Application of Mittens as a Form of Physical Restraint for Patients requiring Naso-gastric Feeding

Department / Service:	Corporate
Originator:	Deborah Narburgh, Head of Safeguarding Dr Riberio, Consultant Physician
Accountable Director:	Vicky Morris Chief Nursing Officer
Approved by:	Safeguarding Committee
Date of approval:	Safeguarding Committee 25th June 2019
First Revision Due:	25th June 2022
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Trustwide
Target staff categories	Medical & Nursing Staff directly involved in the management of patients requiring the use of mittens.

Policy Overview:

A number of conditions can affect a patient's ability to swallow oral fluids, food and medications e.g. stroke. Patients may lose their swallow and gag reflex and are therefore at risk of choking and aspiration. An alternative route is sometimes necessary and naso-gastric tubes are considered the safest alternative.
Patients in the acute phase of their illness can sometimes present as unaware of their surroundings, confused, restless and agitated: this can result in inadvertent removal of naso-gastric tubes and other essential access devices by the patient. For some patients, there may be a lack of comprehension of the potential consequences of regular insertions, poor compliance with medications and reduced oral fluid and food intake.
Mittens are a form of physical restraint to reduce the patient's ability to accidentally remove the naso-gastric tube. This is in order to maximise the potential for recovery and minimise the need for invasive interventions and ensure patients receive optimal fluids, nutrition and medications by the safest route possible when oral swallowing is impaired.

Latest Amendments to this policy:

Date	Amendment	By:
June 2015	Guideline reviewed, no changes made	P Sanmuganathan
November 2016	Documents extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 17	Document extended whilst under review	TLG

December 2017	Sentence added in at the request of the Coroner	
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
May 2019	Document extended for 6 months whilst review takes place	Lisa Miruszenko
May 2019	Full review of policy for use Trust wide. Review by Local Authority Deprivation of Liberty Safeguards team	DN

Contents page:

Some medical conditions can affect a patient's ability to swallow oral fluids, food and medications. They may lose their swallow and gag reflex and are therefore at risk of choking and aspiration. An alternative route is necessary and naso-gastric tubes are considered the safest alternative to ensure patients receive optimal fluids, nutrition and medications by the safest route possible when oral swallowing is affected to maximise recovery potential.

Patients in the acute phase of their illness e.g. stroke can be unaware of their surroundings, confused, restless and agitated: this can result in inadvertent removal of naso-gastric tubes and other essential access devices by the patient. There is a lack of comprehension of the potential consequences of regular insertions, poor compliance with medications and reduced oral fluid and food intake.

This topic is ethically sensitive and fraught with emotion for the patient, their relatives and staff members. These sensitive situations need to be managed alongside the requirement to provide optimal hydration and nutrition for the patient.

Current evidence suggests that prolonged use of chemical restraint in the form of sedative medications can be harmful to the patient, particularly when they have neurological pathology such as acute stroke. The aim is to avoid the use of chemical restraint and use less restrictive and potentially less harmful interventions.

Application of mittens is not considered an extended scope of practice.

All Trust staff receive mandatory Mental Capacity Act and Deprivation of Liberty Safeguards training relevant to their job role. Restriction of a person's freedom of movement, whether they are resisting or not can be considered a form of restraint. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- The person taking the action must reasonably believe that restraint is ***necessary*** to prevent harm to the person who lacks capacity, and
- The amount or type of restraint and the amount of time it lasts must be a ***proportionate response*** to the likelihood and seriousness of harm – a 'proportionate response' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the *best interests of the person who lacks capacity.*

2. Scope of this document

This document applies to medical and nursing staff directly involved in the management of patients requiring the use of mittens in order to deliver care in the least restrictive manner possible where it is deemed to be in their best interests.

3. Definitions

The use of mittens is defined as a form of physical restraint. Section 6(4) of the Mental Capacity Act 2005, Code of Practice, states that someone is using restraint if they:

a) Use force-or threaten to use force- to make someone do something that they are resisting, or
b) Restrict a person's freedom of movement, whether they are resisting or not.

