Use of Safety Hand Mittens as a form of Physical Restraint

Department/ Service:	Corporate
Originator:	Deborah Narburgh, Head of Safeguarding Dr Riberio, Consultant Physician
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Approved by:	Integrated Safeguarding Committee Improving Safety Action Group (ISAG)
Approved by Medicines Safety Committee: *(When medicines are included in the document)*	N/A
Date of approval:	Integrated Safeguarding Committee 25.03.2025 Improving Safety Action Group (ISAG) 01.04.2025
Revision due: This is the most current document and should be used until a revised version is in place	19th April 2028
Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Trustwide
Target Staff Categories:	Medical & Nursing and Allied Health Professional staff directly involved in the management of patients requiring the use of safety hand mittens.

Policy Overview:

The purpose of this Policy is to provide clear guidance for the use of safety hand mittens when required, as part of a patients individualised care plan.
Safety hand mittens are soft mittens, similar to boxing gloves, that cover the hands and prevent patients from pulling out any lines or tubes that are being used to give them medication, fluids or nutrition.
The aim of the use of safety hand mittens is to protect the patient from self-injury or from pulling out or dislodging essential medical equipment e.g. cannula, catheter, intravenous lines, feeding tubes etc.
The use of safety hand mittens is a form of physical restraint and the relevant legislation surrounding consent, mental capacity and human rights must be upheld to ensure staff are lawfully using safety hand mittens when required; in the patients' best interests.

Key Amendments to this Document

Date	Amendment	Approved by:
08.01.2025	Full review and rewrite to cover areas across the Trust where the use of safety hand mittens may be indicated. References updated to reflect new Policy /procedure.	Integrated Safeguarding Committee 25.03.2025 ISAG 01.04.2025
01.09.2025	Policy amended following procurement product review. Training incorporated.	Integrated Safeguarding

	Tissue viability & IPC considerations strengthened.	Committee Chair Approval 19.09.2025
26.09.2025	Director of IPC amendments incorporated – dates of mitten change etc added to Appendix 3.	Integrated Safeguarding Committee Chair Approval 26.09.2025
05.02.2026 V4	Amendment to Advocacy Services provider as of 02.02.2026	D Narburgh Head of Safeguarding

Contents page:

1. Introduction

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The aim of the use of safety hand mittens is to protect the patient from self-injury or from pulling out or dislodging essential medical equipment e.g. cannula, catheter, intravenous lines, feeding tubes etc.

Some medical conditions can affect a patients' cognition (this may be temporary or permanent) and this may lead to the patient not receiving treatment that is deemed to be required in their best interests e.g. naso - gastric feeding, higher care treatment & intervention, medications etc.

Safety hand mittens **should only ever be used as a last resort when all other least restrictive options have been explored** e.g. fixation devices.

The use of safety hand mittens can be visually upsetting for the patient, their relatives and staff members. These sensitive situations require a full explanation of the requirement to use safety hand mittens in the patients' best interests and any alternatives that have been tried /considered.

The rationale for the use of safety hand mittens should be fully assessed and recorded within the patient's medical record in accordance with the use of restraint and Mental Capacity Act and Best Interest Decision Making Principles.

1.1 Relation to other Policy /Procedures

This Policy should be read / used in conjunction with:

- The Mental Capacity Act Code of Practice: Mental Capacity Act Code of Practice - GOV.UK
- Deprivation of Liberty Safeguards: via Trust key documents page
- Consent to Treatment Policy: via Trust key documents page
- Advance Decision to Refuse Treatment : https://www.nhs.uk/conditions/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/
- Lasting Power of Attorney (LPA) for Health & Welfare Decisions: https://www.gov.uk/power-of-attorney
- SWAN Advocacy: via Trust Safeguarding Hub

1.2 Aim of the use of safety hand mittens

The aim of the use of safety hand mittens is to avoid the use of chemical restraint and use less restrictive (and potentially less harmful) interventions.

