



NHS Security Info

Free Download #12

Mechanical Restraint in **Acute Hospital Settings**



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The publication is intended to contribute to professional discussion, organisational risk assessment, policy development and the continuing examination of restrictive practices within healthcare. It does not constitute legal or clinical advice and should not be interpreted as an operational instruction or as authority for any individual member of staff to use mechanical restraint.

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References to particular restraint systems or manufacturers are illustrative only and do not constitute endorsement.

Manufacturer statements concerning safety, efficacy or comparative benefit are identified as manufacturer claims unless independently established. The products discussed in this paper are not intended to represent an exhaustive list of the mechanical restraint equipment currently available. Other manufacturers and suppliers provide restraint equipment that may potentially be suitable for use within healthcare environments.

AEGIS has concentrated on equipment with which it has sufficient knowledge or practical experience to comment. The absence of reference to another product or manufacturer should not be interpreted as either approval or disapproval of that equipment.

NHS Trusts should identify and evaluate potentially suitable equipment through their own risk assessment, clinical and safety review, procurement and governance processes.

Introduction

NHS Trusts have traditionally operated policies that prohibit the use of mechanical restraint in acute hospitals. In some organisations, that prohibition may be explicit; in others, it may simply reflect established practice.

This paper takes the reader through the case for a fresh, evidence-based and risk-informed review of the availability and potential benefits of purpose-designed mechanical restraint equipment.

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1. Consider the following case

A hospital patient becomes violently resistant and cannot safely be released. Several members of staff restrain the patient manually for a prolonged period. The patient continues to struggle and subsequently dies.

The Trust had prohibited mechanical restraint.

The patient's family asks:

Why did the Trust prohibit an intervention which, in some circumstances, might have reduced the duration and intensity of manual restraint and presented less risk to the patient?

Now consider the same incident from the staff perspective.

A Security Officer suffers a serious musculoskeletal injury during the prolonged restraint.

The officer asks:

Why was I required to use my own body to restrain a violently resisting person for a prolonged period when purpose-designed equipment capable of reducing that physical exposure was prohibited?

These are both foreseeable health and safety questions that may have to be answered following serious injury or death.

Where an organisation has prohibited an available form of restraint that might have reduced the risks associated with prolonged manual restraint, it should be able to demonstrate the evidence and risk assessment upon which that prohibition was based.

If it cannot satisfactorily explain why potentially safer alternatives were excluded, that decision may become highly relevant to questions of negligence, employer liability and whether the organisation provided a safe system of work.

“Our policy prohibited it” may explain why safer equipment was unavailable, but it does not establish that the policy was reasonable or lawful.

2. The problem with prolonged manual restraint

NICE NG10 states that manual restraint should not routinely continue for more than **ten minutes** and that alternatives to prolonged manual restraint should be considered.[1]

NICE also identified long-duration manual restraint as requiring further research. It recognised that agitated and violent adults may continue to struggle during manual restraint and that rapid tranquilisation may fail, resulting in prolonged containment. NICE called for investigation of safer and more effective alternatives.[2]

Mechanical restraint does not remove the need to gain initial physical control of a violently resisting person. Unless the person consents and cooperates, sufficient physical control must first be established to enable restraint equipment to be safely applied.

Its benefit comes afterwards.

Appropriate mechanical restraint may reduce the number of staff, physical effort and duration of continuing manual restraint.

It can also reduce the ‘physical contest’ between the person and those restraining them.

Direct manual restraint involves another person continuously exerting strength against the subject.

Practitioner experience suggests that appropriately applied soft restraint can feel less confrontational once that continuing physical contest is removed and this can help to de-escalate agitation.

3. Mechanical restraint does not just mean handcuffs

The traditional image of mechanical restraint is metal handcuffs: custodial, highly visible and potentially undignified. However, that impression should not determine how every form of mechanical restraint is assessed.

Mechanical restraint encompasses a much wider range of equipment, including Soft Cuffs, Emergency Response Belts (ERBs), restraint mitts and purpose-designed whole-body restraint and handling systems.