4. Responsibility and Duties

This guidance does not override the individual responsibility of health professionals to make appropriate decision's according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

5. Policy detail

Details of guidelines

Prior to the use of mittens as a form of physical restraint, discussion should be held with the multi-disciplinary team, the Consultant responsible for the patients care, the patient (where possible) and the patient's relatives. The discussion and outcome should be documented clearly in the patient records. Where restraint is necessary to prevent harm to the person who lacks capacity, it must be:

- the minimum amount of force, for
- the shortest time possible

Clinical indications

Mittens may be considered for the following patients:

- Acutely ill patients
- Disorientated patients
- Restless and agitated patients
- Confused patients

Contraindications and special considerations

Physical restraint in the form of mittens should only be used when all other options have been explored and exhausted. Examples include: diverting patient's attention, nurses/ carers/ relatives holding patient's hands. Only when these methods have been proved unsuccessful can mittens be applied to permit effective and safe delivery of fluids, food and medications.

Contraindications

Mittens cannot be used in patients who are aware of the consequences of removing the naso-gastric tube are therefore making an informed decision not to be fed via the naso-gastric tube. This is in accordance with the requirements of the Mental Capacity Act. Where staff are concerned that the patient is making an 'unwise decision' that may pose a significant risk of harm then the mental capacity assessment (including risk, benefit , alternatives and any options considered) should be formalised and clearly recorded in the patient record.

Special Considerations

Mittens must not be used as an alternative when staffing levels are reduced, patient dependency high or in situations where resources are low.

Mental Capacity Act (2005)

The Mental Capacity Act (2005) provides a statutory framework for people who lack capacity to make decisions for themselves. The Act sets out who can take decisions, in which situations, and how they should go about this. The legal framework is supported by the Mental Capacity Act (2005) Code of Practice. Staff working within the Trust have a legal duty to have regard to the MCA Code of Practice when working or caring for adults who may lack capacity to make decisions for themselves.

Deprivation of Liberty Safeguards

Sometimes there is no alternative way to provide care or treatment other than depriving the person of their liberty. Actions that amount to a Deprivation of Liberty will not be lawful unless formal authorisation is obtained. Further information can be found at:
Deprivation of Liberty Safeguards (DoLS)

Maria Ferreira, a woman with Down's syndrome, died in an intensive care unit after she dislodged a tube with her mittened hand. A recent Court of Appeal ruling R (Ferreira) V HM Senior Coroner for Inner South London and others (2017) ruled that Ms Ferreira was not deprived of her liberty because she was being treated for a physical illness and the same treatment would have been administered to a person who did not have her mental impairment.

In the event staff are unsure as to whether a patient is being deprived of their liberty then a DoLS application should be made.

Training

- Nursing staff must be able to demonstrate competence prior to use of mittens.
- Clinical managers/ ward sisters are responsible for ensuring competence.

Procedure

This should be a socially clean procedure which is conducted at the bedside. Every effort must be made to maintain the patient's privacy and dignity at all times.

Equipment

Purpose made mittens: Posey peek-a-boo mitt

Decision making process (see appendix 5)

1. Assess patients mental capacity

2. Does patient lack mental capacity to consent to examination/ treatment?
3. Alternative methods applied to prevent naso-gastric tube e.g. distraction techniques
4. Patient has removed ≥2 naso-gastric tubes in last 24 hours
5. Decision for mittens discussed and approved by Consultant, MDT and family
6. If all above applicable then mittens can be applied.

Doctors responsibility

- Assess mental capacity of patient and ensure mittens are justified
- Discuss the use of mittens with the patient (where possible) and the patient's relatives/carers
- Clearly document discussion and outcome in patient's medical notes.
- Ensure medical review and record in medical notes every 24 hours for continued use of restraint
- Initiate treatment for any abnormalities

Nursing care management

During procedure

- Will require two nurses or one nurse and one healthcare assistant
- Wash hands and wear apron
- Ensure adequate privacy for the patient
- Explain procedure to patient and gain verbal consent (if possible)
- Ensure Doctor has assessed mental capacity for patients who cannot give verbal consent and appropriate discussions with MDT and relatives/carers have taken place
- One nurse is required to raise the patient's hand(s), one at a time, to ensure optimal positioning of mitten(s). Mittens do not always need to be applied to both hands after a stroke.
- The other nurse to attach mitten to mobile hand ensuring appropriate positioning of mitten.
- Mitten needs to be secure but not tight, as this may reduce circulation to limb.
- Please ensure that they fit the patient.