1.3 Safety considerations when safety hand mittens are in use

- DO NOT allow patients to ingest mitt material; staff should be alert to any patient who may attempt to use their teeth to remove the device as this may result in injury

- Monitor the patient closely when the patient is out of bed**.** Patients who ambulate while wearing this device may be at risk of injury from a fall.

1.3.1 Tissue viability considerations:

- There is a potential risk that the safety hand mittens could cause some damage to the skin if they put pressure on it for prolonged periods of time, or cause problems with the circulation of blood to the hands. When someone is using safety mittens their hands must be checked and cleaned regularly and the condition of their skin monitored, to help prevent these problems
- Assessment should also include taking note of any medical and other devices (e.g. casts, urinary catheters, intravenous lines, oxygen masks, straps and ties) that can lead to additional pressure points (Pressure Injury Prevention and Wound Management, Ami Hommel and Julie Santy-Tomlinson. Author Information and Affiliations. Published online: June 16, 2018)

1.4 Type of Safety Mitten to be used

Only safety hand mittens with the product code detailed below should be used. The product can be ordered via the iProc system. Other mittens are on the market but may pose a ligature risk and have not been clinically evaluated for use within the Trust, therefore must not to be used.

	**Manufacturers Product Code:** • MITTOTW **NHS Supply Chain Product Code:** • GMB85477 **Brand and Supplier:** • Repton Medical Ltd

2. Scope of this Document

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

2.1 Exclusions

Safety hand mittens should not be used in patients whom are deemed to have mental capacity unless clinically indicated, and the principles of consent to treatment applied.

2.2 Contraindications and Special Considerations

Physical restraint in the form of safety hand 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

proven unsuccessful can safety hand mittens be applied to permit the effective and safe delivery of fluids, food and medications etc.

2.3 Informed Decision Making and Refusal

Safety hand mittens cannot be used in patients who are aware of the consequences /risks of removing a particular device etc and are demonstrating by their actions that they do not wish a particular intervention or treatment to be continued. 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 a mental capacity assessment (including risk, benefit, alternatives and any options considered) should be formalised and clearly recorded in the patient record.

2.4 Emergency Situations

Sometimes, people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay – the exception to this is when the healthcare staff giving treatment are satisfied that a valid and applicable advance decision to refuse treatment exists (*see MCA Code of Practice, 6.37*).

3. Definitions

The use of safety hand 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.

Physical restraint refers to: 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.

4. Responsibility and Duties

All Staff groups:

4.1 Manufacturer's Instructions

Safety hand mittens should be applied and used in accordance with the manufacturer's instructions. Failure to do so could render the practitioner negligent.

4.2 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.

4.3 Deprivation of Liberty Safeguards (DoLS)

It is difficult to define the difference between actions that amount to a restriction of someone's liberty and those that result in a deprivation of liberty.

In recent legal cases, the European Court of Human Rights said that the difference was 'one of degree or intensity, not one of nature or substance'. The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards - Joint Committee on Human Rights - House of Commons. There must therefore be particular factors in the specific situation of the person concerned which provide the 'degree' or 'intensity' to result in a deprivation of liberty.

In practice, this can relate to:

• the type of care being provided
• how long the situation lasts
• its effects, or
• the way in a particular situation came about.

Sometimes the cumulative effect of all the restrictions placed upon the person may amount to a deprivation of liberty, even if individually they may not. Deprivation of Liberty Safeguards (DoLS) relates to full and effective control measures being required**;** the use of mittens in isolation would not normally constitute a deprivation of liberty.

Staff should always be looking to seek the least restrictive option in order to deliver the required care or treatment in the person's best interests.

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 via the Safeguarding Hub page on the Trust 'Source' – Deprivation of Liberty Safeguards.
In the event staff are unsure as to whether a patient is being Deprived of their Liberty, then a DoLS application should be made.

