Surrey and Sussex NHS
Healthcare NHS Trust

An Organisation-Wide Policy for Safer Holding

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Type of Procedural Document	Policy
Owner:	Fiona Allsop
Owner's job title:	Chief Nurse
Author:	Richard Bridgeman
Author's job title:	Security Manager
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Equality statement

This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners**.** The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief**,** and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document is available in different languages and formats upon request to the Trust Procedural Documents Coordinator and the Equality and Diversity Lead.

Contents

1 Rationale

Surrey and Sussex Healthcare Trust (SASH) is committed to delivering the highest standards of health, safety and welfare to its patients, visitors, and employees.

The Trust recognises that violence and aggressive behaviour can escalate to the point where safer holding may be needed to protect the person, staff or other legitimate users of Trust premises and facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed.

2 Scope

This policy is intended to provide guidance for managers, staff and security contractors in relation to the nature, circumstances and use of safer holding techniques currently adopted by the Trust. Its aim is to help all involved to act appropriately in a safe manner, thus ensuring effective responses in potential or actual difficult situations. It sets out a framework of good practice, recognising the need to ensure that all legal, ethical and professional issues have been taken into consideration.

3 Safer Holding

3.1 Definitions

Mental Capacity Act 2005 (MCA)

Applies to people aged 18 and over who are unable to make all or some decisions for themselves. The MCA is designed to empower those in health and social care to assess capacity themselves, rather than rely on expert testing.

The Mental Capacity Act Deprivation of Liberty Safeguards (DOLS)

Applies to anyone aged 18 and over who suffers from a mental disorder and lacks the capacity to give informed consent to the arrangements made for their care and/or treatment and for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered, after an independent assessment, to be necessary in their best interest to protect them from harm.

Safer holding

Safer Holding is an intervention that prevents a person from behaving in ways that threaten to cause harm to themselves, to others, or to property.

Physical Safer Holding

Any manual method, physical or mechanical device, material, or equipment that immobilises or reduces the ability of a person to move his or her arms, legs, body, or head freely.

Clinical Holding

Clinical holding is the proactive immobilisation of a part of the body to which a procedure is being carried out.

Chemical Holding

A drug or medication used to manage a patient's extremely violent or aggressive behaviour which is administered, if necessary, against the patient's wishes. Such drugs may of course also be used with the patient's consent, and may (with the patients consent) be used in circumstances in which the threat of harm is less immediate.

Imminent Danger

Any situation or practices in a place of employment which are such that a danger exists which could reasonably be expected to cause death or serious injury.

Lead Person

The most senior person in an area/ward, who takes responsibility for managing a threatening situation.

3.2 Objective of Safer Holding

The objective of any safe holding is to maintain the safety of staff, other persons present and the subject where practicable, by establishing an appropriate degree of control of the aggressive or violent behaviour.

There is no legal or ethical difference between physical and chemical safe holding. All restraining therapy should be specific to the patient's needs and agreed by a

multidisciplinary team. All patient's should be held for the least time possible with clear objectives regarding what is to be achieved by using safer holding. Physical safe holding should always be the last resort.

3.3 Duties

The member of staff identifying the challenging behaviour or intent will:

- Escalate the incident to the Person in charge of the area
- Wherever possible and if it is safe do to so move other patients away from the vicinity
- Attempt to de-escalate by reassurance and other means

The Team Leader (senior person at time of incident) will: -

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- Assume the lead role for any safer holding that does take place, and conduct the risk assessment of the circumstances that will determine whether safer holding is appropriate and justified.
- Have a sufficient understanding of safer holding processes, of the law, and of this policy to ensure a satisfactory outcome for all involved.
- Inform appropriate medical staff and the most senior nurse on duty i.e. Senior Sister , Matron , Site Manager with appropriate urgency
- Ensure that wherever possible de-escalation techniques are used throughout a safer holding process
- Arrange for the family, friends or career to be contacted / be involved if they may have a calming influence on the person.
- Arrange and lead the de-brief, and participate in any subsequent follow up and support.
- Ensure the incident is reported in accordance with Trust Policy.

Responsibilities of Managers (Ward, Clinic & Department)

Managers must:

- Familiarise themselves with this Policy and supporting procedures, and ensure that the contents of the documents are brought to the attention of employees under their supervision.