Monitoring of mittens

- Time when mittens are taken off are timetabled e.g. meal times, visiting times
- Remove mittens and observe hand every 6-8 hours looking for:
    - Signs of tissue damage
    - Swelling
    - Redness
    - Inflammation
    - Pressure sores
    - Other abnormalities

- Document findings and initiate treatment as required (see appendix 1)
- Hand must be washed and dried carefully before mittens are reapplied
- Change mitten every 24 hours – these mittens are machine washable but at present no washing machines on site for this to occur.

Control of infection

- Mittens must be checked on removal (three times per day) and daily for contamination
- Supply clean mittens if contamination found

Complications and side effects

Potential complications:

- Reduced circulation to limb if mitten is secured too tightly
- Development of pressure sores to limb
- Reduced ability to communicate especially if aphasic and mitten is applied to good hand after a stroke

Mitten use must be discontinued at any time if:

- Consent is withdrawn [where patient has capacity]
- Patient becomes more distressed or agitated wearing the mittens
- Deterioration in skin condition is noted
- Patient's condition changes and mittens are no longer required

Nursing responsibility

- To ensure safe and effective care is delivered and documented
- Evaluate and document the use of mittens every 6-8 hours
- Escalate any abnormalities and concerns to appropriate healthcare professional e.g. nurse in charge, doctor
- Ensure medical review and record in medical notes every 24 hours for continued use of restraint
- Each clinical area is responsible for monitoring compliance with this guidance.

6. Implementation of key document

6.1 Plan for implementation

Revision of existing document amended for use Trust wide.

6.2 Dissemination

Trust wide via Document Finder on the Trust Intranet

6.3 Training and awareness

Revision of the policy will be taken via the Safeguarding Committee for dissemination.

7. Monitoring and compliance

Annual audit will be undertaken by the Named Nurse Adults Safeguarding. Further information in monitoring tool on pg15.

8. Policy review

This Policy will be reviewed in accordance with Key Document review timeframes or in the event of any new or emerging legislation or practice developments.

9. References

- Adapted from Heart of England NHS Foundation Trust Guidelines: Use of physical restraint with acute stroke patients – Peter Carr drafted 25/11/2010, approved 15/12/10 and review 30/12/12

- Adapted from Portsmouth Hospitals NHS Trust Clinical Policies: Hand control mittens project team – Dr Jane Williams approved 27/11/2008, annual review commenced September 2009
- Adapted from Sandwell and West Birmingham NHS Trust: Procedure for the appropriate use of safety mittens in patients requiring enteral feeding – Assistant Director of Nursing drafted June 2004, approved January 2009, reviewed January 2011
- Mental Capacity Act (2005) Code of Practice, London HMSO
- Deprivation of Liberty Safeguards Code of Practice , London HMSO

