Worcestershire Acute Hospitals NHS Trust

Restrictive Physical Intervention (Restraint) and Clinical Holding for Children and Young People

Key Document code:	WAHT-TP- 055	
Key Documents Owner:	Dana Picken	Consultant Paediatrician
Approved by:	Paediatric Quality Improvement meeting	
Date of Approval:	9th February 2024	
Date of review: **This is the most current version and should be used until a revised document is in place**	9th February 2027	

Key Amendments

Date	Amendment	Approved by
19th Nov 2020	Document extended for 1 year	Dr J West/Paediatric QIM
26th March 2021	Approved with no amendments	Paediatric QIM
9th February 2024	Document reapproved, no amendments.	Paediatric QIM

Introduction

The child and young person's safety and welfare are of paramount importance and the Trust supports the ethos of caring and respect for children and young person's rights.

On occasions, children/young people may present with a wide range of challenges in terms of non-compliance with essential medical procedures/clinical treatments requiring clinical holding or present with disturbed and challenging behaviour which could pose a risk of harm and require the use of restrictive physical interventions (restraint). This pathway outlines the requirements to ensure children and young people who may require restrictive physical interventions (restraint) or clinical holding for a clinical intervention receive this in a safe and controlled manner in which discomfort and anxiety are minimised.

Restrictive physical intervention (restraint) or clinical holding if used inappropriately, may give rise to criminal charges under civil law or prosecution under health and safety legislation.

All practitioners are responsible for protecting the best interest of children and young people while upholding the standards of practice specified by their respective professional bodies.

Successful use of physical interventions is dependent on a clear pathway, recognised standard of staff training and development, which is supported by proficient management, leadership and staff support.

This pathway has been written in line with the following current national guidance and legislation

- Patient Safety Alert Stage One: Warning the importance of vital signs during and after restrictive interventions/manual restraint
- Restrictive physical intervention and therapeutic holding for children and young people – guidance for nursing staff (RCN 2010)
- The Children Act (1989)
- United Nations Conventions on the Rights of the Child (1990)
- The Human Rights Act (1998)
- Duty of Care (Nursing and Midwifery Council 2008a)

Responsibility and duties

Chief Executive

The Chief Executive is responsible for ensuring that the health and safety needs of all children and young people are at the forefront of local planning and that high quality health services that meet identified quality standards are provided.
The Chief Executive will ensure the Trust is discharging its duty under the Children Act 1989 and is Compliant with the requirements of Care Quality Commission Outcome 7
The Chief Executive will ensure this policy is fully implemented and monitored across the Trust.

Heads of department/Nursing

Responsible for ensuring that staff within their area of responsibility are fully aware of and are working within the remit of this policy.
They must identify any areas where children/young people may be at particular risk and ensure staff are promoting safe practices, are appropriately trained and understand their individual responsibility in using therapeutic holding or restrictive physical interventions.
They must ensure that risk assessments carried out identify factors which may necessitate the use of restrictive physical interventions/clinical holding and that all reasonable practicable measures will be taken to protect the safety and well being of children at all times.
In partnership with Ward Managers they proactively take into account the clinical skills and staffing levels required to safely undertake restrictive physical interventions/clinical holding on a 24 hour basis and that frontline staff are adequately supported on a daily basis.
They must ensure staff continue to maintain their professional accountability with regards to safeguarding children/young people
They must ensure clinical staff report all episodes of restraint relevant incidents using the incident reporting system. Any injury to a child/young person, member of staff or visitor to the Trust premises, involving the use of restrictive physical interventions or therapeutic holding should be considered a clinical incident and reported according to Trust policy. Any injury to a child/young person must also be reported to Head of Child Protection and Consultant in Charge
They must ensure that within the open and transparent culture, children/young people, staff and visitors involved in situations where restrictive physical interventions/clinical holding are used are aware of the range of support available and are encouraged to seek the appropriate assistance.
They must ensure staff are appropriately supported and are encouraged to voice any concerns about the therapeutic holding/restrictive physical interventions applied
Young people and staff must have the opportunity to debrief after an incident including restraint

Clinical Staff

Understand their levels of responsibility in relation to using restrictive physical restraint or clinical holding safely
Work within the remits of this pathway and complete mandatory training provided by the Trust
In accordance with the Health and Safety at Work Act, clinical staff have a duty to disclose any injuries, conditions or disabilities or any personal circumstances that may put them or others at risk
They must follow procedures for reporting incidents
It is expected that clinical staff will immediately report concerns to senior manager if they feel inappropriate physical restraint has been used
They are required to accept responsibility for the safety of young people, visitors and colleagues and are responsible for taking reasonable care of their own health and safety and that of others who may be affected by their actions or omissions at work

Prevention

Every effort should be made for children and young people to receive explanation about their illness and treatment, which maximises their understanding. This may avoid the need for clinical holding or restraint.

Early recognition of increased arousal / agitation. Early intervention and de-escalation.

Clinical holding and restraint should be the last resort: where preventative strategies such as dialogue, diversion and distraction techniques have been ineffective.

Good decision-making about restrictive physical interventions and clinical holding requires that in all settings where children and young people receive care and treatment, there is:

- an ethos of caring and respect for the child's rights, where the use of restrictive physical interventions or therapeutic holding without the child/young person's consent are used as a last resort and are not the first line of intervention.

- a consideration of the legal implications of using restrictive physical interventions. Where necessary, application should be made through the Family Courts for a specific issue order outlining clearly the appropriate restraint techniques to be used.

- an openness about who decides what is in the child's best interest – where possible, these decisions should be made with the full agreement and involvement of their parent or guardian.

Clinical Holding for planned procedures

Clinical holding is the proactive immobilisation of the child or young person or part of the body for example an arm in order to prevent reflex withdrawal causing injury or distress to the child or young person
On occasions children or young people may need to be held in a safe and controlled manner for a variety of clinical procedures, examinations or treatments. For example taking blood samples, inserting intravenous cannulae, catheterisation, lumbar puncture, suturing/gluing wounds ,where it is essential the child or young person is assisted to keep still
The child and young person's safety and welfare are of paramount importance and the Trust supports the ethos of caring with respect for children and young person's rights
All staff must observe the Trust consent policy: in all but the very youngest children, obtain the child's consent or assent and for any situation which is not a real emergency seek the parent/carer's consent, or the consent of an independent advocate.
Staff who are competent and trained should explain to the child/parents to ensure their understanding about the child's care plan and the necessity to use clinical holding where it is in the child's best interests.
Collaborative planning and preparation involving staff ,family and child is essential taking into account the child's emotional, cognitive, physical, and educational needs and development
Effective preparation successfully reduces the need for any undue force or restriction in clinical holding
The child should be given time to play to enable them to explain their fear, anxiety, anger. In some cases a child psychologist /play therapist may need to be involved, particularly for repeated procedures in children and young people with long term conditions
Understanding a child/young person's behavior and responding to their individual needs should be at the centre of patient care ,preparation for clinical holding should take into account the Child /young person's fears and phobias ,medical condition, mental health, learning disability, treatment refusal as part of adolescent behavior ,Staff should anticipate and prevent the need for holding,

where possible by giving the child age appropriate information, encouragement, distraction and, if necessary for certain procedures such as MRI , using sedation as an option

They should make an agreement beforehand with parents/ guardians and the child about what methods will be used, when they will be used and for how long. This agreement should be clearly documented in the plan of care and any event fully documented. If available written information must be given to the child/young person/parent/carer where appropriate **before** the procedure takes place.
Best practice would ensure parental presence and involvement - if they wish to be present and involved. Parents/ guardians should not be made to feel guilty if they do not wish to be present during procedures. Nurses should explain parents' roles in supporting their child, and provide support for them during and after the procedure.
It may be appropriate to make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining and preparing the child/ parents beforehand as to what will happen.
Staff must comfort the child or young person where it hasn't been possible to obtain their consent, although parental consent has been obtained; explain clearly to them why immobilisation is necessary and how it will be carried out. Staff should make every effort to gain their co-operation.
Any marks left following therapeutic holding must be clearly documented in the child's clinical record and noted by the clinician in charge. Parents /Carers must be made aware of this as soon as possible.
Effective preparation, the use of local anaesthetic, sedation and analgesia, together with distraction techniques, successfully reduces the need for undue force in the use of proactive immobilisation - for example, when holding a child's arm from which blood is to be taken or when administering an injection, in order to prevent withdrawal and subsequent unnecessary pain to the child.

Clinical Holding for emergency situations

In an emergency situation the exploration of alternatives may be prohibited by the urgency.
However there should be careful consideration of whether the procedure is really necessary
In life threatening situations and in the best interest of the child, it would be deemed acceptable to initiate clinical holding.
Techniques and principles of safe clinical holding are consistent in any situation
Good practice would ensure that every effort is made to gain co-operation of the child/young person in an emergency situation and that appropriate consent has been sought before clinical holding is initiated.
Clinical holding without the child's consent or assent may need to be undertaken against the child's wishes in order to perform an emergency or urgent intervention in a safe and controlled manner; for example, in order to perform a lumbar puncture.
Any marks left following clinical holding must be clearly documented in the child's clinical record and noted by the clinician in charge. Parents /Carers must be made aware of this as soon as possible.

Documentation

Detailed and accurate records of clinical holding and Restrictive physical interventions should be documented in the child's, /young person notes.
A Datix form should be completed where any circumstances occur which are untoward. These may include:

- The first occasion on which restrictive physical interventions/therapeutic holding are used on an individual young person in an unplanned way.

- Any injuries to the young person which occurred as a result of the intervention
- Any injuries to staff or other persons which occurred
- Any difficulties in accessing staff who have received training in the use of restrictive physical interventions.

Restriction of Liberty

In situations where a child/ young person is insisting on leaving the hospital and there is a concern that this may jeopardize their best interest and welfare, it would be reasonable for staff to take the following action:

Use diversion therapy to avert the child/ young person from leaving
Explain and help them understand that leaving is not considered to be in their best interest and that parents/ carers would be informed. Explain that in some cases; Police would need to be contacted.
Staff should always challenge child/young person about their decision to leave.
Where the consequences of inaction are grave, but the timescale not as immediate, time is available to ensure contact with those with parental responsibility, seek legal advice, and if conditions warrant, seek a court ruling as to which action is in the child's best interests.
Under the Children Act 1989, practice such as seclusion or "time out" which prevents a child/young person from leaving of his own free will, may be deemed a restriction of liberty. And therefore cannot be sanctioned by this trust.
Restriction of Liberty of children being accommodated in the NHS establishment is only permissible in very specific circumstances: Mental Health Act 1983, Court Order or when there is a risk of significant harm under section 31 Children Act 1989.
Prolonged or repeated restraint may amount to detention that may require court approval. / mental health act (1983) detention

Vulnerable Adults : The Mental Capacity Act Deprivation of Liberty safeguards(DoLs)

The Mental Capacity Act Deprivation of Liberty safeguards were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007. The MCA DOL safeguards apply to anyone: - aged 18 and over - who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability - who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment and - for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment to be necessary in their best interests to protect them from harm.
The safeguards are designed to protect the interests of an extremely vulnerable group of service users and to:
- ensure people can be given the care they need in the least restrictive regimes
- prevent arbitrary decisions that deprive vulnerable people of their liberty
- provide safeguards for vulnerable people
- provide them with rights of challenge against unlawful detention
- avoid unnecessary bureaucracy
Where applicable, contact must be made with the Trust Child Protection Team or Legal Department for further advice as soon as possible.

Use of medications

Based on the best interest of the child and the Trust Consent Policy, use of medication for undertaking clinical procedures where clinical holding has not been successful would be a reasonable course of action.
Medication to control a child's /young person's behaviour should be considered very carefully as part of their overall care plan and must be discussed with parents/ cares who hold parental responsibility and with the Multidisciplinary Team. The consent of the child/young person should be sought as per Fraser guidelines.

Documentation

Detailed and accurate records of clinical holding and Restrictive physical interventions should be documented in the child's, /young person notes.
A Datix form should be completed where any circumstances occur which are untoward. These may include:

- The first occasion on which restrictive physical interventions/therapeutic holding are used on an individual young person in an unplanned way.
- Any injuries to the young person which occurred as a result of the intervention
- Any injuries to staff or other persons which occurred
- Any difficulties in accessing staff who have received training in the use of restrictive physical interventions.

Education/Training

Training should be provided for all staff who care for children and young people and who may be required to use clinical holding or techniques or restrictive physical interventions. A moodle package is available that provides a basic introduction and access to an online resource for clinical holding techniques.
The Trust should undertake Trust -wide risk assessment to assess particular risks in each clinical area and thus identify staff training needs.
The training needs analysis will identify what type of training is required in different areas. Training provision should be differentiated between restrictive physical interventions and clinical holding for clinical procedures, and targeted at relevant groups of nurses.

