

# **RCEM National Survey on Security and Restraint in the Emergency Department**

**December 2020**

## Summary

An online survey was sent asking ED clinicians about their experience of managing violent and behaviourally disturbed patients in their departments, and specifically what security services were available to support them. There were 124 respondents from across the 240 UK Emergency Departments from all UK countries. The results show a striking lack of consistency and standards across trusts with ED staff and patients being subjected to frequent potential harm.

### Main results

- Overall, in the 12 months preceding the survey, 98% of respondents reported that their ED had felt unsafe due to agitated or violent patient behaviour and 32% reported that their ED felt unsafe on a daily or weekly basis.
- Only 37% of respondents stated that if their hospital security team were called at midnight to contain a violent patient, they would provide a prompt and ample response, able to restrain a patient if needed.
- 53% of respondents stated that their security teams were not empowered to restrain patients, 10% said their ED either had a delayed or no security response.
- 84% of respondents stated that they did not allow the police to leave when they brought a patient to ED under a section 136 or similar. Of those EDs where police routinely left and transferred responsibility of the section to the ED, 61% of respondents stated that their security team would attend promptly if requested.
- An encouraging example was described of a rapid response team for acute behavioural disturbance that included security who had received specific training for mental health patients.

### Main recommendations

- There is an urgent need for national standards for security services for acute hospitals. This should involve specifying numbers of staff and training and skills required.
- Training in conflict resolution should be mandatory for all ED staff as well as the opportunity to undertake training in breakaway techniques.
- Security staff in an acute hospital should have training in mental health as well as safe restraint and legal basis for restraint. They should be familiar with NICE guidance for violence and aggression<sup>i</sup> and be able to safely restrain a patient at risk to facilitate rapid tranquilisation. This process should be led by a clinician.
- Acute trusts should have effective policies for zero tolerance of violence and aggression against staff. This should include use of security to protect staff and patients, steps to exclude patients if they are a significant risk to others and appropriate reporting and use of the criminal justice system.

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## Introduction

In 2019 the NHS Staff Survey showed 15% of NHS staff experienced physical violence from members of the public and patients in the preceding year (rising to 34% among ambulance staff)<sup>ii</sup>. Anecdotally, Emergency Departments are increasingly having to manage violent, aggressive, or agitated patients and sometimes their relatives within the daily running of the department.

Violence and aggression may arise for many reasons, not just physical or mental health triggers. Fear, pain, or frustration at delays are among other contributing factors. The prevalence of alcohol intoxication and agitation-provoking illicit substance use contributes to the problem. The growing population of elderly patients with dementia or episodes of delirium can also lead to behavioural disturbance that is challenging to manage in the ED.

Whilst steps have been taken to establish Section 136 suites and Mental Health Crisis Assessment Suites remote from EDs, many agitated patients will be suffering from a mental health crisis with concomitant physical health needs. They have often self-harmed and are at further risk of self-harm within the ED. Acute mental health units and section 136 suites do not provide the physical health assessment and care that these patients require. At other times, these facilities will be full, and ED is the next port of call. Further to this, long waits for mental health beds may add to patients' frustration leading to an increased risk of flight, self-harm, or agitation.

This survey was designed to gain a sense of how well equipped our EDs are when faced with violent and aggressive patients. It does not address how confident ED staff are at identifying patients with a risk of violence or with the use of de-escalation techniques. It does not seek to capture patient experience. The survey's main aim was to find out what security presence and skills EDs have to protect staff and patients when there is a risk of violence.

Some of the questions asked are in the context of restraining a patient which may be unpalatable for lay people to read about. RCEM fully endorses NICE guidance which recommends looking for signs of increasing agitation, de-escalation techniques and acting in a way that is least restrictive for a patient. However, patients may present with severe agitation and aggression which sometimes require restraint and sedation in order to facilitate treatment and keep them and others safe.

## Methods

An [online survey](#) was distributed to all UK ED clinical leads and ED mental health leads and was made available at the 2019 Autumn RCEM conference. We received 124 responses from a total of 240 EDs. Each UK country was represented with some EDs submitting responses from more than one clinician.