1. Brak K., Robson W., Leaver G., Walker N., et al. British Association of Critical Care Nurses position statement of the use of restraint in adult critical care units. *Nursing in Critical Care* 2004: 9 (5)
2. Bray K. *et al,* 2004. British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units. *Nursing in Critical care;9(5):199-212*
3. Ciocon J.O. *et al*., 1988. Tube feeding elderly patients: Indications, benefits and complications. *Archives of Internal Medicine*; 148:429-433
4. Department of Health (2001) Reference *Guide to Consent for Examination or Treatment* London
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6. Eisenberg P, Spies M, Metheny N., 1987. Characteristics of patients who remove their nasal feeding tubes. *Clinical Nurse Specialist*; 1(3):94-98.
7. Human Rights Act (1998) London HMSO
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11. Meer J., 1987. Inadvertent dislodgement of nasoenteral feeding tubes: incidence and prevention. *Journal of Parenteral and Enteral Nutrition*; 11(2):187-189.
12. Mental Capacity Act (2005) London HMSO
13. Micek et al (2005) *Delirium as detected by the CAM-ICU predictor. Restraint use among mechanically ventilated patients.* Critical Care Medicine 33 (6) 1260-1265
14. National Collaborating Centre for Acute Care, 2006. *Nutrition Support in Adults, oral nutrition support, enteral tube feeding and parenteral nutrition*. National Collaborating Centre for Acute Care, London
15. Nirmalan M. Physical and pharmacological restraint of critically ill patients: clinical factors and ethical considerations. *British Journal of Anaesthesia* 2004; editoral IV: 789-91
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17. Norton B. *et al*. 1996. A randomised prospective comparison of percutaneous endoscopic gastrostomy and nasogastric tube feeding after acute dysphagic stroke. *British Medical Journal;* 312:13-16.
18. Royal College of Nursing, 2008. *"Let's talk about restraint" Rights, risks and responsibility*. RCN, London

19. Royal College of Nursing, 2004. *Restraint revisited –rights, risks and responsibilities*. RCN, London
20. Soames C, Hawker S (Eds) (2005) Compact *Oxford English Dictionary of Current English* 3rd ed Oxford University Press Ox
21. Williams, J. (2008) Exploring ethically sensitive decision-making in acute hospital care: using hand control mittens in adult patients. In Shaw, T. and Sanders, K. (Eds) Foundation of Nursing Studies Dissemination Series. Vol. 4. No. 8

10. Background

10.1 Equality requirements

Please refer to Supporting Document 1

10.2 Financial Risk Assessment

Please refer to Supporting Document 2

10.3 Consultation Process

Contribution List

This key document has been circulated to the following individuals for consultation;

Key individuals involved in developing the document

Name	Designation
Full update /revision May 2019.	
Caroline Mann	DoLS Team Manager, MCA/DoLS Team, Worcestershire County Council. Approved – no amendments 24.05.2019.

Circulated to the following individuals for comments

Name	Designation
Division of Specialty Medicine	
Division of Emergency Medicine /Urgent Care	
Division of Surgery	
Division of Specialised Clinical Services	
Division of Women & Children	

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Nalinee Owen	Dietetics
Dr Ribeiro	Specialty Medicine
Jaynul Islam	Stroke Operational Manager

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Vicky Morris	Safeguarding Committee

