Qegis

NHS Security Info

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Introduction

On 10th November 2019, Jim O'Dwyer, Senior Consultant at AEGIS Protective Services, posted Security Management Update #5.

The news article included important information on a range of security risks Jim had identified from his expert witness work.

Since publication, several requests have been received from hospital security professionals asking for a downloadable copy.

This document answers that call.

1. Time restriction on Security Officers ‘guarding’ patients in hospital

For years, it has been common practice in the NHS for Security Officers to be assigned to safeguard (aka bed-watch) certain patients, for example, patients who may present a threat of violence or serious self-harming.

The thing is, complaints are now being made that patients whose behaviour is not criminal are effectively being stigmatised as criminal by being ‘guarded’ by persons dressed as ‘law enforcement agents’ (i.e. as opposed to clinical staff) and that this is a breach of their Human Rights. (i.e. Article 3 - the prohibition of torture, inhumane or **degrading** treatment.)

In short, the argument cuts to this. Security is an emergency response service and so, will be a legitimate response to any emergency crisis. However, the legitimacy for their presence would be time limited to a reasonable time frame i.e. the time it would (reasonably) take to assemble a multi-disciplinary team to develop and implement an appropriate care plan for the patient. The figures I heard reported for a ‘reasonable time frame’ was about 2 hours.

So, where uniformed Security Officers are employed to ‘guard’ a patient for more than two hours, it could be construed as unjustifiable and unlawful – putting NHS Trusts at risk of litigation and compensation claims.

One NHS Trust’s temporary solution to the problem has been to, if necessary, post the Security Officers in plain clothes. However, this does mean the Security Officers aren’t able to wear their Stab Vests. So, not a perfect solution.

2. Sharing patient information relevant to physical restraint

Due to an absence of appropriate training, many NHS clinical staff who call security for assistance with an aggressive patient are unaware of the range of medical conditions that could impact on any decision to physically restrain the patient and the importance of conveying this information to the security team as soon as possible in an incident. They may also have reservations about divulging patient information to non-clinical staff.

Where it exists, this ‘knowledge deficit’ needs to be addressed urgently, to avoid a potentially serious adverse outcome.

Note: If you would like details of the kinds of medical conditions that can impact on the safety of any intended physical restraint, please get in touch.

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3. Sufficiency of numbers

Most recognised physical restraint systems advocate a minimum of three staff are needed to ensure physical restraint against resistance can be reasonably safely undertaken, particularly where the immediate objective is to completely immobilise the person in situ.

This means that attempting restraint by only two security officers would be recognisably unsafe.

So, if only two security officers are available to engage in a restraint, unless clinical staff are trained to physically assist in such situations, occasions could arise where there may be insufficient numbers of staff to make physical restraint a viable option.

In settings where a need for restraint is highly predictable, an absence of appropriate arrangements for restraint to take place could put the NHS Trust very clearly in breach of H&S statutory responsibilities and CQC Regulations. In the event of adverse outcomes, it could also result in complaints and compensation claims being settled (typically, out of court) without any evidence of the events being heard, i.e. based on "*Res ispsa Loquitor*" i.e. the facts speak for themselves.

Where clinical staff are relied on to assist Security Officers to effect physical restraints, it is essential that they receive the same training as the Security Officers, so that they can act as a team.

Note: Nice Guidance NG1O - Manual restraint - Manual restraint 6.6.3.7 states:

"Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together ***as a team****, understand each other's roles and have* ***a clearly defined lead****."*

4. Arrangements for Chemical Restraint (Rapid Tranquilisation/Sedation)

Chemical Restraint (aka Rapid Tranquilisation and sedation) is recognised as part of the restraint continuum by the Department of Health, the Mental Health Act, the national institute for health and care excellence (NICE – NG10) and the Care Quality Commission (CQC).

Although a relatively exceptional event, it is predictable across all sites that, at any time, a need can arise to administer rapid tranquillisation by intramuscular injection (IMI) to an unwilling and resistive patient.

It is a process that requires teamwork between clinical staff and security Officers and an absence of combined training will obviously impact on the level of capability that can be expected. An obvious recommendation would be to train clinical staff together with the security team specifically for such situations.

5. Facilitating IMI (for Chemical Restraint)

The decision to prescribe and administer the sedative is a clinical decision – as is the choice of the site to inject.

The Mental Health Act Code of Practice (2015) states:

26.98 Where rapid tranquilisation in the form of an intramuscular injection is needed, ***the person prescribing the injection should state the preferred injection site,*** *having taken full account of the need to avoid prone restraint (i.e. where the person is forcibly laid on their front).*

Note: Traditionally, across the NHS, the recognised, preferred site for IMI has been the upper right quadrant of the back of the patient's right leg – normally facilitated by restraining the patient in the prone position. However, the Department of Health Guidance 'Positive and Proactive Care: reducing the need for restrictive interventions' (Page 26) advocates against any kind of deliberate holding in the prone position.

> *70. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.*

There are other alternative sites suitable for IMI:

- The upper arm - deltoid muscle
- The buttocks - patient needs to be on their side, not prone
- The hip - the ventrogluteal muscle of the hip (patient needs to be on their side)

Note: More info about *Alternative Injection Sites for IM Medication* (and images) available here:

https://www.medicalnewstoday.com/articles/323115.php

https://www.healthline.com/health/intramuscular-injection#howto

So, which option would be the preferred injection site for the clinical staff at your NHS Trust and are they aware of the DoH PBS guidance?

The next question is, have the 'restraint team' been trained to physically facilitate access to the preferred IMI site? It is clearly something that needs to be addressed.

