
Total in that the person may be unable to freely walk or stand as a result of the application of the restraint”

Use of Mechanical Devices: Restrictive physical intervention
(British Institute of Learning Disabilities)

Local procedures must specify the equipment which has been agreed for use according to the patient care group.

3.0 RERAINT: THE LEGAL FRAMEWORK

3.1 Nottinghamshire Healthcare NHS Foundation Trust is committed to the safe and professional management of aggressive and violent incidents consistent with the framework of current legislation.

- Mental Health Act – Code of Practice (2015)
- Mental Capacity Act (2005)
- Health and Safety at Work Act (1974)
- Criminal Law Act 1967 3 (1).
- Common Law: “Cases of Necessity”;

3.2 Mechanical restraint can be used as a restrictive intervention under the Mental Health Act, however it must be proportionate, appropriate to the patient’s condition, take into account the individuals wishes and be compliant with human rights. (26.3 Code of Practice 2015).

3.3 If an individual who lacks capacity is not detained under the Mental Health Act, (or is detained under the MHA but the issue is outside the scope of that Act) and any form of restraint is deemed to be necessary, the law governing such restraint will be found in Section 6 of the Mental Capacity Act 2005. Any restraint used must be reasonable, proportionate to the harm that would otherwise come to the person who lacks capacity, and be in that person’s best interests. It must also represent the less restrictive intervention. In such cases, the use of restraint does not necessarily mean that the person is ‘deprived of their liberty’ within the meaning of Article 5 of the European Convention on Human Rights.

3.4 Although restraint is not the same as deprivation of liberty, the use of restraint will be a factor to take into account when assessing whether the person is or appears to be deprived of their liberty. That is to say whether the person is under continuous supervision/control, and in addition is not free to leave. Unless the person is already deprived of their liberty in hospital by virtue of the Mental Health Act, steps must be taken to render a deprivation of liberty lawful by a Mental Capacity Act Deprivation of Liberty Safeguards application or (following legal advice) an application to Court.

3.5 The Trust will comply with National Guidance issued by the National Institute for Health Care Excellence (NICE) on ‘Violence and aggression: short term management in mental health, health and community settings’ (NG10) and NHS Protect ‘Promoting Safer and Therapeutic Services’ Training Programmes with amendments when available.

3.6 Mechanical Restraint should normally take place using only specifically sanctioned/approved equipment as a tertiary intervention with a positive behavioural support plan developed following multi-disciplinary consultation (26.77 Code of Practice 2015)

3.7 Mechanical Restraint should never be used as punishment or retribution and should be
3.8 A Mechanical Restraint may be used only in order to prevent a patient causing self-injury, injury to another patient or member of staff, or damaging property, when its use is absolutely necessary to achieve the required objective and has been approved in accordance with this procedure.

3.9 Every individualised effort must be made to avoid the use of Mechanical Restraints. The option to use special accommodation instead of a Mechanical Restraint must be considered first. This does not preclude the use of Mechanical Restraints in addition to special accommodation, where the circumstances of the case so demand, and where a patient cannot safely be left unrestrained in special or unfurnished accommodation.

3.10 “The Criminal Law Act 1967, s 3 provides that it is lawful to use such force as is reasonable in the circumstances in the prevention of crime or in effecting (or assisting in) the lawful arrest of offenders, suspected offenders or persons unlawfully at large. Where the accused acts under a mistake as to the circumstances, this provision is applied to the circumstances as he believed them to be. The effecting of an arrest will almost always involve some form of restraint, even if it is symbolic, and this would be a battery but for the present defence. It must be emphasised that, if the force used to prevent a crime or to make an arrest is unreasonable in the circumstances, it will be unlawful and the person using it will not have a defence to a charge of battery or of another offense against the person. A person has no defence, even though he uses reasonable force, if he is acting in furtherance of an unlawful arrest.” (English and Card, 2003, p. 707)

3.11 When it is deemed necessary to use any form of Mechanical Restraint it must be used within the legal frame work of “reasonable force” as described in The Criminal Law Act 1967, s 3. To help staff with guiding the legalities of its use they must fully consider and be able to justify that its use is Proportionate, Legal, Acceptable and Necessary, this must be Based on the facts as known at the time of use (PLAN B).

3.12 PLAN B is a system for identifying the legal use of force by Metropolitan Police Officers and is a system that can be useful to all staff involved in any use of force whether this is mechanical or physical.