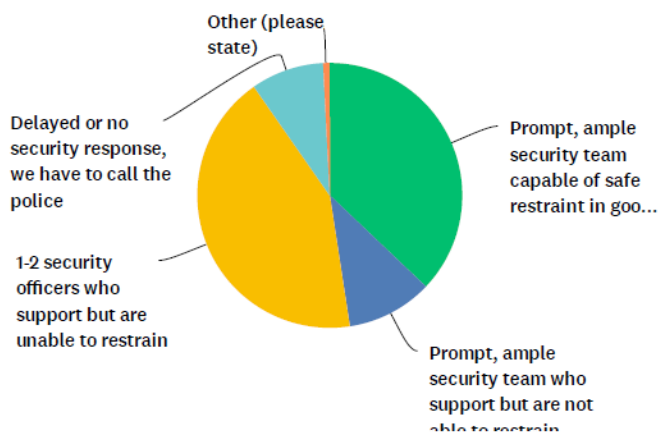
## Results

### Availability, training, and role of security services in the ED

Overall, 37% of respondents reported that a call for security to assist with a violent patient in the ED at midnight would result in a prompt, ample response by a security team who were able to deliver safe restraint. Conversely 63% of respondents reported a response which did not include the ability to safely restrain a patient if needed.

#### Q1 If you were to call for security for a violent patient in your ED at midnight, what response would you get?

Answered: 124 Skipped: 0

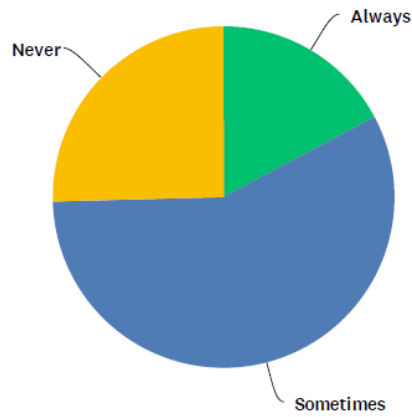


ANSWER CHOICES	RESPONSES	
Prompt, ample security team capable of safe restraint in good time	37.10%	46
Prompt, ample security team who support but are not able to restrain	10.48%	13
1-2 security officers who support but are unable to restrain	42.74%	53
Delayed or no security response, we have to call the police	8.87%	11
Other (please state)	0.81%	1
TOTAL		124

The survey reported an inconsistent response if security services were specifically asked to restrain a patient by a clinician.

### Q3 Do your security team restrain patients when requested to by a clinician?

Answered: 122 Skipped: 2

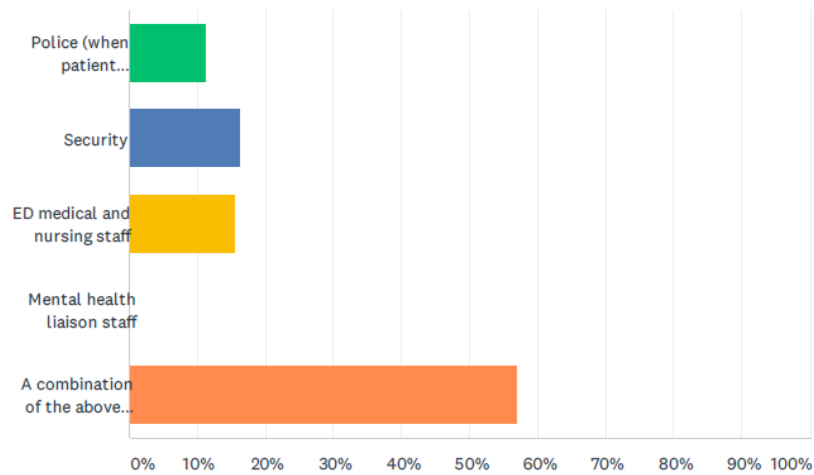


ANSWER CHOICES	RESPONSES	
Always	17.21%	21
Sometimes	57.38%	70
Never	25.41%	31
TOTAL		122

Most of the ED clinicians responding did not know if their security teams received any training in mental health. Only 20% reported that their security teams did receive relevant training, mostly from Liaison Psychiatry.

### Q4 In the event of a patient needing restraint for sedation, who performs the restraint?

Answered: 123 Skipped: 1



ANSWER CHOICES	RESPONSES	
Police (when patient escorted under Section 136 of MHA)	11.38%	14
Security	16.26%	20
ED medical and nursing staff	15.45%	19
Mental health liaison staff	0.00%	0
A combination of the above (state who)	56.91%	70
<b>TOTAL</b>		<b>123</b>

Comments made by respondents revealed that the involvement of security and/or the police often depended on who was available.

Security (although at midnight only 2 on for the entire hospital if no shortages) and clinical staff (we've receive no formal training).

