University Hospitals of Leicester NHS
NHS Trust

Restrictive Interventions Policy

Approved By:	Cinical Policy and Guideline Committee
Date of Original Approval:	**September 2024**
Trust Reference:	**B71/2024**
Version:	1
Supersedes:	Previously formed part of the Management of Violence and Aggression Policy
Trust Lead:	Charlotte Leeds, Restrictive Practice Matron
Board Director Lead:	Chief Nurse
Date of Latest Approval	September 2024
Next Review Date:	**September 2026**

CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Not applicable as this is the first version of this policy.

KEY WORDS

Restrictive intervention, restrictive practice, restraint, mechanical restraint, rapid tranquilisation, chemical restraint, seclusion, mental health, mental capacity, altered behaviours, enhanced patient observation, hand control mitts, mittens, clinical holding

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the use of restrictive interventions. The Policy makes it clear that all restrictive interventions should only be used in a way that respects human rights.

1.2 The Trust is committed to delivering the highest standards of healthcare and ensuring the safety and welfare of its patients, visitors, and staff. The Trust recognises that violence, aggression, and challenging behaviour may escalate to the point where restrictive interventions may be required to protect the person,

patients, visitors and staff from significant injury or harm. The Trust also recognises that there may be occasions when restrictive interventions will need to be utilised in the person's best interests. This policy is in line with the Trust's values in that our services and care are patient-centred, safe, and provided with respect and compassion.

1.3 Any intervention that restricts a person's movement should:

- Be used for the minimum time to prevent harm to the person or to others
- Be reasonable and proportionate to the risk posed in the situation, and
- Be the least restrictive option.

1.4 This policy is intended to provide guidance in relation to the nature, circumstances and use of approved de-escalation and physical restrictive intervention/restraint techniques currently adopted by the Trust. Individuals requiring restrictive interventions will be displaying a behaviour as outlined in other Trust policies (see Section 5), but commonly would include one or more of the following:

- Risk of physical assault by the patient
- Dangerous, threatening, or destructive behaviour
- Self-harm or risk of physical injury by accident
- Extreme and prolonged over-activity that is likely to lead to physical exhaustion
- Attempts to escape or abscond (where the patient is detained under the Mental Health Act (MHA) or deprived of their liberty under the Mental Capacity Act (MCA)).

1.5 Restrictive interventions must only be considered once de-escalation or distraction strategies have been used in combination with appropriate communication, and based on clinical need and safety. They are management strategies only and not treatment techniques. De-escalation, distraction, and appropriate communication should continue to be used during a restrictive intervention.

1.6 Restrictive interventions must not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

1.7 Restrictive interventions may be required as part of a broader therapeutic programme, for example a patient undergoing a planned procedure who is known to have displayed challenging behaviours during previous hospital admissions. In such situations, plans should be made with the patient and any carers/relatives, to identify appropriate support including other means before restrictive interventions are utilised.

1.8 On occasions, emergency management of a situation may be required and restrictive interventions used based on clinical judgement, taking into account relevant best practice policy (such as those published by the National Institute for Health and Care Excellence (NICE)).

1.9 Restrictive interventions should be used in a way that minimises risk to the patient's health and safety and causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary. Staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions; the Trust does not teach pain

management or compliance within its holding principles in physical restrictive interventions training.

1.10 The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- The patient's wishes and feelings, if known (e.g. be an advance statement)
- What is necessary to meet the needs of the individual based on a current assessment and their history?
- The patient's age and frailty, and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- Obligations to others affected by the behavioural disturbance
- Responsibilities to protect other patient, visitors, and staff, and the availability of resources in the environment of care.

1.11 Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected where staffing allows.

1.12 Wherever possible, restrictive interventions and particularly physical restraint should not be carried out on children. Restraint during childhood has the potential to lead to trauma and impact on individuals into adulthood. Clinical holding of children is recommended, and is covered within this policy.

1.13 Decisions about restrictive interventions are not easy or straightforward. It is acknowledged that decisions may be required in urgent and emergency situations in the interests of immediate safety.

1.14 On rare occasions the police may be called to manage patient behaviour within the Trust. In these instances, clinical staff should continue to monitor the patient for any respiratory/cardiac distress and physical and psychological wellbeing wherever possible.

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This policy applies to all staff who may be required to undertake a restrictive intervention as part of their role across the three main UHL hospital sites.

2.2 This policy covers restrictive interventions used with adults and children.

2.3 Staff undertaking restrictive interventions should have current training in physical restrictive interventions.

2.4 Patients who are escorted by services such as prison officers or police, where a risk assessment will have been completed by the appropriate agency and who may remain under restraint, such as handcuffs, for the duration of their hospital stay.

3 DEFINITIONS AND ABBREVIATIONS

Behavioural Disturbance – The Royal College of Psychiatrists describe acute behavioural disturbance as when a person is extremely agitated or distressed, usually in a public place, and in such a state of agitation that they may be at risk of a potentially fatal physical health emergency.

Behaviours that Challenge – The NHS describes behaviours that challenge as:

“A person's behaviour can be defined as "challenging" if it puts them or those around them (such as their carer) at risk, or leads to a poorer quality of life. It can also impact their ability to join in everyday activities. Challenging behaviour can include:

- Aggression
- self-harm
- destructiveness
- disruptiveness

Challenging behaviour is often seen in people with health problems that affect communication and the brain, such as learning disabilities or dementia.”

Clinical Holding – the proactive immobilisation of a part of the body to which a procedure is being carried out; within UHL this is only applicable to the care and treatment of children and only utilised when all other options have been explored.

DoLS – Deprivation of Liberty Safeguards 2007

MCA – Mental Capacity Act 2005

MHA – Mental Health Act 1983

NICE – National Institute for Health and Care Excellence

RRN – The Restraint Reduction Network is a national organisation that has set out Training Standards, available to view here.

Restraint – See also ‘Restrictive Interventions’; this terminology can be used interchangeably.

Defined by the MCA 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 reasonable 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.

Types of restraint:

1. **Physical Restraint** – any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
2. **Mechanical Restraint** – the use of a device or object to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control. The use of straps as a mechanical restraint is not recommended within UHL.
3. **Rapid Tranquilisation (also known as Chemical Restraint)** - the use of medication which is prescribed and administered for the purpose of controlling or disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. (refer to "Guidelines for Rapida Tranquilisation of Disturbed Adult Patients (B11/2016)).
4. **Enhanced Patient Observation** – patients who are in a stable condition but are requiring additional intervention to mitigate risk and maintain safety.
5. **Environmental Restraint** – use of the physical environment to limit a person's movement. Seclusion is a form of restraint which may be used in mental health facilities and therefore must not be utilised within UHL.
6. **Psychological Restraint** – using a communication strategy that puts psychological pressure on people to to do something they do not want to do, or stop them doing something that they want to do. This is not an acceptable form of restraint and instances must be referred to the relevant safeguarding team.
7. **Cultural Restraint** – using cultural norms to make a person do something they do not want to do, or prevent them from doing something that they want to do. This is not an acceptable form of restraint and instances must be referred to the relevant safeguarding team.

