

Restrictive physical interventions and the clinical holding of children and young people

Guidance for nursing staff

CLINICAL PROFESSIONAL RESOURCE





This Royal College of Nursing guidance sets out children's and young people's rights concerning restrictive physical intervention and clinical holding in health care settings within a legal, moral and ethical framework.

The *Restraining, holding still and containing young children* guidance was first published in 1999, and was updated in 2003, following consultation with RCN members. The 2019 guidance replaces previously published information.

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Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

Where the use of restrictive physical interventions or clinical holding of children and young people is concerned, nurses must consider the rights of the child. This guidance is aimed at nursing staff to develop policies, practices and educational programmes in their workplace.

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1. Introduction

This guidance is not intended to be a comprehensive manual covering all situations and methods; instead it is a set of principles and key references which will help nurses to develop policies, practices and educational programmes in their workplace, in conjunction with other members of the multidisciplinary team. The governing body of organisations providing health care should approve the implementation of policies; including ensuring staff receive necessary training focused on proactive and preventative strategies and training in order to practice any necessary techniques competently.

This guidance applies to all children and young people receiving health care interventions.

However, for those being nursed under the Mental Health Act 1983 (as amended 2007), to ensure all patients receive high quality and safe care, there is specific statutory guidance on different forms of restrictive intervention (and considerations for their use) detailed in the Mental Health Act: Code of Practice (Chapter 26) (2015). For young people aged over 16 years of age nurses need to be aware of their professional obligations relating to the Mental Capacity Act (2005).

Registered nurses are bound by a 'duty of care' (Nursing and Midwifery Council, 2018) and are accountable for promoting and protecting the rights and best interests of their patients.

2. Restrictive physical intervention and clinical holding

Where the use of restrictive physical interventions or clinical holding of children and young people is concerned, nurses must consider the rights of the child and the legal framework surrounding children and young people's rights, including the Human Rights Act (Human Rights Act 1998) and the European Conventions on the Rights of the Child, Consent and Capacity Assessment (UN Convention on the Rights of the Child (1989)).

3. Definitions

Restrictive physical intervention

Restrictive physical intervention is increasingly replacing the term ‘physical restraint’. It is described as “any method which involves some degree of direct force to try and limit or restrict movement” (Restraint Reduction Network 2019). It should be necessary, proportionate and justifiable and only used to prevent serious harm. Any use of planned or unplanned restrictive physical intervention should be carried out using the least restrictive interventions and for the minimum amount of time.

All UK countries issue guidance on restrictive physical interventions relevant to school, children’s homes and detention centres. The Restraint Reduction Network (RRN) publish useful training resources and guidance on how to minimise the use of restrictive interventions (Restraint Reduction Network Training Standards, 2019). The recent guidance (Department of Health, 2019) on reducing the need for restrictive interventions for children and young people with learning disabilities and mental health need is relevant to many children and young people within organisations providing health care.

The physical restriction or barriers which prevent a child leaving, harming themselves, or causing serious damage to property are also included in the term restrictive physical intervention. All restriction of liberty in organisations providing health care is governed by the 1991 Children (Secure Accommodation) Regulations, the Children Act 1989 (Department of Health (1997), the Children (Northern Ireland) Order (Department of Health, 1995) and the Children (Scotland) Act (Scottish Office, 1998). Young people aged over 16 years of age are covered by the Mental Capacity Act (2005).

Clinical holding

This means using limited force to hold a child still. It may be a method of helping children, with their permission, to manage a health care procedure quickly or effectively. Clinical holding has been distinguished from restrictive physical intervention by the degree of force used, the intention of the hold and the agreement of the child (Bray et al., 2014), but should still be considered a restrictive physical intervention. Alternative terms for clinical holding include supportive holding (Jeffrey, 2008), holding still (Bray et al., 2016), therapeutic holding (Kennedy & Binns, 2016) and immobilisation (Brenner, 2007). Practitioners should be aware that clinical holding if applied without the child’s assent can result in the child/young person feeling out of control, anxious and distressed (Lambrenos, McArthur, 2003; Coyne & Scott, 2014).

4. The principles of good practice

General principles

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 clinical holding without the child/young person's assent are used as a last resort and are not the first line of intervention (Coyne & Scott 2014).
- a concerted effort to ensure that preventative and pro-active strategies (positive behaviour support, de-escalation) have been explored and enacted before any restrictive intervention or clinical holding is 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 children (where appropriate) and their parent or guardian.
- a clear mechanism for staff to be heard if they disagree with a decision.
- a policy in place which is relevant to the client/patient group and the particular setting and which sets out when restrictive physical interventions or clinical holding may be necessary and how it may be done.
- a sufficient number of staff available who are trained and confident in alternatives to holding and the use of safe and appropriate restrictive physical interventions and clinical holding techniques for children and young people.
- a record of events. This should include why the intervention or hold was necessary, who held the child, where the intervention took place, the holding method used, the length of time and any techniques needed to reduce the future need for restrictive physical interventions or clinical holding (Jeffrey, 2008).