One of the biggest risks associated with performing a restraint to facilitate sedation via IMI is the danger to the persons carrying out the restraint of accidentally becoming a victim of a needle-stick injury! If the clinical staff have not rehearsed the IMI procedure with the restraint team, it will significantly increase the risks of an adverse outcome. Ask yourself this, how it would look in a court or tribunal if suitable training has not been implemented?

The remedy is appropriate training.

6. Emergency Restraint Belts (ERB) – a ‘less restrictive’ restraint option

Note: There are different kinds of ERBs available on the market. The type I’m referring to here are simply belts made of nylon with Velcro. Each strap is approx 125cm long and they come two to a pack.

ERBs can be used to secure a person’s legs at the knees and ankles.

ERBs have been in use by police and security services for over a decade and are not associated with causing injury.

ERBs are lightweight, simple to use and remove and cheap to buy (about £10 each).

ERBs have proved to be invaluable kit in emergency situations, where it is necessary to physically immobilise a resisting person in situ. For example, in order to administer a prescribed sedative by IMI.

ERBs have also enabled patients who need to be restrained, to be safely (carried), relocated to a more appropriate place, reducing disruption, where otherwise this would not have been a practical viable option.

Key Legal Points

1: Significantly, once physical control over a patient has been established, applying ERB(s) facilitates less staff to be needed to be able to maintain the restraint – and so would be more in keeping with the Human Rights principle of using **the least restrictive, least intrusive measure** than if all the staff applying the restraint were to continue to remain lying on top of the person.

2: Using ERB(s) can also present **less risk to an individual** than prolonged manual restraint.

Both key points above have been acknowledged and confirmed by the Care Quality Commission.

CQC Guidance: Brief guide: restraint (physical and mechanical) states:

"We recognise that the use of mechanical restraint may be considered to be the least restrictive intervention in some specific cases and may present less risk to the individual than the alternative of prolonged manual restraint or transfer to a more restrictive setting. This could provide a valid reason for using mechanical restraint in an emergency or 'unplanned' interventions, as well as planned interventions."

So, it could actually be illegal to prohibit use of ERBs

To prohibit use of ERBs can mean that the nature of a restraint is not the least intrusive, least restrictive method to achieve the lawful objective. It can also mean that the restraint is not as safe as it could be. This would have obvious liability connotations for NHS Trusts.

What does the DoH Guidance say on the subject of Mechanical Restraint?

The Doh Guidance - Positive and Proactive Care: Reducing the Need for Restrictive Interventions (DoH 2014) says:

(78) Mechanical restraint 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'.

Note: The DoH Guidance groups all types of equipment that can be used to restrict an individual's movement (e.g. garments, straps, belts, mittens and soft and metal handcuffs) under the single banner of Mechanical Restraints.

*(79) 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."***

*(80) 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."*

(131) The choice of any restrictive intervention that has to be used must always represent the least restrictive option to meet the immediate need.

My reading of the DoH PBS Guidance is that it certainly doesn't rule out the use of ERBs in acute hospital settings, i.e. if a **Risk Assessment** has identified a need for them. The Guidance just seeks to prevent the routine use of mechanical restraints to restrain patients and ensure it is reserved for truly exceptional circumstances.

What the Risk Assessment should consider:

- The increasing demand for NHS services being experienced, particularly mental health
- The demography of the client base being serviced.
- Reducing numbers and availability of police to support healthcare staff.
- The commitments made in the Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2017).
- The Guidance document London's s136 pathway & Health Based Place of Safety specification (see, in particular, 2.36; 4; 3.6; 3.7; and 4.10 - 4.13).
- The history of 'exceptional' incidents occurring at each location that could have been made safer by using ERBs.
- Consultation with the staff onsite (including security officers) to seek their opinion on the risks being encountered, the foreseeability of 'exceptional' incidents occurring and the viability of ERBs helping to reduce risk in such situations.
- Consultation with service users who may be more likely to experience application of ERBs if they were to be introduced.

Note: Prior to introducing use of mechanical restraint as an option in emergency situations, healthcare providers should consult a group 'wider than just the service' to assess whether the device(s) approved represent 'the least restrictive option'; used in the best interests of the person, and that there were no less restrictive alternatives which were appropriate and proportionate to the risks posed'.

The consultation should involve (if not led by) the Trust's Safeguarding Lead and the person responsible for the Trust's Restrictive Intervention Reduction Programme (if different), together with the Patient Experience Lead.

Suggestions for Policy Terms that could be used:

Below are suggested terms that could be used in a Policy on Mechanical Restraint.

- The use of mechanical restraint should be an exceptional clinical event.
- ERBs may only be used where the service user is presenting a threat of harm to self or others or if there is an immediate risk of significant harm if ERBs are not deployed.
- ERBs may be used only where they are a necessary, reasonable, proportionate and justifiable response to the risk posed by the service user;
- ERBs may be used only where they represent the safest, least restrictive intervention, for example, preventing prolonged use of prone restraint.
- ERBs 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;
- ERBs can be used as an intervention if that has been identified in advance decisions by the patient;
- Any use of ERBs must be fully documented and every instance reported to the Board.

Which NHS Trusts are using ERBs?

In 2017, the Department of Health told the BBC it did not record how many hospitals use ERBs, but confirmed they are used in exceptional circumstances in some hospitals, **subject to rigorous assessment**.

Anxiety reduction benefits having ERB, just in case

It is worth reflecting on just how much the residual stress and anxiety levels being endured by Healthcare Security Officers would be mitigated by making ERBs available to them, just in case of a need to use them! Also, depending on the level of risk being encountered, you may feel that having a set of rigid bar handcuffs available at each site (with staff trained to apply them) would be a sensible, prudent and practical precautionary measure to reduce risk.

If you would like to discuss any aspect, please do not hesitate to contact me.

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