CQC describes mechanical restraint as the use of a device to prevent, restrict or subdue bodily movement.[3]

Significantly, CQC has recognised that mechanical restraint may, in specific circumstances, be the least restrictive intervention and may present less risk to the individual than prolonged manual restraint or transfer to a more restrictive setting.[4]

So, the question to be asked should surely therefore be:

Is this the safest, least restrictive and least intrusive form of restraint in these circumstances?

4. NICE guidance and the need for review

NICE NG10 was published in May 2015.[1]

It recommends that mechanical restraint in adults should ordinarily be confined to high-secure settings, subject to its specified secure-transfer exception.[1]

AEGIS recognises the importance of that recommendation.

However, NICE itself identified the problem of prolonged manual restraint and called for research into safer and more effective alternatives.[2]

CQC subsequently recognised circumstances in which mechanical restraint may be less restrictive and present less risk than prolonged manual restraint.[4]

The operational environment has also changed considerably since NG10 was published, including increasing demand upon mental health services and changes to the respective roles of healthcare services and police under Right Care, Right Person.[5]

Violence remains a substantial occupational risk within the NHS.[6]

Acute hospitals must also be prepared for Acute Behavioural Disturbance (ABD).



ABD can involve extreme agitation, unexpected physical strength, apparent insensitivity to pain, sustained physical activity and continued resistance to restraint. It represents a foreseeable high-risk emergency for which Emergency Departments need to be prepared.[7]

At an ASPiH 2018 presentation on simulation training for the management of ABD in the acute hospital, Dr Michael Yousif, Consultant Psychiatrist at Oxford University Hospitals NHS Foundation Trust, observed:

“Nurses get virtually no training on ABD in Acute Hospitals, but it is very, very common, especially in A&E.” [8]

These are precisely the kind of foreseeable circumstances an organisation needs to have considered in advance, along with how manual restraint can be kept as brief as possible and safely concluded.

This is a primary reason why AEGIS advocates for a fresh, evidence-based review of mechanical restraint within acute healthcare, that takes account of contemporary risks, current restraint equipment and experience gained since NG10 was published.

5. Posey Mitts – mechanical restraint in acute healthcare

Notwithstanding NICE's recommendation that mechanical restraint should ordinarily be confined to high-secure settings, subject to its specified secure-transfer exception.[1], Hand Control Mittens, (aka 'Posey Mitts'), are commonly used in acute hospitals to prevent patients interfering with treatment or medical devices and, where their use restricts a person's bodily movement 'for the purpose of controlling behaviour', they constitute a form of **mechanical restraint**.

CQC expressly recognises that devices not traditionally thought of as restraints can become mechanical restraint according to how and why they are used.[3]

Their use illustrates an important principle.

Where a patient presents a foreseeable risk of interfering with essential treatment or medical devices, that risk needs to be managed. If purpose-designed mitts were prohibited, staff might instead need to prevent the behaviour through repeated or prolonged manual intervention.

The relevant question should therefore be: Which intervention presents the least risk and is the least restrictive and least intrusive in the particular circumstances?

A blanket prohibition on the mechanical option prevents that comparison from being properly made.

Appearance also matters.

Hand Control Mittens have the appearance of healthcare equipment and so are unlikely to appear aggressive, punitive or custodial to patients, relatives or other observers. Whereas metal handcuffs and similar custodial restraints can create a very different impression.



Both may constitute mechanical restraint. Yet one may be routinely permitted while the other is prohibited.

This raises an important question: Is that distinction based upon an objective assessment of comparative risk, necessity, restrictiveness and benefit, or is it influenced, at least in part, by the very different emotional response their appearance evokes?

Appearance is relevant, but appearance alone is not a risk assessment.

An AEGIS Freedom of Information request to Liverpool Heart and Chest Hospital NHS Foundation Trust illustrates a further problem.

The Trust was asked: “Does the NHS Trust authorise the use of any kind of mechanical restraint?”

