

# Therapeutic safe holding with children and young people in hospital

Robert Kennedy and Frances Binns on developing a strategy for safe holding in a large tertiary hospital

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## Abstract

This article demonstrates how a strategy to improve patient safety and the patient experience in hospital health care was implemented in a large tertiary children's hospital. A children and young people's therapeutic safe holding policy and training programme for all clinical nursing staff was developed and introduced. The strategy aimed to define best practice and equip healthcare professionals with the appropriate tools to deliver care safely, effectively and in the best interests of the child or young person.

## Keywords

autism, child health, healthcare interventions, learning difficulties, paediatrics, pain, play, therapeutic safe holding

THERE IS well documented evidence that distress in childhood can have a negative effect on the emotional development of a child; it may also lead to physical and psychological problems in later life (Heim and Nemeroff 2001, Hoeksma *et al* 2004). It is imperative, therefore, for all healthcare professionals to recognise situations in which practical interventional strategies may be required and to have an understanding of de-escalation techniques.

All interventions involving children and young people need to be planned and delivered with care, compassion and advocacy, which must be central to every professional's practice (Nursing and Midwifery Council (NMC) 2015, Central Manchester University Hospitals NHS Foundation Trust (CMFT) 2012). This is especially important as, increasingly, more children and young people with complex needs, learning disabilities and/or autism are

being admitted to tertiary services for inpatient and outpatient procedures (Department of Health (DH) 2014). When involving a child in a procedure or gaining consent for a nursing/medical intervention it is essential to employ positive actions/interventions on behalf of the child (Alderson 2008, NMC 2015). Non-compliance/concordance can result in care being rescheduled and any delay or postponement can have a potentially deleterious effect on the child and family (LeBel *et al* 2004).

'Supportive holding' in children's nursing remains a complex and often misinterpreted function of physical intervention during procedural care delivery with the child and family. Children with severe challenging behaviour, autism or complex learning difficulties may also require complex interventional management.

It is widely recognised that 'restraint' is not appropriate in clinical practice as the concept can be associated with negative connotations (Hamers 2015). However, there is a clear difference between the concepts of 'restraint' and 'supportive holding', particularly in children's nursing and health care.

Chambers and Jones (2007) indicate that this is a complex and often misinterpreted function/physical intervention in children's clinical practice. Early theorists such as Erikson (1950) suggested that such negative experiences could have potentially long-lasting and deleterious effects on the child.

Practitioners must be acutely aware of how interventions requiring restriction of movement can affect a child and recognise that the child may be ill-equipped physically and emotionally to deal with the consequent restriction on their liberty and movement (Bloom 1956, Hoeksma *et al* 2004).

Critical incident reporting and review as part of the children's hospital audit of the patient experience during care delivery to children and young people identified the need for complex interventional management; this includes the safe holding of the patient, particularly those with severely challenging behaviour. Literature reviews indicate that safe holding of the patient, which can be defined as 'restricting the movement of a child for a clinical procedure' (Royal College of Nursing (RCN) 2010, Brenner 2014), is commonplace in children's hospitals to deliver safe and appropriate care during a wide range of clinical procedures.

It was clear to the authors of this paper from reviewing the clinical incidents, listening to service users and staff members that there was a need for further staff education and training in managing the best interest of this client group.

There is professional and legislative guidance about the use of physical interventions (RCN 2010, National Institute for Health and Care Excellence (NICE 2015). In the context of the published guidance, the authors undertook a scoping exercise to ascertain the provision of training on safe holding nationally. This revealed a lack of availability or provision in child health and acute children's hospital services locally and possibly nationally.

At the Royal Manchester Children's Hospital, children's healthcare practitioners other than those working in child and adolescent mental health services (CAMHS) have historically not received specific training in techniques of 'restrictive physical intervention' and 'therapeutic holding', often relying on the knowledge and skills of a child's parents to support practices such as nasogastric tube insertion or placement of intravenous cannulae.