- In all wards/ areas where the use of safer holding is foreseeable there should be access to Basic Life Support (BLS) equipment within 3 minutes (National Institute for Clinical Excellence 2005 (NICE, 2005).

- Ensure all staff undergoes Conflict Resolution and other relevant Aggression, Violence and Harassment training as set down by the Trust

- Ensure appropriate Management Plans are in place for all Patients who have been assessed as posing a high risk of Aggression, Violence or Harassment. All such plans must be brought to the attention of all relevant staff.

- Ensure staff involved in (or witness to) safer holding are offered support, post incident including medical, emotional and management support either via the Occupational Health Department (CIC) or Employee Assistance Programme.

- Ensure that the Local Security Management Specialist (LSMS) is informed of the use of safer holding or incident (even if safer holding is avoided), and is copied in on any subsequent correspondence.

The Local Security Management Specialist will:

- Ensure the Security Management Committee is kept fully abreast of any incidents, the outcome and any learning that needs to take place.

- Identify from incident data and risk assessments all high risk areas and support managers to implement appropriate arrangements.

- Provide liaison and support to the Trust Solicitor, and Police & Crown Prosecution Service (CPS) as necessary.

- Liaise with NHS Counter Fraud and Security Management Service (CFSMS), Legal Protection Unit (LPU) and the Police in accordance with Secretary of State Directions

- Be part of the de-brief and any subsequent follow up.

- Ensure security staff are fully aware of the Trust Policies & Procedures relating to Violence and Aggression

- Identify training needs of Trust staff in relation to safer holding

Resuscitation Officers will;

- Liaise with Managers to ensure that where the use of safer holding is foreseeable there should be access to emergency equipment and team within 3 minutes (NICE, 2005).

- Work with the Trust's LSMS as required to review all incidents where the Safer Holding Policy has been used and resuscitation has been required.

Security Management Committee will;

Monitor compliance with this policy.

Receive detailed reports on all incidents where safer holding is used, and agree action as required.

3.4 Safer Holding/Physical Intervention

Planning/Coordinating

Consideration should be given to reversible cause of aggressive or violent behaviour which may be amenable to specific treatment. Such specific treatment should be applied as soon as possible.

Plan any approach with all staff present involved with the incident.

In all wards/ areas where the use of safer holding is foreseeable there should be access to emergency equipment and team within 3 minutes (NICE, 2005)

Allocate responsibility to an identified member of staff to co-ordinate the incident. Important qualities include familiarity with the person, ability to use clear, direct, uncomplicated communication throughout the procedure, and knowledge of any risks associated with physical safer holding.

Allocate responsibility to a staff member to support the restrained person after the safer holding.

Implementation of Physical Interventions/Safer Holding

Any staff using physical safer holding should:

Wherever possible use de-escalation techniques irrespective of the stage of the safer holding.

Monitor the person's overall physical and psychological well-being throughout.

For safety reasons, during a safer holding it is only permissible to hold / apply pressure to the person's limbs. Under no circumstances must direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. (See also section 6.4)

To avoid prolonged physical intervention / immobilisation, consider rapid tranquillisation or seclusion (which may be safer where appropriate) as alternatives

The level of force applied must be reasonable and necessary and proportionate to a specific situation, and be applied for the minimum possible amount of time.

Any person subject to safer holding must be physically monitored throughout the incident.

Post-safer holding, the person who has been safer held will be reviewed for placement on the appropriate observations level, for a period of up to 24 hours. During this time physical observations must be recorded and the observing nurse be fully aware of the possibility of safer holding/positional asphyxia.

3.5 Mechanical Safer Holding

The use of mechanical safer holding at this Trust is prohibited by Trust Staff or any employed contractor.
This includes the use of handcuff's (by Security Teams) or the use of bed sheets etc, applied locally on wards or departments. Any use of mechanical safer holdings constitutes a deprivation of liberty and is therefore against the law.

This prohibition does not apply to the Police, Prison Service or other approved agency or body.

Physical Monitoring

Physical Monitoring is important during and after safer holding. This should be documented as part of the risk assessment and also in the Plan of Care. Monitoring must be undertaken by the Clinical Team in attendance and must include observations e.g. Pulse, Blood Pressure, Respiration, SPO2, GCS etc.