4.4 European Convention on Human Rights

All staff have a duty to:

- Comply with the relevant rights in the European Convention on Human Rights at all times
- An understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced
- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations
- People must be treated with compassion, dignity and kindness
- Health and social care services must support people to balance safety from harm and freedom of choice
- Positive relationships between the people who deliver services and the people they support must be protected and preserved

(Positive and Proactive Care: reducing the need for restrictive interventions, DoH, 2014)

4.5 Infection Prevention & Control

All staff have a duty to ensure safety hand mittens are changed in accordance with the following:

- Where mittens are visibly soiled – change immediately
- Where the patient has a known infection e.g. MRSA, C Diff , norovirus etc – change daily
- All other patient groups – change every 72hrs
- The mittens should have recorded on them the date of APPLICATION and be recorded as per Appendix 3.
- Used mittens should be disposed of as per clinical waste.

5. Policy Detail

5.1 When might restraint be necessary?

Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If 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. *(MCA Code of Practice, 6.44)*

5.2 Patients who lack mental capacity to consent

Anyone assessing a person's capacity to make decisions for themselves or give consent must focus wholly on whether the person has capacity to make a specific decision at the time it needs to be made and not the person's capacity to make decisions generally.

The use of safety hand mittens in the care of patients whom lack the mental capacity to consent to their use, is a form of physical restraint.

Restraint can only be used where a patient lacks mental capacity to consent to it if:

• The staff member *reasonably believes* that it is **necessary** to prevent harm to the patient and,
• The restraint is **proportionate** both to the likelihood and seriousness of harm and
• The restraint must be in the patient's **best interests** and
• The restraint is the **least restrictive**, appropriate means by which to keep the patient safe from harm.

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.

The Mental Capacity Act 2005 (MCA) defines restraint as when someone "uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person's liberty whether or not they are resisting". Section 6 of the MCA states that restraining people who lack capacity will only be permitted if, in addition to it being in their best interests, the person taking action reasonably believes that it is necessary to prevent harm to the person. In addition, the amount or type of restraint used, as well as the amount of time it lasts, needs to be proportionate to the likelihood and seriousness of potential harm.

5.3 Assessment of Mental Capacity

Where consent to medical treatment is required, professional practice requires the treating clinician to assess and record the person's ability to consent to the proposed intervention or treatment.

Reasonable steps should be taken to find out whether the person has the capacity to make the decision about the proposed action.

The person who is going to take the action must have a 'reasonable belief' that the individual lacks capacity to give consent for the action at the time it needs to be taken. Secondly, the person proposing to take the action must have reasonable grounds for believing the action is in the best interests of the person who lacks capacity.

5.4 Who should be involved in the decision to use safety hand mittens?

The decision to use safety hand mittens should be made by the Multidisciplinary team in partnership with the patient and any involved parties e.g. Advocacy, family, carer etc

5.5 Healthcare & Treatment Decisions – working out what is in a person's best interests

Unless there is a valid and applicable advance decision to refuse the specific treatment, or the person has made a lasting power of attorney for health & wellbeing decisions; then healthcare staff must carefully work out what would be in the person's best interests.

As part of the process of working this out, they will need to consider (where practical and appropriate):

- the past and present wishes and feelings, beliefs and values of the person who lacks capacity to make the treatment decision, including any advance statement the person wrote setting out their wishes when they had capacity
- the views of anyone previously named by the person as someone to be consulted
- the views of anyone engaged in caring for the person
- the views of anyone interested in their welfare, and
- the views of any attorney or deputy appointed for the person. In specific cases where there is no-one else available to consult about the person's best interests, an Independent Mental Capacity Advocate (IMCA) must be appointed to support and represent the person

Healthcare staff must also consider whether there are alternative treatment options that might be less intrusive or restrictive (*Mental Capacity Act Code of Practice 2, principle 5*).