10.4 Approval Process

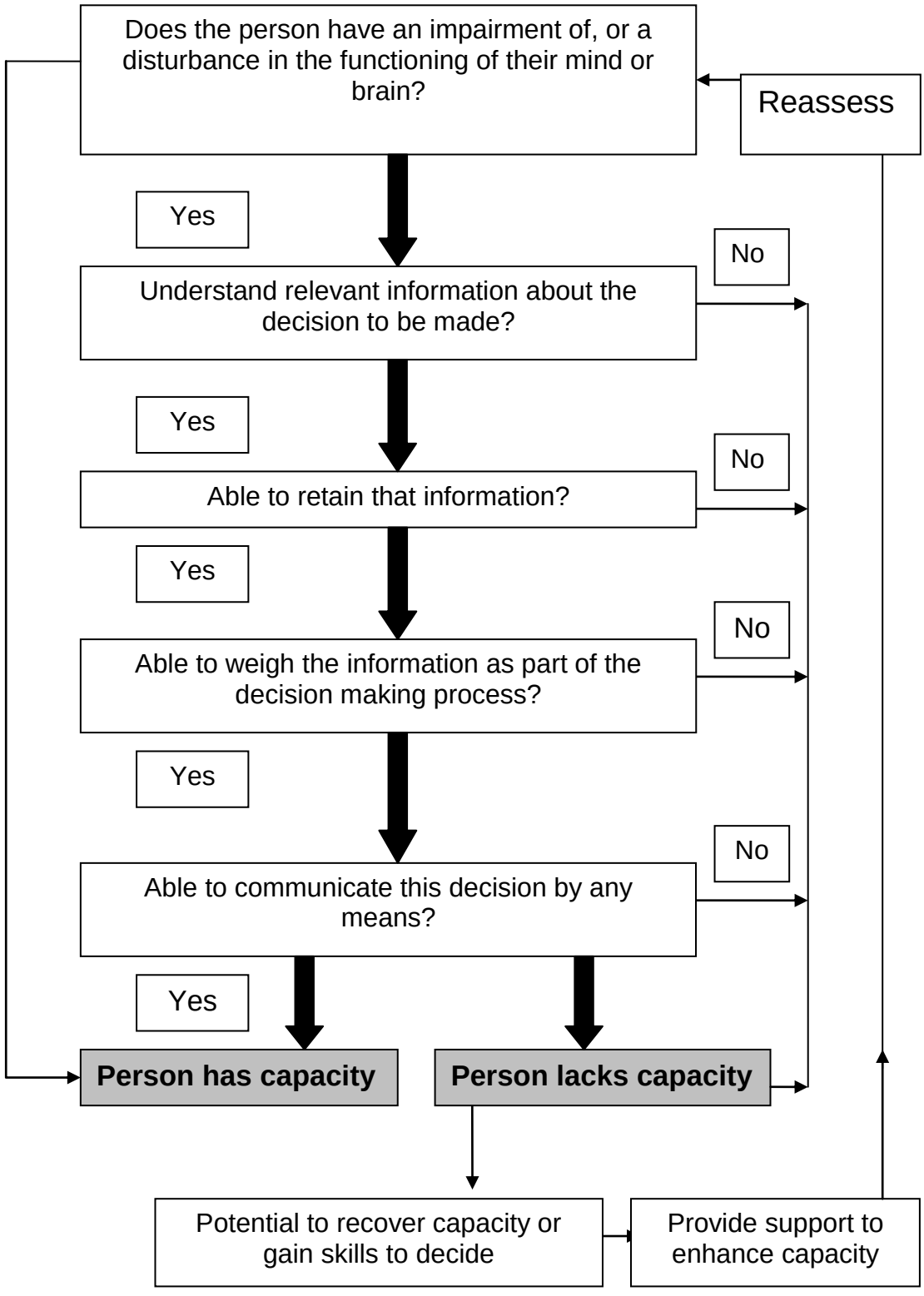
Approval will be via the Safeguarding Committee

10.5 Version Control

Refer to Key Amendments Section. The latest version of this Policy will be available on Document Finder on the Trust Intranet.

Appendices
Appendix 1

Flow Chart
Assessment of Capacity



Appendix 2

Patient Assessment form for the safe use of Hand Control Mittens

Patient label

PATIENT	YES	NO	Please Specify Supporting Information and Actions
1. Has the patient removed essential tubes/lines?			
2. Have other methods been tried? (i.e. distraction techniques, additional taping, re-siting etc)			**Identify type(s) of technique to be used:**
3. Does the patient have capacity to consent to the use of mittens?			
4. Has the patient given informed consent?			
5. If no to 3. Does the patient have a nominated next of kin who can provide assent?			
6. Has the nominated next of kin had reasons for the use of mittens explained and had the opportunity to see and try mittens before they are fitted?			
7. If the patient has no next of kin, is there documented evidence that the clinical team agree that the use of mittens is in the patient's best interests?			
Has the plan of care been • Discussed (patient, NOK, team) • Documented			

Why have hand control mittens been issued for this patient? Please refer to Clinical Guidelines for the Use of Hand Control Mittens.

1. Risk of aspirating contents of NG tube if pulled out when still running □
2. Risk of tissue damage e.g. cannula, NG tube, PEG tube □
3. Risk of reduce nutrition or hydration □
4. Risk that vital medications cannot be given □
5. Other ..... □

Signature ..... date..... Next review date…….