This is especially important:

- Following a prolonged or violent struggle
- If the person has been subject to enforced medication or rapid tranquilisation
- If the person is suspected to be under the influence of alcohol or elicit substances
- If the person has a known medical condition which may inhibit cardio-pulmonary function e.g. obesity, asthma, heart disease etc.

3.6 Rapid Tranquilisation / Chemical Holding

In carrying out rapid tranquilisation the patient should be able to respond to communication throughout the period of rapid tranquilisation. The aim of the rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others (NICE 2005). Staff should refer to the Trust's IV Sedation Policy for further guidance. Medication for rapid tranquilisation, particularly in the context of physical intervention, should be used with caution owing to the following risks:

- Loss of consciousness instead of tranquillisation
- Sedation with loss of alertness
- Loss of airway
- Cardiovascular and respiratory arrest
- Interaction with medicines already prescribed or illicit substances taken
- Possible damage to patient-staff relationship
- Underlying coincidental physical disorders

3.7 Procedure for Holding a Patient

Safer holding - laying hands upon another person is technically common assault. However, controlled safer holding may be justified if the patient in question is presenting a threat to himself or to other patients or staff. For effective and safe safer holding, sufficient members of staff must be available, and it is wise not to approach the patient until these conditions are satisfied.

Always call for assistance.

Ask other people to summon help.

All staff should be appropriately dressed when on duty and before dealing with a potentially violent incident. They should remove any objects that could be potentially dangerous from their clothing (even a stethoscope).

Try to appear calm; communicate to the person continually and quietly.

Continue to communicate to the person, once he has been immobilised.

Bearing in mind that staff are not expected to subject themselves to any unnecessary risks or cope alone with potentially violent situations, there are some situations in which it may be necessary to restrain a person physically:-

(a) When a patient presents a serious threat to another person.
(b) When a patient presents a serious threat to himself.
(c) If a patient is detained under the Mental Health Act and safer holding is necessary to give an **essential psychiatric treatment**, which the patient is resisting.

Whilst restraining a person, it is well to remember that he or she is probably more frightened than the staff. Reassure and talk with the person during the procedure.

Ideally, five or six people should work as a team, one person being Identified as the person in control with the team acting in unison and responding to directives from the person in control.

3.8 After Care

After rapid tranquilisation is administered, staff should recognise the importance of nursing the patient in the recovery position (where safely possible). Staff should monitor and record pulse, blood pressure, hydration, SP02, GCS and respiration using pulse oximeters where possible.

3.9 Post Safer Holding Arrangements

The aim of a post-incident review should be to seek to learn lessons, support staff and patients, and encourage the therapeutic relationship between staff, patients and their carers. (NICE 2005).

A de-brief should take place as soon as practicably possible post-incident unless there are exceptional circumstances preventing this. Reflective reviews and root cause analysis are essential after safer holding.

The review should address:

What happened during the incident
Any trigger factors
Each persons role in the incident
Their feelings at the time of the incident, at the review and how they may feel in the near future
What can be done to address their concerns

As soon as practicably possible following the use of physical interventions the staff involved will meet together. This time will be used to discuss any issues anyone may have as well as reviewing the details of the incident itself. Any significant points raised must be documented and discussed with the LSMS.
All persons involved in the use of physical interventions must be offered post-incident support by the appropriate line manager, and be involved in any support or feedback process.

The person leading the team must ensure the Trust's Incident Reporting form and process is completed.

3.10 Procedure for Safer Clinical Holding of Adults

When considering the need to hold an adult for a clinical procedure, staff should follow the guidance detailed in the algorithm (Appendix 3).

The following points must be considered: It should be borne in mind that safer holding must be used as a therapeutic measure and that the patient is ill

1. It should be carried out as professionally as any other treatment.

2. The team leader should clearly and distinctly tell the patient *"we are holding you to prevent you hurting yourself or anyone else".*

3. Holding could easily be prolonged past the therapeutic level, quite often the initial restraining is sufficient and prolonging this can aggravate the situation.

4. Always talk to the patient and explain clearly what you are doing and why, even though it may at the time appear that the patient is not comprehending. If the patient talks, then in most cases they are prepared to listen.