It answered: “No.”

However, when subsequently asked whether it authorised Posey Mitts where risk assessment deemed their use reasonable and proportionate, the Trust answered:

“Yes, the Trust does authorise the use of Hand Control Mittens if deemed to be a reasonable and proportionate response following a risk assessment. There is a policy in place for this.” [9]

The Trust’s own governance records subsequently included monitoring of compliance with its Hand Control Mittens policy/procedure.[10]

This highlights two important points.

First, mechanical restraint is already accepted within acute healthcare where individual risk assessment and governance determine that its use is justified.

Second, an NHS Trust may operate what it understands to be a prohibition on mechanical restraint while simultaneously authorising an intervention that constitutes mechanical restraint!

The principle applied to Hand Control Mittens should inform consideration of other purpose-designed mechanical restraint equipment.

The intervention should not be accepted or rejected simply because it is “mechanical”.

It should be compared with the reasonably available alternatives and assessed according to its risks, benefits, restrictiveness and intrusiveness in the particular circumstances.

6. Emergency Response Belts and Velcro-Type Leg Restraints

Emergency Response Belts (ERBs) and comparable purpose-designed Velcro-type leg restraints, such as the **MLA Fastrap**, are soft restraint devices designed to control movement of the legs. They can be folded and carried unobtrusively in a small pouch on a Security Officer's service belt.[11]



Used appropriately as leg restraints, **applied in approved configurations around the knees and ankles**, these devices provide effective control without reliance upon pain compliance. They can significantly reduce exposure to kicking and reduce the number of staff required continuously to restrain the person's legs manually.

Their soft construction and unobtrusive appearance are markedly different from conventional metal handcuffs.

Once applied, soft leg restraints may also reduce direct physical contact and the continuing **physical contest** between the restrained person and staff. Practitioner experience suggests that this can feel less aggressive to the person being restrained and may reduce, rather than increase, the impetus to struggle.

A further major advantage is **portability**. Appropriate use can facilitate moving a person from a busy or stimulating environment to a quieter and more appropriate location.

NICE itself identified Emergency Response Belts as an intervention warranting research when considering safer and more effective alternatives to prolonged manual restraint.[2]



Significantly, AEGIS has identified **no published report of death or serious injury caused by an ERB when correctly applied as a leg restraint for its intended purpose.** That apparent safety record needs to be considered alongside the known risks associated with prolonged manual restraint.

AEGIS therefore recommends that restraint-trained Healthcare Security Officers are equipped with two approved ERBs or comparable purpose-designed Velcro-type leg restraints, supported by appropriate training.

Note: ERBs and comparable Velcro-type leg restraints must only be applied to the legs, in approved configurations, in accordance with training and for their intended purpose.

7. Soft Cuffs

AEGIS recommends that purpose-designed **Soft Cuffs** are considered, particularly for patient transport and other situations in which continuing manual restraint would otherwise be required. As with ERBs, safe application requires either cooperation or sufficient physical control of the person.

Once appropriately applied, Soft Cuffs may enable continuing hands-on restraint to be reduced or discontinued. Their soft construction provides a substantially different experience and appearance from conventional metal handcuffs. Safer Handling describes its product as a softer, **more humane alternative** to metal handcuffs and as an alternative to prolonged manual holding.[12]