Restrictive Interventions – See also 'Restraint'; this terminology can be used interchangeably.

These are also commonly referred to as restraint or restrictive practices, and are defined within the Mental Health Act Code of Practice (2015) as:

'deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- Take immediate control of a dangerous situation where there is a real possibility of harm to the person and or others if no action is taken, and
- End or reduce significantly the danger to the patient or others.'

All restrictive interventions should be used for the least time possible ensuring least restrictive practice.

4 ROLES – WHO DOES WHAT

4.1 The Chief Executive and Board of Directors have overall responsibility for Trust compliance with the Law and Trust Policies and Procedures.

4.2 The Chief Nurse has lead responsibility for this policy.

4.3 The Deputy Chief Nurse is the Nominated Deputy for the Chief Nurse.

4.4 The Restrictive Practice Matron is responsible for:

4.4.1 The review and amendments to the policy.

4.4.2 Providing education, advice, and support to staff around restrictive interventions.

4.4.3 Review of all Datix reports raised around restrictive interventions/restraint, supporting with learning from incidents.

4.5 Clinical Directors, General Managers and Heads of Nursing are the leads for disseminating the policy and any learning from incidents to staff within their Clinical Management Groups.

4.6 The Adult Safeguarding Nurses and Childrens Safeguarding Nurses provide day-to-day advice and support to UHL staff where concerns are raised about a patient's mental capacity to consent to or decline care and treatment, or any other safeguarding concerns.

4.7 The Director of Estates and Facilities is responsible for ensuring Security Personnel are aware of and comply with the relevant aspects of this policy.

4.8 Head of Security and Deputy Head of Security are responsible for:

4.8.1 Review of all Datix reports raised around restrictive interventions/restraint and work collaboratively with the Restrictive Practice Matron for the Trust.

4.8.2 Ensuring dissemination of the policy and any learning from incidents to security staff.

4.8.2 Ensuring that any incident involving restrictive intervention/restraint is reported by security staff via Datix, including body maps, and with support to complete these where required.

4.8.3 Ensure staff are supported to report incidents externally to the police where applicable.

4.8.4 Oversight of the review of Body Worn Camera footage where applicable.

4.8.5 Support the safety of patients and staff through providing appropriate de-escalation and physical restrictive interventions/restraint training to departments identified through training needs analysis or ad hoc (such as following an incident). This may include agency staff where their role may be expected to involve undertaking physical restraint.

4.8.6 Act in an advisory capacity, in conjunction with Duty Managers, relating to service level agreements with prisons or police when escorting an individual to UHL premises in order to receive care.

4.9 Duty Managers are responsible, in conjunction with the Head and Deputy Head of Security, for acting in an advisory capacity relating to service level agreements with prisons or police when escorting an individual to UHL premises in order to receive care.

4.10 Department Leaders/Deputies are responsible for:

4.10.1 Providing immediate post-incident support to staff following an incident that involves a restrictive intervention/restraint.

4.10.2 Providing immediate post-incident support to the patient and where applicable other patients/visitors following an incident that involves a restrictive intervention/restraint.

4.10.3 Ensuring staff are supported beyond the immediate post-incident period if and when needed or applicable, including directing staff to other support services available within the Trust (e.g. AMICA, Health and Wellbeing Team, TRiM (Trauma Risk Management)).

4.10.4 Ensuring that any incident involving restrictive intervention/restraint is reported by staff via Datix, including body maps, and with support to complete these where required.

4.11 All clinical and security staff are responsible for:

4.11.1 Adhering to this policy and associated policies.

4.11.2 Only undertaking physical restrictive interventions/restraint if appropriately trained in the model used by the Trust.

4.11.3 Ensuring knowledge of restrictive interventions and the associated legal frameworks.

4.11.4 Maintaining up to date mandatory training in accordance with their job role, which may include Conflict Resolution (Personal Safety) and Basic Life Support.

4.11.5 Reporting incidents on Datix, ensuring the 'Restraint' box is ticked, and uploading a body map.

4.11.10 Understanding their role within any situation involving restrictive interventions/restraint. For example during a physical restraint, a clinical staff member takes lead of the situation and is responsible for monitoring the patient for vital signs, any indication of harm or injury, and ensuring that the restraint is for the minimum amount of time; a security team member would act based on the information and instruction given by that clinical staff member.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 Assessment

On arrival at hospital for emergency care, if the patient presents with risks to themselves/others, or behaviours that challenge then the immediate risks should be assessed by clinical staff. Similarly the immediate risks should be assessed if an adult inpatient begins displaying such behaviours after admission.

Some patients may attend for planned care, and so any known behaviours that challenge that may arise from an admission should be identified and mitigated by the clinical team prior to admission wherever possible. This may include a known learning disability or mental health condition that is known to be exacerbated by attendance at hospital.

Consideration should be given to potentially reversible causes of the risks including delirium, acute behavioural disturbance which require urgent or immediate support. Other possible causes of behaviours that challenge are listed in Appendix 1.

Such assessments should aim to understand the person's behaviour, taking into account their:

- history of such behaviours, personal trauma experiences, their presenting mental and physical state, and their current social circumstances
- social and physical environment
- broader context within which a behavioural disturbance occurs including any reasons not associated with mental health or cognitive conditions.

Where required, the advice of specialist service should be sought for example (not exhaustive) Learning Disabilities, Admiral Nursing Service, Safeguarding, Mental Health Liaison.

The views of the patient, and their family, carers or advocates should be taken into consideration where appropriate, promoting a Triangle of Care approach. These may highlight key information about current and past behaviours including triggers and methods of de-escalation. The patient may be known to services outside of UHL which may hold relevant information.

A previous history of behavioural disturbances does not mean that a person will behave in the same way in the future although a previous history of delirium may place a person at higher risk of developing a delirium or altered behaviour in the future.

The outcome of the assessment should describe known behaviours of concern, factors that may predict their occurrence, and identify the function that a behaviour serves for the person.