3.11 Procedure for Safer Clinical Holding of Children

When considering the need to hold a child for a clinical procedure, staff should follow the guidance detailed in the algorithm (Appendix 4). The following points must be adhered to:

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

2. The child's safety is of paramount importance. Talking and listening should always be the first approach. Anticipate and prevent the need for holding through giving the child information, encouragement, and use of distraction techniques (use of play leaders/specialist). The child should be given time to play to enable them to explain their anxiety, fear and anger.

3. Procedures must be explained to children, young people and or parent/carer in an age appropriate manner so that informed consent is obtained

4. Where possible the child/young person's consent and or that of his/her parents/carer should be obtained for all procedures including clinical holding and documented in the clinical records.

5. Judgement will need to be made by the healthcare professional as to whether the child is competent to give their own consent. If a young person who is deemed Gillick competent (Gillick v N&WAHA 1986) is refusing the procedure, do not proceed unless life threatening. The consultant in charge of the childs care should be contacted urgently to discuss.

6. Presence and participation of the parent/carer should be encouraged where indicated by the child's age and needs and where parents wish to be involved. Parents should not be made to feel guilty if they do not wish to be present during procedures. Nursing staff should explain the parent role in supporting their child. Parents will support during and after the procedure and need time to 'recover' as they too will often be very distressed at seeing their child upset.

7. The procedure and any element of discomfort, truthfully explained in language that the child can understand and the child to be requested to sit still for the procedure.

8. Make an agreement beforehand with child and person with parental responsibility about what methods of clinical holding will be used, when they will be, and for how long. This agreement should be clearly documented in the plan of care and any event fully documented.

9. Following the procedure, the child will be comforted and debriefed, and may need a clear explanation of why holding was necessary.

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

4 Responsibilities

It is the responsibility of the Chief Executive to ensure patients are handled safely and staff are trained in approved handling techniques.

It is the responsibility of the training department in conjunction with the LSMS to provide approved technique, safer holding training

It is the responsibility of departments to:

- Risk assess situations where patients have the potential to become violent
- Risk assess staff who need to receive safer holding training
- Ensure staff book a place on the provided courses
- Staff who are booked on the provided courses, unless there is good reason, must attend the course

5 Compliance Monitoring arrangements

The effectiveness of this policy will be routinely monitored:
Any occasion where a physical assault incident is reported via the Trust's Incident Reporting system, the LSMS will be notified. The LSMS will monitor reported incidents and they will be presented to the Security Management Committee

Security Management Committee

This forum meets Quarterly, discusses such incidents, and oversees any subsequent action plans. This ensures the organisation shares lessons learnt and keeps abreast of developments in the use of safer holding.
Monitoring of incident trends will form part of SMC's remit and will include monitoring against gender, race, age, mental capacity and location.

The identification and review of risks in relation to safer holding will be conducted in each area in line with the Trust Risk assessment Policy and risk Management Strategy.

Staff perception of the management of safer holding will be monitored annually through the National Staff Survey. Patient perception will be monitored by the National Inpatient survey, annually.

Identified training needs will be reviewed and developed by the LSMS with support from the Education and Training Department.

Monitoring approval, amendments and document control

This policy will be reviewed in line with the Trust Policy on Management and Development of Procedural Documents; the standard length of time for review is three years. However, changes within the organisation affecting this process, together with any changes in legislation or the requirements of external regulators may prompt the need for revision before the year period.

6 Training to ensure compliance with this policy

'Assault Avoidance and Clinical Holding' training is not statutory or mandatory.

Department heads should:

- Ensure staff book a place on the provided courses
- Staff who are booked on the provided courses, unless there is good reason, must attend the course

Identified training needs will be reviewed and developed by the LSMS with support from the Education and Training Department.

7 References and associated documents

References

Corporate Manslaughter Act

Counter Fraud and Security Management Services, 2003

Harassment Policy

Health & Safety at Work etc Act 1974

Management of health & Safety at Work Regulations 1999

Mental Capacity Act

National Institute for Clinical Excellence February 2005. “Violence: managing disturbed / violent behaviour”
www.nice.org.uk/nicemedia/pdf/CG025publicinfo

NUH Managing and Dealing with Aggression, Violence

NUH Withholding Treatment from Patients

NUH Personal Development Review Policy

RCN Guidelines - ‘Let’s Talk About Safer holding’ (including violence and abuse) Policy

Secretary of State Directions 2005

The Resuscitation Council for the UK, (2004) “Intermediate Life Support Guidelines”