Whoever is available.

Police will not lay hands for administration of medication.

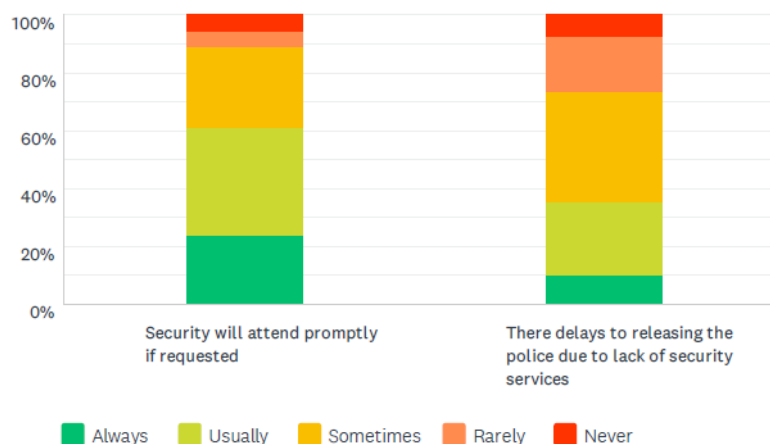
Liaison staff never involved or present. ED medical and nursing staff help. Security often reluctant and need to be persuaded. Police often not present as most of these patients needing sedation are not under a section 136.

## Patients on a section 136 (or similar in devolved nations)

84% of respondents stated that they did not allow the police to leave a S136 patient escorted to their ED. If police did leave a patient under a section 136 in the care of the ED, 61% of replies stated that if requested, security would 'usually' or 'always' promptly respond to assist.

### Q11 If you allow the police to leave:

Answered: 111 Skipped: 13



	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER	TOTAL
Security will attend promptly if requested	23.64% 26	37.27% 41	28.18% 31	5.45% 6	5.45% 6	110
There delays to releasing the police due to lack of security services	10.09% 11	24.77% 27	38.53% 42	19.27% 21	7.34% 8	109

Police leaving patients under a section 136 in ED came up as a common theme in the comments made:

We do not allow the police to leave, they just do.

Police shouldn't leave 136 patients but often try and sometimes do. We don't have enough staff to observe patients at risk of absconding/leaving.

Another respondent stated that most of their security issues in the ED related to intoxicated patients and they described such patients being brought in by the police under arrest, then being de-arrested 'so that the police can leave'.

### The use of body cameras

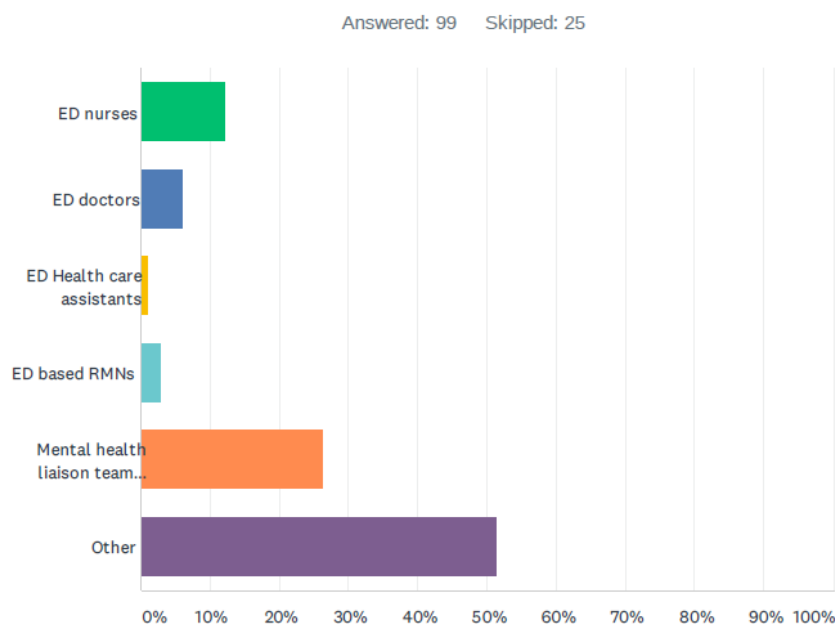
41% of respondents stated that their security team wore body cameras. 87% of respondents said that they thought their security team should wear body cameras.



## Clinical staff roles and training in control and restraint

When asked who was trained in control and restraint in their ED, responses showed that very few ED staff were trained in control and restraint. The category of other mostly referred to security.