5.6 Advocacy

Some cases will require an Independent Mental Capacity Advocate (IMCA). The IMCA represents and supports the person who lacks capacity and they will provide information to make sure the final decision is in the person's best interests. An IMCA is needed when there is no-one close to the person who lacks capacity to give an opinion about what is best for them (*MCA Code of Practice, 6.9*)

5.7 Court of Protection

Some treatment decisions are so serious that the court has to make them – unless the person has previously made a Lasting Power of Attorney appointing an attorney to make such healthcare decisions for them, or they have made a valid advance decision to refuse the proposed treatment. For the purposes of this Policy, this relates to cases where there is dispute about whether a particular treatment will be in a person's best interests.

Useful resources:

Further advice and guidance can be found in MCA Code of Practice, 6.18.

Legal Services advice and support: Herefordshire & Worcestershire Combined Legal Services

Bournemouth University: www.ncpqsw.com

- The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment & care
- Advance Decisions to Refuse Treatment
- The mental Capacity Act Requirements for clinical decisions regarding treatment and care
- Advance Care Planning

5.8 Care Planning – Multi Disciplinary Team

The patient's mental capacity, ability to consent, and use of safety hand mittens should be reviewed on a regular basis.
The patient should have an individualised care plan reflecting the need / use of safety hand mittens.

5.9 Procedure – the guidance below should be used as a guide to reflect the clinical area where safety hand mittens are in use and the purpose for which safety hand mittens are indicated.

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.

Safety hand mittens should always be applied and used in accordance with the manufacturer's instructions.

5.9.1 Equipment

Purpose made mittens: **Product GMB85477 Repton Medical Safety Hand Mittens**

5.9.2 Decision making process

1. Assess patient's mental capacity (Appendix 1)
2. Does patient lack mental capacity to consent to examination/ treatment?
3. Alternative methods considered /tried –please state
4. Patient has removed ≥2 naso-gastric tubes in last 24 hours (Appendix 5)
5. Decision for medical mittens discussed and agreed as in the patient's best interests – this should be led by the patients Consultant, Advocate, involvement of family or MDT as appropriate (Appendix 2)
6. If all above applicable, then safety hand mittens can be applied (Appendix 3).

5.9.3 Doctors responsibility

- Assess mental capacity of patient and ensure the use of safety hand mittens is necessary to deliver the proposed care / intervention and that this is the least restrictive option
- Discuss the use of safety hand 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

5.9.4 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 (where 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 the safety hand mitten(s). Mittens do not always need to be applied to both hands after a stroke.
- The other nurse to attach the safety hand mitten to mobile hand ensuring appropriate positioning of mitten.
- Mitten needs to be secure but not tight, as this may reduce circulation to limb.
- The mittens should have recorded on them the date they were applied e.g. APPLIED 26.09.2025
- Please ensure that they fit the patient.

Monitoring of mittens

- Time when safety hand mittens are taken off are timetabled e.g. meal times, visiting times
- Remove safety hand 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
- Hand must be washed and dried carefully before mittens are reapplied
- Remember to date the mittens stating when they were APPLIED e.g. APPLIED 26.09.2025

Control of infection

- Mittens must be checked on removal (three times per day at 8 hourly intervals) for contamination
- If mittens are soiled they should be removed and changed immediately.
- Patients who have a **confirmed infection** e.g. C.diff, Norovirus, MRSA must have the mittens **changed daily.**
- Used mittens should be disposed of into clinical waste
- The date of any mitten change should be recorded on Appendix 3.

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

Other nursing responsibilities

- To ensure safe and effective care is delivered and documented
- To ensure the correct make of hand mitten is used in accordance with this Policy
- 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

6.1. Plan for Implementation

The latest version of this Policy can be found on the Trust intranet site key document and safeguarding pages.

6.2. Dissemination

Staff will be advised of the updated Policy via dissemination by attendees of the Trust Integrated Safeguarding Committee and associated Trust Governance Forums.