IV Sedation Policy

Associated documents

Mittens policy

8 Glossary/ explanation of terms used in this document

Acronym/ Abbreviation/ Term	*Meaning*
DOLS	**Deprivation of Liberty Safeguards**
BLS	**Basic Life Support**
NICE	**National Institute for Clinical Excellence**
LSMS	**Local Security Management Specialist**

9 Document Control

Consultation record

Relevant service	Speciality, Sponsor or User Group name	Individual's name	Job title	Date consulted	Date feedback received
Adult Safeguarding		Fiona Crimmins		Throughout	
Learning Disabilities		Lynne Ramnanansingh		Throughout	
Children and Young People		Joanne Farrell	Matron	Throughout	
		Elizabeth Alton	Resus. officer		
		Lynn Sanders	Matron AMU		
		Jackie Thompson	Matron ED		
		Dr Barbara Bray			
		Sally Brittain	Deputy Chief Nurse		

Appendix 1 Equality Analysis (EqA)

By completing this document in full you will have gathered evidence to ensure, documentation, service design, delivery and organisational decisions have due regard for the Equality Act 2010. This will also provide evidence to support the Public Sector Equality Duty.

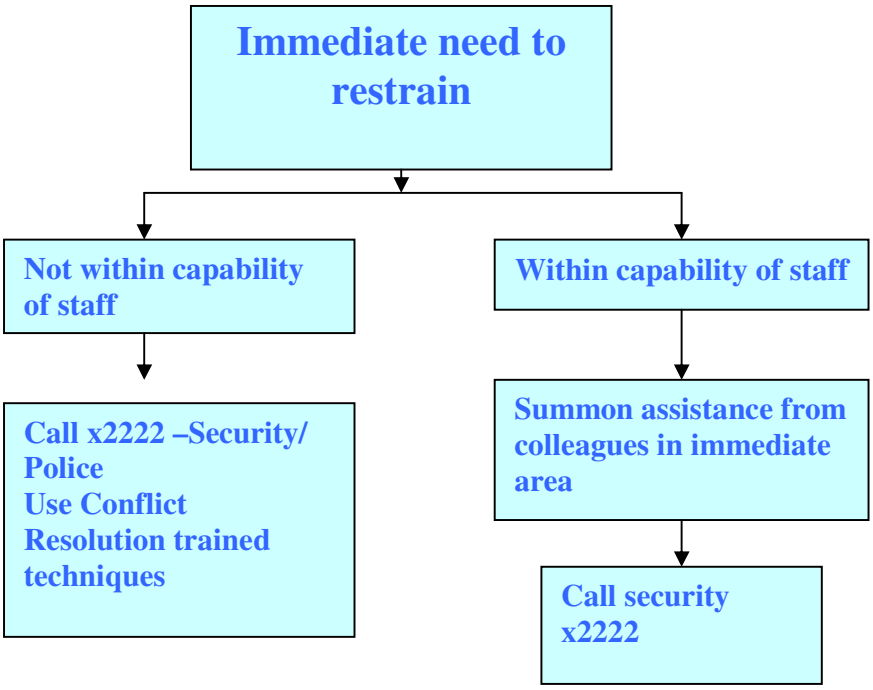
Name of the policy / function / service development being assessed	Safer Holding Policy	
Date last reviewed or created & version number	May 2014 – new policy	
Briefly describe its aims and objectives:	To achieve a safe and secure environment for our p	
Directorate lead	Chief Nurse	
Target audience (including staff or patients affected)	All staff	
Screening completed by (please include everyone's name)	**Colin Pink, Corporate Governance Manager** **Richard Bridgman, Security Manager**	**Date: May 201**

Equality Group ***(Or protected characteristic):***	**What evidence has been used for this assessment?**	**What engagement and consultation has been used**	**Identify positive and negative impacts**	**How are you going to address issues identified?**	**Lead and Timeframe**
Age	All age ranges	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Disability	May impact on this patient group	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Gender reassignment	N/A	N/A	N/A	N/A	N/A
Marriage & Civil partnership	N/A	N/A	N/A	N/A	N/A
Pregnancy & maternity	May impact on this patient group	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Race	N/A	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Religion & Belief	N/A	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Sex	Safer handling	N/A	N/A	Nationally Approved	N/A