There was an evident need to equip staff with the appropriate knowledge and skills by providing training programmes locally. Guidance from professional bodies, such as the RCN (2010) and the NMC (2015), recommends that to help identify staff training needs organisations should undertake risk assessments in relation to physical interventions/therapeutic holding involving children and young people in specific clinical areas. However, there appeared to be no clear guidance to advise practitioners performing safe holding techniques. The development of a hospital policy, Therapeutic Safe-holding Policy (2012), was devised and implemented in conjunction with a bespoke training programme in partnership with key service providers including colleagues in CAMHS.

## Rationale

There is a threefold rationale for the training strategy. First, we became aware that the absence of appropriate staff education – and the need to prevent and manage harm and risk to young patients through inappropriate 'holding' or 'restraint' – increased the risk of charges of assault or battery being made, as well as potential physical harm to the patient (Jeffery 2002). Recent high profile cases such as Winterbourne View have highlighted the importance of addressing such issues (DH 2012).

Second, it is important for a large tertiary hospital to demonstrate compliance with international law and professional regulation. Article 19 of the United Nations Convention on the Rights of the Child (Unicef 1989) highlights 'the state's obligation to protect the child from all forms of physical or mental violence, injury or abuse'. In relation to the organisation, the CMFT Nursing and Midwifery Strategy and Children & Young People's Nursing Vision (2012) highlight the duty to 'deliver a high quality patient and family experience' and to foster a 'positive culture' for children and young people throughout all of the hospital services.

It was evident through organisational clinical governance procedures that implementing the policy and training strategy would lead to a significant reduction in the risk of harm to patients and staff from a health and safety perspective and psychological procedural distress.

The strategy was implemented throughout the entire organisation, focusing initially on nurses to ensure adherence in all clinical areas accessed by children and young people.

Third, the training programme aims to provide staff from all disciplines with the appropriate knowledge and skills to adopt a preventive approach to risk management. The NMC Code (2015) identifies that organisations 'work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community'. This is supported by Principle C of the RCN's 2010 guidance on restraint and therapeutic holding, which states: 'Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.'

Government legislation also seeks to regulate the use of safe holding and restraint with children and young people in healthcare settings, and to underpin training strategies.

Acts and documents, such as the Equality Act [Disability Discrimination Act] (2012), The Children Act 1989 and 2004, Every Child Matters (Department for Education and Skills 2005), the Fraser Guidelines (British and Irish Legal Information

**Box 1 Settings and procedures potentially requiring safe holding (patients aged 0-18 years)**

**Types of procedures requiring safe holding**

- Venepuncture/cannulation
- Lumbar puncture
- Nasogastric tube insertion
- Anaesthetic/gas induction
- Dressing change in burns patients
- Aspects of critical care
- Accessing central venous catheters
- Tracheostomy emergency care/procedure

**Settings:**

- Clinic
- Outpatients
- Ward
- Treatment areas
- Anaesthetic rooms
- Critical care areas (burns, paediatric intensive care unit, paediatric high dependency unit)

1985), the Francis Report (2013) and NICE Clinical Guideline 11 (2015a).

**Training programme**

In developing the training strategy, it was important for the hospital not to adopt a one-size-fits-all approach. The training needed to take into account the various settings in which children and young people are cared for and target staff providing treatment where a conflict resolution model may require implementation (Davidson and Wood 2004).

A scenario-based training programme was, therefore, deemed the most suitable, and this focused on the prevention and management of violence and aggression perspectives of therapeutic holding, but more especially the aspects of therapeutic holding.

The prevention and management of violence and aggression service, for an external NHS foundation trust, was asked to develop a bespoke training package for the tertiary children's hospital. The training focused on team physical interventions