Signature ..... date..... Next review date…….

Signature ..... date..... Next review date…….

NB: Reassess every 24 hours or as soon as the patient's condition changes.

File in patient notes

Adapted with kind permission from Portsmouth Hospitals NHS Trust

Appendix 3

Patient Assessment
Patient wearing a Mitten restraint

Patient label

The main purpose of hand control mittens is to facilitate the provision of essential treatments to patient who remove tubes/line. Mittens can only be applied after assessment of Mental Capacity Function has found a requirement to treat patient in their best interest. The recommended mittens ONLY are to be used. Alternatives such as bandaging MUST NOT be used.

Observe skin three times per day – mittens can ideally be removed when relatives present

	08.00-14.00	14.00-21.00	21.00-08.00
Mittens still required	Yes☐ No☐ Reason_____	Yes☐ No☐ Reason_____	Yes☐ No☐ Reason_____
Circulatory Checks- Remove mittens if Pulse, colour, temperature, sensation are altered	Good circulation Yes☐ No☐ Removal Required Yes☐ No☐	Good circulation Yes☐ No☐ Removal Required Yes☐ No☐	Good circulation Yes☐ No☐ Removal Required Yes☐ No☐
Signs of tissue damage	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Is a venflon on this hand Resited	Yes☐ No☐ Yes☐ No☐	Yes☐ No☐ Yes☐ No☐	Yes☐ No☐ Yes☐ No☐
Swelling present	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Redness	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Inflammation	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Pressure sores	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Other problems eg patient distressed	Yes☐ No☐ state_____	Yes☐ No☐ state_____	Yes☐ No☐ state_____
Mitten clean and dry	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Change every 24 hours	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Dominant hand and the patient also has aphasia	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Mittens removed and replaced after checks. Problems Escalated to Drs	Signed_____	Signed_____	Signed_____
No longer required and removed	Signed_____	Signed_____	Signed_____

If the mitten is situated on the dominant hand after a stroke and the patient is aphasic- extra vigilance will be required to ensure the patient can ask for assistance.

Appendix 4

Information sheet for relatives on the use of hand control mittens

Seeing a relative in hospital can be very frightening. Patients sometimes seem to have many tubes and attachments, which may not always make sense to you. This leaflet has been written to explain why hand control mittens are sometimes used.

Tubes may be placed to provide fluid, medications or feed to a patient. Hand control mittens are only considered for use when patients are unable to keep in these tubes. This can be because of restlessness or confusion and the patient may not be aware that they need to keep these tubes in. The Naso-gastric tubes are often removed unintentionally and can be fairly easy to dislodge.

The nursing staff will have tried other methods to try and keep these tubes in place, but sometimes we have to use hand mittens for a short period of time to ensure that patients receive the treatment they need.

These mittens are only used on these occasions and the need for them has to be reviewed daily. There is a guideline for staff to follow to ensure that they are used appropriately.

Sometimes the team caring for your relative will have to make a clinical decision to use the mittens in the best interests of the patient. Where possible, we will always involve the patient in that decision, but sometimes they are not able to give their consent. Ideally you will have been shown the mittens before they are used, but on occasion we may have to put them on before you visit in order to ensure your relative receives the treatments needed to aid their recovery. It is also distressing for patients' to have tubes put in over and over again and using the mittens can reduce this.

If the mittens are used, it is important that they are removed regularly to check their skin and to give hand hygiene. This may be timed around your visits so that they can be removed when you are visiting.