### Q5 Which of the following are trained in control and restraint?



ANSWER CHOICES	RESPONSES
ED nurses	12.12% 12
ED doctors	6.06% 6
ED Health care assistants	1.01% 1
ED based RMNs	3.03% 3
Mental health liaison team members	26.26% 26
Other	51.52% 51
TOTAL	99

82% felt that clinical staff should receive training in restraint. 18% felt they should not.

I have received no training as a doctor in control and restraint.  
I am not aware the nursing staff are trained.

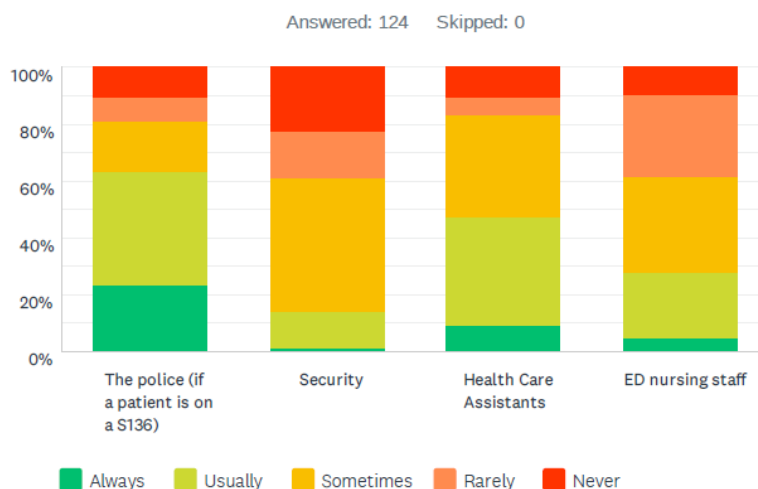
Currently no specific restraint training for ED clinical staff. Liaison psych employed by MH trust and it is standard for them.

We used to have more people trained e.g., ED porters and nurses, but over the years as training budgets have been cut, no-one in ED does.

## Patients requiring 1:1 observation

The graphs below show that there is no consistency in which type of staff carry out 1:1 observation. The most consistent answer is that police observe if the patient is under a section 136.

Q12 In relation to patients requiring 1:1 observations, this is carried out by:



	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER	TOTAL
The police (if a patient is on a S136)	23.08% 27	40.17% 47	17.95% 21	8.55% 10	10.26% 12	117
Security	0.86% 1	12.93% 15	47.41% 55	16.38% 19	22.41% 26	116
Health Care Assistants	8.94% 11	38.21% 47	35.77% 44	6.50% 8	10.57% 13	123
ED nursing staff	4.27% 5	23.08% 27	34.19% 40	29.06% 34	9.40% 11	117

Earlier questions and associated comments revealed that the police are frequently involved in the control and restraint of patients but that they may cease to provide help with restraint if the patient is in the process of receiving tranquilisation or sedation. This was alluded to in a comment made in response to the question regarding clinical staff training in control and restraint.

We have a big problem with police not willing to help restrain to sedate patients.

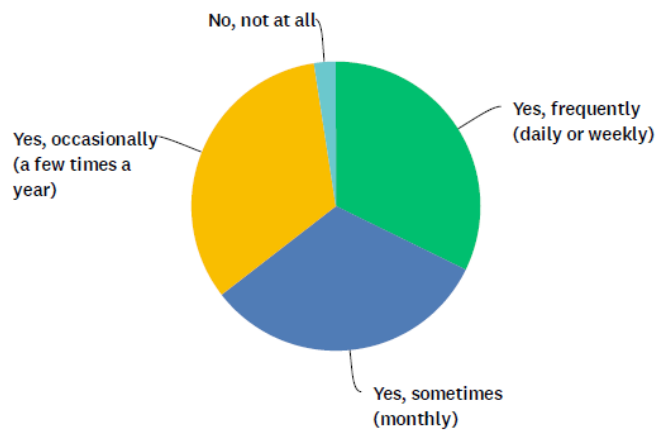
To sedate, police will remove all restraints and leave the ED staff to take over.

Mandatory training in conflict resolution is a complete joke when we are faced with an individual who a few minutes earlier has required six police officers to restrain them.

## Safety and critical incidents due to violent or aggressive patients in the ED

Q13 In the last 12 months has your ED ever felt unsafe due to agitated or violent patient behaviour?