**Table 1 Sample scenarios**

Scenario 1	Number of people	Environment
<ul style="list-style-type: none"> <li>■ Child, aged two years, requires a general anaesthetic</li> <li>■ Child/young person, aged 14 years with specific needs, such as severe autism, requires a general anaesthetic</li> </ul>	Generally four to five people are available for the procedure: <ul style="list-style-type: none"> <li>■ Anaesthetist</li> <li>■ Operating department assistant</li> <li>■ Parent/carer</li> <li>■ Nurse escorting?</li> <li>■ Hospital play specialist (HPS) distracting/supporting</li> </ul>	<ul style="list-style-type: none"> <li>■ Children's theatres (anaesthetic room)</li> <li>■ Oncology: day case or radiology</li> <li>■ Magnetic resonance imaging scan</li> </ul>
Scenario 2	Number of people	Environment
Child, aged ten years, requires a lumbar puncture	Can vary: Four to five people in a lumbar puncture list environment: <ul style="list-style-type: none"> <li>■ Nursing staff</li> <li>■ Parent</li> <li>■ Carer</li> <li>■ HPS</li> </ul> On a ward, there can be a maximum of two staff. (Consideration to non-pharmacological pain management coping strategies [distraction].)	<ul style="list-style-type: none"> <li>■ Children's theatres (anaesthetic room)</li> <li>■ Oncology/haematology – day case</li> <li>■ Occasionally, with neonates on a ward/children in isolation, such as the bone marrow transplant unit</li> </ul>
Scenario 3	Number of people	Environment
Child, aged seven years, requires venepuncture/cannulation procedure but is non-concordant	Can vary: one or two, but maybe more, depending on the complexity of the child's behaviour: <ul style="list-style-type: none"> <li>■ Parent/carer</li> <li>■ Nurse carrying out IV procedure</li> <li>■ HPS/distracting</li> </ul>	<ul style="list-style-type: none"> <li>■ Clinic setting</li> <li>■ Day case unit/paediatric outpatient department</li> <li>■ Ward cubicle or bay</li> <li>■ Community emergency department</li> </ul>

that included risk assessment, emergency holding and supportive holding (to facilitate necessary consented clinical interventions); it also used a positive behavioural support model (Chu 2015). Box 1 lists situations in which safe holding procedures might be required, while Table 1 outlines potential scenarios.

The training also incorporated 'physical disengagements', which are designed to support staff who are being physically attacked by enabling them to break away and create space between them and the person carrying out the assault. The programme also included supportive holding for nursing, medical and care interventions. Supportive and effective interventions are based on:

- Individualised patient risk assessment about challenging behaviour or non-concordance.
- Working together to stop violence in the workplace (Dennis 2015)
- Health and safety, safe systems of work and training, in accordance with the Health and Safety at Work etc Act 1974.

### Further proposals

Training started in January 2014, after which delegates completed an evaluation that demonstrated positive learning outcomes. The training records of staff completion are maintained centrally; an annual audit has been planned to measure the efficacy of the training and its effect on clinical practice. Staff training is maintained through attendance at annual updates and planned three-yearly refresher courses.

Currently, the training is available to nursing staff only, however there are proposals to make it available to all disciplines, including allied health professionals and medical staff. There are also plans for future training to incorporate:

- Child safeguarding procedures in the context of physical interventions.
- Physical interventions based on best practice, as detailed in the NICE guideline NG10 (NICE 2015a) and the Mental Capacity Act 2005: deprivation of liberty safeguards.
- Reasonable adjustments, NHS Monitor Framework NHS England (2015); The Equality Act 2010.
- Making reasonable and achievable adjustments: the contributions of learning disability liaison nurses in 'Getting it right for people with learning disabilities receiving general hospitals care' (Macarthur *et al* 2015)