3.2 Emergency Use of Mechanical Restraint

3.2.1 The use of Mechanical Restraint may be required in response to unexpected episodes of aggressive or violent behaviours. In these instances, Mechanical Restraint can be justified to maintain the safety of the patient or others. However, the decision to use Mechanical Restraint must still be planned, correctly authorized (see local procedures) and must be proportionate to the level of threat presented by the patient.

3.2.2 Before using Mechanical Restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

4.0 DUTIES

4.1 When it is decided to use Mechanical Restraint, managers and staff will be responsible for the following.

4.1.1 Divisional Managers (see local procedures) will decide which areas would require training in the use of mechanical restraint.
4.1.2 Each member of staff who is deemed to require training in the use of mechanical restraint must ensure their attendance on the specified training course/s and records of training and updates must be kept.

Staff applying Mechanical restraint should have appropriate training in their application and use. (26.79 Code of Practice 2015)

4.1.3 Ward managers/Team leaders have a responsibility to complete a training needs analysis for all of their staff members in line with local procedures.

4.1.4 Directorate managers have responsibility to provide and monitor resources to facilitate this.

4.1.5 Once needs have been identified, managers have a responsibility to enable and ensure that staff attend the relevant refresher training to keep licensed in the use of Mechanical Restraint Devices.

4.1.6 Managers must ensure that post incident reviews are carried out following violent incidents and that any necessary actions to address issues of aftercare for staff, patients or others involved in the incident are resolved.

5.0 IDENTIFING THE SITUATIONS THAT MAY REQUIRE MECHANICAL RESTRAINT

5.1 Please refer to local Procedure.

6.0 IDENTIFYING THE APPROPRIATE PIECE OF EQUIPMENT

6.1 It must be remembered that if Mechanical Restraint devices are being used then staff applying the chosen device must be specifically trained to use the item being applied and that this training is up-to-date and current. Breaches of this rule will be looked upon very seriously as a conduct issue.

(If in doubt check your training record on the Trust training database.)

6.2 Please refer to local Procedure for acceptable devices in your area of practice.

7.0 DEVELOPMENT OF A MECHANICAL RESTRAINT TREATMENT PLAN

7.1 Please refer to local Procedure.

8.0 GAINING APPROVAL FOR THE USE OF MECHANICAL RESTRAINT IN AN EMERGENCY

8.1 Please refer to local Procedure.

9.0 MONITORING THE PHYSICAL WELL BEING OF THE PATIENT BEING REstrained MECHANICALLY

9.1 Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the patient’s physical and mental health condition. (26.82 Code of Practice 2015).

This will be further covered in local procedures.

10.0 OBSERVATIONS

10.1 An individual who is mechanically restrained should remain under continuous
observation throughout (unless specific arrangements are implemented in local procedures e.g. bed rails). It may be necessary for the individual to remain at arm’s length and should be reviewed by a nurse every 15 minutes. (26.80-26.81 Code of Practice).

10.2 The individual should have a medical review by a registered medical practitioner at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. These should be more frequent if the nurse has concerns (26.82 Code of Practice 2015).

11.0 AFTERCARE

11.1 A plan of aftercare should be developed for each individual following the application/use of any form of mechanical restraint, this will be covered in local procedures. This will include the psychological support and emotional wellbeing of individuals who are restrained using MR and if necessary their family members who have directly or indirectly been involved in the restraint.

11.1.1 Review of MR use

- Local procedure should include process for review of each use of MR by senior staff. MR use should also be regularly reviewed by each services clinical governance structures.

12.0 DOCUMENTATION

12.1 The nurse in charge of the ward is responsible for ensuring that all documentation and observation forms have been correctly completed and signed, these documents will be clearly defined in local procedures in line with the Code of Practice 2015: “The patient’s clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient’s condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.” (26.84)

13.0 SOURCE DOCUMENTS

13.1 The following documents have been considered in the production of this Policy.

- Secretary of State Directions on work to Tackle Violence against staff and professionals who work in or provide services to the NHS. (November 2003)
- “Safeguarding; No Secrets (2000)”
- Positive and Proactive Care: Reducing the Need for Restrictive Interventions (Department of Health 2014)

14.0 IMPLEMENTATION/STAFF TRAINING AND LICENSING

14.1 It is envisaged that training will be at the point of need initially and then updated and refreshed every 12 months, this again will be clearly defined in local procedures.
15.0 TARGET AUDIENCE

15.1 All staff who have clinical contact with clients.

16.0 EQUALITY IMPACT ASSESSMENT

16.1 This policy has been assessed using the Equality Impact Assessment Screening Tool (appendix 1). The assessment concluded that the policy would have no adverse impact on, or result in the positive discrimination of, any of the diverse groups detailed. These include the strands of disability, ethnicity, gender, gender identity, age, sexual orientation, religion/belief, social inclusion and community cohesion.