6.3. Training and Awareness

All Trust staff undertake mandatory training in respect of Consent, Mental Capacity and Deprivation of Liberty Safeguards at a level in accordance with their job role.

Product specific training will be provided by Repton Medical Ltd.
Patient information will be provided by Repton Medical Ltd.

7. Monitoring and Compliance

Section / page no:	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 the check reported to: *(Responsible for also ensuring actions are developed to address areas of non-compliance)*	Frequency of reporting:
No.	**WHAT?**	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
P. 5	These are the 'key' parts of the process that we a relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor 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'.
	Complete and add rows					
ALL	Appendix 2,3 & 4 compliance Trustwide	Audit compliance – 5 cases per quarter where the use of mittens is recorded within datix	Quarterly	Named Nurse Safeguarding Adults	Integrated Safeguarding Committee	Via Integrated Safeguarding Team quarterly and annual report

8. Policy Review

This Policy will be reviewed in accordance with key document review timeframes or in light of any changes to legislation or case law or procurement of safety hand mittens product.

9. References

Advance Decision to Refuse Treatment : https://www.nhs.uk/conditions/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/

Bournemouth University: www.ncpqsw.com

- The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment & care
- Advance Decisions to Refuse Treatment
- The mental Capacity Act Requirements for clinical decisions regarding treatment and care
- Advance Care Planning

Deprivation of Liberty Safeguards Code of Practice (2008). London: TSO

European Convention on Human Rights: Article 5. Right to security & liberty

Human Rights Act (1998)

Lasting Power of Attorney (LPA) for Health & Welfare Decisions: https://www.gov.uk/power-of-attorney

Mental Capacity Act (2005). London: HMSO

Mental Capacity Act Code of Practice Mental Capacity Act Code of Practice - GOV.UK

Positive and Proactive Care: reducing the need for restrictive interventions (2014). DoH
Positive and Proactive Care: reducing the need for restrictive interventions

Pressure Injury Prevention and Wound Management, Ami Hommel and Julie Santy-Tomlinson. Author Information and Affiliations. Published online: June 16, 2018

The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards - Joint Committee on Human Rights - House of Commons

Internal Policy /Procedure:

- Consent to Treatment Policy: via Trust key documents page
- Deprivation of Liberty Safeguards Policy: via Trust key documents page
- Mental Capacity Act Policy: via Trust key documents page
- SWAN Advocacy: via Trust Safeguarding Hub

10. Background

10.1. Equality requirements

Refer to supporting document 1.

10.2. Financial risk assessment

Refer to supporting document 2.

10.3. Consultation

Contribution List This key document has been circulated to the following individuals for consultation:	
Name	**Designation**
Caroline Mann - Worcestershire County Council	DoLS Team Manager
Integrated Safeguarding Committee Trustwide Divisional representatives	Trustwide representation
Julie Webber	Lead Nurse for Patient Experience
Patient Safety Team	wah-tr.PatientSafety@nhs.net
Intensive Care - Dr Edwin Mitchell	SCSD Associate Medical Director Consultant in Intensive Care Medicine and Anaesthesia Department of Anaesthesia
Legal Services – Rebecca Ollivere - Solicitor	Herefordshire & Worcestershire Combined Legal Services
Rachael Hayter	Director of AHP
Kate Haddigan	LGBTQ+ Network Vice Chair on behalf of Bec Harris LGBTQ+ Network Chair
Reena Rane	EmbRACE network (Chair)
Donna Scarrott	DAWN Network
Susan Smith	Deputy Chief Nursing Officer
Emma Fulloway	Infection Prevention & Control Team
Claire Hughes	Lead Nurse Tissue Viability
Liz Watkins	Associate Chief of Nursing / Director for Infection Prevention and Control
This key document has been circulated to the chair(s) of the following committees / groups for comments:	
Integrated Safeguarding Committee representatives	

10.4. Approval Process

This Policy will be approved by the Trust Integrated Safeguarding Committee and Improving Safety Action Group (ISAG).

10.5. Version Control

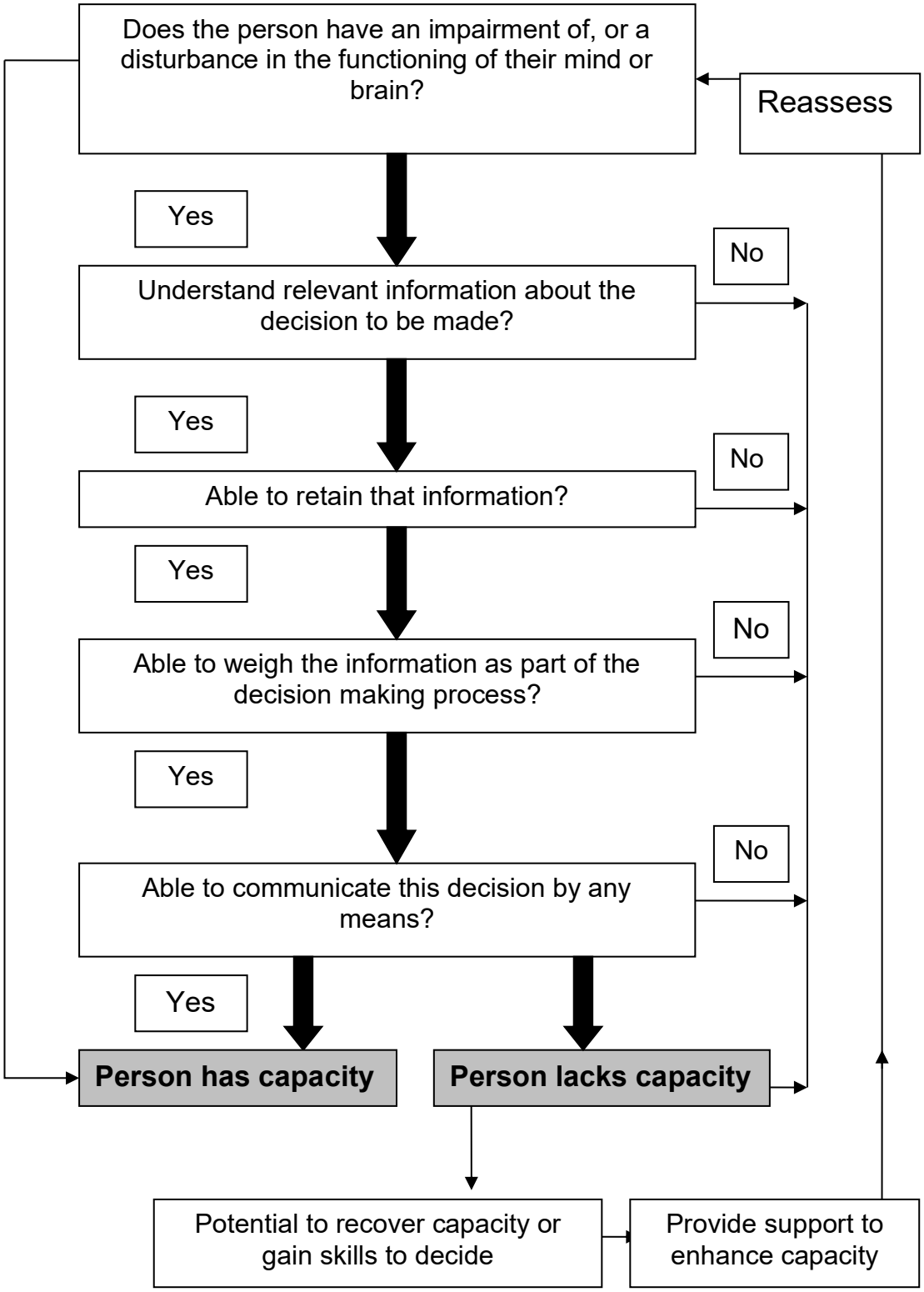
Date	Amendment	Approved by:
07.02.2025	Full review and update for use Trustwide	Integrated Safeguarding Committee 25.03.2025 ISAG 01.04.2025
01.09.2025	Policy updated following procurement product review. Training incorporated. Tissue viability & IPC considerations strengthened.	ISC Chair approval 19.09.2025

26.09.2025	Director of IPC amendments incorporated – dates of mitten change etc added to Appendix 3.	Integrated Safeguarding Committee Chair Approval 26.09.2025
05.02.2026 V4	Amendment to Advocacy Services provider as of 02.02.2026	D Narburgh Head of Safeguarding

11. Appendices

11.1. Appendix 1

Flow Chart - Assessment of Capacity



Appendix 2

Patient label

Patient Assessment form for the use of safety hand mittens

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 safety hand mittens been issued for this patient?

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 reduced 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 safety hand mittens is to facilitate the provision of essential treatments to patients who remove tubes/lines. Mittens can only be applied after assessment of Mental Capacity has found a requirement to treat the patient in their best interests. The recommended safety hand 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

Date:

	08.00-14.00	14.00-21.00	21.00-08.00
Correct type of mitten in use – **if no, remove immediately and replace with product GMB85477**	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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 e.g. patient distressed	Yes☐ No☐ state_____	Yes☐ No☐ state_____	Yes☐ No☐ state_____
Mitten clean and dry	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Record date mittens initially APPLIED **(day 1)**	Date:		

Subsequent mitten changes :			
Change every 3 days unless soiled or, **patient has a confirmed infection e.g. C.diff, Norovirus, MRSA must have the mittens changed daily.**	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Record Date mittens changed	Date:	Date:	Date:
Record Date mittens next due to be changed	Date:	Date:	Date:
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 safety hand 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 safety hand mittens are sometimes used.

Tubes may be placed to provide fluid, medications or feed to a patient. Safety hand 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. 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 safety 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 safety hand 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.

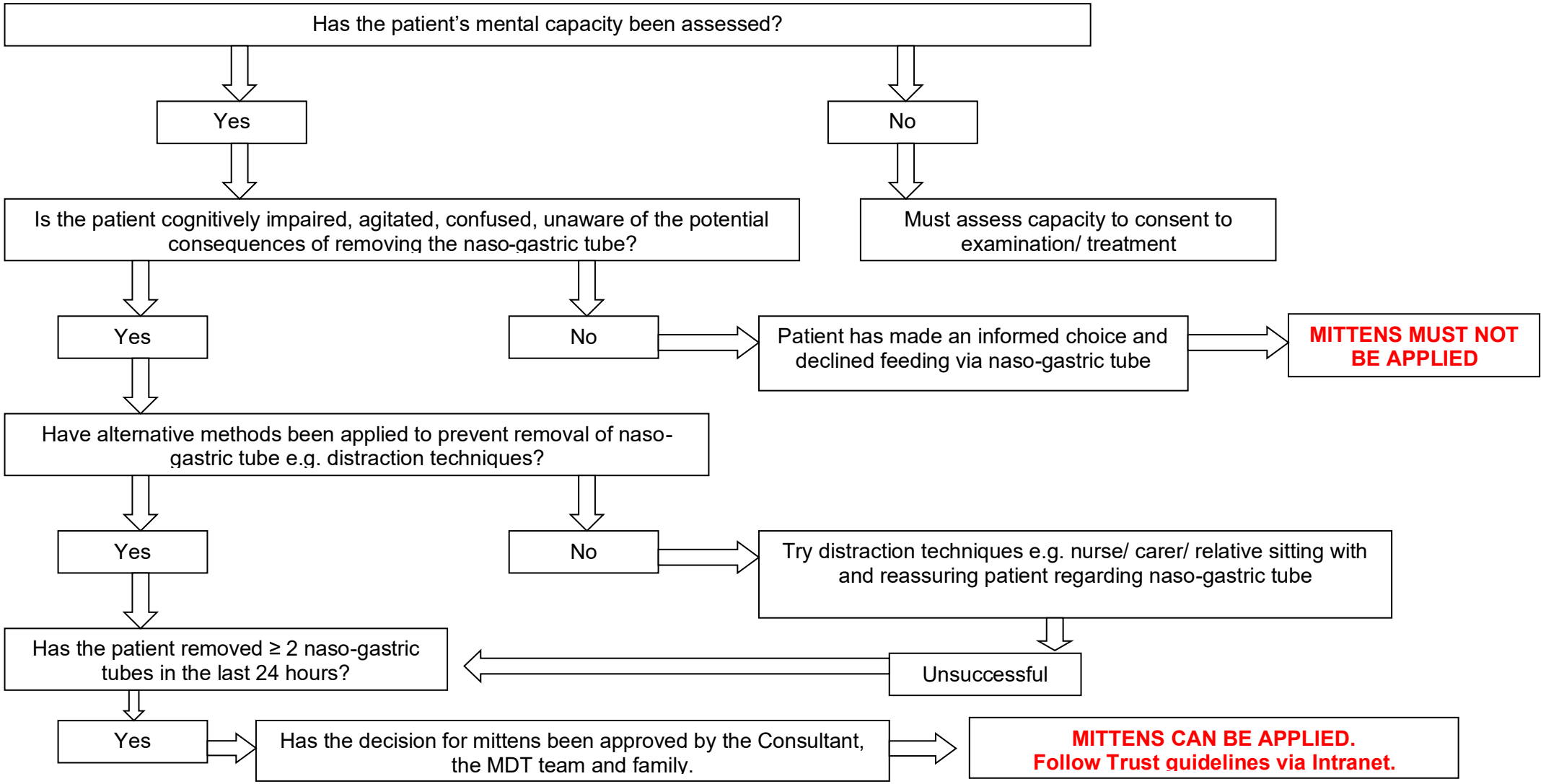
If the safety hand mittens are used, it is important that they are removed regularly to check the patients skin and to give hand hygiene. This may be timed around your visits so that they can be removed when you are visiting.

If you have any concerns about the safety hand 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 Safety Hand Mittens for patients requiring naso-gastric feeding flowchart



12. Supporting Document 1 – Equality Impact Assessment Form

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

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Deborah Narburgh	Head of Safeguarding	deborah.narburgh@nhs.net
Date assessment completed	07.02.2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Use of Safety Hand Mittens as a form of Physical Restraint				
What is the aim, purpose and/or intended outcomes of this Activity?	The purpose of this Policy is to provide clear guidance for the use of safety hand mittens when required, as part of a patients individualised care plan. The use of safety hand mittens is a form of physical restraint and the relevant legislation surrounding consent, mental capacity and human rights must be upheld to ensure staff are lawfully using safety hand mittens when required; in the patients' best interests.				
Who will be affected by the development & implementation of this activity?	x x x ❑	Service User Patient Carers Visitors	x ❑ ❑ ❑	Staff Communities Other _____	

Is this:	x Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Legal Frameworks Codes of Practice Practice Guidance
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Detailed within Policy
Summary of relevant findings	Detailed within Policy

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Disability		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Gender Reassignment		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Marriage & Civil Partnerships		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Pregnancy & Maternity		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Race including Traveling Communities		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Religion & Belief		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Sexual Orientation		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		Legislative frameworks, Codes of Practice and Practice guidance applicable to all adults

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected

characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D Narburgh
Date signed	07.02.2025
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

13. Supporting Document 2 – Financial Impact Assessment

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

ID	Financial Impact:	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:		