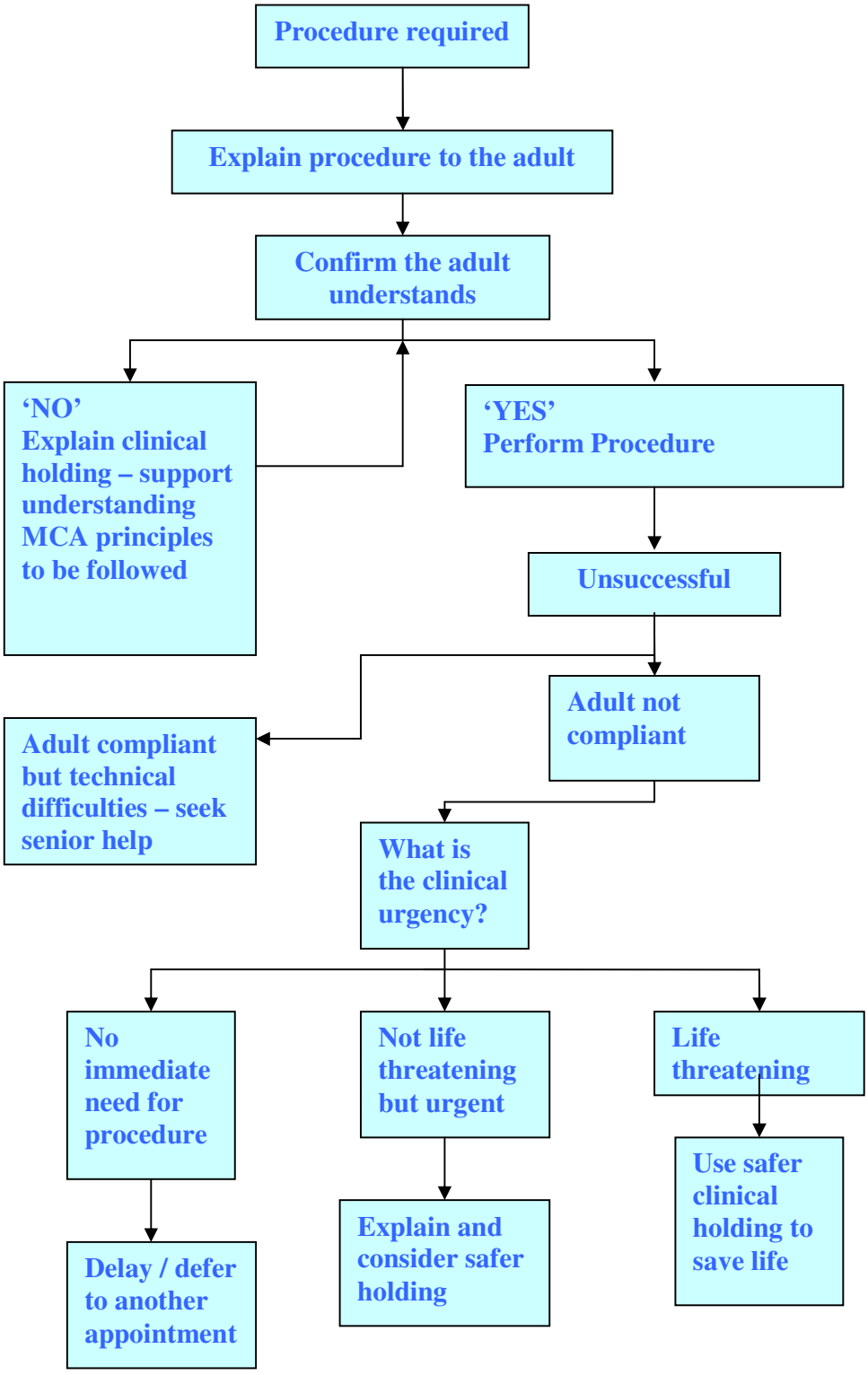
	techniques do not differ for gender			Techniques trained by external competent person	
Sexual orientation	Safer handling techniques do not differ sexual orientation	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A
Carers	N/A	N/A	N/A	Nationally Approved Techniques trained by external competent person	N/A

Appendix 2

Quick reference algorithm – non-clinical



Appendix 3 - *Quick reference algorithm – adult - clinical*



Appendix 4 - *Quick reference algorithm – children*