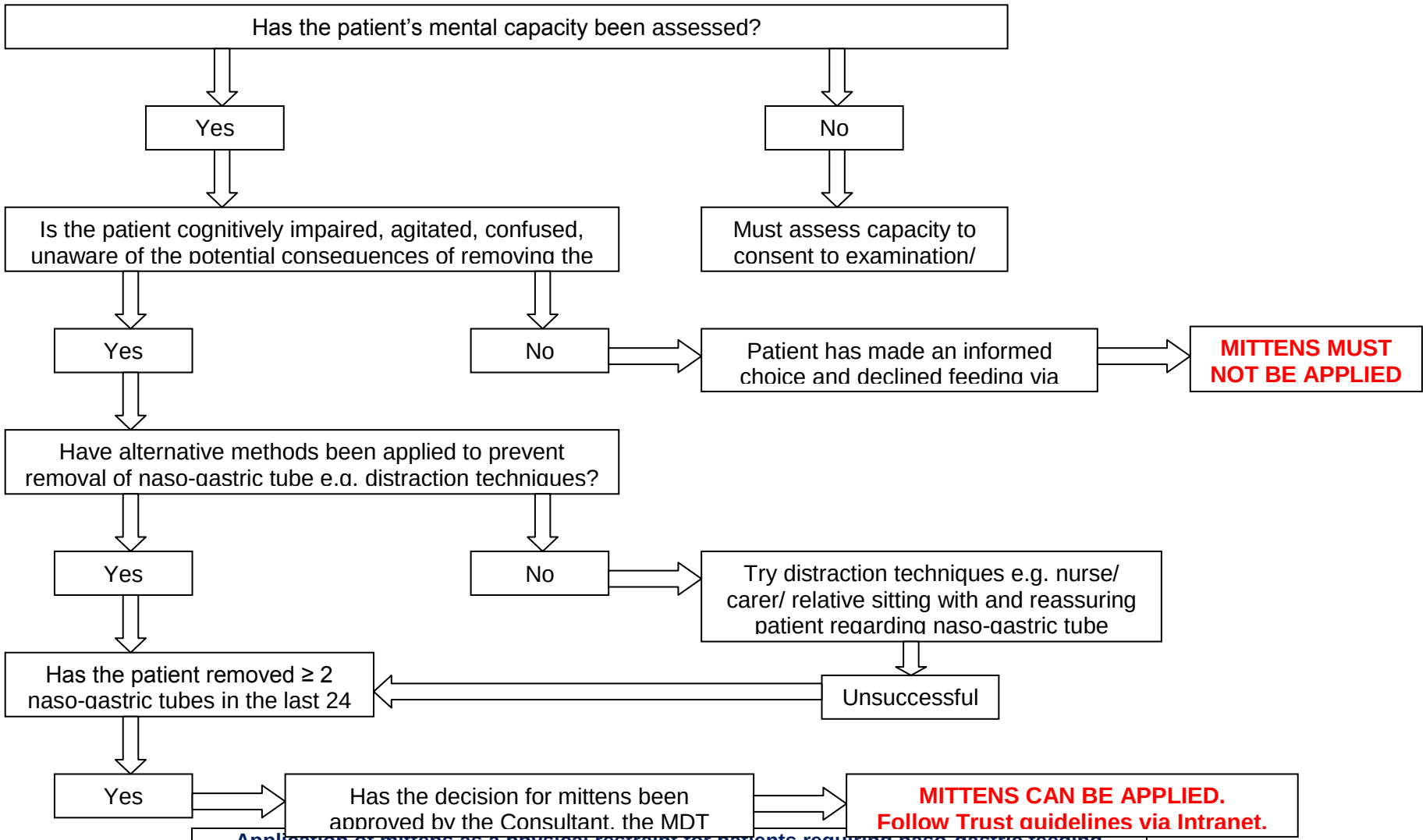
If you have any concerns about the mittens being used or would like to discuss it, then please speak to the nurse in charge of the ward.

Thank you

Adapted with kind permission from Portsmouth Hospitals NHS Trust

Appendix 5

Application of mittens as physical restraint for patients requiring naso-gastric feeding: flowchart



Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
10,11, &12	Appendix 2,3 & 4 compliance Trustwide	Audit compliance – 5 cases per month of DoLS datix records where the application involved the use of mittens	Monthly	Named Nurse Adults	Safeguarding Committee	Bi-annually

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	No	
	• Disability	No	
	• Gender reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
	• Race	No	
	• Religion or belief	No	
	• Sex	No	
	• Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the Policy/guidance likely to be negative?**	N/A	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	N/A

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval