

Clinical

DMI Clinical Holding Standard Operating Procedure

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Author/Title: Owner/Title:	Gary Firkins – De-escalation Management & Intervention Service Lead Liz Lockett - Associate Director of Quality & Risk		
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Introduction

The Standard Operating procedure is designed to meet the needs of patients who may require clinical or personal care within Midlands Partnership NHS Foundation Trust. The use of clinical holding within services who manage people with different levels of cognitive impairment is widely accepted as a possible appropriate response to incidents of behaviour that challenges services, and of instances of resistance to medical procedures that are required.

Since 1996 the British Institute of Learning Disabilities (BILD) and the Department of Health and the Department of Education and Skills, NHS Scottish Executive Standards on Training have worked together across governments in all 4 U.K countries to improve standards in relation to this specific area of practice for children and adults, who may be subject to such approaches.

Staff should always strive to support and care for people in ways that are enabling and empowering. When people are distressed, ill, angry, confused or lack understanding of their situation they may need some degree of restriction to keep them or other people safe.

All restrictive practices should be expressly acknowledged and must be legally and ethically justifiable. Decisions to use restrictive practices must be transparent and establish clear lines of accountability.

Many of these decisions will involve assessing whether the person involved has the mental capacity to make a specific decision, for example to understand that a product or foodstuff may be unsafe, or to refuse or accept treatment.

Anyone carrying out or observing any restrictive practice must be sure that it is absolutely necessary to prevent harm, that it is the least restrictive option available, that it is not done routinely for convenience, and that it is done for the shortest possible time. It is preferable that restrictive practices should be considered and planned in advance and involve the individual (and their family where appropriate) and relevant multi-disciplinary professionals. They must ensure that monitoring, planning and reviewing takes place to find a more positive alternative on a longer term basis.

Current national guidance (DoH, 2014) tends to focus on the management of challenging behaviour within a specific population and this presents difficulties in interpretation for health and social care practitioners, in developing a professional framework, which supports the use of physical interventions within the context of providing clinical assessment, investigation and/or treatment. It is acknowledged that a multi-disciplinary approach must be taken to decision making in this complex area of care; this SOP is designed to support an evidence based and timely decision. The Mental Capacity Act (2007) Code of Practice also supports the delivery of care in people who lack capacity and are unable to make decisions about their care due to a level of cognitive Impairment.

IN A LIFE THREATING SITUATION THE ABOVE MAY NOT APPLY

Framework for Practice

Skills required throughout each stage of the implementation of care, treatment or intervention include:

- Verbal and non-verbal communication, which enable effective negotiation, facilitation, and participation by all involved.
- Multidisciplinary collaboration is essential, as careful consideration of the procedure's necessity is required. Directorate sign up is essential.
- An emergency situation may prohibit the exploration of alternative strategies to holding a child, young person or vulnerable adult for specified care, treatment or interventions.
- The McGuinness (2007) framework presents a strategy for informing the decision-making process in relation to clinical holding for care, treatment or interventions. This framework should be included within a policy and procedure document, which has been developed in conjunction with members of the multidisciplinary team.

The need to communicate and cooperate in the implementation of policies and procedures and the responsibility of management in ensuring that staff are adequately prepared and updated in practices in restraint and holding techniques are standard recommendations issued by the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (2005).

In addition, concerns about practices should be actively addressed and staff at all levels should feel comfortable in discussing issues which may have implications for the child, young person or vulnerable adult.

Careful individualised assessment and planning is required to support decision making, with reference to relevant guidelines and locally developed policies (Folkes 2005) during the pre-intervention, intervention and post intervention periods

Pre-intervention Care

Good preparation for procedures may prevent the need for holding. Assessment of the individual's needs in relation to the intended care, treatment or intervention should be undertaken within the context of a multidisciplinary team, within an environment of care and respect.

It should also include the following:

- Age
- Developmental stage of child, young person or vulnerable adult
- Their ability to understand why the intervention is necessary
- How and where it will be undertaken
- Who will be involved

Procedural Stages

The child, young person or vulnerable adult could be offered where appropriate:

- Given preparation through role play
- Given consideration regarding prior experiences and previous outcomes of painful procedures

- Allowed to highlight concerns., as well as any wishes regarding the procedure, should be ascertained and time should be taken to internalise the information
- Given time to reflect

The necessary time should be taken to:

- Ensure the person understands the risks and benefits of the proposed intervention before consent is sought.
- Ascertain the necessary psychological preparation to support appropriate behavioural strategies aimed at reducing anxiety. This should include play therapists.
- Discuss and agree on the positions to be maintained during the intervention period.
- This may include a planned period of desensitisation

Where necessary, consideration should be given to pharmaceutical strategies such as the use of conscious sedation, which should be prescribed, administered and monitored by experienced medical and nursing staff.

Assess the risk of, and anticipate, situations that may arise during the procedure (Mohr et al 2003)

The pre-intervention phase **must** include:

- Preparation of the environment;
- All necessary equipment to ensure that once the care, treatment or intervention is commenced it is carried out as quickly and efficiently as possible;
- A care plan for the intervention and pre-intervention strategies must be written up and signed up to by the care team, involved in the persons care.

Intervention

If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

If restrictive intervention is used, it must not include the deliberate application of pain.

People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support. (DoH, 2014)

Agreements made during the pre-intervention period should be adhered to as far as is possible and should include:

- Sensitive support for child, young person or vulnerable adult when unaccompanied by family member.

During clinical holding you must use the Trust approved **DMI**® Physical Principles:

During the procedure it is important to ensure that all involved in carrying out the treatment or care adopt the appropriate posture with the individual, and that the procedure is thoroughly explained throughout.

Post Intervention Care

The following should be considered in the post intervention phase:

- Immediately inform the child, young person or vulnerable adult when the care, treatment or intervention is complete

- Consider giving praise and give rewards for having endured a difficult or painful procedure
- Ensure the individual is made comfortable and provide appropriate follow up support and necessary information
- Monitor for complications that may arise as a result of physical or psychological effects of the intervention
- The assessment, care plan and evaluation of the care, treatment or intervention should be carefully documented
- A Trust monitoring form for the use of Restrictive Practices must be filled in on the RiO Clinical System.
- Staff must complete an AMEWS form on RiO recording the physical observations of the service user.
- It would be good practice for staff to make a note of the response and efficacy of the principles when applied with the person. So an ongoing report of the effectiveness and maintenance of the People emotional and physical well being can be recorded.
- Staff involved in the process should be offered Post Incident Support

Appendix1 – Procedure for Clinical Holding.

1. Procedure for Clinical Holding.

1.1 The guidance detailed in the flowchart (Appendix 2) should be followed by staff when considering the need to hold a person for a clinical procedure.

i. Talking and listening to the person

ii. A judgement will need to be made by the healthcare professional as to whether the person is competent to give their own consent.

iv. Procedure should be explained to the person in language that can be understood, to enable the provision of informed consent.

v. Consent is obtained for all procedures except in an emergency situation (Appendix II)

vi. If the person objects to the procedure, explore alternative methods, for example play, distraction, local anaesthetic cream sedation, or general anaesthetic.

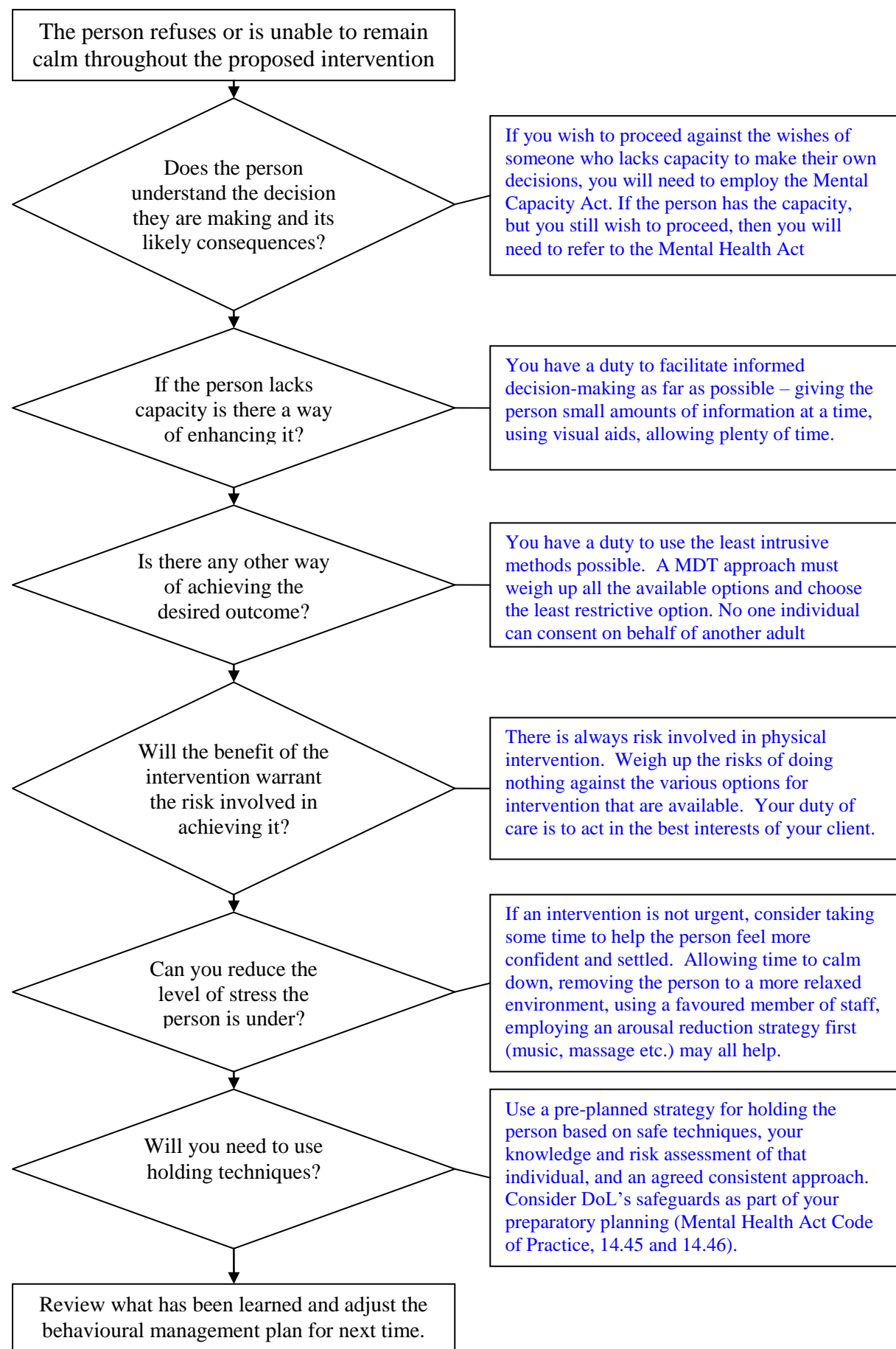
vii. Agree the method of intervention with the person and set a time limit.

viii. If holding is required and consent cannot be obtained, the agreement of two professionals involved in the person's care is obtained and this is documented in the person's medical record.

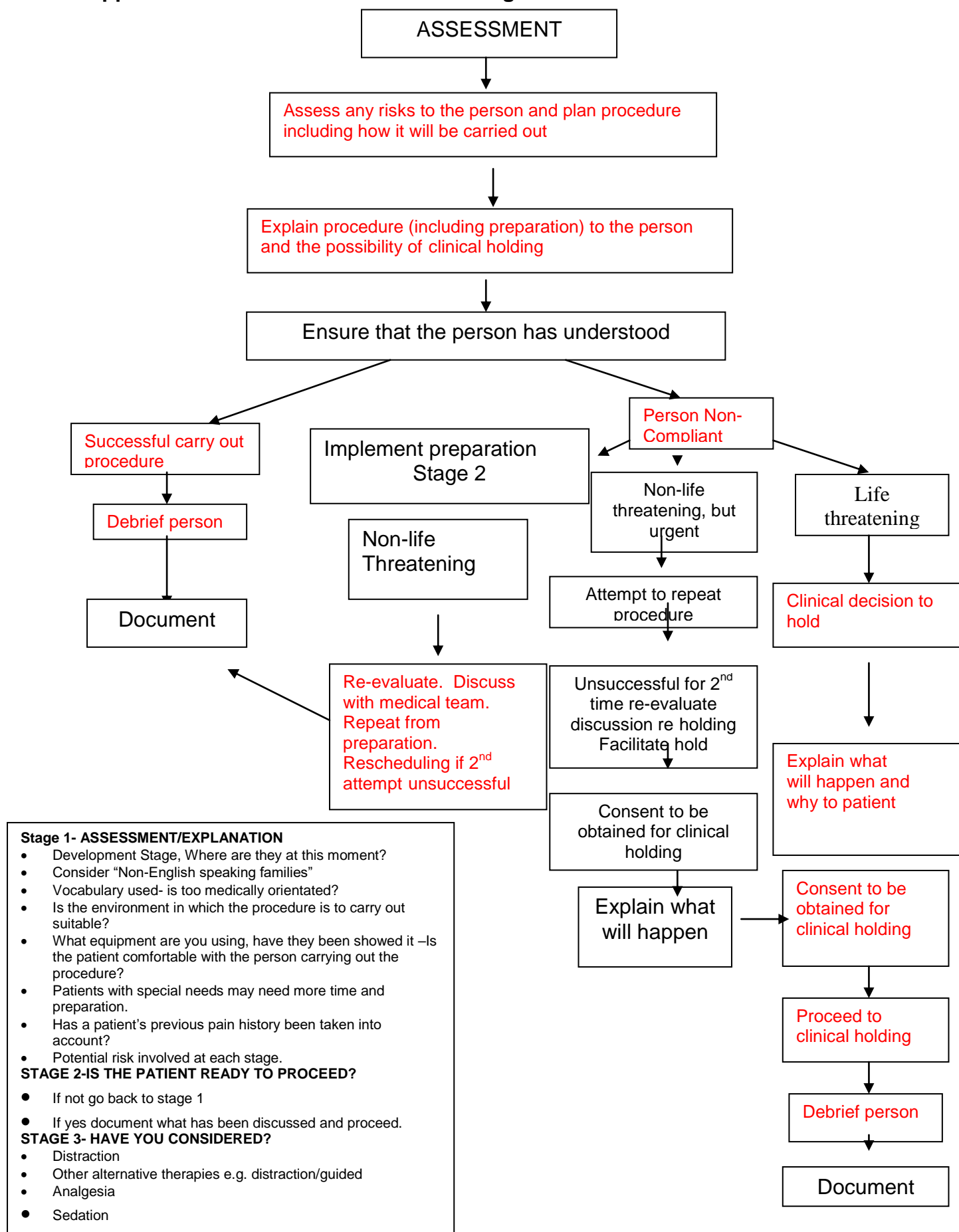
ix. If consent has not been obtained, the person will be comforted and debriefed, with a clear explanation of why holding was necessary.

x. All staff are professionally accountable for their actions and will need to report any untoward incident via the Trust's Incident Reporting form.

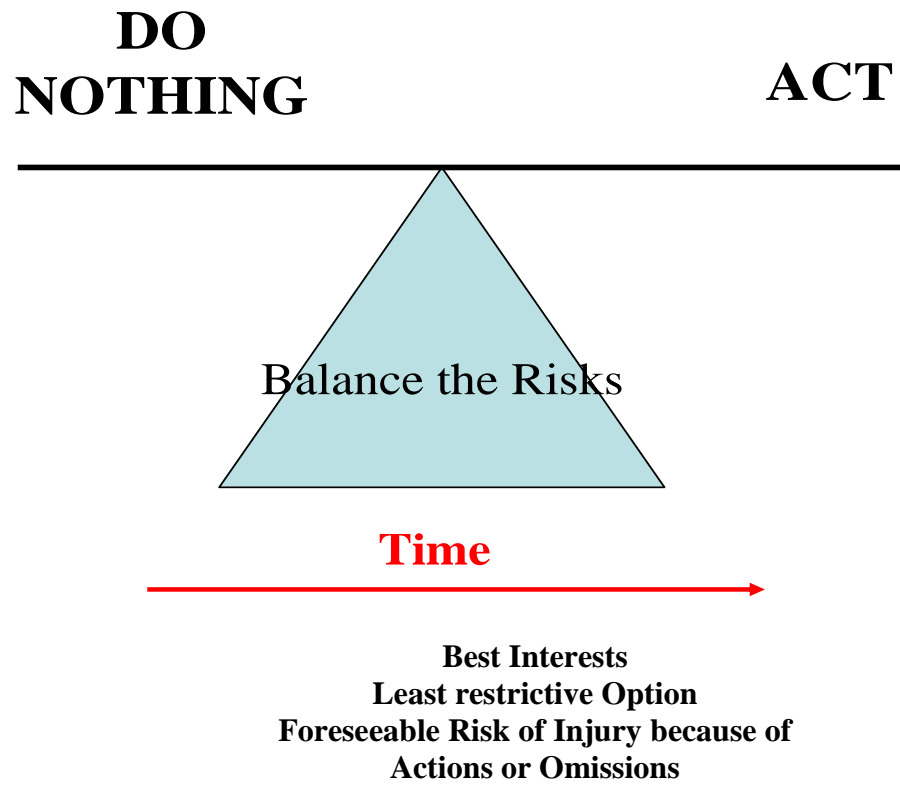
Appendix 2: Ethical Decision Making Tree



Appendix 3 Flowchart for decision making



Appendix 4 Duty of Care Decision Making Tool



Appendix 5 Mental Capacity Act

[Mental Capacity Act \(2005\)](#)

The conditions for a person to have capacity to consent are that they:

- (a) Understand the information relevant to the decision,
- (b) Retain that information long enough to make the decision,
- (c) Use that information in the decision-making process,
- (d) Communicate their decision (by any means)

The Mental Capacity Act places an obligation on us to maximise a person's decision-making abilities as much as possible.

Appendix 6 Mental Capacity Act Checklist

Section 4 Checklist

- No decision should be made solely on the basis of a person's age, appearance or other aspect of behaviour that might lead others to make unjustified assumptions.
- Consider all relevant circumstances
- Consider the likelihood of regaining capacity – could the decision be delayed?
- As far as possible, encourage the person to participate.
- If life-sustaining treatment is involved, then the decision must not be motivated by a desire to bring about their death.
- Consider whether it is possible to ascertain the person's past and present wishes and feelings.
- Consider whether it is possible to ascertain their beliefs and values.
- Seek the views of other people, in particular anyone formerly named by the person to be consulted, those involved in caring for the person, those interested in their welfare, donees of a lasting power of attorney or any court deputy.
- Consult an Independent Mental Capacity Advocate if one is required

Standard Operating Procedure for Positive Behavioural Support relating to Clinical Holding for Minor Invasive Procedures and other physical investigations (Including taking bloods/venepuncture)

The Specialist Learning Disabilities Directorate standard operating procedure is to be read in conjunction with the Trust policy on Clinical Holding and Physical Health policy.

It has been written to ensure that the following points have been considered;

- The person the procedure is being considered for has to be known to our service
- Consideration has been made to ensure the procedure needs to be undertaken because of the person's LD/assessment or related to their treatment from LD services
- Service users not of the above should be referred through to the Health Facilitator or GP
- Consideration has been made to ensure that a sensory integration assessment has taken place. If not a referral should be made to check hypersensitivity and hyposensitivity and to determine whether there is a sensory basis for difficulty unless this is an emergency
- To ensure that all other appropriate avenues/investigations have been explained prior to consideration for clinical holding
- Service users requiring emergency treatments should already be known to the Community Learning Disabilities Team in advance
- All relevant parties should be invited to attend or give their views toward any best interest decision making meeting.

In addition;

1. All proposed procedures should be ratified by the MDT working in the Specialist Learning Disability Directorate
2. Clinical staff considering using the policy are to complete the attached referral documents
3. Following agreement from the Specialist Learning Disabilities Directorate the attached care plan should also be completed
4. This procedure should be part of planned treatment and is for the use of trained staff only (training is 5 days for ISS staff)
5. All care plans regarding interventions should be entered onto the RIO system.
NB. RIO as a separate document –

**Referral Form for Positive Behavioural Support relating to
Clinical Holding for Minor Invasive Procedures and other
physical investigations
(Including taking bloods/venepuncture)**

Procedure Required	
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Name	Date of Birth	NHS Number

Proposed procedure to be carried out:

1. Is the person open to Specialist LD services?	YES /NO
2. Does the procedure form part of the treatment offered by LD services?	YES /NO
3. Is the need for the procedure urgent and should not be delayed? Specify why?	YES /NO
4. Have all other avenues/investigations been explored? If yes, please state the procedures and reasons why these can't be carried out.	YES /NO
5. Is there time to explore alternative approaches such as desensitisation programmes without compromising the person's health? Specify strategy used.	YES /NO
6. Why is the person aversive to procedure? Has the person had a sensory integration assessment - hyper/hypo sensitivity?	YES /NO
7. Within the context of the Mental Capacity Act (2007) has the person's capacity to make an informed choice regarding the proposed procedure been assessed?	YES /NO
8. Is there a plan in place to reduce and review restriction practices agreed by the MDT	YES/NO

Does the persons capacity to make this decision require further assessment? **YES / NO**

Following assessment does the person have the capacity to make this decision?	YES / NO
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Is an IMCA required?	YES / NO
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Reason for Procedure/Intervention

POSITIVE BEHAVIOURAL SUPPORT/DMI CARE PLAN

Summary of Mental Capacity Assessment and Best Interests Decision
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Date capacity assessment and decision date put on RIO: _____

Where possible the views of the service user to the agreed intervention or reasons why service users view not included.
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Cost Benefit/ Implications to Service User and Service

Things you might need to know about me	
This information should be gathered from known assessments, from the person themselves and those people closest to the person who know them well. This information may be helpful in developing primary strategies to reduce problem behaviour occurring.	
Have I had this procedure before and how did I respond?	
Things I find Reinforcing/Distracting	
How best to support me	
The best way to communicate with me is	
If I get angry, anxious, frightened or upset I will (Warning signs)	
If I get angry, frightened or upset you can help me by.	
You need to be aware that I may (actual behaviours) if held by others....	
Do I have sensory issues and have these been assessed?	
Have alternatives been considered?	Please list with the reasons why this has not worked:

If Physical Interventions present a risk how will these be reduced and monitored?

(complete only those that are necessary)

This is to ensure service users are not on medications that may cause risk to them

RISK	ACTION		
Medication and associated side effects To include day to day medication – dose and frequency and all ‘as required’ and ‘rapid tranquilisation’ medications	Medication	Dose	Frequency
	Medication for the treatment of:		
	Associated Side effects of medication:		
	Action to reduce medication risk:		

If Physical Interventions present a risk how will these be reduced and monitored?

(complete only those that are necessary)

RISK	ACTION		
Medication and associated side effects To include day to day medication – dose and frequency and all ‘as required’ and ‘rapid tranquilisation’ medications	Medication	Dose	Frequency
	Medication for the treatment of:		
	Associated Side effects of medication:		
	Action to reduce medication risk:		

If Physical Interventions present a risk how will these be reduced and monitored?

(complete only those that are necessary)

RISK	ACTION		
Medication and associated side effects To include day to day medication – dose and frequency and all ‘as required’ and ‘rapid tranquilisation’ medications	Medication	Dose	Frequency
	Medication for the treatment of:		
	Associated Side effects of medication:		
	Action to reduce medication risk:		

Physiological Risks To include all health risks that the individual is currently experiencing. (such as respiratory/cardiovascular concerns)	Actions to reduce Physiological risk:
Psychological Risks To reduce any psychological distress the individual may have due to their mental health and due to the physical intervention suggested	Actions to reduce psychological risk:
Risks to Staff or Carers To examine the risks that the individuals behaviour may have on the welfare of staff and carers whilst intervening	Actions to reduce staff/carer risk:
Any other risks	

Pre Intervention Plan

This plan could include: Details of who will be involved in holding, what training will be provided, where and when procedure will be undertaken. If medication is to be used what medication will be given, time medication should be given prior to procedure, equipment required, etc. (Advice to service user about the proposed intervention).

Intervention Plan

Include: - who will be responsible for taking lead role and directing the procedure; a description of the procedure; agreed plan to end procedure if causing significant distress to the person or previously agreed reason for ending procedure. (Advise client of procedure).

Post Intervention Plan

The following should be considered in the post intervention phase:

- Immediately inform the child, young person or vulnerable adult when the care, treatment or intervention is complete
- Praise and give rewards for having endured a difficult or painful procedure
- Ensure the individual is made comfortable and provide appropriate follow up support and necessary information
- Monitor for complications that may arise as a result of physical or psychological effects of the intervention
- The assessment, care plan and evaluation of the care, treatment or intervention should be carefully documented
- A Trust monitoring form for the use of Physical Interventions and/or Rapid Tranquillisation must be filled in and kept with the patient's notes (and enter on RIO)
- Please refer to the Post Incident Support Policy.

It would be good practice for staff to make a note of the response and efficacy of the principles when applied with the patient. So an ongoing report of the effectiveness and maintenance of the patient's emotional and physical wellbeing can be recorded.

Post Incident Review Plan

Review and evaluation of what has been learned and adjust the Intervention Plan for next time.

Care Plan was devised by/following discussions (entered on RIO)

Name	Position	Discussed with	Location	Date

Care Plan was agreed by (MDT meeting)

Name	Position	Location	Date

REVIEW	
This person centred physical intervention care plan should be reviewed on	Date:
Subsequent Review Dates for Multidisciplinary Team (MDT)	
Review 2	Date
Review 3	Date
Review 4	Date

Discontinuation Date	
Intervention plan discontinued by the MDT	Date:

Staff Signature:	
Family:	

Appendix 8

Guidance on clinical holding procedures within LD services (Including venepuncture)

The Trust policy has been amended for the Specialist Learning Disabilities Directorate in order to ensure the following points have been considered.

- The person the procedure is being considered for has to be known to our service
- Consideration has been made to ensure the procedure needs to be undertaken because of:
 1. The person's LD/assessment or related to their treatment from LD services
 2. The need for a reasonable adjustment to the treatment of another health service/agency
- Service users not of the above should be referred through to the Health Facilitator or GP
- Service users requiring emergency treatments should already be known to the Community Learning Disabilities Team in advance
- Consideration needs to be made to ensure that a sensory integration assessment has taken place. If not a referral should be made to check hypersensitivity and hyposensitivity and to determine whether there is a sensory basis for difficulty
- Consideration should also be given to any evidence that the person has a history of traumatic life experiences.
- To ensure that all other appropriate avenues/investigations have been explored prior to consideration for clinical holding
- All relevant MDT parties are required to attend or give their views toward any best interest decision making meeting.
- Desensitisation needs to be led by professional who have the appropriate training and experience
- Staff who are delivering clinical holding techniques will need to have the appropriate training and experience from an approved DMI trainer within the Trust.
- All MDT agreements for the use of clinical hold procedures must include a completed checklist which will be reviewed by an approved clinical holding assurance practitioner. This will include the following

Mary Fairgreaves
Elaine Thomas
Cathy Prendergast
Paul Flindall

Checklist for clinical holding procedures in LD services **(Including venepuncture)**

Take out box	
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Name	Date of Birth	NHS Number

Proposed intervention to be carried out:

6. Is the person open to Specialist LD services?	YES / NO
7. Does the procedure required relate to: <div style="margin-left: 40px;">A treatment being delivered by LD services?</div> <div style="margin-left: 40px;">A treatment being delivered by another health service/agency</div>	YES / NO
8. Has the need for the procedure been identified through the initial screening assessment or nursing assessment or equivalent? If Yes has a care plan been developed	YES / NO
9. Is the need for the procedure urgent and should not be delayed? Specify why?	YES / NO
10. Have all other avenues/investigations been explored? If yes, please state the procedures and reasons why these can't be carried out.	YES / NO
11. Is there time to explore alternative approaches such as desensitisation programmes without compromising the person's health? Specify strategy used.	YES / NO
12. Please specify why the person is averse to the treatment? Has the person had a sensory integration assessment - hyper/hypo sensitivity?	YES / NO

Have any issues relating to past trauma been considered. If yes please specify	
13. Has there been an appropriate MDT involvement to consider the procedure.	YES / NO
14. Has the procedure been risk assessed by the professionals who will be using the physical interventions within the environment that it will occur?	YES/NO
15. Have contraindications to the use of physical interventions been considered and if necessary medical opinion sought.	YES /NO
16. Within the context of the Mental Capacity Act (2007) has the person's capacity to make an informed choice regarding the proposed procedure been assessed?	YES/NO

If yes, do they have capacity to consent?

Date capacity assessed _____

Does the persons capacity to make this decision require further assessment? **YES / NO**

If yes who will conduct the assessment and by when?

Following assessment does the person have the capacity to make this decision? **YES / NO**

Is there an advance directive in place? **YES / NO**

Is an IMCA required? **YES / NO**

If the answer is yes who will arrange requesting an IMCA?

Decision made by the MDT following best interest meeting

Clinical holding assurance practitioner signature

Date