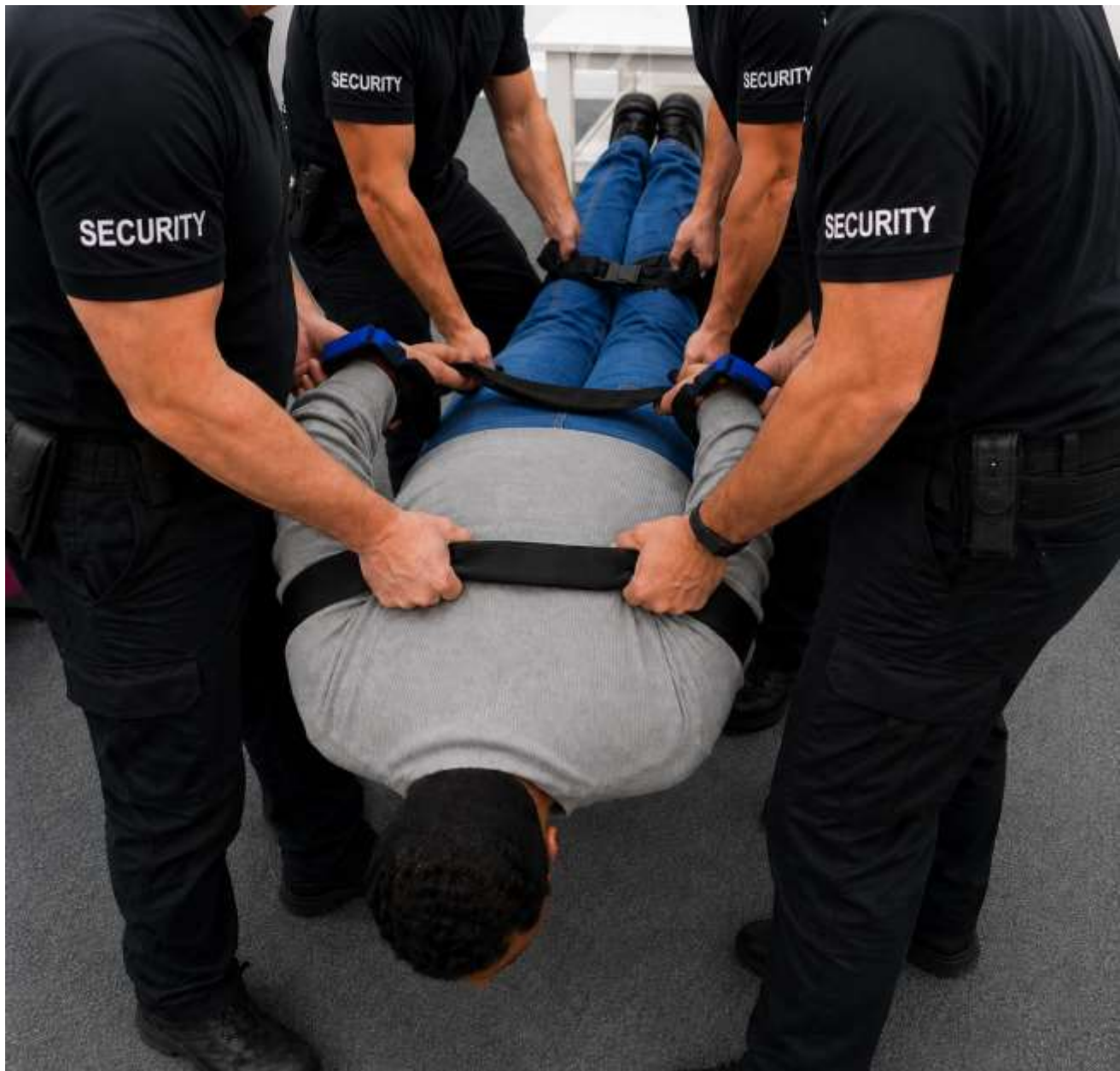


Note: NHS England expressly recognises soft cuffs in the context of secure patient transport, subject to their use being legally justified, reasonable, necessary, proportionate and for the shortest time possible.[13]

8. Whole-body restraint and handling systems

Purpose-designed restraint equipment such as the **WRAP** [14] and **SEELS** [15] demonstrate how far contemporary mechanical restraint has developed beyond conventional handcuffs.

These systems can substantially restrict movement without relying upon pain compliance and **can facilitate controlled movement or transportation of the restrained person.**



Where the person is actively resisting, sufficient physical control must first be established before such equipment can be safely applied.

Once appropriately applied, whole-body systems can substantially reduce continuing hands-on restraint and the physical contest between the restrained person and staff.