Clinical holding

Clinical holding without a child's assent/ consent should only be considered when there is no alternative and an emergency or urgent intervention needs to be performed in a safe and controlled manner.

Clinical holding for a particular clinical procedure requires nurses to:

- give careful consideration of whether the procedure is really necessary, and whether urgency in a situation prohibits the exploration of alternatives to holding.
- anticipate and prevent the need for holding, by giving the child information, encouragement, distraction, analgesia and, if necessary, using sedation (National Clinical Guideline Centre, 2010)
- obtain the child's assent (expressed agreement), in all but the very youngest children, and for any situation which is not a real emergency seek the parent/carer's consent, or the consent of an independent advocate.
- pause prior to a procedure to discuss and agree with a child and their parents/guardians what will happen during a procedure, what people's roles will be and if necessary what holding methods will be used, when they will be used and for how long (Bray et al 2018).
- ensure that any holding used is the least restrictive option to meet the need and is used for the minimum amount of time. Nurses should make skilled use of minimum pressure and other age-appropriate techniques, such as wrapping and splinting.
- 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 or if they do not wish to be the one to hold their child for a procedure (Homer and Bass 2010)
- explain parents' roles in supporting their child, and provide support for them during and after the procedure.

- comfort the child or young person where it hasn't been possible to obtain their assent, and explain clearly to them why holding them still was necessary.
- ensure that any use of holding is fully and clearly documented in the child's plan of care and notes.

Restrictive physical intervention

The restraint of children within organisations providing health care may be required to prevent significant and greater harm to the child themselves, practitioners or others. This should only occur when proactive and preventative strategies (de-escalation, positive behavioural support) have been exhausted (NICE 2015). De-escalation techniques are a set of therapeutic interventions which use verbal and non-verbal skills to reduce the level and intensity of a difficult situation (Price & Baker 2012).

If restrictive physical interventions are needed the degree of force should be confined to that necessary to hold the child or young person for the shortest amount of time whilst minimising injury to all involved (Department of Health 2014). A decision to use any form of restrictive physical interventions, must be based on the assessment that the use of such interventions will cause less harm than not intervening (RRN 2019).

The use of restrictive physical intervention requires nurses to:

- review policies which relate to the organisation's philosophy on the provision of child-centred health care.
- ensure policies should include when and how restrictive physical interventions should be used, who to notify, time limits and the reporting and recording of incidents through critical incident reporting mechanisms.
- anticipate and prevent the need for restrictive physical interventions including provision of training sessions to clearly identify individual roles and responsibilities.
- ensure (when it is likely to be necessary) there is agreement beforehand with parents and the child about what methods will be used and in what circumstances. This agreement should be clearly documented in the plan of care.
- consider the legal implications of restrictive physical interventions. Where necessary, application should be made through the Family Courts (or equivalent in Scotland and Northern Ireland) for a specific issue order outlining clearly the appropriate restrictive physical intervention techniques to be used.
- ensure that restrictive physical interventions are never used in a way that might be considered indecent, that could arouse any sexual feelings or expectations or re-traumatise a child or young person.
- that debriefing of the child and, where appropriate, of parents and staff, is structured and age appropriate and takes place as soon after the incident as possible.
- effectively audit the circumstances and use of restrictive physical interventions.

5. Training

The focus of training for all nurses should be on alternatives to restrictive interventions or holding (RRN, 2019), staff should be trained on the use of proactive and preventative strategies such as positive behavioural support, information provision, preparation, distraction, de-escalation and the appropriate use of local anaesthetics and oral analgesics. Training should emphasise that clinical holding or restrictive physical interventions should only be used as a last resort after careful consideration of a child's rights and with clear rationale that the use of any intervention is proportionate and represents the least restrictive option.

Training provision should provide nurses with an understanding of the techniques of restrictive physical intervention and clinical holding (Page & McDonnell, 2015) and should be targeted at relevant groups of nurses. For example, nurses working in areas such as emergency care departments, special schools, walk-in centres and GP practices should receive training in using restrictive physical interventions as well as clinical holding for procedures; nurses working with children and young people in all other clinical areas should receive, as a minimum, training in clinical holding for clinical procedures and de-escalation techniques.

Greater emphasis needs to be placed on enabling nurses to acquire knowledge and skills through the provision of locally based training programmes. It is recommended that organisations undertake an organisation-wide risk assessment to assess particular risks in each clinical area and thus identify staff training needs.

Practitioners who want to highlight the need for policies and training provision in their organisation may find it helpful to forward a copy of this guidance to risk managers and named executive directors (or equivalent) for their place of employment. If employers do not provide proper training, practitioners may feel compromised in situations where they have found it necessary to use clinical holding or restrictive physical interventions.

RCN members can seek specific advice about these issues by contacting RCN Direct on 0345 772 6100.

The publication *Raising concerns Guidance for nurses, midwives and nursing associates* (NMC, 2018) and *Raising Concerns* (RCN, 2017) may also be of help.

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