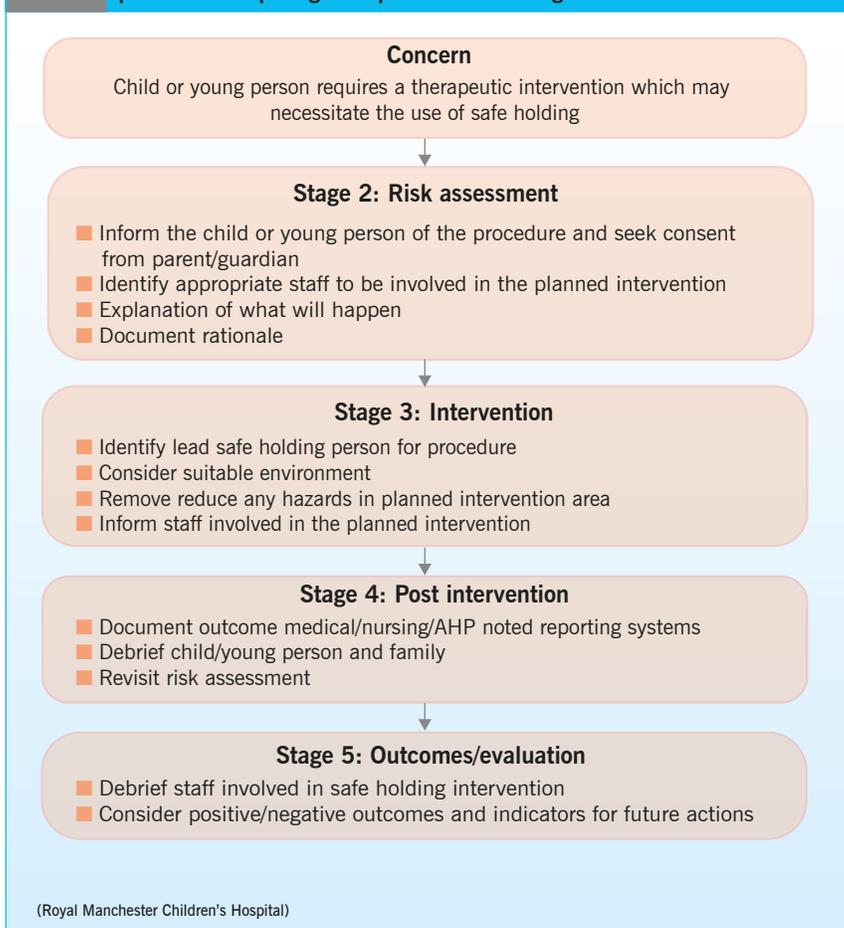
Evaluation and anecdotal service user feedback, as well as increased clinical use (Figure 1), have provided evidence about the benefits of training. The intravenous therapy team has reflected on the positive training outcomes and highlighted the benefits for the child and family

**Figure 1** Example of a safe holding position and distraction technique to support intravenous cannulation



Royal Manchester Children's Hospital. Picture with consent

**Figure 2** Flow chart for managing children and young people undergoing clinical procedures requiring therapeutic safe holding



of such techniques in clinical practice through, for example, non-pain-based touch techniques, whereby the individual is not 'held' or 'restrained' during venepuncture and cannulation procedures (Figure 2).

Taking this approach meets the needs of the individual from a child development perspective because practice and safe holding are determined by the cognitive stage and ability of the child, in partnership with the child (Power 2002, DH 2004), but also considers the perception of others/parents/professionals. In addition, it meets the requirements of the Mental Capacity Act 2005 Code of Practice (Department for Constitutional Affairs 2005), by recognising deprivation of liberty safeguards.

## Conclusion

It is imperative that all healthcare professionals focus on minimising trauma that may arise in the course of care. National policy stipulates the requirement to deliver safe and harm-free care to all, including children and young people. However, it is clear that lack of understanding among professional groups, and pressures on time to deliver safe and effective care may lead to misunderstanding, confused concepts about delivery and implementation, a lack of awareness, fear and anxiety among staff over the potential effects on professional status when considering the NMC Code (2015). There may also be

fears of litigation and personal conflicts about caring versus conflict in practice with risk management.

There is scope for all multiprofessional teams to be provided with training that is necessary, effective and reflective to improve patient and staff experience and reducing physical and psychological trauma at each interventional stage of treatment.

To embed this in all aspects of multiprofessional practice and overcome fear and anxiety, such training needs to become part of basic professional training.

## Implications for practice

- The concepts of restraint and supportive holding are different, and nurses need to understand the difference
- Safe holding can be used to restrict the movement of a child for a clinical procedure in the best interests of the young patient
- Children's nurses who are equipped with the right skills can intervene appropriately and safely when a child requires a procedure, such as cannulation
- Training will minimise risk of harm to patients and staff, and help reduce physical and psychological trauma
- Scenario-based training can enable nurses to recognise situations in which safe holding may need to be considered

## Online archive

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### Conflict of interest

None declared

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