Their safe use requires appropriate training.

Effective team leadership, clear role allocation, competence and practice are essential.

9. Improvised mechanical restraint

Ignoring the need for mechanical restraint does not make that need disappear.

Staff confronted by an emergency still have to manage the emergency.

Where approved equipment is unavailable or prohibited, staff may improvise, using sheets, blankets, clothing, straps or other objects never designed, tested or approved for restraint.

Improvisation under pressure can introduce risks which appropriate equipment, training and governance are specifically intended to control.

The death of **Thomas Orchard** provides a stark warning.

An Emergency Response Belt designed as a limb restraint was used around Mr Orchard's face as a spit/bite guard. The Chief Constable of Devon and Cornwall Police subsequently admitted health and safety failings concerning the introduction of the ERB for that purpose, including inadequate consideration and assessment of the risks. The 2023 inquest found that police failures surrounding the use of the belt may have contributed to his death.[16]

The case involved an improvised use of the equipment, not its intended application as a limb restraint.

Safe restraint requires the right equipment, for the right purpose, used by trained staff and not improvisation under pressure. The safest time to determine what equipment staff should use in an emergency is **before the emergency occurs.**

10. Clinical equipment can also become restraint

Mechanical Restraint is determined by what equipment is being used to do, not by the manufacturer's description of the product.

CQC recognises that ordinary equipment, including straps, lap-belts and bedrails, can constitute mechanical restraint depending upon how they are used.[3]

However, clinical equipment such as cannulas, catheters, drains, lines or monitoring equipment can also incidentally restrict movement. More concerning is where such equipment is deliberately relied upon to prevent or discourage a person from moving.

Equipment does not have to be manufactured as a restraint device before its use can become restrictive.

Where clinical equipment is deliberately utilised to restrict movement or control behaviour, that use should be recognised, justified, risk assessed and governed accordingly.

11. Rigid-bar handcuffs

AEGIS does not recommend the routine issue of rigid-bar handcuffs to individual Healthcare Security Officers. Their custodial appearance, potential for injury and the degree of restriction they impose make them unsuitable as routine personal equipment in an acute healthcare environment.

Their availability and use also require a higher level of organisational control and clinical governance.

However, AEGIS does recommend that every Emergency Department has access to at least one set for exceptional emergency use, to be used only when authorised by the senior clinician and applied by suitably trained personnel.

Their availability should be treated as a controlled organisational emergency resource, subject to strict governance, recording and review.

12. Health & Safety and Manual Handling

The Health and Safety at Work etc. Act 1974 places duties upon employers concerning the health and safety of employees and persons other than employees who may be affected by their undertaking.[17]

The Management of Health and Safety at Work Regulations 1999 require suitable and sufficient assessment of risks and appropriate preventive and protective measures.[18]

Physical restraint can also involve manual handling. HSE confirms that manual handling includes transporting or supporting a load by hand or bodily force and that a person can constitute a load.[19]

The required hierarchy is:

Avoid hazardous manual handling so far as reasonably practicable; assess what cannot be avoided; and reduce the risk of injury so far as reasonably practicable.

HSE expressly advises employers to consider **automation, mechanisation and mechanical aids** where these can reduce or eliminate manual-handling risks.[20]

Where several staff are required physically to hold and control a struggling person for a prolonged period, the organisation should therefore consider whether appropriate purpose-designed equipment could reduce that hazardous physical exposure.

A policy which prohibits mechanical restraint prevents proper consideration of whether mechanical assistance could provide a safer system of work.

The conclusion should follow the risk assessment, not precede it!

13. Consult the people who actually do the job

Employers are required to consult employees, or their representatives, about health and safety matters.[21]

HSE also advises employers to involve workers in risk assessment because the people doing the work know the risks and practical problems involved.[22]

Any organisational assessment of restraint should therefore meaningfully involve the clinical staff and Security Officers who actually undertake it.