17.0 REVIEW DATE

17.1 This policy will be reviewed in 3 years or in light of organisational or legislative changes.

18.0 CONSULTATION

- Standing Nursing & Allied Health professionals Advisory Council
- Nursing & AHPs Executive Forum
- Forensic Management Group
- Mental Health Act Commission
- Extended ELT
- Trust Solicitors

19.0 PROCESS FOR MONITORING COMPLIANCE

19.1 Each incident where patients are subject to Mechanical Restraint must be reported using the Trust’s reporting procedure (IR1), a Restrictive Interventions form on RiO and an entry made in the clinical notes.

19.2 All training will be recorded on the Trust data base.

19.3 Health & Safety Quarterly review

19.4 Patient Safety Group

19.5 Safeguarding Quarterly review

20.0 LEGISLATION COMPLIANCE

20.1 Nottinghamshire Healthcare NHS Foundation Trust is committed to the safe and professional management of aggressive and violent incidents consistent with the framework of current legislation.


20.3 Positive and Proactive Care: Reducing the Need for Restrictive Interventions (Department of Health 2014)

21.0 CHAMPION AND EXPERT WRITERS

21.1 The Champion of this policy is: Dr Julie Hall- Executive Director Of Nursing, Quality & Patient Experience

21.2 Louise Bussell, Deputy Director of Forensic Services

22.0 REFERENCES / SOURCE DOCUMENTS

- Mental Capacity Act 2005 and Code of Practice
- Mental Health Act –Code of Practice (2015),
- BILD Use of Mechanical Devices
- Safeguarding; No Secrets (2000)
- Positive and Proactive Care: Reducing the Need for Restrictive Interventions (2014)
### EQUALITY IMPACT ASSESSMENT (EIA) SCREENING TOOL

| Name of policy/procedure/strategy/plan/function etc being assessed: | The Safe and Exceptional Use of Mechanical Restraint Policy  
This policy relates to how the Trust addresses issues regarding the Safe and exceptional use of Mechanical Restraint in all forms. It provides staff with a clear understanding of their responsibilities and how to implement locally. |
|---|---|
The target audience will be all staff who have clinical contact with clients. The EIA has been carried out in order to ensure the policy has no adverse effect on any of the diverse groups detailed. |
| Names and designations of EIA group members: | Louise Bussell, Deputy Director; Forensic Services  
Dave Mason, Associate Director of Forensic Services  
Jackie Ewington, Professional Lead for Violence Reduction |
| List of key groups/organisations consulted | Violence Reduction Team, Leadership Council, |
Mental Capacity Act 2005 and Code of Practice  
Mental Health Act –Code of Practice (2015),  
BILD Use of Mechanical Devices  
Safeguarding; No Secrets (2000)  
Positive and Proactive Care: Reducing the Need for Restrictive Interventions (2014) |
<table>
<thead>
<tr>
<th>Equality Strand</th>
<th>Does the proposed policy/procedure/strategy/plan/function etc have a positive or negative (adverse) impact on people from these key equality groups? Please describe</th>
<th>Are there any changes which could be made to the proposals which would minimise any adverse impact identified? What changes can be made to the proposals to ensure that a positive impact is achieved? Please describe</th>
<th>Have any mitigating circumstances been identified? Please describe</th>
<th>Areas for Review/Actions Taken (with timescales and name of responsible officer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>The policy would be used regardless of race as based on clinical need.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Gender</td>
<td>The policy would be used regardless of gender and will take into account specific needs relating to gender such as same gender staff as needed on an individual basis for any gender.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Disability</td>
<td>The policy will be implemented depending on clinical need and any specific requirements related to disability will be formulated into the care plan.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Religion/Belief</td>
<td>The policy would be used regardless of religion/belief but will take into account any specific religious requirements within the individual care plan.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>The policy would be used regardless of sexual orientation but will take into account specific needs when planning care approaches.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Age</td>
<td>The policy would be used regardless of age but any</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
</tbody>
</table>
specific care needs related to age will be planned.

