NHS Orkney

CLINICAL HOLDING POLICY

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Engagement and Consultation Groups:	Director of Nursing, Midwifery and Allied Health Professions Hospital General Manager Charge Nurses Dental Mental Health Team
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1 Introduction

1.1 The use of restrictive physical interventions within services for people, (children and adults), with learning disabilities and mental ill health is accepted as a possible appropriate response to incidents of severe challenging behaviour, aggression and/or violence. Standards regarding this specific area of practice have been developed by the British Institute of Learning Disabilities (BILD), the Department of Health (DoH) and the Department for Education and Skills (DfES).

1.2 This Policy has been developed to aid clinicians in making appropriate decisions regarding the assessment and treatment outcomes for any patient who may require some form of physical support or intervention as part of their treatment plan, regardless of cause. Without these interventions such patients may not receive appropriate, safe or effective treatment for reasons not necessarily related to challenging behaviour, but because their behaviour presents a risk to themselves, staff or accompanying persons.

1.3 The patient's safety and welfare is of prime importance and NHS Orkney supports the ethos of caring and respect for the patient's rights. Clinical holding without consent is a last resort and not the first line of intervention.

2 Definitions

2.1 A definition of Clinical Holding as taken from the Mental Capacity Act is 'The use of restrictive physical interventions that enable staff to effectively assess or deliver clinical care and treatment to individuals who are unable to comply.'

2.2 Clinical holding may be defined as the proactive holding of part of the body to allow a procedure to be carried out, e.g. holding an arm while blood is being taken in order to prevent reflex withdrawal and consequent unnecessary pain, distress or injury to the patient, staff or accompanying persons.

3 Responsibilities

3.1 **The Board** has an obligation to provide/offer assessment, investigation and treatment to all people and therefore has a responsibility to those not able to provide informed consent due to permanent or temporary incapacity.

3.2 **Line Managers:**

- must ensure Staff adhere to the Clinical Holding Policy;
- must ensure that Risk Assessments take account of the risk of physical and emotional harm to patients and staff;
- must ensure that all relevant staff receive appropriate training in Clinical Holding;
- must ensure that staff have an awareness of their professional accountability, particularly in regard to Child Protection, consent and confidentiality issues;
- must ensure that patients or their families, carers, significant others receive appropriate information re clinical holding.

3.3 **Staff:** are responsible for ensuring that clinical holding takes place in a controlled and safe manner in accordance with this Policy

- must attend relevant training;
- must undertake an holistic assessment of the patient including cognitive, physical and emotional needs and identifying any procedures for which the patient may require holding. The assessment must be fully documented;
- must obtain consent from the patient or welfare guardian or power of attorney. This consent must be documented. It is recommended that any such decision should be discussed with relatives. It may be reasonable under common law to use clinical holding with any patient (with or without capacity) as an emergency response where the behaviour constitutes an immediate or significant risk to the patient or others;
- must be professionally accountable particularly in regard to Child Protection, consent and confidentiality issues.

The Adults with Incapacity (Scotland) Act 2000 (AWIS) applies to any adult (over the age of 16) who lacks the capacity to make all or some of the decisions for themselves because of a mental disorder or an inability to communicate due to a physical disability. Part 5 of the Act deals specifically with medical treatment and research. The Act stresses an approach to the assessment of incapacity that is decision or action-specific. Registered medical practitioners; or dental practitioners, or opthalmic opticians, or registered nurses who have completed prescribed training may issue a certificate of incapacity under Section 47 of the Act giving authority to carry out medical treatment. Health professionals can only authorise treatment in

their own areas. A certificate is required for all treatment except in an emergency.

The Act is supported by five Principles which must be applied with every intervention into the affairs of adults who lack capacity. The person authorising or effecting the intervention is responsible for ensuring that the principles are upheld. The Principles are:

Benefit – any action or decision must be beneficial to the patient and must only be taken when the benefit cannot be achieved without it.

Least restrictive option – any action or decision taken should be the minimum necessary to achieve the purpose and should restrict the patient's freedom as little as possible for the shortest time possible.

Take account of the patient's wishes – the past and present wishes and feelings of the patient should be taken into account as far as possible and the patient must be offered help in communicating these.

Consultation with relevant others – the views of others with an interest in the patient's welfare should be taken into account, so far as is reasonable and practicable to do so. Such others may include the patient's nearest relative or primary carer; the patient's named person; the patient's continuing or welfare attorney or guardian; any person whom the sheriff has directed should be consulted or any other person appearing to have an interest in the welfare of the patient or the proposed intervention.

Enhancing skills and abilities – any one exercising functions under the Act should, as far as is reasonable and practical to do so, encourage the patient to exercise existing skills and to develop new ones. These skills could include ones concerning property, financial affairs or personal welfare. Any patient who is unable to make decisions regarding medical treatment may be able to make decisions regarding other aspects of his/her care and should be encouraged to do so.

The above mentioned five principles represent good practice in all matters concerning adults with impaired capacity and should be applied whether or not it is a statutory requirement to do so in any particular circumstance. The principles can be particularly helpful when difficult judgements have to be made.

4 Training

Training will include: legal, moral and ethical contexts;
clinical holding techniques;

alternative techniques e.g. distraction

By the end of the training programme participants will:

- make evidence-based decisions re the use of clinical holding which can be benchmarked against legal and professional standards for risk reduction;

- explain risks associated with the use of clinical holding;

- demonstrate verbal and non-verbal de-escalation strategies;

- demonstrate appropriate clinical holding techniques and how to disengage from them.

- In accordance with the BILD Code of Practice refresher training shall be undertaken every 12 months for relevant Staff.

The training is for all Staff who are required to do Clinical Holding on patients - this includes Nursing Staff in all areas of patient care and Dental Staff, as well as any other Staff who may be required to do this in order to deliver essential care or assessment.

5 Documentation

The use of clinical holding must be fully documented in the patient's records. This should be done as part of the planned decision making process as well as after each intervention.

Accurate records:

- except in cases of emergency there must be a valid section 47 in force appropriately applied and signed by a relevant medical practitioner which gives authority to treat the patient who lacks capacity;
- demonstrate due diligence by practitioners;
- may be used to evidence compliance with statutory or regulatory requirements;
- assist in informing future decisions regarding the patient's treatment;
- may be useful in establishing trends and patterns regarding effective or ineffective strategies.

All physical interventions, planned or unplanned, should be recorded as soon as possible after the event but certainly within 24 hours, by the person(s)

involved. The written record shall include:

- the names of staff and patient involved;
- the reason for using clinical holding rather than another strategy;
- the type of intervention used;
- the date and duration of the intervention;
- whether anyone involved sustained injury or distress and any action taken.

Accurate record keeping aids in the prevention of abuse or misuse of physical interventions and in the protection of vulnerable children, young people and adults.

6 Audit

Audits of the records of patients with whom clinical holding has been used will be conducted to ensure adherence to this Policy.

7 Review

This Policy will be reviewed by the Clinical Holding Trainer initially one year after implementation and then every 2 years, or sooner should there be a statutory or regulatory requirement to do so.

8 References

Adults with incapacity (Scotland) Act 2000 Code of Practice (3rd edition) ‘For Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act

British Institute of learning Disabilities ‘BILD Code of Practice for the use and reduction of restrictive physical interventions’. 3rd edition 2010

British Society for Disability and Oral Health - Unlocking Barriers to Care ‘Guidelines for ‘Clinical Holding’ Skills for Dental Services’. 2009

Clinical Holding Policy - Royal Liverpool Children’s Hospital NHS Trust Policy N0. RM 27

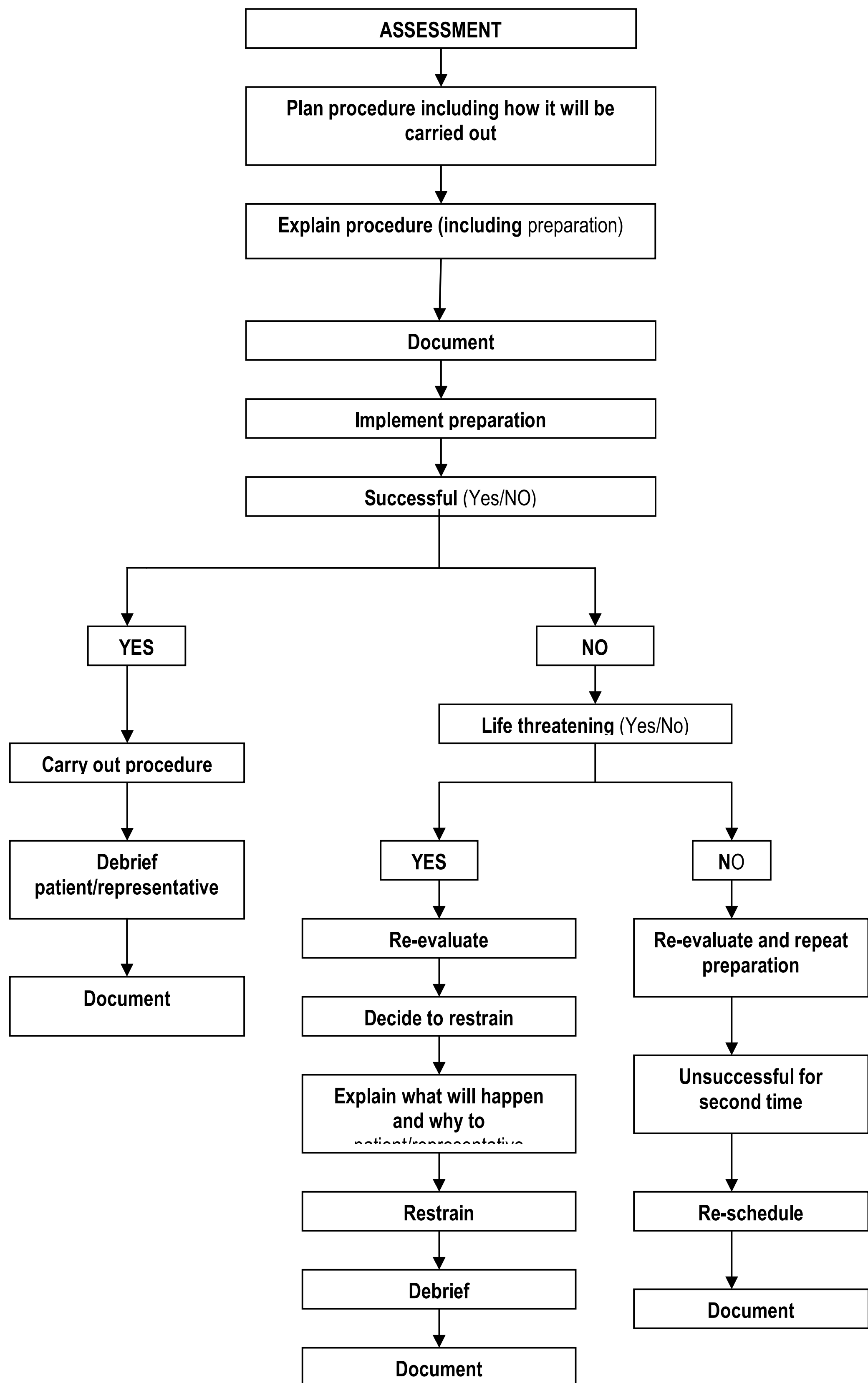
Mental welfare Commission for Scotland (2011) ‘Right to Treat?’

NHS Education for Scotland (2012) ‘Think Capacity Think Consent’

‘Restrictive Physical Intervention and Therapeutic Holding Policy for Children

and Young People' Portsmouth Hospitals NHS Trust. 2011

9 Appendix A FLOW CHART FOR CLINICAL HOLDING


ASSESSMENT
Plan procedure including how it will be carried out
Explain procedure (including preparation)
Document
Implement preparation
Successful (Yes/NO)
YES
NO
Carry out procedure
Debrief patient/representative
Document
Life threatening (Yes/No)
YES
NO
Re-evaluate
Decide to restrain
Explain what will happen and why to
Restrain
Debrief
Document
Re-evaluate and repeat preparation
Unsuccessful for second time
Re-schedule
Document

10 Appendix B

NHS Orkney

CONSENT AND INFORMATION DOCUMENTATION FOR CARRYING OUT CLINICAL HOLDING PROCEDURE

Patients name:

Patient's CHI No: **Treating Consultant:**

Is there a valid section 47 certificate in place to cover this treatment?
Yes **No**

What procedure is to be carried out?

Who requested the procedure?

Professionals involved in the procedure:

Who is making the decision to carry out clinical holding?

Has informed consent for the procedure been obtained and documented in the patient's notes? **Yes** **No**

Name (Print): **Signature:**
(Health Care Professional)

Name (Print): **Signature:**
(Health Care Professional)

Name (Print): **Signature:**
(Health Care Professional)

Name (Print): **Signature:**

Name (Print):

(Patient / Patient's Representative) **Date:**

This document is to be filed in the patient's case notes on completion of the procedure.

NHS
Orkney

NHS Orkney – Equality and Diversity Impact Assessment

Rapid Impact Checklist: Summary Sheet

Document title: **Clinical Handling Policy**

Positive Impacts (Note the groups affected)	**Negative Impacts (Note the groups affected)**
Patients and staff ✓ Will aid clinicians in making appropriate decisions regarding the assessment and treatment outcomes for patients who may require some form of physical support or intervention as part of their treatment plan, regardless of cause. Without these interventions such patients may not receive appropriate, safe or effective treatment for reasons not necessarily related to challenging behaviour, but because their behaviour presents a risk to themselves, staff or accompanying persons	None identified

Additional Information and Evidence Required

none

Recommendations

none

From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

Full EQIA process not recommended.

Name and Signature of Level One Impact Assessor

Name: Maggie Berston

Date: 18/02/15