They should be asked:

1. What happens when restraint becomes prolonged?
2. What risks do you experience?
3. What equipment or other controls could reduce those risks?

Note: A changed review date is not evidence that the risk or the organisational arrangements for its mitigation have actually been reviewed!

Failure to consult the staff who actually face the risk may also become highly significant if the adequacy of the risk assessment is subsequently challenged following injury or death.

An organisation may find it difficult to demonstrate that its assessment was “suitable and sufficient” if those responsible for it did not seek the experience of the people who routinely undertake the hazardous task.

In court, a risk assessment is evidence of how the organisation identified and controlled foreseeable risk. Its credibility may be seriously undermined if the people actually exposed to that risk were never consulted.

A risk assessment conducted without consulting the people who do the job invites the question: How did you know you understood the risk?



14. Restraint equipment requires effective governance

Mechanical restraint must be supported by:

- defined circumstances for use;
- legal justification;
- trained and competent personnel;
- approved methods of application;

- clinical oversight;
- continuous monitoring during restraint and for as long as clinically necessary afterwards;
- regular reassessment of continuing necessity;
- recording and reporting;
- post-incident review; and
- prohibition of improvised or unauthorised applications.

15. Cost

The financial cost of providing appropriate mechanical restraint equipment can be surprisingly modest.



At the time of writing, for example, the MLA Fastrap Leg Restraint, including its belt pouch, is advertised in the UK at £19.45 excluding VAT (£23.34 including VAT).[23]

More sophisticated soft restraint and whole-body systems represent a greater investment and may require specialist training. Some manufacturers do not publish equipment prices and supply their products only to appropriately trained organisations or practitioners.

Safer Handling, for example, states that its Soft Restraint equipment is not issued or sold without certified training; its current one-day Soft Restraint Kit Train-the-Trainer course is advertised at £438 per delegate.[24]

Training, governance, inspection, replacement and refresher training therefore need to be included when assessing the true cost of introducing mechanical restraint equipment.

However, equipment cost needs to be considered against the alternative and the potential human and financial cost of prolonged manual restraint, including staff and patient injury, sickness absence, additional staffing requirements, investigation, litigation and compensation.

In that context, the cost of providing appropriate mechanical restraint equipment may be very modest indeed!



AEGIS Position Statements

AEGIS recommends that acute NHS Trusts:

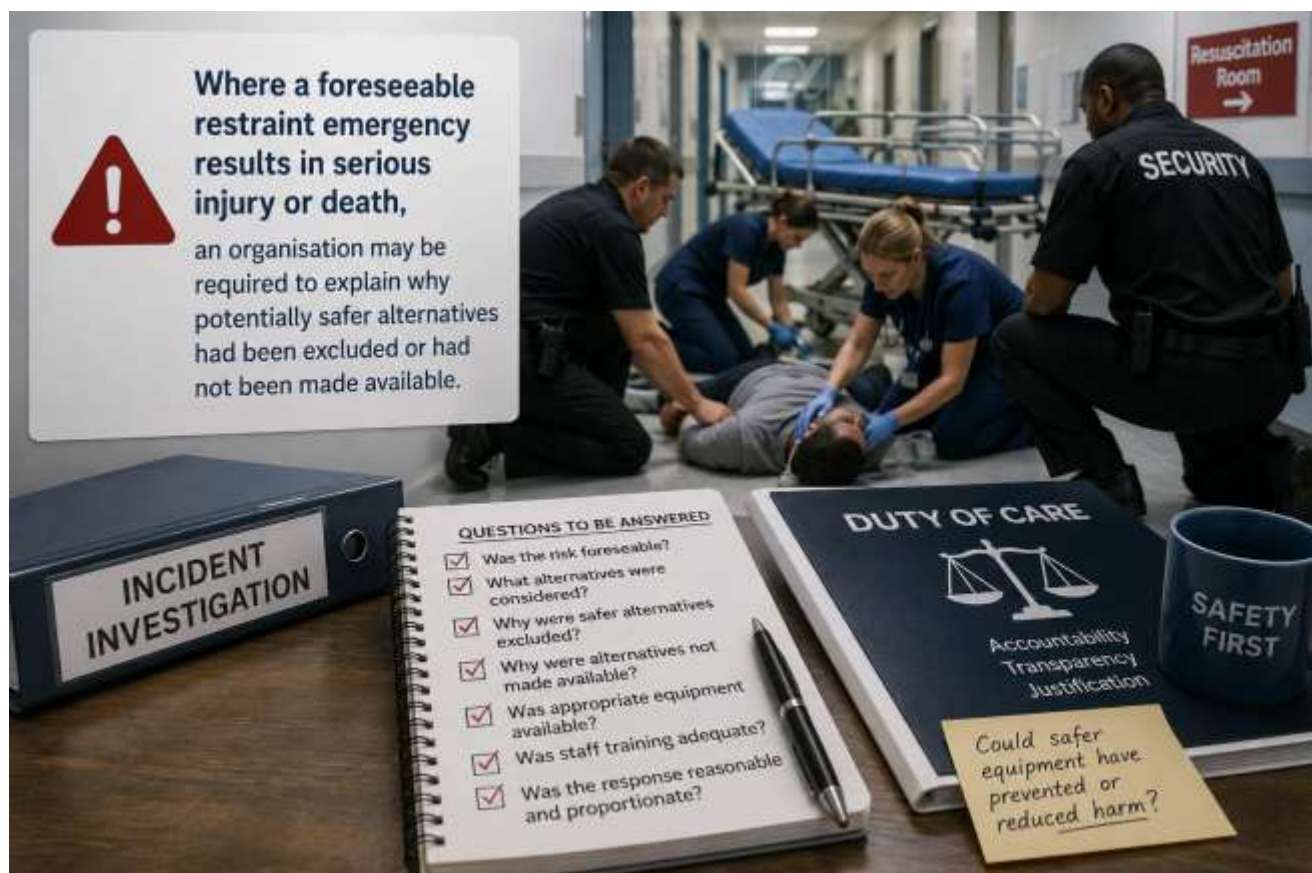
1. Review any blanket prohibition on mechanical restraint.
2. Recognise prolonged manual restraint as a foreseeable hazard to patients and staff.
3. Consult the staff who actually undertake restraint.
4. Consider ERBs/Soft Restraint Belts, Soft Cuffs and appropriate whole-body restraint and handling systems as potential means of reducing prolonged hands-on restraint.
5. Equip restraint-trained Healthcare Security Officers with two approved ERBs or equivalent soft restraint belts and appropriate training.
6. Ensure every Emergency Department has access to at least one set of rigid-bar handcuffs for exceptional emergency use, authorised by the senior clinician and applied by suitably trained personnel.
7. Recognise that Hand Control Mittens/Posey Mitts and other devices can constitute mechanical restraint and ensure their use is properly assessed and governed.
8. Provide clear governance, continuous monitoring, reporting, review and training for every form of mechanical restraint authorised for use.
9. Prohibit improvisation and the use of restraint equipment for purposes or in configurations for which it was not designed or approved.
10. Recognise and govern all situations in which ordinary or clinical equipment is deliberately used to restrict a person's movement.

Key Message:

The safest and least restrictive form of restraint cannot be predetermined simply by labelling one intervention “manual” and another “mechanical”. It must be determined by the circumstances, the risks presented, the individual concerned and the reasonably available alternatives.

Where prolonged manual restraint is becoming dangerous, but restraint remains necessary, “just let go” is not a sufficient safety strategy!

Staff need a safer option – one that has been considered, risk assessed, governed and made available before the next emergency occurs.



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More Info

I hope you find the information useful. If you would like to discuss it or any aspect of Healthcare Security, please don't hesitate to contact me:



Jim O'Dwyer

Senior Consultant

AEGIS Protective Services

E: info@aegisprotectiveservices.co.uk



Website: <https://aegisprotectiveservices.co.uk/>

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