Answered: 124 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes, frequently (daily or weekly)	32.26%	40
Yes, sometimes (monthly)	32.26%	40
Yes, occasionally (a few times a year)	33.06%	41
No, not at all	2.42%	3
TOTAL		124

32% responded that their ED felt unsafe on a daily or weekly basis and a further 32% felt unsafe on a monthly basis. Only 2% responded that their ED never felt unsafe.

Specific harm to staff included a nurse being stabbed multiple times, sexual assaults, staff threatened with knives and in one case a machete, an attempted strangling of a nurse and staff sustaining fractures.

Intoxicated patient brought in by police, not under a S136, spitting, racially and physically abusive. Police refused to restrain for sedation as they say they are not allowed. Security not happy to restrain therefore done by nursing and medical staff.

In addition, multiple incidents relating to physical assault, especially on nursing staff. Very few staff willing to take things further as most prove to be unsuccessful and patients return again and again.

It was also noted that harm comes from verbal abuse but that this is rarely reported.

We see a lot of 'low level' aggression which is difficult to prosecute e.g., screaming at staff but not necessarily profanities, generally animated behaviour and imposing of body space.

Serious self harm incidents whilst in the department awaiting MH bed leading to significant injuries (life changing).

49% of respondents recalled a critical incident or Serious Incident occurring in their department due to agitated or violent patient behaviour in the preceding 12 months. These included staff members being threatened with a machete, being stabbed, choked, punched, sustaining broken bones, being sexually assaulted and being spat at (see [Appendix 1](#)). It was noted that threats and verbal aggression, including racial abuse, often go unrecorded.

Patients came to harm either through self-injury, injury by another patient or through the ED being unable to restrain them, their subsequent absconding and the taking of their own life.

Several comments highlighted that the long waits for mental health beds led to some MH patients becoming agitated and harm ensuing. Others emphasized the role of acute alcohol or drug intoxication causing agitated, aggressive, or violent behaviour in patients.

Violence is increasing, as well as the numbers of unwell MH patients. Delays in MH beds have led to increased risk in the ED that is not a secure MH facility. We have a MH nurse on duty in the department to help care for these patients, however incidents are increasing.


The Trust is stopping the ability of security staff to physically restrain violent patients (we have been told that we are the only Trust that still restrains patients). Staff are concerned about this and the impact it will have.

## Positive Responses

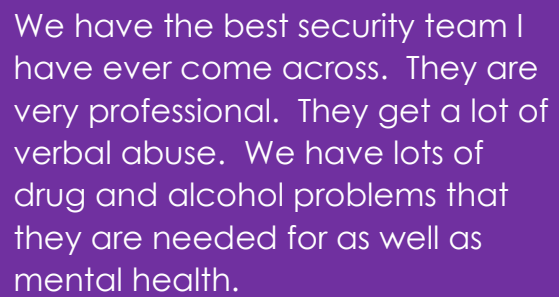
There were some examples of positive practice. One trust described an in house 'rapid response team' for any acute behavioural disturbance which includes security and a doctor as core members, and which assists in assessing the response required.

The same trust reported training their security team in the legality of patient restraint, only restraining if they are satisfied that they have sufficient legal framework as communicated and documented by their clinical team.

3% of responses reported that their trusts deploy a rapid assessment team that includes security to attend the initial triage and risk assessment of patients under a Section 136 of the MHA.



Our security team are excellent! Very responsive and pro-active. Most have really good de-escalation skills. If security have to provide 1:1 monitoring, they do a minimum of 2:1.



We have the best security team I have ever come across. They are very professional. They get a lot of verbal abuse. We have lots of drug and alcohol problems that they are needed for as well as mental health.

## Discussion

### Risk to patients and staff

EDs experience significant challenges from agitated and aggressive patients. Almost all respondents had felt unsafe in the last year and around a third reported feeling unsafe on a daily or weekly basis.

This survey has similar findings to one carried out in Jan 2020 by NHSE.

Anecdotally there has been more aggression in EDs this year with Covid 19. This is in part from anxious relatives who are now not allowed to accompany patients unless they are a carer, and from patients with more severe drug and alcohol or mental health presentations.