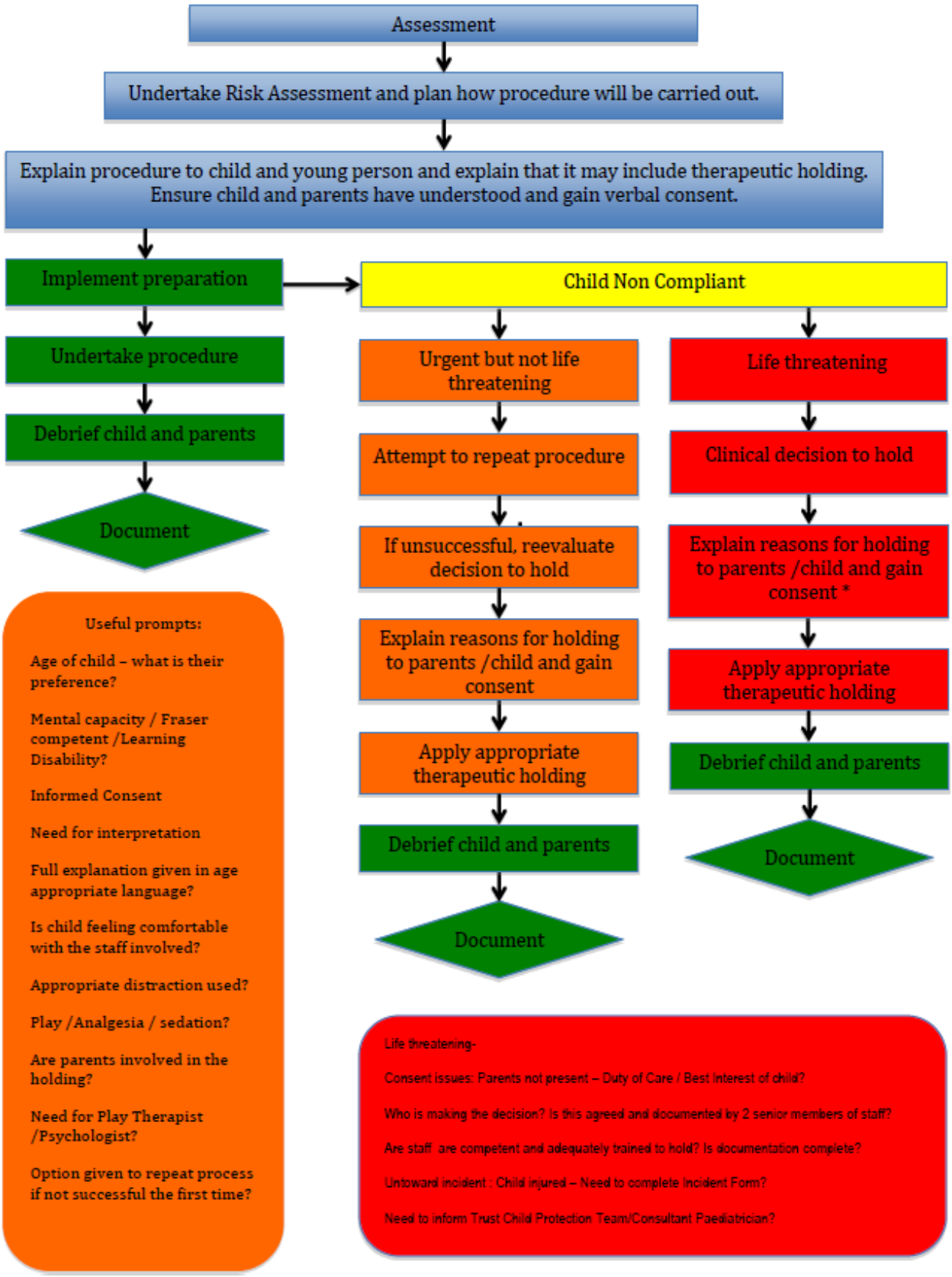
Monitoring and Compliance

This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Treatment pathway. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance.

WHAT?	HOW?	WHO?	WHERE?	WHEN?
These are the 'key' parts of the process that we are relying on to manage risk.	*What are we going to do to make sure the key parts of the process we have identified are being followed?*	*Who is responsible for the check?*	*Who will receive the monitoring results?*	*Set achievable frequencies.*
	Through regular review of the paediatric dashboard at Quality Review meetings	Lead for Risk Management		
Oral rehydration salts Against NICE recommendations	Local audit	Dr Bindal	Results presented at Paediatric Audit Meeting	Annual
Childrens collaborative advance care plan	Audit	Carol Farrell (Paediatric Community nursing team-Orchard)	Research project- In conjunction with University of Birmingham	2018
Childrens Advance care plan	Audit	Carol Farrell (Paediatric Community nursing team-Orchard)	Research project- In conjunction with University of Birmingham	2018
Inpatient full capacity Portocol	Datix form completed when policy is initiated	Lara Greenway	Riverbank ward	Ad hoc as and when needed
Recorded supervision of temporary and locum junior doctors in Paediatrics at WAHNHST.	Meeting documentation recorded and stored on shared M: Drive in individual staff folders.	Temporary or Locum staff meet consultant supervisors within 2 weeks of start of post and then every 4 months in line with policy. Relevant documents to be completed and stored	Results to be given to Clinical Director	When requested

Responsibility of the consultant paediatrician on call Audit of transfers out to PICU and NICU	Through regular review of the paediatric dashboard at Quality Review meetings	Lead for Risk Management	Perinatal and Paediatric Mortality and Morbidity meetings	Meetings held regularly through the year
Guideline for the admission of children and young to inpatient wards	Datix form completed when patient inappropriately admitted to ward		Ward Manager Lara Greenway	Ad hoc basis as and when this incidence occurs

Appendix 1: Guidelines for Clinical Holding for Children undergoing Clinical procedures



Appendix 2: Guidelines for using restrictive physical interventions to prevent significant harm