During assessment and care delivery, staff should ensure that they are mindful of the potential for negative and stigmatising judgments about certain diagnoses, behaviours or personal characteristics to impact on the degree of perceived risk and overlook potential benefits of appropriate treatment. Cultural awareness is important in understanding behaviour and responding appropriately; assessments and care delivery should be undertaken in a way that takes into account any cultural issues.

Nursing staff responsible for the patient's care should activate the Altered Behaviours booklet, including the care plan, where pertinent information should be documented, including antecedents, behaviours displayed, and consequences resulting from those behaviours.

5.2 Acute Behavioural Disturbances

Incidences of acute behavioural disturbances should be managed where possible through verbal de-escalation and non-restrictive interventions, and staff may need to call for assistance of others.

One clinical staff member should take overall control of an incident to ensure a co-ordinated approach, including the management of communication with the person displaying the behaviour. Communication needs should be taken into account, including those arising from sensory impairments, learning disability, autism spectrum disorders, and if English is not the first language of the person.

Staff should ask the person to stop the behaviour in the first instance, and where possible provide an explanation of the consequences of refusing the request to stop the

behaviour. Explanations should be provided calmly, and every attempt should be taken to avoid the explanation being perceived by the patient as a threat.

During de-escalation attempts, staff should focus on establishing rapport, demonstrating concern, helping the patient to relax, and reducing the person's level of agitation.

Staff should follow the relevant policies for managing such behaviours, including the Managing Violence and Aggression, and Enhanced Patient Observation policies.

5.3 Restrictive Interventions

If all non-restrictive interventions have been attempted and the behaviour that challenges continues, then restrictive interventions may be considered only if there remains a significant concern for the health, safety and wellbeing of a person or those around them including staff, other patients, and visitors.

Restrictive interventions must only be used as a last resort and for the shortest possible time; verbal de-escalation should continue throughout a restrictive intervention.

Staff should not intentionally or unintentionally undertake restrictive practices within their role unless they are appropriately trained and are doing so within legal frameworks and in the circumstances outlined below.

Where a patient lacks capacity to make decisions around their safety and associated risks, a form of restraint, such as one outlined below, may be put in place in their best interests. A patient who is detained under the Mental Health Act should have any restrictions on movements/restrictive interventions outlined within their care plan; these are determined by either Mental Health Liaison Service within UHL, or external mental health services that the patient is known to.

All restrictive interventions should be the least restrictive and undertaken for the minimum time needed. Any restraint should be regularly reviewed in accordance with the level of risk. For example, physical restraint should be constantly overseen by a clinician for maintaining the health of a patient (outlined in 5.4) to prevent adverse health effects for the patient including death.

5.3.1 Restrictive Interventions in Best Interests

There may be occasions where a patient refuses a medical examination, intervention and/or treatment, without which they are likely to suffer serious harm or detriment to their health. On such occasions and in accordance with the provisions of the Mental Capacity Act, medical or nursing practitioners may assess that the person lacks capacity to consent to examination or treatment. The best interests decision should be documented at the earliest opportunity.

Having considered and tried less restrictive options, the medical or nursing practitioner may as a last resort, (or in emergency/life threatening situations as a first resort) assess it is necessary to carry out the examination or treatment against the persons wishes, acting in the patient's best interests. To do this safely it may be necessary and appropriate to apply safe holding and/or physical restraint techniques to the patient. When doing so the amount of force used to achieve the outcome must be reasonable, necessary and proportionate to the risks of harm to the patient and others.

Where the patient becomes violent or aggressive towards staff (or is likely to become violent and aggressive) when acting in the patients best interests, and it is necessary to restrain the patient to prevent harm, the medical or nursing staff

may call upon the assistance of security staff this will include all staff who have been trained in restraint to carry out, or assist with, physical holding or restraint of the patient whilst the procedures are carried out. Security staff will act under the instruction and information of the clinical staff to ensure they lawfully use reasonable, necessary and proportionate force.

5.4 Physical Restraint

People must not be deliberately restrained in a way that impacts on their airway, breathing, or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage, and/or abdomen. The head and neck should be appropriately supported and protected.

There must be no planned or intentional restraint of a person in the prone position, where they are forcibly laid on their front, on any surface.

Full account should be taken of the individual's age, physical and emotional maturity, health status (including frailty), cognitive functioning, and any disability or sensory impairment which may confer additional risks to the individual's health, safety and wellbeing when exposed to physical restraint.

The level of force applied must be reasonable, necessary and proportionate to a specific situation, and be applied for the minimum amount of time. To avoid prolonged physical restrictive intervention/restraint, rapid tranquilisation should be considered

Throughout any period of physical restraint:

- A clinical staff member should take the lead for the period of restraint, including monitoring the individual's airway and physical condition to minimise the potential for harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration) should be conducted and recorded using the NEWS2 Protocol and recording charts. Staff should be trained so that they are competent to interpret these vital signs.
- Emergency resuscitation devices should be readily available in the area where restraint is taking place.
- Monitor the person's physical and psychological wellbeing throughout.
- A clinical staff member should take the lead in caring for other patients and/or visitors and moving them away from the area of disturbance if indicated for safety reasons.

Following any physical restrictive intervention/restraint, an individual should be placed under an appropriate observation level for up to 48 hours. The nurse in charge of their care is to be aware of the possibility of restraint/positional asphyxia, and physical observations be recorded accordingly.

All incidences of physical restraint should be recorded in the patient's clinical notes, irrespective of the circumstances in which it came about, or the position or duration of the restraint, alongside a completed body map (Appendix 2) and post-incident review (Appendix 3).

If a physical restraint incident causes minor harm/injury to the patient, a staff member, or visitor, then an appropriate staff member must:

- report the incident on the Trust incident reporting system, Datix
- complete a body map and post-incident review and attach to the Datix record (Appendices 2 and 3) within 24 hours of the incident occurring

- inform other services depending on the risk presented, which may include UHL Safeguarding, UHL Health and Safety, or the police.

In addition, it's advised that where physical restraint has been deemed necessary on multiple occasions but without injury, a Datix should be completed.

5.4.1 Physical Restraint in the Prone Position

Physical restraint of an individual in the prone position presents an increased risk of death due to positional asphyxiation and should be avoided wherever possible. Individuals should not be placed into a prone position, however it's recognised that some may move themselves into that position such as onto the floor.

Staff must ensure:

- the restraint occurs for the minimal possible time
- a clinical staff member takes the lead during the restraint and is present to monitor for signs of positional asphyxiation, excitable delirium, and hypothermia, in addition to the vital signs indicated in 5.4 above.
- they are aware that prolonged restraint and struggling will result in exhaustion and possibly sudden death
- it is preferable to contain rather than restrain
- that police are contacted if the situation becomes unmanageable.