In the White Paper<sup>1</sup>, the Health Secretary emphasized the following:

*'It is essential that all leaders in the NHS at every level support their staff, including enabling them to access any training they need and use the full weight of the law, when necessary, to protect their workforce.'*

In February 2020, The Secretary of State for Health and Social Care wrote a letter to all NHS staff that stated<sup>iii</sup>:

*'I ask you that you please report every incident and act of abuse or violence against you or a colleague. No act of violence or abuse is minor.'*

Trusts and ED operational teams should examine how their "zero tolerance" policy translates into practice. Whilst some departments have a "yellow / red card" system to warn, exclude or remove patients who have exhibited aggression, other departments report no longer having this. ED staff may have to face aggression from the same patients again and again. Without proper security presence, it is impossible to enforce this system.

Patients as well as staff are at risk and this survey gave examples of patients suffering harm, including self-injury with a knife, life-changing injuries, and death. It is unacceptable if EDs are unable to prevent this happening.

Free text responses in the survey showed that ED staff can find themselves powerless to prevent high risk patients from absconding. RCEM standards state that patients at risk of absconding should be observed closely<sup>iv</sup>, either 1:1 or intermittently. However, if a patient absconds and is at risk, ED staff may be unable to go after the person and safely restrain them. Nor should we depend on police to go after this person every time as the police have limited and pressured resources.

A recently published framework around actions when a person goes missing states that organisations should risk assess patients at risk of going missing and have processes to mitigate and respond<sup>v</sup>. Police should only be involved if there is critical concern for the person's safety.

## Security services in ED

This survey shows a striking lack of consistency and standards for managing agitated and aggressive patients across trusts with ED staff and patients being subjected to frequent potential harm.

RCEM have been unable to identify any current overarching standards for security services in the ED and acute trusts. NHS Protect was formerly responsible for tackling violence in the NHS in England along with several other roles (including tackling fraud, criminal damage, and theft). It was replaced by the NHS Counter Fraud Authority in 2017 and no longer appears to cover issues relating to violence within the NHS. In contrast, security staff employed as doormen must have a security industry authority licence which involves training in conflict management and physical intervention skills.

Hospital trusts as employers have an obligation set out by the Health and Safety Executive to risk assess the ED as a workplace and implement controls<sup>vi</sup>, and yet many hospitals do not have adequate security services.

Early detection and de-escalation of aggression by ED staff is vital and security teams are needed which can respond quickly, help de-escalate, warn, and remove people who are aggressive when appropriate.

There are times when a patient is unwell and agitated and despite attempts to de-escalate the situation, the safest thing is to restrain and sedate a patient. This then allows us to safely assess and treat that person and is in keeping with NICE guidance<sup>i</sup>.

In departments that regularly expect security staff to restrain agitated patients who may be suffering from mental illness, it is unclear if our security services have received any training in mental health. These non-medical staff will provide a better outcome for patients and staff if they have had some training in mental health.

The minority of hospital security services wear body cameras, yet 87% of our respondents felt that they should do so.

82% of respondents felt that ED clinical staff ought to be trained in Control and Restraint. This may show that clinical staff feel the need to be trained as they have no other staff to take this role. In practice this may severely affect the therapeutic relationship they may have with a patient if they to be involved with restraint. This may be one explanation why Liaison Psychiatry staff, although trained in control and restraint, do not often practice it.

The consensus view from RCEM is that it is **not** the role of ED nurses and doctors to perform control and restraint, this is the role of security staff. ED staff should, however, have training in de-escalation and conflict resolution to try to reduce the incidence of aggression and violence in the ED. ED staff may also benefit from the opportunity to learn basic breakaway techniques.

There is an irony that those who often find themselves restraining violent or agitated patients (the ED doctors and nurses) have rarely received any training in Control and Restraint, yet those who have been trained (the police, security staff) may not feel empowered to do so.

RCEM welcomes the recent recommendations from the BMA around reducing and preventing violence against staff<sup>vii</sup>. Employers are recommended to have a violence reduction policy, risk assessments, adequate staff to manage risks and a culture of reporting, learning, and preventing further incidents.

RCEM would seek to add to this, a national standard on security staff in ED – both the numbers of security required and stipulating training in mental health, conflict resolution and safe restraint.

### **Police in the ED**

In the case of patients under a Section 136 of the MHA (or similar in devolved nations), in many EDs the police remain with the patient. In others, sometimes the police leave almost immediately, even when asked to remain for the purposes of patient and/or departmental safety. Police may also be deterred from using a section 136 if they know they will have to stay with a patient in ED for several hours.