<table>
<thead>
<tr>
<th>Social Inclusion*¹</th>
<th>The policy supports a least restrictive approach and use of mechanical restraint for the shortest time possible to avoid extended isolation from peers and staff will always be present with the patient. On occasions is use will support improved social inclusion.</th>
<th>N/A</th>
<th>N/A</th>
<th>Review in 3 years led by the author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Cohesion*²</td>
<td>The policy supports a least restrictive approach and use of mechanical restraint for the shortest time possible to avoid extended isolation from the patients community. On occasions its use will support improved engagement in the community.</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
<tr>
<td>Human Rights *³</td>
<td>The use of mechanical restraint supports the right to life (Article 2) and all actions have been taken to ensure all other relevant human rights are maintained in the planning, most specifically avoiding degrading treatment (Article 3).</td>
<td>N/A</td>
<td>N/A</td>
<td>Review in 3 years led by the author</td>
</tr>
</tbody>
</table>

*¹ for Social Inclusion please consider any issues which contribute to or act as barriers, resulting in people being excluded from society e.g. homelessness, unemployment, poor educational outcomes, health inequalities, poverty etc

*² Community Cohesion essentially means ensuring that people from different groups and communities interact with each other and do not exclusively live parallel lives. Actions which you may consider, where appropriate, could include ensuring that people with disabilities and non-disabled people interact, or that people from different areas of the City or County have the chance to meet, discuss issues and are given the opportunity to learn from and understand each other.

ISSUE 5 – FEBRUARY 2017

<table>
<thead>
<tr>
<th>Conclusions and Further Action (including whether a full EIA is deemed necessary and agreed date for completion)</th>
<th>The policy will be available to all groups and can be declined at any point. Feedback will be collected to ensure there are benefits to all groups and mechanical restraint, if used, will be regularly reviewed by MDT and service user. No negative impact or potential positive discrimination has been identified.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Tool Consultation End Date</td>
<td>5:00pm on Wednesday 8 February 2017</td>
</tr>
<tr>
<td>Name of Equality and Diversity (E&amp;D) Group Approving EIA (i.e. Directorate E&amp;D Group, Divisional E&amp;D Forum or Trustwide E&amp;D Steering Group)</td>
<td>Equality and Diversity Sub-Committee of Trust Board</td>
</tr>
<tr>
<td>Name of Responsible Officer Name and Contact Details (tel. e-mail, postal)</td>
<td>Louise Bussell, Deputy Director; Forensic Services 01777 247693 Dave Mason, Associate Director of Forensic Services 01777 247204</td>
</tr>
</tbody>
</table>
APPENDIX 2

Policy/Procedure for: SAFE AND EXCEPTIONAL USE OF MECHANICAL RESTRAINT IN ALL AREAS OF THE TRUST

Issue: 05

Status: APPROVED

Author Names and Titles: Louise Bussell – Deputy Director of Forensic Services

Issue Date: 21 FEBRUARY 2017

Review Date: JANUARY 2020

Approved by: EXECUTIVE LEADERSHIP TEAM (15/02/2017)

Distribution/Access: Normal

RECORD OF CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>AUTHOR</th>
<th>POLICY/PROCEDURE</th>
<th>DETAILS OF CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/11</td>
<td>Shirley Wright</td>
<td>1.21</td>
<td>2.3, 7.6, Removal of duplicated approved equipment. Addition to section 9.1, removal of section 9.2</td>
</tr>
<tr>
<td>29/06/12</td>
<td>Shirley Wright</td>
<td>1.21 (Issue 3)</td>
<td>Additions to 5.1.2, 9.1, 11.2, and appendix 1 restraint review plan. Change to 12.1 (High obs replace continuous obs). Removed 12.3, 12.4, 13.2, and section of appendix 1 restraint review plan.</td>
</tr>
<tr>
<td>Apr 13</td>
<td>A Maughan, M O’Driscoll, S Wright</td>
<td>1.21 (Issue 4)</td>
<td>Previous policy applied to Local Services Division only – changes throughout to reflect the policy is applicable to all Divisions of the Trust.</td>
</tr>
</tbody>
</table>