5.5 Mechanical Restraint

Mechanical restraint includes the use of any object or device to restrict the movement of a person. Examples of mechanical restraint are, but not limited to:

- Utilising bed rails, whether or not they are clinically indicated in the bed rails risk assessment.
- Restricting a person's movement in a bed. The bed position, such as knee breaks in a high position, should not be used to restrict movement.
- The use of bed sheets/blankets to restrict movement for a limited time to support a low or medium level physical restraint. This may only be used by staff who have completed DMI training through the taught techniques.
- The administering of Hand Control Mitts (mittens) to restrict movement of one or both hands. Hand Control Mitts (mittens) should only be utilised when there is a clear clinical need, and their use should be prescribed by a senior doctor. The 'Guidelines for Use of Mittens with Adult Patients' (Appendix 4) should be utilised and followed when mittens are being considered for a patient, including the completion of the associated assessment and care plan.
- Use of other equipment to contain a person in their current space (e.g. a table placed in front of a patient to prevent them from standing and moving around freely)
- The removal of walking aids from within the arms' length of patients who are independent at using the aid during their hospital stay
- Straps are a form of mechanical restraint and **not** recommended for use within UHL.

All staff must be aware of mechanical restraint and ensure that least restrictive options are utilised at all times. Advice should be sought from the relevant Safeguarding team if required.

5.6 Chemical Restraint/Rapid Tranquilisation

Rapid tranquilisation is the administration of carefully monitored amounts of medicines over a brief period of time to achieve rapid, short-term behavioural control of extreme agitation, aggression and potentially violent behaviour to reduce risk of harm.

The aim of rapid tranquilisation (RT) is to quickly calm the severely agitated patient in order to reduce the risk of imminent and serious harm to self or others. An optimal response would be a reduction in agitation or aggression without sedation, allowing the patient to participate in further assessment and treatment.

The use of medicines for the purposes of RT has associated risks and can be distressing for patients. It is essential that RT is used with due regard to the safety of individuals. For the majority of patients RT is not necessary and it should not be resorted to routinely. All decisions and discussions with patients should be documented in the patient record. Intervention may be indicated for patients with a wide range of conditions including but not limited to patients with known psychiatric illness.

RT should be considered in patients undergoing prolonged restraint (longer than 10 minutes) in order to reduce the duration of restraint and facilitate further assessment and treatment.

Medical professionals should be consulted at the earliest opportunity if an assessment for rapid tranquilisation is indicated.

All staff involved in RT should implement and follow the associated 'Guidelines for Rapid Tranquilisation of Challenging/Altered Behaviour in Adult Patients', and a Datix completed every time RT is undertaken.

5.7 Enhanced Patient Observation

Some patients require more than a general level of observation due to displaying behaviours that pose a risk of harm to themselves or others, often due to their cognition or mental health. The terminology used for this is Enhanced Patient Observation (EPO), which was previously referred to as one-to-one, 1:1, or specialing. This is a form of restraint due to restricting patient movement or independence; such patients would usually have a Deprivation of Liberty Safeguards (DoLS) in place or be legally detained under the Mental Health Act (see Section 9 for related policies).

There are four levels of EPO, which indicate the level of support a patient needs. The level of observation is determined through a risk assessment process. Staff should review and implement the 'Enhanced Patient Observation' policy for patients who may require an enhanced level of observation, and where applicable the 'Detention of Patients Under the Mental Health Act UHL Policy'. Any EPO undertaken should be for the minimum time possible to ensure least restrictive practice is adhered to.

5.8 Environmental Restraint

Restraining a patient through the use of their environment should only be done with legal justification, such as a DoLS or Mental Health Act. This may include patients who are not free to leave a ward area, or who are subject to Enhanced Patient Observation for example for the safety of the patient and/or any person or object within their vicinity. The default is that patients would be free to leave the ward if well enough and with the knowledge of their designated nurse, nurse in charge, or senior nurse for that area.

Seclusion is a form of environmental restraint which may be undertaken in Mental Health facilities. It involves the supervised confinement and isolation of a patient in a

robust locked room for the safety of others, and they must be receiving care under the Mental Health Act. As an acute Trust, UHL does not have an appropriate designated seclusion room or area. Patients who are sectioned would be managed in line with the Detention of Patients Under the Mental Health Act UHL Policy, and guidance would be provided by the Mental Health Liaison Service regarding care plans whilst awaiting a move to a Mental Health facility.

Treating a patient in a side room, is not a form of seclusion or environmental restraint, for example if there is an infection risk.

5.9 Psychological and Cultural Restraint

Psychological and cultural restraint involves telling a patient to repeatedly do or not do something which puts pressure on them to comply and may not be in line with their culture or beliefs. Neither are acceptable practice. Any instances must be referred to the relevant safeguarding team.

5.10 Clinical Holding of Children

Is the proactive immobilisation of a part of the body to which a procedure is being carried out. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively for example holding an arm from which blood is being taken in order to prevent reflex withdrawal and thus unnecessary pain or distress or injury to the child. Holding is distinguished from restraint by the degree of force required and the intention. See Appendix 5 for the Clinical Holding in Children Guidelines for Practice.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Staff undertaking physical restraint are required to complete the current Trust model of training in accordance with their role and are expected to maintain this knowledge and skill annually. This model is currently De-escalation, Management and Intervention (DMI).

6.2 The requirement across the Trust for training in de-escalation, disengagement and physical restraint is established through the Security Management (see 4.8.5) via training needs analysis and on an ad hoc basis where needed.

6.3 Staff are expected to maintain their mandatory training as per Trust policy. Those particularly relevant to this policy are, but not limited to, Basic Life Support, Conflict Resolution (Personal Safety), Dementia Category B, and Oliver McGowan.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
Number of incidents reported relating to restrictive interventions/ restraint	Restrictive Practice Matron with support from Head/Deputy Head of Security	• Analysis of data from Datix	• Annually • By exception in case of significant incidents.	Violence & Aggression Assurance Group
Use of Rapid Tranquilisation	Chief Pharmacist	• Analysis of Datix incidents relating to RT • Audit using ePMA data	• Continuous	Medicines Optimisation Committee

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Related UHL policies and guidelines:

Clinical Holding in Children Guidelines for Practice *(forms part of the Restrictive Interventions policy)*

The Deprivation of Liberty Safeguards Policy and Procedures

Detention of Patients Under the Mental Health Act UHL Policy

Enhanced Patient Observation Policy *(currently awaiting approval)*

Guidelines for the Use of Hand Control Mitts (Mittens) with Adult Patients *(forms part of the Restrictive Interventions policy)*

Health and Safety UHL Policy

Incident and Accident Reporting UHL Policy

Mental Capacity Act UHL Policy

Preventing and Managing Violence and Aggression UHL Policy

Prevention and Management of Pressure Ulcers in Adults and Children Policy and Guidance

Rapid Tranquilisation of Disturbed Adult Patients UHL Guideline

Safeguarding Adults in the ED UHL Emergency Department Guideline

Safeguarding Adults Policy and Procedures

Safeguarding Children UHL Policy

Safeguarding Supervision UHL Policy

Violence, Aggression and Disruptive Behaviour Standard Operating Procedure UHL Emergency Department Guideline

External references and legislation:

Acute Behavioural Disturbance in Emergency Departments

Hodas, G.R., 2006. Responding to childhood trauma: The promise and practice of trauma informed care. *Pennsylvania Office of Mental Health and Substance Abuse Services,* 177, pp.5-68.

Human Rights Act (1998). *London: The Stationery Office.* Available at: Human Rights Act 1998

Mental Capacity Act (2005). *London: The Stationery Office*. Available at: Mental Capacity Act 2005

Mental Capacity Act Code of Practice (2007). *London: The Stationery Office*. Available at: Mental Capacity Act: Code of Practice

Mental Health Act 1983: Code of Practice (2015). *Department of Health, UK.* Available at: Mental Health Act 1983: Code of Practice

Restraint Reduction Network resources and further evidence available at: Restraint Reduction Network

"The Triangle of Care – Carers Included: A Best Practice Guide in Acute Mental Health Care" (2014) *Carers Trust and National Mental Health Development Unit, UK.* Available at: Mental Health and Triangle of Care

Working Definition of Trauma-Informed Practice: Guideline (2022) *Office for Health Improvement & Disparities, UK.* Access here: Working definition of trauma-informed practice

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be uploaded onto SharePoint and available for access by UHL Staff through the UHL intranet (Connect). It will be stored through this system.

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APPENDIX 1

Multiple factors may contribute to an altered behaviour or violence and aggression which should be considered when undertaking assessments and delivering care to patients. These may include, but are not limited to:

Physical Needs	Physical illness due to new or existing condition
	State of confusion, e.g. delirium or caused by physical illness
	Unmet needs, including pain, toileting, hunger, thirst
Mental Needs	Poorly treated or untreated symptoms of mental health condition
	Acute episode of exacerbation of mental health condition e.g. psychosis
	Needs linked to a known condition, such as a learning disability, or any neurodiversity
Emotional Needs	Exposure to situations that mirror past traumatic experiences
	Emotional distress, e.g. following bereavement
	Feeling that others (including staff, family, carers, friends, advocates) are not concerned with their subjective anxieties/concerns
	Inconsistent care
	Unmet emotional needs, including boredom, frustration, restrictions placed upon them
Social	Antagonism, aggression or provocation on the part of others
	Sense of personal disempowerment
	Under the influence of alcohol or illicit substances
	Unmet social needs including lack of positive social interaction
	Lack of constructive things to do, boredom
	Excessive or unreasonable application of demands and rules
	Restricted or unpredictable access to preferred items and activities
Environmental	Sensitivity to environmental factors e.g. excessive stimulation, lack of stimulation, noise, heat/cold, overcrowding general disruption
	Confusion linked to an unfamiliar hospital environment and staff
	Restricted access to external space
	Frustrations associated with being in a restricted and controlling environment
Communication	Lack of clear communication by staff with patients
	Difficulties communicating own needs and wants to staff or others
	Staff or others not using or facilitating the preferred communication method(s) of the patient

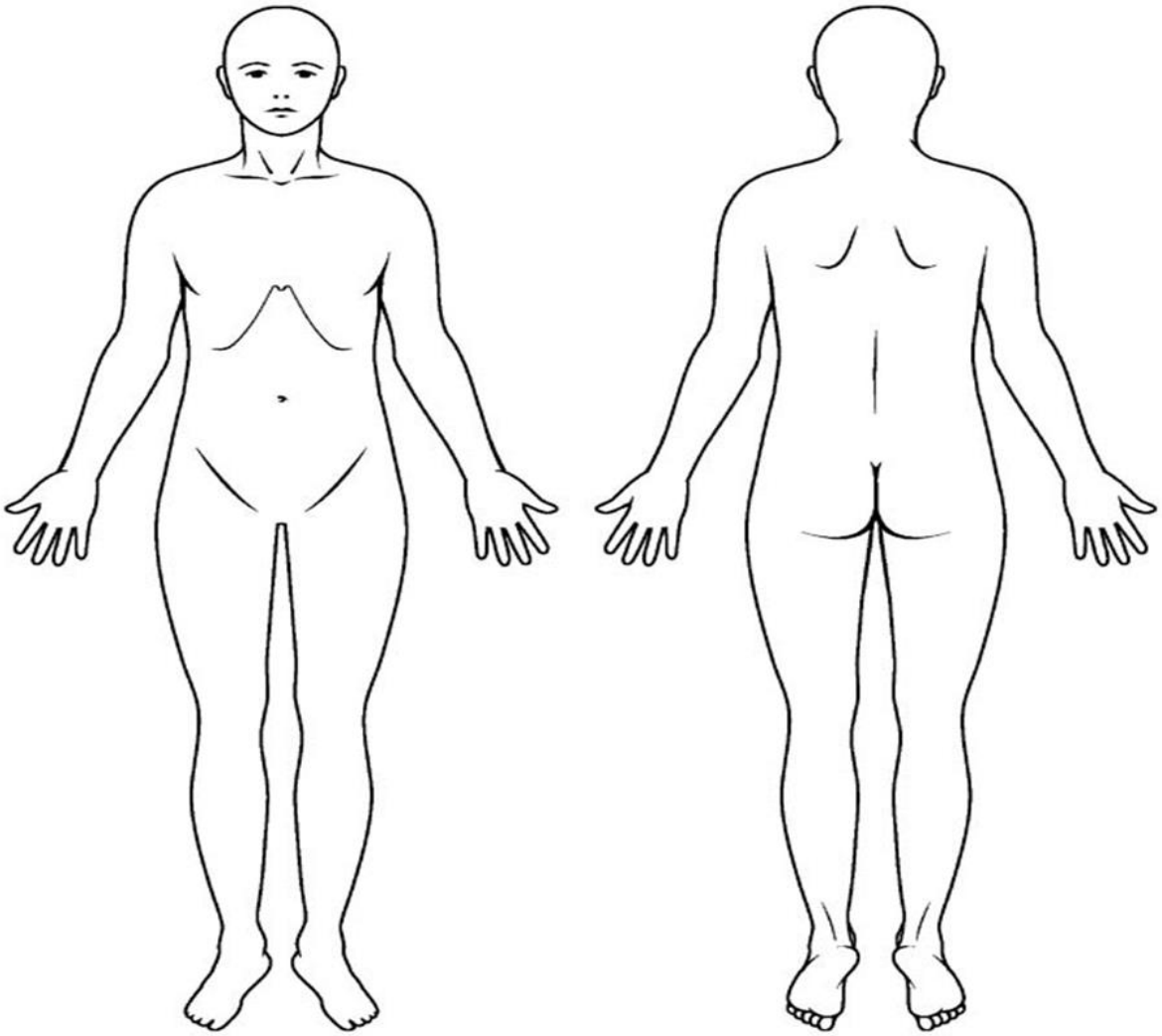
APPENDIX 2

Physical Restrictive Intervention/Restraint Body Map	University Hospitals of Leicester NHS NHS Trust **Restrictive Interventions Policy**

NHS Number/S Number
……
Patient's name:
……
Date of Birth:
……
PLEASE AFFIX PATIENT STICKER

Body Map completed by:	
Staff name	Signature
Designation	Date

Indicate on the body map any areas where the person has been held during a physical restrictive intervention/restraint and describe any injuries observed at the time of the incident. Place a copy in the patient's notes and upload to Datix where applicable.



Injury/Harm location	**Description**

APPENDIX 3

Physical Restrictive Intervention/Restraint Post-Incident Review	University Hospitals of Leicester NHS NHS Trust **Restrictive Interventions Policy**

NHS Number/S Number …… Patient's name: …… Date of Birth: …… PLEASE AFFIX PATIENT STICKER

Post-Incident Review completed by:	
Staff name	Signature
Designation	Date

Incident Details			
Date of Incident:		Datix Number:	
Location Description (if not on Datix):			

Ensure all staff involved in the restraint are added as a contact within the Datix

Techniques used to *prevent* physical restraint from occurring

Verbal

De-escalation ☐ Distraction/orientation ☐ Requesting behaviours are stopped ☐
Please specify

Physical

Physical disengagement ☐ Move to a safer location ☐ Breakaway techniques ☐
Please specify

Support from others

Support sought from other staff to assist ☐ Internal emergency response (security) ☐
External emergency response (police) ☐
Please specify

Physical Restraint Details	
Type of hold(s) & duration: *(specify)*	
Position of hold(s): *(tick)* Seated ☐ Standing ☐ Prone ☐ Supine ☐	
Was the restraint led by a clinical staff member? *(tick)* Yes ☐ No ☐	
Did any person sustain harm or injuries during the restraint? Yes ☐ No ☐ **If yes,** please confirm: *(tick)*	
Patient ☐	***Complete body map; upload to the Datix record; ensure welfare of the patient is identified.***
Staff member ☐	***Ensure support is offered (e.g. Amica, Occupational Health); line manager is made aware; RIDDOR is completed if applicable***
Visitor ☐	***Ensure Datix is complete***

Ensure that relevant services are made aware of the incident either through Datix or direct contact, depending on the level of risk identified. This may include UHL Teams including Safeguarding or Health and Safety, or external services such as police.

1. Introduction and Who the Guideline applies to

Hand Control Mitts (Mittens) are a specific product used to restrict the use of one or both hands, and is a form of mechanical restraint. Mitts are sometimes used when a patient is at risk of removing essential feeding lines and or tubes that would need to be reinserted. This may occur inadvertedly when a patient is acutely unwell and/or are experiencing restlessness, confusion or agitation due to their condition, and they may be deemed to lack capacity to understand the need for essential treatment/interventions.

Only the recommended mitts are to be used, and in line with the manufacturer's guidance.

The least restrictive option should always be utilised; other options should be explored prior to mitts. Meaningful interactions with staff may help to reassure, orientate, distract, and supporting the patient and their wellbeing. Behaviour may then de-escalate and negate the need for mitts to be considered. Refer to the Restrictive Interventions Policy and the Enhanced Patient Observation Policy for further information.

If further support to this document is required refer to guidance within your own own senior structure or contact the Restrictive Practice Matron. Additionally the Adult Safeguarding, Stroke, Nutrition/Lift team, Neurology/Brain Injury Unit, Learning Disability or Dementia Services may be able to advise.

2. Scope

This guideline applies to all patients aged 16 years and over and all healthcare staff working within University Hospitals of Leicester (UHL) including bank, agency staff and those of honorary contracts who are involved in the recommendation and/or use of mitts within the clinical setting.

3. Aims

This document provides detailed evidence-based guidance for the use of Mitts for adult inpatients, with the aim of defining the process that must be followed to ensure all patients who have Mitts have access to staff who are aware of the guideline and have understanding of the assessment and care required.

4. Capacity

If there are doubts about the person's mental capacity to consent to the use of mitts then a mental capacity assessment must be completed and recorded on NerveCentre. If the patient is deemed to have mental capacity then they must consent to the use of mitts before application. If the person declines then their decision must be upheld. In instances where capacity is fluctuating the capacity assessment will need to be revisited.

If the patient lacks capacity to consent to the use of mitts then a best interest decision must be made by the registered professional who is proposing the treatment plan. This is usually a medical or nurse practitioner, or other suitable registered professional. The person making the decision must consult those closest to the patient when making best interest decisions, such as next of kin, or appropriate close relatives or friends. Additionally anyone who has a valid and applicable Lasting Power of Attorney for health and welfare in place must be consulted; written evidence of this paperwork must be

provided. Please refer to the Mental Capacity Act Policy for additional support and information about making best interest decisions.

Applying Mitts is a highly restrictive intervention; staff must consider whether or not there is a risk that the patient is being deprived of their liberty. If so, staff must complete a Deprivation of Liberty Safeguards (DoLS) application via ICE, making reference to the use of mitts, in line with the Trust's DoLS Policy. Mitts must only be used when this is in the person's best interests and it is the least restrictive option available.

5. Guideline Standards and Procedures

If a patient presents as confused, disorientated, restless or agitated, then a medical review should be undertaken as soon as possible, with appropriate treatments or interventions being put in place, and including a capacity assessment. If a patient has removed or is at risk of removing essential feeding tubes/access lines, then mitts may be considered only if all other less restrictive options have been explored in line with the Restrictive Interventions Policy and the Enhanced Patient Observation Policy.

An holistic, individualised and patient-centred approach to care should be taken, which may include:

- Utilising the THINK Delirium support tool
- Contacting next of kin, family, carers or friends who may be able to offer information that could highlight the best ways and approaches in caring for the patient
- Meaningful interaction with the patient to help reassure, orientate, distract, and support them and their wellbeing. This may include exploring different methods of providing information to the patient regarding the perceived requirement for essential feeding tubes/lines.

Mitts may only be considered for use once all other least restrictive options have been explored and exhausted.

When a potential need is identified for mitts, a thorough assessment must be undertaken before being prescribed by a senior doctor. The assessment in Appendix A should be completed and a copy kept in the patient's notes along with clear rationale for the need for mitts, identified risks, Mental Capacity Act assessment (on NerveCentre), and DoLS application. The clinical indication for mitts should be reviewed and documented on a regular basis and at minimum every 24 hours.

Care should be taken when using mitts to ensure their safe use; the Hand Control Mitts (Mittens) Care Plan should be used and placed in the patient's notes. Key principles that should be adhered to are:

- Utilise and exhaust less restrictive options prior to using mitts.
- A Datix must be completed for all incidences of using mitts on a patient's hands.
- Review and document the clinical indication/rationale for mitts at **minimum** every 24 hours; this includes levels of confusion, disorientation, restlessness, agitation, and the need for the treatment/intervention to remain in situ.
- Discontinue the use of mitts at the earliest opportunity
- Remove the mitts at **minimum** every 2-4 hours; mitts should remain off for **at least 2 hours** to ensure no area of skin is inside the mitts for long periods.
- Hands/any skin inside the mitts should be cleaned and inspected by a nurse when the mitts are removed. This should be recorded on the BESTSHOT.

- Hands/any skin inside the mitts should be cleaned before the mitts are put back in situ.
- If there are any concerns or issues noted with skin integrity, then the use of mitts should be discontinued immediately. This may include pressure damage, sweat / signs of moisture damage or other trauma such as from friction. For further guidance, refer to Prevention and Management of Pressure Ulcers in Adults and Children Policy and Guidance (particularly section 3 and Appendix 1).
- Ensure that mitts are not tight around the wrist/hands, and are fitted in line with the guidance of the manufacturer.
- No bandaging, tape or similar to be used with or instead of mitts.
- Guidance should be sought from the Tissue Viability Team if there are any concerns or queries around a patient's skin integrity.
- Consider the presentation, abilities, and safety of the patient. For example if a mitt is placed on the dominant hand after a stroke and the patient is aphasic, additional vigilance is required to ensure the patient can ask for assistance.

Figure 1. Example of mitts that are available to use in UHL.

6. Education and Training

All medical or nursing practitioners who may be involved in the assessment for, prescribing of, and review of mitts should have up to date Tissue Viability training.

Staff should familiarise themselves with the instructions for use of mitts provided by the manufacturer prior to use.

7. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Number of incidents reported on Datix relating to the use of mitts	Analysis of data (in line with Restrictive Interventions policy)	Restrictive Practice Matron	Annually; by exception for incidents of note	Violence & Aggression Assurance Group

8. Supporting References

UHL Policies and Procedures:

The Deprivation of Liberty Safeguards Policy and Procedures

Enhanced Patient Observation Policy *(currently awaiting approval)*

Mental Capacity Act UHL Policy

Prevention and Management of Pressure Ulcers in Adults and Children Policy and Guidance

Restrictive Interventions Policy *(currently awaiting approval)*

9. Key Words

Mechanical restraint, restrictive intervention, hand control mitts, mittens.

10. Guideline Review and Version Control

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APPENDIX A – Assessment for the use of Hand Control Mitts (mittens) with adult patients

NHS Number/S Number …… Patient's name: …… Date of Birth: …… PLEASE AFFIX PATIENT STICKER	**Risks identified – *tick all that apply***
	Risk of aspirating contents of NG tube if pulled out when still running ☐
	Risk of tissue damage e.g. cannula, NG tube, PEG tube ☐
	Risk of reduced nutrition or hydration ☐
	Risk that vital medications cannot be given ☐
	Other ☐ *(specify)*
	If any risks above have been ticked, continue to the next section

Patient	Yes	No	Specify Supporting Information/Actions
1. Has the patient removed essential tubes/lines?			
2. Have other methods been tried? (i.e. distraction techniques, re-siting)			Specify techniques used:
3. Does the patient have capacity to consent to the use of mitts?			
4. **If yes to 3**, 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 mitts explained and had the opportunity to see and try mitts before they are fitted?			
7. If the patient has no next of kin, is there documented evidence that that the clinical team agree to the use of mitts in the patient's best interests?			
8. Have the decisions around **capacity** and use of mitts been documented? (MCA, DoLS, Best Interests)			
9. Has the **plan of care** been: • Discussed (with patient, next of kin, team) • Documented			
If the use of mitts is indicated, complete the 'Care Plan for the Use of Hand Control Mitts (Mittens) for Adult Patients'.			

Assessment completed by:			
NAME	**DESIGNATION**	**SIGNATURE**	**DATE AND TIME**

*Reassess when the patient's condition changes, or at **minimum** every 24 hours.*

APPENDIX B – Care Plan for the Use of Hand Control Mitts (Mittens) with Adult Patients

NHS Number/S Number
……
Patient's name:
……
Date of Birth:
……
PLEASE AFFIX PATIENT STICKER

DATE: ……

A new care plan should be completed every 24 hours. Hand control mitts (mittens) are highly restrictive and should only be used when other methods of support have been attempted (refer to Hand Control Mittens Guideline) and Mental Capacity has been assessed. This care plan should be completed only if the 'Assessment for the Use of Hand Mittens (Mitts) with adult patients' has been completed and mitts are indicated.

Check being completed ***(circle answers)***	**Time period of checks**					
	00:00-04:00	**04:00-08:00**	**08:00-12:00**	**12:00-16:00**	**16:00-20:00**	**20:00-00:00**
Mitts still required	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
State reason from assessment						
Circulatory checks; can use be continued? ***Discontinue use of mitts if pulse, colour, temperature or sensation are altered***	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Signs of tissue damage?***If yes, discontinue use of mitts***	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Venflon in situ on this hand? ***Resite if mitts to be used***	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Swelling present?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any redness?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any inflammation?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any pressure damage?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any sweat / moisture damage?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Evidence of other issues e.g. patient distress. ***State issues***	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Is the mitt clean and dry?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Mitt changed every 24 hours?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Patient to have a minimum of 2 hours between mitt removal and being replaced						
Hand cleaning completed: • After removal of mitt • Before mitt being replaced • Recorded on BESTSHOT	 Yes / No Yes / No Yes / No	 Yes / No Yes / No Yes / No	 Yes / No Yes / No Yes / No	 Yes / No Yes / No Yes / No	 Yes / No Yes / No Yes / No	 Yes / No Yes / No Yes / No
Concerns escalated?						
Is mitt use to be continued?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Staff Name/Initials						
Staff Signature						
Staff Designation						

1. Introduction

The purpose of this guideline is to provide all clinical staff with the required information related to the clinical holding of babies, children and young people for clinical procedures. The guideline is intended as a set of principles and key methods and recognises that on occasion children may need to be held in a safe and controlled manner for a variety of procedures. The child's safety and welfare are of paramount importance and staff must continue to support the ethos of caring and respect for the child's rights. Clinical holding or containing without the child/parent/carer's consent is a last resort and must not be used as the first line of intervention.

2. Scope

This policy applies to all staff working with University Hospitals of Leicester NHS Trust.

3. Professionals Duty of Care

Registered nurses are bound by a 'duty of care' and are accountable for promoting and protecting the rights and best interests of their patients'. Where the use of restraint, holding still and containing children and young people is concerned, all professionals must consider the rights of the child and the legal framework surrounding children's rights. This includes the Human Rights Act (1998) and the European Conventions on the Rights of the Child, Consent and Capacity Assessment (1989). Although regularly used in hospitals for procedure such as Blood Sampling and Cannulation, reports have commented that the restraint has caused more distress to the child than the pain of the procedure itself (Pearch 2005).

4. Definitions

4.1. Restraint

The Department of Health for England defines restraint as: 'The positive application of force with the intention of overpowering the child'. Restraint is, by definition, applied without the child's consent. There is also the Department of Health for England's specific guidance on restrictive physical interventions for people with learning disabilities and autism.

4.2. Clinical Holding

Is the proactive immobilisation of a part of the body to which a procedure is being carried out. It may be a method of helping children, with their permission, to manage a painful procedure quickly or effectively for example holding an arm from which blood is being taken in order to prevent reflex withdrawal and thus unnecessary pain or distress or injury to the child. Holding is distinguished from restraint by the degree of force required and the intention.

4.3. Containing and preventing from leaving

This is defined as physical restraint or Barriers that prevent the child leaving, harming itself, or causing serious damage to property. All restriction of liberty in health authority/board settings is governed by the 1991 Children (Secure Accommodation)

Regulations, the Children Act 1989, the Children (Northern Ireland) Order and the Children (Scotland) Act.

4.4. De-escalation techniques

These are techniques to reduce the level and intensity of a difficult situation. De-escalation means making a risk assessment of the situation and using both verbal and non-verbal communication skills in combination to reduce problems.

5. Guideline Statements and Procedures

It is likely that for clinical procedures such as Blood Sampling or Cannulation the nurse will at most hold the child still for the procedure therefore:

Clinical Holding a child for a particular clinical procedure also requires nurses to:

a) Give careful consideration of whether the procedure is really necessary, and whether urgency in an emergency situation prohibits the exploration of alternatives.

b) Anticipate and prevent the need for holding, through giving the child information, encouragement, distraction and control by talking and listening to the child and their parent/carer.

c) Obtain the child's consent or assent (expressed agreement) for any situation, which is not a real emergency. A judgment will need to be made by the healthcare professional as to whether the child is competent to give their own consent and should be in accordance with Sections 5.22 to 5.26 of the Consent to Examination or Treatment UHL Policy (B35/2024). If required, please seek advice from the Child Safeguarding Team.

d) Seek the parent's/guardian's consent, or the consent of an independent advocate. The procedure should be explained to the child and or parent/carer in a language that can be understood by them.

e) 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. Explore all methods available, for example play, distraction & local anaesthetic cream/spray. The agreement should be clearly documented in the plan of care and any event fully documented.

f) 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. Health Care professionals should explain parents' roles in supporting their child, and provide support for them during and after the procedure).

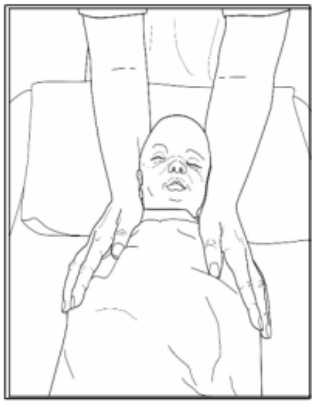
g) Make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting, explaining and preparing the child/parents beforehand as to what will happen?

h) Comfort the child or young person where it hasn’t been possible to obtain their consent, and explain clearly to them why restraint was necessary.

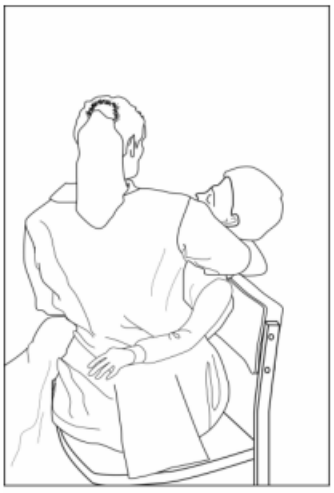
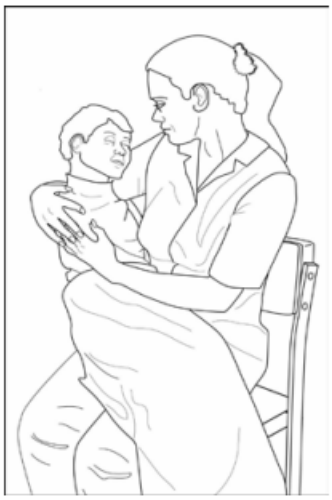
6. Holding Techniques for Infants and Children

Infants, under the age of 1 year, should be wrapped securely in a blanket, as indicated below.





Older children may sit in an upright position on an adult's knee or supported by pillows, if appropriate, as indicated below.


For younger children with complex needs, discuss position with parents / carer.

7. Supporting References

Bray L, Ford K, Dickinson A, Water T, Snodin J, Carter B. A qualitative study of health professionals' views on the holding of children for clinical procedures: Constructing a balanced approach. *Journal of Child Health Care*. 2019;23(1):160-171

Royal College of Nursing (2019) Restrictive Physical Interventions and the Clinical Holding of Children and Young People: Guidance for Nursing Staff. *Royal College of Nursing*. London, UK.

Pearch J (2005) Restraining children for clinical procedures. *Paediatric Nursing Vol 17 No 9 November*

8. Key Words

Clinical holding

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