Police resources are stretched and have other pressing duties to attend to. However, as the Webley<sup>viii</sup> case illustrated, if ED staff allow police to leave, the responsibility for keeping a patient safe from harm rests with the ED's acute trust.

Clinicians in ED are in a no-win situation if they do not have proper security who can go after a patient on section 136 if they abscond. They will always have to ask police to stay if there is any risk of absconding. From a patient's perspective, they should be looked after by health care staff rather than police as this may give the message that the patient has done something wrong. Nor is this the best use of a police officer when their resources are stretched.

Currently each ED should have a local agreement with police as to whose responsibility it is to keep a patient on a section 136 safe within the ED, but nationally we should aspire to have the staff within ED to take this responsibility.

### **Good models of care**

Security services described in a few trusts are responsive and effective, demonstrating good training in legal issues, mental health, and safe restraint. A model of care where security work together with clinicians in a team should be promoted. This may take different forms depending on the size and demographics of the hospital.



## Recommendations

- There is an urgent need for national standards for security services for acute hospitals. This should involve specifying numbers of staff and training and skills required.
- Security staff in an acute hospital should have training in mental health as well as safe restraint and legal basis for restraint. They should be familiar with NICE guidance for violence and aggression<sup>i</sup> and be able to safely restrain a patient at risk to facilitate rapid tranquilisation. This process should be led by a clinician.
- Security staff should wear body cameras as they act as both deterrent and record of incidents.
- Local restraint policies and the roles of both security and the police ought to be built around an agreed national policy.
- Training in conflict resolution should be mandatory for all ED staff as well as the opportunity to undertake training in breakaway techniques.
- ED staff should not be expected to restrain patients to keep them from harm or to protect others.
- Acute trusts should have effective policies for zero tolerance of violence and aggression against staff. This should include use of security to protect staff and patients, steps to exclude patients if they are a significant risk to others and appropriate reporting and use of the criminal justice system.

## Full survey

[Click here for the survey.](#)

## Appendix 1

### Free text comments on types on incidents recorded in individual EDs

*Intoxicated patient brought in by police not under 136, spitting, racially and physically abusive, police refused to restrain for sedation as they say they are not allowed, security not happy to restrain, therefore done by nursing and medical staff. In addition, multiple incidents relating to physical assault especially on nursing staff, very few staff willing to take further as most prove to be unsuccessful and patients return again and again.*

*Nurse stabbed multiple times, superficial cuts, one deep to hand. Dr punched to face cutting lip.*

*We have had security staff injuries - fractures and some ED staff injuries.*

*Agitated patient groped a member of nursing staff - considered a sexual assault. In the last week Paramedics assaulted outside resus room by a patient.*

*I personally have been assaulted once and gone to court.*

*Violent patient and a machete.*

*Patient attempted to strangle a member of staff. Staff sat at central desk, agitated patient approached from behind and placed staff member in choke hold - thankfully in busy area so staff responded and engaged patient who was restrained, and police called.*

*Knife pulled and use of pepper spray.*

*Patients absconding and committing suicide.*

*Patient assaulted other patients in WR. Assaulted police officer who intervened.*

## References

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<sup>i</sup> NICE guidance NG 10 Violence and Aggression: short term management in mental health and community settings <https://www.nice.org.uk/guidance/ng10>

<sup>ii</sup> [https://www.nhsstaffsurveys.com/Caches/Files/ST19\\_National%20briefing\\_FINAL%20V2.pdf](https://www.nhsstaffsurveys.com/Caches/Files/ST19_National%20briefing_FINAL%20V2.pdf)

<sup>iii</sup> Violence against NHS staff: letter to the workforce [www.gov.uk](http://www.gov.uk) 18 February 2020

<sup>iv</sup> RCEM Mental Health toolkit p.4

<https://www.rcem.ac.uk/docs/RCEM%20Guidance/Mental%20Health%20Toolkit%20019%20-%20Final%20.pdf>

<sup>v</sup> <https://www.missingpeople.org.uk/for-professionals/information-and-policy/policy/a-national-framework-for-the-response-to-adults-missing-from-health-and-care-settings>

<sup>vi</sup> <https://www.hse.gov.uk/healthservices/violence/do.htm>

<sup>vii</sup> <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/preventing-and-reducing-violence-against-staff> Published Jan 2020.

<sup>viii</sup> Webley v St George's Hospital NHS Trust and anr [2014] EWHC 299.

<http://www.bailii.org/ew/cases/EWHC/QB/2014/299.html>